THE CONTEXT OF UNPROTECTED SEX: RELATIONSHIP FACTORS AND ALCOHOL AS PREDICTORS OF COLLEGE WOMEN'S SEXUAL RISK-TAKING BEHAVIORS

by

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(Under the Direction of Lily D. McNair)

ABSTRACT

Surveillance data indicate that high-risk heterosexual contact (e.g., sex without a condom and/or with a known HIV+ partner) is the suspected source of infection for 78% of HIV+ women (Centers for Disease Control and Prevention, 2005). Despite increased knowledge about HIV transmission and prevention, consistent safer sex practices have not been adopted by women, particularly in relationships with male significant others. Prior research has shown that, although college women tend to subjectively describe themselves as being at low risk of contracting HIV, their sexual behaviors and lack of HIV testing are largely consistent with a high-risk profile (Yarnall, McBride, Lyna, Fish et al., 2003). Considering prior research, it is likely that a variety of intrapersonal and interpersonal factors contribute to the level of HIV risk that young women face, especially in their relationships with significant dating partners. The purpose of the current study was to examine the interrelatedness of relationship status, sexual power, alcohol consumption, and HIV risk perception as predictors of sexual risk-taking behaviors among college women. Overall, results from the current study indicate that these variables impact women's sexual behaviors. Participants endorsed less consistent condom use with "boyfriends" and in lengthier relationships. Likewise, perceived intimacy was shown to be negatively

associated with condom use. Results also indicated that perceived sexual power was positively correlated with consistency of condom use with new sexual partners but not during the last/most recent month of women's relationships. It was also shown that alcohol use before or during sex moderated the negative association between perceived intimacy and condom use over the course of a relationship. Specifically, more consistent condom use was reported in less intimate relationships when alcohol is consumed less frequently before or during sex. This study also demonstrated that, despite engaging in frequent unprotected sex, the vast majority of participants denied previous HIV testing for themselves or their partners. Taken together, results from the current study reflect the extent to which women's sexual protection is influenced by a multitude of individual and relationship variables. Results are indicative of the complex context in which women's sexual behaviors occur. Implications for continued research on women's HIV risk and prevention are discussed.

INDEX WORDS: HIV/AIDS, Condom Use, Sexual Power, Risk Perception, Alcohol, College Women

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DEDICATION

I dedicate this work and my future as a psychologist to my loving and supportive family. You will always be the most amazing blessing of my life, and I thank God for you everyday. To my parents, Richard and Louise Harris, I can't imagine where I would be without your unwavering support and faith. Thank you for believing in me even more than I believe in myself. I know that everything decent and good in me came from you. To Jamal and Courtney, being your big sister is an honor that I will always cherish. Jamal, I thank you for teaching me to take nothing for granted and for being a constant reminder that all things are possible. Courtney, thanks for bringing so much laughter into my life. When you were really little, you once told me that I was your "role model"…I hope I haven't let you down. I love you guys!

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CHAPTER 1

INTRODUCTION

There was once a time when AIDS was considered a disease that only affected white gay men (Shilts, 1998). During those years, efforts aimed at education and prevention were focused almost exclusively on that circumscribed segment of the population. However, one of the most consistent trends in HIV surveillance data over the last decade is the extent to which men and women of all racial/ethnic groups, sexual orientations, and social classes were becoming increasingly infected (Centers for Disease Control and Prevention, CDC, 2001). While rates of HIV transmission among white men who have sex with men (once the most commonly infected group) have decreased considerably, women and ethnic minorities now find themselves among the fastest growing groups of individuals living with HIV and AIDS (CDC, 2004).

Infection rates continue to climb among certain demographic groups despite the fact that knowledge about self-protection and access to condoms is far greater than ever (Bertrand, Bakutuvwidi, Djunghu, & Niwembo, 1991; Marin, Gomez, & Hearst, 1993). In 1981, only 4% of persons living with AIDS were women. By 2003, women accounted for nearly 27% of AIDS cases among adults (CDC, 2005). Although men still account for approximately 70% of new HIV infections, women are far more likely to contract HIV from heterosexual contact. Through 2003, 43% of cumulative HIV infections among women have been due to sexual contact with a man

whereas only 6% of cumulative cases among men have been attributed to heterosexual contact (CDC, 2005). Surveillance data indicate that high-risk heterosexual contact (e.g., sex without a condom and/or with a known HIV+ partner) is the suspected source of infection for 78% of newly diagnosed women (CDC, 2005).

Literature from a variety of disciplines (including public health, psychology, and women's studies) has generated a number of viable explanations for why new infections are now more likely to occur among women. Countless studies have sought to identify factors related to increased risk. What has been consistently suggested is that there are individual, group, and social factors that decrease at-risk individuals' willingness or ability to adopt safer sex practices (Carmel, Green, Slepon, & Tsur, 1992; Gutierrez, Oh, & Gillmore, 2000; Sterk, Klein, & Elifson, 2004).

Women's high rate of infection can be partially attributed to their greater physiological susceptibility to sexually transmitted infections or STIs (UN Chronicle, 1994). Furthermore, the vast majority of women do not use condoms consistently. This has been shown to be the case across ethnicities and social classes (Gutierrez, Oh, & Gillmore, 2000; Noar, Morokoff & Harlow, 2002; Harlow, Quina, Morokoff, Rose, & Grimley, 1993). In some samples, it has been found that as few as 8% of women use a condom every time they have sex with a man (Pulerwitz, Amaro, De Jong, Gormaker, and Rudd, 2002).

While it can be assumed that many women contract HIV from sexual contact with partners who are relatively unknown to them, this does not represent the majority of cases. Regardless of ethnicity, class, and educational level, women report that they practice safer sex less often with close relationship partners than with partners that they know less well (Misovich, Fisher & Fisher, 1997). Among women who contracted HIV through heterosexual contact, the greatest proportion of those individuals report engaging in unprotected sex with an HIV+ man who was neither engaging in sex with other men nor using intravenous drugs (CDC, 2005). Taken together, these facts illustrate the potential for women to become infected by having unprotected sex with a primary relationship partner whom they might consider to be at low risk of having HIV.

In reviewing the literature on women's continually increasing rates of HIV infection and inconsistent condom use, it becomes clear that health-promoting behaviors have not been widely adopted by the general population. It has been argued by some researchers that the failure for some groups to consistently engage in safer sex is reflective of how inadequately research and prevention efforts account for the way sexual interactions transpire (Ehrhardt & Wasserheit, 1991; Institute of Medicine, 1994). In efforts to contribute to the understanding of women's safer sex practices and decision-making, the present study proposes to evaluate relationship status, risk perception, sexual power, and alcohol consumption as predictors of condom use.

Conceptualizing Women's Safer Sex Decisions

The high rate of HIV infection among women resulting from heterosexual contact reflects the extent to which women are behaviorally and biologically at greater risk for contracting the virus. By examining the aforementioned statistics, it is apparent that science should continue to devote substantial attention and resources to understanding and preventing women's HIV risk behaviors. Despite this urgency, however, recent years have seen a decline in the creation of new theoretically driven approaches to dealing with the epidemic. Instead, prevention protocols continue to rely on models that may not fully account for the complexities of sexual decision-making for those individuals at greatest risk.

The social sciences have generated multiple theoretical approaches providing the foundation upon which contemporary HIV prevention strategies have been founded. However, many of the models currently used to explain and modify HIV risk-related behaviors were born in an age prior to the AIDS epidemic. The most widely propagated prevention programs in place tend to be rooted in social learning theory (Bandura, 1977, 1990, 1994) and/or the theory of reasoned action (Ajzen & Fishbein, 1977; Ajzen & Fishbein, 1980). In their original forms, these models were generated to explain decision-making in the most general of terms and have been augmented to more directly address the unique nature of the sexual decision-making process.

Social Learning Theory and Theory of Reasoned Action

The extant literature on the promotion of safer sex practices has used several cognitive models as its base. Social learning theory (Bandura, 1990, 1994) has been

widely acclaimed for its implications in the area of HIV prevention efforts. This 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 his or her 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 he or she can enact any steps necessary to reduce risk (Bandura, 1990, 1994).

When using social learning theory to conceptualize sexual behaviors, the assumption is that knowledge regarding one's risk does not necessarily lead to healthy practices. Proponents of the applications of social learning theory to HIV prevention suggest that its success (relative to other approaches) stems from this assumption – that mere knowledge about HIV or even the skill to use condoms is not sufficiently predictive of safer sex behaviors (Amaro, 1995; Bertrand, Bakutuvwidi, Djunghu, & Niwembo, 1991).

For all its acclaim, there is still reason to believe that social learning theory does not fully account for the way sexual interactions typically happen (Barker, Battle, Cummings, & Bancroft, 1998). It has been suggested that this approach is especially inadequate at conceptualizing factors relevant to safer sex behaviors in women (Deren, Tortu, & Davis, 1993). Amaro (1995) contends that social learning theory is predicated on an individualistic conceptualization of behavior, paying little

attention to the broader interpersonal and social contexts in which sexual interactions occur.

It cannot be presumed that sexual decisions 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. Additionally, the role of women in safer sex practices usually involves the initiation of discussions about protection, negotiating sex practices, and/or the refusal of unprotected sex (Amaro, 1995). What is not addressed by social learning theory is the way in which interpersonal dynamics impact women's decisions to practice safer sex even when they are adequately self-efficacious and knowledgeable about how to protect themselves from becoming infected.

The theory of reasoned action is another theoretical foundation upon which many current HIV prevention programs have been built. Briefly, the theory of reasoned action posits that decisions regarding human behaviors are based on reasoning and the evaluation of conceivable alternative behaviors (Ajzen & Fishbein, 1977; Ajzen & Fishbein, 1980). According to this theory, behavioral decisions are not made spontaneously, but instead occur based on one's consideration of several key factors such as the consequences of a particular behavior, normative external pressures (e.g., attitudes of peers), and individual motivations. The theory contends that these deliberations occur prior to an individual settling on a "reasoned behavioral decision." (Tesser & Shaffer, 1990).

