

The Effects of Ethnicity and Perceived Power On Women's Sexual Behavior.

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Abstract:

To aid development of programs to prevent HIV transmission in women, differences in sexual attitudes and behavior were examined among women who described themselves as dominant in their relationship with a male partner, sharing dominance equally with a male partner, or being dominated by a male partner. Ethnic differences were also examined among these three groups. Results indicated that perceived dominance was a significant predictor of women's personal empowerment (self-efficacy and outcome expectancies) with regard to sexual decision-making in their current relationship and safer sex behaviors. Ethnic differences were found between African American and White women in personal empowerment and safer sex behavior. Perceived dominance did not appear to affect African American and White women differently.

Keywords: sexual behavior | ethnicity | psychology | female sexuality | HIV | perceived power

Article:

Young women are one of the fastest growing groups of people acquiring HIV, the virus that causes AIDS. The Centers for Disease Control and Prevention (CDC) reported that in 1997 women accounted for 15% of the reported AIDS cases, up from 7% in 1985 (CDC, 1997). Women also are more likely than men to acquire the disease through heterosexual contact. In fact, among young adults aged 20-24 with AIDS, 54% of women versus 4% of men contracted the disease through heterosexual sex (CDC, 1997). The rise of AIDS in women is particularly pronounced in the African American community, with AIDS being the leading cause of death for African American women aged 25-44 (CDC, 1996). Currently, African American women represent 60% of all women with AIDS (CDC, 1998). Both African American and White female college students have been shown to engage in several behaviors that place them at high risk for contracting HIV (Belcastro, 1985; Jadack, Hyde, & Keller, 1995; MacDonald et al., 1990; Reinisch, Sanders, Hill, & Ziemba-Davis, 1992). For example, only about one in four college women consistently insist on using a condom (Butcher, Manning, & O' Neal, 1991; Caron, Davis, Halteman, & Stickle, 1993; Joffe et al., 1992; Johnson et al., 1994; Kusseling, Wenger, &

Shapiro, 1995; Latman & Latman, 1995; Wulfert & Wan, 1993), and the average number of lifetime sexual partners ranges from four to six for college women (Joffe et al., 1992; Reinisch et al., 1995).

Prevention efforts that target college women's risky behaviors are needed. However, to develop the most effective programs, the factors that influence women's safer sex behavior must be better understood. In the past, much research has focused on intrapersonal factors, which, although an important component of behavior, do not address the interpersonal nature of sexual interaction. More recently, researchers have begun to recognize the importance of interpersonal factors and the influence of power dynamics and ethnicity on women's ability to enact safer sex behavior.

Women, Safer Sex, and Power

In a special issue of the *Psychology of Women Quarterly* exploring women and power, Yoder and Kahn (1992) described two ways to conceptualize power: power over (dominance) and power to (personal empowerment). In the past, research on women's safer sex behavior focused predominately on personal empowerment in the form of intrapersonal influences on behavior such as self-efficacy and outcome expectancies for condom use (O'Leary, Goodhart, Jemmott, & Boccher-Lattimore, 1992; Wulfert & Wan, 1993). For example, a woman's self-efficacy for condom use relates to her feelings of control over her own actions (Bandura, 1989)-in other words, her power to enact safer sex behavior. These personal empowerment variables have been shown to provide some explanation of women's safer sex behavior. O'Leary et al. (1992) and Wulfert and Wan (1993) found that safe sex self-efficacy and outcome expectancies were significant predictors of women's safer sex behavior. However, Amaro (1995) criticized this exclusive focus on intrapersonal factors in sexuality research. She argued that this approach ignores the interpersonal aspects of sexual behavior as well as the underlying influences on interpersonal factors that are particularly relevant to women, such as power in relationships, socialization, and social roles (Amaro, 1995). A woman's ability to enact safer sex behavior depends not only on personal empowerment, but also on her ability to influence male partners to engage in safer sex behaviors. Yoder and Kahn (1992) described this type of interpersonal influence as power over or dominance.

