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Just: An Indicator of Minimized Value of the Sexual Act

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Abstract

Disparate rates of HIV/STIs transmission to African American women through heterosexual sex persist. Behavioral scientists do not know how African American women perceive sexual risk; thus, efforts continue to gain better understanding. Qualitative methods were used to discern how linguistics used by African American women may indicate perceptions of minimized value of sex. Interviews with 30 eligible African American women who were 18-29 years, sexually active, and substance users took place during emergency department visits. Interviews were professionally transcribed, coded, and organized into themes. Inter-coder reliability was assessed (Cronbach's Alpha=0.723). The term 'just' was noted 89 times; 22/30 women used 'just' in a way that minimized the perceived value of sex when describing sexual experiences. Quotes included statements that minimized sex as a tool for physical pleasure, an adrenaline rush, a way to avoid boredom, a temporary fix, and a way of escaping stressful realities. Identification of a minimized value of sex among African American women is important and can empower healthcare providers through improved cultural competency when engaging them in sexual discussions.

Keywords

Minimized value of sex; African American women; Sexual risk; Cultural norms; Emergency department

Introduction

The overall risk of acquiring HIV from heterosexual transmission has declined over time. Yet, the risk of contracting HIV and/or STIs through heterosexual transmission remains higher for African American women than women in every other racial/ethnic group (Centers for Disease Control and Prevention) [1,2]. In 2015, African American women experienced an HIV diagnoses three times more often than Caucasian women and four times more often than Hispanic/Latino women [2]. A report of 18,561 HIV cases in Houston, Texas and Harris County (the largest county in the Houston metropolitan area) since 1999 positions this geographical area as 11th in the nation for incident HIV infections [3]. A content analysis by gender and race revealed that 36% were women, of which 71% were African American [3]. In fact, 88% of African American women in Harris County with HIV become HIV positive through condomless sex [4]. When substance abuse is added to the equation, HIV risk for African American women who engage in condomless sex worsens. The rate of illicit drug use among African Americans ages 12 and older in the US was higher (12.4%) than the 2016 national average (10.2%) and binge drinking within this cohort (21.6%) was comparable to the national average (23%) [5]. Seventy percent of women treated for drug abuse report an early onset of physical and sexual abuse [6]. These women reported use of illicit drugs, lower self-esteem, and delinquent behaviors more often than other women [6], including transactional sex and a vast scope of sexual activities that is often perceived as promiscuous [7].

The compounded HIV risk from heterosexual contact and substance use is an important driver of HIV risk among African American women and is possibly related to coping strategies and perceptions whereby the value of the sexual act is minimized. This requires targeted prevention interventions based on theoretical and research approaches. Existing efforts that have targeted African American for HIV prevention offered varied perspectives explaining why African American women continue to acquire HIV/STIs at increased rates. The variables that served as the foundation for tested theoretical and research approaches ranged from structural and/or societal factors, to cultural influences and interpersonal factors [8-21]. These reasons for disparate HIV/STI incidence rates are important; however, more evidence is needed to discover effective intervention strategies with capacities to decrease HIV incidence rates among African American women and subsequently eradicate the HIV epidemic. Understanding why high incident HIV rates persist among African American women requires inclusion of intrapsychic and perceptual perspectives. A qualitative study of 24 African American women identified five themes to better understand issues that should be addressed in sexual risk-reduction interventions for women [22]. Those themes were self-esteem, social influences on behavior, relationship fidelity, sexual risk behavior, and partner's sexual behaviors. In a separate qualitative study among 60 HIV negative heterosexual women in the South, two primary themes surfaced:

1. Contradictions between relationship expectations and personal desires and circumstances that challenged ideals.

2. Challenges within the relationship were discovered [17].

Together, findings of these qualitative studies provide insight into the contextual and sociocultural factors that interact to shape perspectives of individuals who engage in behavior that will either increase or decrease their risk of contracting HIV. However, important questions remain. How might some African American women perceive and/or conceptualize their value of their own sexual experiences? How does this value compare to their perceived personal risk of acquiring HIV? If some African American women perceive themselves as at risk for HIV, what behaviors might they engage in to mitigate this risk? Answers to these three pivotal questions are needed to develop, adapt, and implement tailored strategies for HIV prevention for African American women. Deducing those answers from language and theory is a practical and scientifically sound approach that is capable of discovering indicators of sexual behaviors or sexual risk among African American women.

Language is a mechanism that provides insight into a person's understanding of the world around them and can provide insight into their life experiences with the world [23]. Life experience is a major determinant of a person's sexual script; thus, by studying

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African American women's language, qualitative researchers can identify factors that may indicate some African American women's perspectives on sexual behavior and/or sexual risk. Robin Lakoff identified gender differences in language that she suggested stemmed from cultural role assignments whereby women had subservient roles in comparison to men's important roles [24,25]. Evidence of the cultural norm whereby women have subservient roles and less perceived power in sexual decision making is clearly demonstrated in the language used by women when describing the value of the sexual act. A quote used by a woman describing how sex happens in the absence of a committed relationship reads: 'Well, people don't date like they used to. They used to date a long time (ago). Now, it's not even considered a bad thing if you meet somebody and two, three days later you have sex with them. It used to be, you know, you didn't do that. You were considered, you know, nasty or whatever, but now it's the thing. You meet somebody, it's like an instant attraction, so you like them, you don't even think about this might not work. You try to put everything aside that you already see that is wrong, red flags jumping up, and you just hit the bed. There is no dating and dinner, and flowers, and candy, and it's nothing like that, no planning whatsoever, no finding out about their background, it's let's get it on [17].

The authors used the secondary theme 'sex just happens' when describing some African American women's sentiments that sex is an act that occurs by chance. However, the language used when describing the sexual act requires the attention of HIV prevention researchers and interventionists because it reflects the perspective of the individual before engaging in the act. This trivialized value of sex increases chances that the minimized behavior will occur with minimal consideration given to the woman's personal sexual health. A well-established theoretical model, The Health Belief Model (HBM), also lends insight into the answer. The HBM fosters understanding of the connection between beliefs and behavior.

