EXAMINING THE THEORY OF REASONED ACTION IN RELATION TO SEXUAL RISK-TAKING BEHAVIOR AMONG AFRICAN AMERICAN WOMEN

by

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(Under the Direction of Lily D. McNair)

ABSTRACT

In recent decades the HIV/AIDS epidemic has emerged as a devastating phenomenon disrupting the lives of an exponentially growing number of individuals, families, and communities. The incidence rate of AIDS for African American women is 5 times that of other members of the U. S. population. This study sought to understand the contextual, social, and behavioral framework through which this disproportionate risk occurs. The theory of reasoned action (TRA) was examined in relation to three sexual health-promoting behaviors (i.e. condom use, regular STD testing, and discussing sexual risk with one's partner) within this at-risk demographic. Additionally, factors related to sociocultural issues specific to African American women were evaluated. Results supported the TRA model in relation to two of three sexual health-promoting behaviors examined, however the model was not fully supported for condom use. The differential importance of various referent norms (i.e. ethnic, gender, and partner) were evaluated via hierarchical regression with partner norms accounting for the largest amount of variance in intention to engage in all three behaviors studied. Relationship intimacy and perception of a sex-ratio imbalance were evaluated as moderators of intention with significant results found only for relationship intimacy. Findings suggest that perception of one's romantic partner's beliefs as well as relationship intimacy are particularly salient predictive factors of intention for women within this demographic. Findings also implicate differential cognitive antecedents for these varying health-promoting behaviors. Implications and recommendations are discussed.

INDEX WORDS: Sexual health, HIV/AIDS, African American women, Theory of Reasoned Action
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by

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CHAPTER 1

INTRODUCTION

In recent decades the HIV/AIDS epidemic has emerged as a devastating phenomenon disrupting the lives of an exponentially growing number of individuals, families, and communities. Originally conceptualized as primarily a threat to “white, gay males,” the face of AIDS has dramatically transformed over the last decade (Shilts, 1998). In fact during the 1990s women, particularly women of color, became the fastest growing demographic infected with HIV (Nakashima & Fleming, 2003). In 2002, the Center for Disease Control and Prevention (CDC) reported that the incidence rate of AIDS for African American women was 5 times that of other members of the U.S. population (www.cdc.gov). Attempts to understand the contextual, social, and behavioral framework through which this disproportionate risk occurs are imperative if researchers are to assist in the development of theoretically-driven and population specific prevention strategies. The present research examines the theory of reasoned action in relation to sexual risk-taking behavior in African American women.

The theory of reasoned action suggests that behavioral decisions are based on reasoning and evaluation of behavioral alternatives (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980). According to this theory, individuals do not behave spontaneously but rather consider the consequences of their behavior, in addition to beliefs about how significant others might expect them to perform, prior to settling on a “reasoned behavioral decision” (Tesser & Shaffer, 1990). The model further explains behavior as a function of one’s intention to perform a particular act, with intention determined by one’s attitude (whether positive/negative) toward the behavior as well as individual perceptions
of normative pressure to perform the behavior. Additionally, the model asserts that attitudes toward a particular behavior are determined by beliefs regarding the consequences of performing the behavior and one’s evaluation of those consequences. Subjective norms are purportedly a function of one’s perception of external social pressure to engage in the behavior and individual motivation to comply with this social pressure.

The theory of reasoned action provides a useful conceptual framework through which a number of health behaviors have been studied, including AIDS-preventative behaviors (Terry, Gallois, & McCamish, 1993). Research related to this theory has implications for clinical strategies and interventions aimed at targeting behaviors likely to increase health risks. Given the clinical implications of research in this area, it is important to examine the degree to which the theory of reasoned action helps explain the cognitive antecedents of sexual risk-taking behavior for African American women.

Evaluation of Alternative Cognitive Models

A number of cognitive theoretical models attempt to identify and explain the relationship between various predictors and health care behavior (Terry, Gallois, & McCamish, 1993). Among the most widely researched are the health belief model (Rosenstock, 1974), theory of reasoned action (Fishbein & Ajzen, 1975), and the theory of planned behavior (Ajzen, 1991). It seems relevant to briefly explore these alternative models.

The health belief model (Rosenstock, 1974) has been utilized in the literature to explain factors related to one’s likelihood of engaging in a variety of preventative health behaviors. This theory supposes that health-engendering behavior is a function of an
individual’s perception of their susceptibility to an ailment, severity of the consequences associated with the ailment, the benefits of engaging in healthy behavior, as well as costs of engaging in such behavior. The health belief model has been successful in predicting a wide range of health behavior related to disease prevention, including breast self-examination (Aiken, West, & Woodward, 1994), blood pressure screening (King, 1982), and regular exercise (Juniper, Oman, & Hamm, 2004). However, the model has been less successful in predicting safer sex behavior (Harrison, Mullen, & Green, 1992). This disparity may be explained by the distinction between behaviors associated with safer sex and other health behaviors (e.g. vaccination, pap test, etc.). The health belief model fails to account for the relational component associated with safer sexual practices in comparison to other health behaviors that do not intimately affect other people. Also, this model may be more useful with populations of higher SES who are likely more informed about disease and steps toward disease prevention (Taylor, 1991).

The theory of reasoned action presumes that the behavior of interest is within a person’s control. Ajzen (1985) extended this theory to account for behaviors that are not completely in someone’s control. This extension is the theory of planned behavior (Ajzen, 1985). It states that behaviors that are likely influenced by situational factors beyond an individual’s control cannot be predicted without accounting for the degree to which someone can control the behavior of interest. Given that actual control is often variable and somewhat difficult to measure, researchers generally assess perceived control to measure the construct. While the theory of planned behavior has been supported by the literature, perceived behavioral control of condom use did not significantly account for more variance than that explained by the attitudes, social norms,
and intentions of a number of samples (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Fazekas, Senn, & Ledgerwood, 2001; Rye, 1999).

**Strategies For Measuring Attitudes, Intentions, and Behavior**

Ajzen and Fishbein (1980) detail a clear set of guidelines for operationalizing the components of the theory of reasoned action (Terry, Gallois, McCamish, 1993). Researchers evaluating the relevance of this theory to a specific population should initially determine the manner in which the construct of interest will be measured within a sample. For example, researchers on safer sex could measure this behavior by assessing cognitive factors related to condom use or sexual encounters. Once the method of measuring behavior has been determined, it is recommended that researchers define the corresponding predictor variables (intention, attitude, social norms). It is important to measure these variables at the same level of specificity as the behavior. For instance, one measuring *condom use on next sexual encounter* should measure attitudes toward condom use on next sexual encounter rather than simply *condom use*.

Ajzen and Fishbein (1980) also suggest a standardized instrumental style in order to maximize the ability for researchers to compare data across samples. Behavioral intentions are measured by intention statements such as, “I intend to use a condom on my next sexual encounter.” Participants respond to the likelihood of such statements on a 7-point Likert scale. Attitude may be assessed with statements such as, “My using a condom on my next sexual encounter would be: ” good to bad, again using a 7-point Likert scale. Items evaluating perceptions of subjective norms of referent groups may resemble the following: “People who are important to me think that I: “should” to “should not” use a condom on my next sexual encounter.” Reliability may be improved
by using more than one item to measure subjective norms. Alternative items might ask
individuals to note their perception of whether referent others would “approve” or
“disapprove” of the behavior of interest, still using a Likert scale.

Prior Research on Reasoned Action

A review of the literature yielded numerous studies evaluating and supporting the
theory of reasoned action in relation to health care behaviors, including behaviors related
to sexual risk taking in various populations. A recent meta-analysis (Albarracin, Johnson,
Fishbein, & Muellerleile, 2001) evaluating the theory of reasoned action as a model of
condom use for 96 data sets supports the theory’s tenet that attitudes, social norms, and
intentions significantly contribute to predictions of condom use behavior among the
samples examined. Notably, only 6 databases in this group sampled minority populations.
More research is necessary to understand the potentially distinct relationships between
the precepts of the theory of reasoned action and the sexual risk-taking behaviors of
members of various minority groups who are particularly vulnerable to HIV infection.

Despite the paucity of research investigating the theory of reasoned action in
domestic minority populations, researchers have demonstrated conceptual relationships
consistent with this theory in relation to condom use among international samples
(Bosompra, 2001; Diaz-Loving & Villagran-Vasquez, 1999; Chitamun & Finchilescu,
2003; Wilson, Zenda, & Lavelle, 2001). A study assessing condom use among 30
students at a university in southern Ghana found that while subjective norms and
perceptions of condoms predicted condom use, the latter was more important for
predicting this behavior. Additionally individuals who did intend to use condoms
consistently, as well as those who did not, were likely to comply with the desires of their
referent groups. That is, those who intended to use condoms regularly seemed
distinguished from those who did not endorse such intentions by the beliefs that their
peers approved of condom use (Bosompra, 2001).

Diaz-Loving & Villagran-Vasquez (1999) found that in a sample of 1203
Mexican government workers, condom use was predicted by discrete factors when
distinguishing between “occasional” and “regular” sexual partners. Findings suggest that
personal beliefs and attitudes were more predictive of preventative behavior when
describing “occasional” sexual partners while subjective norms and motivation to comply
with such norms were more predictive in describing behavior with “regular” sexual
partners. This distinction warrants further study and may have implications for
preventative strategies aimed at individuals in monogamous relationships versus those
primarily engaging in “casual” sex.

