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An examination of sexual risk behaviors and future time perspective among African American female juvenile detainees.

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AN EXAMINATION OF SEXUAL RISK BEHAVIORS AND FUTURE TIME PERSPECTIVE AMONG AFRICAN AMERICAN FEMALE JUVENILE DETAINEES

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AN EXAMINATION OF SEXUAL RISK BEHAVIORS AND FUTURE TIME PERSPECTIVE AMONG AFRICAN AMERICAN FEMALE JUVENILE DETAINEES

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Adolescents, specifically detained adolescents, are at high risk for a number of negative health consequences associated with unsafe sexual activity. Youth in detention facilities have presented a series of high-risk behaviors, which have led to high rates of sexually transmitted diseases and unintended pregnancies. The presence of these conditions is indicative of unsafe sexual behavior among this particular subgroup. The purpose of this study was to examine the contribution of the cognitive-perceptual variable, future time perspective (FTP), to understanding the future sexual intentions and past sexual behaviors of African American female juvenile detainees. The study was designed to analyze data collected through a larger experimental study aimed at reducing alcohol and other drug (AOD) use, delinquent as well as risky sexual behavior. A total of 2,279 youth were recruited from two youth detention centers in Georgia. The participants underwent informed assent procedures with project staff and passive parental/guardian consent was used to enroll the participants in the SHARP (Stop HIV and Alcohol Related Problems) project. For the purpose of this study only data from participants who were African American and female were used (n=766). Analyses were conducted on baseline data and the findings revealed that an overwhelming majority of the respondents (86.3%) reported having vaginal sex willingly and 77.1% of the participants had two or more sex partners during their lifetime. Moreover, approximately a third of the participants reported having a STD diagnosis within the last year. Additional analyses revealed that FTP was not related to future safe sex intentions or past

sexual behaviors (i.e. number of sexual partners with and without a condom, medical diagnosis of STDs, and willing engagement in vaginal sex). The findings of this study suggest a need for more research on the effects of FTP on sexual behaviors among the adolescent detained population. Also, HIV prevention programs may be enhanced by modifying their training according to individual differences in time perspective and by educating individuals to envision their future and recognize the consequences of the actions that they take today.

DEDICATION

First, I thank God for His many blessings and mercy. I thank my dissertation chairperson Dr. Connie Kohler and committee members Dr. Agatha Eke, Dr. Diane Grimley, Dr. Alyssa Robillard, and Dr. Toya Russell for their immeasurable guidance and continuing support. Equally important, I would like to acknowledge their commitment and dedication to the health concerns of minority populations, specifically the African American community.

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AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
FTP	future time perspective
HIV	human immunodeficiency virus
PHP	positive health practices
SCT	Social Cognitive Theory
SHARP	Stop HIV and Alcohol Related Problems
STD	sexually transmitted infections
US	United States
YDC	youth detention campus

CHAPTER ONE

INTRODUCTION AND RATIONALE

The acquired immunodeficiency syndrome (AIDS) has heightened society's concern regarding the risky sexual behaviors of African American adolescents and young adults, particularly African American female juvenile detainees. Past research indicates that juvenile detainees in general tend to initiate sexual experiences at an early age, have higher rates of intravenous drug use, and have higher numbers of sexual partners in comparison to their non-detained counterparts which makes them more vulnerable to the human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) (Morris et al., 1995; Weber, Elfenbein, Richards, Davis & Thomas, 1989). Additionally, adolescent female detainee populations have been shown to have earlier ages of sexual onset, experience high rates of sexual activity, exhibit inconsistent condom use, have greater rates of STDs, and have lack of control over certain situations such as condom negotiation and communication of sex history with partners in comparison to their non-delinquent counterparts (Canterbury et al., 1995; Lux & Petosa, 1994).

Juvenile detainees are an ever-growing population in the U.S. In 2003, yearly admissions reached approximately 2.2 million among persons under age 18 (Synder, 2005). Along with the rapid increase of juvenile detainees, the demographics of this population subgroup are also rapidly changing; recently, there has been an increase in female juvenile detainees. Twenty-nine percent (n=643,000) of all juvenile arrests consisted of females younger than 18 years of age in 2003 (Synder, 2005). Furthermore,

race and ethnicity are also variables of concern. African American and Hispanic youth tend to comprise the majority of the juvenile detainee population (six in ten juveniles). Particularly, African Americans are overrepresented at all stages of the juvenile justice system, with 45% of the population in detention or residential facilities being African American (Synder, 2005). The noted increase among African Americans and females as well as the disparity discussed in regards to the prevalence of STDs among this particular population, emphasizes the importance of the need to focus on African American female adolescent detainees.

Adolescents, in general, are at high risk for many negative health consequences related to sexual risk-taking (Kotchick, Shaffer, Forehand, & Miller, 2001); yet, the threat of disease varies across all adolescents. Risk behaviors and prevalence of diseases vary among and within subgroups of adolescents (Vermund, 1989). Several factors contribute to the acquisition of STDs among African American female juvenile detainees including social factors such as high prevalence rates of STDs among their sex partners and biological factors such as cervical ectopy or eversion, and lack of immunity (US Department of Health and Human Services, 1990; Crosby, DiClemente, Wingood, Sionean, & Cobb, 2000). A lack of future orientation may be an underlying cause of African American female detainees' initial and continued participation in risky sex (Lux & Petosa, 1994). At-risk youth who have a positive outlook on their future develop resiliency to risky behaviors (Aronowitz, 2002; Rothspan & Read, 1996). Conversely, a negative viewpoint on the future can lead to an attitude built around instant gratification, engaging in pleasure seeking with no focus on the consequences of present behaviors on future plans (MacLeod, 1995). These behaviors not only jeopardize the health and well-

being of these youth, but they often tend to clash with societal laws thus introducing many adolescents to the juvenile justice system.

Statement of Purpose

The purpose of this study is to examine the contribution of the cognitive-perceptual variable, future time perspective (FTP), to understanding the future sexual intentions and past sexual behaviors of African American female juvenile detainees. Currently, little is known about the relationship between FTP and future sexual intentions, particularly among juvenile detainees. This population in particular is at increased risk for several negative outcomes as they transition into adulthood (Mason et al., 1998). Obtaining an understanding of how African American female juvenile detainees perceive their future could possibly assist in counteracting risky sexual behaviors. The idea of prevention is dependent upon a personal conception of the future. This statement posits that if there is no perceived future, there is nothing worth preventing. With regard to risky sexual behavior, most of the current contraceptive technologies are predicated upon taking an action today to prevent outcomes such as pregnancy and STDs. Particularly, with regard to risky sexual behaviors, a focus on immediate concerns or pleasures can lead to poor health outcomes. For example, given the latency period between the acquisition of the initial HIV infection and the onset of AIDS, individuals who are not focused on the future and who are unable to foresee how current actions may affect their future, may be more likely to place themselves at risk for HIV. Without the understanding of future implications of one's actions there is little reason to believe that one will learn from their mistakes. The onset of HIV does not

change that dynamic; it is actually a product of the dynamic (Blum & Resnick, 1982). Safer sex practices require both planning and forethought in which primary motivation requires a future perspective. Examining past behaviors also can shed light on future behaviors.

Juvenile detainees are a unique population to examine for an orientation to the future because their present activity is currently circumvented due to detainment in a correctional facility. Juvenile detainees are at an increased risk for several negative outcomes as they transition into adulthood (Mason et al., 1998). Currently, there is a lack of research examining the future sexual intentions of detained adolescents and this exploratory study will address the gap and add to this particular field of research. An understanding of how adolescents, particularly juvenile detainees, perceive their future as well as examining the predictors of and protective factors for risky sexual behavior among African American female adolescent detainees could provide a basis for developing effective interventions for protecting them from future high risk sexual activities. Toward this end, two central questions will guide this inquiry:

(1) To what extent does a positive view on the future relate to future safe sex intentions?

(2) To what extent does a positive view on the future relate to past risky sexual behaviors?

(3) Is the relationship of FTP to future safe sexual intentions different when controlling for past risk sexual behaviors?

CHAPTER TWO

LITERATURE REVIEW

This research examines the relationship of FTP to risky sexual behaviors among adolescent female detainees. Accordingly, the review of the literature covers (1) risk and adolescence, (2) sexual risk behaviors among adolescents, (3) sexual risk behaviors among juvenile detainees, (4) sexual risk behaviors among African American female juvenile detainees, (5) description of FTP, (6) FTP and sexual risk behaviors among adolescents, and (7) the underlying theoretical foundation.

Risk is a normal part of adolescence (Baumrind, 1983). Adolescents are often labeled as risk takers because they tend to participate in behaviors that are potentially detrimental to their health (Trad, 1993). It is, however, through taking risks that adolescents learn and oftentimes adopt new behaviors and attitudes. This process contributes to creating a sense of personality and identity, which usually exists separately from the persona they portray among family (Trad, 1993). It is also through risk-taking that adolescents gain peer acceptance and respect; cope with anxiety, frustration, and the anticipation of failure; and confirm for themselves and significant others certain attributes of identity (Jessor, 1991).

Risk behaviors also tend to vary individually, serve a range of functions, and have different meanings at various developmental stages during adolescence (Igra & Irwin, 1996). These types of behaviors are often goal directed, seen in combination with one another, and temporary (Igra & Irwin, 1996). Hence, a certain degree of risk and

experimentation is necessary because it allows the adolescent to hone in on adaptive behavioral skills (Trad, 1993), and it becomes a substrate for cognitive growth (Blum & Resnick, 1982). Previous research has shown that individuals who engage in risky behavior tend to focus on the gains, while those that avoid risk tend to focus on potential losses (Lopes, 1987). The more restricted an individual's range of life experiences the fewer resources one has to draw upon for problem solving. It is from experimentation that the boundaries of one's potential are learned and one begins to develop an internal locus of control (Blum & Resnick, 1982).

Sexual Risk Behaviors among Adolescents

As of December 2004, the Centers for Disease Control and Prevention (CDC) reported that there were 40,059 cumulative AIDS cases among adolescents and young adults ages 13 to 24 (CDC, 2005a). In addition, it was projected that there were 9,362 persons diagnosed with AIDS in 2004 between the ages of 25 to 34, in which the disease may have been transmitted during adolescence (CDC, 2005a). HIV and other STDs have disproportionately affected African American adolescents in comparison to their non-Hispanic white counterparts. Comprising of only 15% of the adolescent population in the United States (U.S.) in 2003, African American adolescents represented 66% of reported AIDS cases reported among 13 to 19 year olds (CDC, 2005b). Non-Hispanic whites accounted for 63% of the adolescent population in the US and represented only 11% of the reported AIDS cases among 13 to 19 year olds in 2003 (CDC, 2005b). Particularly, African American female adolescents are at especially high risk for HIV/AIDS and STDs. In 2002, seventy-two percent of the total HIV infection cases among adolescent

females ages 13 to 19 were African American in comparison to 20% among their non-Hispanic white counterparts (CDC, 2002). It has been further noted that the majority of adolescents within the U.S. are sexually active; however the percentage of sexually active adolescents in some minority populations exceeds 80% (Reitman et al., 1996). This statement supports that there is variance in the amount of sexual risk among minority adolescent populations.

Risky sexual behavior, in particular, is the underlying cause for the significant increase in STDs and HIV among the adolescent population. It can be defined as any risky sexual behavior that may increase the risk of contracting HIV, STDs, or becoming pregnant (Taylor-Seehafer, & Rew, 2000). These behaviors can include early age of sexual onset, inconsistent condom use, engaging in sexual intercourse with multiple and/or high-risk sexual partners (injection drug users, survival sex), or substance abuse (Alexander & Hickner, 1997; Aral, 1994; Keller et al., 1991; Kingree & Betz, 2003; Kotchic, Shaffer, Forehand, & Miler, 2001; Miller, Cain, Rogers, Gribble, & Turner, 1999; Santelli & Beilenson, 1992; Shafer et al., 1993). Other contributing factors noted to play a role in explaining why adolescents may participate in risky sexual behavior are developmental influences, race, gender, and delinquency (Morris et al., 1995; Stevens-Simmon & McAnarney, 1996; Sieving, et al., 1997).

Developmental influences play a major role in the sexual risk taking behaviors of adolescents. This particular stage in life is filled with rapid physical and sexual development (Hiltabiddle, 1996); yet, sexual growth and psychosocial maturity do not complement each other in all adolescents. This can be particularly problematic in those adolescents who physically mature more rapidly than their counterparts. Often

adolescents' reproductive and psychosocial maturity timing is off and therefore, they may engage in social relationships for which they are cognitively unprepared (Gross & Duke, 1980). Previous research states that early pubertal maturity often leads to an earlier age of sexual onset for both males and females (Capaldi, Crosby, & Stoolmiller, 1996; Miller, Norton, et al., 1997; Miller, Norton, Fan, & Christopherson, 1998; Resnick, et al., 1997).

Race and gender have also been noted as correlates of risky sexual behaviors among adolescent populations (Sieving, et al., 1997). Specifically, African American female adolescents are particularly at risk for STDs and HIV (CDC, 2002). It was noted that African American female adolescents are more likely to report early sexual initiation (before the age of 13) and have multiple partners in comparison to their non-Hispanic white and Hispanic counterparts (CDC, 1998; Taylor-Seehafer, & Rew, 2000). It has also been noted that African American female adolescents participate in sexual intercourse with older men who are more likely to be infected with HIV (Sweeney, Lindegren, Buehler, Onorato, & Janssen, 1995).

