Gender-Related Traits, Sexual Self-Efficacy, Importance Of Relationship And The Relationship To College Women's Condom Use

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GENDER-RELATED TRAITS, SEXUAL SELF-EFFICACY, IMPORTANCE OF RELATIONSHIP AND THE RELATIONSHIP TO COLLEGE WOMEN'S CONDOM USE

BY

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DEDICATION

To the memory of my mother, Mary Youmans and brother, Rick Youmans.
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CHAPTER 1

Introduction

This study investigates the predictive ability of gender-related traits, sexual self-efficacy, and the importance of relationships versus life goals to heterosexually active college women's condom use during oral, anal, and vaginal sex. The relationship between gender-related traits and sexual self-efficacy, as well as gender-related traits and placing importance on heterosexual relationships are also investigated.

For those who choose to engage in penetrative heterosex or oral sex, latex condoms are currently the most effective method available for preventing sexually transmitted diseases (STDs). The risks associated with sexually transmitted diseases (STDs) for women are significant, including the possible long-term effects of cervical or other cancers, ectopic pregnancy, infertility, liver disease, and death from AIDS. Women and infants are effected disproportionately by the long-term consequences of STDs (Center for Disease Control, 1998a). Infected pregnant women can experience spontaneous abortion, stillbirth, pre-term delivery, and their infants can experience serious illness. The U.S. has the highest rate of STDs in the developed world (Eng & Butler, 1997). Of the fifteen million new cases of STDs reported yearly in the U.S., about 25% are among teenagers (Eng & Butler, 1997).
Some STDs increase the risk of acquiring HIV two to five times if exposure to the virus is by sexual contact (Center for Disease Control, 1998b). HIV/AIDS is currently the third leading cause of death among 25 to 44 year old women in the U.S. and the leading killer of black women among that age group. Although Hispanic and black women constitute less than one fourth of the U.S. female population, they constitute 77% of the reported AIDS cases (Center for Disease Control 2000). In 1994 the number of AIDS cases in U.S. women attributed to heterosexual transmission surpassed the number of cases attributed to drug injection use (Center for Disease Control, 1995). Forty-one percent of female AIDS cases have been heterosexual transmitted in contrast to just seven percent of men’s cases. Women are more likely to be infected by heterosexual sex due to the more efficient transmission of the virus from male to female and the increased likelihood of women having a risky partner (Amaro, 1995).

Adolescents and young adults have the highest risk for STDs (Santelli, Kouzis, Hoover, Polacsek, Burwell, & Celentano, 1996) which are more easily transmitted from males to females (Ickovics & Rodin, 1992; Masters, Johnson & Kolodny, 1992). Very young sexually active women are at high risk for STDs due to their “…physically and immunologically immature genital tract” (Ericksen & Trocki, 1992, p. 849), and the likelihood of multiple sex partners which increases exposure time to sexually transmissible diseases. A female teenager has a 30% risk of getting genital herpes and a 50% chance of contracting gonorrhea in one single act of unprotected sex with an infected person (Alan Guttmacher Institute, 1994). Additionally, the younger a female is
when she gets involved in heterosex the less likely it is that condoms will be used (Greenberg, Magdar, & Aral, 1992).

Despite being knowledgeable about the risks of STDs, including HIV/AIDS many sexually active women still do not use condoms (Baldwin & Baldwin, 1988; Becker & Joseph, 1988; DiClemente, Forest, & Mickler, 1989; Ingham, Woodcock, & Steamer, 1991), leaving themselves vulnerable to disease and possible death. Recent nationwide research of over 15,000 high school students, found that 42% of sexually active students had not used a condom at last incidence of sexual intercourse. Male students were significantly more likely to report condom use at last intercourse then females (65.5% and 50.7% respectively) and male and female black students were significantly more likely to report condom use than either Hispanic or white students (Center for Disease Control, 2000). A study of adolescents (12-22 years old), reported a similar disparity between male and female use of condoms (59% and 45% respectively) with 15% reporting that they used no protection the last time they had intercourse (Santelli et al., 1996). College students report consistent condom use as little as 16% of the time (DiClemente, 1990; McDonald, Wells, Fisher, Warren, King, & Doherty, 1990) to as frequently as 67% of the time for females and 88% for males (McGuire, Shega, Nicholls, Deese, & Landefeld, 1992), while 38% of the college students surveyed by Boyd and Wandersman (1991) report never using condoms.

Female controlled contraception (i.e., birth control pill, IUD, diaphragm) has certainly enabled women to have more sexual freedom with less worry about pregnancy.
However, with the exception of the little-utilized female condom, other forms of contraception still leave women vulnerable to disease. Women may be protecting themselves from unwanted pregnancy but simultaneously and sometimes unwittingly sacrificing their health as a result. The contraceptive options that offer women the most privacy and personal control are ineffective in disease prevention.

While female-controlled contraception has been primarily liberating, the pressures and expectations accompanying the freedom may also have hindered women’s sexual liberation (Dworkin, 1987; MacKinnon, 1987). Women may find it more difficult to refuse penetrative sex based on pregnancy risk (Few, 1997) and there may also be more pressure to be sexually involved without emotional commitment (Connell & Dowsett, 1992).

Because condoms are male-controlled, women choosing to be sexually active and protected from disease face a complex process. They are not only dealing with their own issues of impulse control and other intrapersonal concerns, but must navigate the interpersonal dynamics associated with heterosexual relationships. Effective condom use interventions will address the intrapsychic and interpersonal (including gender and power) dynamics within the cultural, social, situational and historical context of heterosexual intimacy (Amaro, 1995; Ehrhard & Wassenheit, 1991; Gomez & Marin, 1996).