A number of researchers evaluating the appropriateness of the theory of reasoned
action in application to AIDS-preventative sexual behaviors have examined homosexual
white males (McCusker, Stoddard, McDonald, Zapka, & Mayer, 1992; Cochran, Mays,
Ciarletta, Caruso, & Mallon, 1992; Fisher, Fisher, & Rye, 1995). In one of only a few
found that while intentions predicted both condom use and personally receiving HIV
antibody testing, intentions did not predict asking one’s partner to seek HIV antibody
testing in male samples. Researchers hypothesized that although attitudes, intentions, and
norms may somewhat motivate homosexual and heterosexual males to inquire about a
partner’s HIV testing, concerns regarding initiating discussion of this sensitive topic
Of the literature reviewed, two published studies examined the theory of reasoned action among African American populations. Jemmott & Jemmott (1991) assessed theoretical hypotheses in relation to condom use in 103 female undergraduates via responses to a mailed survey. Findings supported the theory in that intentions to use condoms were predicted by positive attitudes toward condoms and perceptions of norm approval of condom use. Notably, personal beliefs and attitudes predicted intention more than beliefs of referent groups in women with above average AIDS knowledge. This finding lends support to current preventative strategies aimed at increasing awareness of medical and behavioral factors associated with increased sexual risk.

Bogart, Cecil, & Pinkerton (2000) assessed theoretical concepts related to intention to use the female condom among 137 men and women. Results suggest that attitudes, beliefs, and norms predicted intentions to use the female condom for female but not for male participants. Furthermore these factors seemed more salient in both male and female participants when describing “main” rather than “casual” sexual partners. Jemmott & Jemmott (1991) found that perception of the normative beliefs of sexual partners was a significant predictor of condom use among African American women and that this influence was more predictive than the views of other peers and/or family members. Although further study is warranted to lend more evidence to these data, such findings could suggest divergent strategies for interventions for African American males and females; notwithstanding the potentially different strategies utilized based on level of relationship commitment. As a result of the focus of research in this area on condom use, it seems a natural extension of the present literature to evaluate other sexual risk-taking behaviors in addition to condom use.
**Sociocultural Context of Sexual Risk Taking**

Sexual risk-taking is a unique construct in that it predominantly implicates failure to perform certain tasks rather than evaluating behaviors performed. As such, sexual risk taking is operationalized in the literature as engaging in penetrative sex without the use of a condom, failure to discuss one’s partner’s sexual/medical history prior to sexual involvement, refraining from being regularly tested for STDs once sexually active, and engaging in sexual activity with multiple partners (Johnson, 1993).

It is notable that research examining the population-specific issues that must be considered when evaluating the sociocultural context of sexual risk taking behavior in the African American community is limited. Within the literature several factors have been recognized as contributing to the social context of sexual risk taking for African American women (Logan, Cole, & Leukefeld, 2002). The identified factors subsume the unique social and cultural dynamics that relate to African American women’s increased HIV risk via heterosexual contact (McNair & Prather, 2004). Among noted factors acknowledged by the literature are: the sex-ratio imbalance between “marriageable” African American males and females (Adimora, Schoenbach, & Martinson, 2001; Aral & Wasserheit, 1995); reluctance to utilize condoms (Bedimo, Bennett, Kissinger, & Clark, 1998; Cornelius, Okundaye, & Manning, 2000); high rates of African American males’ engaging in sex with multiple partners (Lansky, Nakashima, Jones, & Supplement to HIV/AIDS Surveillance Study Group, 2000); high rates of HIV infection for African American males and the disinclination to disclose HIV status (CDC, 2003b; Wohl et al., 2002).
In many ways, the sex-ratio imbalance in the African American community acts as a catalyst for generating and maintaining the conditions through which sexual risk taking occurs. Research suggests this imbalance creates an atmosphere in which heterosexual African American men have access to a number of sexual partners (Johnson, 1993). Concurrently, women may feel silenced by the virtual unavailability of male sexual partners. This gender imbalance results in decreased interpersonal power within heterosexual relationships for African American women, given that males have more options for sexual partners, and therefore more opportunities for infidelity while in committed relationships, as well as more options should a relationship dissolve (Johnson, 1993). African American women are not unaware of the numerical inequity between the sexes and may hesitate to initiate conversations related to safer sexual practices for fear of creating discord within the relationship thus threatening their dyadic security. Bedimo, Bennett, Kissinger, & Clark (1998) found that among reasons cited by African American women for lack of condom use were fear of their partner’s negative appraisal, inconvenience, and negative views of condoms. Along with research that reports similar findings (Wingood & DiClemente, 1998; Kalichman, Hunter, & Kelly, 1992), this trend suggests that normative beliefs and outcome evaluation may be related to attitudes, intentions, and sexual risk-taking behaviors for members of this population.

Current intervention strategies often neglect factors such as social influence and/or cultural beliefs that are likely relevant to population-specific risk prevention (Semaan & Sogolow, 2002). McNair & Prather (2004) suggest that “culturally-specific” interventions could be enhanced by including components related to social variables. In a recent meta-analysis Logan et al., 2002 noted that interventions with a focus on “culture
and race” showed increased effectiveness when attention was also given to social factors. These findings lend empirical support for the importance of examining the influence of normative beliefs in addition to personal attitudes and beliefs in this population.

*Application of this Theoretical Model to African American Women*

In applying the theory of reasoned action to a specific population, evaluating the inherent assumptions of the model is essential in determining the degree to which its theoretical concepts adequately reflect the cognitive processes associated with behavior among members of a unique demographic. Like most social psychological models, the theory of reasoned action presumes that behavior is a function of individualistic and rational choices. Such decision-making styles or choices are closely inline with the worldview of European Americans but may be less accurate in predicting factors related to the behaviors of African American populations given their affinity toward a communal sense of self (Mays, 1992; Akbar, 1979; Gasch, Poulson, Fullilove, & Fullilove, 1991). Additionally, this theory minimizes the impact of external social, cultural, and discriminatory factors specific to this population that are likely relevant to decision-making processes. Issues propagated by the sex-ratio imbalance in the African American community, such as the high rates of multiple partners for males and high rates of HIV infection among males, in collaboration with the cultural taboos associated with condom use and disclosure of HIV status, create an atmosphere of sexual risk unique to African American women. These issues warrant further explanation and incorporation into a theoretical model for this demographic.

The presumption of an individually-oriented cognitive process may inadequately delineate the underpinnings of sexual-risk taking behavior for African American women.
The theory of reasoned action suggests that personal attitudes as well as the perception of behavioral norms of one’s referent group collude to create a powerful basis of social influence (Fisher & Misovich, 1990). Given the African American worldview emphasizing a communal sense of self, men and women within this community may indicate a sense of belonging to both ethnic and/or gender groups (Cochran & Mays, 1993). Thus these individuals must grapple with: a) determining the behavioral norms of both their ethnic and gender referent groups and b) managing or consolidating opposing patterns of behavior. The theory of reasoned action does not currently distinguish between multiple social influences or indicate a way of implicating the salience of one group’s influence over another. The lack of such a distinction underscores the importance of evaluating perceptions of varying referent norms and the degree to which these perceptions may impact intention and behavior.

An additional issue in applying the theory of reasoned action to African American women is the exclusion of factors external to the individual such as sociocultural issues influencing the dynamics of interpersonal relationships in this population. For example, the aforementioned sex-ratio imbalance among African-Americans, particularly those with higher socioeconomic status, is presumably a pertinent aspect of decision-making for members of both genders in the context of romantic relationships. Women who hypothesize that finding an alternative romantic partner will be difficult may be less likely to mandate behavior and information consistent with sexual health. Conversely, men recognizing their sexual options may be more prone to infidelity as well as noncompliance with the requests of “demanding” sexual partners (Monahan, Miller, & Rothspan, 1997).
The dynamics of sexual intimacy are such that although sexual health issues may be broached within a relationship, oftentimes partners may not feel comfortable honestly disclosing information regarding their sexual health behavior. This phenomenon may be particularly prevalent in African American communities where individuals tend to view discussions of sexual history as “taboo” (Collins, 1991). Research on sexual lying suggests that individuals lie to both actual and prospective sexual partners (Saxe, 1991). However, while DePaulo & Kashy (1998) found that people are likely to lie to both casual and close relationship partners, Williams (2001) noted that those in closer relationships were less likely to lie to their partners than individuals in casual relationships. These findings suggest that relationship closeness and intimacy may foster more honest and forthcoming sexual dialogues. Such dialogues are likely to lead to a clearer understanding of one’s partner’s perception of normative sexual behavior.

Jemmott & Jemmott (1991) found that perception of the normative beliefs of sexual partners was a significant predictor of condom use among African American women. Notably this influence was more predictive than the views of other peers and/or family members. Thus relationship intimacy seems a relevant factor to be included in a model conceptualizing sexual-risk taking behavior.

Purpose and Hypotheses

The purpose of the proposed study is to examine the components of the theory of reasoned action (attitude, social norms, intentions) in relation to sexual risk-taking behavior among African American women. Specifically, the goal of this study is to determine the degree to which women’s attitudes about and perception of referent others’ support of preventative behaviors such as, discussing sexual risk with one’s partner,
being regularly tested for STDs, requesting that one’s partner be tested for STDs, and condom use, impact their intention to engage in such behavior. In an attempt to appropriately apply this theory to this population, relevant sociocultural factors will be considered and related to the manner in which they impact individual intentions and behaviors. Consistent with previous research, intention is expected to predict behavior. The following model is proposed to describe factors predicting sexual health promoting behavior among African American women:

Hypothesis 1: While prior research has demonstrated a link between favorable attitudes regarding condom use and intention to use condoms, the link has yet to be made between other sexual health promoting attitudes and intention. As such, it is hypothesized that women who express more favorable attitudes related to sexual health promoting behaviors (i.e. requesting sexual/medical history of partner, being regularly tested for
STDs, consistent condom use) will report stronger intentions to perform these behaviors. Intention to perform sexual health promoting behaviors will predict reported behavior.