Sexual Risk Behaviors among Juvenile Detainees

An additional factor that is linked to participating in risky sexual behavior and risky behavior in general is juvenile delinquency. Youth involved in the juvenile justice system have been characterized by a myriad of behavioral, physical, and social problems. Juvenile detainees, due to their behavioral problems, tend to be disenfranchised from traditional medical services in the community. Indicative of both their personal behavior and their lack of adequate prior health care services, they also have a greater than expected rate of certain physical and emotional problems, such as substance abuse, STDs,

unplanned pregnancies, and psychiatric disorders (Council on Scientific Affairs, 1990). According to recent research, youth entering the juvenile justice system are more likely to suffer from health problems, particularly STDs, in comparison to youth in the general population (Kaplan et al., 2001). Hein and colleagues (1980) noted that 46% of detained youth enter facilities with some type of medical problem. These health concerns include dental issues, hypertension, history of sexual abuse, asthma, or history of fractures and serious accidents (American Academy of Pediatrics, 2001; Carper, 1974; Lewis, Feldman, & Barrengos, 1985).

Detained adolescents have participated in high risk behaviors (i.e. prostitution, exchanging sex for drugs) oftentimes leading to arrest; therefore, one might expect an elevated risk for disease, specifically HIV and STDs among this particular subgroup (Canterbury et al., 1995). These risky behaviors often lead to poor health outcomes. Recent statistics given by the Institute of Medicine (IOM) suggest that almost 15% of male adolescent detainees and 30% of female adolescent detainees are infected with chlamydia and/or gonorrhea at any given time. These rates among adolescent detainees are higher than those among non-detained adolescents (IOM, 1997).

Past studies have investigated the predictors of HIV preventive sexual behaviors among juvenile delinquents. DiClemente (1991) surveyed 112 sexually active incarcerated adolescents at a detention facility in San Francisco, CA. The participants completed a questionnaire developed by the CDC, which assessed their knowledge of AIDS, and risk-reduction, perceived peer norms, perceived susceptibility, prevalence of sexual behaviors, and the frequency of condom use. The results indicated that a high proportion of the adolescents had three or more partners in their lifetime (n=98, 87.5%)

and within the year of participating in the survey (n=83, 73.8%). The results also revealed early sexual initiation (before the age of twelve) among 52.1% (n=58) and low frequencies of condom use in which 34.6% (n=39) reported rarely or never using condoms. Significant factors that were associated with condom use included race, communication about AIDS with sex partners, and perceived peer norms. Only 19% (n=13) of the African American adolescents were consistent condom users in comparison to 43% (n=16) of the adolescents in the non-African American group (p=0.01). This particular sample was disproportionately male (n=84, 76.4%) and African American (n=71, 65.1%) (DiClemente, 1991). In a subsequent study conducted by DiClemente and colleagues (1991), incarcerated youth (n=113) were less aware of HIV risk-reduction behaviors and had higher rates of HIV risk behaviors in comparison to their non-detained counterparts (n=802).

Shafer et al. (1993) analyzed the relationship between drug use, sexual behaviors, and the occurrence of STDs among male adolescent detainees. Four hundred fourteen sexually active male adolescent detainees, ages 12 to 18, participated in an interview and clinical assessment. The majority of the participants was African American (n = 272, 65%) and had approximately three prior detentions (n=115, 28%). The interview, which was conducted by a trained researcher, focused on lifetime sexual and drug behaviors during the previous three months before being detained. The results indicated that these youth were more likely to use condoms consistently, had a higher prevalence rate of STDs, and reported a greater number of lifetime partners compared with non-detained male counterparts. A diagnosis of at least one STD at entry into the facility was found in 15% of the participants tested (including chlamydia, gonorrhea, and hepatitis B.).

Additionally, the median number of lifetime partners was twelve and only 22% (n=91) reported that they always used condoms. Significant factors that were associated with inconsistent condom use included frequent alcohol use, type of partner (primary or other), and multiple sexual partners. Particularly, for the African American/multi-ethnic subgroup, inconsistent condom use was significantly associated with frequent alcohol use (Shafer, et al., 1993).

In a similar study, Magura and colleagues (1994) assessed condom use among criminally involved minority male adolescents. The sample consisted of 421 sexually active minority male adolescents from the Adolescent Reception Center on Rikers Island in the New York City jail. The majority of the sample was African American (n=245, 58.2%) who ranged in age from 16 to 19 years. The participants completed a confidential ninety-minute personal interview which assessed several variables such as family background, health status, criminal activities, alcohol/drug use, sexual behavior, and attitudes toward drugs, sex, condoms, and AIDS. Results revealed that inconsistent condom use was typical in this sample with 17% (n=72) reporting they never use condoms and only 15% (n=63) reporting that they use condoms every time during sexual intercourse. Also, the median number of sexual partners among this sample was three. Significant associations with condom use were sexual preference, condom acceptability, condom accessibility, self-initiation of condom use, and self-efficacy to avoid AIDS (Magura, Shapiro, & Kang, 1994).

More recent studies on delinquent adolescents have revealed similar findings. In a cross-sectional study conducted by Canterbury and colleagues (1995) (n=1,215), 76% reported having three or more sex partners, 20% reported never using condoms, and 19%

had a current diagnosis of at least one STD. The participants were predominantly African American (66%) and male (89%) who were from several juvenile correctional facilities in one state. The mean age of the study participants was 15.7 years with a range from 12 – 19 years. Upon arrival to the facilities, medical histories were recorded and physical examinations were given to each participant within twenty-four hours. Data was collected via chart abstraction by the investigators, which included demographic variables, health status, sexual behaviors, and specific HIV risk behaviors. Female adolescents were more likely to have a current diagnosis of chlamydia, trichomonas, and gonorrhea than the males. Forty-four percent of the females compared to 19% of the males reported having a past history of STDs. With regard to sexual partners, 79% of African American males and 70% of the white males reported having three or more partners. Also, significantly more African American males (10%) had a current diagnosis of chlamydia/non-gonococcal urethritis than the white males (6%). The females differed only in that the African American females were more likely to be diagnosed with trichomonas (21%) compared to white females (2%) and white females were more likely to report having sex with a known risk partner (19%) than their African American counterparts (2%) (Canterbury, et al., 1995).

Through a retrospective study, Morris and colleagues (1998) monitored the variations in HIV risk behaviors among incarcerated juveniles over a four-year period. The sample comprised of 18% (n=1,204) females with a mean age of 16. Over the course of the study, the racial mixture varied with Hispanics (n=3,458) increasing while African Americans (n=2,156) and whites (n=614) were decreasing. The participants were offered a brief 45 – 60 minute presentation, which described the risk behaviors that are

commonly linked with the acquisition of HIV. Following the presentation, the participants were given the opportunity to be individually counseled by a trained health educator who used a standardized questionnaire to assess their risk behaviors. The questionnaire included items such as alcohol and illicit drug use, sexual history, attitudes towards condoms, and the perception of vulnerability to AIDS. It was noted that 96% of the sample reported being sexually active with 2.1 being the mean number of sexual partners regardless of the age of sexual initiation. Results also revealed that the number of adolescents worrying about AIDS and considering themselves vulnerable to the disease increased, however, the overall protective behaviors remained constant. Among this particular cohort, condom use for vaginal intercourse during the first three years was infrequent due to the majority of the sexually active participants (71%) reporting never using a condom and only 5% using a condom 100% of the time. Condom use was associated with the intention to prevent STDs and pregnancy as well as gender (females were more likely to use condoms than males) (Morris, et al., 1998).

Kelly and colleagues (2000) assessed the prevalence of chlamydia among juvenile delinquents in two juvenile detention facilities in San Antonio, TX. The sample consisted of 135 males and 65 females ranging in age from 12 to 17 years. Results indicated that 92% of the sample was sexually active with a mean of 7.3 lifetime sexual partners. Approximately 17% of the participants had a history of STDs and the majority was sexually active before the age of 13 (69%). A higher proportion of females reported previous treatment for a STD (25.4%), injection drug use (11.7%) and anal intercourse (22.8%) in comparison to the males, whereas, a larger number of males reported having a tattoo (59.2%) and having more than five lifetime sexual partners (52.8%). Also, the

prevalence of chlamydia was 8.7% among the males and 22.2% among the females, in which injection drug use was the only significant correlation (Kelly, Bair, Baillargeon, & German, 2000).

More recently, Teplin and colleagues (2003) reported on the sexual risk behaviors of juvenile detainees (ages 10-18) detained between 1995 and 1998 at the Cook County Juvenile Temporary Detention Center in Chicago, IL. The sample (n=800) comprised of 460 (57.5%) males and 340 (42.5%) females, with the majority being African American (n=430, 53.8%). The adolescents were interviewed about their HIV/AIDS risk and drug use. More than 91.0% of the males and 86.7% of the females were sexually active. The males (60.8%) were significantly more likely than the females (26.3%) to have more than one sexual partner in the last three months ($p<0.001$). This was also significant in regards to race/ethnicity in that a greater proportion of African Americans (64.7%) reported having more than one partner in the past three months compared with non-Hispanic whites (32.7%) ($p<0.001$). Additionally, it was reported that non-Hispanic white females (61.8%) were more likely to have unprotected vaginal sex within the past month than their African American (35.5%) and Hispanic (42.5%) counterparts (Teplin, Mericle, McClelland, & Abram, 2003).

Sexual Risk Behaviors among African American Female Juvenile Detainees

Females in detention facilities have been described as being at an even greater risk for STDs (Kaplan, et al., 2001). More specifically, female adolescent detainees have one of the highest rates of STDs and unintended pregnancies in comparison to their non-detained counterparts (Canterbury et al., 1995). There is, however, limited research

describing this particular population. In a cross-sectional study examining the acceptability of a urine-based test for STDs, African Americans consisted of 69.6% of the sample. Approximately seventy-two hours after admission to the facility, the project staff informed the participants that their urine samples could also be used to test for chlamydia and gonorrhea. The participants were then asked for permission to use their urine sample for this purpose. As a result of the testing, chlamydia and gonorrhea infections were found in 28.3% and 13.1% participants, respectively. Also, one third of all female participants were diagnosed as positive (via urine-based DNA amplification tests), for one or both of the infections (Oh et al., 1998).

In the previously mentioned study conducted by Canterbury and colleagues (1995), 44% of females reported a history of STDs in comparison to 19% of the male participants; however there were no reported differences in risk behaviors among the males and females. Also it was noted that, 21% of the African American adolescent females were positive with trichomonas in comparison to 2% of the white adolescent females (Canterbury, et al., 1995). Moreover, in a cross-sectional analysis of Gilmore et al. (1994), questionnaires were administered to 201 detained adolescents with a mean age of 16 years. The sample was evenly stratified on gender and race (African American and white) with approximately equal numbers in each group. Results indicated that lack of condom use was found among this particular sample. Particularly, the African American female adolescent detainees were less likely to use condoms with casual partners in comparison to their white counterparts (Gillmore, Morrison, Lowery, & Baker, 1994).

Morris and colleagues (1995) surveyed adolescents in thirty-nine juvenile detention facilities across the U.S. Medical staff administered a revised version of the

CDC Youth Risk Behavior Surveillance System (U.S. Department of Health and Human Services, 1990) to 1801 participants. The questionnaire included items such as school performance, drug use, sexual behavior, and sexual abuse. The sample consisted of 12.2% females and the largest subgroup was white females (41.4%). Findings revealed that having multiple partners and pregnancy was strongly correlated with being African American. It was also noted that African Americans had the highest rates of STDs which was strongly correlated with being female, African American, and having multiple sex partners (Morris, et al., 1995). Risky sexual behavior among African American female juvenile detainees is an area that warrants further exploration. An investigation of how African American female juvenile detainees view their future may provide an explanation of why they are more likely to participate in risky sexual behavior.

The Concept of FTP

FTP is defined as "the degree to which the future is perceived as predictable, structured, and controllable" (Heimberg, 1963). As such, it provides the framework for setting goals, effective planning, exploring options, and making commitments. FTP is also considered an important aspect of adolescent development in that this particular population is ever experiencing developmental and transitional periods in which they are normatively expected to prepare for what lies ahead. FTP is primarily the image that individuals have regarding their future, similar to an autobiography (Seginer, 2003). "It tells a personal subjective life story consisting of those life domains individuals deem important, and gives meaning to one's life" (Seginer, 2003).

FTP has also been labeled as a cognitive-motivational concept because it primarily results from motivational goal setting (Nuttin, 1980). Time perspective can be viewed from a present or future stance and has been labeled as a construct underlying various types of risky behaviors (Blum & Resnick, 1982; Wills, Sandy, Yager, 2001; Zimbardo, Keough, & Boyd, 1997). Individuals are not born with a notion of time; rather it develops during early childhood (Blum & Resnick, 1982; Gonzales & Zimbardo, 1985). This above reasoning suggests that time perspective may be related to the early onset and continuation of risky sexual behavior.

A perspective of time affects decision making through identifying the primary set of psychological influences within the temporal framework of the present or future. Some individuals will give attention to future consequences; whereas others will tend to focus on the present (Zimbardo, Keough, & Boyd, 1997). This suggests that those who are future oriented are more likely to engage in preventive health practices so as to attain outcomes anticipated in the future, whereas those who are present oriented will more than likely respond to immediate situational factors (e.g. peers' approval) (Wills, Sandy, & Yeager, 2001). Individuals who are predominantly present oriented tend to focus on immediacy, not focusing on how current behavior could possibly affect (positively or negatively) their future (Eisenberger, 1992; Rothspan & Read, 1996). These individuals tend to lack goal-oriented behavior, have a limited sense of control, and a propensity for immediate gratification. Hence, this type of individual may be more willing to participate in risky sexual behavior, have more sexual partners, and be less selective in their choice of partners (Rothspan & Read, 1996). One could label these individuals as fatalists – those who feel that they have no control over their actions. They tend to feel that their

current actions are insignificant and they oftentimes become inactive and passive (Blum & Resnick, 1982). Consistent with this notion, Kelly and colleagues (1990) found that gay men who believed that they had little control over the likelihood of infection and that infection occurs by chance also reported more sexual partners and were highly likely to engage in unprotected intercourse. Previous research has shown that present oriented individuals were more likely to be sexually experienced and have more sexual partners (Rothspan & Read, 1996).

