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LOYOLA UNIVERSITY CHICAGO

HOW ADOPTING STEREOTYPICAL ROLES MAY IMPACT SEXUAL RISK
BEHAVIOR AMONG YOUNG AFRICAN AMERICAN COLLEGE WOMEN

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN EDUCATIONAL PSYCHOLOGY

BY

ESSIE M. HALL

CHICAGO, ILLINOIS

MAY 2012

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What a journey this has been! I thank and praise God Almighty for providing me with the opportunity to travel this road, giving me a mind to even pursue this path, granting me every provision for the journey, surrounding me with very special people to nurture and support me through to the finish, and giving me the victory, through Christ Jesus.

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To my extended family, thanks for always encouraging me!

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Thank you Lord for all You have done for me! I am because YOU ARE. *The race is not to the swift, nor the battle to the strong....* (Ecclesiastes 9:11). Thank you Father God for giving me the staying power to endure this race to the end! *I can do all things through Christ who strengthens me* (Philippians 4:13). And I purpose to do *all things Ad Majorem Dei Gloriam*, “For the Greater Glory of God,” and good of all!

This dissertation is dedicated to the memory and legacy of my loving parents,
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ABSTRACT

Sexually transmitted infection (STI) prevention issues for women, particularly women of color, are multifaceted and far-reaching. Cultural dynamics unique to black women, such as attitudes, values and beliefs are often not considered. The proposed study assesses culturally specific factors that may inform sexual decision-making for African American college students in an urban setting. The study proposes to analyze how knowledge, the adoption of stereotypical attitudes (four specifically: Mammy, Sapphire, Jezebel, and Superwoman) and religiosity (attendance) may influence the sexual choices of young adult African American college women.

One hundred and ten African American women attending a predominantly Black and urban university were recruited to participate, during the 2004-2005 academic school year. All participants were undergraduates and ranked as follows: 48% freshman, 19% sophomore, 17% junior, and 16% senior. A self-report survey accounting for group demographics, and measures of sexual knowledge, stereotypical role adoption for Black women, and sexual risk-behavior was completed. Pearson product moment correlations and multiple regression analyses were run to determine the significance of relationships among variables. Findings support a significant relationship between stereotypical role adoption for Black women and sexual risk behavior. However, relationships between either sexual knowledge, or religious attendance and sexual risk behavior were not

supported as significant. Implications for future research are discussed. This study seeks to enrich the literature regarding some of the salient factors that are unique to African American college women and potentially mediate their risk for STI exposure/infection. Further, this study aspires to inform future preventative practice in efforts to eradicate the pervasiveness of sexually transmitted infections/diseases among young African American women.

CHAPTER ONE

INTRODUCTION

Sexually transmitted infections (STIs) occur in higher rates among Blacks than any other group. Specifically, Black women are infected at four times the rate of their white counterparts and twice the rate of Latinas (CDC, 2009). However, African American women contract HIV/AIDS at 23 times the rate of White women and four times the rate of Latinas. Even with the potential risk of contracting HIV/AIDS, Black women continue to take large risks in their sexual behavior. However, the mediating variables that inform this behavior are challenging to identify. Many studies correlate intravenous drug use and substance abuse with high risk behavior (Foreman, 2003; Jemmott & Jemmott, 1991; Lewis, Melton, Succop, & Rosenthal, 2000; Mays & Cochran, 1988). Demographic factors and social assumptions, unique to Black women, are often not considered in efforts to understand their sexual risk behavior. This study seeks to analyze how knowledge, the adoption of stereotypical attitudes, and religious attendance may influence the sexual choices of young adult African American college women.

The purpose of this chapter is to discuss the salient literature germane to the issues of sexually transmitted infections (STIs) among young African American college women. Analysis of the literature revealed that the disturbing high prevalence of STIs among Black women, particular of child-bearing age, continue to rise and place this

population in a state of emergency (CDC, 2009). Further, there is a significant need for the literature to address the sexual risk behavior and mediating variables that contribute to STIs among Black college women.

Statement of the Problem

The incidence of new HIV cases was reported as 48,100 in the United States during the year 2009 (Centers for Disease Control, 2011). Although high, the incidence of HIV in the United States has been relatively stable, approximately 50,000 cases annually, from 2006-2009 (CDC, 2011). African Americans, and especially African American women, are among the leading demographic groups in terms of HIV prevalence. In 2009, African American women accounted for 57% of all new HIV cases reported among women (CDC, 2011). Among women ages 22-44 years, the rates of HIV infection for African Americans are about four times higher than the rates of Latinas and almost 16 times higher than the rates among Whites. Of those infected, 85% of Black women contracted HIV through heterosexual contact (CDC, 2011). HIV represented the sixth leading cause of death for Americans between the ages of 25 and 44 over the decade spanning 1997-2007, and the ninth leading cause of death for all blacks in 2007 (CDC/NHHCS, 2010; CDC, 2011).

Young Blacks accounted for over two thirds (65%) of HIV infections among those between the ages of 13-24 years. However, 75% of all HIV diagnoses among young people occur during the ages of 20-24, the college years (CDC, 2011). According to the College Health Surveillance Network (CHSN), college students account for more than one-third of the young adult population in the United States (CHSN, 2011).

Although there has been no national database accounting for the health-related issues among this population, Gayle and colleagues (1990) estimated that 1 in 500 college students are infected with HIV (Gayle, Keeling & Garcia-Tunon, 1990). Factors such as peer pressure, lack of maturity, and alcohol and illicit drug use place students at risk for HIV infection. Further, the college environment is rich with opportunities for high-risk behavior (Duncan, Miller, Borskey, 2002; Lewis, Malow, & Ireland, 1997; Prince & Bernard, 1998). Students may engage in unprotected sex while under the influence of alcohol or other drugs, which is perhaps contrary to their normal behavior. Abandoning safer sex while under the influence puts one at risk for potential infection of HIV and other sexually transmitted diseases.

When addressing the issue of HIV/AIDS among African American women, research primarily targets low-income, urban, or intravenous drug using populations. Few studies have focused on the incidence of HIV/AIDS within the population of African American women who attend college (Foreman, 2003; Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). Ironically, college students are generally not considered an 'at risk' population even though the college years are usually shaped by risky sexual encounters, placing students at great risk (Gayle et al., 1990; Lewis et al., 1997). What is needed in the literature is research that examines social risk factors for Black college women, such as the endorsement of stereotypical roles, which lead to risky sexual behaviors and increased potential for contracting STIs. The literature also needs to examine supplementary factors, such as knowledge and religiosity, which may contribute to protective sexual practice for this population.

Purpose of the Study

This study examines some unconventional factors, unique to African American college women in an urban setting that may inform their sexual risk behavior. Variables include sexual knowledge, religious attendance and the stereotypical roles for Black women.

In identifying factors that inform sexual risk-taking behavior, much of the literature targets the adolescent population (DiClemente, & Wingood, 1995; Rotheram-Borus, Murphy, Fernandez, & Srinivasan, 1998). Because adolescence is a stage where a significant amount of personal development occurs, the rationale for selecting this group is supported. The roles of social factors, cultural identity, religion and environmental context in predicting risk-behavior have been considered. The influence of peers has been noted as significant as well as substance use (e.g., alcohol) (DiClemente, & Wingood, 1995; Rotheram-Borus, Murphy, Fernandez & Srinivasan, 1998).

The purpose of this study is to analyze a few alternative variables that may shape African American women's sexual behavior. Emphasis is given to gender roles that are typecast for Black women, knowledge of sexually transmitted infections/HIV, and religious engagement (identified by attendance). Results are expected to offer insight as to whether these variables significantly impact behavior within a population of Black college women. This study seeks to enrich the literature regarding some of the salient factors that are unique to African American college women's risk for sexually transmitted disease, exposure, infection/HIV, and to inform future preventative practice.

Research Questions and Hypotheses

1. Are the stereotypical roles for Black women (SRBW) related to sexual risk behavior?

H₀. There is a relationship between SRBW and sexual risk behavior.

2. Is there a relationship between sexual knowledge and sexual risk behavior?

H₀ There is a relationship between sexual knowledge and sexual risk behavior.

3. Is religious attendance related to sexual risk behavior?

H₀ Religious attendance will be related to sexual risk behaviors.

Significance of the Study

African Americans represent almost half (46%) of all people living with HIV in the United States, a staggering rate considering they account for a meager 14% of the total population. In addition, Black men represent 70% and women, 30% of new infections within their group (CDC, 2011). AIDS has claimed the lives of an estimated 240,000 Black men and women since its onset (CDC, 2011). The prevalence of HIV/AIDS among underrepresented populations is evident. However, its rate of incidence among African Americans is alarming, placing this group in a state of emergency. According to the CDC (2011), Black youths and young adults between the ages of 13 and 24 accounted for 65% of reported HIV cases in 2009. Among Black women, 57% accounted for the HIV cases reported among women in the United States in 2009 (CDC, 2011). Among women ages 22-44 years, the rates of HIV infection for African Americans are about four times higher than the rates of Latinas and more than 15 times higher than the rates among Whites (CDC, 2011).

The literature cites the influx of HIV/AIDS cases among African American women. However, research tends to target those who contend with *conventional* risk factors such as intravenous drug use and low-income or educational levels (DiClemente, & Wingood, 1995; Rotheram-Borus, Murphy, Fernandez & Srinivasan, 1998). There is a gap in the literature regarding African American young-adult women who do not contend with these traditional risk factors. Additionally, the literature supports the notion that religious involvement may serve as a protective factor for women of color (Cochran, Chamlin, Beeghly, & Fenwick, 2004). However, there is limited research delineating the types of religious involvement regarded as meaningful for African American women at risk for sexual infection.

This study will provide insight as to variables that may mediate STI risk-behavior, among young African American college women. Particular attention is given to stereotypes of Black women, which may be internalized and influential in sexual behavior accordingly. Further, this study will shed light as to potential key factors that warrant consideration in the design and dissemination of prevention programs pertinent to Black women.

Organization of the Study

Chapter One of this study introduced the topic, succinctly described the nature of the problem and points out the importance of this research for young African American women. Chapter Two provides a review of the literature and highlights the relevant issues of gender, race, stereotypes, and religion. Additionally, Chapter Two offers insight into theory of Gender and Power and the Knowledge, Attitudes, Beliefs, and

Behaviors (KABB) as frameworks and models to understand high-risk sexual behavior among Black women. Chapter Three provides the reader with the methodology and procedures used to collect and evaluate data. Chapter Four follows with an extensive review of the results. Finally, Chapter Five provides an overall summary of the study with discussion of the implications, limitations, and recommendations for future research.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this chapter is to discuss the salient literature germane to the issues of sexually transmitted infections (STIs) among young African American college women. Analysis of the literature revealed that the disturbing high prevalence of STIs among Black women, particular of child-bearing age, continue to rise and place this population in a state of emergency (CDC, 2010). Further, there is a significant need for the literature to address the sexual risk behavior and mediating variables that contribute to STIs among Black college women. This literature review seeks to identify, assimilate, summarize, and synthesize a litany of studies that report on the association between sexual knowledge, sexual attitudes, religious factors, and sexual risk behaviors among African American women. The first section begins with an overview of sexuality and sexual risk behavior among women, African American in particular. The sexual risk behavior of young Black college women is also discussed. The second section will describe the Theory of Gender and Power and the Knowledge, Attitudes, Beliefs, and Behaviors (KABB) model. Both respectively represent a theoretical framework and conceptual model commonly referenced in the literature. The third section provides an analysis of the literature and identifies variables that may influence sexual risk behavior for African American women including: sexual knowledge, stereotypical roles, and religiosity. Because of the uniqueness of the African experience in America, and the

variability by which people of the African Diaspora identify, the terms African American and Black are used synonymously in this document to refer to those of African ancestry.

Definitions of human sexuality have continued to evolve over time. According to Merriam-Webster's online, sexuality is "the quality or state of being sexual; the condition of having sex; sexual activity; or the expression of sexual receptivity or interest." The greater weight of meaning, in the above definition, relies primarily on the physical act of sex to validate or define one's sexuality. However, we now know that sexuality embodies much more than the coitus act itself (Kinsey, Pomeroy, Martin, & Gebhard, 1998; Masters, Johnson, & Kolodny, 1995).

Human sexuality represents a broad spectrum of characteristics that uniquely distinguishes one individual from another. The World Health Organization (WHO) references a *working* definition of human sexuality as encompassing "sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships...Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors" (World Health Organization, 2002). We all have a sexual self that represents a physical, psychological and emotional part of our identity/sexuality (Herdt & Howe, 2007). However, as noted in the definition cited by WHO (2002), cultural and social environments shape how our sexuality is expressed. The following discourse will consider the factors unique to female sexuality, and how

culture and environment shape its behavioral expression, particularly for young African American women.

Women and Sexuality

Women and their sexuality have often been a topic of great debate. How this sexuality is defined and determined is ideally subjective, but often *subject* to external influences and factors. Sexuality, it seems, is inextricably linked to gender and social roles, thereby it serves as an expression of the underlying norms within a given culture. Here in the United States, many roles for women have been changing. Yet, there are some deep-seeded societal norms that remain constant and through which women filter their sexual expression.

