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Perceptions About Risk for HIV/AIDS Among Adolescents in Juvenile Detention¹

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Although progress has been made toward reducing risk-taking behavior among teens, adolescents confined in juvenile detention facilities and youths living in inner cities remain vulnerable. Reaching these populations with appropriate risk-reduction strategies continues to challenge health providers and educators. Crucial first steps in the design of relevant programs involve discovering how at-risk teens perceive risk and which risks and dangers within their communities occupy their attention. Participants in this study did not identify HIV/AIDS as a primary concern; instead, they described the dangers and risks they encountered in their home neighborhoods. Based on these findings, this discussion addresses the implications for the development of health education programs to empower teens for responsible behavior after release from detention.

"Nobody really talks about it, nobody thinks about HIV."²

"You don't think about normal people like us . . . having AIDS."²

Public health concerns about adolescents center on their risk for contracting HIV/AIDS and clusters of related disorders. When adolescents confined

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in a large, metropolitan-area juvenile detention facility have the opportunity to talk about their worries, they rarely talk voluntarily about HIV or AIDS. Instead, they describe a multitude of other dangers linked to relationships and interactions in their immediate neighborhoods (Anderson, Casey, McAvoy, & Conde, 1999). Troubles, problems, and dangers are familiar words among detained teens, but *risk* is not a term they use when they describe their concerns. The motivation for this study emerged from clinical experiences and extensive ethnographic research, including participant observation and interviews, with these detained youths that represent an increasing portion of the adolescent population in the United States (Anderson, 1990, 1994, 1996, 1999).

Law enforcement agencies in the United States arrested an estimated 2.6 million persons under the age of 18 during a 1-year interval in 1998 (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 1999). Approximately 600 juvenile facilities admit and confine the juveniles who are remanded to custody following arrest (Hammett, Gaiter, & Crawford, 1998). For example, on one day, October 29, 1997, nearly 106,000 juvenile offenders resided in detention or correctional facilities (OJJDP, 1998a). The number of detained youths increased 47% between similar days in 1983 and 1995 (OJJDP, 1998b). Detained adolescents compose a captive population who must surrender most of their rights during the detention period. Incarcerated behind locked doors and gates, they experience almost complete loss of independence. The majority of these adolescents come from low-income, urban neighborhoods where they experience high rates of infectious diseases such as HIV/AIDS and other sexually transmitted diseases (STDs), in addition to substance abuse, teen pregnancy, and violence (Hammett et al., 1998).

The juvenile detention setting offers nurses and health educators an opportunity to improve health status and risk-reduction behaviors among this captive population of teens. To date, inadequate numbers of public health agencies and health professionals have taken advantage of this opportunity to provide appropriate preventive health and HIV/AIDS education or to "interrupt the cycle of drug use, crime, and violence" among juvenile offenders (Hammett et al., 1998, p. 101).

For a number of years, researchers and health professionals have been attempting, with mixed success, to discover how to motivate teens with health promotion messages and programs (DiClemente, 1998). Strategies are needed that will empower adolescents to adopt risk-protective behaviors. Researchers who work with adolescents and other marginalized groups recommend increased focus on the sociocultural context in which

the disenfranchised reside and their viewpoint about what they consider to be dangerous (Anderson, 1999; Barker, Battle, Cummings, & Bancroft, 1998; Bourgois, 1996; DiClemente, 1998; DiClemente, Hansen, & Ponton, 1996; Kaljee, Staton, Ricardo, & Whitehead, 1995; National Research Council, 1993; Singer & Weeks, 1996). In this report, we contrast the biomedical and public health perspectives with the views of the adolescent study participants.

THE PUBLIC HEALTH PERSPECTIVE

Adolescent Sexual Behavior

The Alan Guttmacher Institute reported that as of 1995, 66.5% of teens had sex by age 18, and 41.5% by age 16 (Alan Guttmacher Institute [AGI], 1998). The median age at first sex in an ethnically diverse sample of 877 adolescents from Los Angeles County was 16.9 years (Upchurch, Levy-Storms, Sucoff, & Aneshensel, 1998). Koniak-Griffin and Brecht (1997) found that 20% of the predominantly Latina and African American childbearing participants in their study sample already had made their sexual debuts by age 12.