When contrasted with social learning theory, the theory of reasoned action offers more consideration for the role that external factors (including other individuals) may have in affecting how people make any decision. When applied to HIV preventive behaviors, this theory suggests that an individual decides to use a condom after having weighed the perceived consequences of all behavioral alternatives (i.e., engaging in unprotected sex, using a condom for sex, or refusing unprotected sex), the expectations of others (including the current sexual partner and peer groups) regarding condom use, and the person's own attitudes about condom use (Terry, Gallois, & McCamish, 1993). By including anticipated partner response as a factor that is considered in making decisions about safer sex, this model acknowledges the fact that decisions about sex are not made in a vacuum, but instead, are imbedded in broader relational and social contexts.

Social learning theory, theory of reasoned action, and a number of other cognitive and/or behavioral models have been shown to be predictive of a variety of health-related behaviors such as seat belt use, smoking, diet, and exercise (Leviton, 1989). However, subsequent findings looking exclusively at sexual behaviors call into question how well any of these models can be generalized to the unique nature of sexual decisions (Barker, Battle, Cummings, & Bancroft, 1998). The cognitive steps that are detailed in the theory of reasoned action, for instance, inadequately consider that sexual encounters are often emotionally charged and physiologically motivated. Factors such as one's emotional needs and arousal level may limit an individual's perceived behavioral alternatives as well as color how they perceive the consequences of their behaviors.

An additional criticism of social learning theory and the theory of reasoned action is that these models do not accurately reflect how women make decisions about sexual protection (Deren, Tortu, & Davis, 1993). Critics of these theories have argued that they do not account for the fact that sex – protected or unprotected – is often less voluntary for women than it is for men (Amaro, 1995). Furthermore, neither of the aforementioned theories addresses the extent to which HIV preventive behaviors are not under the direct and final control of the individual, which is always the case for women when the means of prevention is the traditional male condom.

The Importance of Considering Interpersonal Factors

As discussed previously, HIV prevention programs currently in use have been accused of failing to recognize many of the complexities of sexual encounters. Focusing on intrapersonal variables neglects how commonly sexual decisions are made under highly spontaneous or physically and emotionally aroused conditions (Civic, 2000; MacDonald, Zanna & Fong, 1996). It also does not pay enough attention to the fact that, when compared to their male counterparts, most decisions about sex are less likely to be under the direct control of women (Amaro, 1995; Simoni, Walters & Nero, 2000; Wingood & DiClemente, 1998). Women often find themselves in sexually coercive situations, which, by definition, involve reducing women's power regarding if, when, and how sex will take place. Even when sex is fully consensual, the actual practice of safer sex tends to be under the direct control of men.

For all of these reasons, women's ability to practice safer sex is heavily contingent upon their willingness to enact a set of interpersonal skills related to the

promotion of sexual health through condom use. If male partners prefer not to use condoms, women who are motivated to engage in safer sex must be willing and able to employ negotiation strategies and refuse unprotected sex if negotiation is not an option.

For this reason, giving primary consideration to intrapersonal variables does not create a full picture of factors related to 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 more important than is indicated by the individualistic conceptualizations of behavior offered by social learning theory and theory of reasoned action. These findings and others speak to the importance of considering relationship variables and other interpersonal contextual factors in evaluating why women engage in sexual risk-taking behaviors (Catania, Coates, Kegeles, Thompson-Fullilove, et al., 1992).

Relationships and Risk Perception

A great deal of the research focusing on women's risky sexual behaviors has evaluated how women behave in casual dating relationships (Testa & Collins, 1997). This is likely due to the perception that sex with casual partners may be inherently riskier than sex with primary relationship partners. It is reasonable to assume that casual sex partners will know less about one another's sexual history, including number of previous partners, history of STDs, and HIV serostatus – all factors that

affect individuals' risk of becoming infected. Nonprimary partners would have fewer opportunities to have such discussions and may otherwise feel disinclined to do so.

It is difficult to deny the apparent risks associated with sexual contact between partners whose sexual histories and HIV status are unknown to each other. However, it has been widely replicated that consistency of condom use tends to decrease over the course of a relationship and that the majority of unprotected sex occurs between primary sexual partners (Macaluso, Deman, Artz, & Hook III, 2000; Misovich, Fisher & Fisher, 1997; Morrill, Ickovics, Golubchikov, Beren & Rodin, 1996). People tend to use condoms less frequently in relationships that include a certain level of perceived trustworthiness. Additionally, over the course of heterosexual relationships, partners usually become more concerned about contraception than HIV/STD prevention, often leading couples to opt for birth control methods other than condoms (Hammer, Fisher, Fitzgerald, & Fisher, 1996). Unfortunately, this shift in priorities is most typically based on subjective assessments of partner risk (e.g., trusting or knowing one's partner well) as opposed to actually being tested for HIV and other STIs (Civic, 2000).

In studying the inclination for primary partners to engage in unprotected sex, Civic (2000) showed that while 50% of heterosexual college students reported always using condoms during the first month of a new relationship, only 34% reported doing so within the most recent month of that same relationship. It was also shown that the percentage of individuals who reported never using condoms rose from 10% to 30% over the course of their current relationships. The most common reason for condom nonuse in this sample was individuals' subjective assessment of their partner's risk

(i.e., "I just knew my partner was safe."). On the other hand, objective assessments such as testing negative for HIV were not shown to be significantly predictive of condom nonuse. Additional research has shown that women, in particular, base their decisions to not use condoms on perceived low risk as opposed to partners' previous HIV testing (Carter, McNair, Corbin, & Williams, 1999).

These findings speak to the often ignored risk of HIV infection in established relationships. Furthermore, they offer justification for conducting more research focusing on sexual risk-taking as it may occur within the context of established relationships.

In general, being a member of an established relationship does not reduce the risk of exposure to HIV and other STIs nearly as much as is commonly presumed. Among samples of college undergraduate students, monogamy is the most frequently cited justification for their decisions to engage in unprotected sex (Critelli & Suire, 1998; Simkins, 1994). However, in one sample of HIV+ individuals, only 22% reported being "single," having casual sex partners, or having multiple sex partners at the time they became infected (Crowell, 2004). Instead, the greatest proportion of participants reported being infected while being involved in a more substantial relationship (i.e., exclusively dating one partner, cohabitating, engaged, or married). Relatively young individuals in particular are commonly involved in a succession of short-term monogamous relationships. The majority of college-aged individuals who describe their current relationships as monogamous also objectively report having multiple sexual partners within the last 12 months (Bankole, Darroch & Singh, 1999; Civic, 1999; Fortenberry, Tu, Harezlak, Katz, & Orr, 2002). These types of short-

term committed relationships actually do very little to prevent the spread of HIV and STDs.

Under the false assumption that unprotected sex with short-term primary partners is without risk, individuals who are prone to serial monogamy underestimate their risk of HIV exposure. Yarnall, McBride, Lyna, Fish et al. (2003) found that both students and nonstudents most often subjectively describe themselves to be at "low-risk" of contracting HIV or other STIs. However, the same study found that, when objectively evaluating risk factors (e.g., unprotected sex, number of previous partners, lack of HIV/STD testing for themselves and their partners), these individuals' risk of exposure is similar to other groups that are typically considered to be "high-risk." Crowell (2004) found that although HIV+ persons reportedly felt self-efficacious in discussing condom use prior to becoming infected, they tended to not actually have such conversations with partners because they perceived their risk of infection to be relatively low.

Similar studies have found that traditional college students (ages 18-23) are a particularly high-risk group for a variety of reasons, including infrequent HIV testing, high rates of unprotected sex, and number of sexual partners (Gilbert & Alexander, 1998; Oswalt & Matsen, 1993). This means that college students have a much greater likelihood of encountering an HIV+ sexual partner than they might think. Therefore, subjective assessments of a potential or current sexual partner's risk are insufficient, especially in this population. Nevertheless, trusting one's primary partner and other inconclusive assessments of sexual health are still common justifications for college

students' decisions to engage in unprotected sex in less casual relationships (Civic, 2000).

Faulty risk perception is just one of several factors shown to be predictive of the lack of condom use in primary relationships (Crowell, 2004; Eversley et al., 1993; Yarnall et al., 2003). In established relationships, the decision to use condoms is not just a matter of sexual protection. Instead, condom use or nonuse communicates volumes about the nature a relationship (Worth, 1990). Between casual or nonprimary sex partners, the underlying meanings of protected sex may be minimal. However, when condoms are used in primary relationships, research has shown that powerful messages – both positive and negative – are being inadvertently transmitted between partners (Sobo, 1995, 1998). In a committed romantic relationship, partners often feel that insisting on consistent condom use is indicative of infidelity, promiscuity, and untrustworthiness (Worth, 1990). Over the course of most relationships, priorities shift from protection against HIV and STDs to contraception. Thus, insisting on safer sex when other birth control is being used can be awkward and may convey suspicions that one's partner is HIV-positive or has an STD (Chapman, Stoker, Ward, Porritt & Fahey, 1990; Critelli & Suire, 1998). With such underlying messages being passed from partner to partner (in addition to the increased physical sensation associated with unprotected sex), it is often the case that women's requests to use condoms with primary partners are met with some level of resistance.

Women whose male partners would prefer not to use condoms are significantly more likely to engage in risky sex (Yarnall et al., 2003). There are

several reasons for this, including the fact that, for many women, sex is considered a means of cultivating emotional bonds with partners. More than men, women have been shown to associate unprotected sex with a level of emotional closeness and security that they may feel unable to achieve through other means (Sobo, 1995, 1998). Conversely, insisting on condom use throughout the course of a relationship can be perceived as attempts to distance oneself from relational partners. As eloquently stated by Sobo (1995), "because of the trust and closeness that it connotes, unsafe sex signals the perfect union."

