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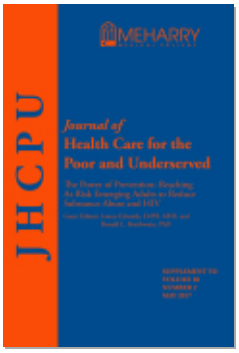

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ORIGINAL PAPER

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

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Abstract: The Human Immunodeficiency Virus (HIV) significantly affects minority emerging adults, among whom the rate of new diagnoses is high and health disparities are more pronounced. Importantly, emerging adults today have limited knowledge of the earlier toll of the virus when it was identified as a killer. Among this population, perceptions of risk for HIV are low and sexual risk taking behaviors are high. The Get SMART Project is a behavioral intervention aimed to provide re-purposed HIV, alcohol, and substance abuse prevention education and HIV testing to African American emerging adults ages 18–24. The project was guided by the Health Belief Model, Community Promise, and Training for Institutional Procedures. Findings revealed that HIV testing is low. Marijuana and alcohol are drugs of choice. Emerging adults do not see themselves at risk for HIV, although they engaged in high-risk behaviors. Additionally, survival expectations influence behavior risk.

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The human immunodeficiency virus (HIV) is having a significant impact on minority emerging adults, who face pronounced health disparities relative to their non-minority peers; among minority emerging adults the rate of new diagnoses is high.[1] Importantly, emerging adults today have limited knowledge of the earlier toll of the virus when it was identified as a killer that cut through every socioeconomic group, eventually wreaking severe havoc on the African American community. Fast forward to today: African Americans continue to be disproportionately affected by HIV, and HIV is greatest among sexual and racial minority populations.[1]

Emerging adults in the United States today have never known a world without HIV.[1] They have no memory of the challenging times when HIV was almost always fatal.[1] The high prevalence of HIV in the African American community among social and sexual networks alone increases the risk for contracting HIV, as African American emerging adults are more likely to engage in risky sexual behavior, participate in "urban sexual suicide" (unprotected sex with multiple partners with an unknown HIV status),* use condoms inconsistently, and engage in sex while under the influence of alcohol and/or drugs (e.g., marijuana, which is sometimes called the *sex drug*).[2] As HIV rates continue to escalate among this population (approximately 1,000 per month, CDC Vital Signs, 2013) academic institutions are essential partners in the many efforts to reduce HIV risk among youth, and they can serve multiple functions in supporting sexual health and wellness among this population.

African American emerging adults are particularly affected. Of the nearly 21,000 infections estimated to occur each year among African Americans, one-third (34%) are among people aged 13 to 24 years.[2] In 2014, an estimated 9,731 youth aged 13 to 24 were diagnosed with HIV in the United States; 81% (7,868) of diagnoses among youth occurred in people aged 20–24.[3] Among those aged 13–24 diagnosed with HIV, African American males have the higher rates of infection among all race/ethnicity groups as well as gender.[3] African Americans, who make up 12% of the U.S. population, account for 44% of new infections overall[4] and 57% among youth.[5]

Young same gender-loving (SGL) African American men are at highest risk of acquiring HIV (as much as 11 times more than young White males).[6] HIV in this subgroup is multifactorial; higher rates of sexually transmitted diseases (STD), stigma, alcohol and substance abuse, socioeconomic status, internalized homophobia, and lack of awareness of HIV status, are likely to escalate HIV acquisition rates. Over 70% of HIV infected SGL young African American men are unaware of their HIV status. The problem is magnified by the low rates of care and treatment (21%) and controlled viral load (18%) of those youth diagnosed with HIV.[2]

The university environment offers a great opportunity for addressing HIV high-risk behaviors, including unsafe sex and multiple sex partners. In prevention studies

*I coined the term *urban sexual suicide* as part of my research. Its definition is included in the text of this paper in parentheses.

conducted in HBCU settings, African American youth generally perceive themselves as having low risk of contracting HIV and STDs despite having higher rates of unprotected sex, multiple sex partners, particularly low rates of HIV testing and awareness of HIV status,[7–8] while engaging multiple high-risk behaviors. However, HBCUs are in a unique position to tackle HIV on campus and in the community through comprehensive sexual health awareness education courses, traditional/non-traditional HIV testing, innovative HIV activities, and equipping students with prevention education, strategies for increased condom use, and tools to facilitate behavioral risk reduction. However, predefined boundaries (attitudes) towards HIV and sex education and/or HIV-associated stigma and social conservatism by school authorities may have contributed to the lack of HIV awareness/education among youth and emerging adults,[9] and thereby increased the rates of acquisition among this population.