A recent analysis of findings from four national surveys shows that increasing numbers of teens are delaying their sexual debuts and more sexually active teenagers are using condoms, thus confirming recent trends (Santelli, Lindberg, Joyce, McNeely, & Resnick, 2000). Despite a significant increase in the number of adolescent women using a contraceptive (primarily condoms) at first intercourse (78% in 1995) (AGI, 1998), the risks among teenagers for teen pregnancy and STDs including HIV/AIDS remain high for both males and females (AGI, 1998; DiClemente, 1998; Warren et al., 1998). Manlove, Terry, Gitelson, Papillo, and Russell (2000) suggested that family stability and effective communications combined with education account for the recent declines in teen pregnancy, but they caution that the needs of higher risk teens will require more intensive intervention strategies (AGI, 2000). Lack of resources increases the vulnerability to STDs among populations of adolescents, particularly those who are low-income, ethnic minority, inner city, and/or incarcerated youths (DiClemente, Lanier, Horan, & Lodico, 1991; Flaskerud & Winslow, 1998; Ford & Norris, 1994; Jemmott, Jemmott, & Fong, 1998; Kowaleski-Jones & Mott, 1998). For example, in one study, poverty among low-income, inner-city youth was a significant barrier to increased condom use, and increased

clinic visits did not result in increased condom use in the same population (Stiffman, Dore, & Cunningham, 1994). Rotheram-Borus, Mahler, and Rosario (1995) indicated that 90% of youths living in stressful life situations, such as those who are incarcerated, homeless, runaways, or hospitalized in psychiatric facilities, are sexually active. Adolescents who have a history of maltreatment are also more likely to be sexually active and use or abuse drugs and alcohol (Finkelhor, 1986; Koniak-Griffin & Lesser, 1996; Rotheram-Borus et al., 1995). Koniak-Griffin and Lesser (1996) examined the relationship between a history of physical and/or sexual abuse with subsequent self-injury in a sample of 151 adolescents. They found that nearly 10% of the study participants reported having made a suicide attempt in the past 12 months. Fifty percent reported a history of child abuse. Participants with a history of abuse were nearly 7 times more likely to attempt suicide than those who did not have a history of abuse (Koniak-Griffin & Lesser).

HIV/AIDS and Co-Risk Factors

The cumulative total of HIV infection and AIDS cases reported from 1992 through 1995 by all states with confidential HIV infection reporting among teens 13 to 19 years of age was 5,193 (Centers for Disease Control [CDC], 1996). The HIV Epidemiology Program in Los Angeles County reported a cumulative total of 7,024 AIDS cases among youths ages 13 to 29 by the end of June 2000, including 151 cases reported among adolescents 13 to 19 years of age living in Los Angeles County (Los Angeles County Department of Health Services [LACDHS], 2000). Despite a downward trend since 1992 for seropositive cases among adults in Los Angeles County, cases among adolescents and youths 13 to 24 years of age have actually increased by approximately 20% as of 1997 (Kerndt, 1997). Although these numbers represent only a small percentage of the total cases of HIV and AIDS, many persons who are diagnosed with AIDS in their 20s (approximately one in five cases) actually became infected in their teens (Public Health Service [PHS], 1994).

Sexually transmitted infections affect 3 million teens per year; in fact, teens experience higher rates of chlamydia and gonorrhea and a higher hospitalization rate for treatment of acute pelvic inflammatory disease (PID) than among other age groups (AGI, 1998). Of the more than 1 million women in the United States who have PID, 70% are women under the age of 25 (Ivey, 1997). Furthermore, many cases are unrecognized due to absence of symptoms. In one study, for example, Pack, DiClemente, Hook, and Oh (2000) found 84% of incarcerated minority male youths with diagnosed STDs reported no symptoms.

The co-occurrence of substance abuse, STDs, and violence among adolescents has been linked to negative health consequences for youths who engage in high-risk behavior (Cox, 1996; DiClemente et al., 1996; Saner & Ellickson, 1996; Singer, Anglin, Song, & Lunghofer, 1995). Illicit drug use among high-school seniors, after reaching a low of 27.1% in 1992, steadily increased to 42.4% in 1997 (Mathias, 1999). Violent behavior is often linked with drug use and delinquency, prompting recommendations for research to identify effective interventions for clustered risk factors among teens (Cox, 1996; Igra & Irwin, 1996; Saner & Ellickson, 1996). Taken together, this cluster of co-risk factors increases the vulnerability of adolescents to HIV/AIDS (Cox, 1996; Igra & Irwin, 1996; Mathias, 1999; Saner & Ellickson, 1996). Other factors escalate the vulnerability of teens to these health-related risks. Poverty, crime, inadequate housing and school facilities, and among underrepresented adolescents of color, segregation and discrimination, represent some of the environmental factors that reduce the resources available to adolescents and thus contribute to their health related vulnerability (Flaskerud & Winslow, 1998).

PURPOSE OF THE STUDY

The purpose of this study, conducted in juvenile detention, was the discovery of the adolescents' perceptions of risk (for HIV and other health-threatening consequences of risky behavior), as well as the dangers they identified in their home neighborhoods. In order to accomplish this goal, we used participatory action research and focus groups.

