

SOCIOCULTURAL INFLUENCES ON SEXUAL DECISION-MAKING IN  
BLACK FEMALE COLLEGE STUDENTS

by

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(Under the direction of Rosemary E. Phelps)

ABSTRACT

The present study was designed to investigate the influences of cultural, ethnic, demographic, and sexual-related factors on sexual decision-making. The sample for this study consisted of 82 Black women in undergraduate and graduate programs at 4 southern universities. Participants ranged in age from 18 to 34, with the majority of the participants aged 21 (20.7%) and 20 (13.4%).

Pearson Product-Moment correlation coefficients were calculated to investigate whether there were relationships between the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV and each of the following variables: ethnic identity, subjective stigma, and total number of partners. Results indicated that there was a statistically significant relationship between ethnic identity and the ability to refuse unwanted sexual activity and to prevent unwanted pregnancy, STDs, and HIV as well as subjective stigma and the ability to refuse unwanted sexual activity.

One-way ANOVAs were calculated to investigate whether differences existed in the ability to initiate sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV and each of the following variables: self-perceived

physical attractiveness, ever having or not having had an unwanted sexual outcome, and frequency of condom use. There was a significant difference in the ability to prevent unwanted pregnancy, STDs, and HIV and frequency of condom use; however, this statistical significance was most likely due to the similarity in the two variables.

Lastly, three multiple regressions were calculated to investigate which cultural, sexual, and self-evaluative variables were the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. There were no significant variables that predicted the ability to initiate wanted sexual activity or to prevent unwanted pregnancy, STDs, and HIV. Subjective stigma and ethnic identity were significant predictors of the ability to refuse unwanted sexual activity.

INDEX WORDS: Sexual Decision-Making, Black Women, Ethnic Identity, Subjective Stigma, Sexuality, College Students

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## CHAPTER I

### INTRODUCTION

Nothing triggers more debate than the topic of sexuality. Whether the effort is to define, promote, or control sexuality, there are a multitude of opinions. One does not have to look hard in the media to see how issues of sexuality are the center of controversy and the focus of national policy decisions (Travis & White, 2000). One possible reason for the controversy is that sexuality appears to be associated with "many of the social and public health concerns and challenges in the United States today" (di Mauro, 1995, p. 1). Sexual behavior is no longer just a personal matter between two people, but also a matter that can affect society in terms of unwanted pregnancies, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS).

Educators, doctors, policy makers, and parents have either attempted to promote abstinence or protect the sexual behavior of others. Their attempts have led to an increase in discussions about sexuality. Even though these constituencies may have different agendas for sexuality discussions, there has been increased recognition of the need for sexuality education, especially in schools (Irvine, 1994). According to the Sexuality Information and Education Council of the United States (SIECUS) (1999), 34 of the 50 states have mandated STD and/or HIV/AIDS education in public schools. Nineteen states require that public schools teach sex education. Moreover, the United States government has allocated funds to support abstinence only or no sex until marriage education

programs (SIECUS, 1999). With increased opportunities for receiving information, youth and adults are more knowledgeable about sexuality topics (Gutiérrez, Balassone, & Gillmore, 1992; Melchert & Burnett, 1990; Morrison, Baker, & Gillmore, 1994).

Despite greater awareness of methods to prevent sexually transmitted diseases, unwanted and teenage pregnancies, and HIV/AIDS, there are still alarmingly high numbers of these conditions. For example, The Centers for Disease Control and Prevention (CDC) (1997) report that over 12 million cases of sexually transmitted diseases occur in the United States every year. It is estimated that approximately 56 million adolescent and adult Americans have an incurable viral STD (SIECUS, 1997b). In addition, new treatments that have extended the lifespan of people living with the AIDS virus and delayed the progression of HIV to AIDS have had little impact on new diagnoses of HIV infection (CDC, 1998). The majority of the new HIV diagnoses are occurring among people who are infected heterosexually, who are between 13 to 24 years of age, people of color, and women (CDC, 1998, 1999).

In reviewing statistics on unwanted and teenage pregnancies, there is good news and bad news. The good news is that teenage pregnancy rates are declining (SIECUS, 1997a). However, the Alan Guttmacher Institute (1996) reported that the United States continues to have the highest teenage pregnancy rate of most developed countries, including England, Canada, the Netherlands, and Japan (as cited in SIECUS, 1997a). The live birth rate for teenage women in 1998 was 51 per 1,000 (Ventura, Mathews, & Curtin, 1999). Henshaw (1998) (as cited in CDC, 1999) found that in 1994 approximately 49% of pregnancies were unintended (i.e., the pregnant women surveyed either did not wish to be pregnant or planned to be pregnant at a later time).

These statistics would suggest that knowledge does not necessarily change sexual behavior. Increased knowledge about the risks of getting pregnant, an STD, or HIV/AIDS has not appeared to reduce high-risk sexual behavior (Donovan & Ross, 2000; Lehr, Dilorio, Dudley, & Lipana, 2000), increase positive attitudes toward condoms (Morrison et al., 1994), increase intentions to use condoms (Jemmott, Jemmott, Spears, Hewitt, & Cruz-Collins, 1992), or improve reliable use of birth control (Melchert & Burnett, 1990). Durlak (1997) (as cited in Vera & Reese, 2000) stated that sexual-risk prevention programs should include knowledge about sexual risk prevention strategies and how to communicate better with one's partner and family, teach behavioral skills in decision-making, address current beliefs about sexual behavior, and address relevant cultural issues.

#### Statement of the Problem

Sexual behavior can create risky consequences for everyone. Consequences of risky sexual behavior for women are quite severe. There can be unintended pregnancies and health risks associated with STDs. Due to few or no symptoms when women contract STDs, they may go untreated or treated with delay causing complications (e.g., infertility, reproductive cancers, pregnancy complications, other chronic diseases) (CDC, 1997; SIECUS, 1997a).

The most serious risky consequence of sexual behavior is HIV infection and AIDS; and women appear to be at great risk. According to the CDC (1998), rates of HIV infection have decreased slightly in men, but have increased in women. Also, heterosexual transmission, rather than intravenous (IV) drug use, now is the reason for the majority of new infections (Sikkema, 1998). Nowhere is this more evident than in

Black and Latina women who account for over 75% of HIV infection among women (CDC, 1999). Statistics are even more alarming for Black women, especially in the case of contracting HIV through heterosexual intercourse. For instance, in all of the AIDS diagnoses of Black women in 1996, 43% of those women were infected due to intravenous drug use, while 53% were infected by heterosexual intercourse (CDC, 1998).

Such statistics have given credence to researchers to use race or ethnicity as a predictor for higher rates of permissive or risky sexual behavior (e.g., Faryna & Morales, 2000; Johnson & Green, 1993; Weinberg & Williams, 1988). It is inappropriate to label women of color, particularly Black women, as a high-risk group for negative aspects of sexual behavior. The CDC has stated that “race and ethnicity are not risk factors, but do reflect social, economic, and cultural disparities that are associated with HIV transmission” (as cited in St. Lawrence, Eldridge, Reitman, Little, Shelby, & Brasfield, 1998, p. 8). Unfortunately, this type of labeling exists as well as long-standing myths and stereotypes about Black women’s sexuality. A major stereotype of Black women’s sexuality is that Black women are sexually promiscuous and irresponsible (Green, 1994; Staples, 1973; West, 1995).

Such generalizations about Black women can create negative outcomes, including adversely affecting their sexuality (Brega & Coleman, 1999; Christensen, 1988). Most significant is that Black women may internalize and accept the sexual stereotypes. This phenomenon can be described as subjective stigma. Subjective stigma is the level to which one “internalizes society’s negative stereotypes and attitudes about his or her stigmatized social group” (Brega & Coleman, 1999, p. 228). For example, Wyatt (1997) found that African American women agreed with sexual stereotypes about African

American women even though the stereotypes contradicted who they were. It would be beneficial to explore subjective stigma and its affect on Black women's sexual experiences.

In addition, studies that have used race or ethnicity as a risk factor have also considered Black women as a homogeneous group (Reid & Bing, 2000). The conceptualization of Black women as a homogeneous group fails to acknowledge differences that are found in the Black community (e.g., culture, economic background, religion) (Mays & Jackson, 1991; Reid & Bing, 2000; Wyatt, 1982).

Researchers have often perceived sexual behavior as a negative act; thus, anyone who is sexually active needs to be protected. This is only partially accurate. Sexual behavior is also considered a pleasurable activity, a significant part of affectionate relationships, and a means to procreate. Very few studies examine the positive aspects of sexual behaviors (e.g., investigating what aspects influence whether one participates in sexual behavior, the processes used to determine the decisions made about sexual activity) (di Mauro, 1995; Donovan & Ross, 2000). Some of the research has focused on such issues as sexual self-concept (Breakwell & Millward, 1997), sexual decisions (Quadagno, Sly, Harrison, Eberstein, & Soler, 1998), and sexual communication (Ward & Wyatt, 1994). In particular, sexual decision-making has been studied to determine what factors influence the decisions people make to engage in sexual activity and choose sexual partners (Christopher & Cate, 1985; Finkelstein & Brannick, 1997; Randolph & Winstead, 1988). Further studies are needed to examine the complexity of sexual decision-making, making sure to include both the positive aspects and risky consequences of sexual behavior.

In conclusion, few studies take into account the heterogeneity of racial and ethnic groups when examining sexuality issues. Furthermore, little research has focused on what influences sexual behavior and sexual decision-making among ethnic groups, especially women in these groups (Worth, 1989). While women can control methods to prevent unwanted pregnancies, when it comes to preventing STDs and HIV, women's options are abstinence and condom use (Morokoff, 2000). Both of these options dictate the need for women to make effective decisions, to be assertive, and to negotiate with their partners (Amaro, 1995; Kline, Kline, & Oken, 1992; Morokoff, 2000; Vera & Reese, 2000). These skills must be studied to better understand what factors influence the decisions women make to protect themselves from unwanted circumstances and to understand what skills women use to attain their sexual goals.

#### Purpose of the Study

The purpose of this study was to empirically examine factors that influence sexual decision-making in Black women. Specifically, this study explored sociocultural, ethnic, demographic, and sexual-related factors that can impact sexual decision-making. Measuring sexual assertiveness has been found to be a useful approach in understanding sexual decision-making (Morokoff, Quina, Harlow, Whitmire, Grimley, Gibson, & Burkholder, 1997). Morokoff (2000) defined sexual assertiveness as one's "ability to initiate wanted sexual activities, refuse unwanted sexual activities, and to protect oneself against unwanted pregnancy, and STDs" (p. 307-308). While many studies of sexual decision-making have included racially diverse populations, few have concentrated on a specific racial or ethnic group to examine within-group differences.

In this study, Black women were the population studied. A primary reason for choosing this population is the history of myths and stereotypes about Black female sexuality (Staples, 1973; Wyatt, 1997). In addition, physical attractiveness is a salient issue among Black women; and messages received may affect their self-perception and behavior. Such messages can also affect how Black women see themselves sexually and how they act sexually. This study attempted to add to the research exploring intragroup differences among Black women and how their cultural experiences influence their sexual decision-making. This can be an asset to sexuality research literature on Black women, and an example of how to expand the way in which researchers view all racial and ethnic groups.

#### Significance of the Study

Given the present concerns about sexuality, one would assume that researchers in psychology are addressing these issues. Hayes (1991) specifically encouraged counseling psychologists to contribute by conducting research that decreases the spread of HIV infection. Researchers in the field of counseling psychology have been pioneers in incorporating preventative (Hayes, 1991) and multicultural (Heppner, Casas, Carter, & Stone, 2000) perspectives in their theories, research, and practice. Thus, counseling psychologists are well-positioned to lead the way in understanding the dilemmas in sexuality issues as well as promoting healthy sexual relationships.

In reviewing the literature in major counseling psychology journals (i.e., Journal of Counseling Psychology, The Counseling Psychologist), counseling psychologists have had a good history of examining sexuality concerns. In 1975, The Counseling Psychologist devoted an entire issue to sex counseling. While most of the articles related

to treating sexual dysfunction, some of them provided information and recommendations on how to promote positive and healthy sexual experiences. For example, Peterson (1975) and Mann (1975) discussed the importance of considering social class, education, race and ethnicity, and religion when examining sexual activity and relationships. Furthermore, Wellbourne (1975) wrote about the need for “counselors” to take an active role in prevention and intervention in sexuality issues. There was also a recommendation to include sex education training for those currently in and training to be in the counseling psychology profession.

Today, there continues to be the call for counseling psychologists to take a more active interest in sexuality issues. Since the groundbreaking issue of The Counseling Psychologist, there has been little published regarding sexuality in terms of activity, health, and relationships. With the emergence of HIV and AIDS, there has been a small renewed interest in researching sexuality topics. Unfortunately most of these articles on sexuality are not empirical studies, but literature reviews, commentaries, and recommendations (Hayes, 1991; Hoffman, 1993; Werth, 1993). It appears that counseling psychologists are discussing the need for sexuality research, but are doing little to investigate this topic. Empirical studies of sexuality issues, especially sexual decision-making, can give a better understanding of what is necessary to improve the well-being of women’s sexual lives.

## Research Questions and Hypotheses

The present study investigated the following research questions and null hypotheses:

Research Question 1: *Are there differences among Black women on ethnic identity in their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant relationships between ethnic identity scores as measured by the Multigroup Ethnic Identity Measure (Roberts, Phinney, Mase, Chen, Roberts, & Romero, 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Research Question 2: *Are there differences among Black women across subjective stigma on their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant relationships between subjective stigma scores as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Research Question 3: *Does Black women's self-perceived physical attractiveness influence their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant differences in Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Research Question 4: *Is there a relationship between Black women's sexual behavior and contraceptive use history and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypotheses:

1. There will be no statistically significant relationships between the total number of sexual partners and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).
2. There will be no statistically significant differences between having unwanted sexual outcomes and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

3. There will be no statistically significant differences between frequency of condom use by Black women and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Research Question 5: *What cultural, sexual, and self-evaluative variables are the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV for Black women?*

Null Hypotheses:

1. The ability to initiate wanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).
2. The ability to refuse unwanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured

by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

3. The ability to prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

#### Definition of Terms

The following definitions are provided to clarify frequently used terms in this study:

1. Sexual decision-making: based on Morokoff et al.'s (1997) definition of sexual assertiveness, "the ability to initiate wanted sexual activity, refuse unwanted

sexual activity, and protect oneself from unwanted or unsafe sexual activity” (p. 307-308).

