PREDICTORS OF COLLEGE WOMEN'S SEXUAL RISK-TAKING BEHAVIOR: AN INTERPERSONAL EMPOWERMENT PERSPECTIVE

by

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(Under the Direction of Lily McNair)

ABSTRACT

Rates of HIV/AIDS continue to increase within the United States, despite widespread prevention efforts. Of new cases attributed to heterosexual contact, the rates of infection for women are nearly twice that of men (CDC, 2001). Additionally, it has been shown that the vast majority of sexually active women fail to use condoms consistently. Research has suggested that there may be variables that exist within the context of interpersonal relationships that impact women's ability to negotiate the use of condoms or refuse unprotected sex. As hypothesized, the current study showed that interpersonal power was predictive of rates of condom use among college women. The present study also investigated how feminine gender roles and perceived mate availability are differentially related to interpersonal power for African American and European American women.

INDEX WORDS: HIV/AIDS, Interpersonal Power, Condom Use, Sexual Risk-Taking, College Women

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DEDICATION

This work, as with all that I have accomplished, is dedicated to my wonderful and loving parents, Richard and Louise Harris. Thank you for all of your love and support through the years. I don't think I'll ever be able to repay you, but I promise that I will try. I love you.

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CHAPTER 1

INTRODUCTION

Despite noble efforts aimed at prevention, the transmission of HIV/AIDS continues at alarming rates. This increase becomes even more exaggerated in examining new cases among women and ethnic minorities. Of new cases attributed to heterosexual activity, the rate of infection in women is twice that of men (Centers for Disease Control and Prevention, 2001). As of June 2001, 42% of cumulative HIV infections in women were attributed to heterosexual contact compared to only 7% of infections in men (CDC, 2001). These numbers are reflective of patterns indicating that women are behaviorally and biologically at greater risk for contracting the virus. For instance, studies have shown that fewer than 20% of high school and college women use condoms consistently (Harlow, Quina, Morokoff, Rose, & Grimley, 1993). Additionally, due to physiological differences, male-to-female transmission is 12 times more likely than female-to-male transmission (Gutierrez, Oh, & Gillmore, 2000). The unwillingness (or inability) to engage in safer sex behaviors combined with anatomical susceptibility place women in a position of distinct disadvantage.

One of the most notable and persistent trends in HIV/AIDS statistics is the extent to which African Americans continue to represent disproportionate numbers of new infections each year. Specifically, while African Americans only account for 13% of this nation's population, they represent 51% of new infections (CDC, 2001). Research indicates that compared to other ethnic groups, African Americans have consistently reported the lowest rates of condom use (Weinstock, Lindan, Bolan, Kegeles, & Hearst,

1993). As a result, African Americans account for 49% of new cases attributed to heterosexual contact in individuals between the ages of 20 and 34 (CDC, 2001).

Taken together, these facts present a particularly precarious situation for African American women. Women of color have been shown to have higher levels of HIV risk-related behaviors such as unprotected sex (Weinstock et al., 1993). Consequently, 66% of women (ages 20-34) infected with HIV are African American compared to the 24% of those women who are European American (CDC, 2001).

In light of these statistics, it is reasonable to conclude that HIV prevention programs have only been modestly effective in discouraging unsafe behaviors in high-risk heterosexuals. Despite the implementation of strategies based on HIV education, preventive sexual practices still have not been adequately adopted by the general population (Amaro, 1995). One possible explanation for this may be that such educational tactics have continually failed to take into consideration potent risk factors other than insufficient knowledge about the virus and its means of transmission.

In response to these trends, it becomes imperative that research endeavor to reveal issues related specifically to women's risk of contracting HIV through heterosexual contact. Future research must also assume the perspective that some of the most potent influences on a person's behavior often originate from sources outside the individual. Therefore, it might be less informative to concentrate on intrapersonal qualities than to notice interpersonal determinants of behavior. Additionally, attention must be given to understanding the extent to which African American and European American women are differentially affected by such variables. In an effort to provide such a focus, the present study is aimed at evaluating the influence that interpersonal powerlessness exerts on

African American and European American women's likelihood of engaging in heterosexual risk-taking behavior.

CHAPTER 2

CURRENT HIV/AIDS PREVENTION PROGRAMS AND SOCIAL LEARNING THEORY

By examining the aforementioned statistics, it is apparent that the AIDS crisis is a matter to which science must devote substantial attention and resources. Despite this urgency, however, recent years have seen a decline in the creation of new theoretical approaches to dealing with the epidemic. Instead, prevention protocols continue to rely on models that, at best only acknowledge portions of the problem, but at worst may be entirely obsolete. Therefore, the age of some of the findings described in this study should be thought of as an indicator of how necessary it is for researchers to consider innovative routes to fighting the battle against HIV/AIDS.

This criticism notwithstanding, it should be noted that the social sciences have attempted to meet the challenge of curbing the spread of HIV by developing a host of prevention strategies emerging from a variety of different theoretical approaches. Many of the models currently in use as foundations for understanding and changing risk behaviors were born in an age prior to the AIDS epidemic. One such approach, social learning theory, has enjoyed widespread acclaim for its implications for HIV research and prevention (Bandura, 1990, 1994). Social learning theory focuses on modeling, perceived efficacy (the belief that a given behavior will yield a desired result), and self-efficacy (an individual's belief that they are capable of executing a particular behavior) as determinants of any action. Applied to sexual situations, this model suggests that an individual's likelihood of engaging in risk-reducing behaviors hinges on their knowledge of methods of avoiding risk, motivation to do so (as determined by the perceived benefits

of safer sex practices), the belief that protective action will be effective, as well as the perception that they can enact any steps necessary to reduce their risk (Bandura, 1990, 1994).

The underlying assumption of HIV prevention programs based on social learning theory is that the simple acquisition of knowledge regarding one's risk will not sufficiently ensure an individual's protective action. In accordance with this expectation, it has been shown that being exposed to prevention programs based on the concepts of social learning theory (as opposed to other theoretical foundations) leads to increased condom use (Kirby, 2000). Furthermore, the same study has demonstrated that such programs are most effective in delaying the initiation of sexual activity. This effect is considered particularly profound in HIV prevention research because younger age at first sexual encounter tends to increase one's risk of infection.

Proponents of the applications of social learning theory to HIV prevention suggest that its success (relative to other approaches) stems from the difference in focus. As opposed to education-based strategies, social learning theory more accurately assumes that mere knowledge about HIV or even the skill to use condoms is not sufficiently predictive of safer sex behaviors (Amaro, 1995). As one of the primary tenets of social learning theory, the evaluation and promotion of self-efficacy has been incorporated into a variety of psychosocially-based interventions (Barker, Battle, Cummings, & Bancroft, 1998). Research conducted on such interventions has shown that the focus on building high-risk individuals' self-efficacy to initiate condom use is integral to making wise decisions about sex. However, literature also suggests that social learning theory does

not adequately conceptualize the way in which sexual interactions transpire (Amaro, 1995; Barker et al., 1998).

CHAPTER 3

LIMITATIONS OF SOCIAL LEARNING THEORY

Despite its comparative effectiveness, social learning theory is not without its boundaries. For instance, there exist certain assumptions that make such cognitive behavioral interventions inadequate at reducing relevant behaviors in populations in greatest danger – particularly high-risk women (Beeker, Guenther-Grey, & Raj, 1998). Studies conducted on these theoretical models have suggested that they may fail to adequately conceptualize factors relevant to behavior change in women (Deren, Tortu, & Davis, 1993).

In evaluating the applications of social learning theory to HIV prevention several limitations become apparent. It seems that this approach fails to describe contextual factors that affect women's willingness and ability to practice safer sex. Amaro (1995) suggests that this model is predicated on assumptions that cannot be generalized to women. First, social learning strategies currently in place are based on an individualistic conceptualization of behavior. As such, these approaches pay little attention to the broader interpersonal and social contexts in which sexual interactions occur, resulting in a misunderstanding of factors generally related to sexual practices. Second, these approaches become less relevant to women because they assume that sexual decisions (including initiation, negotiation, and refusal) are under the complete control of the individual. While this is usually not entirely true even for men (due to the impulsive or reactive nature of sexual activity), it is even less applicable to women for whom sexual encounters are often less voluntary. Lastly, Amaro notes that appropriate attention is not

given to understanding gender roles and other cultural norms that influence or define the behavior of men and women in interpersonal relationships.

Current prevention strategies based on social learning theory typically invoke the concept of power by emphasizing the importance of self-efficacy. As mentioned previously, those models built on such foundations have been shown to be more effective than other approaches presently in use (Kirby, 2000). Despite this evidence, the criticism can still be made that these programs have not taken into consideration the highly interactive nature of (safer) sex. For instance, a fundamental premise of social learning theory is the idea that an individual's confidence in executing a given behavior (self-efficacy) is the key factor in determining safer sex practices (Bandura, 1990, 1994). In this way, self-efficacy is discussed in terms of intrapersonal power.

Though self-efficacy is an important factor in understanding and encouraging risk-reducing behaviors, it does not fully account for issues related to the negotiation of safer sex practices. What is not addressed by social learning theory is the way in which features of interpersonal power are manifested in sexual encounters. For instance, it is entirely possible for a woman to feel efficacious in the initiation of a discussion regarding condom use and still not possess the skills or motivations to negotiate safer sex practices if necessary. Also, it is rarely the case that individuals' preferences and intentions are discussed rationally in sexual situations. It is much more likely that an assortment of physical and emotional factors influences a person's decisions and desires in the moment. Therefore, while the evaluation and promotion of women's self-efficacy can occur calmly and rationally, the execution of efficacious behavior is usually not performed in such a manner. When considered alone, the concept of self-efficacy may not adequately account

for the variation in women's sexual risk-taking behaviors. Wingood, Hunter-Gamble, and DiClemente (1993) found that, while the majority of women were self-efficacious in their initiation of condom use, only a minority reported that they would be able to negotiate condom use if necessary. This suggests that women's communication of their intent to practice safer sex and their ability to refuse unwanted sex are not addressed as long as self-efficacy remains the primary focus in discussions of power in sexual interactions.

CHAPTER 4

THE IMPORTANCE OF INTERPERSONAL POWER IN SEXUAL INTERACTIONS

As with several other social variables, the role of interpersonal power has yet to be adequately considered in programs promoting safer sex for women. Although power is widely assumed to have some role in how sexual interactions unfold, research does not often explicitly explore what that role actually is. By conducting such an exploration, it can be seen that power (emerging from a variety of sources on the social, political, interpersonal, and intrapersonal levels) often defines the course of sexual encounters between men and women. The presence or absence of a balance of power has direct implications for the negotiation of sexual practices, the ability to refuse unwanted contact, as well as the expression of one's sexual desires or intent. As such, it becomes apparent that interpersonal power is a construct that must be remembered in evaluating women's sexual risk-taking behaviors.