Hypothesis 2: The differential impact of perceived ethnic, gender, and partner norms on intention to engage in health promoting behavior is unclear given the absence of literature distinguishing between these three constructs. Thus, the second hypothesis is exploratory. However, given previous literature examining issues relevant to sexual risk-taking (Jemmott, Catan, Nyamathi, & Anastasia, 1995) it is expected that perception of ethnic, gender, and partner’s beliefs (referent norms) will differentially predict intention to perform sexual health promoting behaviors. Women with higher levels of ethnic identity will be more influenced by perceptions of ethnic norms.

Hypothesis 3: Perception of a sex-ratio imbalance, operationalized as perceiving male romantic/sexual partners as limited, will moderate the impact of personal attitude toward behavior on intention to engage in health promoting behavior. Specifically, personal attitude toward behavior will be more predictive of intention among women who report fewer perceptions of limited male romantic/sexual partners.

Hypothesis 4: Relationship intimacy will moderate intention to engage in health promoting behavior. Specifically, perception of partner’s beliefs regarding sexual behavior will be more predictive of behavior among women who report involvement in committed relationships rather than those reporting involvement in casual relationships.
CHAPTER 2

METHOD

Design and Participants

This study used a non-experimental design, as no experimental manipulations were planned. It entailed a survey of African American female college students. A power analysis revealed that 129 women should be recruited, for an effect size of .15. A medium effect size was chosen based on the normative effect size obtained by other studies examining the theory of reasoned action (Chitamun & Finchilescu, 2003). Participants were undergraduate students recruited through the available research pool at the University of Georgia as well as undergraduate women willing to volunteer their efforts from Spelman College. Spelman College is a historically black women’s college and was chosen in order to assist this researcher in obtaining an adequate sample size, given the relatively small number of African American women available at the University of Georgia. Demographic variables of this sample reflected the distribution of the overall population at the University of Georgia and Spelman College.

Measures

Demographics Questionnaire. Each participant was asked to provide information regarding sex, age, relationship status, length of relationship, sexual orientation, number of sexual partners, and racial/ethnic background.

Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982). This questionnaire contains 17 items designed to assess the degree of closeness, affection, and personal disclosure in a relationship. Participants respond to items along a 10-point Likert scale.
ranging from “very rarely” (1) to “almost always” (10). A representative item is, “How often do you confide very personal information to your partner?” The convergent validity of the MSIS with the Interpersonal Relationship Scale (IRS) has been demonstrated with a Pearson’s coefficient of $r = .71$, $p = .001$. The MSIS has test-retest correlations ranging from .84 to .96.

**Racial Identity Attitude Scale (RIAS; Parham & Helms, 1985).** This questionnaire is designed to measure one’s identification with a particular ethnic group. The measure is a 23-item Likert scale arrangement, which ranges from “strongly agree” to “strongly disagree.” It also assesses ethnic identity by examining the ethnic heritage of each participant’s parents. An example of the items included in this questionnaire is, “I am happy that I am a member of the group I belong to.” Scores range from 39-71 with higher scores indicating greater identification with ethnic group membership.

**Sexual Health Attitudes, Intentions, Norms, & Behaviors Inventory (SHAINBI; Dunn & McNair, 2004).** This questionnaire contains 53 items and was designed for the purposes of this study. It assesses individual attitudes toward sexual health promoting behavior such as condom use, discussing one’s partner’s sexual history, and being regularly tested for STDs. Additionally, the measure evaluates one’s intention to engage in such behavior as well as the degree to which one has engaged in sexual health promoting behavior with their current partner. Perceptions of the attitudes of referent groups are also assessed. Participants are asked to respond along a 7-point Likert scale. An prototypic item is, “The people in my life whose opinions I value would approve/disapprove of my using condoms every time I engage in sexual activity.”
Sex-Ratio Perception Questionnaire (SRPQ; Dunn & McNair, 2004). This questionnaire contains 10 items and was designed for the purposes of this study. It is a face-valid survey assessing the degree to which participants perceive an imbalance in the number of marriageable women and men. Participants will be asked to respond along a 7-point Likert scale. Scores range from 7 to 70 with higher scores indicated higher perceptions of a sex-ratio imbalance. A representative item is, “I believe I have dating options within my race.”

Procedure

Consent forms were distributed and participants were asked to sign and keep one copy, while returning the other signed copy to the researcher. After obtaining informed consent, participants were asked to complete the Demographic Questionnaire followed by the RIAS, MSIS, SSIPQ, and the SHAINBI. The complete packet of questionnaires took approximately 50 minutes to complete. Persons participating in the study were debriefed upon completion of the questionnaires.

Descriptive Data

Sample size (n), means (M), and standard deviations (SD) of descriptive variables are presented in Table 1. The sample consisted of 130 African American college women. Of the sample, 24 women were enrolled in a predominantly White institution at a large university and 106 women were enrolled in a historically Black college. Both schools are located in the southeast. With regards to the variables measured in this study, t-tests revealed largely insignificant differences between subjects at the two schools, as such the data were compiled for analyses. Comparisons of means and standard deviations between schools are displayed in Table 2. Of the women participating in the study, 65 reported
involvement in monogamous relationships. The mean length of relationship for women exclusively dating was 18.76 months (SD = 18.3). The mean year in school was 2.66 (SD = 1.03)
CHAPTER 3

RESULTS

Initial analysis of the current data set consisted of confirmatory factor analyses to determine the adequacy of the reliability and validity of the scales created for the purposes of this study. Once such factors were evaluated, a series of regression analyses were utilized to examine the proposed hypotheses. Results of these analyses are detailed below.

Confirmatory Factor Analysis

The Sexual Health Attitudes, Intentions, Norms, and Behavior Inventory (SHAINBI), created for the purposes of this study, includes four separate subscales designed to measure the constructs of attitude, perception of referent norms, intention, and behavior related to sexual health. As such, confirmatory factor analyses using LISREL were performed to verify the placement of items into these specific subscales as well as to assess inter-item reliability. Analyses suggested that some items be eliminated from the Attitudes subscale and revealed distinct facets within the dimensions of the Intention and Behavior subscales. A list of the items used to measure each construct is displayed in Appendix J.

Analysis of the Sexual Health Related Attitudes (SHRA) subscale revealed that eliminating four items provided the highest goodness of fit indices. The Chi Square was 6.30, Degrees of Freedom were 4, Standardized RMR was .06, NNFI was .90, CFI was .96, and RMSEA was .068. Thus, according to Hu and Bentler (1998), the items utilized to assess attitudes regarding sexual health promoting behavior provided an adequate fit to the data observed in this sample.
The subscale evaluating Sexual Health Related Norms (SHRN) was separated into three subcomponents a priori in order to test hypotheses involving unique referent groups. These subcomponents included items measuring perceptions of Ethnic Norms, Gender Norms, and Partner Norms. Analyses of the Ethnic Norms subcomponent yielded the following goodness of fit indices: Chi Square = 2.29, Degrees of Freedom = 1, Standardized RMR = .02, NNFI = .94, CFI = .99, and RMSEA = .10. Analyses of the Gender Norms subcomponent yielded these goodness of fit indices: Chi Square = 2.87, Degrees of Freedom = 2, Standardized RMR = .04, NNFI = .97, CFI = .99, and RMSEA = .06. Analyses of the Partner Norms subcomponent generated the following goodness of fit indices: Chi Square = .04, Degrees of Freedom = 1, Standardized RMR = .00, NNFI = 1.03, CFI = 1.00, and RMSEA = .00. These indices suggest a good fit to the data observed in this sample (Hu and Bentler, 1998).

Analysis of the Sexual Health Related Intention (SHRI) subscale suggested the presence of three distinct facets within the dimension of intention. Specifically, the best model for the data occurred when evaluating items measuring the following factors separately: intention to be tested regularly for STDs, intention to use a condom during sexual encounters, and intention to discuss one’s partners’ sexual history. For this model the goodness of fit indices were as follows: Chi Square = 134.25, Degrees of Freedom = 51, Standardized RMR = .04, NNFI = .93, CFI = .95, RMSEA = .12. Thus, hypotheses involving intention were analyzed using separate subcomponents rather than aggregating scores on this subscale (Hu and Bentler, 1998).

Analysis of the Sexual Health Related Behavior (SHRB) subscale suggested the presence of three distinct facets within the dimension of behavior. Consistent with the
Intention subscale, the best fit for the data occurred along the same demarcations. The goodness of fit indices were as follows: Chi Square = 18.90, Degrees of Freedom = 6, Standardized RMR = .05, NNFI = .89, CFI = .96, RMSEA = .13 (Hu and Bentler, 1998). Hypotheses involving behavior were analyzed using these separate subcomponents.

Analysis of the items on the Sex-Ratio Perception Questionnaire (SRPQ) suggested that eliminating three items would allow the highest goodness of fit indices. The indices for this scale were as follows: Chi Square = 34.91, Degrees of Freedom = 12, Standardized RMR = .07, NNFI = .89, CFI = .93, RMSEA = .13. These indices suggest an adequate fit to the data observed in the sample (Hu and Bentler, 1998).

Correlation Analyses

Table 3 presents the Pearson product-moment correlations among the major variables. These correlations can be used to examine evidence for the relationships among attitudes, referent norms, intentions, and behaviors related to sexual health promoting behavior as well as their relationships with relationship intimacy and perception of a sex-ratio imbalance. Significant correlations are presented between positive attitudes related to sexual health promoting behavior and perceptions of normative positive attitudes toward such behavior. Specifically, personal attitude was significantly correlated with ethnic norms ($r = .352, p<.01$), gender norms ($r = .303, p<.01$), and partner norms ($r = .438, p<.01$). Attitude was also correlated with intent to be tested regularly for STDs ($r = .245, p<.01$), intent to use condoms regularly ($r = .539, p<.01$), and intent to discuss one’s partners’ sexual history ($r = .213, p<.05$).
Table 1.