2. Subjective stigmatization: the extent to which one “internalizes society’s negative stereotypes and attitudes about his or her stigmatized social group” (Brega & Coleman, 1999, p. 228).
3. Sexuality: refers to the composition of one’s sexual activities, sexual identity, reproductive system, gender identity and sex role expectations, interpersonal relationships, and self and body image (Lister, 1986; Wilson, 1986).
4. Ethnic identity: how one interprets and understands his or her own ethnicity, including one’s self-identification as a group member, sense of belonging, and attitudes towards one’s group (Phinney, 1992; Phinney, 1996).
5. Black: an ethnic label used to identify a person of African descent from any country. African American, which is often interchangeably used with Black, will only be used to identify United States citizens of African descent.
6. Self-perceived physical attractiveness: a self-evaluation of how one feels about his or her external appearance, including body size.
7. Sexual intercourse: the specific sexual act that occurs when a penis penetrates a vagina.
8. Unwanted sexual outcomes: an unwanted pregnancy, a sexually transmitted disease, or HIV and AIDS as the result of sexual activity.
9. Contraceptive use: intentional use of a method to prevent pregnancy or prevent contracting a STD and HIV. This may include using a condom or hormonal contraceptives (e.g., birth control pill). Birth control is an alternative term for

contraception. In this study, the term birth control will identify methods that are used only to prevent pregnancy, such as birth control pills, hormonal implants (i.e., Norplant), and hormonal injections (i.e., Depo-Provera).

#### Delimitations

The following delimitations existed in this study:

1. It was delimited to Black women as the sample.
2. It was delimited to participants over 18 years of age.
3. It was delimited to women's heterosexual experiences.

#### Limitations

The limitations of this study were as follows:

1. The availability of normative data for the instruments used in this study was limited. Therefore, the results of this study must be interpreted with caution.
2. This study used a convenience sample of college students and may not be generalizable to Black women who are around the same age and not attending college.
3. The outcome of this study may have been influenced by the fact that participation in the study was on a volunteer basis.
4. Due to the controversial and sensitive nature of sexuality issues, social desirability may have influenced participants' responses, thus affecting the results of this study.

#### Assumptions

The basic assumptions that guided the conceptualization of this study included:

1. Black women are a heterogeneous group.

2. Responses on the self-report questionnaires would be anonymous. Anonymity reduces participant embarrassment and is more likely to garner honest participant responses.
3. Self-report questionnaires can measure the ability to initiate wanted sexual activity, the ability to refuse unwanted sexual activity, the ability to prevent unwanted pregnancy and STDs, ethnic identity, subjective stigma, and self-perceived physical attractiveness.
4. Ethnicity is a more useful factor than race as a variable in this study (Wyatt, 1991).

## CHAPTER II

### REVIEW OF THE LITERATURE

Due to the considerable diversity in the United States, there is a need to investigate what makes racial and ethnic groups similar and different. Hoffman and Driscoll (2000) state that while ethnicity may be relevant to race, it is also used to identify individuals who have a shared culture. Ethnicity and culture influence behavior patterns, one's self-perception, and the perception of others (Belgrave, Marin, & Chambers, 2000; Worth, 1990; Wyatt, 1991). Research indicates that sexuality is influenced by cultural and ethnic factors. When researchers include these factors in sexuality research "the overall context of sexual interactions and cultural mores and values are passed down from generation to generation" (Wyatt, 1991, p. 38).

There is a deficit in the literature regarding ethnicity and sexuality research. Wiederman, Maynard, and Fretz (1996) reviewed articles from 1971 to 1995 in the major sexuality research journals, the Journal of Sex Research and Archives of Sexual Behavior, to determine which articles reported ethnicity of participants, included ethnicity as a variable, and whether there was a change in the journals in the 25-year time frame. Though they found an increase in the literature between 1971 and 1995, very few articles existed regarding the relationship between ethnicity and sexuality.

Another concern regarding ethnicity and sexuality research is the use of ethnicity in studies. Too often ethnicity is used interchangeably with race, using such labels as African American rather than Black or European American rather than White. Ethnic

group membership becomes a single variable measuring ethnicity (Phinney, 1996). Quadagno, Sly, Harrison, Eberstein, and Soler (1998) examined whether ethnicity or other factors (i.e., age, education, marital status, comfort in discussing sex) explained differences in sexual behaviors. They found that ethnicity and other variables did contribute to differences in sexual behavior. In addition, it was also found that when certain factors were controlled, ethnic differences were reduced. While these findings are significant, it is not apparent whether ethnicity is or is not a critical factor in sexual issues because ethnicity was used as an identifying variable of the participants.

Phinney (1996) states that there are three characteristics of ethnicity. One of these characteristics consists of “cultural values, attitudes, and behaviors” that differentiate ethnic groups (p. 919). Another characteristic is ethnic identity. Lastly, the “experiences associated with minority status, including powerlessness, discrimination, and prejudice” are a part of ethnicity (Phinney, 1996, p. 919). Therefore, when researchers include ethnicity in sexuality research, they must consider more than ethnic group membership. They must also incorporate the characteristics of ethnicity. Furthermore, researchers must consider within-group variation among ethnic groups (Mays & Jackson, 1991). Considering characteristics of ethnicity in sexuality research can assist in creating prevention and intervention programs that meet the needs of its participants.

#### Literature that Supports Examination of Black Women and Sexuality

There has been a preoccupation with the sexuality of people of African descent since the time of slavery. The sexual exploitation that occurred during slavery has contributed to this preoccupation and has led to many assumptions, myths, and stereotypes about African American sexuality that continue today (Staples, 1973; Wyatt,

1982). Too often, Black people have been viewed as “sexy, hypersexual, permissive people, who have few morals about sexual promiscuity in or out of marriage” (Wyatt, 1982, p. 335). They have also been perceived as a group that has tolerated promiscuity and illegitimate children (Wyatt, 1982). These assumptions and stereotypes have been used to explain Black sexuality, especially Black female sexuality.

Not only in the United States but also around the world, the most consistent stereotype is that Black women are sexually permissive (Wyatt, 1997). The media has assisted in perpetuating this stereotype by creating the image of the “Jezebel,” an oversexed seducer who exploits men’s weaknesses (Green, 1994; Jewell, 1993; Staples, 1973; West, 1995). This perpetuation has led to some Black women internalizing these negative images. When internalization occurs, Black women may harbor fears of expressing the sexual stereotypes that exist and avoid sexual behavior, or they may accept the stereotypes and adjust their behavior to fit it (Green, 1994; Wyatt, 1997). They may also experience sexual problems, dysfunction, and victimization (West, 1995; Wyatt, 1982).

There is a lack of research on how the internalization of sexual stereotypes and myths affect Black women and their sexuality. Yet, there has been research to validate the various stereotypes and myths. This research has found that Black women have intercourse at an earlier age and a higher frequency of premarital sexual intercourse than White women (Davis & Cross, 1979; Kantner & Zelnik, 1972; Weinberg & Williams, 1988). Kinsey, Pomeroy, Martin, and Gebhard (1953), the early pioneers of sexuality research, have been criticized for generating this type of research (as cited in Weinberg & Williams, 1988; Wyatt, Peters, & Gutherie, 1988).

It was quite revolutionary for Kinsey and his colleagues to have collected comprehensive data on individual sexual behaviors and attitudes using a diverse sample of men and women of various ethnic groups, including African Americans. Unfortunately, the sample size of African Americans, and in particular, Black women was small and contained a significant number of people with a criminal history (Weinberg & Williams, 1988; Wyatt et al., 1988). This biased sample size resulted in findings indicating that Black women engage in premarital sexual intercourse at an earlier age, engage in intercourse more frequently, and are more liberal in their sexual attitudes as compared to White women (Weinberg & Williams, 1988). Despite the biases found, their results have been used to explain the sexual behavior of Black women for decades. There has been a need for more examination of individual behaviors and attitudes, and methods to understand the sexual behaviors and attitudes of Black women (Wyatt, 1982).

There have been studies conducted that contradict the biased research about Black women's sexuality. Timberlake and Carpenter (1990) studied the attitudes of Black middle-class men and women and found that while about three-fourths of the respondents stated that premarital intercourse was permissible, more than half agreed that premarital intercourse was unacceptable for teenagers. There were differences in attitudes according to educational attainment: those with four or more years of college were more accepting of premarital intercourse than those with a high school education or less. In studies about sexual activity, Weinberg and Williams (1988) found that Black women and White women did not differ in the number of sexual partners. Furthermore, Cubbins and Tanfer (2000) found that when demographic factors were controlled, Black women had fewer sexual partners than non-Black women and that Blacks were less likely than non-Blacks

to have had casual sex. Lastly, there are studies that reveal socioeconomic status and educational level as better predictors of the age of first intercourse than race or ethnicity (St. Lawrence et al., 1998; Wyatt, 1989).

With inconsistent and contradictory results, one must be cautious when reviewing sexuality research pertaining to Black women. Hicks and Handler (1978) (as cited in Worth, 1990, p. 121) raise an additional concern that when Black women are studied it is frequently in the “context of social problems”. This seems to occur especially when sexual issues of Black women are examined. It is accurate that Black women are disproportionately diagnosed with HIV and AIDS (Wingood, Hunter-Gamble, & DiClemente, 1993). However, one cannot draw the conclusion that Black women are immoral or lacking in self-control. It is more beneficial to attempt to understand what factors influence decisions that put Black women at risk as well as those that improve and maintain healthy and positive sexual choices.

#### Literature that Supports Examination of Sexual Decision-Making

Research suggests that sexual decision-making is an important aspect of establishing positive sexual experiences and health (Maskay & Juhasz, 1983; Vera & Reese, 2000); yet, there has not been uniformity in the study of sexual decision-making. There continues to be the unanswered question of how sexual decision-making is actually defined. Two commonly used definitions in the literature include sexual decision-making as either the intention to engage or not engage in sexual activity (e.g., Christopher & Cate, 1984, 1985; Lock & Vincent, 1995; Randolph & Winstead, 1988) or as one’s intentions and ability to use contraceptives (e.g., Baker, Morrison, Carter, & Verdon, 1996; Johnson & Green, 1993; Wyatt, Carmona, Loeb, Gutherie, Chin, & Gordon, 2000).

When sexual decision-making was defined in either of these two ways, there was a focus on which factors were most influential.

Some researchers viewed various categorical data as a determinant of who makes better sexual decisions. For example, Wyatt et al. (2000) examined contraceptive decision-making and the sexual health of an ethnically diverse sample of women. They found that younger, more educated women and women with a history of STDs were more likely to use contraceptive methods to prevent both pregnancy and disease. Also, African American women were significantly more likely than European American women to not use contraception (Wyatt et al., 2000). Furthermore, Finkelstein and Brannick (1997) assessed cues that affect whether college students engage in sexual intercourse. They found that identifiable cues (e.g., duration of a sexual relationship, condom availability) were significant in influencing intentions to engage in sexual intercourse.

Other researchers have investigated how psychological and social factors influence sexual decisions. Studies have included factors such as sex role attitude (Belgrave, Marin, & Chambers, 2000; Lock & Vincent, 1995), sense of directedness in decision-making orientation (Langer, Zimmerman, Warheit, & Duncan, 1993), pregnancy risk expectations (Pete & DeSantis, 1990), ambivalence and pressure to engage in sexual activity (O'Sullivan & Gaines, 1998; Rosenthal, Lewis, & Cohen, 1996), and perceived power and control in sexual decisions and behavior (Kline, Kline, & Oken, 1992; Rosenthal, Lewis, & Cohen, 1996; Soet, Dudley, & Dilorio, 1999). Researchers have also examined how cognitive factors aid in the sexual decision-making process. For example, cognitive consideration of the quality of a relationship and commitment level was found to be significant in deciding whether to begin a sexual relationship with a partner

(Christopher & Cate, 1984). Furthermore, reasoning capabilities and cognitive egocentrism have been related to decision-making in contraceptive use (Green, Johnson, & Kaplan, 1992; Johnson & Green, 1993).

Lastly, theories such as the health belief model (Becker & Joseph, 1988), the theory of reasoned action (Baker, Morrison, Carter, & Verdon, 1996), and social cognitive theory (Bandura, 1994) have been posited to explain sexual decision-making. While these theories were not originally created for conceptualizing sexual decision-making, they have been useful in HIV prevention and reducing other risky sexual outcomes (Baker et al., 1996; Finkelstein & Brannick, 1997; Jemmott et al., 1992).

### Social Cognitive Theory

One theory that has been used to explain sexual decision-making is social cognition. Social cognitive theory is defined as the way one makes sense of the social world using cognition, motivation, and affect (Kunda, 1999; Pennington, 2000). According to Bandura (1986), the theory “explains psychosocial functioning in terms of triadic reciprocal causation,” meaning that (a) cognitive, affective, and biological factors; (b) behavior; and (c) environmental factors work together influencing each other (as cited in Bandura, 1999, p. 23).

An important aspect of social cognitive theory is self-efficacy. Self-efficacy is the extent to which one believes in one’s “control over (one’s) own motivation, thought processes, emotional states, and patterns of behavior” (Bandura, 1994, p. 26). These beliefs affect the decisions that people make in every situation, including sexuality. Researchers have found that there is a relationship among self-efficacy and efficacy expectations and engaging in sexual intercourse, sexual risk-taking, and condom use

(Diaz, Morales, Bein, Dihin, & Rodriguez, 1999; Jemmott et al., 1992; Robinson & Telljohann, 1999; Wulfert & Wan, 1995). Social cognitive theory offers a practical framework to conceptualize sexual decision-making and the multiple factors that influence the process.

### Rationale for the Current Study

One major shortcoming of the existing body of research on sexuality is its lack of studies on ethnicity and sexual issues. Specifically, there is little in the literature pertaining to sexual decision-making of women of color. Strong and DeVault (1994) (as cited in Reid & Bing, 2000) stated that ethnic differences must be considered to completely understand sexuality. An effective method for researching ethnicity and sexuality is choosing a cultural or ethnic group and examining that group's within-group differences as well as similarities (Hines, Snowden, & Graves, 1998). Wyatt (1994) stated that there is very little data that exist about the relationship between sexual issues and "being Black or ethnic minority or female" (p. 749). By investigating within-group differences of Black women, this study can assist in filling a much needed gap.

In addition to the lack of research examining the relationship between ethnicity and sexual issues, the majority of the existing literature fails to include variables that may be salient for ethnic groups. Often, this failure is due to ethnicity being used as a demographic variable and not as a comprehensive construct. According to Phinney (1996), ethnicity is comprised of cultural values, attitudes, and behaviors; ethnic identity; and experiences associated with one's ethnic status. When ethnicity has been examined using Phinney's definition, it was related to sexual attitudes (Belgrave, Marin, & Chambers, 2000). Including variables such as ethnic identity and subjective stigma not

only provides a better examination of ethnicity, but also captures issues related to the unique experiences of Black women.