Gender-appropriate sexual behavior undermines female power and legitimizes a passive, responsible, gatekeeper role for women engaging in heterosex. In this culture,
women are not recognized as “desiring sexual subjects (agents)…” (Bem, 1993, p.164), their sexual desire is de-emphasized as is knowledge and awareness of their individual sexual needs and desires (Tolman, 1991, 1994; Wyatt & Rierdel, 1994). For women, the simple act of purchasing and carrying condoms challenges the “patriarchal definition” (Wilton & Aggleton, 1991, p. 155) of female sexuality “….as reactive rather than proactive” (p. 155). Those women who defy the accepted passive sexual role by asserting their own needs, acting on their sexual desires, and taking an active role in their sexual relationships (including safer sex behaviors) risk negative social consequences and social sanctions (Allgeire & Fogel, 1978; Daley & Rozenwieg, 1988; Lewin, 1985).

Heterosex takes place within a cultural, relational, social, and political context that has influenced and continues to influence the individual’s desires, preferences, expectations, and behavior. In designing an effective condom use intervention for women, the power that social and cultural expectations wield on individual behavior in heterosexual relationships must be identified, acknowledged, and explored. Skills taught to women (i.e., assertion skills, condom use skills) without consideration of, or in isolation of, the social, gender, and cultural context will likely be ineffective for most women.

Statement of the Problem

Women’s use of the male-controlled condom is sporadic and unpredictable despite education and knowledge about the potential dangers of unprotected heterosex.
The lack of female-controlled, discreet, user-friendly, and safe alternatives is clearly a factor in women’s unpredictable behavior. Additionally, heterosex occurs within the context of culture, relationship, gender relations, and power. Interventions that isolate the individual behavior from the context have been criticized as being narrow and myopic in scope and understanding, and as a consequence are ineffective.

Research indicates that behavioral expectations in sexual situations are likely to mirror general sex role expectations — instrumental for men and expressive for women (Gagnon, 1990; Simon & Gagnon, 1986) and that women prefer that men are more instrumental than they are in sexual situations (Lawrence, Taylor, & Byers, 1996). Since women are likely to suppress nontraditional sex role behavior (Klein & Willerman, 1979; Stake & Orlofsky, 1992) when sex role behavior is salient, as in heterosex, it is likely that even those women who are instrumental in other domains may acquiesce to their partner’s condom use decision-making.

Few studies have addressed the relationship of gender-related dispositional traits specifically to women’s use of condoms in heterosex. Various studies describe these gender-related traits as traditional/expressive or nontraditional/instrumental gender/sex role behaviors. Two studies that investigated the relationship of these traits to condom use had contradictory results. Among college students, those with androgynous or undifferentiated sex role identity had a more positive attitude then those students who identified as masculine or feminine (the more traditional sex roles) towards condom use and used condoms more often (Hoover, 1996). However, condom use among 16 to 54
year old women attending public health clinics was not directly related to instrumentality and expressiveness (Bowleg, 1997). Populations in these two studies differed markedly in age and race/ethnicity.

Research needs to assess if traditional gendered behavior (expressiveness) is actually an unsafe sexual strategy for young women and conversely if nontraditional behavior (instrumentality) is a safe strategy. If instrumentality and expressiveness are influenced by the domain and context of heterosex and as a consequence make women more vulnerable to risky sexual behavior, condom use interventions need to include strategies that address these factors.

Narrowing the lens, in the interest of addressing context-dependent agency, this study investigates the relationship of sexual self-efficacy, a measure of one’s perceptions of their capability to enact and resist behaviors related to sexual activity (Rosenthal, Moore, & Flynn, 1991) to condom use. One factor of sexual self-efficacy, confidence in “saying no” to sexual activity, predicted college women’s safer sex behavior with a casual partner. Over 30% of the women felt unable to carry condoms with them and 20% felt unable to discuss the use of condoms for protection when other forms of contraception were being used. Another factor of sexual self-efficacy “taking precautionary behaviors” was predictive of condom use in the last 30 days, but not on the most recent occasion (Bowleg, 1997). These two studies utilized the same measurement, whereas Breakwell, Millward, and Fife-Shaw (1994), using a different measurement of
sexual self-efficacy found that those less confident in handling sexual situations were more likely to use condoms.

Goldman and Harlow (1993) found that college women’s self-efficacy in protecting themselves from AIDS was related to abstaining from intercourse, having fewer sexual partners, and having less intercourse after drinking or drugging. Despite feeling more confident than men in protecting themselves from AIDS, there was no gender difference in condom use.

Although women may feel more confident in “saying no”, research indicates that they frequently agree to unwanted sexual activity (Abbott, 1988; Christopher, 1988; Lewin, 1985; Muehlenhard & Cook, 1988; Wyatt & Riederle, 1994). Women may have more familiarity, skill, and comfort with abstaining from sexual behaviors rather than negotiating sexual behaviors such as condom use or other safer sex practices.

The relationship of gender-related dispositional traits and perceived capability in relation to sexual behaviors to women’s condom use is unclear, confusing, and sometimes contradictory. Enhancing women’s sexual self-efficacy to increase condom use, although intuitively and theoretically appealing, may not be supported by research. Investigations need to continue to identify if sexual self-efficacy is related to condom use, and if so, what aspect(s) of sexual self-efficacy and finally, how sexual self-efficacy can be enhanced to positively effect women’s condom use in heterosex.