HIV risk perceptions. Understanding adolescent and young adult perceptions of HIV risk is important for targeted HIV prevention studies. El Bcheraoui et al.[10] investigated patterns of condom use among students of HBCUs and noted that 46% did not use a condom during their last sexual intercourse, and those who perceived themselves as being at average/high risk of acquiring STIs were less likely to use a condom during their last sexual intercourse (Adjusted OR: 0.6; 95% CI: 0.4–0.8). Reasons for not using condoms included unwillingness to spoil the moment, having unplanned sex, and not believing themselves to be at risk for HIV. Condom use during last sexual intercourse was significantly less likely among students who worked fewer than 20 hours a week compared with both unemployed students and students working more than 20 hours a week.

To identify risk factors for HIV acquisition, Camacho-Gonzalez et al.[9] administered surveys to HIV-infected and non-infected emerging adults ages 18–24. The inclusion was limited in that participants only needed to fit the age criteria and reside in the Atlanta metropolitan statistical area. This investigation employed self-administered surveys and 17 focus groups to facilitate exploration. Quantitative ACASI surveys revealed several noteworthy findings. Transactional sex was a frequent practice. Eighty-eight percent of the participants indicated that it is common to exchange sex for material things and daily living expenses. Furthermore, it was noted that the main reason for lack of condom use was fear of rejection (58%) and personal preference (65%). Focus group data discussion with HIV-infected participants included comments such as, "Nobody is using protection." Although, HIV-infected emerging adults share their HIV status upon request for sexual engagement, sexual partners are not concerned about their HIV status and will engage in unprotected sex anyway. Some participants expressed the view that there is no need to discuss HIV with a prospective sexual partner if one is not in a relationship or considering a relationship with the person in question. Rather, in the words of the old, callous expression, common attitudes towards sex are, "Wham, bam, see ya later."

Youth and emerging adults carry the highest incidence of HIV infection in the United States.[9] Understanding emerging adult perspectives on HIV transmission risk is important for targeted HIV prevention research. Numerous studies demonstrate that African American college students are well informed about the severity of HIV/AIDS, know how the infection is transmitted, and are aware of prevention strategies, yet they

continue to engage in unsafe sexual behaviors.[11–12] It appears that these students have knowledge but their attitudes and behaviors are impediments. Several factors play a role in youth and emerging adult's risk factors for HIV acquisition: transactional sex (exchanging sex for money, food, drugs, clothing, and shelter), alcohol and substance use, high levels of risk-taking sexual behaviors, congruent sex partners, and survival expectations. Perceptions of HIV risk among emerging adult populations are low. Furthermore, HIV risk behaviors have been found to be associated with marijuana use and as noted above marijuana is viewed as the sex drug.[13]

Perceived risk priorities. The importance of assessing the local culture and social environment for factors relevant to risk and/or protective behaviors in health and development among young adults has become fundamental to intervention planning.[14] Moreover, the concept of risk is critical in examining health behavior. Risky behaviors among emerging adults are relatively frequent, and the determinants of perceived risk must be given full consideration when planning interventions and prevention studies. Risk portfolios are useful for work with emerging adults. For the purposes of this research, a *risk portfolio* is the ranking and prioritizing of risk based on a set of values, beliefs, and knowledge. Among youth and emerging adults, risk is prioritized to determine what has the greatest harm or danger. Police engagement was noted as a risk priority because it was uncertain if one would live long enough to talk about their encounter. When youth and emerging adults perceive a sense of hopelessness, they have little reason to delay immediate gratification (e.g., unprotected sex, multiple sex partners, violence, alcohol and substance, drunk driving).

According to Geller et al.,[15] police contact may threaten the health of individuals stopped in several ways. The physically invasive, often rough manner in which officers approach individuals raises the risk of injury. Despite the heated contemporary debate on police practices,[16–18] emerging adults who are stopped have expressed feelings of hopelessness and being dehumanized.[19–20] Other researchers such as Shedd[21] suggest high rates of distress and perceptions of injustice among African American emerging adults. Emerging adult African American men stopped by the police fear physical violence/aggression, social injustices, and never being seen as anything other than "symbolic assailants."[19] Racially biased policing is a critical concern among inner-city youth and emerging adults, especially males.

Increasing numbers of emerging adults in urban neighborhoods are exposed to high levels of community violence. Community violence may take many forms, but it generally includes factors such as homicide, rape, other types of sexual assaults, and robbery.[22–23] In many low-income, ethnic minority communities, violence has become a constant stressor that is unpredictable, and can affect innocent bystanders as well as those directly involved.[24–27] High levels of community violence often result in chronic fear and perceptions of danger among emerging adults that affects their day-to-day functioning.[28] The psychological impact of living under conditions of chronic fear and threat can often lead to hopelessness. Many youth and emerging adults who have been victims of community violence (e.g., assault, gunshot wounds) report a sense of futurelessness characterized by a strong belief that they will not reach adulthood.[29–30] The sense of futurelessness exacerbates perceived risk.