The final difference between this study and prior research involves the measurement of sexual decision-making. Unlike most studies on sexual decision-making that use sexual activity or contraceptive usage as a gauge for sexual decision-making (e.g., Lock & Vincent, 1995; Wyatt et al., 2000), this study used an instrument that measures the ability to initiate sexual activity; the ability to refuse unwanted sexual activity; and pregnancy, STD, and HIV prevention. This comprehensive look at sexual decision-making can give a better understanding of what is necessary to improve the well-being of women's sexual lives.

#### Description of Central Variables

The variables examined in the current investigation are ethnic identity, subjective stigma, religiosity, self-perceived physical attractiveness, and sexual and contraceptive history. Phinney (1992, 1996) defined ethnic identity as how one interprets and understands his or her own ethnicity, including one's self-identification as a group member, sense of belonging, and attitudes towards one's group. People vary in their identification with their ethnic group, and salience and significance of their ethnic group identity (Phinney, 1996). Ethnic identity has been used in a variety of studies. This construct has been found to be positively related to psychological well-being (e.g., self-esteem, coping ability), sexual attitudes, perceived efficacy, prosocial attitudes, and physical health (Belgrave et al., 2000; Parker, Sussman, Crippins, Elder, & Schnoll, 1998; Phinney, 1990; Phinney, 1992; Roberts et al., 1999; Smith, Walker, Fields, Brookins, & Seay, 1999).

Belgrave, Marin, and Chambers (2000) studied how cultural factors, including ethnic identity, influence risky sexual attitudes in early adolescent African American females. They found that lower levels of ethnic identity were associated with having more risky sexual attitudes after controlling for the effects of age, family, school, religiosity, and self-esteem. Furthermore, Siegel, Yancey, and McCarthy (2000) examined the relationship between physical and psychological health (i.e., obesity, depression) and psychosocial constructs, including ethnic identity in African American women. They found that low scores on ethnic identity were related to depression, poor health, pounds overweight, alcohol consumption, and hostility. Ethnic identity seemed to strengthen African American women's well-being and their ability to protect their health. Therefore, ethnic identity may be an important variable in understanding sexual decision-making.

Another variable that may impact sexual decision-making is subjective stigma. Like similar constructs such as stereotype threat (Steele & Aronson, 1995), ethnic stigma (Brown, 1998), and social stigma (Crocker & Major, 1989; Harvey, 2001), subjective stigma is based on the concept that being stigmatized or stereotyped can lead to negative consequences affecting one's self-esteem and creating feelings of inferiority (Brega & Coleman, 1999). Subjective stigma is defined as the extent to which one "internalizes society's negative stereotypes and attitudes about his or her stigmatized social group" (Brega & Coleman, 1999, p. 228). Though a person may be a member of a stigmatized group, he or she may not internalize the negative stereotypes and attitudes attributed to his or her group. Individuals' level of subjective stigma can range from feeling self-stigmatized to not feeling stigmatized (Brega & Coleman, 1999). There has been little

research on feeling destigmatized, but feelings of self-stigmatization have been found to be related to low self-worth, low self-esteem, and negative behaviors (e.g., drug abuse, teen pregnancy, academic underachievement) (Brega & Coleman, 1999; Goffman, 1963; Steele & Aronson, 1995). It can be beneficial to examine both ends of the continuum of subjective stigma to determine whether there is a relationship with sexual decision-making for Black women.

Religiosity is another variable examined in this study. Researchers have measured religiosity by examining spiritual well-being, one's personal relationship with God, motivation for religious involvement and faith, religious beliefs, religious denomination or affiliation, church attendance, and religious identification (Ellison, 1983; Blaine & Crocker, 1995; Brega & Coleman, 1999; Davidson, Darling, & Norton, 1995; Genia, 2001; Zaleski & Schiaffino, 2000). Spiritual well-being has been found to be positively associated with self-esteem (Ellison, 1983). It has also been found that there is a relationship between one's personal relationship with God or religious well-being and one's internal locus of control, and alcohol and drug use (Ellison & Smith, 1991; Hammermeister, Flint, Havens, & Peterson, 2001). Lastly, church attendance and religious belief salience have been associated with psychological well-being for Black students (Blaine & Crocker, 1995; Brega & Coleman, 1999).

There has been considerable research examining the relationship between religiosity and sexual issues. Frequency of church attendance and strength of religious beliefs have been found to be related to sexual permissiveness, the number of lifetime sexual partners, and attitudes towards premarital sexual behavior (Brown, 1985; Davidson, Darling, & Norton, 1995). Furthermore, Wyatt (1997) found that African

American women who stated that they were very religious participated in less risky sexual behaviors, but were more likely to not use contraceptives. While these studies do reveal important and useful results, the variables used to represent religiosity have been limited. Factors such as how one perceives his or her faith, commitment to religion, or religious well-being appear to better represent religiosity because they are non-sectarian and focus more on internal aspects. For example, religious well-being is the degree to which one perceives his or her spiritual life in relation to God (Ellison, 1983). Very few studies have examined sexual issues and these more subjective aspects of one's religiosity, especially religious well-being. Since women of color, especially Black women, have been found to be "more religious" than White women (Wyatt et al., 2000), it is imperative to investigate the influence of religiosity on issues of sexuality, especially sexual decision-making.

Along with religiosity, it is also important to examine the influence of self-perceived physical attractiveness on sexual decision-making. Much of the research pertaining to physical attractiveness has focused on an external evaluator of an individual's attractiveness (Garcia, 1998). Very few studies have investigated attractiveness from the perspective of the individual. Past research has found that women with higher self-perceived attractiveness had higher self-esteem, more resistance to peer pressure, more positive beliefs about their health, and good health behaviors (Adams, 1977; Garcia, 1998; Smith, Burlew, & Lundgren, 1991; Wade & Cooper, 1999). Erkut, Szalacha, Coll, and Alarcon (2000) examined self-esteem, acculturation, and self-perceived physical attractiveness in Puerto Rican adolescents. They found that Puerto

Rican adolescent girls who had higher levels of acculturation tended to have lower confidence in their physical attractiveness.

Research pertaining to sexual issues indicates that self-perceived attractiveness is related to the number of sexual partners, choice of contraceptives, and sexual self-esteem (i.e., assessing oneself as a sexual partner) (Palmer, 1995; Wiederman & Hurst, 1998). In addition, Wiederman and Hurst (1997) found a relationship between young women's sexual self schema (i.e., cognitive view of sexual self) and self-rated attractiveness.

There have been a multitude of studies on factors that influence sexual activity. This study used aspects of Black women's sexual and contraceptive use history as factors to examine whether there is a relationship with their sexual decision-making. Specifically, the number of sexual partners, unwanted sexual outcomes, and frequency of condom use were the variables examined. Previous studies have found that past sexual behavior is significantly related to intended sexual behaviors (Braithwaite, Stephens, Taylor, & Braithwaite, 1998; Diaz et al., 1999). A similar inference has been made for past and future condom use (Baker, Morrison, Carter, & Verdon, 1996). Furthermore, Wyatt et al. (2000) found that women with histories of unwanted sexual outcomes (i.e., STDs, unintended pregnancy) were more likely to make decisions about contraceptives alone, most likely choosing a method that only prevented pregnancy.

## CHAPTER III

### METHODOLOGY

This chapter will provide information on the sample size, description of the sample, instrumentation, research design, data collection procedures, and methods of analyzing the data.

#### Sample Size

A power analysis was conducted using Cohen's (1992) sample size tables to determine the sample size for this study. A medium effect size (.30 and .15) was used for the Pearson Product-Moment correlation, analysis of variance, and multiple regression analysis (Cohen, 1992). An alpha of .05 and power of .80 were used. With these criteria, it was determined that approximately 85 participants for the Pearson Product-Moment correlation and analysis of variance, and 102 participants for the multiple regression analysis were needed for inclusion in this study to ensure statistical power.

#### Description of Sample

Surveys were collected from 109 Black females enrolled in undergraduate and graduate programs at The University of Georgia (Athens, Georgia) ( $n = 20$ ), Georgia State University (Atlanta, Georgia) ( $n = 25$ ), Tarleton State University (Stephenville, Texas) ( $n = 11$ ), and Clark Atlanta University (Atlanta, Georgia) ( $n = 26$ ). The University of Georgia has a 6 percent Black student population; Georgia State University has 27 percent; and Tarleton State University has a 7 percent Black student population. Clark Atlanta University is a historically Black university. Twenty-seven surveys were

excluded from the final data set due to participants' self-report of never having been heterosexually active ( $n = 16$ ), participants were currently married ( $n = 8$ ), or participants did not fully complete the survey ( $n = 3$ ). The final data set consisted of 82 participants. None of the participants dropped out of the study or asked that their information not be included. The discrepancy between projected sample size and actual sample size reduced the statistical power to .62 for the multiple regression analysis and may have had an impact on the findings.

Participants ranged in age from 18 to 34. The majority of the participants were 21 (20.7%) and 20 (13.4%). The students volunteered to participate in the study. Participants received an incentive in the form of a chance to win a gift certificate from a major department store.

#### Instrumentation

The instruments for this study were selected to assess demographic, cultural, sexual, and self-evaluative variables. Instrumentation included the following: (a) Sexual Assertiveness Scale (Morokoff et al., 1997); (b) Multigroup Ethnic Identity Measure (Roberts et al., 1999); (c) Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (d) a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999); (e) questions regarding sexual behavior and contraceptive history; and (f) Demographic Questionnaire.

#### Sexual Assertiveness Scale (SAS)

The Sexual Assertiveness Scale (SAS) (Morokoff et al., 1997) is an 18-item instrument used to assess sexual assertiveness in women. The instrument includes 3 subscales that measure the initiation of wanted sexual activity, refusal of unwanted sexual

activity, and pregnancy and STD prevention. Respondents rate their assertiveness on a 5-point scale with 1 = never, 2 = sometimes, 3 = about half of the time, 4 = usually, and 5 = always. The subscale scores range from 6 to 30. The higher the score the more assertive one is in initiating wanted sexual activity, refusing unwanted sexual activity, and preventing pregnancy and STDs. The Cronbach's alpha for the 18-item scale has been reported as .82; and .77 for the 6-item Initiation subscale, .74 for the 6-item Refusal subscale, and .82 for the 6-item Pregnancy/STD Prevention subscale (Morokoff et al., 1997). For the current study, the Cronbach's alpha was .81 for the Initiation subscale, .80 for the Refusal subscale, and .84 for the Pregnancy/STD subscale.

Validity for the SAS has been established using several measures. Using a 4-point Likert-type scale, respondents were asked to measure the amount of time sexual behavior was initiated, unwanted sexual behavior was refused, asked a partner to use a condom or a latex barrier, and condom self-efficacy (Morokoff et al., 1997). The correlation between the SAS Initiation subscale and initiated sexual behavior was .38 ( $p < .001$ ). The correlation between the SAS Refusal subscale and refusal behavior was .33 ( $p < .001$ ). The correlation between the SAS Pregnancy/STD Prevention subscale and condom/latex barrier behavior and condom self-efficacy was .38 and .65 respectively ( $p < .001$ ). The test-retest reliability values ranged from .60 to .78 for 6 months and .59 to .69 for 1 year time periods.

#### Multigroup Ethnic Identity Measure (MEIM)

The Multigroup Ethnic Identity Measure (MEIM) (Roberts et al., 1999) is a 15-item instrument used to assess the degree of identification with one's ethnic group, regardless of the ethnic group. Respondents indicate their level of agreement to

statements using a 5-point scale with 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, and 5 = strongly agree. The MEIM has two subscales: Ethnic Identity Search and Affirmation, Belonging, and Commitment. The Ethnic Identity Search subscale contains five items. The Affirmation, Belonging, and Commitment subscale contains seven items. The remaining 3 items of the full scale inquire about the ethnicity of the participant, the participant's mother, and the participant's father. For the purposes of this study, the two subscales (12 items) were used. Obtaining a mean score from the 12 items creates an ethnic identity score. Scores can range from 1 (low ethnic identity) to 5 (high ethnic identity). The MEIM has been used in many studies using different ethnic group samples and ages and has consistently shown reliability with alphas above .80 (J. Phinney, personal communication, August 7, 2001). In particular, the overall reliability coefficient of the scale is reported as .81 for a high school sample and .90 for a college sample (Phinney, 1992). In addition, the internal consistency of the 12-item MEIM has yielded Cronbach's alphas ranging from .81 to .89 (Roberts et al., 1999), with the Cronbach's alpha for the African American sample .82. For the current study, the Cronbach's alpha was .80.

#### Subjective Stigmatization Scale (SSS)

The Subjective Stigmatization Scale (SSS) (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000) is a 40-item instrument assessing subjective stigmatization. Subjective stigmatization is "the degree to which an individual internalizes society's negative stereotypes and attitudes about his or her stigmatized social group" (Brega & Coleman, 1999, p. 228). Participants respond to items using a 5-point Likert scale with 1 = very untrue and 5 = very true. Items are summed to create a

destigmatization score (i.e., not self-stigmatized) that can range from 40 to 200. The higher the score, the more destigmatized one feels. Brega and Coleman (1999) report the Cronbach's alpha as .83, and the test-retest coefficient as .76 at a one-month interval. For the current study, the Cronbach's alpha was .69.

#### Measure of Self-Perceived Physical Attractiveness

The Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999) is a one-item measure of one's perception of his or her physical attractiveness. Participants respond to the statement, "On a scale of 1 to 7 with 1 = very unattractive and 7 = very attractive, I would rate my physical attractiveness as..." This type of measure has been used in previous studies (Wade, 1996; Wade & Cooper, 1999; Wiederman & Hurst, 1997; Wiederman & Hurst, 1998). Wade (1996) reports the Cronbach's alpha as .72, and it correlates ( $r = .54$ ,  $p < .0003$ ) with self-esteem.

#### Questions Regarding Sexual Behavior and Contraceptive Use History

Questions on sexual behavior and contraceptive use history are used to gain retrospective and current data on respondents' sexual behavior and contraceptive history. The 14 items seek information about a respondent's age of her first consensual sexual intercourse experience, number of sexual partners, contraceptive use and frequency, and unwanted sexual outcomes (i.e., pregnancy, STDs). Two additional items included an open-ended question, developed by the researcher, requesting information about messages heard pertaining to Black women and sexual behavior and relationships; and an item about reasons for having sexual intercourse (Wyatt et al., 2000). However, these two items were not used in the data analyses. See Appendix B for additional information.

### Religious Well-Being Subscale of the Spiritual Well-Being Scale (SWBS)

The Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983) (SWBS) is a 20-item scale used to assess one's perception of his or her quality of life and spiritual well-being, which contains both a religious and social psychological component. Respondents indicate their level of agreement to statements using a 6-point Likert scale with 6 = strongly agree (SA), 5 = moderately agree (MA), 4 = agree (A), 3 = disagree (D), 2 = moderately disagree (MD), and 1 = strongly disagree (SD). The SWBS has two subscales: Religious Well-Being and Existential Well-Being.