*Participant Descriptives for MSIS, Relationship Length, RAIS, SHRA, SHRN, SHRI, SHRB, and SRPQ scores*

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*Note.* MSIS (Miller Social Intimacy Scale) scores range from 17-150 with higher scores indicating greater relationship intimacy and contentment. RAIS (Racial Attitudes and Identity Scale) scores range from 39 – 71 with higher scores indicating greater identification with ethnic group membership. SHRA (Sexual Health Related Attitudes) scores range from 5 - 35 with higher scores indicating positive attitudes toward sexual health promoting behavior. SHRN (Sexual Health Related Norms) scores range from 4 – 28 with higher scores indicating perceptions of positive normative attitudes related to sexual health promoting behavior. SHRI (Sexual Health Related Intentions; STD) scores range from 3-21, SHRI (Condom Use) scores range from 5-35, and SHRI (Sexual History) scores range from 4-28 with higher scores indicating intent to perform sexual health promoting behavior. SHRB (Sexual Health Related Behaviors) scores range from 2 – 14 with higher scores indicating reports of sexual health promoting behavior. SRPQ (Sex-Ratio Perception Questionnaire) scores range from 8 – 56 with higher scores indicating greater overall perception of a sex-ratio imbalance.
Table 2. Comparison of Scores for UGA versus Spelman College Sample

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*Note.* MSIS (Miller Social Intimacy Scale) scores range from 17-150 with higher scores indicating greater relationship intimacy and contentment. RAIS (Racial Attitudes and Identity Scale) scores range from 39 – 71 with higher scores indicating greater identification with ethnic group membership. SHRA (Sexual Health Related Attitudes) scores range from 5 - 35 with higher scores indicating positive attitudes toward sexual health promoting behavior. SHRN (Sexual Health Related Norms) scores range from 4 – 28 with higher scores indicating perceptions of positive normative attitudes related to sexual health promoting behavior. SHRI (Sexual Health Related Intentions; STD) scores range from 3-21, SHRI (Condom Use) scores range from 5-35, and SHRI (Sexual History) scores range from 4-28 with higher scores indicating intent to perform sexual health promoting behavior. SHRB (Sexual Health Related Behaviors) scores range from 2 – 14 with higher scores indicating reports of sexual health promoting behavior. SRPQ (Sex-Ratio Perception Questionnaire) scores range from 8 – 56 with higher scores indicating greater overall perception of a sex-ratio imbalance.
### Table 3.

**Intercorrelations Among All Measures**

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<td>.073</td>
<td>-.244**</td>
<td>-.132</td>
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Note. **. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).
The three subcomponents of intention were significantly correlated with their corresponding behavioral subcomponents. Intent to be regularly tested for STDs and the report of the extent to which this behavior occurs were significantly related \( (r = .354, \ p < .01) \). A significant positive relationship also existed between intent to use condoms regularly and the report of the extent to which this behavior occurs \( (r = .492, \ p < .01) \). Finally, intent to discuss one’s partner’s sexual history was significantly related to the report of the extent to which this behavior occurs \( (r = .421, \ p < .01) \). An inverse correlation was found between relationship intimacy and intent to use condoms regularly \( (r = -.206, \ p < .05) \), while a positive correlation was found between intimacy and intent to be tested regularly for STDs \( (r = .252, \ p < .01) \) as well as intent to discuss one’s partner’s sexual history \( (r = .197, \ p < .05) \). An inverse relationship was also noted between perception of a sex-ratio imbalance and perception of positive partner attitudes toward sexual health promoting behavior \( (r = -.203, \ p < .05) \). Perception of a sex-ratio imbalance was also inversely related to the extent to which women reported discussing their partner’s sexual history \( (r = -.244, \ p < .01) \) with them.

**Hypothesis 1:** Women who express more favorable attitudes related to sexual health promoting behaviors (i.e. requesting sexual/medical history of partner, being regularly tested for STDs, consistent condom use) will report stronger intentions to perform these behaviors. Intention to perform sexual health promoting behavior will predict reported behavior.

Scores on all measures were standardized in order to promote comparison between inventories. In examining hypothesis 1, linear regression analyses were used to determine the degree to which women who express more favorable attitudes related to
sexual health promoting behaviors reported stronger intentions to perform these behaviors. It was hypothesized that attitudes would be predictive of intention. Analyses indicated that attitudes were predictive of one’s intent to be regularly tested for STDs ($R = .245$, $R^2 = .060$, $F(1,121), p<.01$), intent to use condoms regularly ($R = .539$, $R^2 = .290$, $F(1,122), p<.01$), and intent to discuss one’s partner’s sexual history ($R = .213$, $R^2 = .046$, $F(1,119), p<.01$). In evaluating the second portion of the hypothesis in which intention was expected to predict reported behavior, regression analyses were also utilized. Intent to be regularly tested for STDs was predictive of one’s reporting that they are regularly tested ($R = .336$, $R^2 = .113$, $F(1,117), p<.01$). Intent to use condoms was not predictive of one’s reporting that condoms are used regularly ($R = .138$, $R^2 = .019$, $F(1,118), p<.13$). Intent to discuss one’s partner’s sexual history was predictive of one’s report that they typically engage in this behavior ($R = .207$, $R^2 = .043$, $F(1,116), p<.02$). The hypothesized model was thereby supported by these analyses.

**Hypothesis 2: It is expected that perceptions of ethnic, gender, and partner’s beliefs (referent norms) will differentially predict intention to perform sexual health promoting behaviors.**

Hypothesis 2, the extent to which referent norms differentially predict intention to perform sexual health promoting behaviors was an exploratory hypothesis. Hierarchical multiple regression analyses were used to examine this premise. Variables were entered in blocks and ordered from proximal to distal, with the hypothesized proximal factors entered first. The ordering of the blocks for main effects were as follows: ethnic norms, Block 1; gender norms, Block 2, and partner norms, Block 3.
Perception of ethnic norms was entered into Block 1 and explained 28.6% of the variance of intention to be regularly tested for STDs ($R^2 = .286, p<.00$). The addition of perceptions of gender norms entered into Block 2, increased $R^2$ to .334, reflecting a change in $R^2$ of .048 ($p<.00$). Perception of partner norms was entered into Block 3 to determine its contribution in explaining intention to be regularly tested for STDs. The inclusion of perceived partner norms significantly increased $R^2$ to .365 ($p<.01$), thus predicting an additional 3.1% of the variance. These data are represented in Table 4.

In evaluating the differential predictive ability of referent norms for intention to use condoms regularly, the same block order was used. Perceived ethnic norms were entered into Block 1; explaining 6.5% of the variance of intention to use condoms regularly ($R^2 = .065, p<.01$). The inclusion of perceived gender norms did not increase $R^2$ significantly ($R^2 = .065, p<.64$), thus it did not add to estimation of the criterion variable. The addition of perceived partner norms significantly increased $R^2$ to .260 ($p<.00$), and predicted 19.5% of the variance of intention to use condoms regularly (see Table 5).

In examining the differential relationship between referent norms and intention to discuss one’s partner’s sexual history, the same block order was used. Table 6 displays these results. Perceived ethnic norms were entered into Block 1; explaining 11.4% of the variance of intention to discuss sexual history with one’s partner ($R^2 = .114, p<.03$). Perceived gender norms were entered into Block 2 and did not significantly add to the model ($R^2 = .115, p<.53$). The addition of perceived partner norms explained an additional 11.0% of the variance ($R^2 = .225, p<.00$) of intention to discuss one’s partner’s sexual history.
Table 4.

Summary of Hierarchical Regression Analyses for Differential Referent Norms Predicting Intent to be Tested Regularly for STDs (N = 121)

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<td>Partner Norms</td>
<td>117</td>
<td>22.40</td>
<td>.184</td>
<td>.365</td>
<td>.349</td>
<td>.031</td>
<td>.019</td>
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</tbody>
</table>
Table 5.

Summary of Hierarchical Regression Analyses for Differential Referent Norms Predicting Intent to use Condoms Regularly ($N = 121$)

<table>
<thead>
<tr>
<th>Block</th>
<th>Variable</th>
<th>$df$</th>
<th>$F$</th>
<th>$B$ at Final Step</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$R^2$ Change</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8.26</td>
<td>.180</td>
<td>.065</td>
<td>.057</td>
<td>---</td>
<td>.199</td>
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<tr>
<td>Block 2</td>
<td>Gender Norms</td>
<td>118</td>
<td>4.09</td>
<td>-.065</td>
<td>.065</td>
<td>.049</td>
<td>.000</td>
<td>.641</td>
</tr>
<tr>
<td>Block 3</td>
<td>Partner Norms</td>
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<td>13.72</td>
<td>.462</td>
<td>.260</td>
<td>.241</td>
<td>.195</td>
<td>.000</td>
</tr>
</tbody>
</table>
Table 6.