Perceived risk priorities for African Americans are furthered intensified by the

neighborhoods in which they live. According Massey and Tannen,[31] 26% of all African Americans in the United States live in hypersegregated metropolitan areas. Among African Americans living in metropolitan areas, 53.1% of African Americans live in metropolitan areas characterized as highly segregated or hypersegregated. Racially segregated Black neighborhoods create high-risk landscapes that increase the threat to Black lives, whether in the form of disproportionate exposure to lead poison and toxic waste, educational inequality, redlining, subpriming, or transit inequity.[32] Smith and Holmes[33] find that sustained excessive force complaints against police increase exponentially between the least segregated cities and the most segregated cities.

Racial segregation escalates danger in all forms for residents who live in disinvested, redlined Black neighborhoods, creating what we call "high-riskscapes" where the threat of death and harm are perceived as immanent rather than far off. High-riskscapes alter risk portfolios and perceptions of residents' risk and place concerns for STIs low on the list of concern because the threat of violence and the mandates of survival in environments of concentrated poverty and unresolved traumas rank as primary concerns. Hence, we cannot effectively address STI or HIV perceptions without mitigating the impact of high-riskscapes, which elevate immediate threats and diminish longer-term threats, especially when youth and emerging adults believe they will not live past the age of 35.

The GET SMART Project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) is an intervention research project guided in part by the Health Belief Model (HBM) located in an urban HBCU in a Northeastern metropolitan area in the U.S. The project is designed to assess and then address unprotected sexual behavior among students in college campuses and in the community that lead to illicit drug use, excessive alcohol consumption, underage drinking, and precarious sexual behaviors that increase risk for acquiring HIV and sexually transmitted diseases (STDs). The main goal of the project is to provide re-purposed prevention education, access to HIV testing, linkage to care, alcohol and substance use prevention education, and connections to needed resources. The project is aimed primarily for African American emerging adults (ages 18–24) on campus and in the local community.

The incorporation of Community-Based Theater and Fine Arts in the intervention makes the approach taken in the GET SMART Project unique. Framed in a universal language through artistic expressions within two dynamic evidence-based interventions (Community Promise and Training Interventions Procedures (TIPs) for the University), the project tailors itself to the culture, norms, beliefs, attitudes, and practices unique to African American emerging adults. In addition, a modified version of an American Cancer Society-designed program for smoking cessation is built in the intervention. The project takes a multidisciplinary approach to not only address the reduction of alcohol, substance abuse, and HIV/AIDS transmission, but also the structural and social environmental determinants that drive risk-taking behaviors among young adults. Figure 1 is a depiction of the prevention framework of the project.

Methods

Research Design: Quan → QUAL (explanatory sequential mixed-method approach). Built into the GET SMART Project is a continuous assessment of its participants'

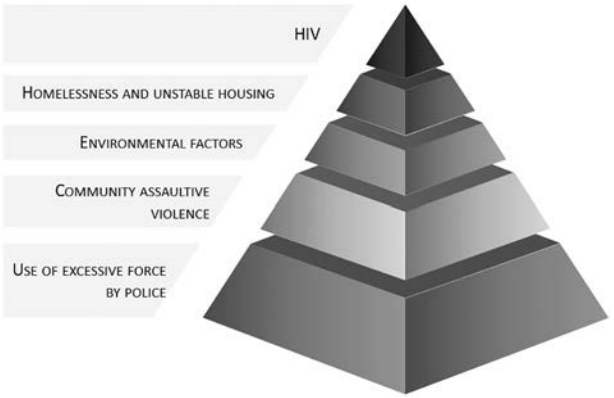

Figure 1. Perceived Risk Hierarchy Theory.(TM)

attitudes, knowledge, beliefs, perceptions, and practices related to personal and environmental risk factors for alcohol and substance use, and HIV. The initial phase of the project was a quantitative approach using a survey methodology to assess alcohol and substance use and sexual risk behaviors that may lead to HIV. The survey design was deemed most appropriate, as it would be efficient in obtaining a valid and reliable quantification of the magnitude of risk behaviors in a university and community setting. The survey instrument used was the Minority AIDS Initiative (MAI) Adult Questionnaire provided by Program Evaluation for Prevention and Contract (PEP-C). This instrument is a modular survey with four sections that cover basic demographic information and knowledge, attitudes, beliefs, and practices relating to alcohol, smoking, illicit drugs, and sexual relations. The instrument reflects, in its series of questions, the multifactorial nature of alcohol and substance use and sexual behavior.

The second phase of the study was a qualitative approach to understanding the results of the initial quantitative phase. By means of facilitated prevention education sessions with group interviews, numeric data were substantiated with qualitative contextual data to add depth and explanation to the responses gathered from the MAI questionnaire. There were approximately 10 prevention education group sessions on campus and three in the community conducted over a span of 12 months, each group including no fewer than five participants (5–7 participants per group, in practice). Additionally, each 60 to 90-minute prevention education session/group interview has a designated facilitator and a scribe to document key discussion points. A 90-minute session sufficed to obtain data saturation from the participants over the 12-month time spam.