In the past several years, researchers have begun to examine the relationship between power over and women's safer sex behavior through the use of interpersonal measures. These interpersonal measures have included partner attitudes toward condom use, anticipated negative reaction from partner, attitudes of women toward their male partners, history of sexual victimization, and sexual assertiveness. For example, Harlow, Quina, Morokoff, Grimley, and Rose (1992) found that anticipated negative reaction, history of sexual victimization, and lack of sexual assertiveness were all significant predictors of unsafe sexual behaviors, such as engaging in unprotected intercourse, choosing risky partners, and having anal sex. Additionally, although intra- and interpersonal factors were found to influence safer sex behaviors, interpersonal factors such as anticipated negative partner reaction appeared to play a greater role in unprotected sexual

intercourse than intrapersonal factors such as self-efficacy (Harlow et al., 1992). In a similar sample of college women, Soet, DiIorio, and Dudley (1998) found that interpersonal factors such as partner attitudes and anticipated partner response were better predictors of condom use than were intrapersonal factors such as self-efficacy and self-evaluative outcome expectancies.

Although these studies have provided valuable insight into the effects of interpersonal factors, the interpersonal measures used in these studies are indirect measures of power over, in that they have not directly assessed women's perceptions of dominance in their relationships. To begin to understand the relationship between power and women's behavior in intimate relationships with men, a more direct measure of women's perceived power is needed.

Power and Ethnicity

In reviewing the psychological literature on women and power, Griscom (1992) criticized past research for ignoring ethnic differences in power. Yet, it has been argued for some time that African American and White women experience power differently. In one of the first works on women and power, McClelland (1975) pointed to differences in the socialization of African American and White women, suggesting that African American women have been allowed to express greater assertiveness. Within the HIV prevention literature, Wingood and DiClemente (1992) have suggested that African American women may have gender roles that are "less traditional" given the dominant U.S. culture. These less traditional roles may afford them greater flexibility in negotiating safer sex behaviors. Using data from focus group interviews with high-risk African American and Hispanic women, Kline, Kline, and Oken (1992) concluded that concern about minority women's ability to control sexual decision-making may be unfounded. They suggested that African American and Hispanic women's lack of traditional gender roles has allowed them more interpersonal power to negotiate safer sex behavior.

These reports conflict with the work of other researchers, who argue that African American women experience more barriers to condom use. Focus group data of Fullilove, Fullilove, Haynes, and Gross (1990) suggest that African American women feel that there is less respect for them in their community. Following the theory of Guttentag and Secord (1983), Fullilove et al. (1990) argued that the sex ratio imbalance in the African American community-the lack of heterosexual, employed, non-incarcerated Black men-has created an imbalance of power in sexual relationships in men's favor. This dyadw power imbalance in the African American community is an added barrier for Black women in their attempts to negotiate safer sex. Although it seems apparent that African American and White women may experience different socialization and social role expectations, it remains unclear how those differences niay affect their ability to influence a partner to engage in safer sex behavior.

In sum, our search of the literature yielded no studies that used direct measures of power over or dominance to examine women's ability to affect sexual decisionmaking and behavior (e.g., condom use) within their relationships. We failed to find any empirical studies that compared

African American and White women's experience of power within intimate relationships. Thus, the purpose of this work was to explore the influences of perceived dominance and ethnicity on women's safer sex behavior. Toward this end, we first examined the relationship between dominance and certain sexual behaviors. Women were grouped into three categories: dominant in their relationship with a male partner, sharing dominance equally with a male partner, or being dominated by a male partner. Three types of outcomes were assessed: perceptions of personal power to enact safer sex behavior (self-efficacy and outcome expectancies), sexual decision-making in their current relationship, and safer sex behavior including using condoms and discussing safer sex with a partner. Second, because of the conflicting theories on the role of ethnicity in women's power in relationships, we explored possible differences between African American and White women in the effects of dominance on personal empowerment, decision-making, and behavior.