*Summary of Hierarchical Regression Analyses for Differential Referent Norms Predicting Intent to Discuss Sexual History with One’s Partner (N = 121)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>df</th>
<th>F</th>
<th>B at Final Step</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$R^2$ Change</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic Norms</td>
<td>119</td>
<td>15.38</td>
<td>.315</td>
<td>.114</td>
<td>.107</td>
<td>---</td>
<td>.029</td>
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<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Norms</td>
<td>118</td>
<td>7.66</td>
<td>-.090</td>
<td>.115</td>
<td>.100</td>
<td>.001</td>
<td>.531</td>
</tr>
<tr>
<td>Block 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner Norms</td>
<td>117</td>
<td>11.31</td>
<td>.346</td>
<td>.225</td>
<td>.205</td>
<td>.110</td>
<td>.000</td>
</tr>
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</table>
Hypothesis 3: Perception of a sex-ratio imbalance, operationalized as perceiving male romantic/sexual partners as limited, will moderate the impact of personal attitude toward behavior on intention to engage in health promoting behavior.

Hypothesis 3 was tested using multiple regression procedures described by Baron and Kenny (1986). Analyses revealed that the relationship between attitudes and intent to be tested regularly for STDs was not significantly moderated by perceptions of a sex-ratio imbalance although there was a trend toward significance (R = .304, \( R^2 = .093 \), F(3,119), p<.086). The relationship between attitudes and intent to use condoms regularly was not significantly moderated by perceptions of a sex-ratio imbalance (R = .557, \( R^2 = .311 \), F(3,120), p<.323). Finally, the relationship between attitudes and intent to discuss sexual history with one’s partner was also not significantly moderated by perception of a sex-ratio imbalance (R = .222, \( R^2 = .049 \), F(3,117), p<.658). Thus, this hypothesis was not supported.

Hypothesis 4: Relationship intimacy will moderate intention to engage in health promoting behavior.

Hypothesis 4 was also tested using multiple regression procedures outlined by Baron and Kenny (1986). The relationship between perceived partner norms and intent to be regularly tested for STDs was moderated by relationship intimacy (R = .421, \( R^2 = .177 \), F(3,117), p<.058). Perceived partner norms and intent to use condoms regularly was also moderated by relationship intimacy (R = .601, \( R^2 = .361 \), F (3, 118), p<.001). Contrary to the hypothesis, perceived partner norms and intent to discuss one’s partner’s sexual history was not moderated by relationship intimacy (R = .440, \( R^2 = .193 \), F (3,117), p<.951). Therefore, this hypothesis was only partially supported.
CHAPTER 4
DISCUSSION

This study sought to evaluate the components of Fishbein and Ajzen’s (1975) theory of reasoned action in relation to sexual health-promoting behavior among African American women. This social cognitive theory explains behavioral decisions as a function of intention to perform a particular act, with intention determined by one’s attitude toward the behavior as well as perceptions of normative pressure to perform the behavior. Previous researchers in this area have evaluated this model in relation to condom use among a variety of populations with significant findings (Bosompra, 2001; Diaz-Loving & Villagran-Vasquez, 1999; Chitamun & Finchilescu, 2003; Wilson, Zenda, & Lavelle, 2001; Albarracin, Johnsom, Fishbein, & Muellerleile, 2001). Given that condom use is only one of a number of behaviors that can reduce one’s sexual risk, it seemed relevant to broaden our scope of sexual health-promoting behavior to include other such actions, such as being regularly tested for STDs and discussing sexual history with one’s partner. The current study sought to expand on the evaluation of sexual risk-taking behavior by considering these sexual health-promoting behaviors in addition to condom use.

In applying this social psychological model to African American women, it was important to extend the social comparison component of the theory (referent norms) so as to elucidate the differential importance of the multiple normative influences members of this demographic may consider in sexual decision-making (i.e. ethnic, gender, sexual partner). Sociocultural issues specific to this demographic were also incorporated into the current evaluation of factors related to health-promoting versus risk-taking behavior.
Specifically, the role of relationship intimacy as well as the extent to which African American women perceive an imbalance in the ratio of sexual partners available to men as opposed to women, were examined along with their impact on attitude and intention to engage in sexual health-promoting behavior.

*Analysis of Revealed Factors*

Confirmatory factor analyses revealed noteworthy demarcations in the manner in which attitude, intention, and behavior were optimally studied within this data set. Results suggested that while attitude (positive/negative) toward condom use, STD testing, and discussing sexual history could be evaluated as falling under one construct; these three facets were best evaluated separately when appraising the constructs of intention and behavior. This suggests that women within this sample may not distinguish between their attitudes toward *specific* sexual health-promoting behaviors but may view these behaviors as *generally* positive or negative courses of action. Thus, a negative attitude toward one behavior within this domain may be predictive of a globally negative attitude toward sexual health-promoting behavior. While further inquiry into this phenomenon is needed, it could suggest the importance of greater efforts to assist African American women in recognizing the distinct costs and benefits of various sexual health related behaviors.

Interestingly, however, African American women in this study did distinguish between the three behaviors of interest when considering their intentions and the extent to which they performed these behaviors. This distinction implicates the presence of unexamined cognitive factors that may explicate the mechanisms through which African American women conceptualize their intention to engage in varying types of behavior.
Cognitive researchers in the area of sexual risk-taking have identified such factors as perceived self-efficacy and outcome expectancy beliefs as potential venues that may influence the extent to which women within this demographic plan and inevitably do or do not use condoms (Jemmott, et. al, 1995). It could be that these or other cognitive factors significantly impact the manner in which African American women differentially conceive of their likelihood of behaving in ways consistent with sexual health.

Evidence for Reasoned Action

The initial hypotheses in this study sought to examine the extent to which the tenets of the theory of reasoned action were supported in relation to sexual risk-taking behavior among collegiate African American women. The first aspect of hypothesis 1 was largely supported by the data, in that attitudes significantly predicted intention to receive regular STD testing, use condoms, and discuss sexual history with one’s partner. Additionally, two intentional subcomponents (regular STD testing and discussing sexual history) significantly predicted their corresponding behavioral subcomponents. It seems that for these two behaviors intent was indeed a salient cognitive factor valuable in determining the likelihood of the occurrence of these sexual risk-reducing behaviors. Intent to use condoms, however, did not significantly predict one’s report that condoms are regularly used. This occurrence may suggest that a qualitative distinction was made between condom use and the other behaviors assessed. Given the prevalence of the male condom as one of the more commonly used prophylactics, perhaps women within this sample distinguished between behaviors they directly control and those under the direct control of significant others.
Consistent with the premise of the theory of reasoned action, the second hypothesis sought to explore the importance of referent norms in predicting intention. In studying this relationship among African American women, the differential ability of referent norms to predict intention was evaluated. Analyses revealed that perception of one’s partner’s beliefs predicted one’s intention consistently more than did perception of ethnic and/or gender norms. This finding corresponds with literature in the area of condom use, noting that normative beliefs of sexual partners are significant predictors of condom use among African American women (Jemmott & Jemmott, 1991). In fact, perception of gender norms was reliably the least predictive across intentional subcomponents. Such trends may underscore the distinct influence that perceived romantic partners’ beliefs may exert over personal intentions related to sexual behavior for African American women. The data could loosely suggest that women in dyads in which they and their partner disagree about the relevance or importance of sexual health-promoting behavior may be more likely to intend to behave and therefore behave in ways consistent with their partner’s beliefs. While this link is beyond the scope of the current study, it lends directions for future research in this area. Notably, within this sample, women’s attitudes were significantly correlated with their perception of their partners’ attitudes about the assessed behaviors.

The third hypothesis examined the extent to which perception of a sex-ratio imbalance moderated the impact of attitude on intention. This hypothesis was not supported by the data. Despite including a number of face valid items, this subscale had the least internal reliability of those created. It could be that this measure did not have sufficient inter-item reliability to detect a significant moderation effect (Hu & Bentler,
Additionally, the sample size may not have provided enough power to detect a statistical relationship of this kind. Even with these limitations, perception of a sex-ratio imbalance was inversely correlated with perceptions of positive partner beliefs as well as discussing sexual history with one’s partner. One possibility is that women who perceive partner availability as limited are those less likely to be involved in intimate relationships and thus could feel less comfortable initiating a discussion about sexual history.

The final hypothesis sought to gauge the degree to which relationship intimacy moderated the impact of perception of partner’s belief on intention. This hypothesis was partially supported in that an effect was seen between perception of partner’s beliefs and intent to be tested for STDs as well as intent to use condoms. However, relationship intimacy did not significantly moderate the impact of perception of partner’s beliefs and intent to discuss sexual history with one’s partner. Furthermore, perception of partner’s beliefs was both positively associated with and highly predictive of intent to discuss sexual history. Perhaps relationship intimacy is not a strong enough moderator to impact the strong relationship between these two variables.

Taken together, the information gathered in this study generally supports the notion of reasoned action for this population in relation to sexual risk-taking behavior. These results add to the current literature in that the consideration of relevant sociocultural factors yielded information regarding culturally specific issues that may impact the decision making of African American women. In examining the cognitive antecedents of multiple behaviors, this study provides a wealth of information geared toward understanding the mechanisms through which cognitive processes differentially impact sexual health-related behaviors (e.g. intent to be tested for STDs predicted
reported testing, yet intent to use condoms did not predict reported condom use). While these outcomes certainly lend directions for future research, let us first explore the limitations of the current study.

Limitations

Several limitations may have affected the strength and external validity of certain findings within this study. First, although no statistically significant differences were found between women attending different schools, it could be that the number of participants from UGA was not enough to detect less prominent differences that may be present. Given the disproportionate amount of women sampled from Spelman College, these findings are likely more representative of psychological relationships present for African American women at Historically Black Colleges and Universities than they are for other African American women. A second limitation could be the limited sample size. While the sample was sufficient to yield significant main effects, more participants would have provided greater variance on measures assessing moderation effects [i.e. MSIS (relationship intimacy) and SRPQ (perception of sex-ratio imbalance)], thus increasing the likelihood of detecting the presence of significant relationships. Third, given the private nature of the behaviors assessed in this study, self-report was utilized to determine the extent to which sexual health-promoting behaviors occurred for these women. This information-gathering technique is limited in that it is susceptible to inaccurate self-monitoring as well as the reporting of socially-desirable behavior.