To provide further justification for exploring the influence of other forms of power, it has been consistently demonstrated that interpersonal factors (e.g., communication, assertiveness) are far stronger predictors of unprotected sex than intrapersonal factors (e.g., education, self-efficacy; Catania, Coates, Kegeles, Thompson-Fullilove, Peterson, Marin, Siegel, & Hulley, 1992). Furthermore, although the majority of men report preferring to not use condoms, an overwhelming 83% also report that they would not object to doing so if their female partner made the suggestion (Baffi, Schroeder, & Redican, 1989). With this being the case, it can be seen that prevention efforts must take into account the extent to which a woman contends with a perceived or actual lack of control over her sexual activity. Furthermore, it would follow that

promoting safer sex behaviors in women must rely on advocating the transcendence of disadvantages emerging from power imbalances.

As with so many other factors that are quite strongly related to women's risky sexual behaviors, the perceptions of power/powerlessness have not been adequately researched and applied to prevention strategies. Despite the paucity of related research, reviewing the limited empirical studies that have been conducted on this subject yields several consistent conclusions.

In discussing how perceptions of powerlessness are related particularly to women's risky sexual behaviors, it is important to observe that there is a difference in self-perceptions of interpersonal power for men and women. From adolescence into adulthood (regardless of race/ethnicity) women view themselves as having less interpersonal power than do men (Gutierrez, Oh, & Gillmore, 2000). Specific to sexual interactions, women report lower levels of assertiveness in initiating sex, negotiating sexual practices/preferences, and refusing unwanted sex than do men (Gutierrez, Oh, & Gillmore, 2000). Even as the number of sexual partners increases, women were not shown to be any more likely to require the use of condoms (Anderson & Dahlberg, 1992). In fact, women with multiple sexual partners have been shown to be more likely to feel incapable of refusing sexual contact. Also, as their number of sexual partners increased women exhibited poorer communication skills and felt they had less control over their HIV-risk (Monahan, Miller, & Rothspan, 1997). These results are representative of broader findings indicating that higher numbers of sexual partners for women were related to the inability to refuse sex and not necessarily more assertiveness in the initiation of wanted sexual encounters (Harlow et al., 1993).

Specifically related to the wielding of power over the actions of another, a study conducted by Soet, Dudley, and Dilorio (1999) examined differences in sexual attitudes and behaviors among women who described themselves as either dominant in their relationship with a male partner, sharing dominance equally, or being dominated by the male partner. Results of this study showed that perceived dominance was a significant predictor of women's personal empowerment regarding sexual decision-making. Specifically, women who reported being dominated by their partner exerted less influence over sexual behaviors, had more difficulty with the interpersonal aspects of safer sex, and were less confident in their abilities to negotiate condom use. These findings indicate that there is a strong link between interpersonal power and risk-reduction. Such a relationship shows that women who perceive themselves to be relatively powerless are more likely to lack a set of competencies essential to the consistent practice of safer sex. Conversely, women who are more confident in discussing condom use are more likely to insist on engaging in protected intercourse (Monahan, Miller, & Rothspan, 1997).

CHAPTER 5

DESCRIPTIONS AND FEATURES OF POWER

In reviewing the literature on how power (or a lack thereof) affects women's sexual behaviors and HIV risk, it is apparent that one of the hurdles that has yet to be surmounted is the need to provide a clear definition of what power actually is. As a construct, it can be understood from various perspectives, though none can provide a comprehensive explanation. Therefore, it is important to consider a variety of theoretical approaches. Research in the fields of psychology, public health, and communication has yielded several conceptualizations of power relating to the process by which sexual interaction occurs. Accounting for the most relevant aspects of sexual behaviors requires the fusion of these perspectives into a multifaceted definition of power. For the purposes of this study, it is suggested that the critical features of power will involve not only control over one's own actions, but also control over the actions of others.

Intrapersonal Power

As a point of conceptual origin, a complete description of power would necessarily include self-efficacy. Discussed under various labels and in many ways, self-efficacy exists as a form of intrapersonal power that determines attitudes and behaviors. In terms of personal empowerment or *power-to*, Yoder and Kahn (1992) suggest that self-efficacy involves the control one feels over one's own thoughts, feelings, and behaviors. This component of control arises from the self and is directed toward the self.

Related to the concept of self-efficacy, self-control involves an individual's mastery over internal drives. This extension of intrapersonal power is profoundly relevant to sexual risk reduction. As discussed previously, indiscriminate sexual

activities or the inability to overcome sexual urges is related to increased risky sexual behaviors (Harlow et al., 1993). In light of this information, it is evident that, along with self-efficacy, self-control represents another component of intrapersonal power that has some consequence in sexual interactions.

Through understanding these ideas, it should be emphasized that the classic conceptualization of risk reduction posited by Bandura's (1990, 1994) model of social learning is highly applicable, but still does not fully address the dynamics of power relevant to risk-reduction. This is because, as stated previously, self-efficacy focuses on intrapersonal factors and does not account for the interpersonal nature of sexual activity. There must also be an extension to the model that accounts for the necessary skills of persuasion and influence over the behaviors of others.

Interpersonal Power

The discussion of what features constitute interpersonal power is a matter of interdisciplinary concern, as this form of power is inherently part of any relationship and of all interpersonal behaviors. Across various research perspectives, a number of commonalities in relevant theories emerge. The first theme fundamental to most conceptualizations of power is that individuals possessing power must have the capability to produce changes in the behaviors or affect of their relational partners. As a measure of these skills, the ability of individuals on whom power is exerted to resist influence is negatively related to the ability of the influencing agent to exercise power (Berger, 1994). To simplify, a person is generally considered powerful when they can produce behavioral or emotional changes in a target individual resulting from influence that the target cannot

escape. As this effect becomes more pronounced, the more powerful a person is understood to be.

Likewise, those who demonstrate power in interpersonal domains are capable of resisting the physical, emotional, and mental influences of relational partners or other environmental sources on their own behavior or affect. It is insufficient for an individual to possess skills related to the persuasion of others without the strength to withstand external pressures. Such abilities would only be effective in situations where there is little dissension between partners or when both partners are not simultaneously trying to exert opposing influences. This is not always the case in any form of human interaction, and an evaluation of women's potential powerlessness in sexual relationships should, therefore, take this issue into consideration. Taken together, power could be understood as a construct including an individual's possession of several skills necessary to enact their will in interpersonal situations along with the motivation to do so.

In line with this construct, Yoder and Kahn (1992) describe *power-over*, or *dominance* as the ability of one person to exert control over the thoughts, feelings, and behaviors of another. In contrast to self-efficacy, this component of control arises from the self but is directed toward others, which makes this a vital feature of interpersonal relationships and, specifically, sexual negotiations. Despite its tremendous import, this is a factor that has often been ignored in prevention efforts aimed at helping women reduce their risk of infection.

A woman's ability to enact safer sex behaviors relies on not only how powerful she feels within herself, but also her ability to influence the behaviors of her male partner. This is because the practice of safer sex requires somewhat different skills of men and

women. As the traditional male condom is the primary means of protection, safer sex for men involves all the major aspects of self-efficacy. For instance, men must possess knowledge about strategies to reduce their risk of infection as well as the motivation to take the necessary precautions. On the other hand, self-protective behaviors require that women possess not only these skills associated with intrapersonal power, but also the willingness and ability to convince their male partners to wear a condom if necessary. Women must, therefore, feel confident in their ability to initiate discussions about condoms as well as their ability to negotiate their desires if there is disagreement. Furthermore, women would need to possess the fortitude to withstand pressures that could be imposed by male partners and to refuse unprotected sexual contact if negotiations prove unsuccessful. While the ability to negotiate and refuse sexual practices is required in some ways of both men and women, the processes and decisions associated with the use of traditional condoms are more directly under the control of men. Thus, women's safer sex practices may be more strongly related to the success or failure of their efforts to communicate about condom use.

Specific strengths, particularly those related to communication, must be present for an individual to gain mastery over the actions of others. As it relates to promoting sexual protective behaviors for women, certain persuasive skills are critical. Research in the field of communication has shown that regardless of race and gender, people with superior communication skills are far more likely to use condoms consistently (Edgar, 1992). This finding suggests that women are at decreased likelihood of engaging in risky sexual behaviors if they are capable of communicating to their partners that condoms will be required. This research combined with suggestions that knowledge about condoms is

not strongly predictive of risk reduction could indicate that social sciences should further investigate those factors that decrease women's ability to communicate effectively about safer sex.

CHAPTER 6

CONTRIBUTORS TO WOMEN'S PERCEPTION OF INTERPERSONAL POWERLESSNESS

As difficult as it is to provide a description of what power actually is, the picture becomes exceedingly more complex when exploring factors that could potentially decrease the control a woman feels capable of exerting over the behaviors of others. It is, therefore, necessary to elucidate those societal and personal variables that undermine women's power in sexual interactions. To adequately understand the source and magnitude of women's sexual risk, their behaviors must be researched as they exist within a framework of other relevant contextual variables. Although there are probably innumerable factors related to women's sexual risk-taking behaviors, to provide an exhaustive list is beyond the scope of this proposed study. The present study will focus its attention on two dynamics that may be related to women's perception and execution of interpersonal power in sexual situations. Specifically, women's gender roles and their perceptions of mate availability will be explored as personal attributes that can have either protective or adverse consequences for women's HIV/AIDS risk-related behaviors.

These factors may exert greater influence on the sexual choices of some women than on others. For instance a combination of issues has resulted in differential risk of infection for African American and European American women. Statistically, it has been shown that African American women are at greater risk for contracting HIV than European American women (CDC, 2001). The intent is not to minimize the importance of those behaviors that place European American women in danger, but rather to explore the possibility that risk factors may be somewhat unique to women in each of these

groups. To the extent that African American and European American women face different risks for exposure to HIV, there exists the need for science to no longer look at their situations as being the same.

Gender Roles

Gender refers to those social characteristics and expectations assigned to individuals on the basis of their biological sex (Lindsey, 1994). These qualities are typically discussed in terms indicating a polarity between what is socially expected of men and women. Such gender roles are usually quite pervasive and not easily circumvented, particularly for women. Although these factors quite clearly influence the way in which men and women relate to one another, they are commonly overlooked by psychosocially-based HIV prevention programs (Amaro, 1995).

Gender roles represent so much more than interesting artifacts of sexual relationships. Instead, it has been shown that gender roles serve as important modifiers of how heterosexual encounters are negotiated and how a couple determines which partner's sexual preferences will be practiced (Ehrhardt & Wasserheit, 1991). For instance, masculine ideology (as it is traditionally defined) has been shown to discourage equality in sexual communication and negotiation of condom use (Catania et al., 1992). Furthermore, traditional feminine roles do not allow for the open expression of sexuality in an assertive manner. This silence not only affects women's freedom to initiate wanted or pleasurable sexual activity, but it also endangers women's health when there is a need to negotiate safer sex with men (Gutierrez, Oh, & Gillmore, 2000). This is due in large part to the fact that the inequalities of traditional gender roles associate femininity with

social silence and sexual passivity while masculinity is associated with virility and dominance (Gutierrez, Oh, & Gillmore, 2000).