Historically women are deemed the weaker sex, where the greater distribution of power rests among men (Amaro, 1995; Lerner, 1989; Shearer, Hosterman, Gillen & Lefkowitz, 2005; Wingood & DiClemente, 2000). The notion of womanhood, exclusive of White middle-class women of the mid-nineteenth century, emphasized modesty, purity, and domesticity, declaring the roles of wife and mother primary (Settles, Pratt-Hyatt, & Buchanan, 2008). Although the feminist revolution has challenged the traditional roles defined for women, allowing for more sexual freedom (Lerner, 1989; Milnes, 2004), the roles still remain a constant in the fabric of American culture. It is even argued that the more liberal attitudes of the 'sexual revolution' serve to undermine women's free will and confine their ability to exercise choice in sexual decision-making (Milnes, 2004). Women who exercise their freedom in sexual expression and engagement are often considered promiscuous, loose, or wild; and yet those who choose

to use contraceptives may find it hard to resist unwanted sexual advances. Both instances serve as authentic examples of how women's sexuality can be relegated to the sexist status quo. Through the conventional lens women are seen as docile, caregivers, submissive and modest (Block, 1984; Shearer et al., 2005). However, for women, the internalization and endorsement of male supremacy potentially compromises both their sexual health and freedom.

Women who adopt these traditional ideologies exhibit less power in their relationships with men and in their sexual decision-making (Amaro, 1995; Raj, Amaro, & Reed, 2001). Therefore, women may place themselves in risky sexual circumstances, increasing their vulnerability for contracting sexually transmitted infections (STIs), while allowing their male partners to determine the terms of their relations. From young adulthood, women's sexual activity remains constant, in many cases beyond menopause (Janus & Janus, 1993; Koster & Garde 1993; Patel, Gillespie & Foxman, 2003; Sherman, Harvey, & Noell, 2005). However, women's protective practice, while sexually active, remains irregular among some ethnic groups.

Sexuality is succinctly a function of individual choice and the influence of external factors. Aside from the freedom of personal expression, sexuality is greatly influenced by the environment in which one's values and beliefs are shaped. It therefore represents, in part, an expression of the intertwining of gender and social norms in a given culture.

In American culture, the hegemonic view of female sexuality is represented as submissive to men, the lesser vessel. This traditional view of female sexuality is

reiterated in the literature, supported in empirical studies, and regarded as dominant in westernized culture (Amaro, 1995; Cole & Zucker, 2007; Cullen & Gotell, 2002; Sprecher & Felmler, 1994; Gomez & Marin, 1996; Pulerwitz, Gortmaker, & DeJong, 2000; Wingood, Hunter-Gamble, & DiClemente, 1993).

Although, much of the literature acknowledges the conventional view of female sexuality, there are few empirical studies that consider the implications for sexual risk among women who adopt this view (Gomez & Marin, 1996). The literature needs additional research studies that consider the pervasive view of female sexuality, and how its internalization may be related to risky sexual practice among women.

Women and Sexual Risk

According to the Census Bureau (CB) (2010), women account for 51% of the total population in the United States. Among women, those of childbearing years represent 40% of the group population (U.S. Census Bureau, 2010). However, for women, the risk for contracting sexually transmitted infections (STIs) remains a growing concern. The Center for Disease Control (CDC) reports women contracting chlamydia at almost three times the rate, and gonorrhea at approximately equivalent rates of men in 2009 (CDC, 2010).

Also, in 2009, there were over one million (1,244,180) cases of chlamydial infections reported in the United States, an increase of 2.8% compared to reports of 2008 (CDC, 2010). Women were infected at a rate of 592 cases per 100,000 females, almost three times more often than men (219 cases per 100,000 males) (CDC, 2010). Among

women, those between the ages of 15-24 reported the highest rates of infection (CDC, 2010).

Reported cases of gonorrhea totaled 301,174 in the United States during 2009. Historically, men were infected at higher rates than women. However, trends for both sexes have been at similar rates and, most recently, slightly higher for women (CDC, 2010). For women in 2009, there were 105 cases per 100,000 females reported as opposed to 91.9 among men (CDC, 2010). Similarly, as for chlamydia, the highest rates of gonorrheal infection are among women aged 15-24 (CDC, 2010).

Left untreated, STIs can create lasting negative outcomes in adolescents' and young adult women's health. It is estimated that some 24,000 women become infertile each year due to either undiagnosed and/or untreated STIs (CDC, 2010). Research also suggests that those who contract STIs, such as three of the most common: chlamydia, gonorrhea, or syphilis, are at greater risk for contracting the human immunodeficiency virus (HIV) (CDC, 2010; NIAID, 2009).

Although, men continue to represent the majority of new HIV and acquired immunodeficiency disease (AIDS) cases in the U.S., women account for a growing share. In 1985, women represented 8% of AIDS diagnoses; by 2005 they accounted for 27%. In 2007 approximately 1.2 million people were living with HIV/AIDS in the U.S., more than 300,000 were women. However, in 2005 only 10,744 cases were diagnosed among women. Most AIDS diagnoses among women are due to heterosexual transmission (70% in 2005). In younger women, 20-24, heterosexual contact accounted for 80% of the AIDS cases (Kaiser Foundation, 2007). Here again lies the potential significance in how

sexual decision-making can impact sexual risk-taking, and how gender role attitudes can thereby inform each respectively. However, when acknowledging the risk and impact of STIs upon people of color, specifically African Americans, culture and race must be critically considered.

Women account for approximately one half of the total population in the United States, where almost one quarter of Americans are women of childbearing years (CB, 2010). The risk of contracting sexually transmitted infections is yet a developing concern, particularly for women. For women, the incidence of contracting some STIs, are at greater or equivalent rates of that for men. Further, the highest incidence occurs among those of childbearing age (CDC, 2010; Kaiser Foundation, 2007).

Left untreated STIs may have lasting negative affects in women's health, placing them at risk for HIV (CDC, 2010; NIAID, 2009). About 30 years ago women accounted for approximately 10% of HIV/AIDS cases. Today they account for approximately 30% of all HIV/AIDS cases (CDC, 2010; Kaiser Foundation, 2007).

Survey research and longitudinal studies have been conducted to track the rate of incidence and prevalence of STIs among women (CDC, 2010; Kaiser, Foundation, 2007). Many findings are the result of secondary data gathered from clinical visits for treatment post infection, while some findings were gathered through focus groups (CDC, 2009; NIAID, 2009).

Through data collected and reported by the Centers of Disease Control, medical journals, and other empirical studies, reliable approximations regarding the frequency and etiology of contracting STIs among women can be made. However, the antecedents that

shape their sexual risk behavior remain questionable. Much of the literature focuses upon explicit factors preceding risky sexual behavior (e.g., poverty, drug use, education, etc.) (Jemmott & Jemmott, 1991; Lewis et al., 2000). Emphasis, in the literature, on implicit factors preceding risky sexual behavior (e.g., values, beliefs, emotional stability, etc.) is limited. Therefore, further research is necessary which examines implicit factors that may influence sexual risk-taking behavior preceding the contraction of STIs among women.

African American Women and Sexuality

For African American women the matter of sexuality has been scrutinized for hundreds of years. Sexuality, in the larger context, refers to the state of being and/or feeling sexual, consisting of both behavior and desire (Masters, Johnson, & Kolodny, 1995; Schwartz & Rutter, 1998; Meriam-Webster's Online, 2011). It is a topic that is fluid in the cultural streams of the Black community (Fullilove, 1990). Although sexuality is not confined by race, gender, age, sexual orientation, etc., researchers have exclusively explored how sexuality is expressed among White, young to middle-aged, heterosexual adults (Dickerson & Rousseau, 2009; Kinsey, Pomeroy, Martin, & Gebhard, 1998). Relatively few studies explore the salient issues of the sexuality of Black women, in particular. In order to gain insight about the African American female's sexuality, one must consider the context that shapes her sexuality, past and present.

African Americans have a very unique heritage, with respect to the conditions that prompted their mass arrival to the Americas. However, accounting for their ancestral roots, one must begin in the continent of Africa. African civilizations in the sixteenth

century were extensively developed across the span of the continent. Specific to the western societies, where the descendants of most African Americans in the U.S. originated marriage was sacred and sex was respected as an essential part of life (Nzioka, 1996; Wyatt, 1997). Nigerian societies such as: Hausa and Nupe shunned pre-marital sex and promiscuity. Furthermore, the Nyakyusa society deemed banter and conversation of an elder's genitalia as egregious (Wyatt, 1997). Older women in respective tribes prepared young girls as they matured to assume the roles of young women, mothers, and wives. The body was revered and honored (Wyatt, 1997). Nevertheless, the advent (mid 17th century) of the Trans-Atlantic slave trade starkly changed the dynamics of sexuality among African women.

The institutionalization of slavery radically changed the context of African American women's sexuality, and still permeates the sexual lens through which they view and express themselves today. Systematically, Black women were stripped of their sexual identity, God-given humanity and personal dignity through legalized rape, forced incest, flogging and debasing, all validated through slavery (Collins, 2005; Wyatt, 1997). Their lives devalued, reduced to the equivalent of animals, Black women were forced to be superexploited within a capitalist system and their premier role was to produce (birth) more slaves (Collins, 2005; Dickerson & Rousseau, 2009; hooks, 1981). A promiscuous and savage sexuality redefined Black women, and upheld racism. "The myth that it was impossible to rape Black women because they were already promiscuous helped mask the sexual exploitation of enslaved Black women by their owners" (Collins, 2005, p. 101).

Many of these stereotypical ideals of Black female sexuality still resonate in today's culture, reflected in popular media, music, literature and the like. Superimposed upon the conventional gender roles for women (e.g., submissive, conforming, caretakers) being uniquely African American and female subjects one to a duplicity of oppression. Therefore, when considering the gender roles that shape sexuality for African American women, there is an undeniable *double-bind*, being both Black and female. That is, the membership of Black women's racial group creates a unique lens through which their gender is viewed (Settles, Pratt-Hyatt, & Buchanan, 2008).

Sexuality is an expression of both behavior and desire. Generally speaking, in America, sexual expression is not limited by the demographics of race, gender, age, or sexual orientation. However, traditional research studies have primarily examined young to middle aged White heterosexual adults in efforts to understand sexuality (Dickerson & Rousseau, 2009; Kinsey, Pomeroy, Martin, & Gebhard, 1998). For Black women in America, sexuality is shaped by more than mere desire. Its expressed behavior represents, in part, the influence of the gender roles and stereotypes of Black women steeped in American culture (Collins, 2005).

Much of what is known about the influence of gender roles and stereotypes on the perceived and expressed sexuality of Black women is found in empirical studies, qualitative research, survey research, scholarly texts and the like (Abdullah, 1998; Childs, 2005; Collins, 2005; Settles, Pratt-Hyatt, & Buchanan, 2008; Thomas et al., 2004; West, 1995; Wyatt, 1997). The literature tends to focus on the influence of institutionalized slavery, gender bias, and racism, in America, that serves to gird the stereotypic views of

sexuality among Black women. Its influence is also reflected in American culture through popular media, music and literature.

The literature serves to confirm the existence of stereotypical ideals regarding Black women's sexuality. However, how these ideals are adopted and subsequently impact sexual behavior is vague. There are relatively few studies that examine how sexual stereotypes may inform behavior among Black women, not to mention *sexual behavior* (Childs, 2005; Thomas et al., 2004; West, 1995). Therefore, further research regarding the sexual stereotyping of Black women and its influence on their sexual behavior is warranted.

African American Women and Sexual Risk

According to the CDC (2010), African Americans represent only 13% of the total U.S. population. Yet, they disproportionately account for reported cases of STIs/HIV. African Americans are infected with chlamydia at approximately nine (9), and gonorrhea at about twenty-one (21) times the rate of their white counterparts respectively (CDC, 2010).

In 2009, almost half of the reported cases of chlamydia were represented within the African American community (CDC, 2010). Among Black women, the incidence of chlamydia (2,095 cases per 100,000) was reported at a rate almost eight times that of White women (270 per 100,000). Similar for all women, the highest incidence rates of chlamydia were reported for Black women between the ages of 15-24 (CDC, 2010).

In terms of gonorrhea, 71% of cases reported in 2009 occurred among African Americans, at a rate 20 times higher than Whites. For Black women, rates were highest

for those aged 15-24 (CDC, 2010). Infection rates were 2,613 cases per 100,000 women for those aged 15-19 alone, with those 20-24 not far behind (2,548 cases) respectively (CDC, 2010).

The CB (2009) estimated that African American women comprised 13% of the female population, and only 7% of the total population. However, in 2005, they accounted for 66% of reported Acquired Immune Deficiency Syndrome (AIDS) cases (Kaiser Foundation, 2007). Heterosexual transmission is the most common vehicle for infection among them (CDC, 2010). When considering Black college-age women, the prevalence rates are more startling. The CDC (2010) reported that young Black college students, ages 20-24, accounted for 63% of reported HIV cases, and yet only represented 16% of the young adult population (CDC, 2010).

African American women contracting HIV, and subsequently AIDS, are obviously engaging in unprotected sexual encounters far too often. Understanding which factors prohibit the protective behavior of Black women is critical. Clearly the mediating variables, unique to this group's sexual risk-taking, merit further review.

Black women account for approximately 7% of the total population in the United States (CB, 2009). Yet, they disproportionately account for the incidence of STIs in America. African American women contract chlamydia and gonorrhea at four to eight times the rate of other groups, where the highest incidence is among women of child-bearing years (CDC, 2010). According to the Kaiser Foundation (2007), Black women accounted for 66% of reported AIDS cases in 2005. While in 2009 young adult Black women accounted for 63% of reported HIV cases. It is quite evident there is a clear

disparity of African American contracting STIs when compared to other groups, and heterosexual contact is often the agent of incidence (CDC, 2010).