Implications/Future Research

The present research illustrates the importance of attitudes as well as the differential importance of referent norms in predicting intention to engage in a number of
sexual health-related behaviors. These findings implicate the notion that risk-reducing interventions might benefit from not only targeting women’s personal attitudes but perhaps more importantly, their perceptions of their partner’s attitudes. Additionally, this research suggests that assisting women in planning to use condoms may not translate into actual use of these items. As such, the aim of future research in this area must be to determine the factors that offset some African American women’s intention to engage in this health-promoting behavior. Potential determinants explored in the literature are perceived self-efficacy and predicted outcome, however these have not been explored with this population. These factors must be further examined in relation to African American women, given their disproportionate risk of contracting HIV/AIDS and other STDs, if we as social scientists are to make significant strides toward decreasing risk within this demographic.
REFERENCES


APPENDIX A

CONSENT FORM (UGA)

I agree to participate in the research study titled, Attitudes about Dating Relationships, which is being conducted by Jamylah Dunn, Department of Psychology, (706) 542-1173. I understand that my participation is entirely voluntary; and I can withdraw my consent at any time without penalty and have the results of this participation, to the extent that it can be identified as mine, returned to me, removed from my research records, or destroyed. If I would like to learn about the results of this study, I may contact Jamylah Dunn by mailing a letter requesting the results of the study entitled Attitudes about Dating Relationship. I will include my name and permanent address in the letter. This researcher can be reached at the following address: Department of Psychology, Psychology Building, The University of Georgia, Athens, GA 30602. If I have concerns about this study, I can also contact the researcher’s faculty advisor, Dr. Lily McNair, at the following address: Associate Provost of Research, Spelman College, 350 Spelman Lane, S.W. Box 2022, Atlanta, GA 30314.

The following points have been explained to me:

1.) The reason for this study is to gain a better understanding of the relationship between attitudes about dating relationships and behavior within dating relationships. This is an important question in order to have a greater sense of the impact of social forces upon certain sexual experiences, and how this may affect potential intervention and prevention approaches.

2.) The procedure will be as follows: I will respond to a series of questionnaires and return them to the researcher when completed. This questionnaire will take approximately 45 minutes to one hour to complete. In order to make this study a valid one, some information about my participation and the purpose of this study will be withheld until after the study.

3) The discomforts and stresses that I may face during this research are: I may be asked to provide personal and possibly upsetting information in order to complete the questionnaires. Specifically, I will be asked about sexual attitudes and behavior. Also, I may face some discomfort or stress as a result of some information about my participation being withheld until after the study. I recognize that I can skip items that cause me undue stress.

4) No risks are foreseen. If I do become uncomfortable or distressed, I will be able to withdraw from the study without losing RP Pool credit. If I would like to receive mental health services, I can contact the University of Georgia Psychology Clinic at (706) 542-1173 or ask the researcher for other referrals.

5) My responses to this study will be confidential, and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law.

6) The researcher will answer any further questions about the research, now or during the course of the study.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

Jamylah K. Dunn, M.S.

Name of Researcher __________________________ Signature __________ Date __________

Telephone: (706) 542-1173
Email: jdunn3@uga.edu

Name of Participant __________________________ Signature __________ Date __________

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

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, 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

CONSENT FORM (Spelman)

I agree to participate in the research study titled, Attitudes about Dating Relationships, which is being conducted by Jamylah Dunn, Department of Psychology, (706) 542-1173. I understand that my participation is entirely voluntary; and I can withdraw my consent at any time without penalty and have the results of this participation, to the extent that it can be identified as mine, returned to me, removed from my research records, or destroyed. If I would like to learn about the results of this study, I may contact Jamylah Dunn by mailing a letter requesting the results of the study entitled Attitudes about Dating Relationship. I will include my name and permanent address in the letter. This researcher can be reached at the following address: Department of Psychology, Psychology Building, The University of Georgia, Athens, GA 30602. If I have concerns about this study, I can also contact the researcher’s faculty advisor, Dr. Lily McNair, at the following address: Associate Provost of Research, Spelman College, 350 Spelman Lane, S.W. Box 2022, Atlanta, GA 30314.

The following points have been explained to me:

3.) The reason for this study is to gain a better understanding of the relationship between attitudes about dating relationships and behavior within dating relationships. This is an important question in order to have a greater sense of the impact of social forces upon certain sexual experiences, and how this may affect potential intervention and prevention approaches.

4.) The procedure will be as follows: I will respond to a series of questionnaires and return them to the researcher when completed. This questionnaire will take approximately 45 minutes to one hour to complete. In order to make this study a valid one, some information about my participation and the purpose of this study will be withheld until after the study.

3) The discomforts and stresses that I may face during this research are: I may be asked to provide personal and possibly upsetting information in order to complete the questionnaires. Specifically, I will be asked about sexual attitudes and behavior. Also, I may face some discomfort or stress as a result of some information about my participation being withheld until after the study. I recognize that I can skip items that cause me undue stress.

7) No risks are foreseen. If I do become uncomfortable or distressed, I will be able to withdraw from the study. If I would like to receive mental health services, I can contact Counseling Services, MacVicar Hall, (404) 270-5293 or Health Services, MacVicar Hall, (404) 270-5249 or ask the researcher for other referrals.

8) My responses to this study will be confidential, and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law.

9) The researcher will answer any further questions about the research, now or during the course of the study.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

Jamylah K. Dunn, M.S.
Name of Researcher ____________________________ Signature ____________________________ Date ____________________________
Telephone: (706) 542-1173
Email: jdunn3@uga.edu

Name of Participant ____________________________ Signature ____________________________ Date ____________________________

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

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu
DEMOGRAPHICS QUESTIONNAIRE

1. Age _____

2. Sex:  Female___ Male ___

3. Year in college:  ___Freshman  
                   ___Sophomore  
                   ___Junior  
                   ___Senior  

4. Ethnic Identity:  Please check all that apply.  
_______________________Black or African American  
_______________________Asian  
_______________________White  
_______________________Hispanic or Latino  
_______________________Native American or Other Pacific Islander  
_______________________American Indian or Alaskan Native  

5. Sexual Orientation  
_______________________Bisexual  
_______________________Heterosexual  
_______________________Homosexual  
_______________________Other  

6. Are you a member of a fraternity or sorority?  ___Yes  ___ No  

7. Are you currently in a monogamous dating relationship?  ___Yes  ___ No  
   a. If yes, how long have you been dating this person?  ____________  
   b. If no, how many dating partners do you presently have?  ____________
### MILLER SOCIAL INTIMACY SCALE

(MSIS; Miller & Lefcourt, 1982)

<table>
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<th>Very Rarely</th>
<th>Some of the Time</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you have leisure time how often do you choose to spend it with him/her alone?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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<td></td>
</tr>
<tr>
<td>How often do you keep very personal information to yourself and do not share it with him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you show him/her affection?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you confide very personal information to him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often are you able to understand his/her feelings?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel close to him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
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<th>A Little</th>
<th>A Great Deal</th>
</tr>
</thead>
<tbody>
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<td>How much do you like to spend time alone with him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How close do you feel to him/her most of the time?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How important is it to you to listen to his/her very very personal disclosures?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How satisfying is your relationship with him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How affectionate do you feel towards him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How important is it to you that he/she understands your feelings?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much damage is caused by a typical disagreement in your relationship with him/her?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How important is it to you that he/she be encouraging and supportive to you when you are unhappy?</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How important is it to you that he/she show you affection?</td>
<td>1-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How important is your relationship with him/her in your life?</td>
<td>1-10</td>
<td></td>
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</tbody>
</table>
APPENDIX E

RACIAL IDENTITY ATTITUDE SCALE

(RIAS; Parham, T.A. & Helms, J.E., 1985)

In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Mexican-American, Hispanic, Black, Asian-American, American Indian, Anglo-American, and White. Every person is born into an ethnic group, or sometimes two groups, but people differ on how important their ethnicity is to them, how they feel about it, and how much their behavior is affected by it. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in:

In terms of ethnic group, I consider myself to be ________________________________.

Use the numbers given below to indicate how much you agree or disagree with each statement.

4: Strongly Agree 3: Somewhat Agree 2: Somewhat Disagree 1: Strongly Disagree

1. I have spent time trying to find out more about my own ethnic group, such as its history, tradition, and customs. ____

2. I am active in organizations or social groups that include mostly members of my own ethnic group. ____

3. I have a clear sense of my ethnic background and what it means for me. ____

4. I like meeting and getting to know people from ethnic groups other than my own. ____

5. I think a lot about how my life will be affected by my ethnic group membership. ____

6. I am happy that I am a member of the group I belong to. ____

7. I sometimes feel it would be better if different ethnic groups didn't try to mix together. ____

8. I am not very clear about the role of my ethnicity in my life. ____

9. I often spend time with people from ethnic groups other than my own. ____

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10. I really have not spent much time trying to learn more about the culture and history of my ethnic group. 

11. I have a strong sense of belonging to my own ethnic group. 

12. I understand pretty well what my ethnic group membership means to me, in terms of how to relate to my own group and other groups. 

13. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group. 

14. I have a lot of pride in my ethnic background, I have often talked to other people about my ethnic group. 

15. I don't try to become friends with people from other ethnic groups. 

16. I participate in cultural practices of my own group, such as special food, music or customs. 

17. I am involved in activities with people from other ethnic groups. 

18. I feel a strong attachment towards my own ethnic group. 

19. I enjoy being around people from ethnic groups other than my own. 

20. I feel good about my cultural or ethnic background. 

Write in the number that gives the best answer to each question.