The HBM proposes that individuals will take action to prevent an illness/disease when four conditions are met:

1. They perceive the disease as undesirable or severe enough to avoid,
2. They perceive themselves as at risk for acquiring the disease,
3. They see more benefit than risk to taking action, and
4. They see few barriers to taking action [26,27].

In the case of HIV, actions to prevent this illness/disease include consistent condom use, routine HIV testing, discussing sexual history with partners before engaging in sexual activity, and (more recently) uptake of pre-exposure prophylaxis [28-30]. Although the persistent stigma of HIV among some African-Americans declares an HIV positive diagnosis as highly undesirable and the HIV positive individual as worthy of avoidance, some African American women perceive themselves as being at lower risk of becoming HIV positive than White women [10,31-35] According to the HBM, an individual will only engage in actions to prevent an HIV diagnoses when they perceive themselves to be at risk for HIV. In the absence of perceived risk, consistent adoption of preventive actions or behaviors to prevent an HIV diagnosis remain dismal. Qualitative research findings infer a disconnect between perception and actual HIV risks among some African American women, as descriptions of personal sexual acts routinely involved high risk sexual behaviors [17,22,36]. If a woman's sexual behaviors are associated with her perceptions of morality, it is logical for her to reject personal assumptions associated with stigmatized sexual behaviors [31,37,38].

Engaging patients in fact-based discussions about sexual activity is important. However, such discussions have the potential to be an unpleasant experience for patients for reasons indicated above. How then might providers approach risk discourse with patients? What signals could prompt clinicians to further explore a patient's assumptions and perceptions related to a minimized value of the sexual act? Specifically, how do we engage African American women in scientifically-informed, non-judgmental, culturally-empathic conversations about their sexual behaviors? We suggest that healthcare providers do this by carefully attuning to the language that some African American women use when discussing sexual behavior and sexual decision making, even in atypical patient settings like the emergency department (ED).

Focus of the Current Study

African American women who are at risk for HIV and STIs frequently present to the ED for primary care. The ED is a clinical environment where high rates of STIs are routinely reported at the national level [39-44]. Of 14,093 patients who were tested in a Houston-based hospital's ED, 262 (1.9%) were found to be HIV positive [45]. Of those, 80 (0.6%) did not previously know that they were positive. As such, it would be worthwhile for ED clinicians to consider potential underlying factors that continue to drive the disproportionate burden of HIV risk to African American women. This study builds on tested theoretical and research approaches of seasoned HIV prevention researchers and introduces language as an important factor for consideration when designing HIV prevention interventions for African American women who acknowledge both substance use and condomless sex. Though physician-patient interaction in the ED is brief, we propose that there are certain conversational cues that may signal perceptions whereby value of the sexual act is minimized, which we suggest aligns with underestimating the risk of HIV/STI transmission associated with their sexual behavior. The primary aim of this research is to present healthcare providers, including ED clinicians, public health practitioners, and health interventionists, with a simple language-based cue of minimized value of the sexual act: the use of the term 'just'.

Method

Research design

This is a focused analysis of data gathered from a larger qualitative study that investigated a sample of 30 young African-American women's sexual experiences, ideals, and decision-making processes.

Participants

A total of 30 female African American women were enrolled from both a private (n=15) and public (n=15) ED in the Houston metropolitan area in the United States. They participated in an in-depth interview to discuss matters related to their sexual decisions and experiences.

Participants were 18-29 years of age, had a non-emergent condition, and self-reported current sexual activity and active substance use (including alcohol and/or illicit drugs). Substance use was not distinguished from abuse or dependence per DSM-5 criteria [46]. The screening process was initiated to determine participant eligibility. We collected basic demographic data, including age, marital status, race/ethnicity, chief complaint, and social histories with high risk behaviors, including substance use (type of substance and frequency of use) and sexual activity (currently active (Y/N); number of partners) [11,12,36,47].

Instruments

Semi-structured interviews were facilitated using an adapted, validated in-depth interview tool [48]. Interviews were tailored to participant's responses. There was with some flexibility in standard question administration to elucidate factors that contributed to either engagement in high risk sex or STI prevention behaviors. All interview questions posed were related to the Sexual Script Theory and/or the Theory of Gender and Power [20,49-59]. Topic foci were feelings about sex, descriptions on the development of sexual intimacy, detailed description of subject's first penetrative intercourse experience, gender differences, details on sexual history, knowledge of partner's sexual activities, sexual risk taking, and protective practices. Interviews were semi-structured; thus, a bank of questions from a validated instrument were asked.

The interview protocol was derived from the team's training and qualitative research experience, with significant influence by the qualitative approaches of research conducted among African American women at risk for HIV [22]. The interview tool was piloted as part of student research training prior to data collection. Students used the tool to perform two mock interviews. The interview protocol began with the question, "What does sex mean to you?" Based on the response, questions about emotions related to sex (i.e., "What do you feel when you have sex?"), sexual history (i.e., "Please describe your first sexual experience."), and the physical nature of sex (i.e., "What are your expectations of pleasure during sex?") were explored next.

Interviewee responses were the primary influence to the direction of questions asked in each interview. Interviews were fluid and were tailored to the subject's comfort level on varied sensitive topics. For instance, if a subject responded negatively to a question about transactional sex, all follow-up questions related to decision-making and risk assessment as it pertained to engagement in transactional sex were skipped in the interview, and the next main interview question was presented.

Procedures

The study was approved by the institutional review board at the University of Texas Health Science Center at Houston (HSC-MS-14-0819). Research-credentialed staff completed and submitted a screening and waiver for recruitment form to screen medical records through research-level access at select hospitals. These records were reviewed and patients were screened on the basis of specific demographic and medical data (see Participants section above). Personal health information was accessed; however, only de-identified data was collected and entered into Microsoft Excel. Eligible women were approached for study participation in private rooms of the ED by trained researchers. To confirm screening information, eligible subjects were asked, 'Do you currently use any substances, including alcohol and/or illicit drugs like marijuana, cocaine, methamphetamine, heroine, or any other substances?' All women acknowledged active substance use and, in some cases, substance use was captured by the triage nurse and confirmed by the researcher in the electronic medical record under social history. After eligibility confirmation, each woman was given more detail about the nature of the qualitative study and offered the opportunity to participate. After informed consent was ascertained and enrollment began, participants completed a 20-40 min interview. Interviews were conducted by trained researchers in private rooms within the ED over a seven month period (September 2015-April 2016).