Data collected from clinical reports, survey research and longitudinal studies are represented in the literature estimating the incidence and prevalence of STIs among African American women (CDC, 2010, 2011; Kaiser Foundation, 2007). However, understanding the mediating variables that precede the risky behavior causing African American women to be disproportionately represented as carriers of STIs, merits further consideration. Again, there is a gap in the literature when considering the implicit factors that may inform sexual risk behavior among Black women. Therefore, examination of these variables, which may be unique to Black women, is needed.

College Risk

The college environment is ripe with opportunity for HIV high-risk behaviors (Adefuye, Abiona, Balogun, & Durell, 2009). Engaging in unsafe sex and multiple sexual partnerships are common behaviors during the college years. While the overall incidence of HIV infection has seen some decline in recent years, rates of HIV infection among young adults have not seen the same decline. As in the general population, African American young adults have been disproportionately affected by the HIV/AIDS epidemic.

According to the Census Bureau, in 2010, about 20 million students were enrolled in U.S. colleges (Census, 2010). In 2002, the CDC reported the “epicenter of the HIV/AIDS epidemic is college students” (as cited in Adefuye et al., 2009). It can be rationalized African American students would represent greater cases of STIs and HIV

infections considering the prevalence of STIs among this group in general. Among both men and women, African American college students are infected by STIs at increased rates and through high-risk heterosexual contact (CDC, 2010; Hightow, MacDonald, & Pilcher, 2005). Further, young black women are often unaware of their partner's risk factors (Hader, Moore, & Holmberg, 2001; Millett, Malebranch, Mason, & Spikes, 2005).

Students tend to engage in more risky behaviors testing boundaries often during the college years. This testing of personal boundaries, particularly sexual, quite naturally places students at higher risk for infection and disease. Students are engaging in high-risk sexual behavior including having sex with multiple partners, while under the influence of drugs or alcohol, and unprotected sex. African American women are likely to become infected while in college (Ferguson et al., 2006; Jemmott & Jemmott, 1991).

The college years pose as a very vulnerable period for young adults, although this population is not traditionally viewed as vulnerable. During this time it is common for young adults to engage in risky sexual behaviors, placing them at high risk for sexually transmitted infections. The potential risk for infection is magnified when considering students of African American descent, particularly women. Black students are infected at higher rates than other groups, whereas, heterosexual contact is a primary agent.

Empirical studies inclusive of survey research, secondary data analysis, and qualitative research are represented in the literature regarding sexual risk behavior during the college years (Bui, Marhefka, & Hoban, 2010; Foreman, 2003; Jemmott & Jemmott, 1991; Randolph, Torres, Gore-Felton, Lloyd, & McGarvey, 2009; Reinisch, Sanders,

Hill, & Ziemba-Davis, 1992). While a great deal of the literature places emphasis on the types of risk-taking college students engage in, few studies examine the implicit factors preceding risky behavior, or antecedents that may be unique to African American college students.

Given the disparity of STIs among African Americans, it would be quite reasonable to expect similar trends among the college population. However, there are few studies that report sexual factors pertaining to this population. Further research is needed to identify the factors that mediate sexual risk behavior among Black college students, particularly women.

Sexuality and Sex Behaviors

Knowledge, Attitudes, and Beliefs around Sexuality

The amount of information an individual possesses of any subject matter will most likely influence the decision-making process and perspective the individual holds regarding that issue. The same tenet is expected to be constant when considering STI/HIV sexual risk-taking. If a specified group had a fluid knowledge-base of STI/HIV risk/risk-behavior, one would think they would have the tools necessary to make health conscious decisions, and exhibit protective behaviors. However, this is not always the case.

Traditionally, research has placed an emphasis on increasing knowledge and awareness of STIs/HIV when targeting preventive efforts (DiClemente, Boyer, & Morales, 1988; Kalichman, Hunter, & Kelly, 1992). In 1987, the Surgeon General exhorted education as most useful in the effort to effect sexual behavioral change (as

cited in Adame, Nicholson, Wang, & Abbas, 1991). Albeit essential, knowledge alone has not proven to be sufficient in impacting sexual risk behavior (Adame et al., 1991; Bazargan et al., 2000; Hollar & Snizek, 1996; Jarama et al., 2007; McGuire, Shega, Nicholls, Deese, & Landefeld, 1992). Nevertheless, knowledge is recognized as a key determiner of the perceptions used to inform subsequent behavior.

Perception, “involves mental interpretation that is influenced by our mental state, past experience, knowledge, motivations, and many other factors” (Slavin, 2012, p. 145). Succinctly, our perceptions represent the core of our beliefs. Knowledge may shape our perceptions, but not all perceptions are based upon knowledge or accurately reflect reality. Research suggests women’s (particularly minority women’s) perception, or rather *misperception*, of their sexual risk may be fatal (Bowleg, Belgrave, & Reisen, 2000; Kalichman et al., 1992; Misovich, Fisher, & Fisher, 1997).

Perceived risk refers to one’s personal appraisal or interpretation of susceptibility to a behavior-related illness, such as STIs. In determining the propensity to contract STIs, an individual’s knowledge, attitudes and beliefs merit consideration. Knowledge about any subject matter generally directs the decisions made pertaining to that area. The assumption for STIs is no different. It is expected that the more knowledgeable an individual is, the more likely they would not engage in risky behaviors. However, if one’s perceived risk is skewed, one’s beliefs about risky behavior is probably also skewed, which ultimately influences their attitude about engaging in risky sexual behavior. Studies suggest that negative attitudes toward contraceptive use and conventional beliefs about sex and gender roles tend to be associated with higher rates of

sexual risk (Bowleg, 2004; Sterk, Klein, & Elifson, 2004). One such example has to do with long-term, intimate relationships.

It is quite common for individuals in close long-term relationships to engage in high risk STI/HIV behavior. Generally considered an asset to one's life experience, companionship, even monogamist, can prove to be a barrier to sexual health. For many women, long-term intimate relationships generally foster a sense of trust and a commitment toward fidelity (Misovich, Fisher, & Fisher, 1997). Therefore, it is unlikely for them to believe their trusted partner would have engaged in behaviors that may ultimately infect them with a STI/HIV (Jarama, Belgrave, Bradford, Young, & Honnold, 2007; Misovich, Fisher, & Fisher, 1997; Sherman, Harvey, & Noell, 2005).

Research suggests minority women have an unrealistic bias about their perceived risk of contracting STIs, which may explain the limited condom use within this population (Kalichman et al., 1992). High-risk minority women tend to be less concerned about STI risk than their nonminority counterparts. Moreover, daily life-hassles were reported of greater concern than STIs (e.g., employment, child care, crime, drugs, health care, etc.) (Kalichman et al., 1992; Mays & Cochran, 1988). Black women often take on an air of invincibility. Whereby, they associate more serious STIs, like HIV, to gay White males or intravenous drug-users, exempting themselves (Fullilove et al., 1990; Hollar & Snizek, 1996). The same perception of low susceptibility for STI/HIV infection was reported among young college students (Adame et al., 1991; Hollar & Snizek, 1996). Therefore, it follows that knowledge, attitudes, and beliefs around sexuality may work collaboratively to inform sexual risk behavior/decision-

making. It may also suggest that the cross-sectioning of young Black female college students, pose for a population with a very unique perception of low susceptibility, thereby positioning them for even greater STI/HIV risk.

However, when addressing the issue of life threatening STIs, such as HIV/AIDS, among African American women, research primarily targets low-income, urban, or intravenous drug using populations. Few studies have focused on the incidence of HIV/AIDS within the population of African American women who attend college (Foreman, 2003; Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). Ironically, college students are generally not considered an “at risk” population even though the college years are usually characterized by risky sexual encounters, increasing students’ vulnerability for STIs/HIV (Gayle et al., 1990; Lewis et al., 1997). Further, college students are typically at an age (18-24) where sexual exploration is common, and according to recent CDC reports, the incidence of contracting STIs is highly probable (CDC, 2011).

Knowledge is very important in shaping behavior. It is definitely necessary to have knowledge, particularly accurate knowledge, in order to make decisions. However, knowledge alone does not necessarily impact perception, which ultimately informs behavior (Adame et al., 1991; Bazargan et al., 2000; Hollar & Snizek, 1996; Jarama et al., 2007). Further, all perceptions are not accurate. Nevertheless, perceptions, how we interpret anything, are at the heart of what we choose to believe, the attitudes we adopt, and the subsequent behaviors in which we engage. Black women and young college

students tend to have a misconception of their risk for STIs/HIV, a low perception of susceptibility (Kalichman et al., 1992; Mays & Cochran, 1988).

Much of what is reported in the literature about high-risk minority groups is found in empirical studies. However, most studies target low-income, urban, or intravenous drug using populations (Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). Empirical studies have also reported college students as a high-risk group for STIs/HIV, typically upholding a low perceived risk for infection (Gayle et al., 1990; Hollar & Snizek, 1996; Lewis et al., 1997). African American women, particularly those in college, represent a unique population for consideration.

The prevalence of STIs/HIV is growing at a rapid rate among young adult African American women. Although they are considered a high-risk population, the research primarily reports those who fit a certain demographic (i.e., poor, inner-city, drug-users). What is needed in the literature is research that examines specific factors distinct to young Black women who meet another type of demographic, college students.

Sexual Behaviors

When considering the sexual behavior of the female, no one work has probably contributed more to its formal understanding than that of Kinsey, Pomeroy, Martin, and Gebhard (1953). Kinsey's pioneering work broadly surveyed the sexual behavior of women using data from interviews, case histories, diaries, etc., and remains quite relevant today (Kring, 2006). For Kinsey et al. (1953) a woman's sexual behavior could be expressed in several ways including: masturbation, nocturnal sex dreams, pre-marital

petting, pre-marital coitus, marital coitus, extra-marital coitus, homosexual responses and contacts, and total sexual outlet.

Of the sexual behaviors noted in Kinsey's research, that of vaginal sex (inclusive of pre-marital, marital, and extra-marital), oral sex (pre-marital petting), orgasm (total sexual outlet) and homosexual contacts emerged often in the literature (Belcastro, 1985; Cullen, Gotel, 2002; Roebuck & McGee, 1977; Ompa et al., 2006). Because the majority of STIs among women are transmitted through heterosexual contact, the following discourse will account for common heterosexual behaviors among women, Black women specifically.

From adolescence to late adulthood, women of all ages and ethnicities are commonly engaging in vaginal, oral, and anal sex, with single and multiple partners (Belcastro, 1985; Buhi, Marhefka, & Hoban, 2010; Lindberg & Singh, 2008; Roebuck & McGee, 1977; Sherman, Harvey, & Noell, 2005). However, there is a dearth of literature that reflects the sexual behavior of minority women, explicitly Black women. Nevertheless, African American women are disproportionately contracting STIs and HIV (CDC, 2009). Sexual behaviors, risk factors, that expose Black women to infection include: monogamist relationships, multiple sex partners, anal sex, and man-sharing (knowingly sharing one male sex partner with multiple women) (Misovich, Fisher, & Fisher, 1997; Ompad et al., 2006; Lindberg & Singh, 2008)

Much of the literature on sexual behaviors examines behavior during adolescence (Bralock & Griffin, 2007; DiClemente, Boyer, & Morales, 1988; Fullilove et al., 1990; Ompad et al., 2006; Roebuck & McGee, 1977). This would be important given that

adolescence is the typical developmental stage of sexual debut. Findings suggest adolescents are engaging in sexual encounters frequently and using condoms scarcely (Beadnell et al., 2005; Misovich et al., 1997; Ompad et al., 2006). Furthermore, the literature suggests that sexual debut at younger ages (e.g., 13) is associated with frequent STIs for older teens (Kaestle, Halpern, Miller, & Ford, 2005; Ompad et al., 2006). This finding is quite critical for African Americans, as research cited in Ompad et al. supports, “Black adolescents have been shown to have an almost three-to four-fold increased risk for earlier sexual debut and four-fold risk for ever having three or more sex partners” (p. 54).

One of the most serious STIs plaguing individuals today is HIV, the precursor to AIDS. More than half of African American women who are HIV-positive were infected through heterosexual contact. College students in general tend to not use condoms consistently and have attitudes ranging from neutral to negative about its use (Foreman, 2003; Lewis, Melton, Succop, & Rosenthal, 2000). Nevertheless, condoms, used properly, may reduce HIV risk by 70 to 100%. There have been mixed reviews regarding which partner (male or female) carries the greater weight in determining to engage in safer sex. Regardless of who initiates protective behavior, barriers to condom use include comfort, convenience, embarrassment in purchasing condoms and difficulty discussing condom use with partners (Fisher & Misovich, 1990; Fisher et al., 1996; Hammer et al., 1996; Lewis et al., 1997; Raab et al., 1995; Sarkas & Heiselberg, 1998).

Condom use or safer-sex practices appear to be predicated upon the intimacy of the relationship. Therefore, those relationships deemed close or ‘tight’ would engage in

more risky sexual behavior more often (Foreman, 2003; Fullilove et al., 1990).

Essentially, the emotional investment ascribed to longer relationships serves as a barrier for safer practices for African American women, regardless of partner infidelity. Further, Black women often have difficulty negotiating condom use with long-term partners; therefore, the male partner's attitude towards condoms often determines condom use (Foreman, 2003). Women often acquiesce in these instances, not 'pressing' the issue. Conceding to the will of her sexual partner can certainly pose as a risk, but for African American women this may also serve as a protective factor in two ways: (1) protection from physical harm and avoidance of conflict/confrontation and (2) protection from loss of the relationship. Both inadvertently serve as physical and emotional protective factors respectively (Foreman, 2003). Ineffective communication is viewed as a barrier to condom use for African American college women (Ferguson et al., 2006; Foreman, 2003). According to research, communication among Black women, with their partners, about protective sexual behavior depends upon several possible factors: (a) the anticipated reaction from the male partner; (b) whether the sexual relationship was casual or committed; (c) their attitude toward condom use; and (d) normative condom use behavior among female friends (Ferguson et al., 2006; Foreman, 2003; Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). Generally, college women tend to rely on their male partners to initiate condom use (Leik et al., 1995; Raab et al., 1995). This was found to be particularly true for African American college women (Jemmott & Jemmott, 1991).