Individuals who have a positive FTP tend to develop resiliency to risky behaviors (Aronowitz, 2002) and are more likely to avoid future illnesses. Many of the behaviors necessary for a healthy lifestyle, including safer sex, are future oriented. Advanced goal setting, preparation, and the forethought necessary for safer sex make it an inherently future-oriented task. Jorgenson (1978) found a non-significant tendency for those who were future oriented to use a variety of birth control techniques. Similarly, Oskamp and colleagues (1974) found that successful users of contraceptive devices were more future oriented.

FTP and Sexual Behavior among Adolescents

Previous research has also investigated and further defined the relationship between FTP and sexual behavior. Blum and Resnick (1982) examined the relationship between developmental influences and adolescent sexual decision making among various subgroups designated by the authors (contracpetors, aborters, pregnant teenagers, and adolescent mothers). The sample consisted of 206 sexually active adolescent females with a mean age of 17.1 years. Approximately two thirds of the sample was white, one

third was African American, and 5% was Native American. The participants completed six pencil-and-paper tasks, which were followed by an intervention that focused on critical incidents of sexual decision-making along with associated family and peer pressure. The results revealed that female adolescents who chose to abort pregnancies were those with the most developed FTP. It was noted that this particular subgroup had "the capacity to understand future consequences" (Blum & Resnick, 1982) in comparison to the other groups. Teen mothers, on the other hand, had the least developed conceptualization of the future. They were found to have the highest level of anxiety and the most external locus of control in comparison to the other groups studied. The teen mothers also tended to be less aware of the future implications of raising a child (Blum & Resnick, 1982).

DiIorio and colleagues (1993) hypothesized that FTP would be associated with safer sex practices among college freshmen. College students (n=352), from two institutions, were surveyed on their knowledge of AIDS, misconceptions about AIDS, knowledge of safer sex practices, perceived susceptibility, and FTP with regard to the practice of safer sex behaviors. The sample was predominately African American (n=246, 69.9%), male (n=312, 88.6%), and 18 years of age (n=320, 90.9%). Among African American males, there was a significant correlation between FTP and safer sex practices ($r=0.22$, $p=0.002$) as well as a significant correlation between misconceptions and safer sex practices ($r=0.12$, $p=0.045$). Hence, one could possibly conclude that the African American males in this particular sample, who perceived the future as more predictable and controllable, were more likely to report safer sex practices and they also held fewer misconceptions about the transmission of HIV. FTP did not correlate with

safer sex practices for either white males or white females. Unfortunately, the author noted that the sample size for the African American females was too small for analysis (DiIorio, Parsons, Lehr, Adame, & Carlon, 1993).

Rothspand and Read (1996) examined the relationship between time perspective, sexual behavior, gender, and the fear of AIDS. The participants were college students attending the University of Southern California participating in an introductory psychology course. There were 65 men and 123 women ranging in age from 17 to 28 years of age. All participants self-reported being unmarried and heterosexual. The participants completed a survey assessing time orientation, past sexual behaviors, and concerns regarding AIDS. The findings indicated that future time orientation was significantly correlated with being less likely to have engaged in intercourse ($p<0.01$) and having fewer sexual partners (lifetime ($p<0.01$) and in the past six months ($p<0.01$)). Having a present-time orientation, particularly hedonism, was significantly correlated with being more likely to have engaged in intercourse ($p<0.01$). Additionally, those individuals labeled hedonists and fatalists were more likely to report having more lifetime sexual partners ($p<0.05$) and more sexual partners over the previous six months ($p<0.05$) (Rothspan & Read, 1996).

Moreover, among a convenience sample of homeless youth (n=414), Rew and colleagues (2002) examined the effects on the outcomes of sexual health practices of homeless adolescents. The majority of the sample was Anglo-American (75.4%) and male (58.9%), ages 16-20. The youth were surveyed via a street outreach program in central Texas. The results revealed that safe sex behaviors was significantly related to FTP ($r=-0.22, p=0.001$), social support ($r=-0.20, p<0.001$), connectedness ($r=0.14,$

p=0.005), perceived health status (*r=0.17, p=0.001*), assertive communication (*r=0.32, p<0.001*), and sexual self-care behavior (*r=0.24, p<0.001*) (Rew, Fouladi, & Yockey, 2002).

In a more recent study by DiIorio and colleagues (2004), FTP was examined as one of many protective factors in a model determining if the likelihood of sexual behaviors for adolescents exposed to sexual possibility situations would vary across levels of protective factors. The sample consisted of 491 boys (61.5%) and girls (38.5%) who were members of several community-based organizations in a southeastern state. The youth had a mean age of 12.3 years and were predominantly African American (98.6%). Data were collected through an interview, which assessed sexual intercourse and the use of HIV risk reduction practices such as self-efficacy, outcome expectations, sex-based communication, self-concept, FTP, and parenting. The results revealed that in terms of protective variables, FTP was not a significant predictor, however, behavior self-concept, popularity self-concept, self efficacy for abstinence, outcome expectations for abstinence, parental control, and personal and parental values were all statistically significant predictors (DiIorio, Dudley, Soet, & McCarty, 2004).

In summary, mixed results are reported with regard to FTP and its relationship to sexual behaviors among the adolescent population. It should be noted, however, that there were variations in the scales used to measure FTP. The studies that utilized the Heimberg scale (DiIorio et al., 1993 & DiIlorio, Dudley, Soet, & McCarty, 2004) results are also inconclusive and these studies in particular did not use a unique population, which theoretically should have a more present-oriented perspective as described in the next section.

Underlying Theoretical Foundation

The underlying conceptual framework for this research is Bandura's Social Cognitive Theory (SCT). SCT is an interpersonal level theory, which suggests possible links between FTP and health behavior (Mahon, Yarcheski, & Yarcheski, 1997; Mahon, Yarcheski, & Yarcheski, 2000; Rothspan & Read, 1996; Rew, Fousladi, & Yackey, 2002; Yarcheski, Mahon, & Yarcheski, 1997). It attempts to address the dynamics of human behavior, which can be explained by an interaction of personal factors, environmental influences, and behavior (Bandura, 1977a; Bandura, 1986; Bandura, 1989). Some of the "crucial personal factors are the individual's capabilities to symbolize behavior, to anticipate the outcomes of behavior, to learn by observing others, to have confidence in performing a behavior (including overcoming any barriers to performing the behavior), to self-determine or self-regulate behavior, and to reflect and analyze experience" (Baranowski, Perry, & Parcel, 1997). The SCT, which is primarily based on the imitation of behavior, helps to explain how individuals grasp, sustain, and uphold certain behavioral patterns and it further contends that behavior is largely regulated antecedently through cognitive processes (Baranowski, Perry, & Parcel, 1997). It implies that an individual's evaluation of a particular behavior, such as risky sexual behaviors, could possibly result in the recognition of a poor outcome (e.g. the acquisition of HIV).

Expectations of behavioral outcomes are primarily formed through response consequences of a given behavior. Humans have the ability to form these expectations, which in turn grants them the capability to predict the outcomes of their behavior before the behavior is performed. SCT posits that the mind is an active force that constructs

one's reality, selectively encodes information, performs behavior on the basis of values and expectations, and imposes structure on its own actions (Jones, 1989). Ultimately, an individual's reality is formed by the interaction of the environment and one's cognitions. Cognitions do change over time as a function of maturation and experience (e.g. attention span, memory, ability to form symbols, reasoning skills); however, it is through an understanding of the processes involved in an individual's construction of reality that enables human behavior to be understood, predicted, and changed (Bandura, 2001).

The constructs of particular interest in the SCT that relate to FTP and future sexual intentions are outcome expectations, self-efficacy, and self-control. Outcome expectations, also known as antecedent determinants, are an individual's perception of the outcome of a particular behavior. An individual develops expectations for a particular situation and perceives it to happen before one actually encounters the situation (Baranowski, Perry, & Parcel, 1997). Expectations are learned in four ways: (1) through previous experience in similar situations (performance attainment), (2) through mere observation of others in similar circumstances (vicarious experience), (3) through hearing about comparable situations from others or social persuasion, and (4) from emotional or physical responses to behaviors (physiological arousal) (Baranowski, Perry, & Parcel, 1997). One must incorporate information about the likely results of a behavior by highlighting the negative and positive aspects of performing a given behavior (Baranowski, Perry, & Parcel, 1997).

FTP reveals itself in many ways. Individuals oftentimes set goals for themselves and anticipate the likely consequences of those particular goals. They also tend to select and create plans of action to produce positive desired outcomes with attempts to avoid

unfavorable ones. This, in essence, is regulating their behavior by outcome expectations, carefully planning for the future. Through the premise of forethought, individuals are motivated and guide their actions accordingly in anticipation of future events. Over an extended period of time, a forethoughtful perspective provides not only direction, but lucidity, and meaning to one's life. Through the progression of life, individuals continue to grow, preplan, reorder priorities, and structure their lives accordingly (Bandura, 2001). Future events cannot serve as the basis of present motivation because they are indeed a figment of one's imagination, being non-existent. They can, however, be converted into current motivators and regulators of behavior by serving cognitively in the present. This posits that behavior is motivated and guided by probable goals and predictable outcomes rather than being guided by an unrealized future state (Bandura, 2001).

One's ability to bring anticipated outcomes to bear on current activities promotes forethought, therefore, forward-directed planning. Bandura defines forethought as a person's capability to motivate and guide his/her actions anticipatorily (Bandura, 1989). The capacity for forethought enables individuals to transcend the dictates of their immediate environment and construct and regulate the present to mold into a desired future. Previous research indicates that past experiences also create expectations of the outcome that will occur as a result of performing a particular behavior, before the behavior is again performed (Bandura, 1977a). Therefore, expectations of behavioral outcomes, more so than actual outcomes, actually influence the likelihood that a behavior will be performed again. Planning for the future enables individuals to dictate their current environment and to shape and regulate the present to mold into a desired future. The ability to symbolize and think ahead (forethought) leads to specific outcome

expectations that can serve as incentives or disincentives for a particular behavior. Individuals self-regulate their behavior based on these anticipated outcomes (Bandura, 1989). To this end, behavior is influenced when forethought is translated into incentives and action through the self-regulatory mechanism.

Self-reflection enables people to analyze their experiences, to think about their own thought processes, and to alter their thinking accordingly. One of the most important types of self-reflection is self-efficacy, which is an individual's confidence in his/her ability to take action in specific situations. Self-efficacy includes an individual's ability to overcome the barriers to performing the particular behavior (Baranowski, Perry, & Parcel, 1997). According to Baranowski and colleagues (1997), "self-efficacy is the most important prerequisite for behavioral change because it affects how much effort is invested in a given task and what level of performance is attained" (pg. 164). In order to effectively implement a behavior change one must have the (1) knowledge and skills, (2) the self-confidence, and (3) the perception of reward/benefit to perform the behavior (Baranowski, Perry, & Parcel, 1997). It is a type of self-reflective thought that affects one's behavior (Bandura 1977b, 1989). According to the SCT, individuals develop perceptions about their own abilities and characteristics that subsequently guide their behavior by determining what a person tries to achieve and how much effort they will put into their performance (Bandura, 1977b). An individual's self-efficacy develops as a result of his/her history of achievement in a particular area, from observations of others successes and failures, from the persuasion of others, and from one's own physiological state while performing a behavior (Bandura, 1977b).

Based upon the perceptions of self-efficacy is how individuals choose what challenges to take on, how much effort to expend on the particular challenge, and how long to persist. Perceived efficacy is also a strong influence on whether people think optimistically or pessimistically; the course of action they choose to pursue; the goals they set for themselves and their commitment to them; and their resilience to adversity. The likelihood that individuals will act on the outcomes they expect depends largely on if they believe that they can produce the expected outcome (Bandura, 2001). Moreover, any factor, which influences behavior choice, can profoundly affect the direction of personal development. This is due to social influences operating in select environments that may continue to promote certain competencies, values, and interests long after the decisional determinant has rendered its inaugurating effect on the individual's life. Therefore, by choosing and shaping their environments, individuals can have a certain essence of control of what they become (Bandura, 2001). With regard to future sexual intentions, detained adolescents must have the true essence of self-efficacy and realize the long-term benefit of practicing safe sex.

Bandura also proposes that self-regulatory systems mediate external influences and provide a basis for purposeful action, allowing people to have personal control over their own thoughts, feelings, motivations, and actions (Bandura, 1989). Self-regulation is an internal control mechanism that governs what behavior is performed, and the self-imposed consequences for that behavior. Self-regulation allows the gradual substitution of internal controls for external controls of behavior. It occurs through the interplay of self-produced and external sources of influence, including motivational standards and social and moral standards. Individuals continually go through the process of setting

goals for themselves and then comparing that goal to their personal accomplishments. In doing so, standards can motivate a person to work harder or modify their behavior in order to meet a goal or standard. Motivation can occur externally, such as a promised monetary reward for achieving a particular goal, or internally, such as when a person feels self-pride when a standard is reached. Three factors seem to determine the degree of self-motivation that occurs (Bandura, 1986; 1989). First, a person's self-efficacy for a given behavior dramatically affects their self-motivation for performing that behavior. If a person feels they are capable of achieving the goal, then they are likely to worker harder and give up less easily compared to a person who has low self-efficacy. The second factor for self-motivation is feedback. Feedback is an externally imposed control that works with an individual's self-regulatory capability in order to make adjustments to behavior. In addition, receiving feedback on performance accomplishments will improve a person's self-efficacy for the behavior. The third factor that influences self-motivation is the anticipated time to goal attainment. Proximal goals are more effective than distal goals in enlisting self-motivation.