Interview questions were viewed and audiotaped using an iPAD application (Voice Recorder by TapMedia Ltd v2.1) with subject's permission and consent. The PI outsourced transcription of interviews to professional transcribers. Accuracy of transcriptions was verified by comparing the taped audio to the typed version. Each participant received a $25 gift card at the conclusion of the interview for their participation. Clinical care was not interrupted for any patient that participated. Further methodological details and primary results can be found in previous publications [11,36].

Analysis strategy

A content analysis was used. Field notes were taken and content was coded independently by each interviewer. Units of analysis were based on the verbiage used by study subjects. Transcribed audio were analyzed to categorize and identify relevant codes and themes using content analysis. A trained coding team (n=4) consisting of a research faculty member, an experienced qualitative research fellow, a research coordinator, and one undergraduate student analyzed the data. The team collectively coded quotes from one interview to create the codebook, ensuring consistency of the coding strategy used. Each interviewer reviewed and coded the transcribed interviews independently. The remaining transcripts were coded by the team once the codebook was set. Codes were organized into themes by the group during face-to face meetings. Codes were collapsed into themes informed by Wingood's focus of Connell's Theory of Gender and Power on the powerless of African American women in sexual decision making and Stephen and Phillip's focus on female's sexual script development research of African American women [15,17,20,50,59,60-68]. Decision trails for independent coding were kept in a Microsoft Excel spreadsheet where the code, quoted text, and location of the text were documented. When coders disagreed on the meaning of and/or the application of codes, discrepancies were discussed during face-to-face meetings. In some cases, discrepancies were resolved and in other cases, coders agreed to disagree. The research team then conducted a frequency analysis on emerging themes using NVIVO11. Data were matched among coders to assess agreement and/or disagreement using reliability statistics (i.e. Cochran's Alpha).

During transcription of the original interviews, the coding team discovered the code 'just', as the term 'just' was consistently used when describing sexual acts and decision-making. Once coding for the term 'just' was determined, the research team then conducted a frequency analysis on the 'just' code using methods described above. When performing the reliability assessment, IBM SPSS 24.0 was used to organize study data for quantitative analysis using qualitative data from the transcribed text identified by the code 'just' in NVIVO 11.

Specifically for coding of 'just', an Excel spreadsheet was created for each coder to discern.

1. Frequency of use and
2. Correlations of term use with a minimized value of the sexual act ('just' group).

All qualitative quotes were presented by women who were stratified to the 'just' group. In some cases, the term 'just' was used in other contexts (e.g., as referring to fairness, objectivity, or as a discourse marker). Use of the term 'just' in ways that did not minimize the value of the sexual act was excluded from the 'just'group. A comparison group was developed and was comprised of women who did not use the term just as well as women who used the term 'just'in

a way that did not minimize the value of the sexual act. This group was labeled as the 'comparison group'. After examination, data were matched among coders to assess agreement and/or disagreement. Regarding the 'just' code, reliability statistics were assessed using IBM SPSS v24.0, revealing a Cronbach's Alpha of 0.723, demonstrating good agreement between the coders' assessments of the term 'just' as representative of minimized value of the sexual act.

Results

Basic demographic information was collected on enrolled subjects, which revealed a normal distribution of age, marital status, and chief complaint category across both study sites (Table 1). Most women (86.67%) were ages 18-25 years, single (90%), and sought primary care in an ED setting (76.67%). A descriptive comparison was performed between women (N=22) who used the term 'just' versus women (N=8) who did not use this term when describing sexual acts. Although no significant differences were identified, findings revealed that women who used 'just' in sexual descriptions were more likely to report an experience with physical abuse, condomless sex, a previous sexually transmitted infection, receipt of a previous HIV test, and perceptions that their sexual partner was unfaithful (Table 2).

Discovery of the 'just' code

Sexual scripts was one of the primary themes described in the original study. This theme reflected stereotypical or traditional gender-specific sexual attitudes and behaviors [11]. Within this theme, 22/30 participants who engaged in discussions about sexual scripts were identified as using the code 'just' in a minimizing way when describing their sexual behavior.

Analysis strategy of the 'just' code

Women discussed their sexual behaviors in ways that seemed to reflect their underestimation of the value of the sexual act and/or focus on the benefits of engagement in sexual activity rather than any associated risks in-the-moment. Specifically, African American women in this sample reflected on:

1. The physical pleasures of their sexual experience
2. The adrenaline rush associated with impulsive sex
3. Engagement in high risk sexual behaviors despite conflicting internal perceptions
4. Sex as a way of escaping other stressful realities.

Table 1: Sociodemographic profile of study subjects.

Variables	**Emergency Departments**	
	Private (n=15)	**Public (n=15)**
Age		
18-21	6	6
22-25	6	6
26-29	3	3
Marital Status		
Single	13	14
Married	1	1
Missing	1	0
Race/Ethnicity		
African American	15	15
Chief Complaint		
Primary Care	12	11
Dental Care	0	1
Pregnancy Related	2	3

Qualitative Findings Relative to the 'Just' Code

Use of the word 'just' to describe sex as merely a physical experience

In some cases, women responded to general questions about how they conceptualize sex and sexuality by focusing solely on the associated physical pleasure. When a woman was asked about what sex meant to her, she replied that sex was "just something to please the body". The primary focus for her was pleasure. When another woman was asked about what she sought when she had sex, she initially replied "orgasms", with laughter. When the interviewer prompted her to reflect on her thoughts and feelings during sex, her response was: "Well I don't be thinking about nothing. You just think about the feeling because it feels good and you rather stay there for a while. Like euphoria. That's it."