When women are in relationships that they would like to maintain, they might be less motivated to behave in ways that might be upsetting to their partners. On the other hand, the possible reactions of less serious dating partners may not weigh as heavily on women's decision-making. Women who are motivated to use sex to preserve or even strengthen a relationship are more likely to acquiesce to male partners' wishes to have unprotected sex (Sobo, 1995, 1998). Considering that the overwhelming majority of men reportedly prefer not to use condoms (Baffi, Schroeder, & Redican, 1989), women could often find themselves in a position of having to choose between protecting their sexual health or the health of a romantic relationship. It is possible that being in such a relationship actually increases one's risk of exposure to HIV due to the decreased condom use that occurs between primary partners.

Women's Sexual Power and Safer Sex Decisions

As with a host of other variables, the role of interpersonal power is not yet adequately understood as it relates to the safer sex practices of women. One reason

for this lack of understanding is that researchers in the social sciences frequently disagree about how to best define and study the construct of power. These limitations aside, it has been widely assumed that power, however it is defined and measured, must play an important role in how sexual interactions unfold (Amaro, 1995). What is not often explicitly explored in the extant literature is exactly what that role may be.

In reviewing relevant literature from numerous disciplines, it can be seen that power emerging from 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 intentions. Because women do not have direct control over the decision to use condoms, they may be especially susceptible to the potential effects of power imbalances in sexual relationships. Therefore, interpersonal power is a construct that must be considered in evaluating women's sexual risk-taking behaviors.

Descriptions of Power

Accounting for the most relevant aspects of sexual behaviors requires the fusion of many perspectives into a multifaceted definition of power. Across various research disciplines, 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 capacity to produce changes in the behaviors or affect of their relational partners. To simplify, a person is generally considered

powerful when he or she can produce behavioral or emotional changes in another individual (Berger, 1994). Secondly, those who demonstrate power must be capable of resisting the physical, emotional, and cognitive influences of relational partners or other environmental sources on their own behavior or affect (Berger, 1994). Taken together, power can be understood as a construct including an individual's possession of the skills necessary to enact their will in interpersonal situations along with the ability to resist opposing influences of others.

Sexual Power in Primary Relationships

As mentioned previously, it has been demonstrated that interpersonal factors (e.g., communication, assertiveness) are stronger predictors of unprotected sex for women than are intrapersonal factors such as HIV-related knowledge and self-efficacy (Catania, et al., 1992). Furthermore, the majority of men report preferring to not use condoms (Baffi, Schroeder, & Redican, 1989) and, in situations of sexual negotiation, men endorse a greater level of "argumentativeness" than do women (Crowell, 2004). This suggests that, not only do young men prefer not to use condoms, but also that women should be prepared for the possibility that male partners may try to actively convince them to engage in unprotected sex. Carter et al. (1999) found that, for men, the relationship between intentions to use condoms and actual condom use was strengthened when their female partners had more control over the safer sex decisions. These results highlight the unique and pivotal role women play in negotiating condom use.

These studies and others (Chan & Fishbein, 1993; Crowell, 2004) imply that, for women to effectively reduce their risk of exposure to HIV, they need to be

assertive enough to suggest and insist on using condoms. While the ability to discuss sexual risk-related topics and request condom use seems to be important even when there are mutual intentions to practice safer sex (Carter et al., 1999), these skills would likely become much more crucial when women are faced with implicit or explicit expressions of male partners' preferences to have unprotected sex. This assumes much about how competent women usually feel in initiating these discussions and insisting on safer sex. It also unfairly presumes that women in heterosexual relationships expect that their requests to use condoms will be well received and heeded.

Anticipated partner response is one of the many ways in which a perceived or actual imbalance of power in a relationship can affect women's willingness and ability to communicate assertively about their interest in using condoms (Holland, Ramazanoglu, Sharpe & Thompson, 1992). In a study of college students' sexual behaviors, women were shown to be less likely to use condoms if they expected that their partners would not respond well to their requests to practice safer sex (Yarnall et al., 2003). Other research looking at how heterosexual couples choose to use condoms has shown that men typically play a greater role in the decision-making process. Additionally, when compared to women, men report a higher incidence of successfully convincing their partners to engage in unprotected sex (Carter et al., 1999).

Many factors have been shown to contribute to women's expectations that male partners will not respond favorably if they insist on using condoms or refuse unprotected sex. First, women are likely to have experienced such a response in the

past given that men endorse a tendency to persuade their female partners to have sex without condoms (Carter et al., 1999; Crowell, 2004). A second factor contributing to women's anticipation of negative responses is the way that masculinity is socially construed. MacPhail and Campbell (2001) discussed how cultural representations of masculinity typically include high levels of sexual activity combined with at least subtle dominance over women. Lastly, there is a pervasive perception that young men "need" sex, which limits the control that young women feel they have over their own sexual choices (Holland, Ramazanoglu & Scott, 1992).

As an interesting contrast, it is less common for the success of a relationship to be predicated on how often the female partner's sexual preferences are taken seriously (Holland, Ramazanoglu & Scott, 1992). This is reflected in many ways, including women's susceptibility to sexual coercion in dating relationships and their unwillingness to act assertively regarding sexual protection. While these issues would likely affect any heterosexual interaction, they seem to be especially relevant to how sexual decisions are made in established dating partnerships. Women in established relationships often use sexual intimacy as a means to maintain or enhance the status of their relationships with significant male partners (Sobo, 1995, 1998). With that said, many women understandably conclude that it is not in their best interest to refuse a male partner's sexual wishes too frequently if they would like to maintain or further their relationships (Holland, Ramazanoglu & Scott, 1992).

In discussing how perceptions of powerlessness are related 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 are not any more likely to describe themselves as powerful or assertive in their dating relationships. In fact, as their number of sexual partners increase, women exhibit poorer communication skills and feel they have less control over their HIV-risk (Monahan, Miller, & Rothspan, 1997). This is reflected in findings indicating that women with more numerous sexual partners are no more likely to request the use of condoms (Anderson & Dahlberg, 1992). To explain these trends, it has been argued that, for women, higher numbers of sexual partners reflect not an increased level of sexual assertiveness, but rather an inability or unwillingness to refuse sexual contact (Harlow et al., 1993).

Recent years have seen an increase in the number of scientific studies investigating how interpersonal power affects women's sexual decisions and practices. One such study (Soet, Dudley, & Dilorio, 1999) examined differences in sexual attitudes and behaviors among women who described themselves as dominant in their relationship with a male partner, sharing dominance equally, or being dominated by a male partner. Women who felt that they were dominated by their partners 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 reflect the possibility 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, thereby leaving them to feel less able to negotiate safer sex or to refuse unwanted or unprotected sexual contact (MacPhail & Campbell, 2001).

When discussing how power affects women's sexual risk-taking, it is worthwhile to pay particular attention to how decisions to use condoms are made in established relationships. First, the majority of sexual interactions do not occur between casual partners. That means that sexual health decisions are made more often between partners who have ongoing contact with one another. Secondly, the majority of unprotected sex occurs not between casual partners, but between partners with an established relationship (Civic, 2000). Lastly, it is possible that power imbalances are more likely to emerge over the life of a relationship, as people tend to fall into certain patterns and roles the longer they are intimate with one another. For these reasons, the current study intends to focus on how relationship status may be related to women's sexual power and use of condoms for HIV prevention.

Alcohol and Risky Sex

Few variables have been more commonly assumed to be related to sexual risk-taking than alcohol. It is often concluded by the research community as well as the general public that the consumption of alcohol disinhibits many ill-advised behaviors, including unprotected sex (Cooper, 1992; Testa & Collins, 1997). For instance, it has been suggested that drinking results in increased sexual risk-taking by affecting sexual arousal (Crowe & George, 1989) and by providing an excuse for individuals' choices to engage in health-endangering behaviors (Cooper, 1992).

Although the specific mechanisms through with alcohol affects behavior is a matter of debate, the general consensus among researchers is that people tend to engage in greater sexual risk-taking when consuming alcohol (Abbey, Saenz, & Buck, 2005; MacDonald, Zanna, & Fong, 1996). Before discussing the relationship between drinking and risky sex for young women, several points are worth mentioning. First, alcohol consumption among college-aged women has been steadily increasing for almost a generation (Wilsnack & Wilsnack, 1991; Wilsnack, Wilsnack, & Klassen, 1984). Second, women tend to consume alcohol in bars, at parties, and on dates (Mongeau & Johnson, 1995) – all social situations that provide opportunities to forge new romantic relationships or strengthen existing ones. Lastly, although women generally feel that consuming alcohol in such settings increases their risk of having to fend off unwanted sexual behaviors or sexual coercion (Parks, Miller, Collins, & Zetes-Zanatta, 1998), these risks are outweighed by the potential for establishing relationships (Buss & Schmitt, 1993).

Women's consumption of alcohol in social settings or on dates is associated with several effects that could increase their likelihood of engaging in risky sexual activity, such as encountering pressure from men to engage in unwanted and/or unprotected sex. Men generally perceive women who are drinking in social settings as being more sexually available and open to sexual advances (Norris & Cubbins, 1992; Testa & Parks, 1996). A study of college students' expectations on first dates revealed that, for men, the prospect of sexual activity on a first date increases when women have been drinking (Mongeau & Johnson, 1995). Furthermore, men have been found to be more likely to overestimate a woman's interest in sexual intimacy

when alcohol is involved in the interaction (Abbey, Ross, & McDuffie, 1994), which could increase women's risk of being coerced or forced to engage in sexual behaviors that they would rather avoid.

Due to the tendency for women to consume alcohol in social settings (Mongeau & Johnson, 1995), it is unlikely that women are consuming alcohol alone. Instead, it is much more customary for both men and women to drink together. When women are in situations where there is the potential for sexual intimacy, men's alcohol consumption is likely to influence sexual risk-taking. Men who are intoxicated while also being sexually aroused have been shown to have stronger intentions to engage in unprotected sex (MacDonald, Zanna, & Fong, 1996). Even among men who report regular condom use, being intoxicated during sexual encounters was associated with more incidents of unprotected intercourse (MacDonald, Zanna, & Fong, 1996). It would follow that, when men are more interested in having sex without a condom, they may be more likely to communicate those intentions to their female partners in either subtle or overt ways. This is especially true given findings that indicate that men have a greater propensity to be argumentative or persuasive when their sexual wishes are in opposition to those of their women partners (Crowell, 2004).