Participant selection and procedures. Emerging adults aged 18 to 24 years were eligible to participate in the survey. The survey was advertised through the university website, student information e-mail, and health and wellness fairs. Participants were verified for eligibility using either a university-issued identification or confirmation using university student e-mail account. The MAI Adult Questionnaire was administered to participants on-site and a small non-monetary incentive was provided for their participation, time, and effort.

Participants in the education sessions were selected through a network-based referral

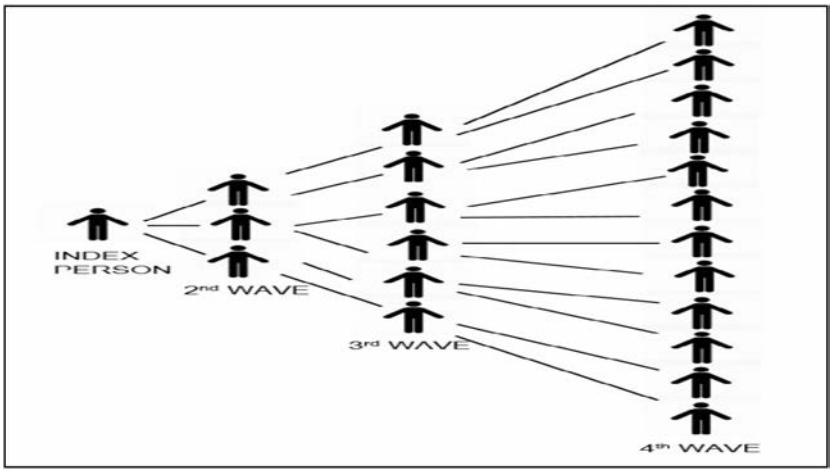

Figure 2. A network-based referral sampling was used to obtain a suitable sample for the FGDs. Eight index persons were initially identified and through their networks, a sample of 176 informants have been part of the FGDs conducted over 18 months.

sampling (see Figure 2). Index individuals were selected from key student organizations from the university and were asked to nominate two or three potential participants bearing similar characteristics to the index individuals. The potential prevention education participants, representing the second wave of informants, were then approached to name other potential participants, which would represent the third wave of informants. In about the fourth iteration of this process, a suitable sample size was obtained. Eight index individuals were selected to ensure adequate dispersion. Participation in the initial survey neither offers preference nor precludes prevention education participation. The university institutional review board (IRB) approved the protocol of this study.

Data analysis. A descriptive analysis of the survey data was conducted on key sociodemographic factors, exposure to substances and alcohol, HIV and STD status, diagnosis, testing, sex as coping mechanism, and sexual behavior. Stata v.14 was used for data entry and subsequent analysis.

Data from prevention education sessions/group interviews were compiled and organized in Microsoft Word. Two qualitative research coders were assigned to develop a codebook based on recurrent concepts identified from the compiled data. The codebook was subsequently tested and the codes generated were applied and assessed for intercoder reliability. As there were only minimal differences observed, no recoding was necessary to resolve variability. Data were then synthesized after the data core and boundaries have been established and common, related, and salient themes have emerged. Atlas.ti v.7.0 was used as the qualitative research software (Atlas.ti Scientific Software Development GmbH, Hardenbergstr. 7,Berlin , 10623 Germany. Atlas.ti v.7.0.).

Data analysis. Among the 365 participants, 95% were African Americans and 5% were Hispanics and Whites. The mean age was 20. Other demographics were as follows: heterosexual (84%), and single (77%). Gay/lesbian and bisexual respondents were at 6% and 7%, respectively. A higher proportion of female respondents (56%) participated in the survey. (See Table 1.)

Table 1.

DEMOGRAPHIC, SUBSTANCE USE, AND SEXUAL BEHAVIORS OF PARTICIPANTS

	Frequency	Percent Distribution
Gender (n=365)		
Male	160	43.8
Female	205	56.2
Transgender	0	0
Race/Ethnicity (n=365)		
Black	347	95.6
White	2	0.5
Hispanic/Latino	6	1.7
Others	4	1.1
More than one race	4	1.1
Sexual Orientation (n=362)		
Heterosexual	304	84.0
Gay/Lesbian	22	6.1
Bisexual	27	7.4
Unsure	9	2.5
Relationship Status (n=362)		
Single	277	76.5
Married	7	1.9
Divorced	2	0.6
Committed Partner	64	17.7
Casual Partner	12	3.3
Lifetime Exposure (n=365)		
Marijuana	225	62.3
Prescription Drugs	30	8.3
Cocaine	6	1.7
Heroin	4	1.1
Alcohol	262	72.6
No Exposure	56	15.5
Previous 3 Months Exposure(n=365)		
Marijuana	172	48.0
Prescription Drugs	12	3.4
Cocaine	7	1.9
Heroin	0	0
Alcohol	210	58.7
No Exposure	94	26.3