METHOD

Procedure

The data for this study were obtained from the third year of a three-year study on the safer sex attitudes and behaviors of college students attending six colleges or universities in a large metropolitan area in the southeastern United States. Upon the Institutional Review Boards approval from the six participating institutions, a request for a random sample of students currently enrolled in a degree-seeking program and under age 25 was made to each registrar office. The lists were checked for address completeness, and those without a complete address were deleted from the sample. In the first year of data collection, 8,529 questionnaires were sent via first class mail; 4.8% were returned unopened because of wrong or insufficient addresses, and 2,044 completed questionnaires were returned, for a 25.1% adjusted response rate.

In the second year, surveys were sent to those who had returned a survey the year before as well as to additional students. To increase the response rate, several changes were made to the procedures. These changes yielded an increase in the response rate, with 68.5% of the students in the follow-up sample responding and 42.9% of the students in the new sample responding.' For the third year of data collection, a total of 2,389 questionnaires were sent to those students who had completed a survey at least once in the previous two years (in either the followup or new sample). Of the surveys sent, 2.3% were returned unopened or identified through telephone follow-up as being sent to the wrong address; 1,493 questionnaires were returned completed, representing a 63.9% adjusted response rate for the sample used in this study.

Sample

For the present study, the analysis was limited to heterosexual, sexually active female students, aged 18 to 25, who were not married. "Sexually active" was defined as ever having had vaginal, oral, or anal intercourse. Because of the small numbers of Asian and Latina women who responded to the survey, the sample for the present study was further limited to only White and

African American students. Out of the 881 women in the total sample, 615 met these criteria and were included in the analyses. The mean age of the subsample was 20.97 (SD = 1.63), with Whites comprising 46.2% of the sample (n = 284) and African Americans 53.8% (n = 331). Because this was the third year of a longitudinal study, the majority of the sample were seniors (41.1%), followed by juniors (34.0%), sophomores (24.1%), and freshmen (.8%). For the analysis, participants with missing data within a group of variables were eliminated from that analysis; thus, sample sizes vary across analyses. Participants who were missing data were found to be no different in academic status, $\chi^2(3) = 3.18, p = .36$, or race, $\chi^2(1) = 1.42, p = .71$, but were slightly younger than those with complete data, $t(613) = 1.81, p = .07$.

Measures

The independent measure, perceived dominance, was assessed with the question, “Who is (was) the most dominant partner in your relationship?” The item was rated on a 5-point scale with (1) always me, (2) mostly me, (3) both of us, (4) mostly partner, and (5) always partner. The item was reverse-coded so that higher scores reflected the woman having more power within that relationship. On inspection of the distribution and review of the literature, this item was transformed into a categorical variable by collapsing 1 and 2 into one group and 4 and 5 into another group to create a total of three groups. The final distribution resembled a normal curve with 22.4% (n = 137) in the partner-dominant group, 52.7% (n = 322) in the equal group, and 24.9% (n = 152) in the self-dominant group.

Self-efficacy was measured by 12 items related to the participant’s confidence in performing safer sex practices. The Self-Efficacy Scale (SES) was developed based on Bandura’s (1986) theory of self-efficacy and was used in the first wave of data collection for this study. The scale began with 21 items derived from a scale developed for high-risk adults (DiIorio, Maibach, O’Leary, Sanderson, & Celentano, 1997). Psychometric testing and the desire for a shorter scale led to the elimination of nine items. Each of the remaining 12 items was rated on a 10-point scale ranging from (1) not at all sure I can do to (10) completely sure I can do, with higher scores corresponding to higher levels of self-efficacy. The 12-item scale consists of four items for each of three factors: refusing to have sex, properly using a condom, and negotiating for condom use (see Appendix for list of items). Cronbach’s alphas for this sample were .74, .93, and .87, respectively.

An outcome expectancy scale was used to assess beliefs about outcomes associated with using condoms and discussing safer sex options. The scales were based on earlier work conducted by DiIorio et al. (1997) using Bandura’s (1986) social cognitive theory as a guide. The original scales used in the first wave of data collection for this study had a total of 34 items. Each item was rated on a 5-point scale ranging from (1) strongly disagree to (5) strongly agree, with higher scores corresponding to more positive outcome expectancies. The results of psychometric testing were used to reduce the scales to a total of 28 items: 12 for condom use, 8 for safer sex

discussion, and 8 for abstinence. For this study, only the condom use and discussion scales were used.