As discussed previously, women often have difficulty insisting on safer sex when their male partners prefer not to use condoms (Sobo, 1998; Yarnall et al., 2003). While this is the case even when women are sober, there is reason to believe that it may be even more challenging to refuse unprotected sex when women have been consuming alcohol.

Women's drinking affects their judgment and ability to communicate assertively in distinct ways. Consistent with the concept of "alcohol myopia" (Steele & Josephs, 1990; Taylor & Leonard, 1983), women under the influence of alcohol are more likely to disregard certain inhibitory cues and, on the other hand, more salient, disinhibitory cues influence behavior more heavily (Testa, Livingston, & Collins, 2000). To test this phenomenon, Murphy, Monahan, and Miller (1998) investigated the effect that a moderate dose of alcohol had on women's judgments of men in terms of attractiveness and the level of sexual risk they posed (based on factors such as sexual promiscuity). Results showed that women who had been drinking were more likely to rate an attractive but high-risk man as having greater relationship potential than did women who were not administered alcohol. Although this study did not evaluate intended behavior, it can be assumed that, by assigning greater relationship potential to high-risk men, women who have been drinking would be more likely to engage in behaviors that are associated with promoting a relationship. Such behaviors include sexual intimacy, which would increase women's HIV risk due to the male partners' high-risk status.

There is also evidence to suggest that, although women are generally poor predictors of HIV risk, their assessment of risk is impaired further in sexual interactions that include alcohol consumption. To that end, Monahan, Murphy, and Miller (1999) showed that women who consumed alcohol exhibited increased confidence in their ability to predict whether a male partner is HIV+ just by interacting with that individual. The overall tendency for individuals to underestimate risk combined with unjustified confidence in these faulty risk

appraisals could be an important factor related to women's sexual risk-taking behaviors.

Additionally, whether due to the pharmacological effects of alcohol or alcohol-related expectancies, drinking has been shown to decrease women's ability to communicate effectively (Peterson, Rothfleisch, Zelazo, & Pihl, 1990). Alcohol-related impairments in communication have implications for sexual risk-taking, especially for women since practicing safer sex is more dependent on the ability to express intentions to use condoms and to successfully negotiate during the sexual decision-making process (Amaro, 1995). It was also suggested by Lanutti and Monahan (2004) that, when drinking, women may have greater difficulty effectively expressing their refusal to have unprotected sex with primary dating partners.

Relationship Status as Context

Looking at the many factors that impact women's condom use, it is appropriate to consider whether being a member of an established relationship could amplify these effects. The majority of unprotected sex occurs within the context of primary, monogamous relationships (Civic, 2000; Crowell, 2004). This is the case despite the fact that the decision to not use condoms does not usually come after obtaining HIV testing (Yarnall et al., 2003), which speaks to the risk of exposure that people create in their less casual dating experiences. It also illustrates the extent to which risk perception (a widely recognized predictor of risky behaviors) is affected by the nature of the relationship between sexual partners.

Interpersonal, or more specifically, sexual power is another variable that influences how women make decisions about safer sex. Even when women

accurately perceive the risk that comes with having unprotected sex, they may lack the assertiveness to insist on using condoms. Women are less likely to insist on condom use when they expect that their partners will respond negatively (Yarnall et al., 2003). This is an especially important factor to consider in looking at how sexual decisions are made in long-standing relationships. To behave assertively could jeopardize the relationship or impact the perceived emotional closeness between partners. These issues are hypothesized here to be more important for primary dating partners, as women in established relationships may feel more strongly motivated to acquiesce to their male partners' sexual preferences. Furthermore, because individuals in established relationships have had greater opportunity to interact with one another and to slip into prescribed roles, there is a stronger likelihood that power imbalances would exist between primary partners.

When compared to these other variables, considerably less attention has been given to examining how relationship factors may interact with the effects of alcohol on risky sex. Perhaps this connection is slightly less intuitive, but given the specific ways that alcohol is associated with increased risk-taking, it is worth further exploration.

It has been demonstrated that women's risk perception is affected when they are in primary relationships (Civic, 2003). Research has also shown that alcohol consumption is associated with faulty appraisals of sexual risk (Murphy, Monahan, & Miller, 1998). Is it possible that, when these factors interact, there is a greater likelihood that women will mistakenly perceive that engaging in unprotected sex with a primary partner is less risky than is actually the case?

It has also been argued that, with consistent dating partners, women may sacrifice their preferences to use condoms in order to meet their goals of preserving or enhancing their relationships (Sobo, 1998). When this is the case, women may have more difficulty demanding safer sex out of concern for what the repercussions may be. To compound matters, there is reason to believe that inebriated women find it more challenging than sober women to reconcile the seemingly incongruent goals of refusing sex while also preserving the possibility of developing the relationship (Lanutti & Monahan, 2004). However, previous research has not evaluated whether this effect is more pronounced among women who are in significant relationships that they wish to maintain or improve. It is plausible that when making these decisions while intoxicated, women with primary sexual partners may be especially prone to let their relationship goals override their goals to have protected sex. The goal of the proposed research is to examine how women's sexual risk-taking behaviors are affected by their risk perception, perceived power in sexual situations, alcohol use, and relationship status.

Purpose and Hypotheses

The primary purpose of this study is to examine the interrelatedness of relationship status, alcohol consumption, and HIV risk perception as predictors of sexual risk-taking behaviors among college women. The following hypotheses will be examined:

1. As has been found by previous research in this area, it is expected that women will report less consistent condom use in primary dating relationships. It is

also hypothesized that relationship length will be negatively associated with consistency of condom use.

2. As addressed in the review of the extant literature, women have been shown to associate unprotected sex with relationship closeness. It is hypothesized here that, compared to relationships in which safer sex is practiced more consistently, higher levels of intimacy with male partners will be endorsed in relationships that are characterized by less frequent condom use.
3. Prior research has indicated that individuals tend to base their perceptions of partners' HIV risk on subjective factors (e.g., trustworthiness) and that unprotected sex is associated with perceived emotional connection between partners. It is hypothesized here that risk perception will mediate the connection between intimacy and condom use within heterosexual relationships.
4. It is hypothesized that higher levels of sexual power will be predictive of more consistent past condom use. It is also predicted that sexual power will moderate the relationship between intimacy and condom use. It is expected that there will be a stronger negative association between intimacy and rates of condom use among women endorsing less sexual power in their relationships.
5. To evaluate the role that alcohol plays in instances of risky sex, it is hypothesized that drinking will moderate the relationship between intimacy and condom use. Specifically, the negative association between relationship

intimacy and condom use is expected to be stronger when women report consuming alcohol before or during sex.

CHAPTER 2

METHOD

Design and Participants

Power analysis conducted using G*Power (Erdfelder, Faul, & Buchner, 1996) revealed that, to detect a medium effect size (i.e., $f^2 = .15$), 120 participants would be needed for this study. 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 intercourse with at least two male partners; (2) have engaged in both protected and unprotected sex at least once; (3) have never been married; (4) have not previously attempted to get pregnant. A prescreening process was used to ensure that all participants inclusion criteria.

A total of 159 women participated in the study. However, 30 of those participants were unable to identify either a partner with whom they usually used condoms or a partner with whom they usually did not use condoms. Participants who did not report differential rates of condom use between their two reported male partners were excluded from data analysis. Results reported here are based on the responses of individuals who met the inclusion criteria and reported differences in their rates of condom use with two reported male partners. Of the 129 participants included in data analysis, 99 were White/European American, 17 were Black/African

American, 8 were Asian, 2 were Native Hawaiian/Pacific Islanders, 1 was American Indian/Alaska Native, and 2 did not report their race or ethnicity.

In the current sample, participants' average age at first consensual sexual encounter was 16.65 years (*SD* = 1.4). For the purposes of the current study, data were collected only from women reporting at least two past or current male sexual partners. There was substantial variability in participants' number of lifetime sexual partners

(*Min* = 2; *Max* = 40; *Mdn = 4*). However, 90% of participants reported 10 or fewer lifetime sexual partners. Six percent of participants (n = 8) reported having ever been diagnosed with a sexually transmitted infection. Twelve percent (n = 16) reported experiencing forced sexual contact, and slightly less than half (n = 62) reported at least once incident of coerced sexual contact.

There was also considerable variability in the number of alcoholic drinks participants reported consuming weekly (*Min* = 0; *Max* = 41). Participants consumed a mean of 8.14 alcoholic beverages per week (*SD* = 7.63; *Mdn* = 6). Additional descriptive data are presented in Table 1.

Table 1

Participant Descriptives (N = 129)

Variable	*M*	*SD*	*Min*	*Max*
Current Age	19.65	1.34	18.00	26.00
Age at 1st Sexual Encounter	16.65	1.41	13.00	21.00
Sexual Partners – Current	.81	.43	.00	2.00
Sexual Partners – Last 12 Months	2.56	1.74	.00	12.00
Sexual Partners – Lifetime	5.68	5.26	2.00	40.00
Number of Alcoholic Drinks per Week	8.14	7.63	.00	41.00

Measures

Demographics Questionnaire. Participants were asked to provide information regarding age, racial/ethnic identity, number of past and current sexual partners, and history of sexual assault or coercion.

Sexual Practices Questionnaire. Participants were asked to complete this measure twice – once for a partner with whom they usually used condoms (identified as "Partner A") and once for a partner with whom they usually did not use condoms (identified as "Partner B"). Participants were asked to state the length of each relationship (in months) and to describe the nature of their relationship with each partner using the following labels: "boyfriend or significant other," "friend but not boyfriend," or "casual sex partner." This measure included items assessing rates of condom use, history of HIV testing for self and partner, and other HIV risk factors. Participants were also asked questions about their alcohol consumption before or during sex as well as their discussions with their partners about HIV risk and prevention.