In another instance, a woman described her perception of sex as encompassing more than the physical aspect, she further suggested that individuals who seem more motivated by the physical aspect might suffer from a sexual disorder. While her thoughts may be viewed as controversial, her response provided a contrast to the aforementioned participant's responses. She used the word 'just' to describe undervaluing the capacity of what sex entails. When asked about what sex meant to her, she indicated: "Strong emotional and spiritual connection with your significant other, not just having free form sex just because you feel like having it. (Interviewer: Free form sex?) Some people problem with just….nymphos they just have a problem with having sex. It's not like that with me. You have to have a connection like words, communication feelings things like that"; similarly, another participant compared the pleasure experienced with her current partner with her previous partners, suggesting that her heightened pleasure was related to the depth of their emotional connection. She said: "It feels good….it …it's not just good it's great. I guess maybe because it's with that one special person because doing things with other people don't always feel the same… well before I got with him now, I was just like I wish it would hurry up and get it over with because I guess I was really…I don't think I was attracted to that person or nothing like that."

Use of the word 'just' to describe sex as an impulsive act

Similar to the focus on the physical function of sex, some women focused on the "thrill" of sex, the use of sex as recreation or to reduce boredom, and spoke about engagement in sex with individuals without forethought. For example, one participant indicated that in a recent encounter with a new partner, she "automatically just jumped for it like I normally do." Another normalized impulsive sex as "just a thing everyone do."

One participant described that she required her partners to have the ability to maintain her attention, with no mention of other requirements for the sexual encounter. When asked about her thoughts and feelings during sex, she noted "they have to keep my attention span because I am very to the point where I just uh I get bored real easy…within 5 min if you can't keep my attention for five minutes then." Sex was described as an occurrence taking place on its own, with no active decision making by the study participant. In response to a question about whether she usually talks about sexual history and safe sex preferences before engaging in sexual contact with a partner, she replied "um, yeah. Not most of the time though. Like one time it happened, just you know, just happened, it wasn't planned."

Table 2: Descriptive comparison of women who used the term 'just' versus women who did not use the term 'just'.

Descriptive Variables		'Just' group (N=22)		Comparison group (N=8)		Pearson's χ^2 test
	Subcategories	**N**	**%**	**N**	**%**	**P-values**
Number of sex partners						.742
	0-6	2	9.1			
	20-100	1	4.5			
	100+	1	4.5			
	'I've had quite a few sex partners'	1	4.5			
	Unknown	1	4.5			
	Not reported	16	72.7	8	100	
Age at sexual debut						.791
1	<13	1	4.5	0		
2	13-14	4	18.2	3	37.5	
3	15-16	8	36.4	3	37.5	
4	17-18	5	22.7	1	12.5	
5	19	2	9.1	1	12.5	
6	Not reported	2		0	--	
Experienced physical abuse						.195
	Abused	4	18.2	0	0	
	Not reported	18	81.8	100	100	
Condomless sex						.697
	Engaged in condomless sex	12	54.5	5	62.5	
	Not reported	10	45.5	3	37.5	
Sexually transmitted infection (STI) history						.407
	Had an STI	8	36.4	3	37.5	
	Have not had an STI	4	18.2	0	0	
	Not reported	10	45.5	5	62.5	
Sexual concurrency						.570
	Involved with <1 sexual partnership	7	31.8	1	12.5	
	Not involved <1 sexual partnership	2	9.1	1	12.5	
	Not reported	13	59.1	6	75.0	
HIV testing history						.098
	HIV tested	10	45.5	1	12.5	
	Not reported	12	54.5	7	87.5	
Perceived partner' infidelity						.472
	Perceived sexual partner as unfaithful	6	27.3	1	12.5	
	Perceived sexual partner as faithful	5	22.7	1	12.5	
	Not reported	11	50.0	6	75.0	

This participant's disengagement in her sexual decision making appeared to reflect her disengagement in the sexual act. When asked about her definition of sex in general, she responded: "Just sex…Um, it's pleasure for the time being…. Good emotion… But it's also, it's a bad thing I feel sometimes. Sometimes it's all somebody wants. And then you're just like an object or tool, just there…. It makes you feel useless sometimes."

Uses of the word 'just' to describe the decision to participate in sex despite internal conflict

A participant described the way she processed the internal conflict faced while engaging in sex with a romantic partner. In spite of her discomfort with doing so, she portrayed her perspective of his engagement as emotional manipulation. She ultimately rationalized that having sex with this partner was obligatory and a relational benefit to which her partner was entitled based on the nature of their relationship. She described her thought process in the following way: "Nothing…just telling me what I wanted to hear and I just went for it because we together so, I feel like I have to trust you if we together." Another participant reflected on her physical and emotional feelings during and after sexual encounters when she described her internal thought process. In response to a question about her thoughts and feelings when she is having sex, one woman replied that: "Sometimes… it's just… I don't have a feeling like that. I mean like when, of course when you're climaxing or when you coming or something like that, that part feel good. But then I think back like "Do I even like him?" or some stuff like that, that I just want to get it over with already."

Similarly, a participant described the disconnect between physical sensations and her emotional experience during sex as something that was undesirable. In response to a question about what she was looking for when she has sex, she replied: "To feel good…Um, to feel some type of way towards the person, I guess. Because you don't want to just have sex with a person and then you don't feel nothing about them." A participant engaged in a similar reflection about the relationship between the physical, emotional, and relational aspects of sex when asked the same prompt question above, stating: "Um,

well when I was younger, I used sex to try to find love. Now I just do it just, you know, pleasure my boyfriend or something. (laugh)… Um, well, my thoughts when I was looking for love was, like, you mean during sex? (Yes) Well I was young but I'll try to remember. I know it was more like the feeling of being wanted by that person. Like, feeling like you know special to that person at that point in time because they putting their all into you. That's what you feel you know, and then you feel all their emotions, it's emotional. But when you realize it's not about that when it's all said and done, then it's just like, it was just sex it was never nothing more." When asked to describe her best and worst sexual encounter, a woman replied, "I know it's just I never think about these things, it's so funny. Best or worst, oh my gosh…Okay. The best time, uh, was when, um, or can I speak, like, generally. So me personally I would say the best time was when I felt like it was with the right person. So the connection was there, the chemistry was there, the love was there, the respect was there. Um, nothing was being forced or wasn't aggressive, wasn't, like, I didn't feel uncomfortable doing it. The worst time it was, like, too aggressive. I didn't feel the connection, I felt like, um, I was doing it just to do it, not doing it because I wanted to do it. I wasn't really all in so it wasn't enjoyable."