The act of safer sex can, in itself, provide confirmation of socially supported gender differences. As stated previously, use of the traditional male condom as the preferred method of HIV prevention is dependent primarily on the male's approval, which may place women at a psychological and physical disadvantage for determining their level of risk (Amaro, 1995; Wingood & DiClemente, 1998). Therefore, even the act of safer sex between two consenting adults is rooted in social gender imbalances and can never be fully understood if removed from that context.

Prevention programs currently in use make only cursory disclaimers regarding the effects of gender on risky sexual behaviors. They most often indicate that the circumstances of women are different from those of men without discussing how adjusted health education strategies are thereby warranted. Even models based on social learning theory do not address gender dynamics (e.g., interpersonal/relationship power, gender roles) as inherent factors in sexual interaction (Amaro, 1995). It is mandatory that effective prevention programs take into consideration that heterosexual couples often exist as a microcosm of socially supported power imbalances rooted in gender differences.

Based on the erroneous notion that safer sex practices require the same skills of men and women, prevention programs have not adequately differentiated the needs of men and women (Amaro, 1995). Again, for men the decision to self-protect may be based largely on their self-efficacy. On the other hand, for women, safer sex can often involve the ability to convince one's male partner to wear a condom or to refuse

unwanted or unprotected sexual contact. This requires that women not only have adequate knowledge regarding HIV transmission, but they must also possess communication and assertiveness skills that may not be required of men in similar scenarios. These are skills that are not congruent with traditional female roles and may not be possessed by women who are more traditionally feminine.

Conventional ideals of femininity do not permit the open discussion of sexual preferences. Women who subscribe to traditional gender roles are expected to only demonstrate their sexuality and needs through receptive behaviors that welcome the sexual advances of a man. For women to exhibit any further sexual assertiveness is to step outside of the realm of what is thought to be gender-appropriate. Therefore, it is important that prevention programs take into consideration that research has indicated that gender role incongruence is most often negatively evaluated by society (Amaro, 1995). Perhaps of even greater importance is recent research that demonstrates that women typically devalue their own behaviors they think to be contradictory to traditional female roles (Adair, 2001). From this information the conclusion could be drawn that women with more traditionally feminine gender roles may be less capable or less motivated to step outside of these roles in their insistence on using condoms.

In determining the barriers women encounter in protecting themselves from HIV exposure, it should be understood that behaviors that are thought to be safe and those that are acceptable are not always the same. It has not been widely considered how a woman's assertion to practice safer sex may come with evaluative repercussions from society, her male partner, and herself (Adair, 2001). Therefore, research and practice must not continue to remove the woman from the social context of what is deemed to be

proper. Instead, women would be better served by efforts that do not discount the effects of gender role subscription and, thereby, provide women with skills necessary to overcome social expectations in the promotion of their own health and well-being.

European American Women and Gender Roles

It has been demonstrated that assertiveness in sexual communication is one of the strongest predictors of HIV risk-related behaviors for women (Catania et al., 1992) such that women who were more assertive were less likely to engage in such practices. However, the skills necessary for assertive communication are those that are more commonly associated with masculine gender roles (Lindsey, 1994). It would logically follow that women who are more traditionally feminine may have more difficulty with these interpersonal aspects of sexual interactions, specifically because the cultivation and execution of these competencies are incongruent with the standards of conduct to which they adhere.

Because of differences in socialization, European American women typically develop gender roles that are more traditionally feminine than those of African American women (Harris, 1996). Potential effects of these differences have been observed in research investigating factors specifically related to the processes of sexual decision-making. Soet, Dudley, and Dilorio (1999) demonstrated that African American women exhibit higher levels of self-efficacy for discussing safer sex options than European American women. As a possible justification for this difference, this study also found that African American women were more likely to describe themselves as the dominant partner in relationships, while European American women were more likely to describe themselves as being dominated by their male partner. The ability to assume a position of

dominance (or at least equality) within a heterosexual dyad would require a woman to invoke strengths that are not associated with femininity as it is traditionally defined. This explanation speaks to how European American women may encounter difficulty initiating discussion regarding their protection or insisting on condom use. It should also be noted that, among women who reported being the dominant partner within their relationship, there was no difference between African American and European American women's involvement in the sexual decision-making process (Soet, Dudley, & Dilorio, 1999).

Mate Availability

As it has been stated previously, extant literature indicates that knowledge about the risks associated with certain sexual behaviors is not a sufficient predictor of behavior change. This is one of the primary reasons current education-based preventive strategies have had limited success. It is, therefore, necessary to understand why certain groups of people continue to find themselves in high risk situations despite their knowledge about prevention.

During the first decade of the AIDS epidemic, Worth (1989) suggested that for a woman to feel able to introduce condom use, certain conditions must preexist. First, there must be a relative equality between the man and the woman. Secondly, a woman must perceive that other options can be identified without posing a threat to the relationship if her current partner refuses to use a condom. These options include either abstaining from sexual contact with the current partner or finding other potential sex partners who would be willing to engage in the desired protective behaviors. It should be noted that either of these has the potential to damage the existing relationship. Facing the

possibility of this effect, a woman essentially has two options: (1) she can decide that she is willing to potentially sacrifice or damage her relationship with a man who may refuse to practice safer sex or (2) she might prefer to take her chances by having unprotected sex to avoid these repercussions. To make this decision, a woman assigns costs to each of these outcomes. If, in her estimation, the significance she assigns to the probability that she will not find another partner is greater than her perceived risk of infection, she may be more inclined to jeopardize her health to maintain the relationship. According to this rationale, it is quite possible that a perceived or actual lack of sexual options and the desire to protect their relationships may lead vulnerable women to ignore long-term risks in their attention to these more immediate issues.

It should be acknowledged that women's sexual relationships exist in a matrix that includes an assortment of external influences on their decisions. Exploring these factors could help elucidate reasons why many women may assign greater weight to maintaining their relationships than to protecting themselves from HIV infection. To borrow from economic theory, when facing the scarcity of a particular resource, it is expected that those who have possession or control of the resource are essentially more powerful than those who are in search of it. Therefore, individuals seeking this resource are most often willing to pay a cost that they might otherwise find quite unreasonable in efforts to secure such a precious commodity.

One current model of heterosexual relationships suggests that these principles are at work in sexual interactions and decision-making. The Sex Ratio Hypothesis (Guttentag & Secord, 1983; Secord, 1983) contends that "when one gender has more available mates than the other, whether *men or women,* members of the scarcer gender possess an

advantage because they have more alternative relationships available to them." This advantage has been shown to produce a variety of effects. For instance, a shortage of available men results in women's inclination to share sex partners, which then leads to a reduction of their power to negotiate sexual protection (Worth, 1989). This is especially dangerous because men in these situations are more likely to have multiple sex partners, thereby increasing the risk of HIV exposure for men and the women with whom they have sex.

African American Women and Mate Availability

These effects have not been shown to be unique for any racial group, yet there are conspicuous racial trends. It can be expected that, to the extent that one group suffers from a more striking sex ratio imbalance, these issues may exert increased influence on sexual decision making for individuals within that group.

An example of how these factors translate into risky behaviors was provided by an exploratory intervention known as the Healthy Mamas Project (Barker et al, 1998). With the promotion of self-efficacy for condom use as one of the program's primary goals, this study showed that only a minority of the participants reported increased resolve to use condoms consistently upon the conclusion of this psychosocially-based intervention. Through participants' feedback presented during focus groups, researchers concluded that the intervention had failed to sufficiently recognize social contexts that weighed heavily upon these women's sexual decisions. Specifically, women who did not appear to have benefited from the program indicated that, when sexual decisions are made, their short-term goals of establishing a sexual relationship and fulfilling their

emotional needs were of higher priority than their long-term goal of avoiding HIV infection.

It could be argued that these women's lack of efficacy fuels their decisions to place themselves at risk of contracting HIV. However, Sobo (1995, 1998) offers an alternative explanation. It was suggested that a woman desiring to be in a monogamous heterosexual relationship is likely to act in ways that she feels will increase her likelihood of accomplishing that goal. When she perceives a low probability of finding the kind of mate she desires, she may pursue relationship options with more urgency and make decisions that are ultimately not in her best interest.

In these instances, the decision to engage in unprotected sex can be considered a purposeful behavior. African American women report that, in long-term relationships, they are more hesitant to initiate condom use because it is a source of potential conflict within the relationship (Barker et al., 1998; Wingood, Hunter-Gamble, & DiClimente, 1993). This is because condoms are sometimes symbolic of infidelity, promiscuity, or untrustworthiness (Worth, 1990). Additionally, African American women have indicated that unprotected sex can provide a sense of emotional security and connection with their partners that is not achieved when using condoms (Sobo, 1995, 1998). Taking these issues into consideration, it can be suggested that women who find themselves in emotional need of relationships that they perceive are somewhat scarce may be more motivated to engage in risky behaviors (e.g., unprotected intercourse) that they feel are likely to help them fulfill this need.

Though this could be true for any group of women, it may be especially true for African American women, 25% of whom will never marry (Sobo, 1998). The relative

scarcity of heterosexual, employed, non-incarcerated African American men (Bramlett & Mosher, 2002) has placed African American women at a disadvantage in feeling empowered to refuse sexual contact that would otherwise be unwanted (Fullilove, Fullilove, Haynes, & Gross, 1990; Guttentag & Secord, 1983; Soet, Dudley, & Dilorio, 1999). This is an imbalance of power that does not exist in the European American community and may, thereby, serve as a more potent predictor of interpersonal powerlessness for African American women.

Sex ratio imbalances create a number of effects that ripple throughout several areas of heterosexual relationships. For instance, though there has been a general decline in marriage rates over the last three decades, this drop is considerably more drastic for African Americans. Specifically, 81% of European American women marry by the age of 30 compared to only 52% of African American women (Bramlett & Mosher, 2002). Furthermore, compared to European American women, African American women are more likely to have their first or second marriages end in divorce. African American women have also been shown to be less likely to remarry following marital dissolution (Bramlett & Mosher, 2002). Additionally, the relative shortage of African American men (ages 25-35) leads many women to share sex partners and may consequently diminish their ability or motivation to negotiate sexual protection (Worth, 1989).

The Relationship Between Race and Risk

Though these findings are well supported by extant literature, there remains a failure to account for why African American women, despite their higher levels of sexual assertiveness, still may not feel empowered in their communication with sexual partners. Similarly, if European American women do not face such a scarcity in available

relationships, there must be other reasons contributing to their inability to successfully negotiate condom use. Variables may exist that are unique to the sexual experiences of African American and European American women.