For the purposes of this study, the 10-item Religious Well-Being subscale (RWB) was used. The RWB subscale assesses a respondent's spiritual life through his or her relationship with God (Ellison, 1983). Items are summed to create a score that can range from 10 to 60. The higher score represents more religious well-being. The SWBS and its RWB subscale have been used in many studies using different populations with various levels of religiosity. Based on data from 7 studies with over 900 participants, the RWB subscale's internal consistency reliability has ranged from .82 to .94. (Boivin, Kirby, Underwood, & Silva, 1999). For the current study, the Cronbach's alpha was .93. Paloutzian and Ellison (1982) reported a test-retest reliability coefficient of .96 from a student population in the Midwest. Validity has been determined based on a correlation between the SWBS and Allport and Ross's Intrinsic Religious Orientation Measure  $r(175) = .79$  ( $p < .001$ ) (Ellison, 1983).

### Demographic Questionnaire

A 21-item demographic questionnaire was developed by the researcher. This questionnaire gathered information about respondents' gender, country of origin (and if

not the United States, length of U.S. residence), age, level of education, marital status, type of community where raised (i.e., state, size, neighborhood socioeconomic status) (Wyatt, 1984), and family income. In addition, respondents answered questions regarding primary caretakers in their family home (i.e., whether both parents lived in the home; if not, who were the primary caretakers in the home; reason why both parents were not living together) (Wyatt, 1984) and their mother and father's country of origin. Lastly, the questionnaire gathered information about church affiliation and church attendance. See Appendix B for additional information.

### Research Design

The present study employed a passive research design (Cook & Campbell, 1979). This design has been extensively used in social science research (Heppner, Kivlighan, & Wampold, 1999). One of the benefits of using this design is that participants are taken directly from the population of interest resulting in good external validity. Another benefit is in the use of self reports. In using self reports, the researcher can “access phenomena that would otherwise be extremely difficult and impossible to measure” (e.g., sexual behavior) (Heppner et al., 1999, p. 304).

Due to the lack of randomization of the sample and no manipulation of the independent variables, this design has low internal validity (Heppner et al., 1999). There is also a threat to the construct validity of putative causes and affect due to evaluation apprehension (Heppner et al., 1999). This threat is due to the possibility of participants responding to make themselves appear healthier than they are. There is also a threat to external validity due to the lack of generalizability across settings and persons (Heppner et al., 1999). Because participants were recruited from southeastern college campuses, the

results are not generalizable to participants of different ages or those recruited from different settings.

## Procedures

### Recruitment of Participants

During spring semester of 2002, participants were recruited by various methods at multiple college campuses: The University of Georgia, Georgia State University, Tarleton State University, and Clark Atlanta University. See Appendices C and F1 for the scripts of initial contact that were used.

The University of Georgia:

A list of campus organizations with significant numbers of Black women was obtained from the Office of Minority Affairs and Programs and the Spring 2002 Directory of Student Organizations. Additionally, a list of professors teaching classes in the African American Studies Institute was obtained. Organization representatives (e.g., president) and professors were contacted by email or campus mail about the study. A request was made to address a general meeting or class and distribute the questionnaires. After affirmative responses were received, the researcher attended an organizational meeting or classes and asked for volunteers. Participants received an incentive in the form of a chance to win a gift certificate from a major department store.

A description of the study was also listed with the University of Georgia Psychology Research Participation Pool. Undergraduate students enrolled in General Psychology and Psychology of Adjustment viewed the description; and if they met the criteria, they signed up for specific days and times to complete the survey. Participants

received an incentive in the form of .5 credits toward a psychology departmental research requirement and a chance to win a gift certificate from a major department store.

Georgia State University:

A staff member from the Office of African American Student Services and Programs assisted in distributing information about the study to campus organizations that had a significant number of Black women. Organization representatives (e.g., president) were contacted by email or campus mail. Additionally, the staff member contacted a professor teaching a class in the African American Studies Institute. A request was made to address a general meeting or class and distribute the questionnaires. After affirmative responses were received, the researcher attended an organizational meeting and/or class and asked for volunteers. Participants received an incentive in the form of a chance to win a gift certificate from a major department store.

Tarleton State University:

A staff member from the Counseling Center assisted in distributing information about the study to campus organizations with significant numbers of Black women. Organization representatives (e.g., president) were contacted by email, campus mail, or telephone. A request was made to address a general meeting or class and distribute the questionnaires. After affirmative responses were received, the staff member attended organizational meetings and asked for volunteers. Participants received an incentive in the form of a chance to win a gift certificate from a major department store.

Clark Atlanta University:

A professor from the School of Social Work assisted in distributing information about the study to professors in the School of Social Work. It was determined that the

researcher would address the largest undergraduate class in the school to recruit participants. The researcher attended the class and asked for volunteers. Participants received an incentive in the form of a chance to win a gift certificate from a major department store.

### Data Collection

Approval to conduct the study was granted by the Institutional Review Board of The University of Georgia. Data were collected during the Spring term of 2002 at organizational meetings and in classrooms at The University of Georgia, Georgia State University, and Clark Atlanta University by the researcher. A research assistant/colleague collected data at Tarleton State University. Multiple approaches were used to collect data at each institution.

The University of Georgia:

In January 2002, a list of campus organizations with significant numbers of Black women was obtained from the Office of Minority Affairs and Programs and the Spring 2002 Directory of Student Organizations. In February 2002, contact persons (i.e., president) of the identified campus organizations were contacted through campus mail, email, and face-to-face contact. At designated times, the researcher attended the campus organization and addressed its members towards the end of the meeting. The members were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Surveys took 15 to 20 minutes to complete. Upon completion of the survey, participants were able to fill out an entry form for a raffle to win a \$50 gift certificate to a

major department store; and they were debriefed about the research. Participants also had the opportunity to ask questions before, during, and after the data collection process.

In February 2002, professors teaching classes with a significant number of Black women were contacted through email and face-to-face contact. Interested professors gave available class time for the researcher to attend and recruit participants. At designated times, the researcher attended the classes and addressed students at the beginning of class. Students were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Participants had until the following class meeting to return the survey and the entry form for a raffle to win a \$50 gift certificate. At the next class meeting, completed survey packets were collected, all students of the class were debriefed about the research, and students had the opportunity to ask questions.

In February 2002, the researcher posted the study on the Psychology Department's Research Participation Pool website. Students were made aware of the subject matter, criteria for participation, designated time and location for participation, and the amount of credit they would receive for participation (.5 credits). At the designated times, volunteers were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were distributed. Surveys took 15 to 20 minutes to complete. Upon completion of the survey, participants were able to fill out an entry form for a raffle to win a \$50 gift certificate to a major department store; and they were debriefed about the research. Participants also had the opportunity to ask questions before, during, and after the data collection process.

Appendices D1 and D2 contain the Participant Consent Form and Debriefing Statement, respectively.

Georgia State University:

In March 2002, a staff member from the Office of African American Student Services and Programs distributed information about the study to campus organizations with a significant number of Black females. Organizational leaders were contacted by campus mail, email, or face-to-face. In April 2002, the researcher attended campus organization meetings and addressed its members towards the end of the meeting. The members were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Surveys took 15 to 20 minutes to complete. Upon completion of the survey, participants were able to fill out an entry form for a raffle to win a \$50 gift certificate to a major department store; and they were debriefed about the research. Participants also had the opportunity to ask questions before, during, and after the data collection process.

In April 2002, a professor teaching a class in the African American Studies Institute was contacted about recruiting volunteers and distributing survey packets during class. At a designated time, the researcher attended classes and addressed students. Students were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Participants had until the following two class meetings to return the survey and the entry form for a raffle to win a \$50 gift certificate. At the next two class

meetings, completed survey packets were collected, all students were debriefed about the research, and students had the opportunity to ask questions.

Appendices F2 and F3 contain the Participant Consent Form and Debriefing Statement, respectively.

Tarleton State University:

In February 2002, a staff member from the Counseling Center assisted in distributing information about the study to campus organizations with significant numbers of Black women through telephone or face-to-face contact. Organizational leaders who agreed to participate designated a time for the staff member to address their meeting. The members were given a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Participants had a week to return the surveys and the entry forms for a raffle to win a \$50 gift certificate to the organizational leader to give to the staff member. Students had the opportunity to ask the research assistant/colleague questions during any part of the data collection process.

Appendices E1 and E2 contain the Participant Consent Form and Debriefing Statement, respectively.

Clark Atlanta University:

In March 2002, a professor in the School of Social Work assisted in giving the researcher access to a group of undergraduate and graduate students during a lecture by the dean of the school. Before the lecture began, the researcher gave students a brief introduction about the survey; and survey packets (i.e., participant consent form, survey, debriefing form, raffle) were given to volunteers willing to participate. Surveys took 15

to 20 minutes to complete. Upon completion of the survey, participants were able to fill out an entry form for a raffle to win a \$50 gift certificate to a major department store, and they were debriefed about the research. Participants also had the opportunity to ask questions before, during, and after the data collection process.

Appendices G1 and G2 contain the Participant Consent Form and Debriefing Statement, respectively.

### Data Analysis

Research Question 1: *Are there differences among Black women on ethnic identity in their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant relationships between ethnic identity scores as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Statistical Analysis: A Pearson Product-Moment correlation coefficient was calculated to measure the relationship between ethnic identity and each SAS subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

Research Question 2: *Are there differences among Black women across subjective stigma on their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant relationships between subjective stigma scores as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Statistical Analysis: A Pearson Product-Moment correlation coefficient was calculated to measure the relationship between subjective stigma and each SAS subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

Research Question 3: *Does Black women's self-perceived physical attractiveness influence their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypothesis:

1. There will be no statistically significant differences in Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Statistical Analysis: A one-way analysis of variance (ANOVA) was calculated to measure differences based on self-perceived physical attractiveness and each SAS

subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV). A one-way ANOVA has one independent variable and one dependent variable. The independent variable, self-perceived physical attractiveness, was analyzed with each dependent variable (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

Research Question 4: *Is there a relationship between Black women's sexual behavior and contraceptive use history and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?*

Null Hypotheses:

1. There will be no statistically significant relationships between the total number of sexual partners and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Statistical Analysis: A Pearson Product-Moment correlation coefficient was calculated to measure the relationship between the total number of sexual partners and each SAS subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

2. There will be no statistically significant differences between having unwanted sexual outcomes and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Statistical Analysis: A one-way analysis of variance (ANOVA) was calculated to measure differences based on having unwanted sexual outcomes and each SAS subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV). A one-way ANOVA has one independent variable and one dependent variable. The independent variable, having unwanted sexual outcomes, will be analyzed with each dependent variable (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

3. There will be no statistically significant differences between frequency of condom use by Black women and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Statistical Analysis: A one-way analysis of variance (ANOVA) was calculated to measure differences based on contraceptive use frequency and each SAS subscale score (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV). A one-way ANOVA has one independent variable and one dependent variable. The independent variable, frequency of condom use, was analyzed with each dependent variable (i.e., ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV).

Research Question 5: *What cultural, sexual, and self-evaluative variables are the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV for Black women?*

Null Hypotheses:

1. The ability to initiate wanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).
2. The ability to refuse unwanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

3. The ability to prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

Statistical Analysis: Simultaneous multiple regression analyses were calculated for each criterion variable. Multiple regression analysis was chosen for its utility in explaining how several predictor variables are related to a criterion variable (Heppner et al., 1999). For this study, the criterion variable for each simultaneous regression analysis was the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV respectively. Religiosity, ethnic identity, subjective stigma, total number of sexual partners, ever having unwanted sexual outcomes, contraceptive use, and self-perceived physical attractiveness were the predictor variables for each of the analyses.

## CHAPTER IV

### RESULTS

The current study investigated how sociocultural factors can impact sexual decision-making by exploring one's ability to initiate wanted sexual activity, refuse unwanted sexual activity, and to protect against unwanted pregnancies or STDs. This chapter reports detailed information on the procedures and results of the analyses conducted for this study.

#### Demographic Data

Data were collected from 82 unmarried women identifying themselves as Black or African American (92.7%) or mixed ethnicity with African descent. Participants ranged in age from 18 to 34. The majority of the participants were 21 (20.7%) and 20 (13.4%) years of age. All were attending undergraduate or graduate school. More than half of the participants were raised with both of their parents in the home (54%), with a majority living in middle class suburban communities. Most participants attended church at least once a month. Demographic characteristics of the total sample can be found in Table 4.1.

All participants were sexually active. The average age of first consensual coitus was 17. All but two have used some form of birth control with a combination of methods including condoms (28%) and birth control pills (20.7%) as the most current methods used. Approximately 30% of the participants have been pregnant and approximately 12% have had an STD. Approximately 32% of the participants have had an unwanted sexual

Table 4.1

Demographic Characteristics of Total Sample

Variable	<u>n</u>	<u>P</u>
Age		
Under 20	10	12.2
20	11	13.4
21	17	20.7
22	8	9.8
23	8	9.8
24	6	7.3
25	3	3.7
26	7	8.5
27	4	4.9
29	1	1.2
30 and over	7	8.5
Highest Level of Education		
Undergraduate	59	72.0
Graduate	23	28.0
Growing-up with Parents in the Home		
Both Parents	44	54.3
One Parent or Other Caregiver	37	45.7

Variable	<u>n</u>	<u>P</u>
Family's Total Annual Income		
0-9,999	9	11.4
10,000-19,999	10	12.7
20,000-29,999	13	16.5
30,000-39,999	12	15.2
40,000-49,999	7	8.9
Over 50,000	19	24.1
Over 100,000	9	11.4
Type of Community Where Raised		
Small or Rural Town	14	18.2
Suburban Area	46	59.7
Urban Area	15	18.3
Crowded Urban Area	2	2.4
Home Neighborhood SES		
Poor	1	1.3
Working Class	15	19.5
Middle Class	41	53.2
Upper Middle Class	15	19.5
Upper Class	5	6.5

Variable	<u>n</u>	<u>P</u>
Church Attendance		
Never	7	8.6
Less than Once a Month	8	9.9
Once or Twice a Month	31	38.3
3 to 4 Times a Month	21	25.9
Over 4 times a month	14	17.3

Note. N = 82.

outcome, meaning that they have either had an unwanted pregnancy and/or STD. Sexual behavior and contraceptive use history characteristics can be found in Table 4.2.