(*Continued on p. 56*)

Table 1. (continued)

	Frequency	Percent Distribution
Previous 30 Days Exposure(n=365)		
Marijuana	148	41.3
Prescription Drugs	12	3.4
Cocaine	7	1.9
Heroin	0	0
Alcohol	192	53.6
No Exposure	110	30.7
Knowledge of HIV Status (n=329)		
Yes	229	69.6
No	100	30.4
HIV Testing on Day of Survey (n=187)		
Yes	44	23.5
No	143	76.5
Last Time Tested for HIV (n=353)		
0–3 months	113	32.0
4–6 months	45	12.8
7–9 months	24	6.8
>9 months	68	19.2
Never Tested	103	29.2
Ever Diagnosed with STD (n=360)		
Yes	32	8.9
No	328	91.1
Used a Condom at Most Recent Sex (n=365)		
Yes	214	58.6
No	151	41.4
Perceive Sex as Coping Response to Stress (n=365)		
Yes	147	40.3
No	218	59.7

Alcoholic beverage drinking (54%) was common among the respondents when asked about exposure within the last 30 days. There is no uniform definition for binge drinking. However, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), binge drinking is four (4) or more drinks for females and five (5) or more drinks for males. According to NIAAA, in 2015, 26.9% of students ages 18 or older reported that they engaged in binge drinking in the past month. Lifetime and three-month exposures displayed the same trend. As for substance use, marijuana (41%) was the most popular among the respondents (both males and females). Thirty-one percent (31%) of the respondents reported having had no exposure to either alcohol or other substances within the past 30 days.

Seventy percent (70%) of the respondents indicated that they were aware of their

HIV status, but only 32% had been tested within the past three months and 29% had never been tested for HIV. On occasions where HIV testing was available on-site during surveys, 77% declined to be tested. Nine percent (9%) of the respondents were diagnosed at least once with STDs. On condom use during the most recent sexual encounter, 59% used condoms while 41% engaged in unprotected sex. About 40% of participants viewed sexual intercourse as a coping strategy for stress related to school, work, relationships, and life in general.

Qualitative perspective. A qualitative approach was used employing a phenomenological approach. The purpose of using this approach is to illuminate the specific—to identify phenomena through how they are perceived by the actors in a situation.[34] Additionally, a phenomenological approach allows researchers to describe the meaning for several individuals of the lived experience surrounding a concept or phenomenon.[35] Moreover, phenomenology is rooted in questions that give a direction and focus to meaning and in themes that sustain an inquiry, awaken further interest and concern, and account for our passionate involvement with whatever is being experienced.[36–37] In the present study, this qualitative method captured the perceptions of HIV, prevention, and risk perceptions among African American emerging adults. The evaluation was exploratory, descriptive, and consisted of a series of three questions; they were asked in an attempt to understand the perceived risk perceptions of emerging adults.

The researcher conducted group interviews in order to generate discussion on HIV perceived risk and sexual behavior. The questionnaire posed the following questions: Do you think that emerging adults are concerned about acquiring HIV? What do you think are some of the reasons why emerging adults do not want to be tested for HIV? What do you believe are the biggest concerns and/or worries among your peers?

The group interviews took place immediately after the prevention education sessions in classrooms chosen for their location and its guarantee of privacy, where interruptions and noise were reduced and comfortable seating was available. No interruptions occurred during the discussions.

Results

Content analysis was used to analyze the data and yielded the following emergent themes:

- Theme One—Stigma, Secrets, and Satisfaction
- Theme Two—Living in the Moment
- Theme Three—Millennial Melancholy

After reaching consensus on the reliability of the coding, quotations that were deemed particularly representative of the themes/categories were selected and agreed upon by the research team. The data analysis was written and completed and tied to the relevant literature to explain the findings.

Stigma, secrets, and satisfaction. In the United States, the burden of HIV is greatest among sexual and racial/ethnic minority populations, and disparities are even more pronounced among the young.[1] However, HIV testing prevalence is low among youth and emerging adults, especially African American females given their high risk of HIV

infection.[37] Knowing one's HIV status is critical for health, prevention, and lowering likelihood of transmission. However, only 35% of young people aged 18 to 24 years and 25% of sexually experienced youth[2] have ever had an HIV test.