Lastly, African American women distinguish between ‘safer sex’ and ‘protected sex,’ according to Foreman (2003). Whereas, safer sex represents no sex until marriage and protected sex represents sexual encounters where protection is used. Abstinence is considered the safest strategy to protect one from STIs and unwanted pregnancy. However, this strategy is least frequently practiced of all sexual behaviors.

Women of all ages are commonly engaging in sexual practice. As noted in Kinsey’s work, there are multiple forms of sexual engagement that suit women. However, vaginal sex (inclusive of pre-marital, marital, and extra-marital), oral sex (pre-marital petting), orgasm (total sexual outlet) and homosexual contacts emerge often in the research (Belcastro, 1985; Cullen & Gotel, 2002; Ompad et al., 2006; Roebuck & McGee, 1977). Much of the literature tends to examine sexual behavior during adolescence, as this stage of development characterizes the onset of sexual urges and desires (Bralock & Griffin, 2007; DiClemente, Boyer, & Morales, 1988; Fullilove et al., 1990; Ompad et al., 2006; Roebuck & McGee, 1977). Findings suggest earlier debut of sexual engagement places teens at greater risk for STIs in late adolescence/young adulthood, where Black teens are at risk three to four times the rate of other groups (Kaestle, Halpern, Miller, & Ford, 2005; Ompad et al., 2006). A similar risk is found among young Black college students, particularly women (Ferguson et al., 2006; Foreman, 2003; Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). Condom use (or safer-sex practices) appears to be predicated upon the intimacy of the relationship between partners and, is often met with resistance.

Several empirical studies including survey research, interviews, and focus groups have been conducted regarding the sexual behaviors of women (Belcastro, 1985; Buhi, Marhefka, & Hoban, 2010; Foreman, 2003; Kinsey et al., 1953; Lindberg & Singh, 2008; Sherman, Harvey, & Noell, 2005). When considering the risk for STIs, empirical studies conducted typically target the adolescent population and identifies them as a risk group for STIs, black teens being most vulnerable (Kaestle, Halpern, Miller, & Ford, 2005; Ompad et al., 2006). A review of the literature also notes that condom use is met with resistance among college students and is contingently used among young Black women (Ferguson et al., 2006; Fisher & Misovich, 1990; Fisher et al., 1996; Foreman, 2003; Hammer et al., 1996; Jemmott & Jemmott, 1991; Lewis et al., 1997; Lewis et al., 2000; Mays & Cochran, 1988; Raab et al., 1995).

There is a dearth in the literature regarding young African American college women, their sexual behavior and protective practice. The issue of what types of sexual behaviors are young Black women engaging in is very important to examine. It is also important to consider the demographic factors unique to Black college women that may impact behavior. Consideration of the antecedents, perceptions, knowledge, and attitudes that influence behavior again merits further review.

Theoretical/Conceptual Framework

Theory of Gender and Power

In an effort to gain insight as to the sexual practices of African American women, amidst the looming risks for sexually transmitted infections, Connell's (1987) Theory of Gender and Power (TGP) is examined. After further review of the literature, the Theory

of Gender and Power (TGP) emerged as a widely accepted model, specifically when targeting this group (Alleyne & Gaston, 2010; Mallory, Harris, & Stampley, 2009; Noar, 2007). Connell's theory (TGP) proposes that sexual inequities and the unequal distribution of power, based upon gender, are functions of deep-seeded societal structures and social norms (Connell, 1987; Wingood & DiClemente, 2000). In this framework, there are three social structures that account for the gendered dynamics between men and women: the sexual division of labor, the sexual division of power, and the structure cathexis (representing affect) (Connell, 1987; Mallory et al., 2009; Wingood & DiClemente, 2000). According to Connell (1987), these structures exist on two levels: societal (e.g., social norms, political forces, historical roots, etc.) and institutional (e.g., school, church, home, media etc.) (Connell, 1987; Wingood & DiClemente, 2000).

The sexual divisions of labor and power had been noted in prior studies as key factors in understanding relationships between men and women (de Beauvoir, 2009; Wingood & DiClemente, 2000). Charolette Perkins Gilman sounded the alarm as to the inequities in treatment between women and men, at the turn of the twentieth century (Wingood & DiClemente, 2000). Thereafter, de Beauvoir pressed the issues of gender and power imbalance further, asserting women were considered as "others" when compared to men (de Beauvoir, 2009; Wingood & DiClemente, 2000). Their insight and pioneering efforts enlightened many as to how these two factors, labor and power, are manipulated and serve to disadvantage women in relation to men. However, Connell developed the third factor, cathexis, to account for the emotional component evident in all relationships, and thereby emphasized the interrelatedness of the factorial triad (Connell, 1987;

Wingood & DiClemente, 2000). Wingood and DiClemente (2000) extended Connell's theory to account for and distinguish the exposures and risk factors that increase women's susceptibility toward STIs, particularly HIV (Noar, 2007; Wingood & DiClemente, 2000).

According to Wingood and DiClemente (2000), gender-based inequities and disparities in expectations have direct implications on physical and psychological well-being. They are also evident in the public health, social and behavioral sciences, and medical sectors as *exposures*, *risk factors*, and *biological properties* (Wingood & DiClemente, 2000). Therefore, Connell's TGP is relevant to understanding matters pertaining to women's health (Wingood, 2000). Common variables associated with risk-taking behaviors include: knowledge, attitudes, beliefs, and skills (Anderson & Cyranowski, 1994; Wingood, 2000). The former three will be considered in the next section.

The Theory of Gender and Power (TGP) asserts that sexual inequities and the unequal distribution of power are gender based, and a function of societal norms (Connell, 1987; Wingood & DiClemente, 2000). Three primary social structures account for differences among the sexes: labor, power, and cathexis. These differences are represented at both the societal and institutional levels (Connell, 1987; Mallory et al., 2009; Wingood & DiClemente, 2000). Extending the TGP further, Wingood and DiClemente (2000) suggest that inequities among the sexes and disparities in expectations are connected to physical and psychological health. Thereby, Connell's

theory is deemed a relevant aid in understanding women's health, particularly risk-taking (Wingood & DiClemente, 2000).

Analysis of the literature, and experimental studies have been conducted using the TGP as a model framework for understanding issues of health and well-being among women (Alleyne & Gaston, 2010; Mallory, Harris, & Stampley, 2009; Noar, 2007). The TGP has also been used in research to identify key factors associated with sexual risk-taking: knowledge, attitudes, beliefs, and skills (Anderson & Cyranowski, 1994; Wingood, 2000).

However, there is a gap in the literature regarding the use of the TGP to understand and identify factors unique to sexual risk-taking among African American college women. The needs of Black women may be distinct when compared to other groups. They certainly are distinguished among groups in terms of rates of STIs/HIV. Therefore, further research is needed using the TGP in an effort to understand the variables of knowledge, attitudes, and beliefs for young Black college women, and how these variables inform their sexual risk behaviors.

Knowledge, Attitudes, Beliefs, and Behaviors (KABB)

Many researchers have used Knowledge, Attitude, Belief, and Behavior (KABB) models to develop questionnaires in an attempt to measure behavioral change resulting from the threat of STIs, particularly HIV/AIDS (Carrier, Nguyen, & Su, 1992; Moskowitz, Henneman, & Holt, 2002; Norris, Masters, & Zawacki, 2004; Peeler, 2006). Traditionally, HIV/AIDS prevention theorists have focused on these factors and maintained that increased knowledge, along with positive attitudes and health promoting

beliefs about HIV/AIDS, will lead to positive behavior changes (Peeler, 2004; Siegel et al., 1991). Similarly, to the TGP, these factors are considered to work in tandem to inform subsequent behavior.

KABB has conventionally been used as foundational model for behavioral research related to the threat of STIs/HIV. Analysis of the literature, survey and experimental research have been conducted using this model; focusing on the factors of knowledge, attitudes, beliefs, and behaviors (Carrier, Nguyen, & Su, 1992; Moskowitz, Henneman, & Holt, 2002; Norris, Masters, & Zawacki, 2004; Peeler, 2006). Further research is necessary to determine the effectiveness of this model regarding the risky behavior of African American college women.

Studies are also needed to address the issues that may increase the cultural salience, relevance, and impact of STI preventive messages among minority communities (particularly African American), where STI-related knowledge, sex role relationships, sexual behavioral patterns, and daily living resources often differ from those of nonminority communities (Kalichman, et al., 1992; Marin, 1989; Mays & Cochran, 1988). One factor that may contribute to perceived risk and subsequent behavioral outcomes is the internalization of stereotypical roles. For cultural minorities, the internalization of stereotypical roles imposes another layer that may prove influential in determining risk. The next section will highlight some of the cultural factors unique to African American women (i.e., stereotypical roles and religiosity), that merit consideration in an effort to understand their sexual decision-making.

Stereotypical Roles for Black Women (SRBW)

Often African American women are faced with managing dual roles as they navigate between the dominant culture and their cultural community. Not only are they battling the universal typecasts of gender roles (e.g., domesticated, weaker vessel, etc.), there are also four stereotypical roles, derivatives of the institutionalization of slavery, women may internalize. The literature suggests that these roles have emerged as a part of the cultural fabric for African American women: Mammy, Sapphire, Jezebel, and Superwoman (Abdullah, 1998; Greene, 1994; Mitchell & Herring, 1998; Thomas et al., 2004; West, 1995).

Mammy

Mammy represents the type of female character who always considers another's well being above her own. During the institutionalization of slavery, she represented an obese, dark-skinned woman with broad features who worked in the master's house; often serving as nanny, housekeeper and cook (Greene, 1994; Mitchell & Herring, 1998; West, 1995). She is the woman who typically sacrifices her own needs to benefit someone else (Thomas et al., 2004). Mammy was seen by whites as non-threatening, nurturing, and selfless in devotion to others (Abdullah, 1998). Mammy was expected to be uncomplaining, congenial and a deferential problem solver (Mitchell & Herring, 1998). The stereotype of Mammy has contributed to African American women being perceived as nurturing, good caretakers, strong, supportive and selfless (Mitchell & Herring, 1998; West, 1995). Internalization of this stereotype may lead to the need to be nurturing and supportive of others, often at one's own expense, while presenting a façade of strength

(Abdullah, 1998; Gainor, 1992; Greene, 1994; West, 1995).

Sapphire

Sapphire, a character from the 1940s and 1950s Amos and Andy radio and television show, was seen as nagging, emasculating, shrill, loud, argumentative, and a master of verbal assaults (Mitchell & Herring, 1998; West, 1995). The perceptions of African American women from this character include arrogance, being controlling, loud, hostile, obnoxious, and never satisfied (Bell, 1992; Mitchell & Herring, 1998; West, 1995). Sapphire is also seen as comedic and is often not taken seriously (Jewell, 1993). She represents the type of woman who has keen yet sarcastic wit and in some instances is quite abrasive. Her role is one of a “tough as nails” persona, one who is not easily shaken emotionally (Thomas et al., 2004). Internalization of this stereotype may lead women to perceive sexuality as one of few assets or may cause sexual acting out or repression of sexual feeling (West, 1995).

Jezebel

Jezebel is characterized as the type of woman whose focus is exercising her sexual prowess. The stereotype of Jezebel was derived from the sexual exploitation and victimization of African American women, often as a way to justify sexual relations with enslaved women. Jezebel is perceived as seductive, manipulative, hypersexed, animalistic in sexual desires, and unable to control sex drives (Mitichell & Herring, 1998; West, 1995). She is thought of as quite promiscuous and very seductive (Thomas, et al., 2004). African American women, seen in this role, are often viewed as promiscuous, loose, immoral, sexual aggressors, and lacking sexual restraint (Bell, 1992; Daniel, 2000;

Greene, 1997, 1994). Internalization of this stereotype may lead women to perceive sexuality as one of few assets or may cause sexual acting out or repression of sexual feelings (West, 1995).

Superwoman

African American women are socialized to appear strong, tough, resilient and self-sufficient (Shorter-Gooden & Jackson, 2000). Many African American women will develop a façade of strength and may have difficulty admitting to difficulties or asking for more support (McNair, 1992). Mitchell and Herring (1998) discuss the “superwoman” as one who believes she is capable of accomplishing multiple tasks successfully. Superwomen often feel weak and like failures if they are not successful or need to ask for help, and may adapt this strategy to avoid being judged by the other stereotypes (Greene, 1994). The Superwoman often avoids anger because it is connected with physical harshness and causes women to feel out of control (Romero, 2000). The internalization of Superwoman may lead to a façade of high self-esteem, which when cracked reveals anxiety and low self-esteem (Jordan, 1997). The façade serves to conceal other vulnerabilities such as anger, fear, shame, pride and loneliness (Jordan, 1997). Superwoman has it all together, presumably (Thomas et al., 2004). She is the organized cooperate executive with the happy family, fancy car and exquisite clothes. All of her ‘ducks are in a row’, so to speak. However, the façade does not necessarily represent her reality, eventually serving as a potential risk factor. Superwoman represents the idea of the “strong” black woman, a stereotype that is associated with emotional and psychological costs (Settles, Pratt-Hyatt, & Buchanan, 2008; Thomas et al., 2004).