## Findings

### Preliminary Analyses

Preliminary analyses were calculated on the full data set of 82 participants. Valid responses were checked prior to survey items being collapsed into their appropriate scales, subscale, and analysis variables. The percentages of valid scale, subscale, and analysis variable responses ranged from 94% to 100%, with the total number of sexual partners having the least number of valid responses. The mean for the scores on the dependent variables were 19.45 (SD = 5.46) for the initiate wanted sexual activity variable, 23.41 (SD = 5.10) for the refuse unwanted sexual activity variable, and 24.05 (SD = 5.79) for the prevent pregnancy, STDs, and HIV variable. Table 4.3 contains descriptive statistics for all of the variables. Appendix A contains information on the correlation coefficients for all of the variables.

Table 4.2

Sexual Behavior and Contraceptive Use History of Total Sample

Variable	<u>n</u>	<u>P</u>
Age of First Consensual Coitus		
Under 14	7	8.7
14	8	9.9
15	12	14.8
16	15	18.5
17	9	11.1
18	9	11.1
19	9	11.1
20	6	7.4
21 and over	6	7.3
Current Method of Birth Control		
Abstain	9	11.0
Birth control Pill	17	20.7
Condoms	16	19.5
Depo Provera	4	4.9
Combination with condoms	23	28.0
Other	2	2.4
No Birth Control Used	11	13.4

Variable	<u>n</u>	<u>P</u>
Frequency of Condom Use		
Never	15	18.3
Less than Half the Time	10	12.2
Half the Time	12	14.6
More than Half the Time	16	19.5
Every Time	29	35.4
Pregnancy		
Never Been Pregnant	57	69.5
Planned Pregnancy	5	6.1
Unplanned Pregnancy	20	24.4
Pregnancy Outcome		
Miscarriage	1	4.0
Abortion	15	60.0
Kept the Baby	7	28.0
Other or Unknown	2	8.0

Variable	<u>n</u>	<u>P</u>
Sexually Transmitted Diseases (STD)		
Never Had an STD	72	87.8
Chlamydia	7	8.5
HPV	2	2.4
Gonorrhea	1	1.2
Other	2	2.4

Note. N = 82. For pregnancy outcome, n = 25. For sexual transmitted diseases (STD), n = 10; however, due to some participants having more than one STD, frequency is higher.

Table 4.3

Descriptive Statistics for Dependent and Independent Variables

Variable	<u>M</u>	<u>SD</u>	Range	<u>N</u>
Initiating Wanted Sexual Activity	19.45	5.46	24.0	82
Refusing Unwanted Sexual Activity	23.41	5.10	20.0	82
Preventing STDs, Pregnancy, and HIV	24.05	5.79	21.0	80
Ethnic Identity	4.21	.43	1.9	82
Subjective Stigma	157.53	10.01	57.0	81
Self-Perceived Physical Attractiveness	5.70	1.20	6.0	82
Total Number of Sexual Partners	6.16	6.41	35.0	77
Religiosity	55.23	8.04	50.0	82

Note. N = 82.

Research Question 1: Are there differences among Black women on ethnic identity in their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?

Null Hypothesis 1: There will be no statistically significant relationships between ethnic identity scores as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Three Pearson Product-Moment correlation coefficient analyses were calculated to investigate whether statistically significant relationships existed between ethnic identity and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted sexual activity, STDs, and HIV. There was no statistically significant relationship found between ethnic identity and the ability to initiate wanted sexual activity ( $r = .04$ ,  $p = .72$ ). There was a positive significant relationship found between ethnic identity and the ability to refuse unwanted sexual activity ( $r = .27$ ,  $p = .01$ ), and ethnic identity and the ability to prevent unwanted pregnancy, STDs, and HIV ( $r = .23$ ,  $p = .04$ ). These findings suggest that while ethnic identity has no relationship with the ability to initiate sexual activity, higher ethnic identity is associated with an ability to refuse unwanted sexual activity and prevent unwanted pregnancy, STDs, and HIV. It is important to note that the correlations are relatively small; therefore, these findings should be interpreted with caution. Based on these findings, the null hypothesis was rejected for Research Question 1. Additional information pertaining to the Pearson Product-Moment Correlation coefficients can be found in Table 4.4.

Table 4.4

Correlation Coefficients Between Ethnic Identity and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

Variable	<u>r</u>	<u>p</u>	<u>N</u>
Initiate	.04	.72	82
Refuse	.27	.01	82
Prevent	.23	.04	80

Research Question 2: Are there differences among Black women across subjective stigma on their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?

Null Hypothesis 1: There will be no statistically significant relationships between subjective stigma scores as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) for Black women.

Three Pearson Product-Moment correlation coefficient analyses were calculated to investigate whether a statistically significant relationship existed between the subjective stigma scores and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted sexual activity, STDs, and HIV. There

were no statistically significant relationships found between the subjective stigma scores and the ability to initiate wanted sexual activity ( $r = -.01$ ,  $p = .90$ ) and the subjective stigma scores and the ability to prevent unwanted pregnancy, STDs, and HIV ( $r = .12$ ,  $p = .28$ ). There was a positive relationship found between the subjective stigma scores and the ability to refuse unwanted sexual activity ( $r = .27$ ,  $p = .01$ ).

These findings suggest that differences in subjective stigma are not related to ability to initiate sexual activity or the ability to prevent unwanted pregnancy, STDs, and HIV. However, there is a relationship between being destigmatized and having the ability to refuse unwanted sexual activity. It is important to note that this correlation is relatively small; therefore, this finding should be interpreted with caution. Based on these findings, the null hypothesis was rejected for Research Question 2. Additional information pertaining to the Pearson Product-Moment correlation coefficients can be found in Table 4.5.

Table 4.5

Correlation Coefficients Between Subjective Stigma and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

Variable	$r$	$p$	$N$
Initiate	-.01	.90	81
Refuse	.34	.002	81
Prevent	.12	.28	79

Research Question 3: Does Black women's self-perceived physical attractiveness influence their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?

Null Hypothesis 1: There will be no statistically significant differences in Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999) and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV subscale scores as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Three one-way analyses of variance (ANOVAs) were calculated to measure differences based on self-perceived physical attractiveness and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. Results indicated no statistically significant differences in self-perceived physical attractiveness and the ability to initiate wanted sexual activity  $F(5, 76) = 1.37, p = .24$ , refuse unwanted sexual activity  $F(5, 76) = .52, p = .76$ , or prevent unwanted pregnancy, STDs, and HIV  $F(5, 74) = .83, p = .53$ . These findings suggest that self-perceived physical attractiveness did not significantly affect the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. Based on these results, the null hypothesis for Research Question 3 is accepted. Additional information pertaining to the ANOVAs can be found in Table 4.6.

Table 4.6

Summary of ANOVAs of Self-Perceived Physical Attractiveness and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
<u>Initiate</u>				
Attractiveness	5	40.04	1.37	.24
Within Groups	76	29.18		
Total	81			
<u>Refuse</u>				
Attractiveness	5	13.82	.52	.76
Within Groups	76	26.83		
Total	81			
<u>Prevent</u>				
Attractiveness	5	27.96	.83	.53
Within Groups	74	33.76		
Total	79			

Note. N = 82.

Research Question 4: Is there a relationship between Black women's sexual behavior and contraceptive use history and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?

Null Hypothesis 1: There will be no statistically significant relationships between the total number of sexual partners and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Three Pearson Product-Moment correlation coefficients analyses were calculated to investigate whether a statistically significant relationship existed between total number of sexual partners and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. There were no statistically significant relationships found between total number of sexual partners and the ability to initiate wanted sexual activity ( $r = .14$ ,  $p = .22$ ), the ability to refuse unwanted sexual activity ( $r = -.13$ ,  $p = .24$ ), or the ability to prevent unwanted pregnancy, STDs, and HIV ( $r = -.07$ ,  $p = .54$ ). These findings suggest that one's total number of sexual partners has no relationship to the ability to initiate sexual activity, refuse unwanted sexual activity, or prevent unwanted pregnancy, STDs, and HIV. Based on these findings, Null Hypothesis 1 was accepted for Research Question 4. Additional information pertaining to the Pearson Product-Moment correlation coefficients can be found in Table 4.7.

Table 4.7

Correlation Coefficients Between Total Number of Sexual Partners and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

Variable	<u>r</u>	<u>p</u>	<u>N</u>
Initiate	.14	.22	77
Refuse	-.13	.24	77
Prevent	-.07	.54	75

Null Hypothesis 2: There will be no statistically significant differences between having unwanted sexual outcomes and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Three one-way analyses of variance (ANOVAs) were calculated to measure differences based on having unwanted sexual outcomes and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. Results indicated no statistically significant differences in unwanted sexual outcomes and the ability to initiate wanted sexual activity  $F(1, 81) = 2.98, p = .09$ , refuse unwanted sexual activity  $F(1, 81) = 1.33, p = .25$ , or prevent unwanted pregnancy, STDs, and HIV  $F(1, 79) = 1.37, p = .24$ . These findings suggest that having or not having unwanted sexual outcomes did not significantly affect the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and

HIV. Based on the results from the ANOVAs, Null Hypothesis 2 of Research Question 4 is accepted. Additional information pertaining to the ANOVAs can be found in Table 4.8.

Table 4.8

Summary of ANOVAs of Unwanted Sexual Outcomes and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
<b>Initiate</b>				
Unwanted Outcome	1	86.84	2.98	.09
Within Groups	80	29.14		
Total	81			
<b>Refuse</b>				
Unwanted Outcome	1	34.58	1.33	.25
Within Groups	81	25.92		
Total	82			
<b>Prevent</b>				
Unwanted Outcome	1	45.64	1.37	.24
Within Groups	79	33.23		
Total	80			

Note. N = 82.

Null Hypothesis 3: There will be no statistically significant differences between frequency of condom use by Black women and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997).

Three one-way analyses of variance (ANOVAs) were calculated to measure differences based on frequency of condom use and the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. Results indicated no statistically significant differences in frequency of condom use and the ability to initiate wanted sexual activity  $F(4, 77) = 1.08, p = .37$  or the ability to refuse unwanted sexual activity  $F(4, 77) = .39, p = .82$ . There was a statistically significant difference found in the frequency of condom use and the ability to prevent unwanted pregnancy, STDs, and HIV  $F(4, 75) = 27.75, p < .001$ . These findings suggest that frequency of condom use did not significantly affect the ability to initiate wanted sexual activity or refuse unwanted sexual activity, but it did significantly affect the ability to prevent unwanted pregnancy, STDs, and HIV. Based on these results, Null Hypothesis 3 for Research Question 4 is rejected. Additional information pertaining to the ANOVAs can be found in Table 4.9.

Research Question 5: What cultural, sexual, and self-evaluative variables are the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV for Black women?

Null Hypothesis 1: The ability to initiate wanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale

Table 4.9

Summary of ANOVAs of Frequency of Condom Use and the Dependent Variables, Ability to Initiate Wanted Sexual Activity, Refuse Unwanted Sexual Activity, and Prevent STDs, Pregnancy and HIV

	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
<u>Initiate</u>				
Condom Use	4	32.26	1.08	.37
Within Groups	77	29.73		
Total	81			
<u>Refuse</u>				
Condom Use	4	10.45	.39	.82
Within Groups	77	26.83		
Total	81			
<u>Prevent</u>				
Condom Use	4	393.54	27.75	.00
Within Groups	79	14.18		
Total	80			

Note. N = 82.

(Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

A simultaneous multiple regression analysis was calculated for the ability to initiate wanted sexual activity variable. The criterion variable for the simultaneous regression analysis was the ability to initiate wanted sexual activity. Religiosity, ethnic identity, subjective stigma, number of sexual partners, ever having unwanted sexual outcomes, contraceptive use, and self-perceived physical attractiveness were the predictor variables for the analysis.

The ability to initiate wanted sexual activity regression model was not statistically significant ( $F(7, 75) = .628, p = .73$ ). Thus, Null Hypothesis 1 for Research Question 5 is accepted. Additional information pertaining to this multiple regression model can be found in Table 4.10.

Null Hypothesis 2: The ability to refuse unwanted sexual activity as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as

Table 4.10

Summary of Multiple Regression Analysis for Variables Predicting the Ability to Initiate Wanted Sexual Activity

Variable	<u>F</u>	<u>df</u>	<u>R<sup>2</sup></u>	<u>SE</u>	<u>β</u>	<u>t</u>
Model	.63	7	.06	5.70		
Subjective Stigma					-.05	-.40
Ethnic Identity					.08	.64
Attractiveness					.83	.67
Religiosity					-.90	-.74
Number of Partners					.10	.82
Condom Use					-.01	-.06
Unwanted Outcomes					.14	.27

Note. N = 75. \*p < .05, \*\*p < .01

measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

A simultaneous multiple regression analysis was calculated for the ability to refuse unwanted sexual activity variable. The criterion variable for the simultaneous regression analysis was the ability to refuse unwanted sexual activity. Religiosity, ethnic identity, subjective stigma, number of sexual partners, ever having unwanted sexual

outcomes, contraceptive use, and self-perceived physical attractiveness were the predictor variables for the analysis.

A significant regression model for the ability to refuse unwanted sexual activity was found ( $F(7, 75) = 3.12, p = .01$ ). The squared multiple correlation for the model was .24. The significant predictors were: subjective stigma ( $\beta = .28, p = .01$ ) and ethnic identity ( $\beta = .22, p = .05$ ). Based on these results, Null Hypothesis 2 for Research Question 5 is rejected. It is important to note that the variance is small and these findings should be interpreted with caution. Additional information pertaining to this multiple regression model can be found in Table 4.11.

Table 4.11

Summary of Multiple Regression Analysis for Variables Predicting the Ability to Refuse Unwanted Sexual Activity

Variable	<u>F</u>	<u>df</u>	<u>R<sup>2</sup></u>	<u>SE</u>	<u>β</u>	<u>t(p)</u>
Model	3.12**	7	.24	4.68		
Subjective Stigma					.28	2.60**
Ethnic Identity					.22	1.99*
Attractiveness					.12	1.06
Religiosity					-.21	-1.90
Number of Partners					-.15	-1.38
Condom Use					-.01	-.06
Unwanted Outcomes					.07	.64

Note.  $N = 75$ . \* $p < .05$ , \*\* $p < .01$

Null Hypothesis 3: The ability to prevent unwanted pregnancy, STDs, and HIV as measured by the Sexual Assertiveness Scale (Morokoff et al., 1997) cannot be predicted by (a) religiosity as measured by the Religious Well-Being subscale of the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982; Ellison, 1983); (b) ethnic identity as measured by the Multigroup Ethnic Identity Measure (Roberts et al., 1999) and subjective stigma as measured by the Subjective Stigmatization Scale (Brega & Coleman, 1999; L. M. Coleman, personal communication, June 22, 2000); (c) total number of sexual partners, having unwanted sexual outcomes, frequency of condom use by Black women; and (d) Black women's self-perceived physical attractiveness scores as measured by a Measure of Self-Perceived Physical Attractiveness (Wade & Cooper, 1999).