RESEARCH DESIGN

Current behavioral approaches to risk-reduction interventions have been structured primarily on the basis of quantitative research and collective experience from the biomedical and public health arenas. Although these behavioral approaches have been employed in education programs as the best strategies to motivate behavior change among adolescents, evaluations of their effectiveness reveal a history of mixed success and failure, particularly in reports of effects from longitudinal data (Brown & Eisenberg, 1995; Jemmott et al., 1998; Kirby, Korpi, Barth, & Cagampang, 1997). For example, DiClemente (1998) reported that few abstinence-based behavioral intervention programs have documented long-term effects on risky behaviors

among adolescents. Bourgois (1998) suggested that "the behaviorist paradigm of 'individual health risk behavior' " misses much of the reality of the day-to-day dynamics that occur in the places where marginalized and vulnerable people carry on the everyday business of their lives (p. 2323). Barker and associates (1998) also suggested that the focus on individual behavior be shifted to examine the sociocultural context of that behavior accompanied by a corresponding "re-conceptualization [of] theory" (p. 280).

Uncovering the beliefs that motivate the health practices of individuals and groups requires attention to the context of their ecological and sociocultural environment and the interactional dynamics that shape attitudes and behaviors. Bronfenbrenner (1995) proposed that individual development takes place in the time and space context of a person's family and community structure. This uniquely individual development process-in-context continues throughout life. Learning the life-ways of vulnerable populations depends on attention to these dynamic processes. Children and youth, often viewed as passive receivers of adult wisdom, in reality actively produce "their own social worlds" (Caputo, 1995, p. 29). The experiences of youth and the specific worlds they create for themselves within the neighborhoods and communities where they live offer the greatest potential for insight into their perceived needs and concerns. The process by which incarcerated teens view their detained status, review their past experiences, and plan their future trajectories provides the focus for this study of adolescent risk perceptions. Discovering the community context and interactional dynamics that shape the perceptions and behaviors of at-risk adolescents calls for an approach that engages the adolescents themselves in the research enterprise.

METHOD

We blended participatory research (Participatory Action Research [PAR]) (Chrisman, Strickland, Powell, Squeochs, & Yallup, 1999; Whyte, 1991) with focus groups and individual interviews for this study. This blended approach brought the detained adolescents into active participation with the researchers during field study activities (Anderson, 1999; Flaskerud & Anderson, 1999). We worked together toward common goals that led to mutually shared outcomes. The participatory approach enabled the discovery of adolescent beliefs about risk and danger. By enlisting the teens in the research process, this design promoted a shared partnership between the teens and the researchers.

Sample and Setting

A total of 42 adolescents (19 young women and 23 young men), 14 to 19 years of age, participated in the project. Nearly one half of the participants (47.6%) were of Latin (Mexican or Latin American) descent. Participants of European American and mixed ethnicity each comprised 16.7% of the sample, followed by African Americans (11.9%), and Asian Americans (7.1%). In order to protect their privacy and avoid conflicts among the teens, participants were not asked questions about illegal behaviors, law violations, arrest histories, or related information. At the time this study was conducted, the range of offenses represented among the total detained population included (a) minor violations or delinquent offenses not indexed by the Juvenile Justice Department such as curfew and loitering; (b) offenses listed on the property crime index such as burglary and motor vehicle theft, and (c) offenses listed on the violent crime index such as robbery and murder.

The study participants all resided with other detained adolescents in the detention facility. During the adjudication process that follows their arrest for alleged violations of a law or court order, detainees are locked inside the facility for varying intervals depending on the outcome of their court appearances. They sleep, eat, attend school classes, participate in sports and recreation activities, and perform daily chores in their living units. Facility regulations assure that the detained teens receive close supervision during all of these activities.

Recruitment Procedures³

The project and recruitment protocol and informed consent procedures received approval from the presiding judge, the facility, and the university Human Subject Protection Committee prior to the initiation of the project. We structured this protocol to assure the teens that their participation would be voluntary and would not influence either the duration of their detention or their adjudication process. We conducted recruitment in conjunction with informal, general health-education class sessions we offered to all interested residents in three separate living units. One of these units served all of the detained adolescent women in the facility. The other two units housed young men being detained for minor offenses on one end of the detention continuum (short detention intervals) and more serious offenses (longer detention intervals) on the other end, chosen to provide a balanced perspective. The project was conducted on these living units during evening and weekend

hours, in spaces that provided privacy for sound and afforded visual surveillance by probation staff.

At the close of the education session, class participants received printed and verbal explanations that informed them about the research project. These explanations included directions regarding the procedure for informing research staff about their participation decision. The procedure ensured the privacy of their decision from each other and from probation staff. We subsequently returned to the unit to conduct the consent/assent process and the initial demographic interview with individual volunteers.

Data Collection Procedures and Participatory Research Strategies

During the assent interviews and the first focus group sessions, the adolescents learned about and contributed input to the shaping of their roles as research partners. The participants were told that the project was being conducted to learn what they thought health professionals and adults should know to help teenagers. We used a combination of methods that included sequential focus group discussions, individual interviews, and participant observation.