Social and moral values also regulate behavior. The relationship between thought and conduct is mediated through the exercise of moral agency (Bandura, 1986; 1989). Through evaluative self-reactions, such as self-approval or self-reprimand, internalized morals and standards can regulate conduct (Bandura, 1986; 1991). Moreover, it is thought that people develop moral standards from a variety of influences, such as direct instruction, feedback on behaviors from significant others, and modeling of moral standards by others (Bandura, 1986; 1989; 1991). Standards are also developed from institutionally organized systems, such as education, media, religion, political, and legal

agencies. Individuals do not passively absorb all the standards of behavior to which they are exposed. Instead, the standards that are internalized are dependent on the degree to which the model is like oneself, the value of an activity, and one's perception of their degree of personal control over the behavior (locus of control). It is through the process of self-regulation that pro-social behavior can be internally maintained (Bandura 1989; 1991).

Although the SCT is the overall framework of the current study, additional concepts will be included that will contribute to a better understanding of FTP and future sexual intentions – self-esteem. Self-esteem is defined as the individual's assessment or judgment of self-worth (Rosenberg, 1965). It is a personality trait that refers to the degree to which individuals like or dislike themselves (Rosenberg & Kaplan, 1982). Because self-esteem functions as a trait, it is assumed to be stable across time within individuals. According to Maibach & Murphy (1995), self-esteem can moderately influence a wide spectrum of behavioral domains and encompasses the notion of global self-approval.

Self-esteem is generally considered the evaluative component of the self-concept, a broader representation of the self that includes cognitive and behavioral aspects as well as evaluative or affective ones (Blascovich & Tomaka, 1991). While the construct is most often used to refer to a global sense of self-worth, narrower concepts such as self-confidence or body-esteem are used to imply a sense of self-esteem in more specific domains. Self-esteem is widely known in the field of psychology, and has been related to virtually every other psychological concept or domain, including personality (e.g., shyness), behavioral (e.g., task performance), cognitive (e.g., attribution bias), and

clinical concepts (e.g., anxiety and depression). While some researchers have been particularly concerned with understanding the nuances of the self-esteem construct, others have focused on the adaptive and self-protective functions of self-esteem (Blascovich & Tomaka, 1991).

The majority of research exploring the relationship between self-esteem and health appears to have been done in terms of the influence of self-esteem on health-related behaviors. "The original theoretical formulation of positive health practices (PHP) by Yarcheski and Mahon (1989) included the exogenous variables of age, gender, and education, and the endogenous variables of self-esteem, social support, and PHP" (Yarcheski, Mahon, & Yarcheski, 1997). Previous research suggests that self-esteem is a correlate of healthy behaviors. Also, Bandura (1977b) stated, "one's sense of self-worth influences one's behavior." The above statements and the theoretical framework mentioned provide a definitive link between self-esteem and PHP.

In addition, previous research has shown the direct relationship between positive self-evaluations and positive outlooks on future time perspectives in college and high school students (Mahon, Yarcheski, & Yarcheski, 1997; Mahon, Yarcheski, & Yarcheski, 2000; Rothspan & Read, 1996; Yarcheski, Mahon, & Yarcheski, 1997). Therefore, it can be stated that self-esteem plays a significant role in FTP. Inferring from the research and theoretical background cited above, it could be stated that FTP has a direct relationship with PHP. Self-esteem is a correlate of FTP and also has an indirect influence on PHP through FTP (Yarcheski, Mahon, & Yarcheski, 1997). These theoretical components will serve as the framework for this research.

Conceptual Framework

Figure 1 depicts the conceptual framework for the current research. As noted in the framework, an individual's trajectory can be altered due to participation in risky behaviors such as illicit drug use or prostitution. These types of behaviors can oftentimes introduce an individual to the juvenile justice system, which is the population of interest for this particular research. Individuals on this trajectory could possibly discount the future and focus on immediate consequences, thereby lessening their resiliency. Such individuals tend to have a present-oriented perspective while focusing on instant gratification, not honing in on how their current behavior could possibly affect their future. This perspective is likely to be correlated with negative outcome expectations. It is predicted that these individuals will be more likely to have low self-esteem, leading to a lack of self-control and low self-efficacy. Individuals with these types of behavioral characteristics also are expected to have a strong tendency towards inactivity and passivity, which is commonly associated with a present-oriented perspective. The ability to regulate one's behavior based on expectations provides the mechanism for forethoughtful behavior. It is the process of forming symbols that allows individuals to represent future events cognitively in the present (Bandura, 1989). Hence, behavior is influenced when forethought is translated into incentives and action through the self-regulatory mechanism. The boxes with the thicker lines indicate the current research, for which it is predicted that those individuals with a present-oriented perspective (box 1) are influenced by negative outcome expectations (box 2) which are translated to disincentives and a lack of positive future aspirations (box 3). This type of thinking is predicted to be correlated with negative future sexual intentions (box 4).

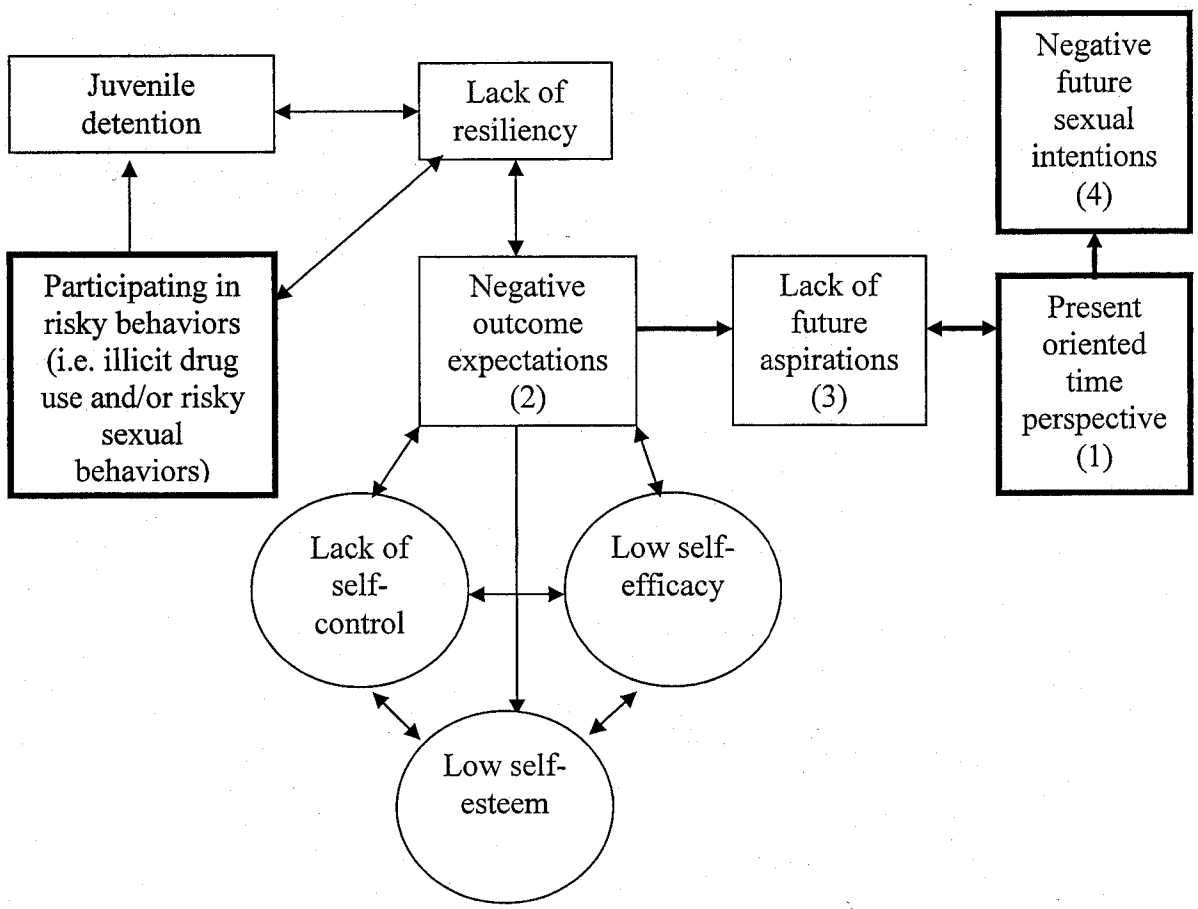

Figure 1. Conceptual Framework.

Summary

Previous research notes that adolescent female detainee populations have been shown to experience high rates of sexual activity, exhibit inconsistent condom use, and lack control over certain situations such as condom negotiation and communication of sex history with partners (Canterbury, et al., 1995; Lux & Petosa, 1994). Accordingly, detained females are disproportionately diagnosed with a number of STDs (Canterbury, et al., 1995). As the representation of females in detention facilities continues to

increase, more attention must be given to the physical, behavioral, and psychological issues that are unique to this population of youth.

Additionally, most of the current research that examines correlates of risky sexual behavior targets African American women to the exclusion of African American female adolescents (Crosby et al., 2000), and more specifically, African American female adolescent detainees. While these studies focus on a range of populations, variables that examine FTP typically are not included in these investigations. Particularly, the studies have not thoroughly examined the relationship between FTP, future sexual intentions, and past sexual behaviors. Qualitative research has indicated that FTP has an important impact on how adolescents view their health, particularly from the present viewpoint (Mahon, Yarcheski, & Yarcheski, 1997; Mahon, Yarcheski, & Yarcheski, 2000; Rothspan & Read, 1996; Yarcheski, Mahon, & Yarcheski, 1997), disregarding future intentions. Juvenile detainees are a unique population among whom present activity is circumvented by their current situation of being in a correctional facility. Therefore, focusing on future intentions for this population subgroup is very important. Hence, the relationship of FTP to future sexual intentions and past sexual behavior among African American female adolescents in detention facilities is an issue of public health importance that must be addressed. To this end, the purpose of the present exploratory study is to examine the contribution of the cognitive-perceptual variable, FTP, to understanding the future sexual intentions and past sexual behaviors of African American female juvenile detainees. The methodology for conducting this research is detailed in the next chapter, and will provide the appropriate framework to begin to understand the

relationship among FTP, future sexual intentions, and past sexual behaviors of detained adolescent females.

CHAPTER THREE

METHODS

Research Design

The current study employed a cross-sectional design in which secondary analyses was performed on baseline data from the parent study, Project SHARP. The participants in the study sample who denoted Black/African American as their racial/ethnic group were selected. Next, those participants who selected the gender category female were selected. This created a purposive sample, in which a small subset of the larger population was chosen, which included only African American females (n=766). All variables that were utilized in this particular study were a part of the parent study, Project SHARP.

Description of Parent Study

Project SHARP (Stop HIV and Alcohol Related Problems) was an experimental study, which addressed the prevention of HIV and alcohol-related problems among juvenile detainees at two youth detention campuses (YDC) in Georgia. Specifically, the study analyzed the effect of a health education program on adolescents' attitudes, knowledge, and beliefs about sexual activity and drug/alcohol use (Braithwaite, Robillard, Woodring, Stephens, & Arriola, 2001; Kingree, Braithwaite, & Woodring, 2000).

Procedure

A research staff member approached youth within three days of their entrance into the YDC to determine their interest in participating in the program. The research staff member briefly described the program by stating that it addressed the prevention of HIV and alcohol related problems. The reading of the assent form to the participants followed the description of the study to the youth. Each youth was then allowed the opportunity to ask any questions related to assenting to participate in the program. The participants who agreed to participate signed an assent form, which authorized the researchers to contact their parent or guardian to request permission for participation. Approximately four weeks after entering the YDC, the assented participants completed the pre-intervention interview and were then randomized to either the experimental or the control group.

The experimental group participated in a health education program, which consisted of eight sessions, sixty minutes in length. During the last four weeks of the youth's stay, a research staff person conducted a post-intervention interview with each girl in the experimental and control groups. All interviews were face-to-face and were conducted by trained research staff that resided in the communities located near the two YDCs. The training of the research staff consisted of an eight-hour group training session. It included a detailed overview of interviewing techniques and a thorough review and clarification of each question in the interview for consistency. For each interview, female interviewers were consistently matched with female participants.

Target Population and Sample

The target population consisted of 2,280 participants, who were recruited from two YDCs. These campuses served adolescent offenders from across the state of Georgia. Over half of the participants were female (n = 1,341, 58.8%) and African American (n = 1,295, 56.8%). The remainder of the sample was as follows: 37.3% (n = 850) were white, 2.2% (n = 50) were Hispanic, 0.7% were Asian (n = 16), 0.4% were Native Americans (n = 10), and 2.5% (n = 57) classified themselves as "other." The participants ranged in age from 11 to 18 (M = 15.18, SD = 1.17) and the average highest grade completed was eighth grade (SD = 1.23). Moreover, 55.5% of the participants had been detained previously because of a separate offense.

The sample used in the current study was comprised of all African American female participants. The seven hundred sixty-six African American female adolescents were selected ranged in age from 11 to 18 years of age (M=14.81, SD=1.23). Approximately half of the participants (n = 372, 48.6%) reported being previously locked up and the number of days that they had been previously locked up ranged from 1 day to 365 days (M=38.0, SD=45.2).

Description of Instruments and Measures

A structured interview questionnaire was used to collect information from the participants via face-to-face interviews. An emphasis was placed on providing self-report measures that were culturally sensitive and age appropriate. Additionally, all measures have been shown to possess good internal consistency as well as predictive validity for the adolescent population. This current study is examining FTP, future sexual intentions, and past sexual behaviors.

Future Time Perspective

In previous research, Heimberg (1961, 1963) developed and refined the FTP Inventory as a measure of the FTP construct. The attributes in the conceptual definition of FTP stem primarily from the rationale used by Heimberg (1961) to construct the FTP Inventory. A self-report inventory was developed by Heimberg in an attempt to measure attitudes regarding the future. Forty-nine items were devised or adapted from the literature (e.g. Israeli, 1935, 1936; Loehlin, 1956) on the basis of hypotheses concerning conceptions and behaviors relevant to FTP. Examples of the items are: "I know the kind of person I would like to be five years from now", "The future seems very vague and uncertain to me", and "I am afraid of getting older." In a pilot study (Heimberg, 1961); the alpha coefficient for the inventory with 49 college undergraduates was 0.86. The inventory correlated significantly with measures of understandability of the future and the self, evaluation of the future, and potency of the self. These promising results warranted further refinement and validation of the FTP Inventory.