AIDS and Relationships Questionnaire (ARQ; Monahan, Miller, & Rothspan, 1997). In its original form, this questionnaire consists of 22 items and assesses a variety of issues related to one's safer sex practices. Participants are asked to respond to a series of 7-point Likert scale items where 1 is *"strongly agree"* and 7 is *"strongly disagree."* In a previous study conducted by this researcher, an exploratory factor analysis using principal components extraction and varimax rotation was conducted based on participants' responses to this measure. In a sample consisting of

African American and European American college women, 5 factors with eigenvalues greater than 1 emerged.

Reliability analysis revealed that this 22-item measure had strong internal consistency ($\alpha = .831$). Additionally, the 5 factors that emerged accounted for 64% of the variance in responses to these items.

For the purposes of the current study, the most relevant subscale is Factor 3 (Risk Perception), which includes three items related to individuals' perceived susceptibility to HIV infection. A representative item from Factor 3 is "I often worry about getting AIDS from having sex." Factor 3 was used as a measure of risk perception for the purposes of hypothesis testing. Participants were asked to complete these items twice – once regarding a relationship in which condoms were/are used most of the time and once pertaining to a relationship in which condoms were/are not usually used.

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 to assess participants' level of interpersonal power in sexual situations. Items measure 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 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 levels of assertiveness/power.

Sexual Relationship Power Scale (SRPS; Pulerwitz, Gortmaker, & DeJong, 2000). This measure of relationship power dynamics consists of 23 items, which can be divided into 2 subscales: Relationship Control and Decision-Making Dominance. Items on the first subscale were answered using a 4-point Likert scale where 1 = "Strongly Agree" and 4 = "Strongly Disagree." A representative item from the Relationship Control subscale is "Most of the time, we do what my partner wants to do." The Decision-Making Dominance subscale features items such as "Who usually has more say about whether you have sex?" Participants answered these items using the following response choices: 1 = "your partner," 2 = "both of you equally," and 3 = "you." These subscales were demonstrated to be valid when used separately or combined for data analysis. The normative sample included women (18-45 years old) who were sexually active, not trying to get pregnant, and from various ethnic/racial groups. The SRPS demonstrated strong construct validity during test construction and was a significant predictor of the following variables: history of physical violence in the relationship, satisfaction with the current relationship, and current safer sex behaviors. Participants were asked to complete these items as they pertained to their relationship with both "Partner A" and "Partner B." Responses were used as measures of sexual power for hypothesis testing.

Miller Social Intimacy Scale (*MSIS;* Miller & Lefcourt, 1982). This questionnaire consists of 17 items assessing level of closeness, affection, and personal disclosure in an interpersonal relationship. Using a 10-point Likert scale (1 = "very rarely"; 10 = "almost always"), participants were asked to respond to items in regards to their relationships with a partner with whom they usually practice(d) unsafe sex and a partner with whom they usually practice(d) safer sex.

Daily Drinking Questionnaire (DDQ; Collins, Parks, & Marlatt, 1985). This questionnaire asks participants to indicate their average daily alcohol consumption for each day of a typical week. Responses on this measure were used to determine whether global alcohol consumption (as opposed to situation-specific consumption) is related to condom use.

Procedures

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, Sexual Practices Questionnaire, AIDS and Relationships Questionnaire (Monahan, Miller, & Rothspan, 1997), Sexual Assertiveness Scale (Morokoff et al., 1997), Sexual Relationships Power Scale (Pulerwitz, Gortmaker, & DeJong, 2000), Miller Social Intimacy Scale (Miller & Lefcourt, 1982), and Daily Drinking Questionnaire (Collins, Parks, & Marlatt, 1985). Participants were asked to complete all but the

Demographics Questionnaire, SAS, and DDQ twice – once for a partner with whom they usually used condoms and once for a partner with whom they usually did not. The packet of questionnaires took approximately 50 minutes to complete. Participants were debriefed upon completion of the questionnaires.

CHAPTER 3

RESULTS

Correlational Analyses

Tables 2 and 3 present correlation matrices for variables of interest. All participants completed measures pertaining to their relationships with Partner A (i.e., partner with whom they used condoms more often) and Partner B (i.e., partner with whom they used condoms less often). Difference scores on variables of interest were computed to reflect differences in participants' perceptions and behaviors in each of their reported relationships. The difference scores for each variable were computed by subtracting participants' scores on a measure for Partner A from their scores on the same measure for Partner B (e.g., $MSIS_{diff} = MSIS_B - MSIS_A$). Table 2 presents relevant correlations using difference scores.

Several hypotheses were made that do not involve comparisons between participants' relationships with Partner A and Partner B. In testing those hypotheses, the unit of analysis was the relationships described by participants (N = 258). Table 3 presents correlations between variables of interest for both relationships described by each participant.

Many of the primary variables of interest were significantly correlated in the hypothesized directions as illustrated in Tables 2 and 3. These correlations justify continuing with further analyses.

Table 2

Intercorrelations Among Variables of Interest Using Difference Scores (N = 129)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Age at 1st Sexual Contact	---											
2. # of Lifetime Partners	-.247**	---										
3. SAS	-.084	.186*	---									
4. DDQ	.045	.026	-.034	---								
5. Condom Use: 1st $Month_{diff}$	-.035	-.068	.005	.145	---							
6. Condom Use: Recent $Month_{diff}$	.077	-.126	-.071	.038	.075	---						
7. Condom Use: $Overall_{diff}$	.028	-.126	-.068	.044	.261**	.777**	---					
8. Alcohol Use During Sex_{diff}	.112	-.176*	-.168	.036	-.020	-.022	.034	---				
9. ARQ_{diff}	-.020	-.076	-.049	.033	-.018	-.037	-.024	-.177*	---			
10. $SRPS_{diff}$	-.025	.051	-.102	-.030	.043	.020	.091	.094	.360**	---		
11. DRQ_{diff}	.037	.075	-.124	-.029	-.004	.084	.185*	-.017	.284**	.725**	---	
12. $MSIS_{diff}$	-.136	.288**	.156	-.043	.132	-.337**	-.291**	-.409**	.288**	.206*	.110	---
13. Relationship $Length_{diff}$	-.093	.074	.128	-.084	.357**	-.228**	-.250**	-.235**	.168	-.117	-.119	.439**

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

Table 3

Intercorrelations Among Variables of Interest for All Relationships Reported (N = 258)

Variable	1	2	3	4	5	6	7	8
1. Length of Relationship	---							
2. Condom Use: 1st Month	.079	---						
3. Condom Use: Recent Month	-.192**	.590**	---					
4. Condom Use: Overall	-.162**	.724**	.904**	---				
5. Alcohol Use During Sex	-.140*	-.095	-.053	-.065	---			
6. ARQ	.035	.107	.055	.085	-.096	---		
7. SRPS	-.061	.209	.118	.189**	-.075	.208**	---	
8. DRQ	-.073	.161	.126*	.176**	-.102	.123*	.657**	---
9. MSIS	.318**	-.020	-.201**	-.179**	-.364**	.229**	.109	.042

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

Relationship Type, Relationship Length and Condom Use

It was predicted in Hypothesis 1 that participants would report less consistent condom use in primary dating relationships. Participants were asked to identify Partner A and Partner B as being a "boyfriend or significant other," "friend but not a boyfriend," or "casual sex partner." The majority of participants described both Partner A ($n = 93$) and Partner B ($n = 97$) as a "boyfriend or significant other." To evaluate Hypothesis 1, an independent samples t-test was computed to determine if reported rates of condom use were higher with non-boyfriends (i.e., partners described as "friend[s] but not boyfriend[s]" or "casual sex partner[s]"). Comparing boyfriends with non-boyfriends, there was no significant difference between rates of condom use during the first month of a relationship ($t(256) = 1.105$; $p = .296$). However, participants reported using condoms significantly less often during the last/most recent month of relationships with boyfriends ($t(256) = -2.292$; $p = .024$). Although not specifically predicted in Hypothesis 1, it is noteworthy that participants endorsed lower levels of perceived risk in their relationships with boyfriends as compared to non-boyfriends ($t(256) = 3.618$; $p = .000$).

Hypothesis 1 also predicted that relationship length would be negatively correlated with rates of condom use. Difference in the length of relationships with Partner A and Partner B was negatively correlated with differential rates of condom use throughout the course of the relationship ($r = -.330$; $p = .000$) and during the last/most recent month of the relationship ($r = -.268$; $p = .002$). Interestingly, differential relationship length was positively correlated with differential rates of condom use during the first month of participants' relationships ($r = .357$; $p = .000$).

This suggests that lengthier relationships may initially feature more frequent condom use, but that condom use decreases greatly as relationships continue. In general, these associations lend support for Hypothesis 1 and are largely consistent with previous research.

Intimacy, Risk Perception and Condom Use

Hypothesis 2 stated that significantly higher levels of intimacy would be endorsed in relationships that featured less consistent condom use. First, it should be noted that a paired-samples t-test did not detect a significant difference between MSIS scores for Partners A and B ($t(125) = -1.680$; $p = .095$). However, differential intimacy was correlated with differential rates of condom use over the course of a relationship ($r = -.291$; $p = .001$), as well as during the last/most recent month of a relationship ($r = -.337$; $p = .000$). Additionally, perceived intimacy was negatively correlated with use of condoms throughout ($r = -.201$; $p = .001$) and during the last/most recent month ($r = -.179$; $p = .004$) of both relationships reported by participants. Results indicated that greater perceived intimacy was associated with less consistent condom use, which is in accordance with previous research suggesting that women may associate unprotected sex with relationship closeness.

Support found for the first two hypotheses justifies evaluation of Hypothesis 3, which stated that risk perception would mediate the relationship between perceived intimacy and rates of condom use. Participants' scores on the MSIS and ARQ Factor 3 were used as measures of intimacy and risk perception, respectively. The proposed mediational model was tested using procedures recommended by Baron and Kenny (1986). Specifically, three simple linear regression equations were computed in

which (1) risk perception was regressed on intimacy; (2) condom use was regressed on intimacy; and (3) condom use was regressed on both intimacy and risk perception. The proposed mediation would have been supported if each of these equations were significant in the hypothesized directions. In the final step of these analyses (i.e., regressing condom use on intimacy and risk perception), a significant effect was not found, which precluded support for the proposed mediation.