Outcome expectancies related to condom use were measured by 12 items each beginning with the stem, "If I use a condom . . ." (see Appendix for list of items). Factor analysis revealed three subscales measuring self-evaluative, social, and physical outcome expectancies, consistent with Bandura's (1986) framework. Cronbach's alphas for the present sample were .85, .74 and .35, respectively, for the condom subscales.

Outcome expectancies related to discussion about safer sex practices were measured by 8 items each beginning with the stem, "If I discuss safer sex with my partner . . ." (see Appendix for list of items). Factor analysis revealed two subscales, one measuring positive expectancies and the other negative expectancies. For the present sample, Cronbach's alphas were .90 and .34, respectively, for the discussion subscales.

Sexual decision-making was measured using a 6-item scale adapted from Brown (1992). The scale began with the stem, "Who makes (made) the most decisions about. . ." (see Appendix for list of items). Each item was rated on a 5-point scale ranging from (1) always me to (5) always partner. Responses were reverse-coded so that higher responses would reflect more control of decision-making. Factor analysis revealed two subscales: decision-making about birth control/condom use and decision-making about sexual activity. This sample had a Cronbach's alpha of .75 for the birth control subscale and .82 for sexual activity.

Condom use behavior and discussion about safer sex practices were measured by the Safer Sex Behavior Questionnaire (SSBQ). The instrument has been assessed for content validity, reliability, and construct validity (DiIorio, Parsons, Lehr, Adame, & Carlone, 1992). A full list of items is provided in the Appendix. Each item was rated on a 4-point scale ranging from (1) = never to (4) = always. Condom use behavior was measured using 5 items. The reliability for the current sample was .78 for the condom use scale. Discussion about safer sex was measured using a 7-item scale. Cronbach's alpha for the current sample was .76 for the discussion scale.

RESULTS

The chi-square analysis for differences in levels of dominance among African American and White women are presented in Table 1. There is a trend ($p = .06$) that suggests African American and White women differ in dominance group membership. Using the SPSS 7.5 residual statistics function, the greatest difference between African American and White women was found in the greater percentage of African American women who described themselves as the dominant partner (self-dominant group). White women were more likely to describe themselves as sharing power equally with a partner. There was no difference in the percentage of White and African American women who described their partner as being dominant.

Analyses of variance (ANOVA) were run for five families of variables. This strategy follows the recommendations of Huberty and Morris (1989) for exploratory multivariate analyses. The Bonferroni adjustment to alpha was used within each family of analysis (Huberty & Morris, 1989). Because of differences in group variances, post hoc tests of differences among the three dominance groups were conducted using the Games and Howell correction of Tukey's HSD (Maxwell & Delaney, 1989). The means and standard deviations for the variables, along with the results of the post hoc comparison tests, are found in Tables 2 and 3. Tables 4 through 8 summarize the ANOVA results for the five groups of variables. Overall, there were several significant differences in main effects for dominance and race. There were no significant findings for the interaction of race and dominance.

Chi-square Analysis of Levels of Dominance by Race

<i>Dominance Group</i>	<i>African American</i>		<i>White</i>		<i>Total</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Partner dominant	77	23.5	60	21.2	137	22.4
Equal	159	48.5	163	57.6	322	52.7
Self dominant	92	28.0	60	21.2	152	24.9

Note: $\chi^2 = 5.612$, $df = 2$, $p = .06$.

Self-efficacy for three factors was examined: self-efficacy for refusing sex, self-efficacy for condom use, and self-efficacy for discussion. Results indicated significant dominance differences in all three self-efficacy scales (see Table 4). Post hoc pairwise analyses (found in Table 2) found no differences between women who reported sharing power equally with a partner (equal group) and those who reported being more dominant than their partner (self-dominant group). However, respondents whose partner was more dominant (partner-dominant group) had lower self-efficacy than the other two groups across all three variables. With regard to race, the analyses found significant race differences only for self-efficacy for discussion of safer sex, with African American women reporting higher self-efficacy than White women (see Table 3).