After signing assent forms, the participants sequentially joined a small group composed of 2 to 5 teens. Eleven groups of adolescents were formed, 5 with the young women, and 6 with the young men. Each of these groups met for 1 to 3 focus group sessions, totaling 23 sessions, each lasting 45 minutes to 2 hours. Four of the longer sessions were extended to a second day. Subsequent to the first focus group session, all of the adolescents were invited to participate in individual interview sessions. Of those who agreed, a total of 30 were eventually interviewed from one to four times, depending on the length of their stay in the facility. The additional individual and focus group interviews served as a means for continuing contact with participants, as well as an opportunity for the teens to participate in the analysis and verification process.

Individual interviews filled in the gaps that focus groups created. As Agar and MacDonald (1995) pointed out, focus groups frequently uncover data that otherwise would be unavailable to researchers. At the same time, however, group process often moves forward according to the interaction dynamics within the group. Even though the researchers, who of necessity act as moderators of the discussion, may exert considerable influence on the content of the discussion (Agar & MacDonald), interactions among the teens

frequently move things along too fast for clarifications and full explanations. The combination of sequential group and individual interview helps to fill in the gaps left when these three methods are used alone.

In our previous work with this population, we explored the relative risks and benefits accrued by tape-recording group and individual interviews. By first explaining the reasons for taping the discussions and involving the teens in the decision about whether to tape the session, we achieved consensus among both participants and researchers. We duplicated this procedure during the present study. In all but one instance, the participants decided in favor of recording the sessions. At the end of each session, we turned off the tape recorders to allow time for off-the-record discussions. Most participants, however, wanted us to tape-record everything that was said. At this time, we also offered the teens an opportunity to listen to the recording of their own sessions.

Participatory Data Analysis Procedures

Data analysis became an interactive process between the researchers and the participants. Periodic review of the data by researchers and participants during each phase of analysis, beginning with the initial review and ending with the final mutually agreed-on analysis, made this research project into a mutual endeavor. Card sorts constructed from clusters of words used by the participants during their first focus group session gave them the opportunity to take part in the content-analysis process. As they sorted the cards into clusters and prioritized them according to level of importance, they extended their discussion, expanding or contracting the depth of meaning each topic held for them. In the process, they clarified and qualified the content of their original discussions. Tape-recordings of these discussions added another level of refinement to the participatory enterprise. As researchers, we reviewed these data sets, comparing and contrasting them with the original group and interview discussions as well as the demographic data.

FINDINGS

The participatory process, introduced as a research partnership, intrigued the teens. They expressed some initial hesitancy during which they asked a few questions to be sure they understood the intent of the

project focused on learning their perspective. Then they responded with interest and enthusiasm and took full advantage of the opportunity the project offered for open discussion about their concerns. Some said, "No one ever asked us these questions before" and, "We keep talking, because you are listening. . . . [usually] no one listens to us." They adhered to the ground rules that they helped to establish at the beginning of the discussion session, and when someone in the group forgot, the others enforced the rules through reminders to each other.⁴

The participants engaged in active discussion with one another beginning with the opening question, then branched off into related side topics that interested them. Their discussions shifted from their past experiences to the reality of their present situation, and finally to their hopes and expectations for the future. In so doing, they opened the door on a view of the process by which they were calculating the effects of events from previous encounters in their home neighborhoods, dealing with their present detention status, and creating their future dreams. The view they offered exemplified Caputo's (1995) claim that children and youths are indeed the producers of their own culture and their particular life-ways.

The findings are clustered under the following two primary categories: (a) perceptions about HIV/AIDS, including promiscuous behavior, protection and getting tested, and relationships and trust; and (b) teen definitions of risk and danger. In this presentation of findings pseudonyms protect the identities of the participants.

Perceptions About HIV/AIDS

The participants rarely volunteered concern about HIV/AIDS until questions about the topic were specifically addressed to them. When asked to identify dangers or problems that worried teens, they detailed numerous concerns that focused primarily on their relationships with people in their neighborhoods. Asked if teens ever thought about things such as getting exposed to AIDS as being dangerous, they denied being troubled by this fear. One group of young men⁵ explained.

- Tim: Ah, that doesn't really cross our minds at all.
Moon: Nah.
Mic: We don't . . . worry about that . . . [we have] other things to worry about.
Tim: Yeah, it's like . . .
Moon: More important things than this [AIDS].

Most of the participants said teens didn't worry about AIDS because "AIDS [is] no trouble in my neighborhood" or "[they] don't know very many people with AIDS." Furthermore, they claimed that teens didn't talk about AIDS with each other. One explained that teens might, "think about it when they're by themselves, but they ain't gonna be kickin' it with their friends, drinking their beers, smoking a cigarette . . . [and start talking about AIDS]."