Numerous studies show that women’s sexuality is more closely tied to emotional or relational factors than men’s sexuality (Carroll, Volk, & Hyde, 1985; Hynie, Lydon,
Cote, & Weiner, 1998; Mosher & Maclan, 1994; Traeen & Kralem, 1996). Hynie and colleagues found that the relational role (generally female) in sexual behavior is less likely to be associated with condom use than the recreational approach (generally male) and that expressiveness was related to the endorsement of the relational role of sexuality. No previous research has explored the correlation between the importance women place on heterosexual relationships versus life goals and condom use.

A majority (approximately 75%) of male and female college students would sacrifice a major life goal (i.e., career, financial success, contributing to society) for a heterosexual relationship (Hammersla & Friese-McMahn, 1990). Of these students, those with a feminine sex role orientation were the most likely to choose a relationship and those with a masculine sex role orientation were the least likely. Both male and female college students view talking about safer sex practices or AIDS as a threat to the relationship (Cline, Johnson, & Freeman, 1992) and feel that the discussion of condom use or using a condom would destroy the trust and intimacy of the relationship (Galligan & Terry, 1993).

It is key in understanding women's sexuality to recognize the importance of relationship to women’s identity (Amaro, 1995). Women who have high emotional closeness in their relationship also seem to have low intentions to use condoms (Santelli et al., 1996). Research needs to address the role that prioritizing heterosexual relationships has on heterosexually active college women’s condom use. It is important
to understand if placing high importance on heterosexual relationships is a disincentive for women to use condoms and further puts them at risk for contracting STDs.

This study focuses on understanding heterosexually active female college student's condom use as a behavior that is complicated by not only individual factors but relational, social, and cultural factors. Instrumentality and self-efficacy are counter to cultural expectations for females, especially where gender is particularly salient as in heterosexual relationships. A woman who may identify as instrumental may be unwilling or unable to project that instrumentality in the domain of heterosex. The skills may be lacking, the intrapersonal conflict too overwhelming, and the interpersonal consequences too severe.

If having a heterosexual relationship is a high priority for a woman, and she perceives that asserting the need to use condoms may alienate a partner (by contradicting acceptable gender roles, by appearing too experienced, etc.) the woman may risk her health to meet the prioritized goal of the heterosexual relationship. The relationship goal may pre-empt her dispositional instrumental traits and/or diminish her sexual self-efficacy.

By identifying characteristics of women who are prone to sexually risky behavior more effective interventions can be created. If frequency of condom use is positively related to instrumentality and high sexual self-efficacy and is negatively associated with expressiveness and low sexual self-efficacy, interventions may need to focus on enhancing the more effective behaviors. If placing high importance on heterosexual
relationships is related to risky sexual behavior, interventions should target this dimension of behavior. Designing effective interventions for such a complex, multidimensional problem is clearly complicated. Identifying the salient issues brings more focus to the process.

Research Questions

1. Do instrumentality and expressiveness predict condom use of heterosexually active female college students?

2. What is the relationship of instrumentality and expressiveness to sexual self-efficacy among heterosexually active female college students?

3. Is placing importance on heterosexual relationships vs. life goals more predictive of condom use by heterosexually active college women than instrumentality, expressiveness, or sexual self-efficacy?

4. What is the relationship of instrumentality and expressiveness to placing importance on heterosexual relationships versus life goals among heterosexually active college female students?

Hypotheses

1. Instrumentality and expressiveness will predict heterosexually active college women's use of condoms in the past 12 months during anal, oral, and vaginal sex.

2. Instrumentality will be positively correlated with sexual self-efficacy and
expressiveness will be negatively correlated with sexual self-efficacy among heterosexually active female college students.

3. Placing importance on heterosexual relationships versus life goals will predict heterosexually active college women’s condom use in the past 12 months during anal, oral, and vaginal intercourse and account for more of the variance of heterosexually active college women’s condom use than instrumentality, expressiveness, and sexual self-efficacy.

4. Among heterosexually active college women instrumentality will be negatively correlated with placing importance on heterosexual relationships versus life goals and expressiveness will be positively related to placing importance on heterosexual relationships versus life goals.

Definition of Terms

1. **Instrumentality/Expressivity:** Instrumentality and expressiveness are gender-related traits assessed by identifying the individual’s socially desirable instrumental (generally associated with traditional masculinity) and expressive traits (generally associated with traditional femininity) as measured by Spence, Heimreich, and Stapp’s (1974) Personal Attributes Questionnaire (PAQ). Instrumentality is conceptualized as active, assertive, taking initiative, individualistic, and achievement-oriented. Expressiveness is conceptualized as passive, nurturing, caring, selfless, and relationship-oriented.
2. **Sexual Self-Efficacy:** The individual's perceived ability and comfort to successfully engage and initiate a variety of sexual activities. This includes being able to refuse engagement in certain behaviors, taking initiative, or being assertive in achieving sexual satisfaction and using precautions when engaging in sexual activity. This is measured by the Sexual Self-Efficacy Scale (Rosenthal, Moore, & Flynn, 1991).

3. **Importance of Heterosexual Relationships:** The degree to which an individual is willing to sacrifice other identified life goals for an opposite sex relationship. This will be measured Freise-McMahan's (1989) "Goals in Life Scale".