The pool of items that was used in the pilot study was factor analyzed to provide a criterion for retention of the most useful items. Data for the factor analysis came from 168 respondents, which included 119 Fort Bragg enlisted men and 49 college students. Pearson product-moment correlations were computed among all of the items and an arbitrary number of factors were extracted. Analysis was ultimately based on 107 respondents for whom complete data were available. Heimberg factor analyzed these particular items and as a result the present 25 items were selected based on their loadings. The reliability of the FTP Inventory was indicated by an alpha coefficient of 0.86

(Heimberg, 1963). The alpha coefficient computed in a pilot sample of 48 tenth grades (25 boys, 23 girls) from a New Jersey high school was 0.84 (Yarcheski, 1984) which demonstrated an acceptable level of internal consistency for the use of the FTP Inventory with adolescents. More recently, Mahon and Yarcheski (1994) reported alpha coefficients of 0.89 and 0.86 for middle and late adolescents, respectively.

Heimberg using theoretically relevant variables investigated construct validation of the FTP Inventory. As predicted, positive correlations were found between FTP and internal locus of control ($r = 0.50$) and also between FTP and semantic differential ratings using the concepts "the future" and "me" and semantic differential ratings of the understandability of "other people." Additionally, significant negative correlations were found between FTP and anxiety ($r = -0.53$) and between FTP and anomie ($r = -0.43$) (Heimberg, 1963).

In the present study, the Heimberg FTP Inventory was slightly modified representing a 12-item, 5-point, Likert-type scale with response options ranging from "1" = strongly disagree to "5" = strongly agree. The range of possible scores was 12 to 60. Higher scores indicated an extended FTP. Examples of FTP items included: "My future seems dark to me"; "I generally act on the spur of the moment (quickly without thinking)"; and, "I will probably die before I am 30." In the present study, the alpha coefficient was 0.79. FTP is operationally defined as the participant's total score on the modified FTP Inventory.

Future Sexual Intentions

An investigator-developed scale measured future sexual intentions. It was a 9-item, 5 point Likert–type scale with response options from "1" not likely to "5" definitely. The range of possible scores was 9 to 45. Higher scores indicated safe future sexual intentions. The questions lead off with "when you leave the YDC, how likely do you think the following activities are for you." Examples of items include: "...using a condom or request your partner use them every time you have sex", "...engaging in sexual activity after drinking", or "...asking your partners whether they had a sexually transmitted disease." The test of reliability was performed on the scale, generating a Cronbach's alpha coefficient of 0.77.

Past Sexual Behaviors

The past sexual behavior measure of willingness to have sexual intercourse was assessed using one investigator-developed item from the interview. The willingness to have sexual intercourse item asked respondents: "Have you ever willingly had vaginal sex?" The response options for this item was "1" = yes or "2" = no. For this particular variable, the response options were recoded to "1" = yes and "0" = no. Medically diagnosed STDs were assessed using a single item from the interview, which consisted of several components. Participants were asked: "Did a doctor or nurse ever say that you had any of these diseases in the last year...genital warts, chlamydia, syphilis, gonorrhea, herpes, trich (trichomonas), crabs (pubic lice)?" The response options to these questions was "1" = yes and "2" = no. For this particular analysis, the response options were recoded to "1" = yes and "0" = no. If respondents answered yes to having any of the

STD's the answer was coded as yes. If the respondents answered no to all of the STD's the answer was coded as no.

The past sexual behavior measure, number of sexual partners, was analyzed using a single item. The number of sexual partners was determined from an item that asked: "How many different partners have you had vaginal sex with in your lifetime?" Lastly, the past sexual behavior measure of condom use in the month before entering the YDC was assessed using one item: "With how many partners did you have sex without a condom?"

Control Variables

Control variables included the participants' age which was determined using a single item, which asked, "How old are you?" Importance of religion was determined from an item that asked: "How important are your religious beliefs to you?" The response options were as follows: "1" not at all important, "2" slightly important, "3" moderately important, "4" quite important, "5" very important.

Analysis

Descriptive techniques designed to summarize data on a single dependent variable utilized the Statistical Package for Social Sciences 13.0 (SPSS). For this particular analysis, only participants who reported being African American and female were used. Descriptive statistics (median, mean, standard deviation, frequency, and range) were calculated to assess demographic characteristics. The following demographic characteristics are reported: age; educational status, marital status; pregnancy status;

being previously locked up; school attendance, behaviors, and grades; future life plans; and importance of religion. Particularly, for the demographic characteristics age and educational status, the median, mean, standard deviation, and range are reported. For the demographic characteristics marital status, pregnancy status, being previously locked up, grades, and future plans, frequencies are reported.

It has been hypothesized in the current study that FTP is positively correlated with future sexual intentions among the participants of Project SHARP. The current study will examine the relationship of FTP to future sexual intentions as well as past sexual behavior. All variables utilized in the current study were a part of the parent study, Project SHARP. Findings gleaned from this study may assist in the planning and administration of appropriate health education and health promotion activities for African American female adolescent detainees. Also, it will increase our understanding of this unique high risk population and their anti-health and social behaviors. The goal of this study is to test the following hypotheses:

1. Higher FTP scores will be related to safe future sexual intentions among African American female juvenile detainees. There will be a positive relationship between extended FTP and safe future sexual intentions. As in previous research utilizing the FTP Inventory, (DiIorio, Parson, Lehr, Adame, & Carlone, 1993; Mahon, Yarcheski, & Yarcheski, 1997; Mahon, Yarcheski, & Yarcheski, 2000; Yarcheski, 1984), Pearson product-moment correlations was used to determine if there is a relationship between FTP and future sexual intentions because they are measured as interval level variables.

2. Higher FTP scores will be inversely related to past willing engagement in vaginal sex among African American female juvenile detainees. There will be a negative relationship between extended FTP and past willing engagement in vaginal sex. To test the proposed hypothesis, point-biserial correlation was used to determine if there is a relationship between FTP and past willing engagement in vaginal sex. Any two-point variable (e.g. willingly engaged in vaginal sex (yes/no)) meets the criteria for an interval-scaled variable. When one or both of the variables in a correlation is truly dichotomous, the analysis results in a special product-moment coefficient with restricted interpretation and perhaps a restricted range. A point-biserial correlation is the appropriate statistic to use between one dichotomous variable and one continuous variable (Thorndike, 1997).
3. Higher FTP scores will be inversely related to the number of sexual partners among African American female juvenile detainees. There will be a negative relationship between extended FTP and the number of sex partners. To test the proposed hypothesis, the Pearson product-moment correlation was computed to determine if there is a relationship between FTP and the number of sex partners. These variables are measured as interval level variables.
4. Higher FTP scores will be inversely related to being medically diagnosed with a STD among African American female juvenile detainees. There will be a negative relationship between extended FTP and the medical diagnoses of STDs. To test the proposed hypothesis, point-biserial correlation was used to determine if there is a relationship between FTP and medically diagnosed STDs. As noted earlier, any two-point variable (e.g. medically diagnosed STD) meets the criteria for an interval-scaled

variable. When one or both of the variables in a correlation are truly dichotomous, the analysis results in a special product-moment coefficient with restricted interpretation and perhaps a restricted range. A point-biserial correlation is the appropriate statistic to use between one dichotomous variable and one continuous variable (Thorndike, 1997).

5. Higher FTP scores will be inversely related to the number of sexual partners with whom a condom was not used among African American female juvenile detainees. There will be a negative relationship between extended FTP and the number of sexual partners in which a condom was not used. To test the proposed hypothesis, Pearson product-moment correlations were used to determine if there is a relationship between FTP and the number of sex partners in which they did not use a condom. These variables are measured as interval level variables.

Following the bivariate analyses, a multiple regression analysis was conducted to determine the associations among future sexual intentions, FTP, and past sexual behaviors. This particular type of regression is used to account for (predict) the variance in an interval-level dependent variable (e.g. future sexual intentions), based on linear combinations of interval, dichotomous, or dummy independent variables (e.g. FTP, willingly engaged in vaginal sex, number of sexual partners, and medically diagnosed with STD). Multiple regression can establish that a set of independent variables explains a proportion of the variance in a dependent variable at a significant level (through a significance test of R^2), and can establish the relative predictive importance of the independent variables (by comparing beta weights) (Huck, 2000; Tabachnick & Fidell, 2001).

Variables that were not significant in the bivariate analysis above were entered into the regression to test the relationship because other relationships of interest may be displayed. There is an interest in finding out the degree to which the independent variables contribute to successful predictions or valid explanations. Each independent variable is evaluated in terms of what it adds to the prediction of the dependent variable that is different from the predictability afforded by all the other independent variables. The predicted outcome is that FTP will be a significant predictor of future sexual intentions and past sexual behavior.

Control variables will also be entered (age, importance of religion) into the model. Not surprisingly, older adolescents tend to report more sexual activity and have more sexual partners than do younger adolescents (Harvey & Spigner, 1995; Levy, Lampman, Handler, Flay & Weeks, 1993; Miller, Forehand, & Kotchick, 2000; Orr, Beiter, & Ingersoll, 1991; Sonenstein et al., 1991). It has also been noted that older age was associated with less consistent condom use in both minority and mixed race samples (Anderson et al., 1990; Pendergrast, DuRant, & Gaillard, 1992; Reitman et al., 1996; Shrier, Emans, Woods, & DuRant, 1996). An additional study found that older females were more likely than younger females to use some form of birth control, while age was not associated with contraceptive use for males (Luster & Small, 1994). It has also been previously noted that younger adolescents (ages 12-15) have earlier ages of sexual debuts in comparison to older adolescents (ages 16-19) (Bachanas et al., 2002).

Moreover, adolescents who report higher levels of importance of religion are less likely to engage in sexual intercourse (Bingham & Crockett, 1996; Crockett, Bingham, Chopak, & Vicary, 1996; Levinson, Jaccard, & Beamer, 1995). Additionally, adolescents

who were more likely to be affiliated with a religious entity were significantly more likely to have a higher self-efficacy in communicating with sexual partners (new and steady) about sex, STDs, HIV, and pregnancy prevention. These adolescents were also able to refuse an unsafe sexual encounter (McCree, Wingood, DiClemente, Davies, & Harrington, 2003). On the other hand, however, Miller and colleagues (2000) noted no relationship between religiosity and adolescent sexual behavior among minority youth.

The purpose of the present exploratory study is to examine the contribution of the cognitive-perceptual variable, FTP, to understanding the future sexual intentions and past sexual behaviors of African American female juvenile detainees. Overall, the previously described data analyses were conducted to determine if a relationship exists between FTP, future sexual intentions, and past sexual behaviors. Significant correlations will depict that an extended FTP is positively related to safe future sexual intentions and less risky past sexual behaviors.

CHAPTER FOUR

RESULTS

Descriptive Statistics

The sample consisted of 766 African American female adolescents ranging in age from 11 to 18 years of age (M=14.8, SD=1.2). Demographic and historical characteristics of the participants are given in Table 1. A majority of the participants reported never being married (n=761, 99.3%) and reported having no children (n=681, 88.9%). Eleven (1.4%) of the participants reported being currently pregnant and approximately half (48.6%) of the participants reported being previously locked up. Approximately, 72% (n=554) of the participants reported a religious affiliation in which the majority of the participants reported being protestant (n=528, 68.9%). Approximately 27% (n=210) of the participants reported attending religious services at least once a week during the month prior to entering the YDC, while 57.8% (n=443) reported that their religious beliefs were very important to them.

The majority of the participants (76.8%) reported attending school during the month before entering the detention center. The highest grade of school completed ranged from fourth grade to twelfth grade (M =8.2, SD=1.3) with 33% (n=253) of the participants reporting making some A's and B's in school. Several participants, however, reported disciplinary problems during school during the month before entering the detention center. Three hundred forty-seven participants (45.3%) reported that their

parents or guardians had to be contacted for disciplinary problems at school, 186 (24.1%) reported being in detention in school, and 212 (27.7%) cut school or classes without permission. With regard to future plans, the majority of the participants (n=700, 91.4%), reported plans to return to school and 92.0% (n=705) reported wanting to complete high school. Additionally, over half (n=417, 54.4%) of the participants had the desire to attend college and 17.1% (n=131) had plans to attend trade school upon completion of high school and several had future aspirations in a range of career fields. The choices of careers varied such as cosmetology (n=64, 8.3%), doctors (n=37, 4.8%), lawyers (n=71, 9.3%), and teachers (n=24, 5.5%).

Table 1. Characteristics of the Participants (N=766)

Characteristic	**n**	**%**	**M**	**SD**
Age			14.8	1.2
Marital Status				
Never married	761	99.3		
Currently Pregnant	11	1.4		
Previously Locked Up	372	48.6		
Number of days previously locked up			31.9	49.3
Religious Affiliation	554	72		
Protestant	528	68.9		
Catholic	10	1.3		
Jewish	1	0.1		
Muslim	6	0.8		
Mormon	1	0.1		
Other	4	0.5		
None	14	1.8		
Not reported	202	26.4		
Attended religious services at least once a week	443	57.8		
Attended school during the month prior	588	76.8		
Highest grade of school completed			8.2	1.3
Made some A's and B's in school	253	33		
Made some Bs and C's in school	228	29.8		

Parents/guardians contacted for disciplinary problems at school	347	45.3
In school detention	186	24.1
Cut school or class without permission	212	27.7
Plans to return to school	700	91.4
Desire to attend college	417	54.4
Desire to attend trade school	131	17.1

Future Sexual Intentions

Overall, the majority of the participants reported that they intended to practice risk reduction behaviors in the future. Seventy-seven percent of the participants reported that they have plans to limit the number of sexual partners that they have. Additionally, 75.2% plan to talk to their partners about HIV/AIDS, 72.8% plan to talk to their partners about safer sex, 73.0% plan to ask about their partners' sexual history, and 67.9% plan to use a condom every time they have sex. The mean future sexual intentions score was 39.5 (SD=5.8) with a range of 13 - 45, and the mean for FTP was 42.3 (SD=7.8) with a range of 20 - 60, as shown in Table 2. The items for FTP are shown in Table 3.