Although the stereotypical roles diverge in many ways, the literature converges on one important issue: they are derived from the legacy of slavery and serve to dehumanize and degrade Black women through the channels of exploitation (Collins, 2005; Townsend et al., 2010; West, 1995). West (1995) was a pioneer in describing how the former stereotypes, Mammy, Sapphire, and Jezebel, manifest in professional predisposition and were evident in therapeutic practice. Since then, several research studies have acknowledged how stereotypical roles for African American women serve to adversely affect their physical and psychological well-being (Giscombe, 2010; Gordon, 2008; Mensinger, Bonifazi, & LaRosa, 2007).

There are four stereotypical roles that may be inadvertently internalized by African American women: Mammy, Sapphire, Jezebel, and Superwoman. These roles emerged as residual factors from the institutionalization of slavery in America (Abdullah, 1998; Greene, 1994; Mitchell & Herring, 1998; Thomas et al., 2004; West, 1995). Empirical studies including survey research, experimental research, analysis of the literature, and qualitative studies have been conducted regarding the influence of these stereotypical roles upon the lives and behavior of Black women. Further research is warranted as there are few studies examining this issue, not to mention among young Black college women. More specifically, an analysis on how the adoption of stereotypical roles/attitudes will impact the sexual risk behavior of young Black women is needed.

The internalization of any stereotypical role may be strongly correlated to African American women's relationships/decision-making over many contexts, including

familial, professional, and intimate. However, the development of an individual's sexual identity is understood within the context of the messages and meanings they are given about sexual roles and behaviors (Stephens & Phillips, 2003). One such place, of cultural significance, is the Black church.

Religious Attendance

One factor that has proven to be culturally salient and fundamental within the African American community is religion. Blacks have been considered to maintain one of the highest levels of religiosity in the world (as cited in Poulson, Bradshaw, Huff, & Peebles, 2008). Historically, strong religious values have served as protective factors for African Americans in developing the coping skills and resilience needed to overcome racial barriers; and Black women are distinguished for upholding their faith-based values (Taylor, Chatters, & Levin, 2004). Regarding sexual practices, traditional religious values teach toward either abstinence or a sexual relationship after marriage that supports fidelity (Steinman & Zimmerman, 2004). Therefore, how well these values are internalized and subsequently practiced could be important in determining sexual risk taking. Research supports a strong correlation between an individual's religious practice and sexual behavior, particularly for Black women (Davidson, Moore, & Ulstrup, 2004; Elifson, Klein & Sterk, 2003). Religious beliefs and practice can influence sexual decision making, reducing sexual partners and increasing protective behaviors, such as condom use. The internalization of religious beliefs can create feelings of guilt, thereby, functioning as a protective factor when determining sexual risk-behavior (Corneille, Tademy, Reid, Belgrave, & Nasim, 2008). Furthermore, utilizing religion as a coping

mechanism has been considered a protective factor of physical and psychological health, even among young adult African Americans (Berkel, Armstrong, & Cokley, 2004; Bryant, 2008).

However, the way in which religion/religiosity is expressed can take on many forms. One's religiosity can be represented by multiple characteristics: church affiliation, participation, attendance, prayer, meditation, etc. Researchers have conducted studies using single-item characteristics to measure religiosity (i.e., attendance or affiliation) (Alex-Assensoh & Assensoh, 2001; Bingham, Miller, & Adams, 1990; Davidson et al., 2004; Steinman & Zimmerman, 2004), and using multiple-item characteristics (Allport & Ross, 1967; Jones, Darroch, & Singh, 2005). Nevertheless, religious attendance remains, possibly, the most widely used indicator to measure religiosity (Steinman & Zimmerman, 2004; VanWicklin, 1990)

Religious attendance represents a behavioral dimension of religiosity that is observable. This is probably why attendance is a preferred indicator in the research, particularly in the health sciences (Kennedy, Kelman, Thomas, & Chen, 1996; Taylor, Chatters, & Levin, 2004). Attendance has been noted as a sufficient measure of religiosity (Gorsuch & McFarland, 1972). Further, Mason and Windle (2002) distinguished attendance as the only religious dimension correlated to behavioral change in their longitudinal study.

Religion has historically had a profound impact upon the African American community, particularly in the lives of Black women (Lincoln, & Mamiya, 1990; Taylor, Chatters, & Levin, 2004). However, indicators of religion can represent single or multi-

item measures. Nevertheless, religious attendance has been well established as a suitable indicator of religiosity (Davidson, Moore, & Ullstrup, 2004; Gorsuch & McFarland, 1972; Steinman & Zimmerman, 2004; Taylor, Chatters, & Levin, 2004).

Several quantitative and qualitative research studies including: focus groups, survey research, and longitudinal studies have been conducted using the single-item indicator of religious attendance to understand risk behaviors and health in adolescents and adults (Davidson, Moore, & Ullstrup, 2004; Kennedy et al., 1996; Steinman & Zimmerman, 2004; Taylor, Chatters, & Levin, 2004). However, few studies examine the significance of religious attendance and sexual risk behavior among women (Davidson, Moore, & Ullstrup, 2004), not to mention Black women.

Further examination is needed in the literature that considers the relationship between religious attendance and sexual risk behavior among Black women, particularly college women. Given the historical relevance of religion in the African American community, and among Black women, it would be plausible that religiosity would also influence their sexual decisions and choices. However, more research is warranted to gain more insight as to the possible relationship between these factors.

Summary

African Americans are impacted by sexually transmitted infections (STIs) at higher rates than any other group. Specifically, Black women are infected at four times the rate of their white counterparts and twice the rate of Latinas (CDC, 2010). However, African American women contract HIV/AIDS at 23 times the rate of White women and four times the rate of Latinas. Black women are consistently taking enormous risks

regarding their sexual behavior, even risking contracting HIV/AIDS. However, the mediating variables that inform this behavior are challenging to identify. Many studies target correlations between intravenous drug use and substance abuse with high-risk behavior when identifying variables that mediate risk for African Americans (Foreman, 2003; Jemmott & Jemmott, 1991; Lewis et al., 2000; Mays & Cochran, 1988). The cultural dynamics unique to Black women, such as attitudes, values and beliefs are often not considered. This study proposes to analyze how knowledge, the adoption of stereotypical attitudes, and religion may influence the sexual choices of young adult African American college women.

CHAPTER THREE

METHODOLOGY

Methods

The following chapter underlines the research methodology and procedures implemented in the study, including sections describing the: purpose and objectives of the study, research design, population and sample, measures, methods and procedures, and data analyses.

Purpose of the Study

This study examined culturally-specific mediating factors that may affect sexual risk-behavior among African American college women in an urban setting. Variables included sexual knowledge, religious attendance and the stereotypical roles for Black women.

The purpose of this study is to scrutinize the cultural layers that have shaped African American women's sexual risk behavior. Specifically, this study sought to determine if the variables of stereotypical gender roles, religiosity, and sexual knowledge served to predict sexual risk behaviors in a sample of young African American college women. Results are expected to offer insight as to how the adoption of gender stereotypes, sexual knowledge, and religious attendance may be related to, and subsequently impact, the sexual risk behavior within a population of Black college women. This study seeks to enrich the literature and heighten sensitivity to some the

salient factors related to sexual risk for STI/HIV exposure and infection, particular to young African American college women. Further, this study seeks to enhance STI/HIV preventive programs that attempt to quell the vast rate of infection in a group disproportionately represented in the United States, young adult Black women.

Research Questions and Hypotheses

The three research questions for this study were:

1. Are the stereotypical roles for Black women (SRBW) related to sexual risk behavior?
2. Is there a relationship between sexual knowledge and sexual risk behavior?
3. Is religious attendance related to sexual risk behavior?

The hypotheses corresponding to the research questions respectively were:

1. There is a relationship between SRBW and sexual risk behavior.
2. There is a relationship between sexual knowledge and sexual risk behavior.
3. Religious attendance will be related to sexual risk behaviors.

Research Design

A systematic, quantitative, non-experimental research design was used to examine the potential relationship between psychological and psychosocial variables (stereotypical roles for Black women, sexual knowledge, religious attendance and sexual risk-behavior). Because this study is founded upon the scientific methodological approach, the assumptions and principles of the positivist paradigm was utilized to guide analyses (McGregor & Murnane, 2010). A correlational research method was used to identify relationships between variables as hypothesized. Data was used from a secondary data set, where there were no identifiable indicators of participants. However, the surveys

were completed and collected from a convenience sample of African American college women at various times. Regression analyses are specific models essential in the interpretation of correlational data (Johnson, 2001). The benefit of using a correlational design includes the ability to identify and quantify the strength between two or more variables. However, one major limitation lies in the inability of correlation designs to infer causation between variables.

Sample and Measures

Population and Setting

African American women attending a predominantly Black and urban university, were recruited to participate. The university is located in the city of Chicago, Illinois and represents one of four public state institutions within the metropolitan area. There are approximately 2,700,000 people living in the city of Chicago, comprising more than 20% of the total state population (Census Bureau, 2010). The demographic makeup of the city's population includes 45.0% White, 32.9% Black, 28.9% Latino, 5.5% Asian, and 0.5% Native American (Census Bureau, 2010). Considered a *melting pot*, Chicago has the fifth highest foreign-born population in the United States.

The university, from which the sample was pooled, boasts a vast pastoral campus, amidst this great metropolis. The university is composed of a number of different schools and colleges. It is accredited by the North Central Association of Colleges and Schools, and awards Bachelor, Master, and Doctorate degrees in a number of distinct areas and disciplines. Of those enrolled at this institution, 78.4% are African American,

8.8% are White, and 6.5% are Latino, 71.2% are female, and 28.8% are male (SU, 2012).

Participants were recruited during the 2004-2005 academic school year.

Data Collection

The data in this study is from an archival data set. The principal investigator, who received full institutional review board (IRB) approval to conduct the original study, was Dr. Karen Witherspoon, currently professor of psychology at Chicago State University (CSU). The initial research was funded by a grant from the university's HIV/AIDS Research and Policy Institute. Several research assistants were involved in collecting the data, and the writer was specifically involved in coding variables for data entry.

Surveys were administered in a classroom setting. No financial incentives were offered. However, instructors did offer extra credit for participation.

Demographic Characteristics

The original research was designed to assess HIV knowledge and risk behavior in a sample of African American women attending an urban university. African American female students account for more than 59% of this college's undergraduate population. There were 110 African American female undergraduate participants. Class rank was as follows: 48% freshman, 19% sophomore, 17% junior, and 16% senior. Ninety-five percent identified with heterosexuality, one percent with homosexuality, and four percent with bisexuality. Fourteen percent were employed full-time, 43% were employed part-time, and 40% were unemployed. Household income was reported in terms of weekly earnings and in \$100 increments. Income ranged from less than \$100 to \$600 weekly. Twelve participants (10.9%) reported earning less than \$100 weekly. Seventeen women

(15.5%) reported earning \$101-\$200 per week. Another 17 respondents (15.5%) reported a weekly income of \$201-\$300. Twelve women (10.9%) earned \$301-\$400 per week, while 19 women (17.3%) earned \$401-\$500 per week. The majority of participants, 31 (28.2%), reported a weekly income of \$501-\$600. In terms of religious affiliation: 24 respondents (21.8%) reported no religious preference, ten women (9.1%) identified as Protestant, seven participants (6.4%) classified themselves as Catholic, one respondent (0.9%) identified as Jewish, and the overwhelming majority, 67 participants (60.9%), reported their religious affiliation as “other”. Participants also reported how often they attend religious services. Frequency ranged from “less than once a year” to “more than once a week”. Nine women (17.3%) reported attending religious services less than once per year, whereas 16 women (14.5%) reported attending once or twice a year. Twenty-one participants were among those who attended 3-11 times per year, while five participants (4.5%) identified as attending once a month. There were 12 respondents (10.9%) who reported a higher frequency of attendance, 2-3 times a month. Nineteen women (17.3%) claimed to attend services once a week. Similarly, 18 participants (16.4%) reported attending services more than once a week. Age was not queried in this sample. Analysis will be done for descriptive statistics.

Instruments

Stereotypical Roles for Black Women Scale (SRBWS). The Stereotypical Roles for Black Women Scale (SRBWS) (Thomas et al., 2004), initially a 61-item attitude scale, was designed to examine perceptions and stereotypes of African American women. The final version of the SRBWS represents a 34-item measure. For the purposes of this

study, the internalization, or adoption of common stereotypical roles for black women was assessed using the final scale. There are four subscales that correspond to the stereotypes of Mammy, Jezebel, Sapphire, and Superwoman. A 5-point Likert-type scale, ranging from “1 =strongly disagree” to “5 =strongly agree”, was used to rate items. Higher scores reflected more agreement or support of the various images. Mammy items included “I feel guilty when I put my own needs before others” and “People often expect me to take care of them.” Jezebel items included “Black women will use sex to get what they want” and “Black women are often treated as sex object.” Sapphire items included “Black women are usually angry with others” and “People respond to me more if I am loud and angry.” Superwoman items included “Black women have to be strong to survive” and “If I fall apart, I will be a failure. Moderate internal consistency reliability coefficients were found for each of the subscales: Mammy (.52), Sapphire (.70), Jezebel (.72), and Superwoman (.67), and supported using normative data 123 of 300 African American women ages 18-63 (Thomas et al., 2004; Townsend et al., 2010). Moderate overlap between the subscale variables was implicated by scale intercorrelations. Further, Thomas et al. (2003) performed more analyses to identify the relationship between SRBW and self-esteem, and to consider the impact of the SRBW on self-esteem and racial identity attitudes. In both cases, regression analyses were performed.