4. **Condom Use:** Refers only to the male controlled condom and is measured by the frequency of condom use during vaginal, oral, and/or anal sex in the last 12 months.

5. **Heterosex:** Heterosex refers to heterosexual sexual activity (Kitzinger & Wilkinson, 1997).

**Significance of Study**

Condom use by women is a complex behavior requiring planning (purchasing and carrying), negotiation, assertiveness, and it contradicts the traditional female role in heterosex. Do gender-related traits and sexual self-efficacy predict sexual risk taking as measured by condom use or does the complexity and context of condom use nullify the effects of individual traits and attitudes? Furthermore, are those women who place significant importance on heterosexual relationships vs. life goals more likely to engage
in risky behavior despite their individual traits and attitudes — is context related to risk taking?

By identifying those attitudes and traits that may offer some protection to sexually active women and those that put them at higher risk, more effective interventions may be designed and implemented. If the implicit messages about sexuality and gender seem to be associated with increased risky behavior then re-education focused on deconstructing these belief systems may be a more efficacious approach then the attempts to intervene on the micro level.

This study will add to the sparse, and sometimes contradictory research on college women’s condom use and gender-related traits and sexual self-efficacy. Exploring the relationship of “placing importance on heterosexual relationships versus life goals” to condom use is a new dimension in condom-use research. It is hoped that this research may provide helpful information to counselors, public health professionals, and educators in their work to decrease the epidemic of STDs to this vulnerable population.

Delimitations

1. This study is limited to heterosexual/bisexual female college students (ages 18-25). Only unmarried students who were heterosexually active in the past 12 months, defined as having engaged in vaginal, oral, and/or anal intercourse were included in assessment of the hypotheses.
CHAPTER II

Literature Review

This literature review, drawn from published articles and dissertations, addresses research relevant to each of the four variables. Research focused specifically on women and condom use has largely been in reaction to the HIV/AIDS epidemic and an afterthought to the initial research focused on higher risk populations (homosexual males and IV drug users). The epidemic of STDs in this country, the spread of heterosexual transmitted HIV/AIDS, the disappointing results of interventions to increase female condom use, and the recognition that the use of condoms in heterosexual relationships is a complicated and complex process for women, has increased the quantity and quality of research on women's condom use.

A general discussion of each variable will be followed by research which specifically relates to this study.

Instrumentality and Expressiveness

This study assesses instrumentality and expressiveness within gender. Instrumentality refers to such traits as assertiveness, individuality, independence, directness and initiative, while expressiveness refers to passivity, concern for others, indirectness, dependence, and an emphasis on relationship. Although studies frequently
associate instrumentality and expressiveness with masculinity and femininity respectively and may use the terms interchangeably, this study adheres to Spence’s position that instrumentality and expressiveness are “gender-related trait clusters” (Spence & Buckner, 1995; Spence & Hall, 1996) and not a measure of “broad gender constructs” (p. 685), including gender orientation, gender schematization, or sex typing (Spence, 1985, p. 76).

“Dualistic formulations” (Spence, 1985, p. 65) have historically been applied to gender characteristics variously identified as agency/communion (Bakan, 1966), masculinity/femininity, instrumentality/expressiveness (Parsons & Bales, 1955) and abstract/relational. The dualistic constructs maintain a profile in current sociological and psychological gender research and have been generously applied to describe gender role, gender orientation, and other broad gender-related concepts and characteristics.

The general social acceptance of the dualistic conceptions of gender – masculinity being accepted as agentic and instrumental and femininity being conceptualized as communal and expressive - is reinforced by the social sciences’ tacit acceptance of these stereotypes. Spence and Buckner (1995) question the utility of using the terms masculine and feminine in scientific discourse. Noting that the Personal Attributes Questionnaire (PAQ; Spence & Helmreich, 1978) has been found to have weak and inconsistent associations with gender-related behaviors other than instrumentality and expressiveness, Spence maintains that it is a valid measure for only the gender-related variables of instrumentality and expressiveness (Spence & Buckner, 1995). The PAQ measures only
socially desirable agentic, self-assertive and nurturant, interpersonally oriented traits (Spence, 1993; Spence & Sawin, 1985).

Studies that utilize the results of the PAQ as a measure of the constructs of masculinity or femininity are criticized by Spence. Studies using the PAQ that cite masculinity as having a positive association with self-esteem for example, are making a conceptual leap by invalidly interchanging the constructs of masculinity and instrumentality.

Two scales, the PAQ and Bem’s Sex Role Inventory (BSRI; Bem, 1974), have been widely used to measure gender role identity, masculinity, femininity, and androgyny since the 1970s. Lippa and Hershberger (1999) criticize both the BSRI and the PAQ for excluding such gender-related phenomenon as non-verbal behaviors, appearance, hobbies and interests, and sexual behavior. They also point out that masculinity and femininity are “...fluid concepts that are, to some extent, culturally and historically relative.” (p. 135), contrary to the “fixed and limited item content” (p. 135) represented by the BSRI and the PAQ.