Three types of outcome expectancies for condom use were measured: self-evaluative, social, and physical outcome expectancies. The analyses found significant dominance differences only for social outcome expectancies (see Table 5). Post hoc analyses revealed that no differences were found between the equal and self-dominant groups, but that respondents in the partner-dominant group held lower social outcome expectancies than respondents in the other two groups. The analysis of race showed that African Americans were significantly higher than Whites across all three scales of outcome expectancies for condom use.

Two types of outcome expectancy for discussion were measured: positive and negative expectancies. The results showed significant dominance differences in negative outcome expectancies with a trend ($p = .08$) in positive outcome expectancies (see Table 6). Post hoc analyses indicated that for negative outcome expectancies no differences were found between equal and self-dominant groups or between partner and self-dominant groups. However, respondents in the partner-dominant group held lower negative outcome expectancies than respondents in the equal group. The analysis of race showed that African Americans were significantly higher than Whites in positive outcome expectancies.

Table 2

Mean Scores on Dependent Variables by Dominance Level

<i>Dependent Variable</i>	<i>Partner</i>		<i>Equal</i>		<i>Self</i>	
	M	SD	M	SD	M	SD
<i>Self-efficacy *</i>						
Refusing sex	34.08,	6.80	36.631,	4.78	36.79b	4.67
Discussing safer sex	33.63,	7.47	36.301,	5.31	35.78.h	5.90
Using a condom	28.77,	10.9	32.00b	8.73	30.40,,1,	9.79
<i>Outcome expectancy for condom use*</i>						
Self-evaluative	17.84,	2.41	18.23,	2.44	18.15,	2.83
Physical	15.62,	3.65	15.70,	3.68	16.04,	3.71
Positive expectancies	25.83,	3.70	26.58,	3.47	26.36,	3.58
Social	15.91,	2.88	16.861,	2.58	16.81,,	2.66
<i>Outcome expectancy for discussion**</i>						
Negative expectancies	8.11,	1.68	8.61),	1.47	8.57,1,	1.57
<i>Sexual decision-making**</i>						
Birth control decisions	8.13,	1.98	8.93,	1.08	9.56,	2.03
Sexual activity decisions	10.17,	2.30	10.111,	1.72	10.55,	2.15
<i>Safer sex behavior**</i>						
Condom use	14.01,	3.97	14.00,	3.65	14.97,	3.93

Discussion of safer sex 19.64, 4.75 22.091, 4.27 21.611, 4.18

*Means with different subscripts are significantly different at $p < .017$ using the Games and Howell correction of Tukey's honestly significant difference comparison.

**Means with different subscripts are significantly different at $p < .025$ using the Games and Howell correcting of Tukey's honestly significant difference comparison.

Two aspects of sexual decision-making were measured: birth control use and sexual activity. Significant dominance differences were found only for sexual activity decisions (Table 7). Post hoc analyses indicated that all three dominance groups were different from one another (see Table 3). The partner-dominant group reported the least influence on sexual decision-making regarding when, where, and what we of sex to have; the self-dominant group reported the most influence. There were no racial differences in sexual decision-making.

Two types of safer sex behaviors were measured: discussion and condom use. Significant dominance differences were found for safer sex discussion, with a trend in condom use ($p = .08$; Table 8). Post hoc analyses revealed that for discussion no differences were found between the equal and self-dominant groups, but respondents in the partner-dominant group were lower than the other two groups. The analysis of race showed that African Americans reported significantly more condom use than Whites.

Tables 3-8 are omitted from this formatted document.

DISCUSSION

The results of this study indicate that there are meaningful differences among women who perceive themselves as dominant in intimate relationships, women who share dominance equally with a partner, and women who perceive their partner as more dominant. In particular, women in the self-dominant and equal groups were significantly different from the partner-dominant group on multiple measures. These differences were always in the direction of women in the partner-dominant group exerting less influence over sexual behaviors. Women who reported having a dominant partner had lower self-efficacy for discussing and refusing sex, had more negative outcome expectancies for discussing safer sex with a partner and for partner reaction to condom use, participated less in decisions about sexual activity, and had less discussion of safer sex with a partner. The pattern that emerges from these results is that women who perceive their partner as dominant in their relationship may have more difficulty with the interpersonal aspects of safer sex behavior than women who see themselves as equal or dominant.