Table 2. Mean Scores for FTP and Future Sexual Intentions

Variable	M	SD
FTP	42.3	7.8
Future Sexual Intentions	39.5	5.8

Table 3. FTP Items

Item	N	M	SD	% Strongly Agree	% Agree	% Neither	% Disagree	% Strongly Disagree

My future seems dark to me	750	3.88	1.15	4.6	12.1	7.8	39.6	33.8
It is very hard for me to visualize the kind of person I will be 10 years from now	750	3.28	1.36	10.1	28.1	6.9	30.5	22.3
I expect that my plans for my future will change many times between now and the time I leave school	750	2.29	1.23	26.2	46.3	3.4	14.2	7.7
I don't know what kind of work I will do in the future	750	3.46	1.31	8.2	23.2	4.4	38.8	23.2
I can't even imagine what my life will be like in 20 years	750	3.02	1.36	12.4	35.2	5.6	27.5	17.1
The future seems very vague and uncertain to me	750	3.48	1.21	5.9	22.6	7.7	42	19.7
It's really no use worrying about the future, because what will be, will be	750	3.28	1.38	11.2	26.9	5.9	31.3	22.6
I know the kind of job I want when I leave school*	760	4.14	0.97	40.1	46.1	2.5	8.4	2.2
I generally act on the spur of the moment (quickly without thinking)	750	2.85	1.25	12.9	38.1	6.1	32.5	8.2
I will probably die before I am 30	750	4.15	1.00	2.5	5.2	11.9	34.3	44.0
I will probably never have enough money	750	4.12	0.99	2.9	6.1	6.8	42.3	39.8
I think I will have a nice family when I'm older*	758	4.35	0.83	49.7	40.3	4.2	3.3	1.4

*These items were reversed coded.

Past Sexual Behaviors

Past sexual behaviors of the participants are given in Table 4. The participants reported a high rate of vaginal sex with 653 (85.2%) reporting to have willingly participated in vaginal sex. However, involvement in performing and receiving oral sex was much lower among the participants. Two hundred ninety (37.9%) participants reported that they had received oral sex during their lifetime while only sixty-four (8.4%) reported that they had ever performed oral sex during their lifetime. Lifetime involvement in anal sex was extremely low with twenty (2.6%) of the participants willingly participating in anal sex.

The average age of onset for willingly having vaginal sex, oral sex, and anal sex was 13.5 (SD=1.3), 14.7 (SD=1.3), and 14.4 (SD=1.3) years of age respectively. The participants were asked questions concerning the number of sexual partners that they had during their lifetime. Participants reporting involvement in vaginal sex had an average of 3.9 (SD=4.1) lifetime partners, 1.9 (SD=2.0) partners within the last year, and 0.9 (0.8) partners within the last month. The number of lifetime partners for performing oral sex and receiving oral sex was 1.4 (SD=0.9) and 2.3 (SD=2.2) respectively. Additionally, there was an average of 1.4 (SD=0.90) lifetime anal sex partners for participants acknowledging involvement in this behavior.

Frequency of contraceptive use among the participants reporting involvement in vaginal, oral, or anal sex was relatively low. Almost half of the participants (45.1%) reported having vaginal sex without a condom during the month before entering the YDC. The average number of partners with whom condoms were not used was relatively low (M=0.64, SD=0.94). Additionally, 72.0% of the participants reported receiving oral

sex without a condom or latex barrier, while 68.1% reported performing oral sex without a condom or latex barrier. Moreover, of the females who acknowledged involvement in anal sex, 42.9% did not use a condom during the month before entering the YDC.

In terms of the participants' level of involvement in risky sexual activity during the past three months before entering the detention facility, the majority of the participants reported no past involvement in sex with a prostitute or trading sex for drugs or money. Eighteen participants (2.4%) reported that they had exchanged sex for money within the past three months; five (0.7%) had exchanged sex for drugs, and two (0.3%) reported having sex with a prostitute. The majority of the participants (n=465, 72.8%) reported that they had not been diagnosed with a STD during the last year prior to entering the YDC. Only nineteen (2.5%) of the participants reported being diagnosed with genital warts and six (0.8%) with syphilis.

Table 4. Past Sexual Behaviors

Characteristic	n	%	M	SD
Participation in vaginal sex	653	85.2		
Received oral sex	290	37.9		
Performed oral sex	64	8.4		
Willingly participated in anal sex	20	2.6		
Age of onset vaginal sex			13.5	1.3
Age of onset oral sex			14.7	1.3
Age of onset anal sex			14.4	1.3
Number of lifetime sexual partners				
Vaginal sex			3.9	4.1
Performing oral sex			1.4	0.9
Receiving oral sex			2.3	2.2
Anal sex			1.4	0.9
Number of partners in last year (vaginal sex)			1.9	2.0
Number of partners in last month (vaginal sex)			0.9	0.8
Participation in vaginal sex without a condom	345	45.1		

Characteristic	n	%	M	SD
Number of partners with non-use of condom			0.6	0.9
Vaginal sex				
Participating in sex without a condom				
Performing oral sex	522	68.1		
Receiving oral sex	552	72		
Anal sex	329	42.9		
Exchanged sex for money	18	2.4		
Exchanged sex for drugs	5	0.7		
Had sex with a prostitute	2	0.3		
Had sex with an injection drug user	2	0.3		
Medical Diagnosis of STDs				
Genital warts	19	2.5		
Chlamydia	79	10.1		
Syphilis	6	0.8		
Gonorrhea	59	7.7		
Herpes	9	1.2		
Trichomonas	54	7.1		
Medical Diagnosis of Crabs (pubic lice)	21	2.7		
Future sexual intentions				
Plans to limit the number of sexual partners	595	77.7		
Plans to talk with their partners about HIV/AIDS	576	75.2		
Plans to talk with their partners about safer sex	558	72.8		
Plans to ask about their partners' sexual history	559	73		
Plans to use a condom every time they have sex	520	67.9		

Hypothesis Testing

The hypothesis testing results are given in Table 5. The Pearson product-moment or point-biserial correlation coefficient (r) and significance level are provided.

Table 5. Results

Hypothesis 1		
	r	*p*

FTP and Future Sexual Intentions	0.063	0.194
Hypothesis 2		
	r	*P*
FTP and Past Willing Engagement in Vaginal Sex	0.001	0.97
Hypothesis 3		
FTP and Number of Sexual Partners	*r*	*p*
Lifetime	-0.067	0.17
Last year	-0.01	0.83
Last month	-0.125	<0.05
Hypothesis 4		
	r	*p*
FTP and Medically Diagnosed with a STD	0.016	0.667
Hypothesis 5		
	r	*p*
FTP and Number of Sexual Partners Without a Condom	-0.056	0.242

Hypothesis 1

The first hypothesis advanced that there would be a positive relationship between extended FTP and safe future sexual intentions. A Pearson product-moment correlation was calculated to test the hypothesis. The correlation was close to zero (*r=0.063, p=0.194*) indicating no relationship between FTP and future sexual intentions. Hypothesis one was not supported by the data.

Hypothesis 2

The second hypothesis advanced that there would be a negative relationship between extended FTP and past willing engagement in vaginal sex. A point-biserial correlation was calculated to test the hypothesis. The correlation was close to zero

($r=0.001$, $p=0.970$) indicating no relationship between FTP and past willing engagement in vaginal sex. Hypothesis two was not supported by the data.

Hypothesis 3

The third hypothesis advanced that there would be a negative relationship between extended FTP and the number of sex partners. A Pearson product-moment correlation was calculated to test the hypothesis. The correlation was close to zero ($r=-0.067$, $p=0.170$) indicating no relationship between FTP and the number of lifetime sexual partners. The correlation was close to zero ($r=-0.010$, $p=0.831$) indicating no relationship between FTP and the number of partners in the last year before entering the YDC. The correlation was close to zero ($r=-0.125$, $p<0.05$) indicating a weak relationship between FTP and the number of partners in the last month before entering the YDC. FTP is not related to number of sexual partners for each category (in your lifetime, last year before entering the YDC, and the last month before entering the YDC). Hypothesis three was not supported by the data.

Hypothesis 4

The fourth hypothesis advanced that there would be a negative relationship between extended FTP and the medical diagnosis of STDs. A point-biserial correlation was calculated to test the hypothesis. The correlation was close to zero ($r=0.016$, $p=0.667$) indicating no relationship between FTP and being medically diagnosed with a STD. Hypothesis four was not supported by the data.

Hypothesis 5

The fifth hypothesis advanced that there would be a negative relationship between extended FTP and the number of sexual partners with whom a condom was not used. A Pearson product-moment correlation was calculated to test the hypothesis. The correlation was close to zero ($r=-0.056$, $p=0.242$) indicating no relationship between FTP and the number of sexual partners in which condoms were not used. Hypothesis five was not supported by the data.

Regression Analysis

A standard multiple regression analysis was performed with future sexual intentions as the dependent variable and FTP, past willing engagement in vaginal sex, number of sexual partners (lifetime, year and month prior, and without a condom), and medically diagnosed STDs as the independent variables, and age and importance of religion as control variables. Analysis was performed using SPSS REGRESSION and SPSS FREQUENCIES for evaluation of assumptions. Results of the evaluation of assumptions led to transformation of the variables to reduce skewness, reduce the number of outliers, and improve the normality, linearity, and homoscedasticity of residuals. The cases that had missing data were eliminated from the analysis.

Table 6 displays the standardized regression coefficients (β) and the standard errors. Two independent variables contributed significantly to the prediction of future safe sex intentions: the number of sexual partners with whom a condom was not used and

the number of sexual partners during the last month before entering the YDC. The correlation between future safe sex intentions and the number of sexual partners with whom a condom was not used was -0.240 with a Beta coefficient of 0.2390. The correlation between future safe sex intentions and the number of sexual partners a month before entering the YDC was -0.103 with a Beta coefficient of 0.2070. Overall, the regression equation was significant ($F\ (8,423) = 5.040, p<0.001$), with an R^2 of 0.085. However, one cannot make a strong argument that FTP nor past sexual behaviors can be used to predict future safe sex intentions. The model accounted for only 6.8% of the variance in the dependent variable, future safe sexual intentions, thereby, 93.2% of the variance is not accounted for. This means that something else besides what is being measured in this particular study accounts for the variation in scores of future sexual intentions.

Table 6. Standard Multiple Regression of Future Sexual Intentions, FTP, and Past Sexual Behavior

Predictors	β	SE	Correlation
FTP	0.053	0.036	0.061
Past willing engagement in vaginal sex	0.153	0.653	-0.172
Number of sexual partners			
Lifetime	-0.039	0.047	-0.083
Last Year	0.187	0.175	-0.059
Last Month	-0.207[a]	0.443	-0.103
Without a condom	-0.239[b]	0.033	-0.240
Medically diagnosed STDs	-0.038	0.598	-0.058
Age	0.040	0.242	0.028
Importance of Religion	0.081	0.242	0.088

[a] $p<0.05$

[b] $p<0.01$

CHAPTER FIVE

CONCLUSIONS

Discussion

From a developmental perspective, empirical evidence supports that as individuals progress from childhood through adolescence, their perceptions of their futures become more extended, goal oriented, and realistic (Lessing, 1972). Central to the present study is the proposition that one's perception of the future may provide motivation and guidance for future behavior. Thus, adolescents possessing an extended (or a more positive) FTP are able to conceptualize futures with well-defined expectations and are able to conduct their lives in such a manner as to achieve predetermined goals (DiIorio, 1993). It was hypothesized in the current study that, for this particular sample, perceived distant events would correlate with past behavior and influence future behavior. The population of interest, however, could possibly have constricted future time perspectives due to their current status as detainees, where events that are expected to occur in the not too distant future could have little impact on future intentions. Specifically, this exploratory study sought to determine if selected cognitive-perceptual factors could explain future safe sex intentions among African American female juvenile detainees. Results revealed that FTP was not related to future safe sex intentions or past sexual behaviors among this particular sample.

Past Sexual Behaviors

The past risky sexual behaviors observed with the current sample are consistent with other research (Canterbury et al., 1995; DiClemente, 1991; Kelly, Bair, Baillargeon, & German, 2000; Magura, Shapiro, & Kang, 1994; Shafer et al., 1993; Teplin, Merricle, McClelland, & Abram, 2003). An overwhelming majority of the sample willingly participated in vaginal sex (n=659, 86.3%) and almost half reported engaging in vaginal sex without a condom the month before entering the YDC (n=344, 45%). Approximately 77.1% (n=589) of the participants had multiple sex partners during their lifetime and almost a third of the participants reported having a medically diagnosed STD within the last year. Results showed an overall STD prevalence of 32.7%.

These findings were consistent with past research in which high proportions of adolescents reported having three or more sexual partners in their lifetime (Canterbury et al., 1995; DiClemente, 1991; Magura, Shapiro, & Kang, 1994; Shafer et al., 1993; Teplin, Merricle, McClelland, & Abram, 2003) and several were currently suffering from a STD (Canterbury et al., 1995; Kelly, 2000; Shafer, 1993). More specifically, Magura and colleagues (1994) found that inconsistent condom use was the norm throughout their sample of 421 sexually active male adolescent detainees. Seventeen percent reported that they never used condoms and condoms were used less frequently with steady partners (Magura, Shapiro, & Kang, 1994). It was also noted that 75% of a sample of detained males and females had three or more sexual partners, 25% never used a condom in their lifetime, and 19% had a current diagnosis of at least one STD (Canterbury et al., 1995). More recently, Kelly and colleagues (2000) noted the prevalence of chlamydia was 22.2% among female detainees and 8.7% among male detainees. Also, their results

indicated that 92% of the sample was sexually active with a mean of 7.3 lifetime sexual partners (Kelly, Bair, Baillargeon, & German, 2000).