Although the scales consist of items that were demonstrated to be gender stereotyped and are generally gender differentiating (Spence & Helmreich, 1978), within sex variability is frequently larger then between sex variability (Spence & Buckner, 1995). By self-identifying as instrumental or expressive, participants are tapping dispositional psychological characteristics or “global attributes” (Lawrence, Taylor, & Byers, 1996) devoid of identified context.
Instrumentality/Expressiveness in Context

Gender differences in social behavior are affected by the salience of gender role expectations in a given context (Eagly & Wood, 1991). Individuals may have high levels of instrumental and expressive traits but because they are not expected to display them in their daily life, they may choose not to, especially if there is no reward and/or the possibility of social criticism (Stake, Zand, & Smalley, 1996). There are fewer gender differences between males and females when they have the same gender role versus when they have "...traditional gender appropriate roles" (p. 186). Klein and Willerman (1979) found that women suppressed their dominance behavior (consciously or unconsciously) with men when sex role demands were present but were equally dominant with men and women when the sex role demands were no longer salient and dominance was made desirable. The authors hypothesized that women suppress certain "dispositional inclinations" in response to sex role demands, a hypothesis that seems to be supported by Hacker's (1981) findings that in mixed sex friendships, one third of the women admitted their weaknesses but concealed their strengths, while males exhibited the opposite response.

The influence of context on instrumentality/expressiveness has been identified in other studies. Mothers of infants had higher instrumentality and expressiveness scores and fathers had lower instrumental scores when describing themselves as parents (Uleman & Weston, 1986). College women and men's global, sexual, and ideal-sexual gender-relevant attributes reflect the traditional cultural expectations - men are more
instrumental than women and women are more expressive than men. Women rated the ideal male as being more instrumental in sexual encounters than the ideal female. Women are less instrumental in sexual situations than they are globally and would prefer to be more instrumental in sexual situations than they are currently. The authors speculate that fear of negative consequences for contradicting acceptable gender role behavior and/or a lack of behavioral skills may prevent women from actualizing a more instrumental role in heterosex (Lawrence et al., 1996).

The essentialist position that gender is “internal, persistent and generally separate from the on-going experience of interaction with the daily sociopolitical contexts of one’s life” (Bohan, 1997, p. 33) overlooks the asymmetries of social power and ignores the social, cultural, historical, and economic dimension of gender. Constructionists note that conventional theories overlook the double binds in women’s lives and the “asymmetries of social power, rights, and privileges that constitute our contemporary social structure and that are ascribed to individuals according to their biological sex, not their personal styles or skills” (Morawski, 1987, p. 58).

Our social identities are situation-dependent – able to be employed when appropriate. Gender is “…a powerful ideological device, which produces, reproduces, and legitimates the choices and limits that are predicated on sex category” (West & Zimmerman, 1987, p. 147). “Thus if, in doing gender, men are also doing dominance and women are doing deference (the resultant social order, which supposedly reflects
natural differences), is a powerful reinforcer and legitimator of hierarchical arrangements” (p. 146).

The PAQ, not being domain-specific, is an adequate indicator of an individual’s self-perception of her gender-related traits. A woman who may have more instrumental characteristics may choose not to display this behavior in a context in which gender-related behavior is salient as in heterosex. Morawski (1987) notes that “social structures constrain certain enactments of gender and enable others” (p. 61) which is a position that is validated by Klein and Willerman’s (1979) findings.

Instrumentality/Expressiveness and Contraceptive/Condom Use

This study specifically assesses condom use by sexually active women. Studies focusing on contraceptive use by women frequently do not partial out for condom use and often do not consider the different dynamics involved. Whitley and Schofield’s (1986) meta-analysis of studies in the 1970s and 1980s conclude that contraceptive use was negatively related to traditional gender role adherence for women. Traditional gender role adherence refers to the more emotional, passive, and communal (expressive) approach to heterosexual activity for women and a more active and pleasure-oriented (instrumental) approach for males (Byers, 1996; Whitely & Schofield, 1986).

Koblinsky and Palmeter (1984) found in their study of 122 undergraduate female students that nontraditional attitudes towards women’s roles significantly predicted more positive attitudes about involvement in a variety of sexual behaviors, including initiating
sexual encounters, sexual intercourse, showing their partner how to facilitate their orgasm, and requesting their partner to use a condom. Traditional/nontraditional attitudes were measured by the Attitudes Towards Women’s Scale (AWS; Spence & Helmreich, 1972) which measures egalitarian beliefs about the rights of women (Spence, 1993) and “...people’s beliefs regarding appropriate roles for men and women in society” (Kleinplatz, McCarrey, & Kateb, 1992, p. 337).

Despite the intuitive appeal, the PAQ and BSRI generally have “trivial and typically nonsignificant relationships to sex role attitudes and behaviors” (Spence, 1993 p. 624), including the AWS. However, the AWS had a significant positive correlation to the BSRI masculine scale and a significant negative correlation to the feminine scale when only college women who had scored at the extremes of the masculine scale and feminine scale were included (Kleinplatz et al., 1992). The inclusion of only the extreme scores may account for the atypical correlation results.

Attitudes towards condoms and condom use were not associated with college student’s (n = 214) gender but were related to gender orientation, as measured by the BSRI short-form (Hoover, 1996). Androgynous or undifferentiated participants had significantly more positive attitudes towards condoms as contraceptives and prophylactics and used them more frequently than students identified as masculine or feminine. The short-form of the BSRI has been found to be interchangeable with the PAQ (Lubinski, Tellegen, & Butcher, 1983) including only socially desirable instrumental and expressive gender-related traits.
In her study of 140 women attending public health clinics, Bowleg (1997) formulated a model, which included assessing the relationship of gender role to condom/latex barrier use. There was no direct relationship of gender role (instrumentality or expressiveness) to their most recent condom/latex barrier use or use within the last 30 days during vaginal, oral, anal sex with primary or other partners.