In terms of the relationship between the SRBW and self-esteem, multiple regression revealed partial correlations between variables and identified particular variance attributed to the stereotypic roles (Thomas et al., 2004). The Mammy and

Sapphire stereotypes were found to be negatively correlated with self-esteem, $\beta = -.24$, $p < .01$ and $\beta = -.28$, $p < .01$, respectively.

Validity evidence for the SRBWS has been found to support a relationship between two of the subscales (Mammy and Sapphire) and self-esteem (Thomas et al., 2004).

Much of the literature uses survey research to measure the adoption of stereotypes, typically addressing issues of identity, gender roles, or trait characteristics (Hart & Kenny, 1997; Mensinger, Bonifazi, & LaRosa, 2007; Weitz & Gordon, 1993). Qualitative approaches would utilize focus groups or interviews to assess the measure such attitude adoptions (Giscombe, 2010). Although no studies were found to validate the SRBWS, there are at least two, within the literature, that extend the scale's scope creating an alternative measure for assessing black adolescents (Townsend et al., 2010; Wallace, Townsend, Glasgow, & Ojie, 2011).

Townsend et al. (2010), piloted the SRBWS, originally normed from an adult sample (Thomas et al., 2004), with a group of 15 African American girls, ages 11 through 15, checking for relevance and comprehension of survey items accordingly. Changes were made to the original scale at the recommendation of the young participants. The revised scale was thereby piloted with a new group of 15 girls. Finally, 270 participants were surveyed, and factor and reliability analyses were implemented to determine the latent factor structure of the new scale (Townsend et al., 2010). The factor analysis identified just one relevant factor, termed the Modern Jezebel. The Modern Jezebel factor embodies a merging of both Jezebel and Sapphire stereotypes from the SRBWS, whereas

the Mammy and Superwoman stereotypes were deemed irrelevant (Townsend et al., 2010). The Modern Jezebel emerged as a new construct distinguished from the SRBWS. Subsequently, the Modern Jezebel Scale (MJS) was coined and represented a 7-item measure with an internal consistency of 0.82. MJS items include: “Black girls are loud and have an attitude. Black girls use sex to get what they want. Black girls are always mad and ready to fight” (Townsend et al., 2010).

Townsend et al. (2010) used the MJS to consider the impact of stereotypic images, along with identity components and colorism (consonant with the “color-complex,” where African Americans resembling Eurocentric attributes are deemed more beautiful/desirable) on sexual attitudes in black girls. Whereas, Wallace et al. (2011), also used the MJS to explore the relationship between negative stereotypical attitudes and colorism, and substance abuse among poor African American girls (Wallace et al., 2010). Regression analyses were performed in both studies accordingly.

Sexually Transmitted Disease (STD) Knowledge Score. The STD knowledge score (Beadnell et al., 2003), represents a set of 21 true/false questions used to measure knowledge of sexually transmitted disease/infections. The scale assesses knowledge of HIV, other STDs and preventive sexual behaviors; contained items of different levels of difficulty, and had good internal consistency ($\alpha=0.74$). There were no other studies found to support the validity of this measure. Therefore, the reliability of the original score is reported. For the purposes of this study, STD knowledge score served to rate participants’ sexual knowledge of disease and infection. A total score was calculated,

where higher scores (of correct responses) represented greater STD knowledge (Beadnell et al., 2003).

Sexual Risk Reduction Index. The Sexual Risk Reduction Index (SRRI) (Beadnell et al., 2003), a 17-item self-report instrument, was extracted from an overall index used to assess the sum of participants' risky sexual behavior, without condoms. Unprotected sexual risk behavior included: receptive oral, anal, and vaginal acts (Beadnell et al., 2003). Each sex act is weighted, accounting for the different levels of sexual risk. Therefore, higher scores reflected a greater degree of sexual risk-taking, while lower score (Beadnell et al., 2003).

Within this study, SRRI served as an indicator denoting the type of risky sex acts participants engaged in. Participants indicated whether they engaged in the sexual behavioral items included in the measure. Sexual risk items ranged from least risky, to moderately risky, and finally most risky. Least risky items included "I don't do anything sexual (no kissing, petting or intercourse)" and "I am sexual (kissing, petting, masturbating) but am not having intercourse (penis in mouth, vagina or rectum)." Moderate risk items included "I am having sex with only one partner" and "I am not having sex with a person who uses needles." Whereas, the most risky sexual behavioral items included "I have reduced my number of sex partners" and "I have DONE NOTHING yet to make myself sexually safer." Participants were asked to check all items that applied to their behavioral practice. Each checked item indicated the participant did indeed engage in the stated behavior and was interpreted in the affirmative with a weighted score of "1" assigned. Each unchecked item indicated the participant did

not engage in the stated behavior and was interpreted in the negative with a weighted score of “2” assigned. The index was treated as a continuous measure and a total score was calculated. Higher scores reflected more protective behaviors and lower scores reflected more risky behaviors. There were no other studies found to support the reliability or validity of this measure.

Demographic Scale. A four-item scale was developed to assess participants’ general background information. Items reflected level of education, employment status, household income, religious affiliation and attendance, and gender and race.

Procedures

Potential participants in psychology courses were given an introductory letter explaining the purpose of the study, and a consent form during the 2004-2005 academic year. Surveys, consisting of 62 items and four measures, were administered to participants. Additionally, opportunity to review and ask appropriate questions was offered. Participants were reminded that their involvement was entirely voluntary and anonymous. No monetary incentives were provided. However, participants were offered extra class-credit by their respective instructors.

Power

Statistical power was considered based upon the conventional value of .08 in the absence of calculated values emerging from the literature. Adhering to Cohen’s d , a medium anticipated effect size of $r=.30$ with an alpha level of .05 was chosen. Therefore, 84 participants were required for this study. Adequate power was achieved by the total sample size of 110 participants.

CHAPTER FOUR

RESULTS

Analysis of Questions and Hypotheses

This chapter presents the results from the study. Results are organized and presented as responses to the three research questions and hypotheses stated in Chapter One. A probability level of .05 or less was considered significant on all measures. Mean scores and scale ranges for each of the variables used are listed in Table 1. A summary of findings concludes the chapter accordingly.

Table 1. Mean Scores for all Variables

Variable	Mean	Standard Deviation	Observed Minimum	Observed Maximum
Mammy	3.16	0.787	1.60	5.00
Sapphire	2.49	0.703	1.00	4.70
Jezebel	2.45	0.705	1.00	4.13
Superwoman	3.18	0.732	1.73	5.00
Religious Attendance	2.64	1.13	1.00	4.00
Knowledge	28.05	3.46	20.00	35.00
Risk	28.01	2.82	20.00	34.00

Research Question 1: Are the stereotypical roles for Black women (SRBW) related to sexual risk behavior?

The first hypothesis suggested there was a relationship between SRBW and sexual risk behavior. Pearson's product moment correlation coefficient (Pearson's r) was run to determine the relationship between the SRBW and sexual risk behavior. Table 2

presents the Pearson's r for all variables in the study. Results support the first hypothesis, and identify a relationship among roles. Correlations between risk-behavior were found to be significant among Mammy ($r = .178$), Jezebel ($r = .168$) and Superwoman ($r = .270$) at $p < .05$ respectively. The Sapphire subscale was not significantly related to sexual risk behavior ($r = .144$, $p < .10$) (see Table 2). However, because significant relationships were found among subscales, regression analysis was also implemented.

Table 2. Pearson Correlations among Variables

Variable	Risk	Mammy	Sapphire	Jezebel	Super-woman	Religious Attendance	Knowledge
Risk	-----						
Mammy	.178*	-----					
Sapphire	.144	.459*	-----				
Jezebel	.168*	.382*	.662*	-----			
Superwoman	.270*	.695*	.524*	.434*	-----		
Religious Attendance	-.017	.044	-.053	.081	.023	-----	
Knowledge	.143	-.032	-.145	-.151	-.049	-.129	-----

* $p < .05$

Multiple regressions were conducted to analyze the relationship between Risk (behavior), as the dependent variable, and the stereotypical roles of Mammy, Sapphire, Jezebel, and Superwoman as the independent variables in order to determine the amount of variance in risk scores. A simultaneous regression was conducted. In simultaneous regression all of the predictor variables (SRBW) are entered at once to determine their effect upon the criterion variable (risk behavior). Results indicate SRBW accounts for 5% of the variance in sexual risk behavior. The results indicate Superwoman as significant in predicting sexual risk behavior (see Table 3).

Table 3. Simultaneous Regression Analysis for Stereotypes

Variables**	B	SE_B	T
Mammy	-0.089	0.475	-0.187
Sapphire	-0.185	0.537	-0.343
Jezebel	0.354	0.504	0.703
Superwoman	1.036	0.534	1.939*

*p < 0.05

**Adjusted R² = 4.1%, N=106

Research Question 2: Is there a relationship between sexual knowledge and sexual risk behavior?

The second hypothesis suggests there is a relationship between sexual knowledge and sexual risk behavior. Pearson's product moment correlation coefficient was run to determine the relationship between sexual knowledge and sexual risk behavior. A relationship between risk-behavior and knowledge was found ($r = .143$, $p < .10$).

Research Question 3: Is religious attendance related to sexual risk behavior?

The third hypothesis suggests religious attendance will be related to sexual risk behaviors. Pearson's product moment correlation coefficient (Pearson's r) was run to determine the relationship between the religious attendance and sexual risk behavior. Table 2 presents the Pearson's r correlations for all variables in the study. No relationship was found to be significant between attendance and sexual risk behavior (see Table 2). Therefore, regression analysis was not conducted.

Exploratory Analysis

Additionally, to further explore the variables given significant relationships were found, although small, a simultaneous regression was run to understand the influence of all the variables of interest in the model. A simultaneous regression combines all the

variables, considering each of them important, to determine variance in predicting the criterion variable. Using a simultaneous model will help clarify what percentage total of all variables predict sexual risk behavior. Conversely, a stepwise regression only includes variables that are significant contributors to variance in the model. Therefore, a simultaneous multiple regression analysis was conducted to analyze the relationship between Risk, as the dependent variable, and Knowledge, Religious Attendance, as well as the stereotypic roles of Mammy, Sapphire, Jezebel, and Superwoman as the independent variables, in order to determine the amount of variance in risk scores. Multiple regression analysis determines the proportion of variance for the dependent variable as determined by the predictor variables (Knowledge, Religious Attendance, and Stereotypic Roles), in addition to providing the partial correlations. Additionally, utilizing simultaneous multiple regression analysis accounts for the KABB model, mentioned in the literature, as a conceptual framework used to understand risk behavior (Peeler, 2004; Siegel et al., 1991). The results indicate 5.1% of the variance in risk score could be attributed to the predictor variables (Knowledge, Religious Attendance, and Stereotypic Roles), $F(6,99) = 1.934$, $p < 0.10$. Knowledge was positively correlated with risk ($\beta = 0.132$, $p < 0.10$). Superwoman subscale scores were also positively correlated with risk ($\beta = 1.020$, $p < 0.10$) (see Table 4).

Table 4. Simultaneous Regression

Variables	B	SE_B	T
Knowledge	0.132	0.077	1.702
Religious Attendance	-0.027	0.239	-0.111
Mammy	-0.110	0.474	-0.232
Sapphire	-0.125	0.543	-0.231
Jezebel	0.432	0.508	0.851
Superwoman	1.020	0.532	1.920*

*p < 0.05

**Adjusted R² = 5.1%, N = 106

Finally, a stepwise multiple regression analysis was conducted to analyze the relationship between the Risk, as the dependent variable, and the Knowledge, Religious Attendance, as well as the stereotypic roles of Mammy, Sapphire, Jezebel, and Superwoman as the independent variables, in order to determine the amount of variance in risk scores. Therefore, stepwise regression identifies which predictor variables are the most powerful predictors of risk behavior. The results indicate 6.4% of the variance in risk score could be attributed to the predictor variables (Stereotypic Role - Superwoman), $F(1,104) = 8.185$, $p < 0.10$. Superwoman subscale scores was also positively correlated with risk ($\beta = 1.025$, $p < 0.10$). The R² change = 0.064 ($F = 8.185$, $p < 0.10$) indicates the stereotypic role, Superwoman, adds significant prediction to variance in risk (see Table 5).

Table 5. Stepwise Regression for Superwoman

Variables**	B	SE_B	T
Superwoman	1.025	0.358	2.861*

*p < 0.05

**Adjusted R² = 6.4%, N = 106

Additional Statistical Findings

Also, the stereotypical roles show slight multicollinearity, which means they depend on each other. The total risk score appears to be normal, as seen by histogram and Normal P-P Plot, and the residuals are random (see Figures 1-3).