As shown in the steadily increasing rates of HIV transmission, current preventive models have not been widely adopted by the general population. Most alarmingly, these approaches have not been assimilated into the sexual interactions of the people who are most at risk. The present study contends that these models are not being adopted because they fail to consider contextual factors that influence (and often dictate) women's level of comfort in demanding safer sex. If this is shown here to be true – that gender roles and mate availability differentially affect European American and African American women's power in sexual interactions – then it would follow that at-risk populations would be better served by preventive programs that take into account these unique social variables.

CHAPTER 7

PURPOSE AND HYPOTHESES

The primary purpose of this study is to evaluate both common and differential factors related to sexual risk-taking behaviors in African American and European American women. The following hypotheses will be examined:

1. In evaluating shared predictors of sexual risk for women in general, it is hypothesized that lower levels of interpersonal power (as measured by the ability to negotiate condom use or to refuse unwanted/unprotected sex) will be associated with higher levels of risky sexual behaviors for both African American and European American women.
2. Prior research has consistently shown that European American women typically subscribe to traditionally feminine gender roles while African American women are likely to endorse characteristics associated with masculine or androgynous gender roles. It is expected that this will be supported in the current study. Therefore, it is hypothesized that feminine gender roles will be more strongly associated with interpersonal powerlessness for European American women than for African American women.
3. Due to census data indicating that there is a more pronounced shortage of African American men (ages 25-35) than of their European American counterparts, it is expected that African American women will more strongly perceive a shortage in potential mates available to them. As an extension of this expectation, it is hypothesized that for African American women, a stronger positive correlation will exist between interpersonal power and perceptions of available mates.

4. As a continuation of the previously presented hypotheses, two models examining the relationship between interpersonal power and sexual risk-taking will be explored. Specifically, it is predicted that the relationship between feminine gender roles and condom use will be mediated by interpersonal power for European American women. By contrast, it is hypothesized that the relationship between mate availability and condom use will be mediated by interpersonal power for African American women.

CHAPTER 8

METHOD

Design and Participants

Power analysis revealed that, to detect a medium effect size, 112 participants would be needed for this study (56 African Americans and 56 European Americans.) Participants were recruited through the Research Participants (RP) pool of psychology undergraduate students at the University of Georgia. Criteria for participation included only women who (1) currently or have previously had sexual contact with men; (2) were unmarried; and (3) identified as either African American or European American. Because the complexity of issues related to other ethnic groups was beyond the scope of the current study, those women who identified with other racial categories were regretfully excluded.

A total of 172 women (48 African American, 123 European American, 1 with no race identified) participated in the study. European American participants were recruited through the RP pool. As expected, the RP pool did not yield an adequate number of eligible African American participants. Therefore, additional participants were recruited through African American student organizations (e.g., sororities and cultural groups) and at campus facilities that are frequented by African American students. A total of 60 African American women completed the measures, but only 48 of them reported having engaged in consensual sex with a male partner.

Despite ongoing efforts to recruit additional African American participants, the researcher was unable to meet the minimum number of participants required for sufficient power to detect a medium effect size (i.e., $f^2 = .15$). However, a post hoc power analysis

revealed that using data from 48 participants was sufficient for detecting a large effect size (i.e., $f^2 = .35$). Although the researcher was unable to recruit the number of African American participants initially proposed, the post hoc power analysis justified continuing with hypothesis testing. Therefore, all further analyses were conducted using the data collected from the 48 eligible African American participants.

To allow for comparisons between groups, data from 56 European American participants were randomly selected and used for analyses. This number of participants was selected because power analysis indicated that, to detect a medium effect size, 56 participants would be needed in each group. European American participants (mean age = 19.20 years, *SD* = 1.341) were significantly younger than the African Americans in the sample (mean age = 21.48 years, *SD* = 3.377; $t(102) = 4.652$, $p = .000$). However, the two groups did not differ significantly from one another on other potentially confounding variables (e.g., age at first consensual sexual activity, number of partners in past year). Independent samples t-tests also revealed that there were no significant differences between groups for condom use ($t(102) = 1.435$, $p = .154$). Additional descriptive data are presented in Table 1.

Table 1

Participant Descriptives for Condom Use, Number of Current Sexual Partners, SAS, BSRI, and Mate Availability

Measure	*M*	*SD*	*Min*	*Max*	*n*
Rates of Condom Use					
African Americans	3.65	1.45	0.00	5.00	48
European Americans	3.21	1.59	0.00	5.00	56
Number of Partners					
African Americans	.583	.54	0.00	2.00	48
European Americans	.732	.52	0.00	2.00	56
SAS					
African Americans	90.58	14.24	58.00	114.00	48
European Americans	90.93	12.94	51.00	115.00	56
BSRI Femininity					
African Americans	5.10	.76	3.40	6.50	48
European Americans	5.09	.51	3.85	6.15	56
Mate Availability					
African Americans	2.08	.79	1.00	4.00	48
European Americans	2.40	1.06	1.00	5.00	55

Measures

Demographics Questionnaire. To ensure that they met inclusion criteria, participants were asked to provide information regarding age, sexual history, rates of condom use, and racial/ethnic identity. Information in this questionnaire regarding participants' rates of condom use and number of current sexual partners was used as measures of sexual risk-taking behaviors in hypothesis testing.

Bem Sex-Role Inventory (BSRI; Bem, 1974). Participants completed this measure assessing their level of femininity, masculinity, and androgyny. This was accomplished by 60 items gauging the extent to which the individual identified with stereotypically masculine, feminine, or gender neutral characteristics. Participants were asked to respond to items along a 7-point Likert scale where 1 is *"never or almost never true"* and 7 is *"always or almost always true."* The BSRI assesses gender roles by determining the degree to which subjects endorse characteristics such as shyness and assertiveness, which are often based on social gender-based expectations. The BSRI has been shown to have internal reliability coefficients ranging from .75 to .86, and test-retest reliability ranging from .90 to .93.

AIDS and Relationships Questionnaire (ARQ; Monahan, Miller, & Rothspan, 1997). This questionnaire, consisting of 22 items, assesses a variety of issues related to one's safer sex practices. Participants were asked to respond to a series of 7-point Likert scale items where 1 is *"strongly agree"* and 7 is *"strongly disagree."* These responses were used to assess participants' level of interpersonal power related to communication about condom use as well as factors that influence this communication. Regarding their most recent heterosexual encounters, participants were asked to indicate the degree to

which they feel they have good communication skills pertaining to HIV/AIDS risk reduction.

As a hypothesized predictor variable, the construct of interpersonal power was addressed by participants' comfort discussing sexual issues with their partners, ability to successfully negotiate sexual practices, and resistance of potential partner influence to engage in unwanted or unprotected sex. These issues were addressed by individual items of the ARQ. Therefore, data obtained from this measure were factor analyzed, with the emerging factors serving as measures of various aspects of interpersonal power in further analyses.

Exploratory factor analyses (EFA) using Principle Components extraction and Varimax rotation were computed for African American and European American participants separately. Through each of these procedures, 6 factors emerged for each group. Information regarding these factors is presented in Tables 2 and 3. However, items did not load similarly for each of the groups, which would preclude between group comparisons. Therefore, an EFA was conducted for the combined sample, revealing a total of 5 factors with eigenvalues greater than 1. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy (*KMO* = .755) indicated that the distribution of values in the sample was adequate for using the factors that emerged. Reliability analysis revealed that this 22-item measure had strong internal consistency (α = .831). Additionally, the 5 factors that emerged accounted for 64% of the variance in responses to these items.

The complete list of the items used in data analysis is presented in Table 4. Factor 1 (Safer Sex Communication) contained items such as "I have pretty good communication skills in dating situations," and "The last time I had sex, I was very

comfortable talking about using a condom." Factor 2 (Safer Sex Practices) was characterized by items such as "I refuse to have sex unless a condom is used." A representative item from Factor 3 (Risk Perception) is "I often worry about getting AIDS from having sex." Factor 4 (Self-Efficacy Regarding HIV) contained items such "There's a lot I can do to keep myself from getting AIDS." The final factor (Factor 5; Making Condoms Fun) included two items indicating the extent to which participants feel they can make using condoms fun and exciting. For the current study, interpersonal power has been conceptualized to include communication skills regarding sexual protection and the ability to negotiate safer sex. Therefore, the five factors that emerged from the ARQ were used as measures of interpersonal power during hypothesis testing.

Table 2

ARQ Items and Factor Loadings for African Americans (n = 48)

Item	Factor Loading
Factor 1	
The last time I had sex, my partner was very comfortable talking to me about using a condom.	.907
The last time I had sex, I was very comfortable talking about using a condom.	.857
The last time I had sex, my partner responded pretty positively to me when I wanted to use a condom.	.835
The last time I had sex, I responded pretty positively to my partner when my partner wanted to use a condom.	.818
I refuse to have sex unless a condom is used.	.775
I'm real good at persuading my partner we need to use a condom.	.585
Factor 2	
The last time I had sex, my partner was very open to what I had to say.	.816
Generally speaking, my partner responds pretty positively to me when I want to use a condom.	.810
Generally speaking, I've responded pretty positively when my partner wants to use a condom.	.726
I make sure a condom is available if it looks like I'm going to have sex.	.592
Factor 3	
I am fearful about the possibility of getting AIDS.	.802
I often worry about getting AIDS from having sex.	.646
The probability of my getting AIDS is high.	.599
The last time I had sex, I initiated the use of a condom.	.536
Factor 4	
I make using a condom pretty exciting (sexually).	.954
I make using a condom fun.	.952
Factor 5	
There's a lot I can do to keep myself from getting AIDS.	.745
There's no point in taking precautions regarding AIDS. It's all a matter of luck anyway.	-.738
I have too much "other stuff" to worry about, to worry about taking precautions about getting AIDS.	-.697
I feel I have control over whether I get AIDS or not.	.331
Factor 6	
I think it's necessary to get to know my partner well before I have sex.	.815
I have pretty good communication skills in dating situations.	.579

Table 3

ARQ Items and Factor Loadings for European Americans (n = 56)

Item	Factor Loading
Factor 1	
The last time I had sex, I was very comfortable talking about using a condom.	.855
The last time I had sex, my partner was very open to what I had to say.	.851
The last time I had sex, my partner was very comfortable talking to me about using a condom.	.823
I have pretty good communication skills in dating situations.	.413
Factor 2	
Generally speaking, I've responded pretty positively when my partner wants to use a condom.	.851
The last time I had sex, I responded pretty positively to my partner when my partner wanted to use a condom.	.814
Generally speaking, my partner responds pretty positively to me when I want to use a condom.	.692
The last time I had sex, my partner responded pretty positively to me when I wanted to use a condom.	.641
The last time I had sex, I initiated the use of a condom.	.555
I'm real good at persuading my partner we need to use a condom.	.496
Factor 3	
There's no point in taking precautions regarding AIDS. It's all a matter of luck anyway.	.840
I feel I have control over whether I get AIDS or not.	-.720
I have too much "other stuff" to worry about, to worry about taking precautions about getting AIDS.	.719
There's a lot I can do to keep myself from getting AIDS.	-.690
Factor 5	
I am fearful about the possibility of getting AIDS.	.802
The probability of my getting AIDS is high.	.741
I often worry about getting AIDS from having sex.	.649
Factor 4	
I think it's necessary to get to know my partner well before I have sex.	.696
I make sure a condom is available if it looks like I'm going to have sex.	.682
I refuse to have sex unless a condom is used.	.680
Factor 6	
I make using a condom fun.	.890
I make using a condom pretty exciting (sexually).	.832