Her study uses some of the same variables as this current research. However, her population consisted of women (ages 16-54) recruited from clinics in the Washington, DC and Alexandria, Virginia Metro area. Eighty-nine percent of the women were black and Latina. In contrast to this study, Bowleg (1997) included women whose primary partner was a woman and had questions specifically applicable to women having sex with women. The economic status of the women in this study may have depended on their relationship, an unlikely scenario with single college students.

Based on reported interactions from a peer-led focus group consisting of male students from an elite college, Lever (1995) questions if female assertiveness in sexual activity triggers resistance in males, as it may be perceived by the males as an attempt to take control. The group members admitted getting angry when a woman suggests condom use during a sexual encounter, some members agreeing with the student who stated that, “...you’re just not used to having girls tell you to do something”.

Lever (1995) notes that women may have more power over safer sex practices early in the relationship because men may be willing to comply “rather than miss a sexual opportunity” (p. 173). It is questionable if women realize they have more power or have
the skills to enact it. The public health emphasis then on women taking responsibility may actually be setting up or escalating a power struggle between the genders.

Summary

A significant difficulty in the research on instrumentality/expressiveness and condom use is related to the inconsistency in the use and application of constructs and measures. Only one study cited used the PAQ (Bowleg, 1997), finding no direct relationship of instrumentality/expressiveness to condom use. Although this study used a female population exclusively, the demographics (including age, sexual orientation, marital status, socioeconomic status, ethnic/racial composition), factors that could significantly affect outcomes, are quite different than the demographics of this study’s population.

The short-from of the BSRI has been identified as being comparable to the PAQ. Hoover’s (1996) study using this instrument found that more masculine (instrumental) and more feminine (expressive) typed persons had less favorable attitudes towards the condom as contraceptive and prophylactic, and to use it less frequently than those of nontyped gender role orientation. There were no significant gender differences in attitudes towards condom use or frequency of use. Within gender differences were not addressed.

Women identified as nontraditional have more positive attitudes towards a number of sexually related variables including requesting a partner to use condoms.
However, most studies indicate little correlation between instrumentality/expressiveness and nontraditional/traditional behavior, although intuition might lead one to believe otherwise. A significant relationship between nontraditional/traditional attitudes and condom use then cannot be generalized to instrumentality or expressiveness.

As with all self-report measures, researchers cannot be assured that participants' responses are accurate, particularly in the arena of sexual behaviors where participants may still be operating under the pressure of social acceptance and sex role expectations. Women may be inclined to under-report sexual behavior and men to over-report and both genders may exaggerate use of protective behaviors.

The context of heterosexual condom use is integral to understanding why attitudes may not translate into behavior. Demonstrations of female dominance have been shown to be context dependent (Klein & Willerman, 1979). In many social situations expressive traits are expected from women. Although individual women may be dispositionally instrumental, the lack of social rewards or reinforcement may inhibit instrumental behavior, particularly in the context of heterosex. Women contradicting female gender role and gender appropriate sexual behavior by negotiating condom use to protect themselves from disease or pregnancy may encounter angry resistance from their partner, which could undermine their efforts.
Self-Efficacy

Bandura (1977, 1997) posits that “...the power to originate action for given purposes is a key feature of personal agency and that beliefs of personal efficacy constitute the key factor of personal agency” (Bandura, 1997, p. 3). Perceived self-efficacy then refers to “…beliefs in one’s capabilities to organize and execute the courses of action required to produce attainments” (p. 3). Perceived self-efficacy is not dependent on skill level but rather on the individual’s beliefs about what they are capable of doing under differing circumstances with the skills they possess.

Expectations of self-efficacy are the most influential determinants of behavior change according to Bandura (1977). Efficacy beliefs influence the direction of actions people choose to pursue, the amount of effort they will expend, and how much perseverance they will have when faced with obstacles, in other words their “resilience to adversity” (Bandura, 1997, p. 3). Efficacy beliefs also influence whether people will have hindering or helpful thought patterns, how much depression and stress they will experience in coping with taxing environmental demands and the level of accomplishments they realize. Self-efficacy beliefs are hypothesized to be domain-specific, potentially varying according to situation and function (Forsyth & Carey, 1998).

Underestimated efficacy inflicts high personal costs as the individual avoids activities and endeavors that could expand their lives and enrich their competencies. “Education opportunities not taken, valued careers not pursued, interpersonal
relationships not cultivated, risks not taken and failure to exercise a stronger hand in shaping one’s life cause considerable personal loss” (Bandura, 1997, p. 71).

Self-efficacy appraisals are constructed from four principal sources of information (Bandura, 1997): (a) enactive mastery experiences, (b) vicarious experiences, (c) verbal persuasion and other social influences, and (d) physiological and affective states. Enactive mastery experiences provide the most influential source of efficacy information. With limited access to experiences that might provide opportunities to gain mastery in the domain of condom use and condom use negotiation, persistence in the face of obstacles will likely be diminished.

Self-efficacy can be strengthened by observing the successful behavior of similar others, role models providing positive reinforcement. In a culture that is conflicted about the appropriate way to teach adolescents about sexuality (abstinence vs. education and access to “protection”) female role models successfully negotiating sexual interactions (other than just “saying no”) are controversial and consequently do not have high visibility.