The internal conflict in each of these cases related to the feeling of disconnect relative to the physical sexual act from the emotional connection that these women expected during sex. The emotional connection is not required in order for the women to engage in the sexual act. However, the presence of an emotional connection seems meaningful to women enrolled. Choosing to engage in sexual acts that they deem meaningful suggests a willingness to do what feels good to oneself. This has the potential to translate to willingness to do what is good for oneself (ie. sex with condoms).

Use of the word 'just' to describe sex as a distraction

Lastly, one participant described sex as an escape from reality. In response to the question about her thoughts and feelings during sex, she replied "it's just drifting you off in another land somewhere… a pleasant land."

Discussion

Merriam-Webster defines the term 'just' as an adjective and an adverb. 'Just' as an adjective is defined as:

1. A basis in or conforming to fact or reason.
2. Conforming with what is morally upright or good.
3. Legally correct [69].

Conversely, 'just' as an adverb is defined as:

1. Exact or precise.
2. By a very small margin.
3. Only or simply.
4. Quite or very; perhaps or possibly.

Although the term 'just' has varied definitions, the context in which the word was used within this sample of African American women was uniform. To our knowledge, this is the first manuscript that explores how some African American women may use the word 'just' during sexual health discourse as a signal of minimized value of the sexual act. A previous interview-based qualitative study explored relationship dynamics and sexual decision making among 60 HIV negative, African American women. Sex just happens was discovered as a secondary theme [17]. Research findings presented here strengthens former research by further exploring the frequent use of the term 'just' in a way that signals minimized value of the sexual act when African American women communicate about their sexual behaviors and sexual decision-making process. This routine description of the sexual act is of concern because heterosexual contact is the primary mode of HIV transmission for African American women [2]. However, some African American women seem to lack concern about being at risk for HIV and likely do not perceive themselves as being at risk for HIV, a serious health condition that would have a direct effect on them and their quality of life [22-70]. Additionally, some African American women are aware of their sexual partner's concurrent relationships and continue to engage in condomless sex with them [15,71]. Collectively, a negligent value of the sexual act may contribute to a willingness to engage in condomless sex with partner's in concurrent partnerships. This point of view worsens the inherent risk afforded to African American women by race and gender [47]. Review of participant responses revealed a focus on physical elements of the sexual encounter. A more in-depth qualitative analysis exposed a social norm where some of the African American women enrolled routinely used the word 'just' to limit the value of sex as a purely physical act that is impulsively performed and/or used as a tool for distraction.

Moreover, some African American women used 'just' in ways that allowed them to engage in sex with partners while ignoring their own internal conflict. Preliminary evidence of internal conflicts demonstrated among women who used the term 'just' when describing sexual acts showed up in several ways that included a higher prevalence of experience with physical abuse, condomless sex, a previous diagnosis of a sexually transmitted infection, a previous HIV test, and perceptions that their sexual partner was unfaithful. Findings of this study provide a meaningful contribution to the literature on social determinants of sexual health, as it demonstrates the importance of paying attention to descriptive words used and adds an important yet unnoticed element to the ongoing discussion on innovative strategies for HIV prevention interventions.

Interview responses indicated that some African American women may not have the tools needed to discern the conflict between their expressed values of health preservation compared to their behaviors and decisions to engage in behaviors that undermine their goals of having sexual health. If this is the case, then healthcare providers will do well to engage patients in reflective listening and gently present the conflict between patients' stated values and behaviors (e.g., their stated goal of avoiding HIV/STI infection as juxtaposed with their engagement in risky sexual behaviors). If time permits, providers should consider highlighting the patient's incongruence and offer a safe space in which to consider a different perspective.

Prior research indicated that dissonance-based health interventions, or those that induce some amount of internal discomfort by highlighting the mismatch between beliefs and behavior, have been effective in changing health-related attitudes and behaviors [72]. Considering the cognitive processes in which women engage to assess their own sexual risk is important. Recently, the Perceived Risk Hierarchy Theory posited that young adults between 18 and 24 years utilize a framework for survival and success to prioritize risk [10]. In order for young adults to connect with prevention practices and behaviors, the priority risks must be acknowledged and addressed in a satisfactory way. Priority risks for some African American women

may include use of excessive force by police, community assaults and acts of violence, environmental factors, and homelessness and unstable housing [10]. Until the immediate needs are met, cognitive processes to trivialize sexual risk may manifest as temporary survival tactics. The Perceived Risk Hierarchy Theory addresses an important critique of the Health Belief model, which is that it seems to overlook the role that environmental or social factors has on influencing behavior [10,73]. In one participant's example, she minimized her discomfort about engaging in sex with her partner due to the social expectation of sex as a required relational norm.

In a social environment where being in a partnership elevates one's social status and those who do not successfully attain and/or maintain long-term romantic or sexual partners are lambasted, it could be the case that some African American women are very well aware of the dangers of serial monogamy, partner concurrency, and other behaviors. However, some African American women continue to internally minimize the potential costs of their sexual behavior by magnifying the benefits that come with partnership [10]. Astute providers should be aware of the social pressures for partnership among some African American women in their respective communities, as they empathetically discuss risk behaviors with patients.

It should be noted that this was a sample of African American women who also engaged in substance use along with sexual risk behaviors, thus, other personality or psychiatric factors could be underlying a tendency to minimize the value of the sexual act and/or associated health risks. Specifically, those who are more sensation-seeking than risk averse may be more open to engaging in impulsive and potentially dangerous behaviors such as substance use and risky sex. Impulsivity is a central diagnostic feature of many mental health disorders, including bipolar disorder, borderline personality disorder, and post-traumatic stress disorder [74,75]. Our use of the phrase "minimized value of the sexual act" does not imply that sex is only valid if it occurs for some purpose other than pleasure. Sex is a physically pleasurable experience, and can be enjoyed without an emotional or relational goal to fulfill.

Research has suggested that women tend to engage in less protective practices as their level of commitment to or emotional investment in the relationship increases [76,77]. Women may even fail to engage in sexual protective behavior despite their acknowledgement that their male partner is not committed to sexual monogamy, with the hope that he will at least engage in protective practices with extra-relational partners [12,17,60,78]. As patients may interpret the provider educating them about the relative risk associated with their behaviors as an attempt to shame them for their sexuality, providers may consider taking a "sex-positive" stance. Providers should not seek to discourage sexual expression, but to balance pleasure seeking with self-care. Good sexual self-care is having accurate information about why the sexual act should be valued, inherent sexual risks, and consistently engaging in practices that minimize those risks. Safety and sexual health are as important as physical and mental pleasure and satisfaction.