Table 4

ARQ Items and Factor Loadings for the Combined Sample (N = 104)

Item	Factor Loading
Factor 1: Safer Sex Communication	
The last time I had sex, my partner was very comfortable talking to me about using a condom.	.858
The last time I had sex, I was very comfortable talking about using a condom.	.824
The last time I had sex, my partner was very open to what I had to say.	.755
The last time I had sex, my partner responded pretty positively to me when I wanted to use a condom.	.722
The last time I had sex, I responded pretty positively to my partner when my partner wanted to use a condom.	.682
I'm real good at persuading my partner we need to use a condom.	.593
I have pretty good communication skills in dating situations.	.454
Factor 2: Safer Sex Practices	
I refuse to have sex unless a condom is used.	.657
I make sure a condom is available if it looks like I'm going to have sex.	.645
I think it's necessary to get to know my partner well before I have sex.	.629
Generally speaking, my partner responds pretty positively to me when I want to use a condom.	.609
Generally speaking, I've responded pretty positively when my partner wants to use a condom.	.581
Factor 3: Risk Perception	
I often worry about getting AIDS from having sex.	.729
I am fearful about the possibility of getting AIDS.	.722
The probability of my getting AIDS is high.	.719
The last time I had sex, I initiated the use of a condom.	.540
Factor 4: Self-Efficacy Regarding HIV	
There's no point in taking precautions regarding AIDS. It's all a matter of luck anyway.	-.775
I have too much "other stuff" to worry about, to worry about taking precautions about getting AIDS.	-.732
There's a lot I can do to keep myself from getting AIDS.	.696
I feel I have control over whether I get AIDS or not.	.565
Factor 5: Making Condoms Fun	
I make using a condom pretty exciting (sexually).	.911
I make using a condom fun.	.911

Sexual Assertiveness Scale (SAS) for Women (Morokoff, Quina, Harlow, Whitmire, Grimley, Gibson, & Burkholder, 1997). This scale was validated by its authors as a measure of sexual assertiveness in women. In the current study, the SAS was used in assessing participants' level of interpersonal power in sexual situations. Items measured the extent to which participants feel comfortable communicating their sexual desires and intentions, with items such as "It is easy for me to discuss sex with my partner." The questionnaire consists of twenty-five 5-point Likert scale items with responses ranging from "never" to "all the time." Factor analyses conducted by the authors of this measure revealed three distinct subscales: Initiation, Refusal, and Pregnancy-STD Prevention. Analysis also demonstrated good internal consistency for these factors. Cronbach's alpha for Initiation was .77; for Refusal, .74; for Pregnancy-STD Prevention, .82; and for the total scale, .82. In the current study, individual items were reverse coded as necessary for ease of interpretation, such that higher scores indicated greater assertiveness.

As shown in Tables 7, 8, and 9, SAS scores were negatively correlated with condom use in the current sample. However, it was hypothesized that greater levels of interpersonal power would be associated with more consistent condom use (as indicated by a positive correlation). Based on this finding, a reliability analysis was conducted on items of the SAS for this sample, revealing internal consistency that was much lower than what was demonstrated through validation of this measure. Specifically, Cronbach's alpha for the total scale was only .3083. Additionally, factor analysis revealed a total of six factors using data from the current sample whereas only three factors (e.g., Initiation, Refusal, and Pregnancy-STD Prevention) were identified upon validation. Based on

these analyses, the SAS will not be used in further hypothesis testing, due to the lack of internal reliability and the failure to reproduce factors originally identified by authors of the measure.

Dominance in Relationships Questionnaire (DRQ). This 6-item instrument was created for this study as a face-valid means of assessing participants' perceptions of the distribution of power within their sexual relationships with male partners. The items required the participants to identify the extent to which they perceived themselves or their partners as being more dominant. They were also asked to indicate the extent to which they shared power equally with their partners. Participants responded using a 7-point Likert scale (where 1 = "*strongly agree,"* 4 = *"neither agree nor disagree,"* and 7 = *"strongly disagree"*) in regards to their current/most recent relationship and all of their sexual relationships (past and present).

Reliability analysis revealed that the internal consistency of these six items was somewhat questionable ($\alpha = .6531$). However, it was determined that by eliminating two items (regarding the extent to which participants feel that power was shared equally in their current/most recent and previous relationships), reliability was improved ($\alpha = .8042$). Therefore, the four remaining items were used in hypothesis testing as a measure of interpersonal power. Table 5 contains the original DRQ, consisting of 6 items. Table 6 contains the 4-item DRQ used in data analysis.

Table 5

Original DRQ Items and Reliability Analysis

Please answer the next group of questions as they relate to your current or most recent sexual relationship with a man:

I am/was the more dominant partner in this relationship.

My partner is/was the more dominant partner in this relationship.

My partner and I share(d) power equally in this relationship.

Please answer the next group of questions as they relate to all of your sexual relationships with men (past and present):

I am usually the more dominant partner in these relationships.

My partners are usually more dominant in these relationships.

My partners and I usually shared power equally in these relationships.

Reliability Coefficient $\alpha = .6531$

Table 6

DRQ Items Used in Hypothesis Testing and Reliability Analysis

Please answer the next group of questions as they relate to your current or most recent sexual relationship with a man:
I am/was the more dominant partner in this relationship.
My partner is/was the more dominant partner in this relationship.
Please answer the next group of questions as they relate to all of your sexual relationships with men (past and present):
I am usually the more dominant partner in these relationships.
My partners are usually more dominant in these relationships.
Reliability Coefficient $\alpha = .8042$

Dating Priorities Questionnaire (DPQ). This measure, consisting of fifty-two 5-point Likert scale items, was created for this study as a measure of both women's perceptions of mate availability and considerations within relationships that could affect their levels of assertiveness in sexual situations. To assess mate availability participants were asked to respond to two series of questions. The first set of items, with responses ranging from *"strongly agree"* to *"strongly disagree,"* was designed to assess which characteristics women prefer for their (potential) mates to possess. Examples of characteristics included in these items are employment, education, and attitudes about relationships. This section of the questionnaire also assesses the importance participants assign to certain issues within their relationships that may impact their likelihood of using condoms consistently. For instance, participants were asked to describe their efforts to avoid relationship conflict and the perception of their risk of transmitting or contracting HIV/AIDS. The second series of questions was designed to assess the extent to which women perceive that there may be a shortage of men that they would be willing to date. Participants responded by indicating the percentage of men of their own racial/ethnic group whom they think possess characteristics they may desire in potential mates (responses ranging from *"none or almost none/0 – 20%"* to *"all or almost all/80-100%"*). Items were constructed to be face-valid and were guided by those qualities that research has suggested may diminish the pool of eligible mates within a particular ethnic group (Bramlett & Mosher, 2002).

Reliability analysis revealed that this measure as a whole had insufficient internal consistency ($\alpha = .3078$), which would not have been improved by omitting certain items.

Additionally, an exploratory factor analysis was conducted for the total data set. Kaiser-Meyer-Olkin Measure of Sampling Adequacy revealed that these data were inadequate for factor analysis (*KMO* = .476). Further interpretation of this measure was not completed.

A single item was included in the questionnaire packet to assess participants' perceptions of mate availability. Participants were asked to indicate how many men in their own ethnic group possess the characteristics that are important to them in a boyfriend or husband. Responses were on a 5-point Likert scale ranging from *"none or almost none/0 – 20%"* to *"all or almost all/80-100%."* This item was used in further analyses as a measure of perceptions of mate availability.

Procedure

Each participant was assigned an identification number to maintain the confidentiality of responses. Two copies of an Informed Consent form were distributed to each participant. The researcher kept a signed copy from each of the participants while allowing them to retain a copy for their records. Upon providing consent, participants were asked to complete the Demographics Questionnaire, Bem Sex Role Inventory (BSRI; Bem, 1974), AIDS and Relationships Questionnaire (ARQ; Monahan, Miller, & Rothspan, 1997), Sexual Assertiveness Scale (SAS; Morokoff et al., 1997), Dating Perceptions Questionnaire (DPQ), and Dominance in Relationships Questionnaire (DRQ). The packet of questionnaires took approximately 30 minutes to complete. Participants were debriefed upon completion of the questionnaires.

CHAPTER 9

RESULTS

Correlational Analyses

Tables 7, 8, and 9 present correlation matrices for variables of interest in the total sample ($N = 104$), African Americans ($n = 48$), and European Americans ($n = 56$), respectively. Many of the primary variables of interest, including measures of interpersonal power and sexual risk-taking, were significantly correlated in the hypothesized directions. These correlations justify continuing with further analyses. For the purposes of hypothesis testing, the following will be used to measure the construct of interpersonal power: ARQ factor scores and DRQ. Additionally, the dependent variable, sexual risk-taking will be measured by the reported number of current sexual partners and rates of condom use.

Table 7

Intercorrelations Among All Measures for Combined Sample (*N*=104)

Measure	1	2	3	4	5	6	7	8	9	10	11	12
1. Condom Use	---											
2. # of Partners	-.209*	---										
3. SAS	-.300**	.256**	---									
4. Femininity	.142	.291**	-.051	---								
5. ARQ Factor 1	-.598**	.095	-.025	-.086	---							
6. ARQ Factor 2	-.665**	.256**	.287**	-.106	.662**	---						
7. ARQ Factor 3	-.275**	.299**	.121	.126	.156	.198*	---					
8. ARQ Factor 4	-.033	-.122	.065	-.186	.037	-.031	.007	---				
9. ARQ Factor 5	-.204*	.141	-.121	-.096	.327**	.318**	.166	.054	---			
10. DRQ $Total_{Current}$	-.031	-.143	.284**	-.058	.053	.110	-.185	.038	.014	---		
11. DRQ $Total_{Past}$	.110	-.141	.106	.036	-.078	-.059	-.159	-.041	.025	.598**	---	
12. Mate Availability	.083	.263**	-.012	.122	-.042	.026	.137	-.045	-.056	-.265**	-.130	---

Note. **. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 8
Intercorrelations Among All Measures for African Americans (*n*=48)