A simultaneous multiple regression analysis was calculated for the ability to prevent unwanted pregnancy, STDs, and HIV variable. The criterion variable for the simultaneous regression analysis was the ability to prevent unwanted pregnancy, STDs, and HIV. Religiosity, ethnic identity, subjective stigma, total number of sexual partners, ever having unwanted sexual outcomes, and self-perceived physical attractiveness were the predictor variables for the analysis. Condom use frequency was removed from the equation because of the variable's similarity to the criterion variable.

The regression model was not statistically significant for the ability to prevent unwanted pregnancy, STDs, and HIV ( $F(6, 73) = 1.56, p = .17$ ). Based on these results, Null Hypothesis 3 for Research Question 5 is accepted. Additional information pertaining to this multiple regression model can be found in Table 4.12.

Table 4.13 provides a summary of the findings for the research questions and null hypotheses.

Table 4.12

Summary of Multiple Regression Analysis for Variables Predicting the Ability to PreventUnwanted Pregnancy, STDs, HIV

<u>Variable</u>	<u>F</u>	<u>df</u>	<u>R<sup>2</sup></u>	<u>SE</u>	<u>β</u>	<u>t</u>
Model	1.56	6	.12	5.77		
Subjective Stigma					.10	.89
Ethnic Identity					.20	1.68
Attractiveness					-.24	-2.09
Religiosity					-.06	-.53
Number of Partners					-.07	-.63
Unwanted Outcomes					-.09	-.73

Note. N = 73. \*p < .05, \*\*p < .01

Table 4.13

Summary of Findings for the Research Questions and Null Hypotheses

Research Questions	Findings
1. Null Hypothesis 1	Rejected
2. Null Hypothesis 1	Rejected
3. Null Hypothesis 1	Accepted
4. Null Hypothesis 1	Accepted
Null Hypothesis 2	Accepted
Null Hypothesis 3	Rejected
5. Null Hypothesis 1	Accepted
Null Hypothesis 2	Rejected
Null Hypothesis 3	Accepted

CHAPTER V  
SUMMARY, CONCLUSIONS, IMPLICATIONS, LIMITATIONS AND  
RECOMMENDATIONS

Summary

The purpose of this study was to empirically examine cultural, ethnic, demographic, and sexual-related factors that influence sexual decision-making in Black women. Scales measuring the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and protect oneself against unwanted pregnancy, STDs, and HIV have been found to be a useful approach in understanding sexual decision-making (Morokoff et al., 1997). Since sexual decision-making has been found to be a significant aspect of establishing positive sexual experiences and good sexual health, examining specific factors that may affect this process is important.

The research questions which guided this study were: (a) Are there differences among Black women on ethnic identity in their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?; (b) Are there differences among Black women across subjective stigma on their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?; (c) Does Black women's self-perceived physical attractiveness influence their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?; (d) Is there a

relationship between Black women's sexual behavior and contraceptive use history and their ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV?; and (e) What cultural, sexual, and self-evaluative variables are the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV for Black women?

The sample for this study consisted of 82 undergraduate and graduate Black female students at The University of Georgia, Georgia State University, Tarleton State University, and Clark Atlanta University. Participants ranged in age from 18 to 34, with the majority of the participants aged 21 (20.7%) and 20 (13.4%). Students volunteered to participate in the study. Participants completed self-report questionnaire packets in various settings on the college campuses during the spring semester of 2002.

Pearson Product-Moment correlation coefficients were calculated to investigate whether there were relationships between the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV and each of the following variables: ethnic identity, subjective stigma, and total number of partners. Results indicated that there was a statistically significant relationship between ethnic identity and the ability to refuse unwanted sexual activity and the ability to prevent unwanted pregnancy, STDs, and HIV. There was also a statistically significant relationship between subjective stigma and the ability to refuse unwanted sexual activity. There were no significant relationships between the total number of sexual partners and any of the dependent variables; ethnic identity and the ability to initiate unwanted sexual

activity; or subjective stigma and the ability to initiate sexual activity and prevent unwanted pregnancy, STDs, and HIV.

One-way ANOVAs were calculated to investigate whether differences existed in the ability to initiate sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV and each of the following variables: self-perceived physical attractiveness, ever having or not having had an unwanted sexual outcome, and frequency of condom use. Results indicated that there were no significant differences in participants who had or have not had unwanted sexual outcomes or self-perceived physical attractiveness scores and any of the dependent variables. In addition, there were no significant differences in the ability to initiate sexual activity and refuse unwanted sexual activity among participants with differences in the frequency of condom use. There was a significant difference in the ability to prevent unwanted pregnancy, STDs, and HIV and frequency of condom use; however, this statistical significance was most likely due to the similarity in the two variables. There were no significant differences in the ability to initiate sexual activity and refuse unwanted sexual activity among participants with differences in the frequency of condom use.

Lastly, three multiple regressions were calculated to investigate what cultural, sexual, and self-evaluative variables were the best predictors of the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV. There were no significant variables that predicted the ability to initiate wanted sexual activity or the ability to prevent unwanted pregnancy, STDs, and HIV. Subjective stigma and ethnic identity were significant variables found to predict the ability to refuse unwanted sexual activity.

## Conclusions and Discussion

### Factors Related to the Ability to Initiate Wanted Sexual Activity

In this study, Black women's ability to initiate wanted sexual activity scores tended to be normally distributed. A little more than half of the participants reported that they initiated sexual activity with their partner. Unfortunately, there were no unique factors to explain the differences in the scores. The results showed that there were no factors significantly related to the ability to initiate wanted sexual activity.

One explanation for these findings may be that sexual initiation is not significantly affected by ethnic experiences. Sexual initiation may be more influenced by issues of gender role or norms. Despite more liberal attitudes about sexuality, many women continue to comply with gender roles regarding sexuality where they are passive participants (Morokoff et al., 1997). It has been reported that less than 15% of married women are likely to be the initiator in sexual relationships (Blumstein & Schwartz, 1983). In contrast, Wyatt and Lyons-Rowe (1990) (as cited in Wyatt et al., 1993) found that women who stated that they had satisfactory sexual relationships or happy marriages reported having higher rates of initiating. Thus, it may be necessary to examine gender roles and satisfaction in relationships to determine whether there is a relationship with the ability to initiate sexual activity.

Another explanation for the failure to find significant relationships could be the lack of variability in the participants. The study used a convenience sample of college-educated Black women. The majority of the participants came from two-parent middle class suburban homes. A larger sample with non-college educated women may have garnered significant findings.

Lastly, there may have been a failure to acquire statistical significance due to the sensitive nature of the topic. There is a possibility that participants under- or over-reported information regarding their sexual behavior and contraceptive use history. In the current study, a small, but noteworthy, number of the participants avoided answering questions about the number of sexual partners. This, in turn, lowered the amount of usable data and may have affected the results of the study.

#### Findings from Research Question 1 Regarding Ethnic Identity

Results indicated a significant relationship between ethnic identity and the ability to refuse unwanted sexual activity. There was also a significant relationship between ethnic identity and the ability to prevent unwanted pregnancy, STDs, and HIV. These results suggest that higher levels of ethnic identity are associated with a higher ability to refuse unwanted sexual activity and a higher ability to prevent unwanted sexual outcomes.

Very little research has been conducted on ethnic identity and the ability to refuse unwanted sexual activity. Therefore, there are no direct comparisons of the results found in this study. What has been found regarding ethnic identity is that those who have higher levels of ethnic identity are more likely to have higher levels of self-efficacy (Smith et al, 1999). Likewise, Sionéan, DiClemente, Wingood, Crosby, Cobb, Harrington, Davies, Hook, and Oh (2002) found that adolescents with high self-efficacy issues were more likely to refuse unwanted sexual activity than their counterparts with lower self-efficacy. This similar effect may be an explanation for the findings in this study. Further investigation is needed on this new discovery.

Another explanation for these findings is the literature support for ethnic identity being associated with one's physical health (Siegel, 2000). Those who state that they have a sense of belonging and strongly identify with their ethnic group are more likely to have better health and work towards being healthy. Though past research has focused on alcohol consumption and obesity, the results can apply to sexual health, including preventing unwanted pregnancy, STDs, and HIV.

Lastly, Phinney (1992, 1996) defines ethnic identity as how one interprets and understands his or her own ethnicity, including self-identification as a group member, sense of belonging, and attitudes towards one's group. Having a higher ethnic identity may create a greater sense of responsibility pertaining to one's ethnic group as well as the expectation of positively representing the group. Therefore, the ability to refuse unwanted sexual activity and preventing unwanted sexual outcomes may be a way to protect one's belongingness in the group. These modes of sexual decision-making may also be a way to prevent a negative behavior or outcome (e.g., appearing promiscuous, out-of-wedlock pregnancy) for one, representing the entire ethnic group. Understanding the history of sexual exploitation of Black women and the perpetuation of the promiscuity stereotype could create more culturally conscious decisions pertaining to Black women's sexual activity.

#### Findings from Research Question 2 Regarding Subjective Stigma

Results indicated a significant relationship between subjective stigma and the ability to refuse unwanted sexual activity; however, no significant relationship was found between subjective stigma and the ability to prevent unwanted pregnancy, STDs, and HIV. These findings suggest that the less stigmatized Black women are the more likely

they are to refuse unwanted sexual activity; however levels of stigmatization do not influence the ability to prevent unwanted sexual outcomes. Subjective stigma is defined as the level to which one internalizes the stereotypes about his or her group (Brega & Coleman, 1999). There is little explanation why these results have occurred due to the lack of supporting literature on subjective stigma. In addition, it was surprising that there was statistical significance for the ability to refuse unwanted sexual activity, but not for the ability to prevent unwanted sexual outcomes. While it is possible to infer that Black women who do not internalize or accept the images and attitudes that Black women are sexually promiscuous and impulsive are more comfortable with who they are as Black women and feel more empowered to refuse unwanted sexual activity, this possible explanation does not translate to the ability to prevent unwanted pregnancy, STDs, and HIV. Further research is needed to examine how subjective stigma relates to the ability to refuse unwanted sexual activity as well as other aspects of sexual decision-making.

#### Findings from Research Question 3 Regarding Self-Perceived Physical Attractiveness

Results indicated no significant relationships in self-perceived physical attractiveness and the ability to refuse unwanted sexual activity, and self-perceived physical attractiveness and the ability to prevent unwanted pregnancy, STDs, and HIV. These findings suggest that level of self-perceived attractiveness does not impact the ability to refuse unwanted sexual activity or prevent unwanted sexual outcomes.

One explanation for these findings is the use of a one-item measure for self-perceived physical attractiveness. Though the one-item measure has been used in past studies (i.e., Wade & Cooper, 1999), it may not have been appropriate for this study. A multiple item measure of self-perceived physical attractiveness may produce significant

results similar to those found in past research. It has been found that self-perceived attractiveness is related to the number of sexual partners, contraception choices, and one's sexual self-view (Palmer, 1995; Wiederman & Hurst, 1998).

Another explanation for these findings may be that the scores on self-perceived physical attractiveness were skewed on the higher end. Over half of all participants rated themselves a 6 or 7 on the scale. Since the scores were not more evenly distributed, getting significant results was less likely to occur.

Lastly, self-perceived physical attractiveness may be an important variable for obtaining a sexual partner, but not in influencing the sexual decisions made within the relationship. It has been found that women who perceive themselves as physically attractive tend to have more sexual partners (Palmer, 1995). Once in the sexual relationship, other factors may figure into women's ability to make positive sexual decisions (e.g., her partner's attraction to her). Further research is needed to explore whether sexual decision-making is related to a partner's attraction.

#### Findings from Research Question 4 Regarding Total Number of Partners, Unwanted Sexual Outcomes, and Condom Use Frequency

There were no significant relationships between the total number of sexual partners and the ability to refuse unwanted sexual activity or the ability to prevent unwanted pregnancy, STDs, and HIV. There were no significant relationships between unwanted sexual outcomes and the ability to refuse unwanted sexual activity or the ability to prevent unwanted pregnancy, STDs, and HIV. Furthermore, there was no significant relationship between frequency of condom use and the ability to refuse unwanted sexual activity, but there was a significant relationship between condom use

frequency and the ability to prevent unwanted pregnancy, STDs, and HIV. This last finding was expected due to the frequency of condom use variable and preventing unwanted sexual outcomes subscale measuring similar items.

These nonsignificant results were surprising given that past research findings have indicated relationships with past sexual behavior and contraceptive use history and current sexual behaviors and decisions (Braithwaite et al., 1998; Diaz et al., 1999; Wyatt et al., 2000). One explanation for the results in this study could be due to social desirability and participants underreporting their sexual behavior. Also, these are one-item measures “which may involve greater random error than measurement via scales” (Sionéan et al., 2002, p. 62). The lack of variability among participants’ sexual behavior and contraceptive use history may also have affected the results.

Furthermore, the Sexual Assertiveness Scale (Morokoff et al., 1997) items are answered with the most current sexual relationship in mind. One’s ability to make sexual decisions may have more to do with the sexual relationship and partner, not the numbers of sexual partners, frequency of condom use, or negative sexual outcomes. It may be more beneficial to explore the length of one’s sexual relationship or partner’s willingness to use condoms as possible factors influencing sexual decision-making.

#### Findings from Research Question 5 Regarding the Ability to Refuse Unwanted Sexual Activity and the Ability to Prevent Unwanted Pregnancy, STDs, and HIV

The ability to refuse unwanted sexual activity regression model was statistically significant. The best predictors of the ability to refuse unwanted sexual activity were subjective stigma and ethnic identity. This finding suggests that Black women who feel less stigmatized by negative stereotypes have a sense of belonging, identify with their

ethnic group, and are more likely to refuse unwanted sexual activity. One explanation for this finding is that having positive feelings about one's ethnic group may make one feel better about herself. Therefore, a strong sense of self may empower a person to not be coerced into participating in unwanted sexual activities. Results of the regression analyses underline the need for additional research.

There were no predictors of the ability to prevent unwanted pregnancy, STDs, and HIV. The lack of significant results could have been due to the discrepancy between projected sample size and the actual sample size. Obtaining a smaller sample size increased the possibility of obtaining nonsignificant results because of less power.

Of note is that religiosity was not a significant predictor in any of the regression models. This finding suggests that one's relationship with God has little influence on sexual decision-making. This result is surprising especially with many participants in this study scoring very high on the Religious Well-Being subscale and past studies finding a relationship between religiosity and risky behavior (Ellison & Smith, 1991). One explanation may be that the sample was overall very religious, and this lack of variability could have resulted in nonsignificant findings. An alternative construct or instrument examining faith or religiosity may be more valuable. Another explanation may be that sexual experiences are kept separate from anything religious due to its taboo nature. Lastly, the rules of religion (e.g., distinct gender roles, ban on birth control) may influence women to entrust sexual decisions to their male partners or make a decision that is based on a religious belief and not one that will protect them from unwanted sexual outcomes.