Verbal persuasion can lead an individual to believe that she or he can cope with the challenges that the particular behavioral goal presents. However, verbal persuasion regarding condom use must operate within the backdrop of sexuality and gender discourses and socialization messages, which clearly undermine and refute women’s self-efficacy in nontraditional sexual behaviors. The verbal persuasion would have to be loud enough and persistent enough to break through the white noise of traditional gender
socialization, interpersonal issues, the woman’s own sex impulses, and possibly have to compete with the verbal persuasion of a coercive partner.

Physiological and affective states signal to the individual his or her ability to cope with the challenge. High arousal is likely to debilitate performance, consequently negatively effecting self-efficacy. Fewer opportunities to rehearse a given behavior generally results in high arousal when attempting the behavior, signaling that the coping skills may be inadequate to handle the challenge. Not given the opportunity to rehearse the mechanics and negotiation skills for safer sex in a safe and non-threatening environment, women may find that anxiety thwarts their motivation and ability to enact new behaviors.

Women helped to identify the benefits and costs of traditional and nontraditional gender-role behavior can make decisions based on analysis versus blind conformity. An important aspect of safer sex education consists of assisting women in recognizing options related to sexuality that have been out of awareness, realistically assessing their strengths and weaknesses, identifying their skill sets, and building skills that will help them feel capable of enacting safer sex behavior.

**Self-Efficacy and Safer Sex**

Safer sex is a global term applied to sexual practices (non-penetrative sex, penetrative sex with latex condom, oral sex with a dental dam or latex condom) that protect sexual partners from STDs. Implementing safer sex practices involves not only
knowledge and intentions but the perceived capability to carry out the plan in the face of possible coercion, passion, allurements, fear of rejection, personal embarrassment, desire for social acceptance, or situational constraints (Bandura, 1997). "The weaker the perceived self-efficacy, the more affective and social factors can increase the likelihood of risky sexual behaviors..." (Kasen, Vaughn, & Walter, 1992, p. 188). Favorable attitudes towards contraceptive use increases the intentions to use them, but it is the efficacy beliefs that determine if those intentions are carried out (Basen-Enquist & Parcel, 1992).

Risk reduction in sexual activity requires more than education and targeting of a specific behavior, rather it requires "enhancing interpersonal efficacy" (Bandura, 1997, p.180) and calls for social and self-regulative skills and a sense of personal efficacy to exercise control over sexual situations. Tiefer (1994) expresses a similar view writing that sexuality needs to be defined and located "...primarily in personal and relational, rather than physical, terms" (p. 81).

Condom use and condom use negotiation complicates women's and men's practice of safer sex. Image control, supplying the condom, eroticizing the use of a condom, planning for sexual activity, and the implications about trust all factor into condom use. Contradicting gender role and not having control over the use of a condom are factors that further complicate women's use of condoms.

Studies vary considerably in their measurement of the construct of self-efficacy or sexual self-efficacy. Forsyth and Carey (1998) note that many self-efficacy studies
related to protective behaviors assess constructs other than self-efficacy (e.g., intentions vs. perceived capability). They report that self-efficacy “...measures should contain items with content that reflects respondents beliefs in their capacities to perform behaviors within a domain of functioning under circumstances that present gradations of challenge” (p. 560). Research referred to in this study varies from a one question format to multiple-item questionnaires measuring several aspects of self-efficacy, including the mechanics and the negotiation of condom use and also the comfort with one’s own sexuality.

Evidence of the important role of self-efficacy in protective sexual behaviors has been documented in high school students. Self-efficacy was found to be directly related to 9th grade students use of condoms and strongly associated with condom use intentions (Basen-Enquist & Parcel, 1992). Significant gender differences were found in a study of 10th grade students (Kasen, Vaughan, & Walter, 1992). Females were more confident in their ability to refuse sex with most potential sex partners, to question sex partners about past sexual behaviors, refuse to have sex with a partner who would not use a condom and more confident that they could refuse sex after drinking alcohol or smoking marijuana. Males were more confident in their ability to buy condoms and use them correctly.

Self-efficacy was positively related to AIDS preventive behavior in a predominately white and 67% female college population (n = 602; Goldman & Harlow 1993). The self-efficacy scale consisted of four questions; one using rather ambiguous language (i.e., “I believe I can take steps to prevent myself from getting AIDS”) which is
the only item that truly addressed self-efficacy. The other three questions addressed
behaviors (“I am fairly selective of sexual partners”, “I am cautious and careful about not
getting myself into situations that could lead to getting the AIDS virus.” And I would
make it a point to ask about partner’s sexual history”). There was no significant gender
differences in condom use but women reported more AIDS preventive behaviors: (a)
abstained more from sexual intercourse, (b) had fewer instances of intercourse after
drinking or drugging, (c) had fewer sexual partners, and (d) significantly greater feelings
of self-efficacy than men in protecting themselves from AIDS. It was postulated that the
significant disparity in self-efficacy scores may be an indication of women’s familiarity
with the traditional role as “gatekeeper” or responsible partner in heterosex. Women’s
“amorphous sense of vulnerability” (p. 496) indicated by their “perceived risk of HIV
infection” may be related to having less control over condom use and reliance on
communication skills in negotiating safer sex practices with her sex partner.