Measure	1	2	3	4	5	6	7	8	9	10	11	12
1. Condom Use	---											
2. # of Partners	-.301*	---										
3. SAS	-.307*	.254	---									
4. Femininity	.163	.328*	-.008	---								
5. ARQ Factor 1	-.704**	-.301*	-.006	-.024	---							
6. ARQ Factor 2	-.695**	.306*	.193	-.075	.837**	---						
7. ARQ Factor 3	-.401**	.279*	.205	.131	.307	.368*	---					
8. ARQ Factor 4	-.069	-.130	.205	-.247	-.014	-.015	-.139	---				
9. ARQ Factor 5	-.169	.172	-.250	-.008	.261	.233	.259	.017	---			
10. DRQ $Total_{Current}$	-.151	.095	.414**	.091	.062	.172	-.027	.004	-.029	---		
11. DRQ $Total_{Past}$	-.046	-.048	.068	.234	.073	.059	.058	-.204	.286	.606**	---	
12. Mate Availability	-.048	.381**	.076	-.034	.034	-.002	.080	-.096	-.073	-.178	-.126	---

Note. **. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 9
Intercorrelations Among All Measures for European Americans (*n*=56)

Measure	1	2	3	4	5	6	7	8	9	10	11	12
1. Condom Use	---											
2. # of Partners	-.105	---										
3. SAS	-.308*	.277*	---									
4. Femininity	.126	.266*	-.117	---								
5. ARQ Factor 1	-.522**	-.080	-.066	-.165	---							
6. ARQ Factor 2	-.658**	.180	.379**	-.159	.597**	---						
7. ARQ Factor 3	-.144	.281*	.048	.138	.023	.000	---					
8. ARQ Factor 4	-.033	-.088	.084	-.108	.100	.034	.190	---				
9. ARQ Factor 5	-.236	.117	-.001	-.214	.384**	.422**	.095	.089	---			
10. DRQ $Total_{Current}$	-.023	.270*	.213	-.246	.086	.280*	-.222	.007	.045	---		
11. DRQ $Total_{Past}$	.198	-.183	.149	-.246	-.191	-.030	-.299*	.084	-.220	.562**	---	
12. Mate Availability	.202	.166	-.082	.299*	-.113	-.058	.080	.026	-.046	-.260	-.090	---

Note. **. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Power and Risky Sex

Hypothesis 1 stated that lower levels of interpersonal power would be associated with higher levels of risky sexual behaviors for both African American and European American women. The construct of interpersonal power was conceptualized to include participants' comfort discussing sexual issues with their partners (e.g., condom use, sexual desires), ability to successfully negotiate sexual practices, resistance of potential partner influence to engage in unwanted or unprotected sex, and perceptions of power in relationships. These constructs were measured by the ARQ factors and DRQ.

A hierarchical multiple regression computed for the total sample indicated that scores on ARQ Factor 1 (Safer Sex Communication), ARQ Factor 2 (Safer Sex Practices), and ARQ Factor 3 (Risk Perception) were significant predictors of condom use ($R = .708$, $R^2 = .501$, $p = .049$). These results offered support for Hypothesis 1, indicating that higher levels of interpersonal power were associated with lower sexual risk-taking for both African American and European American women. Table 10 contains details of this regression analysis.

Table 10

Summary of Hierarchical Regression Analysis for Variables Predicting Condom Use in the Combined Sample (N=104)

Variable	*B*	*SE B*	*β*
Step 1			
ARQ Factor 1 (Safer Sex Communication)	-.848	.114	-.594**
Step 2			
ARQ Factor 2 (Safer Sex Practices)	-.689	.138	-.475**
Step 3			
ARQ Factor 3 (Risk Perception)	-.158	.079	-.144*
Step 4			
ARQ Factor 4 (Self-Efficacy Regarding HIV)	-.128	.257	-.035
Step 5			
ARQ Factor 5 (Making Condoms Fun)	.070	.084	.064

Note. R^2 = .353 for Step 1; ΔR^2 = .128 for Step 2; ΔR^2 = .020 for Step 3; ΔR^2 = .001 for Step 4; ΔR^2 = .004 for Step 5.

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

Gender Roles and Power

In Hypothesis 2, it was proposed that feminine gender roles would be more strongly associated with interpersonal powerlessness for European American women than for African American women. Prior to conducting analyses directly related this hypothesis, BSRI scores were calculated for each participant. Using the approach outlined by Bem (1974) during scale development, analysis of each participant's responses on the BSRI began with the calculation of the Masculinity and Femininity scores, indicating the extent to which sets of these characteristics were endorsed. Each participant's Masculinity score was computed as the mean self-rating for all masculine items. Likewise, Femininity scores represented the mean self-rating for feminine items. Each participant's Androgyny score was calculated by subtracting the Masculinity score from the Femininity score.

It was expected that, consistent with extant literature, European American women would be significantly more feminine than African American women. However, an independent samples, one-tailed t-test indicated that there was no significant difference on Femininity (as measured by BSRI) between the two groups ($t(102) = .109$, $p = .457$).

Inability to replicate these findings did not preclude continued examination of Hypothesis 2. Correlational analysis revealed that, for European American women, Femininity is related to participants' perception of their current/most recent partners as being dominant in relationships (as measured by DRQ; $r = -.319$, $p = .008$). By contrast, this relationship was not significant for African American women ($r = .076$; $p = .304$). Therefore, there was support for Hypothesis 2 in that feminine gender roles were more

strongly related to lower levels of interpersonal power for European American women than for African Americans.

Mate Availability and Power

Hypothesis 3 predicted that African American women's perceived mate availability would be significantly lower than that of European American women. By extension, it was proposed that the positive correlation between mate availability and interpersonal power would be stronger for African American women than for European American women.

As discussed previously, the DPQ could not be used for data analysis as a measure of perceived mate availability. Therefore, mate availability was assessed using an item asking the participants to rate the percentage of men in their ethnic group that possess the characteristics most important to them in a potential boyfriend or husband. As in previous analyses, interpersonal power was measured by ARQ factor scores and DRQ.

An independent samples, one-tailed t-test supported the first portion of Hypothesis 3. Specifically, African American women's perceptions of mate availability were significantly lower than those of the European American sample ($t(101) = -1.690$, $p = .047$). Descriptives regarding perceived mate availability for African Americans and European Americans are presented in Table 1.

To examine Hypothesis 3 further, Pearson correlations were computed to determine if mate availability was positively related to interpersonal power. (Correlational analyses were conducted separately for African American and European American participants to allow for comparisons between groups.) Analysis revealed that

perceived mate availability was not correlated with any of the measures of interpersonal power (see Tables 8 and 9).

These findings indicate partial support for Hypothesis 3. While it was true that African American women have lower perceptions of mate availability than European American women, mate availability was not correlated with power for either group. It was initially proposed that a Fisher's Z transformation would be computed to determine if the correlation between mate availability and power was stronger for African American women than for European American women. Due to the lack of statistical significance, direct comparison of the correlations between groups was not warranted.

Potential Mediators of the Relationship Between Power and Risky Sex

As discussed previously, Hypothesis 1, regarding the relationship between interpersonal power (as measured by ARQ Factors 1, 2, and 3) and risky sex was supported by the data. Hypothesis 4 proposed an integration of the findings regarding power, risky sex, gender roles, and mate availability. For European American women, it was predicted that the relationship between feminine gender roles and condom use would be mediated by interpersonal power. Hypothesis 4 also predicted that the relationship between mate availability and condom use would be mediated by interpersonal power for African American women.

According to Baron and Kenny (1986), testing for mediation required the computation of three simple linear regressions. For European American women, Femininity was identified as the predictor variable, condom use (as a measure of risky sexual behaviors) as the criterion variable, and interpersonal power (as measured by ARQ Factors 1, 2, and 3) as the mediators. To test the proposed model, three simple linear

regressions were to be computed for each measure of power in which (1) power is regressed on Femininity; (2) condom use is regressed on Femininity; and (3) condom use is regressed on both Femininity and power. To find support for this mediation model, all of these regressions would need to be significant in the predicted directions. However, the first step of this analysis showed that Femininity is not a significant predictor of any of the measures of power. It was, therefore, determined that the proposed mediational model was not supported and further analysis were not conducted. Details of the regressions computed to test this model are presented in Table 11.

A similar procedure was utilized to determine if the relationship between mate availability and risky sex is mediated by interpersonal power for African American women. To test this, mate availability was identified as the predictor variable, condom use as the criterion variable, and interpersonal power (as measured by ARQ Factors 1, 2, and 3) as the mediators. Three simple linear regressions were to be computed for each measure of power in which (1) power is regressed on mate availability, (2) condom use is regressed on mate availability, and (3) condom use is regressed on both mate availability and power. As previously mentioned, the relationship between mate availability and power was not significant in the hypothesized direction. This finding precludes possible mediation as it was initially proposed. Therefore, further analyses were not conducted. Based on these findings, there was a lack of support for the two models proposed in Hypothesis 4.

Table 11

Simple Linear Regression Analyses to Evaluate Interpersonal Power as a Mediating the Relationship Between Femininity and Condom Use for European American Women (n=56)

Variable	*B*	*SE B*	*β*
ARQ Factor 1: Safer Sex Communication	-.362	.295	-.165
ARQ Factor 2: Safer Sex Practices	-.346	.292	-.159
ARQ Factor 3	.375	.367	.138

Note. Each measure of interpersonal power was regressed on Femininity. R^2 = .027 for ARQ Factor 1; R^2 = .025 for ARQ Factor 2; R^2 = .019 for ARQ Factor 3.

CHAPTER 10

DISCUSSION

The present study attempted to explore factors related to sexual risk-taking behaviors among African American and European American college women. Relating to the practice of safer sex, the construct of interpersonal power was conceptualized to include several important factors, including communication, the ability to negotiate condom use, and the refusal of unwanted/unprotected sex. Using several measures to assess various facets of this construct, there was overall support for the relationship between interpersonal power and risky sex. Specifically, women who endorse stronger communication skills regarding safer sex were likely to use condoms more consistently. Additionally, general levels of sexual assertiveness were predictive of condom use. These results are consistent with the extant literature in this area (Amaro, 1995; Edgar, 1992).

These findings are in accordance with commentary offered by researchers to explain why some women have difficulty engaging in consistent condom. For instance, it has been argued that safer sex is a highly interpersonal process for women because of the need to negotiate the use of condoms (Amaro, 1995). Therefore, given the imbalance of power within many heterosexual relationships, women may sometimes lack the skills or assertiveness to insist on safer sex practices. Results from this study support this notion by revealing that interpersonal factors, such as communication skills and assertiveness, are predictive of rates of condom use. This is important given that a large portion of the research conducted in the field of HIV prevention focuses on intrapersonal factors (e.g.,

knowledge about HIV) while paying little attention to the interpersonal context in which sexual activities occur.

The current study also evaluated additional variables that were hypothesized as being differentially related to interpersonal power for African American and European American women. First, it was hypothesized that there would be a stronger negative correlation between feminine gender roles and interpersonal power for European Americans than for African Americans. Although it was shown here that there was no significant difference in femininity between groups (which is inconsistent with the literature; Harris, 1996), there was support for this hypothesis. European American women who indicated that their current/most recent relationship is dominated by their male partners endorsed higher levels of feminine characteristics. However, there was no correlation between femininity and any of the measures of interpersonal power for African American women.