## Implications

The findings from the current study suggest that cultural and ethnic factors influence sexual decision-making as measured by the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and protect oneself against unwanted pregnancy, STDs, and HIV. Little research has focused on what influences sexual behavior and sexual decision-making among Black women (Worth, 1989). This study added to the research by exploring within-group differences among Black women and how their cultural experiences influence their sexual decision-making.

One important implication of the findings from the current study is that cultural and ethnic experiences influence sexual decision-making. Specifically, refusal of unwanted sexual activity and preventing unwanted sexual outcomes are influenced by how Black women view themselves in cultural context. Black women may feel empowered when they have pride and a sense of belonging (i.e., ethnic identity) with their ethnic group. This empowerment can increase their sexual decision-making ability and allow them to better communicate their needs to their sexual partners. This ability may not only create a more satisfying sexual relationship, but also protect their sexual health. However, women are not in relationships alone. Women must feel comfortable and have trust in their relationships to be able to succeed in acting upon positive sexual decisions. These constructs need to be incorporated into strategies used to assist in increasing sexual decision-making skills.

Also of importance is the impact of subjective stigma on sexual decision-making skills, especially refusing unwanted sexual activity skills. Black women who internalize sexual stereotypes may have difficulty refusing unwanted sexual activity. Some may see

their sexuality as one of the few assets they have to offer and use sexual activity as a means of esteem or resources. This puts women at risk for sexual exploitation, sexual abuse, or negative sexual health. On the other hand, some Black women who internalize stereotypes may repress their sexuality and deny themselves a positive sexual relationship (West, 1995). This type of internalization may isolate Black women from having relationships at all out of fear of being perceived as a Jezebel or it can lead to sexual dysfunction. Helping these women not accept the stereotypes about their ethnic group may be necessary to enable them to have sexual activity only when they want.

Another implication is that Black women's religiosity may not influence sexual decision-making. While Black women seem to be "more religious" (Wyatt et al., 2000), they are not necessarily more or less chaste in behavior or sexual decisions. This is similar to past studies that found that while religiosity may influence initiating first coitus, it does not have an impact once one is no longer abstinent (Zaleski & Schiaffino, 2000). While churches may do an efficient job of promoting abstinence, there seems to be silence about sexual behavior beyond the "just say no" or "wait until you are married" message. The unwillingness to communicate in the church may have created an inability to communicate outside of the church. This lack of communication can lead to less sexual satisfaction and risky sexual behavior. Research pertaining to how one's level of practicing religious rules and what those rules are as they relate to sexuality may result in significant data regarding sexual decision-making.

Findings concerning religiosity in this study should be viewed with caution. Religiosity is a complex factor, and it is difficult to measure. Researchers do not agree on how to appropriately measure this construct or define it. Further research is needed to

improve and create instruments that address the complexity of religiosity, including faith, spirituality, and religious practices and beliefs. More comprehensive instruments could provide better information regarding religiosity's relationship with sexual decision-making.

Lastly, counseling psychologists can play integral roles in developing and implementing comprehensive methods for improving sexual decision-making skills by incorporating cultural and ethnic components. As stated earlier, counseling psychologists are the pioneers in prevention and multicultural issues. They can take the lead in creating a better understanding of cultural diversity and promoting healthy sexual relationships.

The findings from the current study serve to enhance the existing knowledge of incorporating sociocultural factors into sexuality research, theory, and practice. Despite some of the nonsignificant results, the findings suggest that social cognitive theory served as an effective model for conceptualizing sexual decision-making. The information garnered from this inquiry provides an initial framework that can be useful for psychologists, educators, and researchers. Further investigation is needed.

#### Limitations

Along with the limitations listed in Chapter I, additional limitations for this study are as follows:

1. There were single item measures (i.e., self-perceived physical attractiveness, unwanted sexual outcomes, condom use frequency) used in this research that may not have assessed the variables effectively, thus possibly resulting in nonsignificant results.

2. The Sexual Assertiveness Scale for Women is designed to examine the current or last sexual relationship. There is no way of knowing whether items endorsed are only applicable to the relationship in focus or if there is a pattern across all sexual relationships.
3. Due to exhausting recruiting resources and missing data, the sample size of the study was smaller than the sample size estimated to ensure statistical power. Some of the analyses may have resulted in Type II error.
4. Participants were recruited from four different colleges. The differences among the colleges were not explored. Students in Texas may have been significantly different than students in Georgia. The students from schools in urban environments may have been different than those in less urban schools. The students from the historically Black college could have been different from students in the predominantly White colleges.
5. The multiple methods that were used to complete the research packets could have affected how participants answered the questions. Social desirability could have occurred with participants who completed their surveys during class time or at a meeting as opposed to those who completed the survey in a private room or at their leisure.
6. Data were collected from self-report questionnaires. Qualitative data could provide additional insight regarding Black women's sexual decision-making processes and the cultural and ethnic constructs explored in this study.

### Recommendations for Future Research

1. It is recommended that this study be replicated with a larger and more diverse (i.e., non-college educated Black women) sample. Statistical power will be increased, and there may be more variability in experiences.
2. Since women make sexual decisions in the context of relationships (Amaro, 1995), it is recommended that future studies include more inquiry about sexual partners and relationships.
3. It is recommended that Black women who may be from outside of the United States or those who are first generation American be included in future studies to further explore the impact of cultural factors.
4. It is recommended that future studies examine more than one sexual relationship using the Sexual Assertiveness Scale for Women to determine whether scores are indicative of one relationship or multiple relationships.
5. It is recommended that future studies incorporate a pre- and posttest design with an intervention component. This will not only provide Black women with the opportunity to learn better sexual decision-making skills, but also examine the relationship with ethnic identity and subjective stigma and how those constructs may impact sexual decisions.
6. Most sexual health programs, especially those dealing with sexual decision-making, are intended for women. Women have been given the responsibility to make informed, healthy, and positive decisions not only for themselves, but also for the men in their relationships (Morokoff et al., 1995). Men need to be included in the process. It is recommended that a sexual decision-making scale be created to

understand men's sexual decision-making and explore whether the results found in this study apply to Black men.

In summary, the goal of the current study was to investigate whether sociocultural factors influence the ability to initiate wanted sexual activity, refuse unwanted sexual activity, and prevent unwanted pregnancy, STDs, and HIV in Black women. Findings from this study provide important information for understanding cultural influences on sexual decision-making. Further investigation is clearly needed.

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APPENDICES

## APPENDIX A

## Correlation Coefficients for Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Stigma	-	.21	.15	-.02	.01	.12	.02	-.01	.34**	.12	.24*	.11	-.03	.08	-.08	.04	.02
2. Ethnic Identity		-	-.03	-.11	-.01	.08	.03	.04	.27*	.23*	.04	.06	.07	.02	-.14	-.01	.16
3. Attractiveness			-	-.01	-.03	-.22*	-.08	.09	.14	-.21	-.02	.13	-.07	-.13	-.10	-.14	-.04
4. Unwanted Outcomes				-	.22	-.06	-.20	.19	-.13	-.13	-.23*	-.55**	-.83**	-.02	.17	-.12	-.20
5. Partners					-	-.15	-.18	.14	-.13	-.07	-.47**	-.35**	-.11	.15	.07	-.15	-.20
6. Condom Use						-	.04	-.06	.10	.74**	.28*	-.07	.10	.001	-.16	.16	.12
7. Religiosity							-	-.16	-.14	-.01	.23*	.23*	.04	.05	-.02	-.07	.60**
8. Initiate								-	.04	-.18	-.13	-.13	-.12	.16	.08	-.004	-.14
9. Refuse									-	.33**	.13	-.01	.15	-.22*	-.05	.30**	-.03
10. Prevent										-	.37**	.10	.08	-.08	-.23*	.36**	.00
11. Age of 1 <sup>st</sup> Sex											-	.19	.19	.15	-.34**	.13	.06
12. Ever had STD												-	.14	-.04	-.11	.14	.04
13. Unwanted Pregnancy													-	-.02	-.11	.11	.14
14. Age														-	-.11	-.18	.08
15. Live with Both Parents															-	-.16	.13
16. SES of Neighborhood																-	-.08
17. Church Attendance																	-

Note. \* $p < .05$ , \*\* $p < .01$

## APPENDIX B

Questions Regarding Sexual History and Demographics

1. What age were you when you first had consensual sexual intercourse? \_\_\_\_\_
2. What was your relationship to your consensual first partner? \_\_\_\_\_
  - A. How many consensual sexual partners have you had before age 14? \_\_\_\_\_
 

between 15 and 17?	_____
between 18 and 21?	_____
over 21?	_____
3. Have you ever used any form of birth control Yes          No
  - A. Which method(s) have you used? (Circle all that apply)
 

Natural methods (Rhythm, sympto-thermal, billings)	Condom
Withdrawal	IUD
Diaphragm	Pill/Depo Provera/Norplant
Foam, Jelly, chemical means	Tubal Ligation
Other: _____	
  - B. Which method(s) are you currently using? \_\_\_\_\_
  - C. How often do you use condoms?
 

(1) Never	(2) Less than half the time
(3) Half the time	(4) More than half the time
(5) Every time	
4. Have you ever been pregnant? Yes          No
  - A. If yes, was the pregnancy Planned    Unplanned

What was the outcome of the pregnancy?

- (1) Had the baby and kept the child                      (2) Gave the baby up for adoption  
 (3) Had a miscarriage    (4) Had an abortion  
 (5) Other

5. Have you ever had a sexually transmitted disease?

Yes; please specify \_\_\_\_\_ No

6. What messages have you heard about Black women and sexual behavior and relationships?

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7. What is your gender?                      Female                      Male

8. How old are you? \_\_\_\_\_

9. What is your highest level of education?

- \_\_\_\_\_ Less than high school  
 \_\_\_\_\_ Some high school  
 \_\_\_\_\_ High school graduate  
 \_\_\_\_\_ Some college/Currently attending college  
 \_\_\_\_\_ College graduate (B.A., B.S., etc.)  
 \_\_\_\_\_ Some post college education/graduate school/professional school  
 (medical, law, etc.)  
 \_\_\_\_\_ Graduate/professional degree (M.S., M.A., Ph.D., M.D., J.D., etc.)

10. What is your current marital status?

- Single/have never been married                       Married  
 Separated     Divorced  
 Widowed

12. To the best of your knowledge, what is your family's total annual income (if married, report marital income)?

- \$0 to 9,999     \$10,000 to 19,999  
 \$20,000 to 29,999     \$30,000 to 39,999  
 \$40,000 to 49,999     over \$50,000  
 over \$100,000

13. Did you live with both of your parents growing up (at least birth to end of high school)?

- Yes  
 No; Which parent did you live with [if neither, who was your primary care-taker/guardian(s)]? \_\_\_\_\_

Which best describes the reason for you not living with both parents?

- Because of divorce or separation  
 Because your parents never married  
 Because of the death of one parents  
 Because of the death of both parents  
 Because of some other reason; please explain \_\_\_\_\_

14. What state(s) were you raised in? \_\_\_\_\_

15. Would you say that your neighborhood was:

- |       |              |       |                    |
|-------|--------------|-------|--------------------|
| _____ | Poor         | _____ | Working class      |
| _____ | Middle class | _____ | Upper middle class |
| _____ | Upper class  |       |                    |

16. What is your religious present religious affiliation? \_\_\_\_\_

17. How often do you attend church?

- |       |                         |       |                             |
|-------|-------------------------|-------|-----------------------------|
| _____ | Never                   | _____ | Less than once a month      |
| _____ | Once or twice a month   | _____ | Three to four times a month |
| _____ | Over four times a month |       |                             |

## APPENDIX C

Script Used for Initial Contact

Hello. My name is Kamioka Gabriel and I am a doctoral student at the University of Georgia in the Counseling Psychology department. The reason I am contacting you is because I am currently conducting research and I am interested in recruiting members of your organization to participate in my survey. My research study is titled “Influences on Sexual Decision-Making,” and the purpose of this research is to better understand how culture, ethnicity, and sexual history may influence sexual decision-making of women. I would like to use about 15 to 20 minutes of your meeting time to recruit participants, have them fill out the questionnaires, and answer any questions they may have concerning my study. Also, participants have an opportunity to win a \$50 gift certificate.

## APPENDIX D1

Participant Consent for The University of Georgia

## Influences on Sexual Decision-Making

**Participant Consent Form**

I agree to take part in a research study titled “Influences on Sexual Decision-Making,” which is being conducted by Kamieka O. S. Gabriel, M.A. (under the supervision of Rosemary E. Phelps, Ph.D.) in the Department of Counseling and Human Development Services at The University of Georgia, Athens, Georgia (706-542-1812). The purpose of this research is to better understand how culture, ethnicity, and sexual history may influence sexual decision-making of women. There are no right or wrong answers. If I feel certain questions do not apply to me, I can skip over those questions.

The reason for including me in this research study is because I am a female over the age of 18. **I understand that participation is entirely voluntary and anonymous, which means that no one will know my answers to these questions and there is no way to trace my answers back to me. I can stop participating at any time without giving any reason, and without penalty.** I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The procedures are as follows: information will be gathered from a set of questionnaires distributed and completed at designated locations (e.g., meetings, classes) and times. It will take no more than 30 minutes to complete the questionnaires. On completion of the survey, I will receive an opportunity to win a \$50 gift certificate from a major department store. If I would like to participate in the raffle, I will write my name and address on a postcard. All postcard will be placed in a box and two postcards will be chosen at random from all entries. If I am one of the winners, I will be notified and sent the gift certificate in the mail by March 2002.

There are questions relating to my current and past experiences, including questions about explicit sexual activity, which may make me feel somewhat uncomfortable, embarrassed or upset. If I become overly upset, I can refuse to answer any questions and withdraw from completing the questionnaire without penalty. I will also be able to ask questions before, during, and after the time of administration of the questionnaire. The following are referral numbers to university and community support services (i.e., counseling agencies) to further discuss any upsetting issues.

**Counseling & Testing Center Clark Howell Hall - (706) 542-3183**

**Mental Health Clinic, University Health Service - (706) 542-2273**

**The Center for Counseling and Personal Evaluation, Aderhold (706) 542-8508**

**Psychology Clinic, Psychology Building - (706) 542-1173**

**Athens Rape Crisis Center (706) 353-1912**

**Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is available 24 hours a day.**

My participation in this study will help to develop programs to provide support and services for women. It will also provide me with an opportunity to reflect upon topics and concerns affecting my life. My participation is important. Any and all input that I provide is appreciated.