FTP and Past Sexual Behaviors

The past risky sexual behaviors reported above could explain why there is no relationship between FTP and past sexual behavior. To begin, because the majority of the sample participated willingly in vaginal sex, there was a small amount of variation in the measure, which affected the correlation. This could also explain why there is a lack of correlation between FTP and the number of sex partners. The sample reported high numbers of sex partners, again lending no variation in the measure, particularly among the number of lifetime partners and the number of partners in the last year. The measure of the number of partners in the last month had a weak but statistically significant correlation. This statistically significant correlation maybe due to FTP being an unstable measure that changes as individuals mature, hence a correlation to the most recent sexual encounter. Similarly, the low prevalence of STD's among this particular sample may also explain why there is no relationship between FTP and self-reported medically diagnosed STDs. One explanation for the low STD prevalence is that it was a self-reported measure. Although the results provided evidence of more recent (within the last year) STD diagnoses, there were no questions that assed the frequency of STD diagnosis during the participants' lifetime.

Furthermore, past researchers noted that decision-making skills or lack thereof might provide the link as to why adolescents partake in risky sexual behaviors. Adolescents may be less skillful than adults in identifying options because they lack

sufficient knowledge of alternatives. For example, in a recent study, a sample of adolescents (ages 14 – 19) opted not to use condoms even while being aware of safer alternatives. Their decisions were not related to an assessment of the potential negative consequences of contracting a STD or pregnancy, but to their perception of the condom's ease of use, acceptance by peers, and role in spontaneous sex (Kegeles, Adler, & Irwin, 1988). Additional studies (Namerow, Lawton, & Philiber, 1987) have also suggested that adolescents fail to recognize the consequences of their sexual behaviors. For example, although adolescents may be knowledgeable of how to avoid contracting HIV/AIDS, some will still not practice safe sex behaviors (Gardner & Herman, 1990). The decisions of these adolescents may be a function of failing to understand the consequences of their actions or the likelihood that these consequences could occur. This may also be the case with this particular sample in which they are knowledgeable of safer sex practices, however, intend not to practice them in the future – nor do they recognize how this relates to their perspective on their future.

FTP and Future Sexual Intentions

Past research indicates overall that there is a positive relationship between FTP and positive sexual behaviors (Blum & Resnick, 1982, DiIorio et al., 1993; Rothspan & Read, 1996). Blum and Resnick (1982) noted that those adolescents who chose to abort their pregnancies had "the capacity to understand future consequences" (pg. 801). Also, a significant correlation was reported between FTP and safer sex practices among African American male college students (DiIorio et al., 1993). Additionally, FTP was significantly correlated with being less likely to have engaged in intercourse and having

fewer sexual partners among heterosexual college students (Rothspan & Read, 1996). It is important, however, to note that among the studies presented above there are variations in the scales used to measure FTP and only one study utilized the Heimberg scale (DiIorio et al., 1993). Yet, it is clear that individuals tend to set goals based on the comparison between their motives and values and their expectations concerning the future. This, however, does not seem to be the case with the current sample. The data revealed that there was no correlation between an extended FTP and safe future sexual intentions. There is no past research to support this finding because past research has not been conducted among adolescent detainees. A finding such as this highlights that there is a missing link that must be addressed regarding FTP and future sexual intentions, particularly among African American female juvenile detainees.

Bandura (1986) states that an individual's conceptualization of the future has an impact on the decisions for present day behavior. This thought, however, is contradicted in the current findings. Past research does seem to suggest that the future orientation of delinquents is less optimistic (Rychlack, 1973; Trommsdorff & Lamm, 1980), less structured (Trommsdorff & Lamm, 1980), less extended (Black & Gregson, 1973; Siegman, 1961), and more oriented toward private concerns (Trommsdorff & Lamm, 1980) in comparison to their non-detained counterparts. However, what was expected was not the case in the current study as the results point in the other direction. Another possibility is that being labeled as a delinquent and the related life context could provide the adolescent with a basis for pessimism and limited time perspective (Nurmi, 1991). Because the findings were inconsistent with our expectations, it is important to continue

to explore the role of one's concept of the future in the study of future safe sex intentions among adolescents and other groups.

Perhaps more specific measures of perceived future consequences of safer and unsafe sex practices might be more appropriate. This particular sample may have not made the shift from concrete to abstract reasoning to make the connection between current behaviors and future aspirations. Piaget (1972) described abstract reasoning as the ability to extrapolate and to draw upon old experiences to solve new problems not previously encountered. An important aspect of the transition from concrete to abstract reasoning is the understanding of time as an abstraction and the development of a personal sense of future (Piaget, 1972). Additionally, the particular scales that were used to measure FTP and future sexual intentions may not have adequately measured what they intended to measure. More refined items should be created to properly measure FTP and future sexual intentions among this particular population. However, after conducting a factor analysis, particularly principal component analysis, for FTP, stable factors emerged; also the reliability analysis produced a Cronbach's alpha coefficient of 0.79. We cannot, however, assume the validity of the scale for this particular group due to their special circumstances.

Past research, which utilizes the Heimberg scale, notes positive self-evaluations, positive health practices, and positive outlooks on future time perspectives among adolescents and college students (Mahon & Yarcheski, 1994; Mahon, Yarcheski, & Yarcheski, 1997; Mahon, Yarcheski, & Yarcheski, 2000; Rew, Fouladi, & Yockey, 2002; Yarcheski, 1984; Yarcheski & Mahon, 1986; Yarcheski, Mahon, & Yarcheski, 1997). The ages of the various samples studied ranged from 12 – 32, with the majority of the

studies focusing on ages 15 – 20. The investigator-modified measure used in this particular study may have not captured the sample's FTP possibly due to being a younger population (11 – 18, M=14.81). More importantly, none of the past research that utilizes the Heimberg scale focuses on the detained population. Also, the scale used in the current study was modified from the original scale, which does not allow for a true comparison of mean scores of FTP across the various samples previously studied. Due to the investigator-modified scale, it is possible that the measures used did not adequately measure the sample's FTP and the entire scale or additional measures should have been utilized.

Limitations

There are several limitations to the methodology of this particular study. To begin, the recruitment process was self-selection; therefore, the participants who chose not to participate in the study may have been different from the study participants in that they were volunteers and may have been a more motivated group of individuals. Secondly, the interviews with the participants took place at the YDCs where the participants lived and therefore, the participants may have been reluctant to discuss aspects of their behaviors and may have answered in socially desirable ways. In response to this particular bias, the occurrence of positive or socially desired behaviors may have been overestimated. Additionally, the method of data collection may have been a limitation to the study in that participants may not have thoroughly and accurately discussed sensitive information such as their sexual history during the face-to-face interviews. There may have been bias in terms of responses on the self-reported

measures. Specifically, with regard to STDs, participants may not have admitted to being diagnosed with a STD due to embarrassment or fear that persons outside the study may somehow see the information. This may also be true for other sensitive material as well. Finally, information on STD prevalence was collected through self-report, which was not confirmed by a medical diagnosis. There may have also been females presently suffering from a STD that had not yet been diagnosed at the time of the study. Additionally, recall bias may also be cited as a limitation of this study due to the fact that respondents may not have been able to accurately recall their past sexual behavior. Lastly, an appropriate measure for FTP is needed for this particular population. In this particular case, the participants had a fairly high FTP and future sexual intention mean score leading to a ceiling effect. The variables appear to have no effect on each other because the participants reached the maximum performance level.

Conclusions

There maybe several reasons why relationships did not exist between future sexual intentions, past sexual behavior, and FTP among this particular sample. Oftentimes, a typical issue among institutionalized delinquents may be that the time for addressing various age-specific developmental tasks, such as future education, occupation, and marriage, has passed by the time of their release and they are unable to experience these types of events at the normal time. This can cause additional problems as they begin to transition into adulthood (Nurmi, 1991). Past research also notes that the date of release is usually a significant predictor in how one views the future. The nearer the date of release the greater the similarity is between detained individuals and the non-

detained individuals (Landau, 1969). Specific to this particular sample, one could possibly conclude that these individuals do not realize how their outlook on their future is strongly linked to future sexual behavior. These youth, due to their current circumstances, may have yet to make this link. Their trajectory could possibly change as there release date nears.

In conclusion, based on these data, there is no relationship between the observed variables (FTP, future sexual intension, and past sexual behaviors). FTP does not predict future sexual intentions. Intervening with these youth at this particular point in their lives could be crucial. To understand the risk status of these minority youth more clearly, their perspective must be understood and addressed. Making decisions and planning for the future are particularly important skills throughout the life span. According to Nurmi (1991), the implications for manifesting a future orientation during adolescence are diverse. In this regard, it is necessary to examine the potential outcomes and to evaluate how this change over time.

Implications

Evidence such as this, which acknowledges the continual problem, underscores the fact that the consequences of sexual risk-taking are of grave concern and are in immediate need of efforts to prevent their occurrence. Obviously in the current sample, the risks associated with adolescent sexual risk behavior continue to mount. While substantial progress has been made in identifying the precursors and consequences of risky adolescent sexual behavior, there is indeed a missing link with regard to FTP and future sexual intentions. There is a dire need for the refinement of the FTP concept and

scale. Measures should be developed specifically for this population, targeting younger and possibly less developed adolescents. Additionally, interventions should be developed to assist these youth in enhancing their abilities to make the connection that risky sexual behavior can negatively interfere with their future goals, specifically linking concrete to abstract thinking.

An intervention centered on time perspective should consist of education and activities designed to help participants become more cognizant of, and responsive to the long-term implications of their past and present actions as well as to keep such cognitions in the forefront at the time of participation in, or decision making around future sexual behaviors. The intervention should provide the participants with a conceptual framework for understanding why focusing on the immediate or short-term consequences of risky sexual behavior is not worth the effort. Whereas focusing on the long-term benefits of safe sexual behavior outweigh the costs or risky sexual behavior. An example activity for the intervention could be built around decisional balance with a temporal dimension. This activity would require the participants to generate a list of immediate costs and benefits of risky sexual behaviors, and then to contrast those short-term costs and benefits with the balance of long-term costs and benefits of engaging in safe sexual behavior. Inevitably, the participants will discover that almost all of the costs associated with safe sexual behavior appear at the time of decision-making, while almost all of the benefits accrue over long periods of time. This particular activity will sensitize the participants to the notion that the benefits of safe sexual behaviors greatly outweigh the costs when taking a long-term perspective, even though the opposite might be the case when taking a short-term perspective. Throughout the intervention, the discussions will emphasize the

connections between present behavior and future outcomes, and will note that the individuals often lose sight of these connections when making decisions about sexual behaviors.

Recommendations for Future Research

As the number of African American female adolescents entering detention facilities continues to increase there is an increased need to address the behaviors specific to this population. Although the findings of this study suggest no relationship between future safe sex intentions, past sexual behaviors, and FTP, this has not been supported by much of the research on the detained population. The research on health related issues among detained females, particularly African American female adolescent detainees, is scarce. Public health practitioners could be instrumental in addressing these issues among the detained population, particularly the behavioral determinants of health status, such as future sexual intentions and FTP.

Based upon the results of this study, the following recommendations are offered. Non-detained youth could be included in the sample to conduct a sub-group analysis. In terms of methodology, qualitative methods such as focus groups should be incorporated so as to capture major themes not brought out through this quantitative study. Moreover, the methods of data collection could be structured in such a way that would allow for more accurate information to be obtained, especially concerning sexual behaviors. In addition, a more valid and reliable way to measure FTP should be adapted to accurately measure the perspective of younger and less developed adolescents. Lastly, more

confirmatory measures of STD prevalence including health screenings at the time of admission into the YDC's could also be incorporated.

Although one must always be cautious in interpreting correlational data, the inconsistent relationships of future sexual behaviors, past sexual behaviors, and FTP suggest that more research needs to be conducted in this particular area. Also, HIV prevention programs may be enhanced by modifying their training according to individual differences in time perspective and by educating individuals to envision their future and recognize the consequences of the actions that they take today.

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APPENDIX A

PROJECT SHARP PRE SURVEY

Pre 1 3/20/00

	Month/Day/Year	Name and Initials
Interviewer	/ /	
Race:	1. White 2. Black 3. Hispanic 4. Asian 5. Native American 6. Other:	**Gender:** 1. Male 2. Female

BEGIN TIME: _____:_____ AM / PM

INTERVIEWER CIRCLE ONLY ONE NUMBER BY THE QUESTION. DO NOT READ ANYTHING IN CAPITAL LETTERS TO THE PARTICIPANTS. READ THE FOLLOWING STATEMENT TO THE PARTICIPANT.

Hello, my name is _____. I am working with Emory University in Atlanta to conduct this survey. We are surveying the youth at youth development campuses (YDCs) to learn about adolescents' attitudes, knowledge, and beliefs about sexual activity and drug/alcohol use. This is not a test so there are no right or wrong answers. We are interested in learning what you think and feel.

This survey is completely voluntary and your answers will be kept private. There are some personal questions about your behavior on this survey. Please be honest because your answers will be kept private. None of the facility staff will ever know how you answered. You don't have to answer any questions you don't want to answer. If you don't want to answer a question tell me to go on to the next question.

You will not be asked specific instances of your behavior such as the time and place when you committed a particular crime or when you were a victim of a crime. However, if you do tell me about a specific time and place in which you committed a crime or were a victim of a crime I will have to report that information to the authorities.