There are several reasons that youth and emerging adults do not get tested for HIV. Not surprisingly, the majority of the participants believed that it is better not to know their HIV status, while others did not see themselves at risk. However, emerging adults appeared to distance themselves from risk although they continue to engage in multiple risk behaviors. This is what one study participant said:

> I prefer not know my HIV status. I am satisfied not knowing and life is easier that way. What you don't know can't hurt you. If a person doesn't look right, I won't have sex with them unless I am smoking weed or maybe high. Some of the main reason why people don't get tested is because they don't want to know if they have HIV. Plus, we don't see ourselves at risk. The people I hang out with are okay. They are clean. HIV ain't that big of a problem. Don't they have pills that will take care of it anyways? This is information that I really don't need to know.

Often, emerging adults do not see themselves at risk for HIV. They have a strong sense of invincibility and entitlement. One study participant said,

> I just don't see myself at risk for HIV. I know how the virus is transmitted and how to protect myself even when I don't use a condom. Although, I often have unprotected sex occasionally with a few partners, I just don't see myself at risk and neither do they. There are others things to be worried about. There's no need to be tested. I am satisfied not being tested and not knowing. The results from a test could mess things up and I don't want to deal with whatever that is.

Another study participant, who was very animated, contributed the following:

> Getting tested for HIV is my business. Nobody needs to know that information but me and who I am having sex with at the moment, if I chose to tell them. These people are nosey and all up in your business!! All you need is for someone to find out your HIV status and it's all over the news. Hell no, I am not taking that chance. Whatever my HIV status is my secret and I will tell only when I feel like it. More people should be like me. Just have sex, get high, smoke a little and have some juice, enjoy yourself, and live life. If I were positive, I don't think I would tell. And, that's really easy and all I have to say about it.

Living in the moment. According to Warner and Swisher, uncertain survival expectations are emerging as an important marker of inequality in the U.S. as adolescent and young adult pessimism about future survival has been linked to a range of deleterious behaviors, such as fighting and violence, suicide attempts, and delinquency.[38] Contrary to popular notions of perceived invincibility, research suggests that some emerging adults, particularly those exposed to violence and other hazards, have grave concerns about their safety and are uncertain of their future survival.[39] Survival expectations have been inextricably linked to numerous problem behaviors including weapon use, unsafe sexual behaviors, HIV/STD transmission, depression, alcohol and substance use, low self-esteem, unemployment, cigarette use, and fast food consumption.[40–41]

Study participants indicated several reasons that they live life on a day-to-day basis. A participant shared that in the beginning of the semester he has to purchase books. Quite often the money saved for meals is used to buy supplies throughout the semester. Therefore, a student may go hungry from time-to-time. Additionally, low-income students have concerns that surpass class exams and extra-curriculum activities. It is not uncommon for students to hide hunger. Disproportionately great financial barriers contributes to stress for students and parents, presenting new challenges in paying for college cost. Furthermore, it was clearly expressed that the future is not a promise. It is not always a dream deferred but more likely a dream denied. Therefore, engaging in safe sex was not a priority for many which strongly impacts low condom use and high-risk behaviors. In general, the prevention menu may lack the necessary components for sexual health. One study participant explained:

> I know people living with HIV and they look okay to me. I like having sex and I like it with different girls and sometimes I don't have condoms on me. Condom use or lack of condom use communicates different message to people, you know what I mean. I live for this moment and if I get offered sex, I am taking it and probably without a condom. I just don't see myself at risk for HIV anyways. I can't worry about something that may never happen. You have to get what you can whenever you can. Life is short. And, I just want to have a good time.

Another participant said,

> I have the desire for immediate gratification and to get what I can right now!!! I don't care about anything except what I want. I know that sounds selfish! It's dope when you can live life the way you want while you're here. I know too many friends that are gone. They are dead!! Almost every week, every day, somebody gets killed or hurt real bad in a fight or something. I need to get mine now!! Sex helps you get through the day and deal with stress. If I have a condom, I may or may not use it. It really depends but if I am high, I might forget to practice safe sex.

Millennial melancholy. According to Jamieson and Romer,[42] a proportion of youth and emerging adults exhibit perceived fatalism about the future. Real-life experiences of African American youth and emerging adults are very different from their peers from other racial and ethnic groups. When asked what are your biggest concerns, challenges, and/or worries, the responses were quite alarming.

One of the most frequently mentioned topics was police aggression and excessive force. Participants highlighted their experiences and perceptions that African American youth and emerging adults are more likely than White youth and emerging adults to be viewed with suspicion and more likely to be victims of unwarranted stops, arrest, and assaults. Additionally, it was noted that police relations in Black neighborhoods versus White were also very different. Neighborhood disadvantage and disorganization also appear to be associated with certain patterns of police operations in marginalized neighborhoods.[19] Quite a few study participants noted that they were concerned about their well-being when engaging with police officers. This study participant stated, "My priority every day is to make it back home, the way I left out. I don't want any trouble

with the police. For some reason it seems like we attract police attention and the risk for being stopped is high, especially if you're with a group of people." Another study participant noted, "I don't trust any cop because they think that all we do is sell drugs, steal cars, and rob people and that's not my thing. Every young Black man is not a criminal."