Findings of this qualitative study substantiate the importance of healthcare providers, including physicians, nurses, social workers, and public health practitioners, to be attentive to the words their patients use to describe their sexual encounters and sexual decision-making processes, including the seemingly mundane. A need exists for healthcare providers to further their understanding of cultural norms, diversity of language, and the cultural morals and values of their patient populations. These realities are paramount to their effectiveness in decoding what information is being communicated between themselves and the patient. By considering the language that people use to communicate with healthcare providers about their sexual behavior, clinicians may be better positioned to:

1. Identify patients who minimize the value of the sexual act and may be at risk for HIV and STIs,

2. Engage them in conversations about why sex should be valued while inquiring about their risk perceptions, and

3. Encourage the adoption of a new perspective on the value of the sexual act coupled with tools to implement comprehensive HIV prevention strategies.

The importance of these considerations are made clear with evidence suggesting that modifying one's appraisal of risk may positively impact intentions and behavior, especially if anticipatory emotions or perceived severity are engaged, self-efficacy is increased, and response costs (i.e., barriers to taking action) are reduced.

Limitations and Conclusions

A primary limitation of the study is the small sample size. Due to sample size, the findings cannot be generalized to other groups of African American women who report substance use and sexual activity. Lack of cultural awareness and knowledge by the professional coding team contributed to minimal transcription errors that were easily corrected by study team members through review and correction [79]. This pilot study should be replicated with a larger sample size and at other EDs. This was a sample of young, African American women who engaged in substance use and sexual risk behaviors, thus, findings should not be generalized to all young African American women. Lastly, the population is not representative of the general population in the Houston area, as there was undocumented diversity in the sample based on education and health care access. Some participants expressed (although the information was not systematically captured) that they were in college or had completed college and had a usual source of medical care. These limitations challenge the generalizability of study findings by demographics, such as income and education, within the subpopulation of African American women. However, this pilot study paves the way for additional research in this area [80].

Finally, this study was an analysis of qualitative data designed to assess a different theoretical question, namely the factors that influence young African American women's engagement in either protective sexual behavior or "risky" sex. As such, the semi-structured interview was designed to prompt more in-depth discussions of certain designated topics, while missing chance opportunities to more thoroughly engage participants in other sexual health related discourse. The researchers' discovery of the frequent use of the term 'just' as a conversational signal of minimized value of the sexual act was an unintentional finding. As such, interviewers did not have the opportunity to inquire directly to participants about whether or not their use of the term 'just' truly signaled a minimized value of sex.

Future Research

Future qualitative researchers are encouraged to use a flexible interview approach in studies of sexual risk perceptions among young African American women. Interviewers should be trained to notice whether participants use the word 'just' in a way that reflects minimized value of the sexual act. Researchers should explore this

line of thinking with women directly. This inquiry could be as simple as engagement in reflective listening. For example, a researcher could say, "When you described sex a moment ago, you stated, 'it's just a thing that everyone does.' Help me to understand what you intended to communicate by using the word just." Engagement in direct questioning will prevent researchers from imputing unintended meaning. These tailored questions will improve the data quality substantially. Findings of future research studies that explore utility of the word 'just' in this way would substantiate or challenge the premise of this manuscript and contribute to the body of research on sexual perspectives. This will improve the evaluation of future findings related to how African American women communicate their engagement in and value of sexual activity.