Promiscuous Behavior

When the topic of HIV/AIDS did emerge spontaneously, most often it was mentioned in connection with other STDs that they considered the dangerous consequences from promiscuous sexual behaviors. One young woman remarked, "Well, I think sex is more dangerous for teenagers because some teenagers are responsible, and some are not. I know some teenagers are not responsible because they just wanna hurry up and have sex . . . hurry up and do it." Later in the conversation she added, "Sex is the most, like risk, the most dangerous thing to do. . . . Even if you use condoms, you can still get something."

In a discussion among another group of young women, Liby talked about warnings teenagers sometimes receive from family, friends, or health professionals. For her, the warnings came too late.

Sometimes people can't get to you in time before you do it. . . . Sometimes your peers get to you before your parents, you know? Like, I know my father [didn't] even know I was having sex 'til I told him I was pregnant. They don't even know that you know about drugs 'til you come out high one day.

Later in the same group, Liby confessed, "I was promiscuous. . . . I had sex quite a bit and I didn't think about it, that [AIDS] would ever happen to me. . . . But then I met a woman that's been living with . . . my cousin. . . . She's HIV positive . . . she's going on full-blown AIDS now." Raz listened to Liby's account of the struggles of the woman with AIDS then remarked,

Even with my boyfriend . . . even if you've been with him, you know, for a few months, [if] you don't see no paper that says he is HIV negative, pssh, keep that condom on! Because I mean, I look back and I regret . . . when I was with my ex [boyfriend] . . . a lot of time when we didn't use condoms and stuff. . . . What a stupid mistake. . . . I pray that I don't have it.

Protection and Getting Tested

Once the topic of AIDS had been raised in the groups, the participants discussed the topic quite openly. All of them could identify the mode of transmission and strategies for prevention of AIDS. Many stated they had been tested in the past. Others talked about getting tested routinely every 6 months, or before starting a new relationship. Kip explained to his group, "I make sure, and in between every relationship, I go [get tested]." Both male and female participants knew where to go for HIV testing. They mentioned clinics, free clinics, clinics in their school, their doctors or health maintenance organization (HMO), or juvenile hall as places where they had been tested. One young man explained, "I used to go to a clinic and . . . pay what? \$30 to take the AIDS test. I used to go to the clinic every 6 months." Another said, "The only way I got tested . . . was from here, in jail." One of the young women described a free clinic: "They have these little, I call 'em roller clinics, they got wheels, little vans, and they come and give you free everything, free immunizations, free condoms, STD screening, AIDS testing."

The participants indicated that using condoms, making sure their partners did not have "any diseases," and getting tested were the best ways to protect themselves. Several described the availability of free condoms. One young man told his group that his doctor gave him free condoms.

He's nice with me. . . . He gives me a sack of condoms. . . . I be carrying 'em around. . . . All my homies, I'll be passing 'em out, saying, "Here," and they'll be tripping out, like, "Damn, what are you doing walking around with a bag of condoms?" Like hey, you know, you're my homie.

Other participants described street fairs where education and free condoms were provided. Others said they could obtain free condoms at their clinics. Nevertheless, when they were asked if they thought teenagers they knew in their neighborhoods or schools used condoms, most groups replied with an emphatic "No, no way" or "They think they don't have to wear 'em."

When the researchers commented that until the participants were asked about it, few of them had mentioned AIDS as a dangerous risk for teens, teens in several groups explained. For example, Kip, in one of the men's groups said,

Until you said that . . . I didn't know . . . you could be out there doing better things. . . . This made me realize a lot, you know. . . . It's like . . . now [I] know. . . . When I get out, with the grace of God, I'm [planning to] do

everything good, condoms, everything. I ain't risking my stuff . . . taking no risk, just take care of myself.

After mentioning that she had never worried much about AIDS or other STDs, Suma explained,

When you think of AIDS, you think of, you know, drug abusers, particularly ones who shoot up. . . . You know, you don't think . . . [about] an average teenager having AIDS, at least not in my neighborhood. . . . And I didn't realize . . . until you brought it up, [then] I was like, dang.

During a subsequent interview, Suma again remarked, "Now I realize, we *should* worry about AIDS. . . . I know when I leave here, I'm gonna make sure if I ever have sex again, that I'm protected, get tested . . . be sure he gets tested."

Relationships and Trust

During the course of these discussions, participants of both genders embarked on discourses about relationships and the issue of trust. They recognized that AIDS testing, "knowing your partner," and using condoms were only safe when they felt confident with their partners. Ami delineated her perspective on the issue of safe sex:

Even when you do use a condom . . . it could break, it could slip off, you know what I'm saying? Or you could be gettin' with a partner who . . . ain't trustworthy, you know . . . punch some holes, or slip it off. . . . So sex is like putting your life on the line, that's a risk for everybody.