21. My ethnicity is 
   (1) Asian  
   (2) Black or African American  
   (3) Hispanic or Latino  
   (4) White  
   (5) American Indian or Alaska Native  
   (6) Mixed, parents are from two different groups 

22. My father's ethnicity is (use numbers above) 

23. My mother's ethnicity is (use numbers above) 

53
The following questions are related to your assumptions and beliefs with respect to sexual behavior. Some questions will require you to consider your sexual partner. Please think of your current or most recent sexual partner when responding to these questions. The phrase ‘sexual/medical history’ is used in a number of questions. This phrase relates to the degree to which condoms have been used in previous relationships and whether one has ever been diagnosed with a sexually transmitted disease (STD). Please place an ‘X’ on the line consistent with your belief.

1. How often are you tested for sexually transmitted diseases?
   - more than twice a year
   - once every six months
   - once a year
   - once every couple of years
   - once in my life
   - never

2. Currently, how frequently do you use condoms when you engage in sexual activity?
   - every time
   - almost every time
   - most times
   - about half of the time
   - sometimes but less than half
   - once in a while
   - never

3. With how many partners have you discussed your partner’s sexual/medical history with them prior to engaging in sexual activity?
   - every partner
   - almost every partner
   - most partners
   - about half of my partners,
   - some partners but less than half
   - a few partners
   - no partners.

4. Of your most recent sexual encounters, please estimate how many times you or your partner used condoms?
   Number of recent sexual encounters:____
   Number of times a condom was used:____
5. Of your total sexual partners (past and present), with how many have you discussed their sexual history with them prior to engaging in sexual activity? For example, if you have had 7 partners and have discussed their history with 2, your response would be 2/7.
Discussed: ____
Total: ____

6. Of the time you have been sexually active (since losing your virginity), please estimate how many times you have been tested for sexually transmitted diseases?
Length of time sexually active (i.e. # of years or months): ______
Number of times you have been tested for STDs (including HIV/AIDS): ______

On the following questions please place an ‘X’ on the line that best reflects the degree to which you have engaged in the following activities.

7. Please estimate how often you have been regularly (as defined as once every 6 months) tested for sexually transmitted diseases:
never:_____:_____:_____:_____:_____:_____:_____:always.

8. In your sexual relationships, please estimate how often you have discussed your partner’s sexual history with them prior to engaging in sexual activity [or within the context of your relationship]:
never:_____:_____:_____:_____:_____:_____:_____:always.

9. In your sexual relationships, please estimate how often you or your partner have used condoms:
never:_____:_____:_____:_____:_____:_____:_____:always.

10. For me, discussing my partner’s sexual/medical history with them prior to engaging in sexual activity would be: (please respond to all three lines)
harmful:_____:_____:_____:_____:_____:_____:_____:beneficial
pleasant:_____:_____:_____:_____:_____:_____:_____:unpleasant
worthless:_____:_____:_____:_____:_____:_____:_____:valuable
11. For me, being tested regularly (as defined as once every 6 months) for sexually transmitted diseases would be: (please respond to all three lines)

harmful:____:____:____:____:____:____:____:beneficial

pleasant:____:____:____:____:____:____:____:unpleasant

worthless:____:____:____:____:____:____:____:valuable

12. For me, using condoms every time I engage in sexual activity would be: (please respond to all three lines)

harmful:____:____:____:____:____:____:____:beneficial

pleasant:____:____:____:____:____:____:____:unpleasant

worthless:____:____:____:____:____:____:____:valuable

13. For me, using a condom on my next sexual encounter would be: (please respond to all three lines)

harmful:____:____:____:____:____:____:____:beneficial

pleasant:____:____:____:____:____:____:____:unpleasant

worthless:____:____:____:____:____:____:____:valuable

14. Most African American women who are important to me think that I should:____:____:____:____:____:____:____:should not be tested regularly (as defined as once every 6 months) for sexually transmitted diseases.

15. I believe my sexual partner thinks that we should:____:____:____:____:____:____:____:we should not discuss our sexual/medical history prior to engaging in sexual activity.

16. I intend to discuss my partner’s sexual history prior to continuing to engage in sexual activity:

extremely unlikely:____:____:____:____:____:____:____:extremely likely.

17. Most African Americans who are important to me think that I should:____:____:____:____:____:____:____:should not discuss my partner’s sexual history with them prior to engaging in sexual activity.

18. I believe my sexual partner thinks that we should:____:____:____:____:____:____:____:we should not use condoms every time I engage in sexual activity.
19. Most African American women who are important to me think that
   I should: _____:_____:_____:_____:_____:_____:_____:should not discuss
   my partner’s sexual history with them prior to engaging in sexual activity.

20. Others expect me to discuss my partner’s sexual history with them prior to
    engaging in sexual activity with them:
    extremely likely:____:____:____:____:____:____:____:extremely unlikely.

21. Others expect me to be tested regularly (as defined as once every 6 months) for
    sexually transmitted diseases:
    extremely likely:____:____:____:____:____:____:____:extremely unlikely.

22. Most African American women who are important to me think that
    I should:____:____:____:____:____:____:____:should not use
    condoms every time I engage in sexual activity.

23. Others expect me to use condoms every time I engage in sexual activity:
    extremely likely:____:____:____:____:____:____:____:extremely unlikely.

24. Most African American women who are important to me think that
    I should:____:____:____:____:____:____:____:should not use a
    condom during my next sexual encounter.

25. Others expect me to use condoms during my next sexual encounter:
    extremely likely:____:____:____:____:____:____:____:extremely unlikely.

26. The people in my life whose opinions I value would:
    approve:____:____:____:____:____:____:____:disapprove of my
    being tested regularly (as defined as once every 6 months) for sexually
    transmitted diseases.

27. I believe my sexual partner thinks that
    we should:____:____:____:____:____:____:____:we should not be
    tested regularly (as defined as once every 6 months) for sexually transmitted
diseases.

28. The people in my life whose opinions I value would:
    approve:____:____:____:____:____:____:____:disapprove of my
    using condoms every time I engage in sexual activity.

29. I believe my sexual partner thinks that
    we should:____:____:____:____:____:____:____:we should not use a
    condom on our next sexual encounter.
30. Most people who are important to me discuss their partner’s sexual history with them prior to engaging in sexual activity:
   completely true:____:____:____:____:____:____:____:completely false.

31. I plan to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases:
   strongly agree:____:____:____:____:____:____:____:strongly disagree.

32. The people in my life whose opinions I value would:
   approve:____:____:____:____:____:____:____:disapprove of my discussing my partner’s sexual history with them prior to engaging in sexual activity.

33. Most people who are important to me use condoms every time they engage in sexual activity:
   completely true:____:____:____:____:____:____:____:completely false.

34. Most African Americans who are important to me think that
   I should:____:____:____:____:____:____:____:should not be tested regularly (as defined as once every 6 months) for sexually transmitted diseases.

35. Most people who are important to me will use a condom on their next sexual encounter:
   completely true:____:____:____:____:____:____:____:completely false.

36. The people in my life whose opinions I value discuss:
   discuss:____:____:____:____:____:____:____:do not discuss their partner’s sexual history with them prior to engaging in sexual activity.

37. The people in my life whose opinions I value get:
   get:____:____:____:____:____:____:____:do not get tested regularly (as defined as once every 6 months) tested for sexually transmitted diseases.

38. Most African Americans who are important to me think that
   I should:____:____:____:____:____:____:____:should not use condoms every time I engage in sexual activity.

39. The people in my life whose opinions I value use:
   use:____:____:____:____:____:____:____:do not use condoms every time they engage in sexual activity.
40. I intend to discuss my partner’s sexual history prior to initially engaging in sexual activity:
   extremely likely: _____: _____: _____: _____: _____: _____: _____: extremely unlikely.
If you have already begun having sex with a current partner, please answer in relation to your intention with a new partner.

41. The people in my life whose opinions I value would:
   approve: _____: _____: _____: _____: _____: _____: _____: disapprove of my using a condom on my next sexual encounter.

42. Most African Americans who are important to me think that
   I should: _____: _____: _____: _____: _____: _____: _____: should not use a condom on my next sexual encounter.

43. Most people who are important to me get tested regularly (as defined as once every 6 months) for sexually transmitted diseases:
   completely true: _____: _____: _____: _____: _____: _____: _____: completely false.

44. I intend to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases:
   extremely likely: _____: _____: _____: _____: _____: _____: _____: extremely unlikely.

45. I will try to discuss my partner’s sexual history prior to initiating or continuing to engage in sexual activity:
   definitely true: _____: _____: _____: _____: _____: _____: _____: definitely false.

46. I will try to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases:
   definitely true: _____: _____: _____: _____: _____: _____: _____: definitely false.

47. I will try to use a condom on my next sexual encounter:
   definitely true: _____: _____: _____: _____: _____: _____: _____: definitely false.

48. I plan to discuss my partner’s sexual history prior to initiating or continuing to engage in sexual activity:
   strongly agree: _____: _____: _____: _____: _____: _____: _____: strongly disagree.

49. The people in my life whose opinions I value will use: _____: _____: _____: _____: _____: _____: _____: will not use a condom on their next sexual encounter.

50. I plan to use condoms every time I engage in sexual activity:
   strongly agree: _____: _____: _____: _____: _____: _____: _____: strongly disagree.