The women in the partner-dominant group had less confidence in their abilities to negotiate sex and the use of condoms successfully and to discuss safer sex. They also expressed greater fear of the negative consequences of engaging in these interpersonal behaviors. Although this provides

support for earlier research by Harlow et al. (1993) and Soet et al. (1997), which found that anticipated negative partner reaction affected safer sex behavior in women, the current findings provide more specific information. This study identifies women (those who perceive their partner as dominant) who may be particularly susceptible to a partner's influence and need more support in enacting safer sex behavior. Those women who report sharing power or being the dominant partner may be more facile at engaging in the interpersonal aspects of safer sex and therefore may be more successful in protecting themselves.

Level of dominance had a significant effect on women's decision-making about where, when, and what type of sexual activity. This was the only variable for which all three groups significantly differed from each other. In this instance, level of dominance seemed to perform as a continuum, with partner-dominant women reporting the least input into decisions about when, where, and what type of sexual activity and self-dominant women reporting the most, the equal group falling in the middle. This may be important in that women who do not have control over the logistics of sexual activity may also have difficulty making appropriate arrangements for protecting themselves and ensuring safer sex. On the other hand, with regard to sexual decision-making, there was no difference across groups in making birth control decisions. It seems that women, regardless of their power in a relationship, take on the primary responsibility for birth control. It is interesting to note that for that 3-item factor "using or not using birth control" and "type of birth control" were the higher loading items, whereas "using or not using a condom" was much lower. This would follow the traditional lines of responsibility for contraception options, with women taking less responsibility for condom use.

Although group differences in condom use behavior were not significant at the $p < .05$ level in this analysis ($p = .08$), this finding may be due to several factors, including problems with the condom measure (a measure of multiple condom use behaviors) or the single-item measure of dominance. Future research should use more sophisticated measures of dominance and perhaps a direct measure of condom use.

Racial differences were found for all variables except sexual decision-making. African American women expressed more confidence in their ability to discuss safer sex and more positive outcome expectancies for condom use and discussion of safer sex and reported using condoms more than White women. These findings support research indicating that African American women may feel more comfortable with condom use (Baldwin, Whiteley, & Baldwin, 1992; Beckman, Harvey, & Tiersky, 1996). The source of this comfort is unclear, however. One possibility is that condom use may be more normative in the African American community so that African American women are more comfortable discussing and using condoms. Another possibility may be that the "less traditional" roles prescribed for African American women may give them more latitude in enacting condom use (Kline et al., 1992; McClelland, 1975; Wingood & DiClemente, 1992). Conversely, there was no difference between racial groups in sexual decision-making. It appears that both White and African American women maintain traditional patterns of assuming responsibility for birth control but not sexual activity.

No race by dominance interactions were found. White and African American women did not appear to be differentially affected by dominance status—that is, race did not alter the effect that dominance had on women’s safer sex behavior. Although this is only an initial attempt to explore these relationships, it seems from the current analysis that perceptions of dominance in a relationship affect White and African American women’s sexual behavior similarly. Perhaps with the refinement of measures of dominance, more subtle differences may appear.

Implications

It is encouraging that over 50% of women in this study described themselves as sharing dominance equally with a male partner, and 25% reported being the dominant partner. Nonetheless, considerable attention should be paid to the 22% of women who report their partner being more dominant. These women report significantly lower levels of personal empowerment with regard to sex behaviors, less input in sexual decision-making, and fewer safer sex behaviors. It should be noted that this study was conducted with college women, and so these rates of dominance may not generalize to noncollege populations. However, the importance of a woman’s status within her intimate relationships is something all helping professionals need to consider when encouraging a women to adopt healthy sexual practices. In addition, the inclusion of the issue of dominance in current HIV prevention programs for college women could greatly enhance their effectiveness in promoting safer sex behaviors. In particular, discussions on the effects of power in relationships on women’s sexual behavior, sexual assertiveness, and communication skills training could be incorporated into HIV prevention programs.