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References

1. Center for Disease Control and Prevention (CDC) (2008). HIV/AIDS fact sheet 2008: HIV/AIDS among women.
2. Center for Disease Control and Prevention (CDC) (2016) HIV Among Women.
3. City of Houston Health Department (2015) AIDS: Summary of Adult Reportable Houston/Harris County Cases.
4. Texas Department of State Health Services HIV/STD Program (2014) Black Women and HIV in Harris County.
5. Bose J, Hedden S, Lipari R, Park-Lee E (2016) Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health.
6. Velasquez M, Stotts A (2003) Substance Abuse and Dependence Disorders in Women. In M. K. a. M. A. Keitel (Ed.), Handbook of Counseling Women (pp. 482-503). Sage Publications, Inc.: Sage Publications.
7. McDuff DR, Solounias BL, RachBeisel J, Johnson JL (1994) Psychiatric consultation with substance abusers in early recovery. Am J Drug Alcohol Abuse 20: 287-299.
8. Bowleg L (2004) Love, sex, and masculinity in sociocultural context. Men and Masculinities 7: 166.
9. Davis SK, Tucker BA (2013) The Effects of Social Determinants on Black Women's HIV Risk: HIV Is Bigger Than Biology. Journal of Black Studies 44: 273.
10. Edwards LV, Lindong I, Brown L, Hawkins AS, Dennis S, et al. (2017) None of Us Will Get Out of Here Alive: The Intersection of Perceived Risk for HIV, Risk Behaviors and Survival Expectations among African American Emerging Adults. J Health Care Poor Underserved 28: 48-68.
11. Hill M, Andrews S (2017) Evolution of the DECISION: Pilot study findings reveal a logic model to sexual decision making. J Gen Emerg Med 2: 1-15.
12. Hill M, Granado M, Stotts A (2016) Theoretical Implications of Gender, Power, and Sexual Scripts for HIV Prevention Programs Aimed at Young, Substance-Using African-American Women. J Racial Ethn Health Disparities 4: 1175-1180.
13. Hotton AL, French AL, Hosek SG, Kendrick SR, Lemos D, et al. (2015) Relationship Dynamics and Sexual Risk Reduction Strategies Among Heterosexual Young Adults: A Qualitative Study of Sexually Transmitted Infection Clinic Attendees at an Urban Chicago Health Center. AIDS Patient Care and STDS 12: 668-674.
14. Jones L (2006) Sexual discourse and decision-making by urban youth in AIDS-afflicted Swaziland. African Journal of AIDS Research 5: 145-157.
15. Jones R, Oliver M (2007) Young urban women's patterns of unprotected sex with men engaging in HIV risk behaviors. AIDS and Behavior 11: 812-821.
16. Kim D, Pang MG (2007) The effect of male circumcision on sexuality. BJU International 3: 619-622.
17. McLellan E, Toledo L, O'Daniels C, Villar-Loubet O, Simpson C, et al. (2013) "A man's gonna do what a man wants to do": African American and Hispanic women's perceptions about heterosexual relationships: a qualitative study. BMC Women's Health 13: 1-14.
18. Newman PA, Williams CC, Massaquoi N, Brown M, Logie C (2008) HIV prevention for Black women: structural barriers and opportunities. J Health Care Poor Underserved 19: 829-841.
19. Wingood GM, DiClemente RJ (1998) Gender-related correlates and predictors of consistent condom use among young adult African-American women: a prospective analysis. Int J STD AIDS 9: 139-145.
20. Wingood GM, DiClemente RJ (1998) Partner influences and gender-related factors associated with noncondom use among young adult African American women. Am J Community Psychol 26: 29-51.
21. Wyatt G (1997) Stolen Women: Reclaiming Our Sexuality, Taking Back Our Lives: Wiley.
22. Paxton KC, Williams JK, Bolden S, Guzman Y, Harawa NT (2013) HIV Risk Behaviors among African American Women with at-Risk Male Partners. J AIDS Clin Res 4: 221.
23. Flowers D, Sheared V (1997) The significant of African-American language and learning in an adult education context: 'going back to our roots'. 27th Annual SCUTREA conference proceedings.
24. Lakoff R (1973) Language and Woman's Place. Language in Society 2: 45-79.
25. Wheeler RS (1999) The Workings of Language: From Prescriptions to Perspectives: Greenwood Publishing Group.
26. Becker M (1974) The health belief model and personal health behavior. Health Education Monographs 2: 324-473.
27. Janz N, Becker MH (1984) The Health Belief Model: A Decade Later. Health Educ Q 11: 1-48.
28. Aghaizu A, Mercey D, Copas A, Johnson AM, Hart G, et al. (2013) Who would use PrEP? Factors associated with intention to use among MSM in London: a community survey. Sexually Transmitted Infections 89: 207-211.
29. Auerbach JD, Kinsky S, Brown G, Charles V (2015) Knowledge, attitudes, and likelihood of pre-exposure prophylaxis (PrEP) use among US women at risk of acquiring HIV. AIDS Patient Care and STDS 29: 102-110.
30. Auerbach JD, Riordan M (2012) Will and Should Women in the U.S. Use PrEP? Findings from a Focus Group Study of At-risk HIV negative Women in Oakland, Memphis, San Diego, and Washington, DC.
31. Earnshaw VA, Bogart LM, Dovidio JF, Williams DR (2013) Stigma and racial/ethnic HIV disparities: Moving toward resilience. Am Psychol 68: 225-236.
32. Gerrard M, Gibbons FX, Bushman BJ (1996) Relation between perceived vulnerability to HIV and precautionary sexual behavior. Psychol Bull 119: 390-409.
33. Higgins JA, Hoffman S, Dworkin SL (2010) Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. Am J Public Health 100: 435-445.
34. Roberts ST, Kennedy BL (2006) Why are young college women not using condoms? Their perceived risk, drug use, and developmental vulnerability may provide important clues to sexual risk. Arch Psychiatr Nurs 20: 32-40.
35. Zukoski AP, Thorburn S (2009) Experiences of stigma and discrimination among adults living with HIV in a low HIV-prevalence context: A qualitative analysis. AIDS Patient Care STDS 23: 267-276.
36. Hill M, Granado M, Villarreal Y, Fuega J, Robinson D, et al. (2017) Predictors of sexual scripts among young, sexually-active, substance-using African American women. Journal of AIDS and Clinical Research 8: 655.
37. Calabrese SK, Underhill K (2015) How Stigma Surrounding the Use of HIV Preexposure Prophylaxis Undermines Prevention and Pleasure: A Call to Destigmatize "Truvada Whores". Am J Public Health 105: 1960-1964.
38. Darlington CK, Hutson SP (2017) Understanding HIV-Related Stigma Among Women in the Southern United States: A Literature Review. AIDS Behav 21: 12-26.