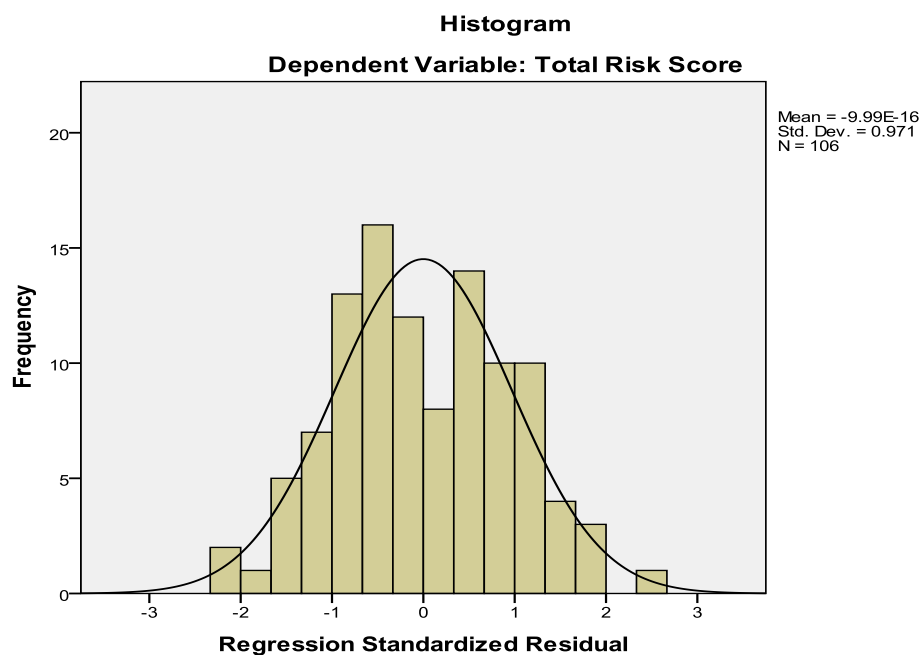


Figure 1. Normal Distribution of Risk Behavior

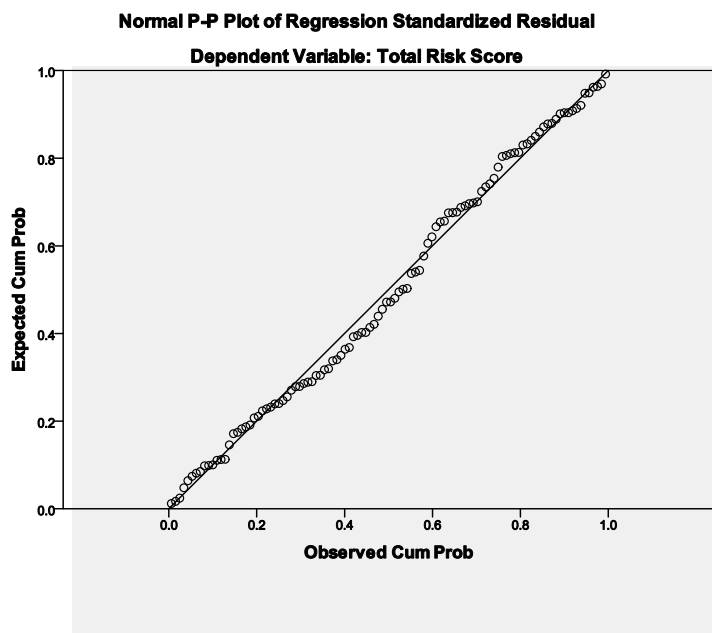


Figure 2. Normal Probability Plot of Regression for Risk Behavior

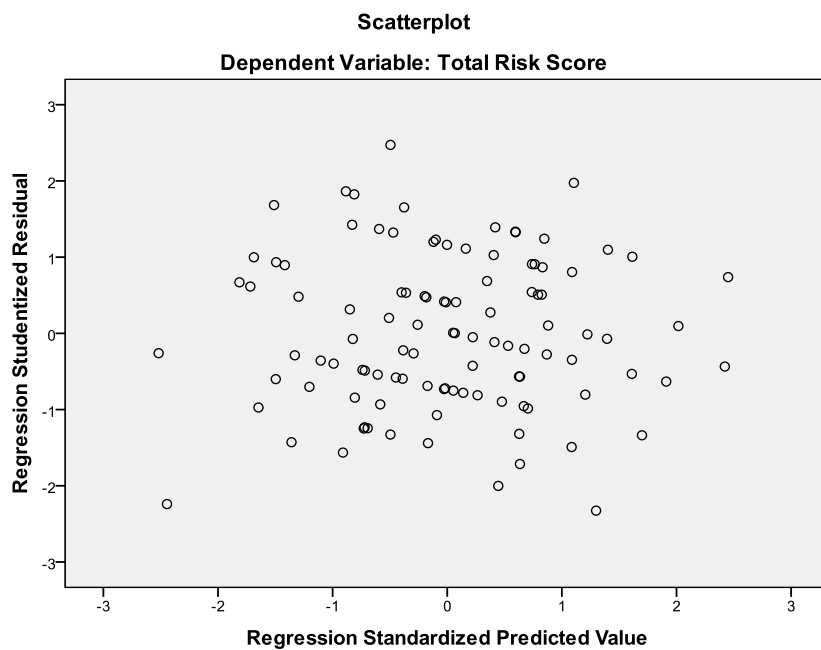


Figure 3. Random Distribution of Risk Behavior

Summary

The above analyses were implemented in an effort to address the three research questions and hypotheses proposed in this study. All three questions and hypotheses sought to determine whether a relationship existed between variables (SRBW, knowledge and religion) in predicting sexual risk behavior among African American college women. If a relationship was identified, analyses was conducted to determine the magnitude, direction, and predictability of variables in relation to sexual risk behavior. Therefore, the Pearson's r , stepwise and simultaneous multiple regressions were employed accordingly. Results indicated that among the SRBW, Mammy, Jezebel and Superwoman were related to sexual risk behavior. However, the Superwoman role was most powerful in predicting sexual risk behavior. The variables of knowledge and religion were virtually not significant in predicting sexual risk behavior. In the next section, findings are discussed in more detail with recommendations for future studies.

CHAPTER FIVE

DISCUSSION

Findings

Women and their sexuality have often been a topic of interest for many years. Sexuality, it seems, is inextricably linked to gender and social roles, thereby it serves as an expression of the underlying norms within a given culture. According to the Census Bureau (CB) (2010), women account for 51% of the total population in the United States. Among women, those of childbearing years represent 40% of the group population (U.S. Census Bureau, 2010). However, for women, the risk for contracting sexually transmitted infections (STIs) remains a growing concern.

STI prevention issues for women and particularly women of color are multifaceted and far-reaching. Several themes emerge from the literature including: the examination of gender roles, gender stereotypes, social conditions, and cultural expectations that serve to inform sexual decision-making (Collins, 2005; Pequegnat & Stover, 1999). This study attempted to explore some of the variables and cultural factors that contribute to the decision making of young African American women, placing them at risk for STIs and HIV. Specifically, this study examined the relationship between the stereotypical roles for Black women (SRBW), knowledge, religiosity and sexual risk behavior among a group of Black college women.

Analysis of the first research question revealed that there indeed was a significant relationship between three of the SRBW and sexual risk behavior. The roles of Mammy ($r = .178$), Jezebel ($r = .168$), and Superwoman ($r = .270$) were significantly and positively correlated to sexual risk behavior at $p < .05$. Specifically, the stereotype of Superwoman was even more significant in predicting sexual risk behavior.

There may be a several reasons for this outcome. It would be plausible for the former roles Mammy and Jezebel to be related to risk, as the former is characterized as a people pleaser and the latter as hypersexed. The adoption of the Mammy attitude also aligns with the theoretical framework presented in this study. According to the Theory of Gender and Power, women who adopt the more conventional gender stereotype are less likely to feel empowered in the sexual decision-making within intimate relationships. Rather than drum up discord regarding protective behavior, those who endorse Mammy would be inclined to acquiesce according to their partner's wishes. Those who adopt Jezebel attitudes would probably assert their sexual preferences, but as supported in the literature, could easily compromise sexual safety if the relationship is deemed as close. Also, considering the TGP, Jezebel may be capable of asserting her power, regarding sexual encounters, but may be compromised to assert herself in other social areas (i.e., labor and cathexis). Therefore, Jezebel may even find herself using her sexual power and prowess to get what she wants in other areas (i.e., the workplace, home, politics, etc.), where she is not treated equally.

However, it may seem counter-intuitive for the Superwoman role to be distinguished as a predictor of risk. The role of Superwoman is probably perceived as the

strongest of all the SRBW. The name “Superwoman”, suggests a person who is rather invincible, strong and confident. However, the actual role of Superwoman characterizes one who uses a façade of strength to mask her underlying weaknesses. Nevertheless, those who endorse Superwoman clearly tend to put other people’s needs before their own. Although she is characterized as strong, dependable, and successful, she is not empowered to value her needs above others’. Using the framework of the TGP to understand the characterization of Superwoman, she would be challenged by the inequities in gender roles, both at the societal and institutional levels. Therefore, her inability to assert herself in relation to her intimate partners would speak to both the structure of cathexis and power in Connell’s theory. Superwoman is not emotionally (cathexis) secure enough to assert her desire to engage in protective behavior; and is also yielding her voice (power) in the relationship, with regard to sexual decision-making, the greater weight given to her partner.

The Sapphire role was not significantly related to sexual risk behavior. This may be rationalized by the characterization of her role. Sapphire is considered shrill, rude and obnoxious. Her very nature may serve to empower her in sexual encounters, enabling her to insist upon protective practice.

Analysis of the second hypothesis revealed there was no significant relationship between knowledge and sexual risk ($r = .143$, $p < .10$). This finding is supported in the literature. While it is recognized that knowledge is essential in STI/HIV prevention, alone it is insufficient (Bazargan et al., 2000; Hollar & Snizek, 1996; Jarama et al., 2007; McGuire et al., 1992). Although minimal, there were intercorrelations found among

knowledge and two of the SRBW and religious attendance. Knowledge was inversely related to Sapphire and Jezebel roles, and inversely related to religious attendance.

Intuitively, it can be rationalized that due to the characterization of the Sapphire and Jezebel roles, knowledge would be inversely related. Sapphire is characterized as flippant and can be viewed as a head-strong, therefore resistant to receiving information. Jezebel is characterized as sexually out of control, therefore, her inability to control her sex drive makes her vulnerable to risk behavior regardless knowledgeable she may be.

However, the inverse relationship of religious attendance to sexual knowledge is somewhat surprising. Historically, religious affiliation has been a staple in the black community. The Black church has had a vast impact on African American culture and has indirectly impacted behavior through the years (Hunt & Hunt, 2001; Lincoln & Mamiya, 1990). Nevertheless, the black church has also come under scrutiny and criticism for its silence regarding sexuality (Dyson, 2003). Discussing sex period, not to mention sexual health, remains an issue of taboo. Given this context, it is understandable how sexual knowledge is not strengthened by church attendance.

Analysis of the third hypothesis revealed no significant relationship between religious attendance and sexual risk behavior. It appears to be a universal stance, among various faiths, to encourage sexual modesty (Steinman & Zimmerman, 2004). Therefore, it makes intuitive sense that the direction of the last model was negative. Although results did not support the third hypothesis, the direction of the model is correct. Perhaps a more in depth measure for religiosity and a larger participant sample is warranted. Multi-item indicators use characteristics of attendance, affiliation, attitudes and religious

attributions as measures of religiosity and religious assessment (Hunt & Hunt, 2001; Parsons, Cruise, Davenport, & Jones, 2006; Taylor, Chatters, & Levin, 2004). However, considering attendance alone maybe inadequate in assessing the influence of religiosity on sexual behavior. Some studies support extending the scope of assessment when accounting for religion as a factor in research (Cornwall, Albrecht, Cunningham, & Pitcher, 1986; Zaleski & Schiaffino, 2000). Due to its influence in Black culture, it is quite relevant to try and understand the influence of religion on sexual behavior for young adult college women. Nevertheless, because religion embodies a multifaceted characteristic, it may also be challenging to capture or measure.

Implications

Academic

Educators who seek to eradicate the infection rate of STIs/HIV among young college Black women should consider gender and cultural factors that may impact decision-making. One such factor includes SRBW. Of the four roles investigated in this study three should be considered (Mammy, Jezebel, and Sapphire) in education programs and interventions. Attention should be given to the existence, interpretation and adoption of stereotypes for Black women. Coupled with an emphasis on increased STI/HIV knowledge, a focus on the aforementioned stereotypes can help educators understand characteristics and traits that undermine Black college women's ability to assert their power in maintaining and improving their sexual health. Also, considering the cultural influence of religiosity on sexual behavior would be a key focus for young African American women. However, educators must seek to utilize more in depth queries of

religiosity to ascertain a greater understanding of its influence on behavior. Nevertheless, given the historical influence of the Black church on African American culture and the limited documented engagement of the church with issues of sex, sexuality, sexual health and prevention, it seems the church would be a rich setting for educators to encourage Black women and engage in proactive sexual health promoting interventions.

Additionally, in an effort to confront and dispel many of the stereotypical images associated with African American women, and promote behavioral change, educators should consider a Bandura's Social Cognitive Theory. Bandura's theory emphasizes the interrelatedness and bidirectionality of the interface between the person, his/her behavior and the environment (Bandura, 1986, 2001). Modeling is another key concept of Bandura's theory important to consider. The stereotypical images of Black women inundated in much of American culture and reinforced through mass media, societal norms, and political arenas serve as vicarious models for young Black college women, and can subconsciously inform sexual decision-making. Therefore, educators should consider the impact of these models and seek to demystify the perceptions associated with them accordingly.

Practical

From a clinical perspective, debunking the myths of the stereotypical roles for young Black women are key, particularly those associated with sexual risk: Mammy, Jezebel, and Superwoman. More specifically, addressing the role of Superwoman is very relevant, given its association with sexual risk is counterintuitive of the very nature of the myth. Black women who adopt this role need to understand that the image of being

strong without expression of vulnerability is a mere façade, not representative of their reality. Further, this façade of strength is hurting Black women, not helping them. Therefore, discrediting the myth will not only serve as a protective factor for sexual health, but also has mental health implications. Maintaining the Superwoman role also serves as stressor for women and, according to the literature, can even propel women to consider suicide (Manetta, 1999). Also, it may be important to target the role of Sapphire and identify the traits of this role that serve to protect women sexually. If it is possible to parse out positive characteristics from this role, they can be encouraged among women accordingly. Finally, religiosity should be readily encouraged among Black women. Given the negative direction of the relationship between religiosity and sexual behavior, encouraging general religious behaviors of attendance, affiliation and participation would continue to endorse sexual health.