The researcher will answer any further questions about the research, now and during the course of the project, and can be reached by the telephone number listed above. Also, if I am interested in receiving a summary of these findings, I can contact the researcher and information will be forwarded to me.

---

Signature of Researcher

Date

For questions or problems about your rights please call or write: Chris A. Joseph, Ph.D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-6514; E-Mail Address [IRB@uga.edu](mailto:IRB@uga.edu).

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. **I will keep the first two pages of this form, sign below, and return this page when I return the research materials.**

---

Signature of Participant

Date

## APPENDIX D2

Debriefing Statement for The University of Georgia**Debriefing Statement**

Thank you for participating in the study Sociocultural Influences on Sexual Decision-Making in Black Women. It is very important that you do not share information about this study with others, because they may be participants in the future.

The purpose of this study is to examine what factors influence the decisions women make to protect themselves from unwanted circumstances (i.e., unwanted pregnancy, sexually transmitted disease) and to understand what skills women use to attain their sexual goals. This study will also explore the differences among Black women and how their cultural experiences influence their sexual decision-making.

Some of the questions were sexually explicit and may have caused you to recall some negative memories or experiences. If this has occurred, I can talk with you about the resources available or you can contact the following agencies to further discuss these experiences:

Counseling & Testing Center, Clark Howell Hall - (706) 542-3183

Mental Health Clinic, University Health Service - (706) 542-2273

The Center for Counseling and Personal Evaluation, Aderhold (706) 542-8508

Psychology Clinic, Psychology Building - (706) 542-1173

Athens Rape Crisis Center (706) 353-1912

Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is available 24 hours a day.

If you would like to learn the results of this experiment, please contact Kamieka Gabriel by mailing a letter requesting results on this study, Sociocultural Influences on Sexual Decision-Making in Black Women. Please include your name and address in the correspondence. The researcher can be reached at the following address:

Department Of Counseling & Human Development Services

402 Aderhold Hall

The University of Georgia

Athens, Ga 30602-7142

If you have any additional questions regarding this study, please contact Kamieka Gabriel at 706-542-1812. Once again, thank you for your participation.

## APPENDIX E1

Participant Consent for Tarleton State University  
Influences on Sexual Decision-Making

**Participant Consent Form**

I agree to take part in a research study titled “Influences on Sexual Decision-Making,” which is being conducted by Kamioka O. S. Gabriel, M.A. (under the supervision of Rosemary E. Phelps, Ph.D.) in the Department of Counseling and Human Development Services at The University of Georgia, Athens, Georgia (706-542-1812). The purpose of this research is to better understand how culture, ethnicity, and sexual history may influence sexual decision-making of women. There are no right or wrong answers. If I feel certain questions do not apply to me, I can skip over those questions.

The reason for including me in this research study is because I am a female over the age of 18. **I understand that participation is entirely voluntary and anonymous, which means that no one will know my answers to these questions and there is no way to trace my answers back to me. I can stop participating at any time without giving any reason, and without penalty.** I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The procedures are as follows: information will be gathered from a set of questionnaires distributed and completed at designated locations (e.g., meetings, classes) and times. It will take no more than 30 minutes to complete the questionnaires. On completion of the survey, I will receive an opportunity to win a \$50 gift certificate from a major department store. If I would like to participate in the raffle, I will write my name and address on a postcard. All postcard will be placed in a box and two postcards will be chosen at random from all entries. If I am one of the winners, I will be notified and sent the gift certificate in the mail by March 2002.

There are questions relating to my current and past experiences, including questions about explicit sexual activity, which may make me feel somewhat uncomfortable, embarrassed or upset. If I become overly upset, I can refuse to answer any questions and withdraw from completing the questionnaire without penalty. I will also be able to address questions before, during, and after the time of administration of the questionnaire to either the above named researcher or Becky Tabony (254-968-9044). The following are referral numbers to university and community support services (i.e., counseling agencies) to further discuss any upsetting issues:

**Student Counseling Center, Tarleton State U., SDC Room 212            254-968-9044**  
**Mental Health & Mental Retardation, 906 W. Lingleville Hwy.            254-968-4181**  
**Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is**  
**available 24 hours a day.**

My participation in this study will help to develop programs to provide support and services for women. It will also provide me with an opportunity to reflect upon topics and concerns affecting my life. My participation is important. Any and all input that I provide is appreciated.

The researcher will answer any further questions about the research, now and during the course of the project, and can be reached by the telephone number listed above. Also, if I am interested in receiving a summary of these findings, I can contact the researcher and information will be forwarded to me.

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Signature of Researcher

Date

For questions or problems about your rights please call or write: Chris A. Joseph, Ph.D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-6514; E-Mail Address [IRB@uga.edu](mailto:IRB@uga.edu).

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. **I will keep the first two pages of this form, sign below, and return this page when I return the research materials.**

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Signature of Participant

Date

## APPENDIX E2

Debriefing Statement for Tarleton State University**Debriefing Statement**

Thank you for participating in the study Sociocultural Influences on Sexual Decision-Making in Black Women. It is very important that you do not share information about this study with others, because they may be participants in the future.

The purpose of this study is to examine what factors influence the decisions women make to protect themselves from unwanted circumstances (i.e., unwanted pregnancy, sexually transmitted disease) and to understand what skills women use to attain their sexual goals. This study will also explore the differences among Black women and how their cultural experiences influence their sexual decision-making.

Some of the questions were sexually explicit and may have caused you to recall some negative memories or experiences. If this has occurred, you can talk to Becky Tabony (968-9044) about the resources available or you can contact the following agencies to further discuss these experiences:

Student Counseling Center, Tarleton State University, SDC Room 212      254-968-9044

Mental Health & Mental Retardation, 906 W. Lingleville Hwy.      254-968-4181

Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is available 24 hours a day.

If you would like to learn the results of this experiment, please contact Kamieka Gabriel by mailing a letter requesting results on this study, Sociocultural Influences on Sexual Decision-Making in Black Women. Please include your name and address in the correspondence. The researcher can be reached at the following address:

Department Of Counseling & Human Development Services  
402 Aderhold Hall  
The University of Georgia  
Athens, Ga 30602-7142

If you have any additional questions regarding this study, please contact Kamieka Gabriel at 706-542-1812. Once again, thank you for your participation.

## APPENDIX F1

Initial Contact for Georgia State University

Hello. I am a doctoral student in the Counseling Psychology Department at the University of Georgia. I am contacting you because I am currently conducting research for my dissertation and I am interested in recruiting **Black female members** from your organization to participate in my survey. My research study is titled “Influences on Sexual Decision-Making,” and the purpose of this research is to better understand how culture, ethnicity, and sexual history may influence how women make decisions related to sexual issues. I would like to attend your next meeting recruit participants, have them fill out the questionnaires, and answer any questions they may have concerning my study. Participants have an opportunity to win a \$50 Macy’s gift certificate.

You can reach me by email or phone, 404-579-6473.

Thank you.

Kamieka O. S. Gabriel, MA

## APPENDIX F2

Participant Consent for Georgia State University

## Influences on Sexual Decision-Making

## Participant Consent Form

I agree to take part in a research study titled “Influences on Sexual Decision-Making,” which is being conducted by Kamioka O. S. Gabriel, M.A. (under the supervision of Rosemary E. Phelps, Ph.D.) in the Department of Counseling and Human Development Services at The University of Georgia, Athens, Georgia (706-542-1812). The purpose of this research is to better understand how culture, ethnicity, and sexual history may influence sexual decision-making of women. There are no right or wrong answers. If I feel certain questions do not apply to me, I can skip over those questions.

The reason for including me in this research study is because I am a female over the age of 18. **I understand that participation is entirely voluntary and anonymous, which means that no one will know my answers to these questions and there is no way to trace my answers back to me. I can stop participating at any time without giving any reason, and without penalty.** I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The procedures are as follows: information will be gathered from a set of questionnaires distributed and completed at designated locations (e.g., meetings, classes) and times. It will take no more than 30 minutes to complete the questionnaires. On completion of the survey, I will receive an opportunity to win a \$50 gift certificate from a major department store. If I would like to participate in the raffle, I will write my name and address on a postcard. All postcard will be placed in a box and two postcards will be chosen at random from all entries. If I am one of the winners, I will be notified and sent the gift certificate in the mail by March 2002.

There are questions relating to my current and past experiences, including questions about explicit sexual activity, which may make me feel somewhat uncomfortable, embarrassed or upset. If I become overly upset, I can refuse to answer any questions and withdraw from completing the questionnaire without penalty. I will also be able to ask questions before, during, and after the time of administration of the questionnaire. The following are referral numbers to university and community support services (i.e., counseling agencies) to further discuss any upsetting issues.

**The Counseling Center Clark (106 Courtland, Third Floor)- (404) 651-2211  
Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is  
available 24 hours a day.**

My participation in this study will help to develop programs to provide support and services for women. It will also provide me with an opportunity to reflect upon topics and concerns affecting my life. My participation is important. Any and all input that I provide is appreciated.

The researcher will answer any further questions about the research, now and during the course of the project, and can be reached by the telephone number listed above. Also, if I am interested in receiving a summary of these findings, I can contact the researcher and information will be forwarded to me.

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Signature of Researcher

Date

For questions or problems about your rights please call or write: Chris A. Joseph, Ph.D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-6514; E-Mail Address [IRB@uga.edu](mailto:IRB@uga.edu).

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. **I will keep the first two pages of this form, sign below, and return this page when I return the research materials.**

---

Signature of Participant

Date

## APPENDIX F3

Debriefing Statement for Georgia State University**Debriefing Statement**

Thank you for participating in the study Sociocultural Influences on Sexual Decision-Making in Black Women. It is very important that you do not share information about this study with others, because they may be participants in the future.

The purpose of this study is to examine what factors influence the decisions women make to protect themselves from unwanted circumstances (i.e., unwanted pregnancy, sexually transmitted disease) and to understand what skills women use to attain their sexual goals. This study will also explore the differences among Black women and how their cultural experiences influence their sexual decision-making.

Some of the questions were sexually explicit and may have caused you to recall some negative memories or experiences. If this has occurred, I can talk with you about the resources available or you can contact the following agencies to further discuss these experiences:

The Counseling Center Clark (106 Courtland, Third Floor)- (404) 651-2211

Rape, Abuse, and Incest National Network 1-800-656-HOPE. This hotline is available 24 hours a day.

If you would like to learn the results of this experiment, please contact Kamieka Gabriel by mailing a letter requesting results on this study, Sociocultural Influences on Sexual Decision-Making in Black Women. Please include your name and address in the correspondence. The researcher can be reached at the following address:

Department Of Counseling & Human Development Services  
402 Aderhold Hall  
The University of Georgia  
Athens, Ga 30602-7142

If you have any additional questions regarding this study, please contact Kamieka Gabriel at 706-542-1812. Once again, thank you for your participation.

## APPENDIX G1

Participant Consent for Clark Atlanta University

## Influences on Sexual Decision-Making

**Participant Consent Form**

I agree to take part in a research study titled “Influences on Sexual Decision-Making,” which is being conducted by Kamioka O. S. Gabriel, M.A. (under the supervision of Rosemary E. Phelps, Ph.D.) in the Department of Counseling and Human Development Services at The University of Georgia, Athens, Georgia (706-542-1812). The purpose of this research is to better understand how culture, ethnicity, and sexual history may influence sexual decision-making of women. There are no right or wrong answers. If I feel certain questions do not apply to me, I can skip over those questions.

The reason for including me in this research study is because I am a female over the age of 18. **I understand that participation is entirely voluntary and anonymous, which means that no one will know my answers to these questions and there is no way to trace my answers back to me. I can stop participating at any time without giving any reason, and without penalty.** I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The procedures are as follows: information will be gathered from a set of questionnaires distributed and completed at designated locations (e.g., meetings, classes) and times. It will take no more than 30 minutes to complete the questionnaires. On completion of the survey, I will receive an opportunity to win a \$50 gift certificate from a major department store. If I would like to participate in the raffle, I will write my name on a postcard. All postcard will be placed in a box and one postcard will be chosen at random from all entries. The winner will be announced when all entries have been handed in.

There are questions relating to my current and past experiences, including questions about explicit sexual activity, which may make me feel somewhat uncomfortable, embarrassed or upset. If I become overly upset, I can refuse to answer any questions and withdraw from completing the questionnaire without penalty. I will also be able to ask questions before, during, and after the time of administration of the questionnaire. The following are referral numbers to university and community support services (i.e., counseling agencies) to further discuss any upsetting issues.

**The University Counseling Center, Kresge Hall, rm. 210**  
**Rape, Abuse, and Incest National Network**  
*This hotline is available 24 hours a day.*

**(404) 880-8044**  
**1-800-656-HOPE**

My participation in this study will help to develop programs to provide support and services for women. It will also provide me with an opportunity to reflect upon topics and

concerns affecting my life. My participation is important. Any and all input that I provide is appreciated.

The researcher will answer any further questions about the research, now and during the course of the project, and can be reached by the telephone number listed above. Also, if I am interested in receiving a summary of these findings, I can contact the researcher and information will be forwarded to me.

---

Signature of Researcher

Date

For questions or problems about your rights please call or write: Chris A. Joseph, Ph.D., Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-6514; E-Mail Address [IRB@uga.edu](mailto:IRB@uga.edu).

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. **I will keep the first two pages of this form, sign below, and return this page when I return the research materials.**

---

Signature of Participant

Date

## APPENDIX G2

Debriefing Statement for Clark Atlanta University**Debriefing Statement**

Thank you for participating in the study Sociocultural Influences on Sexual Decision-Making in Black Women. It is very important that you do not share information about this study with others, because they may be participants in the future.

The purpose of this study is to examine what factors influence the decisions women make to protect themselves from unwanted circumstances (i.e., unwanted pregnancy, sexually transmitted disease) and to understand what skills women use to attain their sexual goals. This study will also explore the differences among Black women and how their cultural experiences influence their sexual decision-making.

Some of the questions were sexually explicit and may have caused you to recall some negative memories or experiences. If this has occurred, I can talk with you about the resources available or you can contact the following agencies to further discuss these experiences:

The University Counseling Center, Kresge Hall, rm. 210	(404) 880-8044
Rape, Abuse, and Incest National Network	1-800-656-HOPE
<i>This hotline is available 24 hours a day.</i>	

If you would like to learn the results of this experiment, please contact Kamieka Gabriel by mailing a letter requesting results on this study, Sociocultural Influences on Sexual Decision-Making in Black Women. Please include your name and address in the correspondence. The researcher can be reached at the following address:

Department Of Counseling & Human Development Services  
402 Aderhold Hall  
The University of Georgia  
Athens, Ga 30602-7142

If you have any additional questions regarding this study, please contact Kamieka Gabriel at 706-542-1812. Once again, thank you for your participation.