It will take approximately an hour and a half to complete the survey. I will mark your answers on my copy; you can follow along with your copy. Please ask me to repeat myself, if at any time you do not understand a question or the instructions. Take your time answering the questions and remember there are no right or wrong answers. Do you

have any questions before we start?

A. First, a few questions about your background. Keep in mind throughout the survey that your answers will be kept private. None of the staff at the facility will ever know how you answered.

A1. GENDER (CIRCLE ONE)
1. MALE
2. FEMALE

A2. How old are you? _____

A3. What is your birth date? _____/_____/_____
month day year

A4. Is your racial/ethnic group...
1. White (non-Hispanic)
2. Black/African American (non-Hispanic)
3. Hispanic
4. Asian or Pacific Islander
5. Native American or Alaskan Native
6. or Other? (specify): _____

A5. Where were you before you entered the Pelham or Irwin YDC?
1. RYDC (specify which one) _____
2. YDC (specify which one) _____
3. Home (skip to A7)
4. Other: _____

A6. If you were at another facility before the Pelham or Irwin YDC, (i.e., waiting somewhere before being assigned to Pelham or Irwin YDC), how many days were you there? _____

	YES ∇	NO ∇
A7. Were you ever locked up before this time? [IF NO, SKIP TO A10]	1	2

A8. ↳ IF YES, Where were you locked up? _____

A9. ↳ IF YES, For how long were you locked up? _____

A10. What is the highest grade of school you have finished?
04 05 06 07 08 09 10 11 12

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

During the <u>month</u> before entering the detention center or YDC were...

	YES ∇	NO ∇
A11. You attending school? [IF NO, SKIP TO A16]	1	2
↳ IF YES...		
A12. Cutting school or classes without permission?	1	2
A13. Arriving late or leaving early without permission?	1	2
A14. You in detention (had to stay after school as punishment) at school?	1	2
A15. Your parents or guardians contacted about disciplinary problems?	1	2
A16. Do you plan to go back to school when you get out?	1	2

A17. How well do you do in school?

1. Mostly A's
2. Some A's and some B's
3. Mostly B's
4. Some B's and some C's
5. Mostly C's
6. C's, D's and F's
7. or Are you failing most classes?

A18. Do you plan to complete high school? 1 2
[IF NO, SKIP TO AA]

A19. IF YES, What do you plan to do or think you will do when you complete high school?

1. Trade/Tech School
2. Work
3. Military
4. College
5. No plans

The options <u>DK</u> (Don't Know) or <u>RF</u> (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

6. Other: (specify): _____

AA. Did you earn your GED? 1 2

AAA. Are you working towards your GED (taking GED classes)? 1 2

AAAA. Do you plan to get your GED rather than your high school diploma? 1 2

A20. What would you like to do when you grow up?

_____

PROBE: TYPE OF JOB, OCCUPATION, HOW WILL YOU MAKE MONEY

	YES ∇	NO ∇
A21. Do you have a religious affiliation? [IF NO, SKIP TO A23]	1	2

A22. ↳ IF YES, What is your religion?

1. Protestant (e.g., Baptist, Lutheran, Episcopal)
2. Catholic
3. Jewish
4. Muslim
5. OTHER: (specify) _____
6. None

A23. How often did you attend religious services during the past month before entering a youth detention center or the YDC...

1. More than once a week
2. Once a week
3. 2-3 times a month
4. Once a month or less
5. or Never?

A24. How important are your religious beliefs to you?

1. Not at all important
2. Slightly important
3. Moderately important
4. Quite important
5. or Very important?

A25. What is your marital status?

1. Never married
2. Married
3. Divorced
4. Separated

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

5. or Widowed?

A26. Who did you live with during the year before entering a detention center or YDC (list all members in the household?

A27. How many children do you have? _____

	YES	NO
A28. Are you or your girl (for young men) pregnant?	1	2

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

E. Now I am going to read you some statements about the future. The scale is from 1 to 5. One stands for Strongly disagree, 2 for Disagree, 3 Neither disagree or agree, 4 for Agree, and 5 for Strongly agree.

How strongly do you disagree or agree with the following statements.

	Strongly Disagree ∇	Disagree ∇	Neither ∇	Agree ∇	Strongly Agree ∇
E1. My future seems dark to me	1	2	3	4	5
E2. It is very hard for me to visualize the kind of person I will be 10 years from now	1	2	3	4	5
E3. I expect that my plans for my future will change many times between now and the time I leave school	1	2	3	4	5
E4. I don't know what kind of work I will do in the future	1	2	3	4	5
E5. I can't even imagine what my life will be like in 20 years	1	2	3	4	5
E6. The future seems very vague and uncertain to me	1	2	3	4	5
E7. It's really no use worrying about the future, because what will be, will be	1	2	3	4	5
E8. I know the kind of job I want when I leave school	1	2	3	4	5
E9. I generally act on the spur of the moment (quickly without thinking)	1	2	3	4	5
E10. I will probably die before I am 30	1	2	3	4	5
E11. I will probably never have enough money	1	2	3	4	5
E12. I think I will have a nice family when I'm older	1	2	3	4	5

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

T. This section asks about your sexual activity. Please be honest. None of the staff at the facility will ever know how you answered these questions.

	YES ∇	NO ∇
T1. Have you ever willingly had <u>vaginal sex</u> (Vaginal sex is when a male puts his penis inside a female's vagina)? ↳ IF NO SKIP TO T24	1	2

T2. IF YES, How old were you the first time you willingly had vaginal sex?

_____

How many different partners have you had vaginal sex with...

T3. in your lifetime? _____

T4. in the last year before entering a facility? _____

T5. in the last month before entering a youth detention center or YDC?

_____

IF ZERO PARTNERS IN THE MONTH BEFORE, SKIP TO T24

T6. How many times did you have vaginal sex in the last month before entering a youth detention center or YDC? _____

T7. Of the ___ times you had vaginal sex in the month before entering a youth detention center or YDC, how many times did you have sex without a condom?

_____

T8. On how many of these occasions did you agree to have sex without a condom? _____

T9. On how many of these occasions did you use alcohol before sex without a condom? _____

T10. With how many different partners did you have sex without a condom?

_____

T11. With how many different partners did you use alcohol before sex

The options <u>DK</u> (Don't Know) or <u>RF</u> (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

without a condom? _____

T12. On how many of these occasions did your partner use alcohol before sex without a condom? _____

T13. On how many of these occasions did you use marijuana before engaging in sex without a condom? _____

T14. With how many different partners did you use marijuana before sex without a condom? _____

T15. On how many of these occasions did your partner use marijuana before sex without a condom? _____

T16. Of the ___ times you had vaginal sex in the month before entering a youth detention center or YDC, how many times did you have sex with a condom? _____
IF ZERO, Skip to T24

T17. With how many different partners did you have sex with a condom in the month before entering a youth detention center or YDC? _____

T18. On how many of these occasions did you use alcohol before having sex with a condom? _____

T19. With how many different partners did you use alcohol before sex with a condom? _____

T20. On how many of these occasions did your partner use alcohol before having sex with a condom? _____

T21. On how many of these occasions did you use marijuana before having sex with a condom? _____

T22. With how many different partners did you use marijuana before sex with a condom? _____

T23. On how many of these occasions did your partner use marijuana before having sex with a condom? _____

YES NO

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

∇ ∇

T24. Have you ever willingly had <u>anal sex</u>? (Anal sex is when a male puts his penis inside a person's anus) 1 2

↳ IF NO SKIP TO T31

T25. IF YES, How old were you the first time you willingly had anal sex? _____

How many different partners have you had anal sex with...

T26. in your lifetime? _____

T27. in the last year before entering a facility? _____

T28. in the last month before entering a youth detention center or YDC? _____

IF ZERO PARTNERS IN THE MONTH BEFORE, SKIP TO T31

T29. How many times did you have anal sex in the last month before entering a youth detention center or YDC? _____

T30. How many times did you have anal sex without a condom in the month before entering a youth detention center or YDC? _____

T31. Have you ever willingly <u>performed oral sex</u> (given) on another person? (Oral sex is when a person puts his or her mouth on another person's penis or vagina.)

1 2

↳ IF NO SKIP TO T38

T32. IF YES, How old were you the first time you willingly performed oral sex? _____

How many different partners have you willingly performed oral sex with...

T33. in your lifetime? _____

T34. in the last year? _____

T35. in the last month before entering a youth detention center or

YDC? _____

IF ZERO PARTNERS IN THE MONTH BEFORE, SKIP TO T38

T36. How many times have you performed oral sex on another person in the Month before entering a youth detention center or YDC? _____

T37. How many times did you perform oral sex on another person without a condom or latex barrier in the month before entering a youth detention center or YDC? _____

T38. Have you ever willingly had someone perform oral sex on you (received)? 1 2

↳ IF NO SKIP TO T45

T39. IF YES, How old were you the first time you willingly had someone perform oral sex on you? _____

How many different partners have performed oral sex on you...

T40. in your lifetime? _____

T41. in the last year? _____

T42. in the month before entering a youth detention center or YDC? _____

IF ZERO PARTNERS IN THE MONTH BEFORE, SKIP TO T45.

T43. How many times did you have someone perform oral sex on you in the month before entering a youth detention center or YDC? _____

T44. How many times did someone perform oral sex on you without a condom or latex barrier in the month before entering a youth detention center or YDC? _____

In the 3 months before entering a detention center or the YDC, how many times have you...CIRCLE ONE.

T45. Had sex with a prostitute?	0	1	2	3	4	5	6
T46. Exchanged sex for money?.....	0	1	2	3	4	5	6

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

T47. Exchanged sex for drugs?.....	0	1	2	3	4	5	6
T48. Had sex with an Injecting Drug User? ...	0	1	2	3	4	5	6

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

In the past year, have you ever had any of the following happen to you...

	YES ∇	NO ∇
T49. Sore bumps or blisters near your sex organs or mouth?	1	2
T50. Burning or pain when you urinate?	1	2
T51. Feeling that you need to urinate frequently?	1	2
MALES ONLY: T52. A drip or drainage from the penis?	1	2
FEMALES ONLY: T53. Vaginal discharge or odor from the vagina?	1	2
T54. Pain in the lower pelvis or deep in the vagina during sex?	1	2
T55. Burning or itching around the vagina?	1	2
T56. Bleeding from the vagina at times other than your regular menstrual cycle?	1	2

Did a doctor or nurse ever say that you had any of these diseases in the last year...

T57. Genital warts?	1	2
T58. Chlamydia?	1	2
T59. Syphilis?	1	2
T60. Gonorrhea?	1	2
T61. Herpes?	1	2
T62. Trich?	1	2
T63. Crabs (pubic lice)?	1	2

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

When you leave the YDC, how likely do you think the following activities are for you...

	Not likely At all	Somewhat Likely	Likely	Very Likely	Definitely
T64. Using a condom or request your partner use them every time you have sex	1	2	3	4	5
T65. Limiting the number of sex partners you have	1	2	3	4	5
T66. Asking a partner what their HIV status is	1	2	3	4	5
T67. Talking to your partner about safer sexual behavior	1	2	3	4	5
T68. Engaging in sexual activity after drinking	1	2	3	4	5
T69. Engaging in sexual activity after using marijuana	1	2	3	4	5
T70. Asking your partners whether they have a sexually transmitted disease (i.e., herpes, syphilis)	1	2	3	4	5
T71. Asking someone about their sexual history before having sex with him or her (i.e., how many different partners)	1	2	3	4	5
T72. Waiting to have sex until you are older	1	2	3	4	5
T73. Sharing needles with anyone	1	2	3	4	5
T74. Drinking alcohol	1	2	3	4	5
T75. Using marijuana	1	2	3	4	5
T76. Attending an Alcoholics Anonymous or Narcotics Anonymous meeting?	1	2	3	4	5

The options DK (Don't Know) or RF (refused to answer) should not be given to participant, but noted next to the question if the participant gives the answers.

APPENDIX B

APPROVAL FORMS

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Institutional Review Board for Human Use

Form 4: IRB Approval Form
Identification and Certification of Research
Projects Involving Human Subjects

UAB's Institutional Review Boards for Human Use (IRBs) have an approved Federalwide Assurance with the Office for Human Research Protections (OHRP). The UAB IRBs are also in compliance with 21 CFR Parts 50 and 56 and ICH GCP Guidelines. The Assurance became effective on November 24, 2003 and expires on October 7, 2008. The Assurance number is FWA00005960.

Principal Investigator:	LEEKS, KIMBERLY D
Co-Investigator(s):	
Protocol Number:	**F051123004**
Protocol Title:	*An Examination of Sexual Risk Behaviors and Future Time Perspective Among African American Adolescent Female Detainees*

The IRB reviewed and approved the above named project on 1/11/2006. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project received FULL COMMITTEE review.

IRB Approval Date: 1/11/2006

Date IRB Approval Issued: 01-13-06

Identification Number: IRB00000196

HIPAA Waiver Approved?: N/A

Partial HIPAA Waiver Approved?: N/A

Ferdinand Urthaler, MD

Ferdinand Urthaler, M.D.
Chairman of the Institutional Review Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

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GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM
DOCTOR OF PHILOSOPHY

Name of Candidate Kimberly D. Leeks

Graduate Program Health Education/Promotion

Title of Dissertation An Examination of Sexual Risk Behaviors and Future Time Perspective Among African American Female Juvenile Detainees

I certify that I have read this document and examined the student regarding its content. In my opinion, this dissertation conforms to acceptable standards of scholarly presentation and is adequate in scope and quality, and the attainments of this student are such that she may be recommended for the degree of Doctor of Philosophy.

Dissertation Committee:

Name		Signature
Connie L. Kohler	**, Chair**	Connie L. Kohler
Agatha Eke		Agatha Eke
Diane Grimley		Diane Grimley
Alyssa Robillard		Alyssa Robillard
Toya V. Russell		Toya V. Russell

Director of Graduate Program Katherine Lee

Dean, UAB Graduate School Bryan W. Nee

Date 8/28/06