Sexual Power, Intimacy and Condom Use

It was predicted in Hypothesis 4 that higher levels of sexual power would be predictive of more consistent past condom use. Composite scores on the SRPS and SAS were used as measures of sexual power. Unexpectedly, participants' SAS scores were not significantly correlated with frequency of condom use and were, therefore not included in multiple regression analyses. Possible reasons for the lack of correlation between SAS scores and rates of condom use will be discussed later. However, a significant positive association was found between participants' SRPS scores and their reported rates of condom use during the first month of their relationships (r = .209; p = .001). On the other hand, sexual power was not significantly correlated with rates of condom use during the last/recent month of women's relationships (r = .118; p = .062). Although these results are mixed, they provide partial support for Hypothesis 4. Analyses generally reflect the extent to which women with higher levels of perceived power practice safer sex more consistently, at least during the initial stages of their relationships. Results also suggest that women's safer sex behaviors later in relationships may depend less on

their perceived power, and perhaps other relationship considerations become of greater import.

Hypothesis 4 also predicted that sexual power, as measured by SRPS scores, would moderate the relationship between intimacy and condom use. That is, for women with lower levels of sexual power, a stronger negative relationship between intimacy and rates of condom use was expected. This was analyzed using procedures recommended for proposed models featuring a continuous moderator variable, a continuous independent variable, and a linear relationship between the independent variable and the dependent variable (Baron and Kenny, 1986). First, scores on the independent, dependent, and moderator variables were centered by subtracting the mean of each variable from actual scores obtained by each participant. Second, the product of the proposed moderator (SRPS scores) and the independent variable (MSIS scores) was computed. Third, a multiple regression analysis was conducted in which MSIS scores, SRPS scores, and the product term (MSIS × SRPS) were found to be significant predictors of condom use during the first month (R^2 = .050; p = .006), last/most recent month (R^2 = .058; p = .002), and throughout participants' relationships (R^2 = .078; p = .000). However, support for the proposed moderation was not found because there was no significant effect for the calculated product term (MSIS × SRPS) when statistically controlling for the effects of intimacy and power. These analyses are presented in Tables 4, 5, and 6.

Table 4

Summary of Regression Analyses on the Effects of Intimacy on Rates of Condom Use in First Month of Relationship as Moderated by Sexual Power (N = 125)

Predictors	B	SE B	β
MSIS	.019	.020	.384
SRPS	1.608	.840	.474
MSIS × SRPS	-.002	.007	-.535

Note. R^2 = .050 (p = .006). MSIS = *Miller Social Intimacy Scale* (Miller & Lefcourt, 1982); SRPS = *Sexual Relationships Power Scale* (Pulerwitz, Gortmaker, & DeJong, 2000).

Table 5

Summary of Regression Analyses on the Effects of Intimacy on Rates of Condom Use in Last/Most Recent Month of Relationship as Moderated by Sexual Power (N = 125)

Predictors	B	SE B	β
MSIS	-.012	.021	-.220
SRPS	.484	.895	.133
MSIS × SRPS	.000	.007	.008

Note. R^2 = .058 (p = .002). MSIS = *Miller Social Intimacy Scale* (Miller & Lefcourt, 1982); SRPS = *Sexual Relationships Power Scale* (Pulerwitz, Gortmaker, & DeJong, 2000).

Table 6

Summary of Regression Analyses on the Effects of Intimacy on Overall Rates of Condom Use as Moderated by Sexual Power (N = 125)

Predictors	B	SE B	β
MSIS	.007	.018	.145
SRPS	1.308	.763	.418
MSIS × SRPS	-.005	.006	-.428

Note. R^2 = .078 (p = .000). MSIS = *Miller Social Intimacy Scale* (Miller & Lefcourt, 1982); SRPS = *Sexual Relationships Power Scale* (Pulerwitz, Gortmaker, & DeJong, 2000).

Alcohol Use, Intimacy and Condom Use

Lastly, Hypothesis 5 stated that alcohol consumption would moderate the relationship between intimacy and condom use. Specifically, it was proposed that the relationship between intimacy and rates of condom use would be stronger when participants reported more frequent alcohol consumption before or during sex. It was necessary to first center participants' scores on variables to be used in these analyses by subtracting the mean value on each variable from observed scores. Next, the product of the proposed moderator (alcohol consumption) and the independent variable (MSIS scores) was computed. Multiple regression analysis was performed in which MSIS scores, frequency of alcohol consumption before or during sex, and the product term were included as predictors. Partial support for Hypothesis 5 was found. In evaluating differences between Partners A and B, it was found that alcohol use before or during sex moderated the negative association between perceived intimacy and condom use over the course of a relationship. More consistent condom use was reported in less intimate relationships when alcohol is consumed less frequently before or during sex. On the other hand, consuming alcohol more frequently before or during sex in less intimate relationships was associated with greater inconsistency of condom use. Table 7 contains details of these regression analyses.

Table 7

Summary of Regression Analyses on the Effects of Intimacy on Rates of Overall Condom Use as Moderated by Alcohol Use Before/During Sex (N = 125)

Predictors	B	SE B	β
$MSIS_{diff}$	-.007	..092	-.320**
Alcohol Use_{diff}	-.087	.072	-.113
$MSIS_{diff}$ × Alcohol Use_{diff}	.002	.001	.001*

Note. R^2 = .131 (p = .001). MSIS = *Miller Social Intimacy Scale* (Miller & Lefcourt, 1982).

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

CHAPTER 4

DISCUSSION

The overall goal of the present study was to explore individual and interpersonal variables related to college women's safer sex practices in heterosexual relationships. There is a large body of research on factors contributing to women's risk of contracting HIV/AIDS and other STIs through inconsistent condom use (Amaro, 1995; Crowell, 2004; Yarnall et al., 2003). Many of these studies have suggested that this risk is greatest in women's relationships with male significant others (as opposed to more casual partners) for a variety of reasons, including less consistent condom use, lack of HIV testing, and faulty risk perception (Civic, 2000; Crowell, 2004). Overall, results from the current study were consistent with prior research and carry implications for future efforts to understand women's risky sexual behaviors.

Researchers have offered considerable commentary regarding why some women may be unable or reluctant to engage in consistent condom use (Critelli & Suire, 1998; Simkins, 1994; Sobo, 1998). The current sample supported this by identifying several intrapersonal and interpersonal factors contributing to women's likelihood of engaging in unprotected sex with male partners. First, condoms were used less frequently in relationships with partners that participants described as "boyfriends." Likewise, condom use was shown to decrease over the course of participants' relationships. The current sample demonstrated less frequent condom use in the last/most recent month of relationships that participants perceived as more

intimate. This effect was anticipated, as it is consistent with prior research. Taken together, these trends may reflect changes in the importance placed on using condoms (Hammer et al., 1996) and how condom use is construed (Sobo, 1995) over stages of relationship development.

Prior research regarding risk factors in primary dating relationships has pointed to the tendency for women to rely on subjective assessments of their partners' HIV status (Carter et al., 1999; Crowell, 2004). It bears mentioning that the overwhelming majority of participants in the current study reported not knowing whether Partner A or Partner B received an HIV test during their relationship. In fact, only 19 partners (7%) were reported by participants to have received HIV tests during their relationships. Furthermore, only 10 of those partners (4%) were reported to have shared the results of their HIV tests with participants prior to having sexual intercourse with each other for the first time. Based on the lack of HIV testing reported, it can be concluded that participants in this study based their assessment of partners' risk on subjective factors, as has been shown previously (Civic, 2000).

Yarnall et al. (2003) demonstrated that, while college individuals typically describe themselves as being at low risk of contracting HIV, their sexual behaviors are more consistent with a high-risk profile. Retrospectively, the tendency to underestimate risk has been linked to inconsistent use of condoms among HIV+ individuals (Crowell, 2004). This highlights the potential ramifications of basing decisions about safer sex primarily on subjective assessments of partners' level of risk. As stated above, most participants in the current study reported infrequent HIV testing for themselves and their partners, supporting the notion that women's

perceptions of partners' risk are not based on objective factors. At an average age of 19.65 years and with a mean of 5.68 lifetime sexual partners (*Mdn* = 4.00), participants in this study reflect the extent to which college women are behaviorally at higher risk of HIV infection than they acknowledge.

In the extant literature, alcohol consumption has been tied to women's sexual risk-taking in a multitude of ways (Abbey, Saenz, & Buck, 2005; MacDonald, Zanna, & Fong, 1996; Testa & Collins, 1997). Although the current study did not evaluate specific mechanisms of this influence, women's alcohol consumption before and during sex appeared to be an important part of the total context in which sexual decisions are made. For instance, there was a significant negative correlation between intimacy and frequency of drinking before and during sex. Similarly, participants reported less frequent alcohol consumption before or during sex with partners that they described as "boyfriends." There was a significant negative correlation between drinking during sex and frequency of condom use during the first month of participants' relationships. Additionally, differential rates of alcohol consumption during sex were related to women's differential risk perception. This suggests that, in relationships that feature more frequent drinking before and during sex, participants perceive greater risk of contracting HIV through sexual contact with that partner.

Regarding the relationships between alcohol use and risk perception, measures used here do not allow for inferences about causality. It is plausible that, due to the disinhibitory effects of alcohol consumption and/or alcohol-related expectancies, women may decide to engage in more ill advised sexual behaviors when they have

been drinking. It has been speculated elsewhere that consuming alcohol is often considered a justification for engaging in certain risk-taking activities, including unprotected sex or sex with risky partners (Cooper, 1992). This is consistent with a large body of research on "alcohol myopia" and other theories regarding the mechanisms by which drinking is related to risk taking (Steele & Josephs, 1990; Taylor & Leonard, 1983; Testa, Livingston, & Collins, 2000). Another possibility alluded to in prior research (Murphy, Monahan, & Miller, 1998) is that, when women have been drinking, they may experience stronger intentions to engage in sex with male partners that they perceive as risky. Alcohol consumption has also shown to increase women's confidence in their abilities to determine if a male partner is HIV+ based on social interactions (Monahan, Murphy, & Miller, 1999).