Limitations

There are several limiting factors that merit consideration and may have impacted the results of this study. First, this study was based upon a convenience sample of participants. One hundred ten participants were polled from an urban Midwestern university. The institution serves a student population that is primarily Black and of a low to middle socioeconomic status. Results may have been considerably different if more young Black college women were polled from various demographic backgrounds and university settings. Therefore, generalizability would not be appropriate to the larger population of young Black college women. Secondly, data was obtained through participant surveys. Because this represents a self-report measure, some data may be

inaccurate. Due to the sensitivity of the issues discussed in this study and the explicit nature of many survey queries, it is likely that some participants may have not been completely honest in their responses, confounding the accuracy of collected data.

Another limitation involves the intercorrelations among SRBW. Many of the participants identified with the characteristic attitudes of multiple stereotypes. These sort of “eclectic” adoptions could thereby cloud the ability to distinguish which SRBW has the greater leverage on subsequent sexual risk behavior. Further, many of the stereotypical roles could assert similar behavior characteristics. Finally, as iterated above, the assessment of religiosity as defined by religious attendance may be inadequate in addressing the influence of faith on sexual risk behavior. The literature supports the value of religion in the shaping and sustaining African American culture and behavior (Alex-Assensoh & Assensoh, 2001; Hunt & Hunt, 2001; Lincoln & Mamiya, 1990). Its insignificant impact in this study could be explained by the need to expand the depth of religious assessment (Zaleski & Schiaffino, 2000).

Recommendations for Future Research

Base upon the findings from this study, the following suggestions are recommended for future research and prevention efforts:

1. Because a convenience sample was used, the data collected for this study did not fully represent the targeted population. Therefore, recruiting and collecting data from a broader population including various educational levels, socioeconomic statuses, ages, university settings, and the like would offer a more objective representation of the targeted population, African American college women. Also, the use of internet-

- based surveys in conjunction with face-to-face surveys could serve to broaden the sample base and strengthen the accuracy of the collected data.
2. Analysis of the cultural factors that mediate sexual decision-making among African American women, particularly of college age, is warranted. One instrument used in this study was the Stereotypical Roles for Black Women Scale (SRBWS). This particular instrument provides researchers the unique opportunity to understand, in part, how four common stereotypes (Mammy, Jezebel, Sapphire, and Superwoman) can impact Black women. However, the scale itself is yet relatively new. Therefore, there is a dearth of research that uses the instrument at all, not to mention with a population of African American college women. Therefore, further research is recommended utilizing SRBWS with African American college women to support the reliability and validity of this measure accordingly.
 3. Findings from this study suggest that there is no significant relationship between religiosity and sexual risk behavior. However, the influence of religiosity within the African American Diaspora is well documented (Alex-Assensoh & Assensoh, 2001; Hunt & Hunt, 2001; Lincoln & Mamiya, 1990). Further, Black women have historically been strongly affiliated with the Black church. To understand the influence of religiosity on sexual risk behavior, study considered the characteristic of church attendance. Perhaps this model was too narrow to understand the impact of religiosity. Further research is recommended utilizing a more in depth query of religiosity, on multiple dimensions. Understanding how religion influences behavior for black women may not be easy to capture or measure. Studies suggest that this

- factor should be considered on multi-levels, but no empirical studies have been found to parse out more factors. The literature has cited the work of Allport and Ross (1967), who developed the Religious Orientation Scale (ROS), as a more comprehensive measure of the multidimensional construct of religiosity (Young & Hubbard, 1992; Zaleski & Schiaffino, 2000). The ROS is designed to explore one's religious motivation/association on two levels/dimensions (intrinsic and extrinsic). Therefore, it's important to look at more than attendance, as no studies have been found to show an empirical relationship between religiosity and sexual risk behavior.
4. Future research should also consider the influence of stereotypical roles when attempting to understand sexual risk behavior among Black women. The results from this study indicated Superwoman was significant in predicting sexual risk behavior. It is important that future research continue to examine the impact of stereotypical role adoption and how various roles serve to undermine Black women's sexual self-efficacy.
 5. Finally, further research targeting African American college women is warranted. Black college age women have the highest incidence of STIs, new cases. Expanding the scope of research of this population is critical in the effort to eradicate their high risk for infection.

APPENDIX A
SURVEY

*****SURVEY PACKET FOR BLACK WOMEN PARTICIPANTS*****

This survey packet contains question of a very personal nature. Do not write your name anywhere on the surveys. All data will be summarized in group responses. Remember, this survey is anonymous.

The first group of questions is about your GENERAL BACKGROUND.

1. What is the highest level of school completed?

1. Freshman (0-29 credit hours)
 2. Sophomore (30-59 credit hours)
 3. Junior (60-89 credit hours)
 4. Senior (90 or more credit hours)

What is your major? _____

2. What is your current work status?

1. Employed, full time (35 hours per week or more)
 2. Employed, part time (35 hours a week or less)
 3. Unemployed, looking for work
 4. Unemployed, not looking for work
 5. Other: What? _____

3. Including money from all sources, what is your household income in a typical week? By "household," we mean the people you live with and share income with. [Because income is a sensitive topic for many people, we want to remind you that all your answers are confidential.]

1. Less than \$100/week
 2. \$101 to \$200/week
 3. \$201 to \$300/week
 4. \$301 to \$400/week
 5. \$401 to \$500/week
 6. \$501 to \$600/week

4. What is your religion, if any?

1. No religious preference
 2. Protestant, What denomination? _____
 3. Catholic
 4. Jewish
 5. Other, What? _____

5. How often do you attend religious services?

1. Less than once a year
 2. Once or twice a year
 3. 3 to 11 times a year
 4. Once a month
 5. 2-3 times a month
 6. Once a week
 7. More than once a week

6. What is your Gender? Your Race?
- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> 1. Male | <input type="checkbox"/> 1. Black |
| <input type="checkbox"/> 2. Female | <input type="checkbox"/> 2. White |
| | <input type="checkbox"/> 3. Hispanic |
| | <input type="checkbox"/> 4. Asian |

The next questions ask what you already know about HIV, other sexually transmitted diseases (STDs) and about prevention. For each statement, **CIRCLE T** for TRUE if you think the statement is correct, or **F** for FALSE if you think it is not correct. Please answer every statement, **even if you are not sure of the answer**. It's OK to guess.

	TRUE [1]	FALSE [2]
7. Withdrawing (“pulling out”) the penis before ejaculating (“cumming”) works just as well as a condom for preventing sexually transmitted diseases (STDs).	T	F
8. AIDS is less contagious than the common cold.	T	F
9. If your symptoms go away you probably don’t have a sexually transmitted disease (STD).	T	F
10. A diaphragm with jelly works better than a condom to prevent sexually transmitted disease (STDs).	T	F
11. Condoms (rubbers) break about half the time for most people.	T	F
12. If you have unprotected sex (sex without a condom) with someone who has a sexually transmitted disease (STD) you will catch it for sure.	T	F
13. You could catch the AIDS virus by eating food prepared by a cook who has it.	T	F
14. If you get a sexually transmitted disease (STD), you probably got it from the last person you had sex with.	T	F
15. You can tell if someone is infected with the AIDS virus because they look sick.	T	F
16. A person can be infected with the AIDS virus and not have the disease AIDS.	T	F
17. A woman can <u>only</u> get AIDS from a man if she has anal (rectal) sex with him.	T	F
18. AIDS can reduce the body’s natural protection against disease.	T	F

19. Men always have a discharge (drip from the penis) when they have a sexually transmitted disease (STD). T F
20. A condom (rubber) should be worn so it is snug at the tip. T F
21. It's a good idea to use hand lotion for lubrication when using a condom (rubber). T F
22. A condom (rubber) should be unrolled before putting it on a man's penis. T F
23. With the new female condom (*Reality*) you can use any kind of lubricant. T F
24. You might catch the AIDS virus when you donate blood. T F
25. Only people who have lots of sex partners get sexually transmitted diseases (STD). T F
26. Some kinds of sexually transmitted diseases (STD) don't give you symptoms until six weeks or more after you catch the infection. T F
27. Men seem to catch the AIDS virus much easier than women do. T F
28. People tell us they use many different ways to reduce their risk of getting a sexually transmitted disease (STD) or the AIDS virus (HIV). You may or may not have taken steps to make yourself safer. If you have, please check the things that you have already done. CHECK AS MANY AS APPLY.
- a. I have DONE NOTHING yet to make myself sexually safer. [SKIP TO QUESTION 29]
- b. I have reduced my number of sex partners.
- c. I make sure my partner(s) use(s) a male condom for vaginal sex (penis in my vagina).
- d. I make sure my partner(s) use(s) a male condom for oral sex (penis in my mouth).
- e. I make sure my partner(s) use(s) a dental dam or other barrier for oral sex (mouth on my genitals).
- f. I make sure my partner(s) use(s) a male condom for anal sex (penis in my rectum or anus).
- g. I use a spermicide (foam or jelly), or female condom for vaginal sex.
- h. I am sexual (kissing, petting masturbating) but am not having intercourse (penis in mouth, vagina or rectum).
- i. I don't do anything sexual (no kissing, petting or intercourse).
- j. I am having sex with only one partner.
- k. My partner doesn't have any other partners.
- l. I am not having sex with a person who uses needles.
- m. I am not having sex with a partner who has other partners (male or female).
- n. I am not having sex with a person who does not look healthy.
- o. I wash my partner before sex.
- p. I check my partner for sores or drips before sex.
- q. Other. Please explain: _____

How do you identify your sexual orientation?

- ___1. Heterosexual
 ___2. Homosexual
 ___3. Bisexual

This is a scale to determine attitudes and beliefs. There are no right or wrong answers. Please use the following scale to complete the questions.

CIRCLE THE NUMBER that indicates how much you agree or disagree with each statement.

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

- | | | | | | |
|---|---|---|---|---|---|
| 1. Black women are often loud and obnoxious. | 1 | 2 | 3 | 4 | 5 |
| 2. Black women are all about sex. | 1 | 2 | 3 | 4 | 5 |
| 3. Black women have to be strong to survive. | 1 | 2 | 3 | 4 | 5 |
| 4. Black women need to nag others to get a response. | 1 | 2 | 3 | 4 | 5 |
| 5. Black women will use sex to get what they want. | 1 | 2 | 3 | 4 | 5 |
| 6. Men can be controlled with sex. | 1 | 2 | 3 | 4 | 5 |
| 7. If given a chance, Black women will put down Black men. | 1 | 2 | 3 | 4 | 5 |
| 8. Black women are often treated as sex objects. | 1 | 2 | 3 | 4 | 5 |
| 9. I am often expected to take care of family members. | 1 | 2 | 3 | 4 | 5 |
| 10. If I fall apart, I will be a failure. | 1 | 2 | 3 | 4 | 5 |
| 11. Black women are usually angry with others. | 1 | 2 | 3 | 4 | 5 |
| 12. I often put aside my own needs to help others. | 1 | 2 | 3 | 4 | 5 |
| 13. I often feel ignored by others. | 1 | 2 | 3 | 4 | 5 |
| 14. I find it difficult to ask others for help. | 1 | 2 | 3 | 4 | 5 |
| 15. I feel guilty when I put my own needs before others. | 1 | 2 | 3 | 4 | 5 |
| 16. I do not want others to know if I experience a problem. | 1 | 2 | 3 | 4 | 5 |
| 17. People often expect me to take care of them. | 1 | 2 | 3 | 4 | 5 |
| 18. People respond to me more if I am loud and angry. | 1 | 2 | 3 | 4 | 5 |

- | | | | | | |
|--|---|---|---|---|---|
| 19. I tell others that I am fine when I am depressed or down. | 1 | 2 | 3 | 4 | 5 |
| 20. People treat me as if I am a sex object. | 1 | 2 | 3 | 4 | 5 |
| 21. It is difficult for me to share problems with others. | 1 | 2 | 3 | 4 | 5 |
| 22. I should not expect nurturing from others. | 1 | 2 | 3 | 4 | 5 |
| 23. I am hardly ever satisfied. | 1 | 2 | 3 | 4 | 5 |
| 24. Black women are out to get your man. | 1 | 2 | 3 | 4 | 5 |
| 25. I often have to put someone in their place, read them or check them. | 1 | 2 | 3 | 4 | 5 |
| 26. Young Black women are gold-diggers. | 1 | 2 | 3 | 4 | 5 |
| 27. I often threaten to cuss someone out. | 1 | 2 | 3 | 4 | 5 |
| 28. Sex is a weapon. | 1 | 2 | 3 | 4 | 5 |
| 29. I am overworked, overwhelmed, and/or underappreciated. | 1 | 2 | 3 | 4 | 5 |
| 30. Black women are demanding. | 1 | 2 | 3 | 4 | 5 |
| 31. I am always helping someone else. | 1 | 2 | 3 | 4 | 5 |
| 32. I will let people down if I take time out for myself. | 1 | 2 | 3 | 4 | 5 |
| 33. It is easy for me to tell other people my problems. | 1 | 2 | 3 | 4 | 5 |
| 34. I feel guilty if I cannot help someone. | 1 | 2 | 3 | 4 | 5 |

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