Fred's remarks exemplify a similar assessment among the young men's groups: "I don't really trust the females I be with too much . . . you never know what they're doing [for protection] . . . so I take it upon myself whenever I feel worried . . . get checked up, and if I find anything wrong . . . it's [the relationship] over." Concern about trust emerged as a major issue for the participants in many other relationship situations they encountered in their daily lives.

Teen Definitions of Risk

Recognizing from previous projects with teens in the detention setting that *risk* was not a common word in the teens' vocabularies, we opted to use the terms *danger*, *problems*, and *trouble* when we asked the participants to talk about risk. They most often began by giving us lists of things they considered troublesome for teens. After iterating such problems among teens as gangs, drugs, and violence, the participants devoted most of their discussions to characterizing danger according to the full range of their relationships at home and in their schools and neighborhoods. They considered that problems arose in their lives when they discovered they could not trust someone or felt they were being disrespected. Indeed, they often mentioned that they did not trust anyone. Suma described her experience after confiding in a psychiatrist, "She betrayed my trust . . . that scared me from being able to trust anyone, you know. . . . I'm always keep it to myself, cause then . . . I won't have all this pain [it] caused. . . . If you've been betrayed a lot, [trust] is hard."

The participants reviewed their relationships in conjunction with important events and situations in their lives. The contextual aspects of this review fell naturally into three overlapping space and time segments: (a) doing time, (b) reliving past experiences, and (c) planning the future.

Doing Time

Doing time, that is confinement in juvenile detention, meant loss of freedom, individuality, and self-determination. The sense of powerlessness that accompanied their captive status pervaded every waking moment. Within the detention milieu, they were required to dress in uniform juvenile hall clothes, adhere to a regimented daily routine, and obtain permission before they could go to the drinking fountain for a drink, use the bathroom, or talk to a staff member. They talked about missing their parents, friends, partners, and for some, their children. They complained about the food, the rules, the long nights, the lack of privacy. Nighttime was the worst; some slept in rooms by themselves, or with one roommate. These teens described the loneliness. Others slept in large dorms on bunk beds set out in rows where their sleep was disturbed by the noises made by probation staff and other teens laying in the bunk above (or below, or beside) them—creaking mattresses, coughing, groaning, snoring, sneezing, crying, or the sounds of

flushing toilets coming from across the room. These teens discussed the constant intrusions on their privacy.

Nighttime also was the time they worried most about “what’s happening at home” or in their neighborhood. One young man described how he worried that his friends and classmates might get into the same kind of trouble as he had. Many of the participants worried about their girlfriends or boyfriends, wondered what they were doing “right now,” if they’d forgotten them while they were locked up. Cori described her distress about her relationship with her sister:

Me and my sister, we used to have this like thing that nothing could come between us, and it’s like I want that . . . closeness we had. . . . I want her [to] love me . . . trust me again. [But] I took advantage of her and I treated her like crap. . . . And I wish I didn’t do that, because she’s not there for me anymore. So the only person I have that, like, loves me, she’s not talking to me and she doesn’t want me. [Now] I’m stuck up in this place at Christmas.

A young mother told us about her sleepless nights worrying about her toddler who was living at home with her grandmother. A pregnant participant talked of her concerns about what would happen after her baby was born.

Doing time also meant time out away from distractions in the neighborhood as well as the situations that led to their arrest. “Being locked up gives us time to think” was a common refrain. In addition to worrying, the teens devoted their thinking time to recollections about their past—happy and sad events or mistakes they had made. They also spent considerable time thinking about the future and the changes they wanted to make that would improve their lives. However, Libby voiced a common refrain when she said, “I just wish that I wouldn’t have to come here in order to change [my mind about things].”

Reliving Past Experiences

Confinement gave the teens time to think about what they had been doing “on the outs” before they were arrested. They reviewed their past behaviors and talked about how they had “messed up” at home, in school, or with their friends. The dangers they associated with messing up most often originated in their relationships with their peers, parents, and the adults they encountered in their neighborhoods. One young woman told her group about her situation:

I really didn't have a mom . . . so I had to take care of myself . . . selling drugs and working, I couldn't go to school, and if I couldn't go to school, I couldn't [continue to be on] the swim team, so I kind of like, put my dreams on hold.

Later, she described the "stupid decisions" she thought she had made when she started a relationship with a boyfriend:

His nickname was "Chronic." . . . All we would do is smoke weed. . . . When I started sobering up, I was like, damn, look at all the stupid stuff I've done. . . . Then what snapped me out of it was I thought I was pregnant. I was like, "Oh no, we can't be doing this no more." . . . I broke up with him.