It is also possible that the current findings reflect differences in how women retrospectively assess their risk of contracting HIV from heterosexual partners. For instance, intoxicated women may not initially perceive their choices of sexual partners or behaviors as being particularly risky but may later think that their behaviors placed them at greater risk than they initially acknowledged. Whatever the mechanism by which alcohol use relates to risk perception, results here speak to the importance of continuing to investigate how drinking factors into women's safer sex decisions and practices.

Related to how drinking affects the context in which sex often occurs, support was found for alcohol use before and during sex as a moderator variable in the relationship between intimacy and condom use. Differential rates of alcohol use before or during sex moderated the negative association between perceived intimacy

and condom use over the course of a relationship. This finding suggests that, in less intimate relationships, consuming alcohol prior to or during sexual activity decreases the likelihood that condoms will be used. Once again, this study does not permit inferences regarding causation, but results emphasize how alcohol consumption is likely an important aspect of young women's sexual relationships.

Additional analyses conducted here illustrated other factors that are part of the context in which women's safer sex decisions are made. Researchers have investigated interpersonal predictors of women's condom use (Macaluso et al., 2000; Misovich, Fisher & Fisher, 1997; Walters & Nero, 2000), taking into consideration that sexual protection is a complex interactive process. Women's perceived power in relationships has been consistently thought of as having an impact on their likelihood of practicing safer sex, which often requires the ability to initiate discussions about condoms and HIV risk, to negotiate condom use, and to refuse unprotected sex if necessary (Amaro, 1995; Crowell, 2004). In the current study, results were mixed regarding the impact of women's sexual power and assertiveness on condom use. Generally, higher levels of perceived sexual power (as measured by SRPS scores) were associated with more frequent condom use during the first month of women's relationships. SRPS scores, however, were not significantly correlated with condom use during the last/most recent month of romantic relationships. Again, this may reflect the extent to which safer sex decisions during various stages of women's relationships are based on qualitatively different considerations.

Participants in this study completed several measures assessing the construct of sexual power/assertiveness. One of the most widely used and well validated

measures of this construct, the Sexual Assertiveness Scale (Morokoff et al., 1997), was included in the procedures for this study and was significantly correlated with other measures of perceived power used here. Surprisingly, participants' SAS scores were not predictive of condom use within their relationships. It is believed that this is related, at least in part, to methodological issues. While participants completed this measure only once to reflect their overall level of sexual power, other measures of power were completed twice as assessments of participants' perceptions of their relationships with two particular partners. The finding that participants' more global perception of their own sexual assertiveness (i.e., SAS score) was not significantly predictive of condom use with specific partners speaks to how greatly women's power over sexual situations may differ from one partner to another. That is, individuals may perceive themselves as having a certain level of sexual assertiveness in general but behave more or less assertively with specific partners. Although not a focus of the current study, results support the possibility that women's perceptions of their own assertiveness may not be constant; instead women's behaviors, as well as their perceptions of those behaviors, differ in respect to the unique dynamics that exist between relationship partners. Additionally, the instruments administered to participants did not include a report of lifetime rates of condom use, which may be more likely to correlate significantly with global self-assessments of sexual assertiveness.

While participants' SAS scores were not related to condom use, higher levels of sexual power as determined by participants' SRPS scores were predictive of more consistent condom use. In addition to methodological considerations, the lack of

support for hypotheses using SAS scores could reflect conceptual differences in how these two measures assess the construct of sexual assertiveness. The SAS contains items focusing exclusively on sexual interactions. Items are designed to assess the extent to which women feel comfortable behaving assertively in terms of sexual discussions as well as the initiation, negotiation, and refusal of sexual contact. By contrast, SRPS items focus more broadly on power dynamics in women's sexual relationships. Arguably, this measure provides less specific information than can be obtained using the SAS but may also more adequately account for factors contributing to women's appraisals of their own power in relationships. These results raise the possibility that the construct of sexual assertiveness may include not only women's control over sexual decisions, but also their influence on decisions made regarding other critical areas of sexual relationships.

Despite several significant findings presented here, there are other methodological limitations that may have affected the results of this study and, therefore, warrant discussion. Support for several hypotheses was found through the use of regression analyses. Although results from these analyses were statistically significant, they accounted for relatively small portions of the total variance in constructs of interest. This could reflect the complex nature of the variables being studied. It is also likely that this is related to weaknesses in how constructs have been conceptualized and measured. For these reasons, results of the current study are noteworthy but should be interpreted cautiously.

Another shortcoming of this study was the difficulty in detecting many expected differences between participants' behaviors in their relationships with partners with

whom they used condoms more or less often. The purpose of this study's research design was to establish some methodological control for individual differences or potential nuisance variables while also allowing for comparisons between women's relationships that feature differential rates of condom use. The research design used here may have made it more difficult to detect significant effects. Nevertheless, it was believed that these limitations would be outweighed by the potential benefits. By assessing variables of interest in two distinct relationships with differing rates of condom use, the influence of potential confounding variables was minimized, thereby allowing for greater confidence in interpreting results. Additionally, the design used here accounted for how women's behaviors may differ greatly from one heterosexual relationship to another.

That being said, the results presented here offer a number of important implications for the future study of women's sexual risk-taking in relationships. Consistent with prior research, it was shown here that there are many changes that occur as heterosexual relationships develop. Data demonstrated women's tendency to link unprotected sex with emotional closeness as relationships progress. Likewise, higher levels of perceived sexual power were correlated with more frequent condom use with new sexual partners, but that effect did not persist throughout relationships. Additionally, frequency of consuming alcohol before or during sex was negatively correlated with relationship length, illustrating women's greater likelihood of having sex while intoxicated with partners that they have known less time. Together, these findings illustrate that the context of sexual decisions for short-lived or new

relationships is markedly different from the context in which decisions are made between more long-term, significant dating partners.

These differences should be incorporated in further research on women's sexual decision making. If there are dissimilar factors contributing to women's sexual risk-taking depending on the length or nature of their relationships, it may be fruitful to tailor HIV risk-reduction efforts to account for these differences. For instance, HIV prevention efforts may be of greater benefit by focusing on ways to bolster at-risk women's efficacy and assertiveness in initiating condom use in casual sexual interactions or with new sexual partners. On the other hand, it may be helpful for interventions to focus on encouraging women to pursue less risky means of fostering emotional closeness as their relationships develop or if they would like to increase condom use with long-term significant others.

The impetus for conducting this study stemmed from prior research documenting women's risk of contracting HIV from primary dating partners. It is believed that this increased risk of infection relates, at least in part, to the connotations of unprotected sex within relationships that women find important. Further research is warranted to identify what emotional needs women are attempting to meet by engaging in unprotected sex. It would be advantageous for research to more adequately parse the construct of intimacy and other factors impacting women's motivations to engage in risky sex. Ideally, efforts to increase women's safer sex behaviors could focus on risk reduction while also acknowledging that cultivating and maintaining emotional closeness is an important goal in women's primary dating relationships.

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APPENDIX A

Consent Form

I, _____, agree to participate in the research study entitled "Women's Relationships, Drinking, and Sexual Practices," which is being conducted by Monique Harris in the Department of Psychology at The University of Georgia (706-542-1173) under the direction of Dr. Lily McNair, Department of Psychology at The University of Georgia (706-542-1173). My participation is voluntary; I can stop taking part at any time without giving any reason, and without penalty. I can ask to have information related to me returned to me, removed from the research records, or destroyed.

If I would like to learn about the results of this study, I may contact Monique Harris or Lily McNair by mailing a letter requesting the results of the study entitled "Women's Relationships, Drinking, and Sexual Practices." I will include my name and permanent mailing address in the letter. The researchers can be reached at the following address: Department of Psychology; Psychology Building; The University of Georgia; Athens, GA 30602.

The following points have been explained to me:

1. The purpose o f this study is to gain a better understanding of how women make decisions about sexual activities and their perceptions of their heterosexual relationships.
2. The benefit that I may expect for my participation in this research is that I will receive RP Pool Credit (for psychology majors only). Other than receiving RP Pool Credit, I may not benefit directly from participating in this study.
3. The procedures are as follows: I will respond to a series of questionnaires and return them to the researcher when completed. The questionnaire packet will take approximately 50 minutes to complete.
4. The discomforts and stresses that may be faced during this research are: I will be asked to provide some personal and possibly upsetting information in order to complete the questionnaires. Specifically, I will be asked about sexual contact and HIV/AIDS.
5. Participation entails the following risks: Rarely, individuals may find some items psychologically distressing. If I do become uncomfortable or distressed, I will be able to withdraw from the study without losing RP Pool Credit. Also, if particular questions make me uncomfortable, I can skip those items without penalty. If I would like to receive mental health services, I can contact The University of Georgia Psychology Clinic at 706-542-1173 or Counseling and Psychological Services (CAPS) at 706-542-2273. The researcher will also provide additional referrals for mental health service providers upon my request.
6. In order to make this study a valid one, some information about my participation will be withheld until after the study.
7. My participation in this study will be confidential, and will not be released in any individually identifiable form unless required by law. All data will be coded so that it cannot be linked back to me.
8. The researcher will answer any further questions about the research, now or during the course of the project and can be reached by telephone at 706-542-1173.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

L. Monique Harris	_____	_____
Name of Researcher	Signature	Date
Telephone: 706-542-1173		
Email: lmharris@uga.edu		

_____	_____	_____
Name of Participant	Signature	Date

Please sign both copies, keep one and return one to the researcher.