It is difficult to present a justification for why the current sample did not replicate consistent findings that European American women are significantly more feminine than African American women (Harris, 1996). However, it should be noted that, in the current sample, African American women scored significantly higher on the BSRI Masculinity subscale ($t(102) = 2.112$, $p = .037$). Further research could be conducted to determine if masculine characteristics are associated with the construct of interpersonal power, which is conceptually similar to stereotypically male gender role expectations.

It was also hypothesized that African American women would have lower perceptions of mate availability than their European American counterparts.

Additionally, it was suggested that the positive correlation between perceptions of mate availability and interpersonal power would be stronger for African American women than for European Americans. It was shown that African Americans do, in fact, have lower perceptions of mate availability. However, there was a lack of support for the second part of this hypothesis in that perceived mate availability was not significantly correlated with any of the measures of power (ARQ Factor 1, 2, and 3) for either group.

The rationale guiding the hypothesized relationship between mate availability and power was that individuals who perceived fewer dating options might be less inclined to insist on condom use. This is based on previous research that has shown that women are less likely to insist on using condoms when they perceive that this may threaten their relationships. When this is the case, women may practice unsafe sex to protect (or even enhance) the status of the relationship. These women also display less assertive communication, especially when they feel their alternative dating options are limited (Barker et al, 1998). It is possible that, in the current sample, insistence on using condoms is not perceived as a threat to relationship security. Therefore, even for women who perceive a shortage of available mates, this lack of dating alternatives may not weigh heavily into their decisions about whether to communicate assertively about sexual protection.

Two models were proposed in which it was hypothesized that power would mediate (1) the relationship between femininity and risky sex for European American women and (2) the relationship between mate availability and risky sex for African American women. However, the data did not offer support for either of these mediational models.

Despite some significant findings, several important limitations of this study can be identified. First, the researcher was unable to recruit an adequate number of eligible African American participants, which led to insufficient statistical power to detect a medium effect size. It may be possible that additional participants would have affected the conclusions. Although post hoc power analysis confirmed that the sample size was adequate for detecting a large effect size, it is possible that the limited number of participants would not permit the detection of smaller effects.

A second important limitation of the current study involves the instruments used to assess interpersonal power. Conceptually, it may be true that the construct of power is multifaceted. The need to account for this complexity was addressed in the selection of measures that assess various domains of interpersonal power related to HIV risk reduction (e.g., communication, sexual assertiveness). However, as shown in Tables 7, 8, and 9, the measures of power were not highly correlated with each other. If all of these measures assessed different aspects of a single construct (i.e., interpersonal power), it would be expected that participants' scores on each of the instruments would be significantly correlated. Because this was not shown to be the case, it is possible that communication skills and sexual assertiveness are not merely two aspects of interpersonal power. Instead, these may be separate and distinct constructs that are not as strongly related to one another as initially suspected.

The ability to assess interpersonal power in this sample was also hampered by psychometric issues with the SAS. As mentioned previously, there was a negative correlation between condom use and power as measured by the SAS. Reliability analysis conducted post hoc indicated weak internal consistency with the current sample and did

not support use of SAS scores in hypothesis testing. It is difficult to identify reasons for the lack of internal reliability as well as the questionable factor structure. However, these limitations contraindicated use of the SAS in hypothesis testing for the current study.

A major component of this study was the construction of the DPQ as a measure of mate availability. Items were included to create a face-valid assessment based on characteristics that have been shown to decrease women's perceptions of the numbers of eligible mates available to them. However, reliability analysis and factor analysis indicated that the measure's structure was insufficient for use in hypothesis testing. A possible explanation for the lack of internal consistency may be that, despite its face-validity, the DPQ addressed the issue of mate availability in a manner that was too broad. For instance, although there are a number of variables that affect perceived mate availability (e.g., employment, education, attitudes about relationships), it is possible that women's perceptions regarding each of these factors are not highly related to each other.

In spite of several limitations, there are important implications for the results of this study. First, it was shown that various domains of interpersonal power (e.g., ARQ Factors 1, 2, and 3) were predictive of sexual risk-taking behaviors in women. This suggests that women who (1) have stronger communication skills regarding sexual protection, (2) are able to refuse unwanted/unprotected sex, and (3) perceive that they are at risk of infection actually engaged in more consistent condom use. These competencies all involve interpersonal skills that may not be adequately addressed by current prevention programs, the majority of which focus primarily on self-efficacy. Interestingly, ARQ Factor 4, which seems closely related to the concept of self-efficacy regarding HIV prevention, was not significantly correlated with condom use. Based on

these findings, it may be important for prevention efforts to focus on helping women build general communication and assertiveness skills as a means of decreasing risky sexual behaviors.

Given the relationship between power and sexual risk-taking, further research regarding factors that affect interpersonal power is warranted. Although femininity and mate availability may not be the most important factors contributing to deficits in interpersonal power, there may be other variables that significantly diminish the degree to which women feel they can communicate effectively or feel comfortable being assertive regarding sexual protection. Additional research could have direct implications for the development of more effective HIV prevention programs that promote interpersonal skills related to consistent safer sex practices.

One of the overarching goals of this research was to evaluate how femininity and mate availability differentially affect African American and European American women. This was of importance given the continued disproportionate increase in HIV infections among African American women. Because the proposed relationship between perceived mate availability and power was not supported by the data, this study did not offer any clear suggestions for why African American women are at increased risk. It should be the aim of future research to uncover contextual variables that translate into exaggerated risk of HIV infection in this segment of the population. Continued research delving into these issues is essential because relevant findings should lead to the development of culturally sensitive prevention programs that adequately address the unique factors contributing to African American women's heightened risk of infection.

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APPENDIX A

Demographics Questionnaire

1. Age _____

2. How do you describe yourself? **(Please answer both A and B)**
   a. _____ Hispanic or Latino or of Spanish Origin
      _____ Not Hispanic or Latino
   b. (Mixed racial heritage should be indicated by checking more than one category.)
      _____ American Indian or Alaska Native
      _____ Asian
      _____ Black or African American
      _____ Native Hawaiian or Other Pacific Islander
      _____ White

3. Have you ever had consensual sex?
   _____ No
   _____ Yes

4. How old were you the first time you had consensual sex?
   _____ (age in years)

5. How many different people have you had sex with in the past year?
   _____ (number of people)

6. With how many people are you currently having sex?
   _____ (number of people)

7. Have you had sexual relations with <u>women</u>? ____ No _____ Yes

8. Have you had sexual relations with <u>men</u>? ____ No _____ Yes

9. Have you ever had a sexually transmitted disease?____ No _____ Yes

10. Has anyone ever forced you to have sex against your will?
    _____ No (Please go to Question 12)
    _____ Yes

11. How many times has this happened?
    _____ (number of times)

12. Has anyone ever convinced you to have sex when you didn't want to at first?
    _____ No (Please go to Question 14)
    _____ Yes

13. How many times has this happened?
_____ (number of times)

Please think about the last time you had sex with a man…

14. Did you talk about using a condom with that person?
_____ No (Please go to Question 16)
_____ Yes

15. We talked about all the important issues regarding using a condom for disease prevention.

1----------	2 ----------	3 ----------	4 ----------	5 ----------	6 ----------	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

16. This person was willing to use a condom.

1----------	2 ----------	3 ----------	4 ----------	5 ----------	6 ----------	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

17. Who first brought up the topic of condoms?
_____ I did
_____ My partner did

18. Did you use a condom the last time you had sex? _____ No _____ Yes

Once again, please think about the last time you had sex with a man…

19. Have you ever talked to this man about <u>his</u> sexual history?
_____ No (Please go to Question 23).
_____ Yes

20. I feel we talked a lot about my partner's sexual history.

1----------	2 ----------	3 ----------	4 ----------	5 ----------	6 ----------	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

21. Did you talk about… (Please check all that apply.)
    _____ how many sex partners he has had
    _____ whether he is seeing anyone else
    _____ how long he dated his last partner
    _____ how far he went (sexually) with his last partner
    _____ whether he ever had a sexually transmitted disease
    _____ what their past relationships were like
    _____ whether he's ever used IV drugs
    _____ whether he's ever had sex with other men
    _____ whether he's ever taken an HIV/AIDS test
    _____ whether he's HIV positive or negative

22. Did you talk about his sexual history before the first time you had sex with him?
    _____ No
    _____ Yes

23. Have you ever talked to this person about <u>your</u> sexual history?
    _____ No (Please go to Question 27)
    _____ Yes

24. I feel we talked a lot about my sexual history.

1----------	2 ----------	3 ----------	4 ----------	5 ----------	6 ----------	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

25. Did you talk about… (Please check all that apply.)
    _____ how many sex partners you have had
    _____ whether you are seeing anyone else
    _____ how long you dated your last partner
    _____ how far you went (sexually) with your last partner
    _____ whether you ever had a sexually transmitted disease
    _____ what your past relationships were like
    _____ whether you've ever used IV drugs
    _____ whether you've ever had sex with other women
    _____ whether you've ever taken an HIV/AIDS test
    _____ whether you're HIV positive or negative

26. Did you talk about you sexual history with this man before the first time you had sex with him?
    _____ No
    _____ Yes

27. How often do you use a condom during sexual intercourse?
    _____ I never use a condom during sex
    _____ Only once or twice I have used a condom during sex
    _____ Occasionally (about 25% of the time)
    _____ About half of the time I have sex
    _____ Most of the time (about 75% of the time)
    _____ Every time I have sex I use a condom

28. During the past six months, how often have you had sex?
    _____ never
    _____ less than once a month
    _____ 2 or 3 times a month
    _____ once a week
    _____ 2 or 3 times a week
    _____ more than 3 times a week

29. Have you ever received a negative response when you asked your partner to use a condom?
    _____ No
    _____ Yes

30. Did you ever ask this person to use a condom again? _____ No _____ Yes

31. Thinking back to the last time you had sex, did your partner give a negative response to you regarding using a condom?
    _____ No
    _____ Yes

32. Will you ever ask this person to use a condom again? _____ No _____ Yes

APPENDIX B

Bem Sex Role Inventory (Bem, 1974)

Put an 'X' in the parenthesis (X) that best describes you.
Pick **1** if the word/phrase **almost never** describes you.
Pick **2** if the word/phrase is rarely true.
Pick **3** if the word/phrase is seldom true.
Pick **4** if the word/phrase is both an accurate AND inaccurate descriptor for yourself.
Pick **5** if the word/phrase is often true.
Pick **6** if the word/phrase is mostly true.
Pick **7** if the word/phrase **almost always** describes you.