Another student noted, "I never know what may jump-off when I am outside. I have to be prepared to protect myself. I may get into a fight with someone who may be trying to rob me or just want to pick a fight." Another student shared, "Last year my cousin was shot in the leg while coming home from a party. He didn't know the guy but the guy just shot him for no reason. People out here are crazy and tripping. You never know when you may catch a bullet, fist, stick, or knife. This *hit is crazy and I am supposed to worry about an STD or HIV?"

Increasing numbers of youth and emerging adults in urban neighborhoods are exposed to high levels of community violence.[43–44] In many low-income, ethnic minority communities, violence has become a stressor that is unpredictable, often occurs in public places/neighborhoods, and can affect innocent bystanders.[22–23] High levels of community violence may result in perceptions of chronic danger that affects the daily social functioning of the entire community.[27]

Several participants reported a high prevalence of exposure to witnessing violence. Community violence has been described as a source of trauma for some emerging adults, while some perceive community violence as the norm because it is a part of their day-to day existence. A study participant stated,

> I can always tell when something crazy has happened in my neighborhood. Everybody is standing outside and the police are all over place. Sometimes this stuff gets to me and sometimes I let it go as long as long as my family is not involved. But at least two to three times a week something is going on in my neighborhood. Like somebody gets shot, held-up at gunpoint, took too many drugs, got stabbed or banged up. Every now and then, I will dream that I will get out of here alive and that my little brother will be able to grow- up in a better neighborhood. Our neighborhood is not all that safe, especially for the little kids. There's a lot that goes on that everybody doesn't see.

Homelessness has become a growing problem among youth and emerging adults. Homelessness and housing instability are significant public health issues that increase the risks of HIV acquisition and transmission and adversely affect the health of people living with HIV. People coping with homelessness and housing instability face enormous day-to-day challenges that affect their ability to reduce HIV risk.[45] Emerging adults need the safety, stability, and structure of a secure home/housing environment. However, homelessness is a growing trend among this population, and college students are sometimes overlooked. One study participant noted the following:

> People take having a place to live for granted. My family has been evicted before and me and my dad slept in a car for a while. Just because you go to college doesn't mean that you have money or resources. Nobody in my family has ever gone to college before. I am the first. My dad lost his job and things started to fall apart. Don't think that things are always good for students. People just don't talk about it.

Another participant who lives with relatives had this to share:

> I live with my grandmother. We lost our apartment a year ago and my mom is working two jobs so that we can get our own place again. My mom and my little brother live with my aunt. It was not enough room there for all of us. I miss being with my family but right now I have no good choice. I have been trying to find a job so that I can help out but no luck yet. My grandmother has one bedroom apartment and I sleep on the couch. All I think about is when my family has their own place again. Whatever it takes.

The following quotation illustrates another perception of unstable housing/potential homelessness:

> My father is responsible for paying our rent. Sometimes he pays and sometimes he may miss a month or two. I never know how things are going to be around here. Therefore, I take it one day at time. We have come so close to being evicted and one day I know it's going to happen. That's a fear I that I am often faced with. I have to think about what I have right here and right now and that's just the way it is. Sometimes, I can understand why people trade sex for different things. At least they may hook up with someone and have a nice place to stay. I know of people who trade sex for different things (e.g., money, food, clothes, and gifts) but I don't want to do that. I want more for my life.

There was a perception shared by participants: hopelessness was associated with more inconsistent condom use, multiple sex-partners, and increased alcohol and substance use. When operating from hopelessness frame of reference, long-term goals are often replaced with short-term gains, whatever they may be.

Discussion

The data in this study highlight priority risk among African American emerging adults as they relate to condom use, HIV acquisition, assaultive violence, communal trauma, and survival expectations. HIV prevention among African American emerging adults remains a significant public health problem. It is critical that attempts to address prevention education and strategies among this population strongly consider the multiple sources of distress, threats and perceived priorities identified and experienced, given the salient perceptions why HIV acquisition and transmission are viewed as low risk and/or no risk at all.

Emerging adults may or may not acquire HIV; HIV acquisition is often not a priority for this population based on their perceptions of other imminent risk combined with an overwhelming attitude of invincibility. Furthermore, these attitudes may influence the reasons that emerging adults often fail to get tested. HIV testing prevalence is low among both youth and young adults. No increase in testing among young adult males and decreased testing among African American females puts them at higher risk than their counterparts of HIV infection.[46] Previous research[10] suggest that youth and emerging adults who perceived themselves at average/high-risk were less likely to have used

a condom during their last sexual intercourse. It is clear that sexual risk behaviors may be complicated by other factors such as alcohol and substance use, immediate gratification, lack of concern for acquiring HIV, as well as sensation-seeking and excitement.