39. Bachmann LH, Pigott D, Desmond R, Jones M, Lumpkins J, et al. (2003) Prevalence and factors associated with gonorrhea and chlamydial infection in at-risk females presenting to an urban emergency department. Sex Transm Dis 30: 335-339.
40. Haukoos JS, Hopkins E, Byyny RL, Conroy AA, Silverman M, et al. (2009) Design and implementation of a controlled clinical trial to evaluate the effectiveness and efficiency of routine opt-out rapid human immunodeficiency virus screening in the emergency department. Acad Emerg Med 16: 800-808.
41. Mehta SD, Rompalo A, Rothman RE, Londner MS, Zenilman JM (2003) Generalizability of STD screening in urban emergency departments: Comparison of results from inner city and urban sites in Baltimore, Maryland. Sex Transm Dis 30: 143-148.
42. Mehta SD, Rothman RE, Kelen GD, Quinn TC, Zenilman JM (2001) Unsuspected gonorrhea and chlamydia in patients of an urban adult emergency department: A critical population for STD control intervention. Sex Transm Dis 28: 33-39.
43. Monroe KW, Weiss HL, Jones M, Hook EW (2003) Acceptability of urine screening for Neisseria gonorrheae and Chlamydia trachomatis in adolescents at an urban emergency department. Sex Transm Dis 30: 850-853.
44. Todd CS, Haase C, Stoner BP (2001) Emergency department screening for asymptomatic sexually transmitted infections. Am J Public Health 91: 461-464.
45. Hoxhaj S, Davila JA, Modi P, Kachalia N, Malone K, et al. (2011) Using nonrapid HIV technology for routine, opt-out HIV screening in a high-volume urban emergency department. Ann Emerg Med 58: S79-84.
46. Hasin DS, O'Brien CP, Auriacombe M, Borges G, Bucholz K, et al. (2013) DSM-5 criteria for substance use disorders: Recommendations and rationale. Am J Psychiatry 170: 834-851.
47. Hill MJ, Holt M, Hanscom B, Wang Z, Cardenas-Turanzas M (2018) Gender and race as correlates of high risk sex behaviors among injection drug users at risk for HIV enrolled in the HPTN 037 study. Drug Alcohol Depend 183: 267-274.
48. Ingham R, Stone N (2015) Topics for In-depth Interviews and Focus Group Discussions.
49. Albarracin D, Johnson BT, Fishbein M, Muellerleile PA (2001) Theories of reasoned action and planned behavior as models of condom use: A meta-analysis. Psychol Bull 127: 142-161.
50. Boutin-Foster C, McLaughlin N, Gray A, Ogedegbe A, Hageman I (2010) Reducing HIV and AIDS through Prevention (RHAP): A theoretically based approach for teaching HIV prevention to adolescents through an exploration of popular music. J Urban Health 87: 440-451.
51. DePadilla L, Windle M, Wingood G, Cooper H, DiClemente R (2011) Condom use among young women: Modeling the theory of gender and power. Health Psychol 3: 310-319.
52. Hennessy M, Bleakley A, Fishbein M, Brown L, Diclemente R, et al. (2010) Differentiating between precursor and control variables when analyzing reasoned action theories. AIDS Behav 14: 225-236.
53. Kim JL, Sorsoli CL, Collins K, Zylbergold BA, Schooler D (2007) From sex to sexuality: Exposing the heterosexual script on primetime network television. J Sex Res 44: 145-157.
54. Parsons JT, Vicioso KJ, Punzalan JC, Halkitis PN, Kutnick A, et al. (2004) The impact of alcohol use on the sexual scripts of HIV-positive men who have sex with men. J Sex Res 41: 160-172.
55. Reed D, Weinberg MS (1984) Premarital coitus: Developing and established sexual scripts. Soc Psychol Q 47: 129-138.
56. Stokes C (2007) Representin' in Cyberspace: Sexual Scripts, Self-Definition, and Hip Hop Culture in Black American Adolescent Girls' Home Pages. Cult Health Sex 2: 169-184.
57. Tolman DL, Kim JL, Schooler D, Sorsoli CL (2007) Rethinking the associations between television viewing and adolescent sexuality development: Bringing gender into focus. J Adolesc Health 40: 9-16.
58. Wingood GM, DiClemente RJ (1992) Cultural, gender, and psychosocial influences on HIV-related behavior of African-American female adolescents: Implications for the development of tailored prevention programs. Ethn Dis 2: 381-388.
59. Wingood GM, DiClemente RJ (2000) Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. Health Educ Behav 27: 539-565.
60. Bowleg L, Lucas KJ, Tschann JM (2004) "The Ball Was Always In His Court": An Exploratory Analysis of Relationship Scripts, Sexual Scripts, And Condom Use Among African American Women. Psychol Women Q 28: 70-82.
61. Erickson PI, Badiane L, Singer M (2013) The social context and meaning of virginity loss among African American and Puerto Rican young adults in Hartford. Medical Anthropology Quarterly 27: 313-329.
62. Holman A, Sillars A (2012) Talk about "hooking up": The influence of college student social networks on nonrelationship sex. Health Commun 27: 205-216.
63. Hussen SA, Bowleg L, Sangaramoorthy T, Malebranche DJ (2012) Parents, peers and pornography: The influence of formative sexual scripts on adult HIV sexual risk behaviour among Black men in the USA. Cult Health Sex 14: 863-877.
64. Robinson BB, Bockting WO, Rosser BR, Miner M, Coleman E (2002) The Sexual Health Model: Application of a sexological approach to HIV prevention. Health Education Research 17: 43-57.
65. Ross JN, Coleman NM (2011) Gold Digger or Video Girl: the salience of an emerging hip-hop sexual script. Cult Health Sex 13: 157-171.
66. Roye CF, Tolman DL, Snowden F (2013) Heterosexual anal intercourse among Black and Latino adolescents and young adults: A poorly understood high-risk behavior. Journal of Sex Research 50: 715-722.
67. Vannier SA, O'Sullivan LF (2011) Communicating interest in sex: verbal and nonverbal initiation of sexual activity in young adults' romantic dating relationships. Archives of Sexual Behavior 40: 961-969.
68. Wiederman M (2005) The gendered nature of sexual scripts. The Family Journal 13: 496-502.
69. Merriam Webster Dictionary (1828) 2017 Merriam-Webster, Incorporated.
70. Center for Disease Control and Prevention (CDC) (2012) Estimated HIV incidence among adults and adolescents in the United States, 2007-2010. Atlanta, GA.
71. Cornelius LJ, Okundaye JN, Manning MC (2000) Human immunodeficiency virus- related risk behavior among African-American females. J Natl Med Assoc 92: 183-195.
72. Freijy T, Kothe EJ (2013) Dissonance-based interventions for health behaviour change: A systematic review. Br J Health Psychol 18: 310-337.
73. Traube DE, Holloway IW, Smith L (2011) Theory development for HIV behavioral health: Empirical validation of behavior health models specific to HIV risk. AIDS Care 6: 663-670.
74. Abba N, Chadwick P, Stevenson C (2008) Responding mindfully to distressing psychosis: A grounded theory analysis. Psychother Res 18: 77-87.
75. Dileo JF, Brewer WJ, Hopwood M, Anderson V, Creamer M (2008) Olfactory identification dysfunction, aggression and impulsivity in war veterans with post-traumatic stress disorder. Psychological Medicine 38: 523-531.
76. Adimora AA, Schoenbach VJ, Doherty IA (2006) HIV and African Americans in the southern United States: Sexual networks and social context. Sex Transm Infect 33: 539-545.
77. Amaro H (1995) Love, sex, and power. Considering women's realities in HIV prevention. Am Psychol 50: 437-447.
78. Hill M, Holt M, Hanscom B, Wang Z, Latkin C, et al. (2017) Gender and race as correlates of high risk sex behaviors among injection drug users at risk for HIV enrolled in the HPTN 037 study. Drug Alcohol Depen 183: 267-274.
79. Stone J, Focella E (2011) Hypocrisy, dissonance and the self-regulation processes that improve health. Self & Identity 10: 295-303.
80. Texas Department of State Health and Human Services Program (2014) Black Women and HIV in Harris County.

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