1. Self-reliant

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

2. Yielding

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

3. Helpful

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

4. Defends own beliefs

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

5. Cheerful

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

6. Moody

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

7. Independent

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

8. Shy

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

9. Conscientious

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

10. Athletic

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

11. Affectionate

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

12. Theatrical

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

13. Assertive

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

14. Flatterable

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

15. Happy

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

16. Strong personality

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

17. Loyal

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

18. Unpredictable

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

19. Forceful

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

20. Feminine

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

21. Reliable

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

22. Analytical

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

23. Sympathetic

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

24. Jealous

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

25. Has leadership abilities

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

26. Sensitive to the needs of others

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

27. Truthful

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

28. Willing to take risks

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

29. Understanding

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

30. Secretive

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

31. Makes decisions easily

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

32. Compassionate

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

33. Sincere

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

34. Self-sufficient

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

35. Eager to soothe hurt feelings

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

36. Conceited

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

37. Dominant

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

38. Soft spoken

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

39. Likable

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

40. Masculine

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

41. Warm

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

42. Solemn

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

43. Willing to take a stand

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

44. Tender

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

45. Friendly

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

46. Aggressive

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

47. Gullible

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

48. Inefficient

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

49. Acts as a leader

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

50. Childlike

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

51. Adaptable

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

52. Individualistic

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

53. Does not use harsh language

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

54. Unsystematic

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

55. Competitive

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

56. Loves children

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

57. Tactful

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

58. Ambitious

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

59. Gentle

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

60. Conventional

( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7

APPENDIX C

AIDS and Relationships Questionnaire (Monahan, Miller, & Rothspan, 1997)

1. I think it's necessary to get to know my partner well before I have sex.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

2. I refuse to have sex unless a condom is used.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

3. I am fearful about the possibility of getting AIDS.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

4. The probability of my getting AIDS is high.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

5. I often worry about getting AIDS from having sex.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

6. There's no point in taking precautions regarding AIDS. It's all a matter of luck anyway.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

7. I have too much "other stuff" to worry about, to worry about taking precautions about getting AIDS.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

8. I make sure a condom will be available if it looks like I'm going to have sex.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

9. There's a lot I can do to keep myself from getting AIDS.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

10. I feel I have control over whether I get AIDS or not.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

11. I make using a condom fun.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

12. I make using a condom pretty exciting (sexually).

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

13. I'm real good at persuading my partner we need to use a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

14. Generally speaking, **I've** responded pretty positively when my partner wants to use a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

15. Generally speaking, **my partner** responds pretty positively to me when I want to use a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

16. The last time I had sex, **my partner** responded pretty positively to me when I wanted to use a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

17. The last time I had sex, **I** responded pretty positively to my partner when my partner wanted to use a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

18. The last time I had sex, **my partner** was very comfortable talking to me about using a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

19. The last time I had sex, **I** was very comfortable talking about using a condom.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

20. The last time I had sex, **my partner** was very open to what I had to say.

1---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
strongly agree agree a neither agree disagree a disagree strongly
agree little nor disagree little disagree

21. The last time I had sex, **I** initiated the use of a condom.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

22. I have pretty good communication skills in dating situations.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

APPENDIX D

Sexual Assertiveness Scale (Morokoff et al., 1997)

Please rate and answer each of the following items on a scale from 1 to 5:
1 – Never
2 – Rarely
3 – Some of the time
4 – Most of the time
5 – All of the time

	Never	Rarely	Some of the time	Most of the time	All of the time
1. I feel uncomfortable talking during sex.	1	2	3	4	5
2. I feel that I am shy when it comes to sex.	1	2	3	4	5
3. I approach my partner for sex when I desire it.	1	2	3	4	5
4. I think I am open with my partner about my sexual needs.	1	2	3	4	5
5. I enjoy sharing my sexual fantasies with my partner.	1	2	3	4	5
6. I feel uncomfortable talking to my friends about sex.	1	2	3	4	5
7. I communicate my sexual desires to my partner.	1	2	3	4	5
8. It is difficult for me to touch myself during sex.	1	2	3	4	5
9. It is hard for me to say no even when I do not want sex.	1	2	3	4	5
10. I am reluctant to describe myself as a sexual person.	1	2	3	4	5
11. I feel uncomfortable telling my partner what feels good.	1	2	3	4	5
12. I speak up for my sexual feelings.	1	2	3	4	5
13. I am reluctant to insist that my partner satisfy me.	1	2	3	4	5

14. I find myself having sex when I really do not want it.	1	2	3	4	5
15. When a sexual technique does not feel good, I tell my partner.	1	2	3	4	5
16. I feel comfortable giving sexual praise to my partner.	1	2	3	4	5
17. It is easy for me to discuss sex with my partner.	1	2	3	4	5
18. I feel comfortable initiating sex with my partner.	1	2	3	4	5
19. I find myself doing sexual things with my partner that I do not like.	1	2	3	4	5
20. Pleasing my partner is more important than my own sexual pleasure.	1	2	3	4	5
21. I feel comfortable telling my partner to touch me.	1	2	3	4	5
22. I enjoy masturbating myself to orgasm.	1	2	3	4	5
23. If something feels good in sex, I insist on doing it again.	1	2	3	4	5
24. It is hard for me to be honest about my sexual feelings.	1	2	3	4	5
25. I try to avoid discussing the subject of sex.	1	2	3	4	5

APPENDIX E

Dating Priorities Questionnaire

Use the following choices to respond to next group of questions:
A. Strongly Agree
B. Somewhat Agree
C. Neither Agree nor Disagree/Neutral
D. Somewhat Disagree
E. Strongly Disagree

____ I want to get married one day.

____ I prefer being in relationships where my partner dates other people.

____ I am willing to date a man of a race other than my own.

____ I would consider being in a sexual relationship with another woman.

____ In a relationship, I think it is important that I try not to upset my partner.

____ I am worried that I may contract HIV/AIDS from my partner.

____ It is important that I not do anything to embarrass myself when I'm around my partner.

____ I think that sex is an important part of a relationship.

____ I would break up with my boyfriend if he often said mean things to me.

____ I would not be willing to date a man who is already dating another woman.

____ I would not date a man who has ever dated another man.

____ I could be in a relationship with a man who says mean things to his girlfriends.

____ In a relationship, I think it's important to talk about my concerns with my boyfriend.

____ In a relationship, it is important that my partner like me a lot.

____ In a relationship, it is important that my boyfriend think highly of me.

____ I am worried that I may give HIV/AIDS to my partner.

____ It is important that my partner avoid causing me emotional pain.

____ In a relationship, it is important that my boyfriend feel emotionally close to me.

____ I would not break up with my boyfriend if he hit me.

____ I would date a man who currently dates other men.

____ In a relationship, I think it is important that my partner try not to upset me.

____ In a relationship, it is important that I feel emotionally close to my boyfriend.

____ It is important that I avoid getting AIDS.

____ I would only be willing to date a man who has at least as much education as I do.

____ I would only be in a relationship with a man who is respectful of women.

____ I would not date a man who has ever had sex with another man.

____ It is important that I avoid giving AIDS to people I have sex with.

____ I prefer being in relationships where I date other people.

____ In a relationship, it is important that I think highly of my boyfriend.

____ I prefer to be the dominant partner in my relationships.

____ I would be unhappy if I never got married.

____ I would consider being in a romantic relationship with another woman.

____ I would not break up with my boyfriend if he often said mean things to me.

____ In a relationship, I think it's important for my boyfriend to talk about his concerns with me.

____ In a relationship, it is important that I like my partner a lot.

____ I would consider being in a committed relationship with another woman.

____ I would not date a man who has ever been convicted of a crime.

____ I would be happy if I never got married.

____ Sex is not very important in a relationship.

____ It is important that I avoid causing my boyfriend emotional pain.

____ In a relationship, I try very hard to avoid being rejected by my partner.

____ I am only willing to be in romantic relationships with men.

____ I would date a man who has had sex with another man before.

____ I would not date a man who has ever hit any of his previous girlfriends.

____ I prefer dating a man who does not have any children with another woman.

____ I prefer for my boyfriend to be the dominant partner in my relationships.

____ I would date a man who currently has sex with other men.

____ I am only willing to date a man who makes at least as much money as I do.

____ I think it would be difficult to find my ideal mate.

____ I am not worried that I may never get married.

____ In a relationship, I try very hard not to reject my partner.

____ I would only date a man who usually prefers to date women of my race.

____ I could be in a relationship with a man who does not have a job.

____ I do not ever want to get married.

____ I prefer being in monogamous relationships.

____ I would break up with my boyfriend if he ever hit me.

____ I think it would be easy for me to find my ideal mate.

____ I am only willing to be in sexual relationships with men.

____ I could date a man who has been convicted of a crime.

____ I am worried that I may never get married.

____ I would be willing to date a man who has dated another man before.

____ I would not date a man who currently has sex with other men.

____ I would be willing to date a man who is married to another woman.

____ I could be in a relationship with a man who hit any of his previous girlfriends.

____ I would not be interested in having a committed relationship with another woman.

____ I will not date men of a race other than my own.

____ I could date a man who has served time in prison.

____ I would be willing to date a man who is dating another woman.

____ I do not think that I will ever get married.

____ I would not date a man who is married to another woman.

____ I am happiest when I am free to date more than one person.

____ I would date a man who has children from another woman.

____ I would date a man who is disrespectful of women.

____ I would not date a man who has ever served a prison sentence.

____ I don't care if my boyfriend has less money than I do.

____ I would date a man who has less education than I do.

____ I only want to be in a relationship with a man who has a job.

____ I could not date a man who does not prefer to date women of my race.

____ I think that I will get married one day.

____ I could not be in a relationship with a man who says mean things to his girlfriends.

Use the following choices to answer the next group of questions about men of your racial or ethnic group:

A. 0 – 20 % (none or almost none)
B. 21 – 40% (some)
C. 41 – 60 % (about half)
D. 61 – 80% (most)
E. 81 – 100% (all or almost all)

____ How many do not cheat on their wives or girlfriends?

____ How many want to be in monogamous relationships?

____ How many engage in sexual activities with other men?

____ How many have children with women other than their current wives or girlfriends?

____ How many have never been convicted of a crime?

____ How many have served time in prison?

____ How many have ever been verbally abusive to their wives or girlfriends?

____ How many are respectful of women?

____ How many would never hit a woman?

____ How many have at least a college education?

____ How many are unemployed?

____ How many prefer to date women of different races/ethnicities?

____ How many are economically stable?

____ How many are HIV positive?

____ How many have the characteristics most important to you in a potential boyfriend or husband?

APPENDIX F

Dominance in Relationships Questionnaire

Please answer the next group of questions as they relate to your current or most recent sexual relationship with a man:

I am/was the more dominant partner in this relationship.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

My partner is/was the more dominant partner in this relationship.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

My partner and I share(d) power equally in this relationship.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

Please answer the next group of questions as they relate to all of your sexual relationships with men (past and present):

I am usually the more dominant partner in these relationships.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

My partners are usually the more dominant partner in these relationships.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree

My partners and I usually shared power equally in these relationships.

1	2	3	4	5	6	7
strongly agree	agree	agree a little	neither agree nor disagree	disagree a little	disagree	strongly disagree