Recent research suggests that African American emerging adults face unique structural and environmental factors that contribute to health inequities, such as high rates of incarceration, economic trauma, and violence.[47] These environmental stressors, common in marginalized urban areas, may lead to hopelessness or negative expectations for the future among this population.[48–49] The link between neighborhood disadvantage and uncertainty about future survival is evident.[38] According to Bollard,[48–49] when operating from a hopelessness perspective, individuals may replace long-terms goals such as graduating from school or staying healthy, with short-term goals or satisfactions. In this fragile environment, the immediate benefits of risky behaviors—such as unprotected sex or sex with multiple partners—become more attractive. Hopelessness could be associated with inconsistent condom use and other deleterious behaviors (e.g., alcohol, substance use, multiple sex partners, and anal sex).

For some emerging adults, uncertain survival expectations are emerging as important markers of high-risk behaviors. Emerging adults who believe they will not live to the age 35 are more likely to have greater impulsive sensation-seeking.[50] Furthermore, pessimistic survival expectations have been linked to numerous problem behaviors, including HIV/AIDS transmission, depression, fighting, unsafe sex, and unemployment.[42]

Our findings highlight the importance of unique and novel interventions that are user friendly and urgently needed. Those that can link perceptions of risk, risky behaviors, and survival expectations that are strongly associated with HIV awareness and low perceptions of HIV risk. Our qualitative data revealed aspects of perceived risk, and risk priorities that are very real and alarming among this population. In examining emerging adult risk portfolios, it clearly demonstrated that compared to risk for HIV acquisition/transmission, the leading and priority risk were identified as use of excessive force by police, community assaultive violence, environmental factors (e.g., homicide, riots, and violence), and homelessness/unstable housing). One participant noted, "You want me to be worried about being tested for HIV or getting the virus, and I am uneasy about getting home without anything happening to me every day."

In addressing HIV education and prevention strategies among African American emerging adults, we have recognized the importance of acknowledging and addressing (where possible) the perceived priority risk among this population. Out of this work emerged, the *Perceived Risk Hierarchy Theory*™ *(PRHT)* which posits that emerging adults prioritize risk within their own framework for survival and success. The PRHT is a theory about the way in which emerging adults calculate risks and rewards. The priority risk must first be acknowledged, addressed, and satisfied so that emerging adults can began to attend to and think about and authentically connect with prevention, practices/behaviors, and a future orientation (see Figure 2). As with Maslow's hierarchy of needs,[51] once a person has met his/her deficiency needs, the focus shifts and the context and meaning of life changes. The likelihood of action depends on the individual's perception of risk and survival. Therefore, the prevention menu (available

prevention strategies) is more likely considered when priority risks are minimized. It was widely noted among our group that in this world the odds are high that violence and/or trauma maybe the cause of their demise before acquiring HIV as well as other chronic diseases. As one study participant stated, "None of us will get out of here alive. One thing or another will probably get me."

In spite of fragile families, aggressive policing, crumbling communities with high rates of violence, disappearing jobs and access to financial resources, African American emerging adults are known to be resilient. Resilience among youth has been viewed as a dynamic process whereby a young person is able to positively adapt within the context of significant adversity[52] and overcome the negative effects of risk exposure.[53] As they continue to draw support from one another, perseverance becomes their compass. However, we must compose and continue to play the necessary messages of HIV prevention, alcohol prevention, and substance abuse prevention. Moreover, because beliefs about the future are informed by evaluations of present conditions, it is necessary for newly developed interventions to counteract hopelessness and promote positive future orientations by targeting problem-solving and coping-skills, create service-learning opportunities, encourage healthy self-esteem, job readiness/resources and skills to navigate police interactions. Tupac Shakur once said to a group of African American youth and emerging adults, "Death is not the greatest loss in life. The greatest loss is what dies inside while you're still alive."

Limitations. In light of our findings, there are limitations that should be noted. First, the use of a convenience sample limits generalizability. Second, all data from students were self-reported and there may be a social desirability effect. Third, survey data may contain inaccurate responses due to recall bias.

Conclusion. In summary, in increasing the awareness of HIV and prevention strategies among African American youth and emerging adults, it is necessary to recognize, acknowledge, and address (where possible) the identified risk priorities. By addressing the risk priorities, emerging adults may be able to better understand and accept their risk for HIV. Additionally, it is essential to connect HIV prevention education to their real world view and experiences (both the positive and negative) such as alcohol and substance use, unemployment, multiple sex partners, education, and survival expectations. Such pessimism is associated with poor health and socioeconomic disadvantage in adulthood.[54] Prevention interventions must begin to empower youth and emerging adults by improving their knowledge of sexual health risk and strategies for addressing risk reduction. Furthermore, resilience and a positive future orientation should be culturally embedded in prevention efforts. A generation free from HIV is possible when there is hope and insight.

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