THANK YOU FOR YOUR PARTICIPATION

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address **IRB@uga.edu**

APPENDIX B

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 10)
    _____ 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 12)
    _____ Yes

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

APPENDIX C

Instructions Sheet for Partner A

Think about all of your male sexual partners, past or present. Is there one person with whom you **used condoms most of the times you had sex?** If you only had sex with this person once, did you use a condom that time? Think of one partner with whom you used condoms **at least half the times you had sex with him.**

This person will be referred to as "Partner A".

In this section, answer all questions as they pertain to your relationship with **Partner A**.

APPENDIX D

Instructions Sheet for Partner B

Again, think about all of your male sexual partners, past or present. Is there one person with whom you **DID NOT use condoms most of the times you had sex?** If you only had sex with this person once, did you use a condom that time? Think of one partner with whom you used condoms **less than half the times you had sex with him.**

This person will be referred to as "Partner B".

In this section, answer all questions as they pertain to your relationship with **Partner B.**

APPENDIX E

Sexual Practices Questionnaire

Please respond to the following items as they apply to your relationship with **Partner A/Partner B**. If you are no longer dating or having sex with this person, answer these items as you would have during the period of time when you and **Partner A/ Partner B** were involved in a sexual relationship.

1. How would you describe this person?
_____ Boyfriend or significant other
_____ Friend (but **not** a boyfriend)
_____ Casual sex partner

2. How long did you know him before you had sex with him for the first time?
_____ (in months)

3. Are you still in a sexual relationship with this person?
_____ No (Please go to Question 5)
_____ Yes

4. How long have you been in a sexual relationship with him?
_____ (in months)

5. How long were you in a sexual relationship with him?
_____ (in months)

6. How often did you use condoms ***during the first month*** after you started having sex with him?
_____ Never
_____ Occasionally (about 25% of the time)
_____ About half of the time
_____ Most of the time (about 75% of the time)
_____ Always

7. How often did you use condoms ***during the last month (or most recent month)*** of your relationship with him?
_____ Never
_____ Occasionally (about 25% of the time)
_____ About half of the time
_____ Most of the time (about 75% of the time)
_____ Always

8. Did you talk about using a condom with this person?
   _____ No
   _____ Yes

9. 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

10. This person was usually 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

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

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

13. Have you ever talked to this man about <u>his</u> sexual history?
    _____ No (Please go to Question 16).
    _____ Yes

14. 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

15. 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

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

17. Have you ever talked to this person about <u>your</u> sexual history?
    _____ No (Please go to Question 20)
    _____ Yes

18. 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

19. 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

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

21. How often do/did you use a condom during sexual intercourse with this person?
    _____ We never use a condom when we sex
    _____ We use a condom occasionally (about 25% of the time)
    _____ We use a condom about half of the time
    _____ We use a condom most of the time (about 75% of the time)
    _____ We use a condom every time we have sex

22. Have you ever received a negative response when you asked this person to use a condom?
    _____ No (Please go to Question 24)
    _____ Yes

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

24. Did you ever consume alcohol before or during sex with this person?
    _____ No
    _____ Yes

25. How often did you consume alcohol before or during sex with this person?
    _____ Never
    _____ Occasionally (about 25% of the time)
    _____ About half of the time
    _____ Most of the time (about 75% of the time)
    _____ Always

26. Did **you** ever get an HIV test during this relationship?
    _____ No (Please go to Question 29)
    _____ Yes

27. Did you share the results of that test with your partner?
    _____ No
    _____ Yes

28. Did you receive results of your HIV test before you had sex with this person for the first time?
    _____ No
    _____ Yes

29. Did **your partner** ever get an HIV test during this relationship?
    _____ No (Please go to Question)
    _____ I don't know (Please go to Question)
    _____ Yes

30. Did he share the results of this test with you?
    _____ No
    _____ Yes

31. Did he receive the results of his HIV test before you had sex with him for the first time?
    _____ No
    _____ Yes

APPENDIX F

AIDS and Relationships Questionnaire Factor 3: Risk Perception

(Monahan, Miller, & Rothspan, 1997)

Please respond to the following items as they apply to your relationship with **Partner A/Partner B.** If you are no longer dating or having sex with this person, answer these items as you would have during the period of time when you and **Partner A/ Partner B** were involved in a sexual relationship. **Circle the number that best applies to you.**

1. I am/was fearful about the possibility of getting AIDS.

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

2. The probability of my getting AIDS is/was high.

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

3. I often worry/worried about getting AIDS from having sex.

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

APPENDIX G

Sexual Relationship Power Scale (Pulerwitz, Gortmaker, & DeJong, 2000)

Please respond to the following items as they apply to your relationship with **Partner A/Partner B.** If you are no longer dating or having sex with this person, answer these items as you would have during the period of time when you and **Partner A/ Partner B** were involved in a sexual relationship. **Circle the number that best applies to you.**

1. If I asked my partner to use a condom, he would get violent.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

2. If I asked my partner to use a condom, he would get angry.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

3. Most of the time, we do what my partner wants to do.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

4. My partner won't let me wear certain things.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

5. When my partner and I are together, I'm pretty quiet.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

6. My partner has more say than I do about important decisions that affect us.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

7. My partner tells me who I can spend time with.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

8. If I asked my partner to use a condom, he would think I am/was having sex with other people.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

9. I feel trapped or stuck in our relationship.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

10. My partner does what he wants, even if I do not want him to.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

11. I am more committed to our relationship than my partner is.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

12. When my partner and I disagree, he gets his way most of the time.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

13. My partner gets more out of our relationship than I do.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

14. My partner always wants to know where I am.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

15. My partner might be having sex with someone else.

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

16. Who usually has more say about whose friends to go out with?
_____ Your partner _____ Both of You Equally _____ You

17. Who usually has more say about whether you have sex?
_____ Your partner _____ Both of You Equally _____ You

18. Who usually has more say about what you do together?
_____ Your partner _____ Both of You Equally _____ You

19. Who usually has more say about how often you see one another?
_____ Your partner _____ Both of You Equally _____ You

20. Who usually has more say about when you talk about serious things?
_____ Your partner _____ Both of You Equally _____ You

21. In general, who do you think has more power in your relationship?
_____ Your partner _____ Both of You Equally _____ You

APPENDIX H

Dominance in Relationships Questionnaire

Please respond to the following items as they apply to your relationship with **Partner A/Partner B.** If you are no longer dating or having sex with this person, answer these items as you would have during the period of time when you and **Partner A/ Partner B** were involved in a sexual relationship. **Circle the number that best applies to you.**

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

APPENDIX I

Miller Social Intimacy Scale (Miller & Lefcourt, 1982)

Please respond to the following items as they apply to your relationship with **Partner A/Partner B.** If you are no longer dating or having sex with this person, answer these items as you would have during the period of time when you and **Partner A/ Partner B** were involved in a sexual relationship. **Circle the number that best applies to you.**

	Very Rarely			Some of the Time				Almost Always		
1. When you have leisure time how often do you choose to spend it with him?	1	2	3	4	5	6	7	8	9	10
2. How often do you keep very personal information to yourself and do not share it with him?	1	2	3	4	5	6	7	8	9	10
3. How often do you show him affection?	1	2	3	4	5	6	7	8	9	10
4. How often do you confide very personal information to him?	1	2	3	4	5	6	7	8	9	10
5. How often are you able to understand his feelings?	1	2	3	4	5	6	7	8	9	10
6. How often do you feel close to him?	1	2	3	4	5	6	7	8	9	10
	Not Much			A Little				A Great Deal		
7. How much do you like to spend time alone with him?	1	2	3	4	5	6	7	8	9	10
8. How much do you feel like being encouraging and supportive of him when he is unhappy?	1	2	3	4	5	6	7	8	9	10
9. How close do you feel to him most of the time?	1	2	3	4	5	6	7	8	9	10
10. How important is it to you to listen to his very personal disclosures?	1	2	3	4	5	6	7	8	9	10
11. How satisfying is/was your relationship with him?	1	2	3	4	5	6	7	8	9	10
12. How affectionate do you feel towards him?	1	2	3	4	5	6	7	8	9	10
13. How important is it to you that he understands your feelings?	1	2	3	4	5	6	7	8	9	10
14. How much damage is caused by a typical disagreement in your relationship with him?	1	2	3	4	5	6	7	8	9	10
15. How important is it to you that he be encouraging and supportive to you when you are unhappy?	1	2	3	4	5	6	7	8	9	10
16. How important is it to you that he show you affection?	1	2	3	4	5	6	7	8	9	10
17. How important is/was your relationship with him in your life?	1	2	3	4	5	6	7	8	9	10

APPENDIX J

Daily Drinking Questionnaire (Collins, Parks, & Marlatt, 1985)

Please fill in a number for each day of the week indicating the average number of drinks you consume during a typical week.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please add together the numbers in the above boxes. The combined weekly average number of drinks is: (circle one)

A = 0 drinks
B = 1 – 3 drinks
C = 4 – 11 drinks
D = 12 or more drinks

APPENDIX K

Debriefing Statement

Thank you for your participation in the study entitled "Women's Relationships, Drinking, and Sexual Practices. It is very important that you do not share information about this study with your classmates because they may be participants in the future. Your cooperation with this policy is greatly appreciated.

The purpose of this study was to explore how relationship status, interpersonal power, and alcohol use are related to women's sexual behavior. The results of this study will help us better understand how women discuss condom use with their male partners and how decisions about safer sex are made. It is also expected that our findings will contribute to the development of more effective intervention strategies aimed at preventing the transmission of HIV/AIDS. If you are interested in the significance and practical implications of this research, please contact Monique Harris at 706-542-1173.

If you are concerned about any stress or discomfort that you have experienced while participating in this study, you are encouraged to seek services at The University of Georgia Psychology Clinic at 706-542-1173. Additional referrals may be provided upon request.

If you would like to learn about the results of this study, please contact Monique Harris by mailing a letter requesting the results of the study entitled "Women's Relationships, Drinking, and Sexual Practices." Please include your name and permanent address in this letter. You can contact the experimenter through the address provided on your Consent Form.

If you have any additional questions regarding this study, please contact Monique Harris at 706-542-1173. Once again, thank you for your participation.