The young men had similar complaints about trust between partners, and a few claimed, "girls, they're the worst problem." One participant put the situation in perspective from his experience. "I always be cheating on her and she always be cheating on me. And, like, she always tell me, 'Oh, I'm on the pill,' and, like, 'I can't get pregnant' and stuff. . . . And then . . . she gets pregnant." Participants' concerns about relationships extended to include peers who were friends, fellow gang members, enemies who invaded their neighborhoods, as well as certain adults who they felt treated them with disrespect, such as some of their teachers, the police in their neighborhoods, and people who participated in the neighborhood watch program. Disrespectful treatment from those adults whom the participants thought should be helping them caused them considerable anguish and compromised their trust and respect for the individuals and for the roles and occupations they represented. Among the male participants, disrespect and threats to their reputations that originated from their rivals or enemies occupied considerable attention during their discussions about neighborhood relationships and dangers. Concerns about how they would cope with these issues after they returned to their communities permeated their thoughts while they were doing time.

Planning the Future

An integral part of reliving the past concerned the creation of a plan for the future. Confinement served as an opportunity for the participants to consider the future in light of their present plight and their past experiences. They talked about their plans to finish school, get a job, and "kick back" from places and activities they felt had led to "messing up" in the past. Wistful recollections of the time they had lost during the past and during their confinement sometimes pervaded their iterations of resolutions for future improved behaviors. Such statements as "Now I wish I would have done it differently"

emerged in many of these discussions as the participants shifted between reliving the past and planning the future. Cori mentioned her sadness that she had gone from being a young child to acting like an adult, copying her older sister's behaviors in her desire to be like her:

I always made fun of . . . people who never did drugs and had good lives. Now I wish I was them . . . and I wish I [hadn't grown up so fast]. . . . At 11 [years of age], I should [have been] talking about rainbows and popsicles, you know.

The realization that when the teenagers returned to their neighborhoods they would re-encounter past problems or new ones often raised questions they felt unable to address. Participants' concerns about returning home encompassed a variety of issues, but their greatest concerns focused on the pressures they anticipated from their "homies" to engage in the same kinds of acts that led to their present detainment and the violence they thought they were likely to encounter in their neighborhoods. These issues were often interconnected. They described numerous incidents of violence they had already experienced when "enemies" entered their neighborhoods, as well as the violence and abuse they had suffered as a result of intentional or well-meaning acts of adults in authority that led to trouble. Many of the young men described what happened when adults involved in the Neighborhood Watch Program called the police. In their view, the arrival of the police often resulted in the arrest of teens that were not involved in illegal acts. Participants of both genders described the dangerous events that occurred when "enemies" of their own or other gangs entered the neighborhood. They worried about the pressures they would feel to "stand for" their neighborhood by engaging in confrontations with the "enemy." The participants also talked about their fears about trying to go about life in the "hood" without getting into trouble when the seemingly simple acts of walking to and from school or waiting at a bus stop could subject them to a "drive-by [shooting]."

Participants also addressed the issue of recidivism. They were not unaware of the high rates of returns to detention; indeed, a number of them were back in detention for a second or third time. Suma best characterized this concern:

You get institutionalized . . . this place is actually better than some girls' homes, you know. I mean [here] they don't get abused . . . [get] three meals, clean linens—some people don't get that at home. This is a comfort zone for us, you know?

During another discussion, Suma summarized the concerns of many participants when she explained how she felt about the future:

I was talking to a friend the other day, she was like, "What are you gonna do when you get out?" I was like, "I dunno," [then she asked] "Where you wanna go?" I didn't have an answer for her. I mean, I know what I wanna do . . . what my dreams are . . . but it's hard because I'm afraid that, you know, I'm [going to] get into trouble, and the rules of probation are so strict.

DISCUSSION

Our focus in this report has centered on giving voice to detained adolescents. Although they addressed many of the same concerns (drugs, sex, violence) expressed by public health and biomedical professionals, their perceptions focused on the more pressing dangers they encountered daily in their round of activities, primarily those that involved their relationships with the people with whom they interacted every day. Other marginalized populations iterate similar concerns that have been ably reported by researchers such as Barker and associates (1998), Bourgois (1996, 1998), Davis (1974), hooks (1990), Kaljee and colleagues (1995), Singer and Marxuach-Rodriguez (1996), Vigil (1982), Whitehead (1997), and Whitehead, Peterson, and Kaljee (1994) to name only a few. Existing social and political pressures and public policies that emerge from these pressures effectively lock out the disenfranchised, ensuring that their voices are rarely heard. The recent trend toward community partnerships that is evident in the goals for Healthy People 2010 (Department of Health and Human Services, 2000) offers some hope, although as Agar and Reisinger (1999) pointed out, identifying and involving the many different communities in the United States "poses a formidable challenge" (p. 374).