Limitations

First, the single-item measure of dominance provides only a crude measure of power in a relationship. However, due to the lack of literature describing and directly measuring this concept, an initial exploration of dominance as a representation of interpersonal power seemed an appropriate first step. Further research is needed to explore the components of interpersonal power and to develop reliable ways to measure it. Additionally, the reference to “most recent” partner in measuring dominance may have introduced error into the measurement as women may be reporting current, recent, or more remote relationships. These data are cross-sectional, and therefore causal relationships between dominance status and behavior cannot be determined. Prospective data are needed.

NOTE

1. To investigate the two independent samples from the first two years for possible bias due to the low response rate, we compared our sample characteristics to the enrollment figures of the schools from which the sample was drawn. With the exception of gender, there were no differences in the demographic characteristics (race, age, academic status) between our sample and the population at each school. In addition, we compared the rates of sexual activity of our sample to national statistics from the 1995 National College Health Risk Behavior Survey and

the National Survey of Family Growth; we found that our rates of sexual activity for both males and females were similar.

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APPENDIX

SELF-EFFICACY

Refusal

1. I can always say no to sex with someone who is pressuring me to have sex
6. I can always say no to sex without a condom, even if it is with someone new who I really want to have a relationship \with
8. I can always say no to sex with someone even if I have had sex with them before
10. I can always say no to sexual intercourse with someone I have just met even if I am very attracted to that person

Condom Use

2. I can always put a condom on (myself/partner) so that it will not slip or break
4. I can always put a condom on (myself&partner) even if the room is dark
9. I can always use a condom without fumbling around
11. I can always be the one to put the condom on even if I'm with a new sex partner

Discussion

3. I can always talk to any potential partner to make him/her understand why we should use a condom
5. I can always discuss preventing AIDS and other STDs with my sex partner
7. I can always discuss the importance of using condoms with any sex partner
12. I can always convince any sex partner to use a condom with me

OUTCOME EXPECTANCIES-CONDOM USE

Self Evaluative

2. I will feel safer
3. I will feel that I did the right thing
5. I will feel more responsible
8. I will feel proud

Physical

1. Sex will be less spontaneous
4. Sex will be less exciting
9. Sex will be less romantic
11. Sex will be uncomfortable

Social

6. My sex partner(s) will resist
7. My sex partner(s) will respect me
10. My sex partner(s) will approve

12. My sex partner(s) will be upset

Son, DUDLEY, AND DIIORIO

OUTCOME EXPECTANCIES-DISCUSSION

Positive

13. I will feel safer

14. I will feel that I did the right thing

15. My sex partner(s) will approve

16. My sex partner(s) will respect me

17. I will feel proud

19. I will feel more responsible

Negative

18. My sex partner(s) will resist

20. My sex partner(s) will be upset

SEXUAL DECISION-MAKING

Birth Control

1. Using or not using birth control

2. Type of birth control

3. Using or not using a condom

Logistics

4. When to have sex

5. Where to have sex

6. Type of sexual activities

SAFER SEX BEHAVIOR

Condom Use

1. I use a condom when I have sex

2. I stop foreplay long enough to put on a condom (or for my partner to put on a condom)
6. If I know a situation may lead to sex, I carry a condom with me
8. I have sex without a condom when I am swept away by the passion of the moment
10. If my partner insists on sex without a condom, I refuse to have sex

Discussion of Safer Sex

3. I ask potential sex partners about their sexual histories
4. I ask my potential sex partners about a history of bisexual/homosexual practices
5. I do not have sex when I do not know my partner's sexual history
7. If I disagree with what my partner tells me about safer sex practices, I state my point of view
9. I ask my potential sex partners about a history of IV drug use
11. It is difficult for me to discuss sexual issues with my sex partner
12. I initiate discussion of safe sex with my partner