51. I intend to use condoms every time I engage in sexual activity:
   extremely likely: _____: _____: _____: _____: _____: _____: _____: extremely unlikely.
52. I plan to use a condom on my next sexual encounter:
   strongly agree:____:____:____:____:____:____:____:strongly disagree.

53. I intend to use a condom on my next sexual encounter:
   extremely likely:____:____:____:____:____:____:____:extremely unlikely.
APPENDIX G

SEX-RATIO PERCEPTION QUESTIONNAIRE

(SRPQ; Dunn & McNair, 2004)

The following questions are related to your beliefs regarding heterosexual dating options in your community or social network. Please place an ‘X’ on the line consistent with your belief.

1. I have dating options within my race.
   true:____:____:____:____:____:____:____:false

2. Once a relationship ends, it is
easy:___:___:___:___:___:___:___:difficult to find another suitable mate.

3. In the ‘dating pool,’ there are more available women than men.
   true:___:___:___:___:___:___:___:false

4. I feel I need to date outside my race in order to find a suitable partner.
   true:___:___:___:___:___:___:___:false

5. I find it fairly easy:___:___:___:___:___:___:___:fairly difficult to find someone to partner with.

6. In the ‘dating pool,’ there are more available men than women.
   true:___:___:___:___:___:___:___:false

7. I am very rarely:___:___:___:___:___:___:___:very often concerned that there are ‘not enough men’ to go around.

8. I feel that males in my community/social network have significantly more:___:___:___:___:___:___:___:significantly fewer dating options than do females.

9. Women with qualities similar to mine are very likely:___:___:___:___:___:___:___:very unlikely to find a suitable mate.

10. Regardless of personal qualities, males are more likely:___:___:___:___:___:___:___:less likely to find a suitable mate.
Thank you for your participation in the study entitled *Attitudes about Dating Relationships*. It is very important that you do not share information about this study with your classmates because they may participate in the future. Your cooperation with this policy is greatly appreciated.

The purpose of this study was to explore the relationship between personal attitudes and intentions on sexual health promoting behavior. Previous research suggests that perceptions of the attitudes of normative groups may influence to extent to which personal attitudes predict intention to engage in health promoting behavior. This research sought to examine the extent to which perceptions of ethnic, gender, and partner norms differentially impact intention to engage in sexual health promoting behavior. The aim of this study is to elucidate social and cultural factors that may contribute to sexual risk-taking in the context of relationships for African American women. The questionnaires were used to assess these factors.

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.

If you would like to learn about the results of this study, please contact Jamylah Dunn by mailing a letter requesting the results of the study entitled *Attitudes about Dating Relationships*. Please include your name and permanent address in the letter. The researcher can be reached at the following address:

Department of Psychology  
Psychology Building  
University of Georgia  
Athens, GA 30602

If you have any additional questions regarding this study, please contact Jamylah Dunn at (706) 542-1173. Once again, thank you for your participation.
Thank you for your participation in the study entitled *Attitudes about Dating Relationships*. It is very important that you do not share information about this study with your classmates because they may participate in the future. Your cooperation with this policy is greatly appreciated.

The purpose of this study was to explore the relationship between personal attitudes and intentions on sexual health promoting behavior. Previous research suggests that perceptions of the attitudes of normative groups may influence to extent to which personal attitudes predict intention to engage in health promoting behavior. This research sought to examine the extent to which perceptions of ethnic, gender, and partner norms differentially impact intention to engage in sexual health promoting behavior. The aim of this study is to elucidate social and cultural factors that may contribute to sexual risk-taking in the context of relationships for African American women. The questionnaires were used to assess these factors.

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 Counseling Services, MacVicar Hall, (404) 270-5293 or Health Services, MacVicar Hall, (404) 270-5249.

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APPENDIX J.

ITEMS WITHIN SUBCOMPONENTS OF MAIN VARIABLES

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHRA: Sexual Health Related Attitudes</strong></td>
</tr>
<tr>
<td>• For me, using condoms every time I engage in sexual activity would be: harmful…beneficial.</td>
</tr>
<tr>
<td>• For me, using condoms every time I engage in sexual activity would be: pleasant…unpleasant.</td>
</tr>
<tr>
<td>• For me using condoms every time I engage in sexual activity would be: worthless…valuable.</td>
</tr>
<tr>
<td>• For me, being tested regularly (as defined as once every 6 months) for sexually transmitted diseases would be: pleasant…unpleasant.</td>
</tr>
<tr>
<td>• For me, discussing my partner’s sexual/medical with them prior to engaging in sexual activity would be: pleasant…unpleasant.</td>
</tr>
<tr>
<td><strong>SHRN: Sexual Health Related Norms (Ethnic)</strong></td>
</tr>
<tr>
<td>• Most African Americans who are important to me think I should…should not discuss my partner’s sexual history with them prior to engaging in sexual activity.</td>
</tr>
<tr>
<td>• Most African Americans who are important to me think that I should…should not be tested regularly (as defined by once every 6 months) for sexually transmitted diseases.</td>
</tr>
<tr>
<td>• Most African Americans who are important to me think that I should…should not use condoms every time I engage in sexual activity.</td>
</tr>
<tr>
<td>• Most African Americans who are important to me think that I should…should not use a condom on my next sexual encounter.</td>
</tr>
<tr>
<td><strong>SHRN: Sexual Health Related Norms (Gender)</strong></td>
</tr>
<tr>
<td>• Most African American women who are important to me think I should…should not be tested regularly (as defined as once every 6 months) for sexually transmitted diseases.</td>
</tr>
<tr>
<td>• Most African American women who are important to me think that I should…should not discuss my partner’s sexual history with them prior to engaging in sexual activity.</td>
</tr>
<tr>
<td>• Most African American women who are important to me think that I should…should not use condoms every time I engage in sexual activity.</td>
</tr>
<tr>
<td>• Most African American women who are important to me think that I should…should not use a condom during my next sexual encounter.</td>
</tr>
<tr>
<td><strong>SHRN: Sexual Health Related Norms (Partner)</strong></td>
</tr>
<tr>
<td>• I believe my sexual partner thinks that we should…we should not discuss our sexual/medical history prior to engaging in sexual activity.</td>
</tr>
<tr>
<td>• I believe my sexual partner thinks that we should…we should not use condoms every time I engage in sexual activity.</td>
</tr>
<tr>
<td>• I believe my sexual partner thinks that we should…we should not be tested regularly (as defined as once every 6 months) for sexually transmitted diseases.</td>
</tr>
<tr>
<td>• I believe my sexual partner thinks that we should…we should not use a condom on our next sexual encounter.</td>
</tr>
<tr>
<td><strong>SHRI: Sexual Health Related Intentions (STDs)</strong></td>
</tr>
<tr>
<td>• I plan to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases: strongly agree…strongly disagree.</td>
</tr>
<tr>
<td>• I intend to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases: extremely likely…extremely unlikely.</td>
</tr>
<tr>
<td>• I will try to be regularly (as defined as once every 6 months) tested for sexually transmitted diseases: definitely true…definitely false.</td>
</tr>
</tbody>
</table>
**SHRI: Sexual Health Related Intentions (Condoms Use)**

- I will try to use a condom on my next sexual encounter: definitely true...definitely false.
- I plan to use condoms every time I engage in sexual activity: strongly agree...strongly disagree.
- I intend to use condoms every time I engage in sexual activity: extremely likely...extremely unlikely.
- I plan to use a condom on my next sexual encounter: strongly agree...strongly disagree.
- I intend to use a condom on my next sexual encounter: extremely likely...extremely unlikely.

**SHRI: Sexual Health Related Intentions (Sexual History)**

- I intend to discuss my partner’s sexual history prior to continuing to engage in sexual activity: extremely unlikely...extremely likely.
- I intend to discuss my partner’s sexual history prior to initially engaging in sexual activity: extremely likely...extremely unlikely.
- I will try to discuss my partner’s sexual history prior to initiating or continuing to engage in sexual activity: definitely true...definitely false.
- I plan to discuss my partner’s sexual history prior to initiating or continuing to engage in sexual activity: strongly agree...strongly disagree.

**SHRB: Sexual Health Related Behaviors (STDs)**

- How often are you tested for sexually transmitted diseases?
  - More than twice a year
  - Once every six months
  - Once a year
  - Once every couple of years
  - Once in my life
  - Never

- Please estimate how often you have been regularly tested (as defined as once every 6 months) tested for sexually transmitted diseases: never...always.

**SHRB: Sexual Health Related Behaviors (Condom Use)**

- Currently, how frequently do you use condoms when you engage in sexual activity?
  - Every time
  - Almost every time
  - Most times
  - About half of the time
  - Sometimes but less than half
  - Once in a while
  - Never

- In your sexual relationships, please estimate how often you or your partner have used condoms: never...always.

**SHRB: Sexual Health Related Behaviors (Sexual History)**

- With how many partners have you discussed your partner’s sexual/medical history with them prior to engaging in sexual activity?
  - Every partner
  - Almost every partner
  - Most partners
  - About half of my partners
  - Some partners but less than half
  - A few partners
  - No partners.

- In your sexual relationships, please estimate how often you have discussed your partner’s sexual history with them prior to engaging in sexual activity [or within the context of your relationship]: never...always.

**SRPQ: Sex-Ratio Perception Questionnaire**

- Once a relationship ends, it is easy...difficult to find another suitable mate.
- In the 'dating pool,' there are more available women than men. true...false
- I find it fairly easy...fairly difficult to find someone to partner with.
- In dating 'dating pool,' there are more available men than women. true...false
- I am very rarely...very often concerned that there are 'not enough men' to go around.
- I feel that males in my community/social network have significantly more...significantly fewer dating options than do females.
- Regardless of personal qualities, males are more likely...less likely to find a suitable mate.