As partners in this research project, the participants willingly shared their perceptions of risk for HIV/AIDS as they taught the researchers about how they defined adolescent risk. At the same time, they took advantage of the opportunity to consider their present, past, and future, offering a glimpse of the process they employed in making sense of their individual and collective experiences. Without being asked to do so, they automatically positioned their accounts within the context of their social and ecological environments. In so doing, they exemplified Bronfenbrenner's (1995) model for the interactional and ecological dynamics of development and Caputo's (1995) characterization of children and youths as active agents in their own behalf.

Trapped and powerless in juvenile detention, these adolescents nevertheless exhibited remarkable strength and courage as they confronted their past misdeeds and misfortunes, and embarked on creating their future plans. One of the major premises of participatory research is the empowerment of research participants with the knowledge, skills, and tools generated by the project through the dissemination of the research findings to the people who participated (Chrisman et al., 1999; Flaskerud & Anderson, 1999). The participants in this study actively engaged in aspects of the data collection and analysis process. Most of them commented that they had learned many things as a result of the project. Aside from the education sessions conducted in conjunction with recruitment, however, the researchers did not present educational content during the project. Most of what the participants learned came from their own efforts; the knowledge and insights they acquired originated from their input into the project.

Ashkenazi (1997) commented on the interactive cooperation and mutual rewards between fieldworkers and their informants, acknowledging the double edge carried by this sword. "All ethnographers, as human beings, are susceptible to this sort of flattery [approving comments from their informants]" (p. 475). He characterized the beneficial outcomes from such partnerships with research participants in terms of improved relationships; at the same time, he mentioned the negative consequences that can occur when ethnographers allow themselves to focus only on those areas that are comfortable for their informants. If we consider such relationships from the perspective of partnerships with the communities where we conducted our research, then one of the foremost project goals centered on those areas that our participants considered most important (Chrisman et al., 1999). Indeed, the discovery and application of a community's strengths should be the ultimate outcome of research leading to effective intervention programs.

We attempted to blend the positive aspects of both the participatory research strategies and the selected methods used in this project. With mutual benefits as the intended outcome, we nevertheless tried to be vigilant and alert to the potential pitfalls and cautionary warnings from Ashkenazi (1997). We recognized the inherent dangers in the mutual respect that emerged between the teen participants and us. The reverse side of this danger, however, became apparent in the recommendations for AIDS education interventions that the teenagers gave us.

Planning Relevant AIDS Education for Adolescents

When we mentioned that few of the participants had voluntarily talked about HIV/AIDS, teens in many of the groups said that teenagers should be more concerned about AIDS than they considered themselves and their peers to have been. During the course of these discussions, the teens acknowledged that most courses they had attended had not captured their interest or motivated them to take risk-reducing precautions. They claimed that what caught their attention and inspired them to think about AIDS as an issue of relevance to themselves were personal accounts from persons living with AIDS, being able to learn a full range of health-related content in preference to classes focused only on AIDS, and having an opportunity to talk with someone they considered trustworthy. As one young woman remarked,

I think the biggest thing is just . . . knowing that there's someone . . . that's sincere . . . out there that you can really, really trust. . . . I don't know where you would find 'em, you know, it just has to come from the heart. . . . If we [could] have a group like this one, with you two, we wouldn't never come back in here.

The associated partnership that developed between participants and researchers in this study achieved a positive outcome for the participating teens. They made discoveries about themselves and each other as they talked. At the same time that they demonstrated themselves to be in possession of empowering insights, they also were contributing to the researchers' learning. These seemingly powerless detention captives proved themselves capable of executing active interventions on their own behalf. Indeed, adolescents may well be their own most valuable resource. Researchers and health professionals and educators might consider tapping this valuable resource in planning future AIDS education courses by making the adolescents who are the target of their programs into equal partners in the education enterprise.

NOTES

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2. These statements were made by detained adolescent study participants during focus group discussions about risks and dangers.

3. We provide a fairly detailed description of the procedures used in all phases of this study because incarcerated teens are a particularly vulnerable and powerless population. These explanations also document the steps taken to actively involve the teens in the participatory aspects of the research.

4. Group discussions and interviews took place on the living units. Facility rules severely limit verbal communication between the detained teens during most daily activities. When the participants discovered they shared common experiences, they engaged in reminiscences among themselves. They took advantage of the opportunity to discuss their experiences in the neutral atmosphere of mutual respect fostered by the participatory research enterprise.

5. We have been asked why we refer to the participants as "young women" or "young men." We chose to use this form of address as sign of respect, in part because a number of the participants were 17 to 18 years of age, in part as recognition of their respectful behavior whenever we met with them, and in part because they experience considerable disrespect from adults in authority. The teen participants most frequently referred to themselves and each other as "kids" or "girls/boys" and in conversation with each other, the young men greeted each other with "Hey, dude" or "Hey, man" when they entered their group.

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