Self-efficacy was significantly related to condom use in a study of 212
heterosexually active, predominately Caucasian undergraduate students, 70% of whom
used condoms inconsistently or not at all (Wulfert & Wan, 1993). The self-efficacy
measurement consisted of one global question, “How confident are you that you will be
able to use condoms for vaginal intercourse over the next six months?” The
measurement addressed the respondents’ level of confidence in their ability to enact a
specific behavior (condom use with vaginal intercourse). However, specificity of
context, an important aspect of self-efficacy and sexual behavior was not addressed.
The same authors conducted three other studies in which the relationship of self-efficacy to condom use was assessed. Self-efficacy was measured by a global question assessing the level of confidence in always using condoms in the next three months. A three-item scale assessed the respondents level of confidence in using condoms in three conditions - when highly aroused, every time that they had intercourse, and resisting unprotected intercourse if no condoms were available. Respondents were college students in two studies (n = 403; n = 105) and 421 sexually active, older adult, singles recruited from the membership of a singles network. Self-efficacy was found to be a significant predictor of intended condom use. According to the authors, and referencing a previous study (Wulfert, Weaver, & Wan, 1994), the use of a short-item scale to measure self-efficacy has been shown to be as adequate, or more adequate than a multi-item measure some circumstances.

Brien, Thombs, Mahoney, and Wallnau (1994) explored the relationship of self-efficacy to three types of condom users — namely, ritualistic (defined as always using condoms with all partners), sporadic, and nonusers among 18 to 23 year old college students (n = 362) using the Condom Use Self-Efficacy Scale (CUSES). The CUSES assesses an individual’s expectation of their ability to use condoms in varying situations/circumstances, including when faced with a partner’s disapproval, when under the influence of alcohol/drugs/passion, and feeling confident to put a condom on self or partner quickly (identified as the mechanics of condom use). Gender was not important in distinguishing the groups. Ritualistic users had the highest self-efficacy scores and
were more confident about using condoms under a variety of conditions. They were also more confident than nonusers about dealing with conflict with a partner concerning condom use, had less fear about partner rejection and were more assertive, having more confidence in their ability to insist on the use of a condom. The authors conclude that the barriers to condom use are less related to the mechanics of condom use and more related to confidence in dealing effectively with relationship problems, emotional concerns, communication problems and also intoxication.

Predominantly freshmen and sophomore college students (n = 265) were surveyed about their perceived self-efficacy in engaging in HIV protective behaviors (Dekin, 1996). A 22-item questionnaire was used to measure perceived self-efficacy toward HIV protection. Items specifically related to self-efficacy asked respondents to rate statements such as “It would be easy for me to end a sexual encounter if my sexual partner refused to use a condom”. This may not be the most effective mechanism to measure self-efficacy, as one may perceive the task as difficult, but still have the confidence in their ability to enact the behavior (Forsyth & Carey, 1998). There was a significant gender difference in some areas of perceived self-efficacy. Men were less likely to believe they could end a sexual encounter with a partner who objected to condom use, were less likely to intend to use condoms with a new sexual partner to protect against HIV, and had lower self-efficacy regarding controlling condom use then women. This study specifically assessed condom use for oral, anal, and vaginal sexual activity but found no significant gender
differences in condom use. Only about one third of the respondents reported consistent
condom use for vaginal and anal sex and less the 10% for oral sex.

Sexual Self-Efficacy and Condom Use

As previously discussed, sexuality discourses and socialization in this culture
diminish, ignore, and judge women’s sexual desire and activity differently than men’s.
Studies have found a positive correlation of self-acceptance of sexuality to condom use
(Fisher, 1990; Fisher & Fisher, 1992) whereas high-risk sexual behaviors have been
associated with negative feelings about sexuality (Harlow, Quina, Morokoff, Rose, &
Grimley, 1993). General sexual attitudes, as measured by the Sexual Opinion
Questionnaire (Fisher, Byrne, & White, 1983), were not related to self-efficacy or
condom use (Wulfert & Wan, 1993).

Empowering women to accept and appreciate their own sexuality gives them
more control over the activities in which they get involved. Sexual self-efficacy indicates
the self-perception of having the capability to be able to enact and resist behaviors related
to sexual activity such as, planning for protected sex and buying condoms.

The sexual self-efficacy scale utilized by Rosenthal, Moore, and Flynn (1991)
measures a series of sexual activities that are appropriate to both sexes. Sexual self-
efficacy operationalized as the “perceived mastery over many aspects of sexual activity
and AIDS precautionary behavior” (p. 79) measures the ability to “say no” (referring to
taking responsibility for sexual behavior and taking the initiative to refuse sex),
assertiveness (initiating and being assertive in getting sexual satisfaction), and precautions (taking precautions related to sexual behavior). Respondents were instructed to indicate if they were capable of an identified behavior and if so, to rate their degree of confidence.

Women, in a study of 1008 Australian post-secondary students, had significantly more confidence in saying “no” to sexual activity, but had less confidence in getting their sexual needs met. One third of the females felt unable to carry condoms around with them “just in case”. This is significant given that both genders expect men to provide condoms and the rate of condom use depends on them doing so (Sacco, Rickman, Thompson, Levine, & Reed, 1993). The authors speculate that women’s discomfort with carrying condoms may be related to the avoidance of appearing promiscuous by having planned for sexual activity. There was no significant gender difference in the participant’s levels of confidence in their ability to use precautions, although 20% of males and females felt that they could not discuss condoms for AIDS protection when other contraception was being used. The authors note that a sense of confidence about contraception may not be applicable to safer sex behaviors.

Bowleg (1997) using Rosenthal and colleagues Sexual Self-Efficacy Scale in her study, found that none of the subscales predicted condom use for the most recent sexual encounter and only the “precautionary subscale” predicted condom use during the last 30 days. Bowleg questions if the predictive ability of the precautionary subscale is a result of “favorable recall”. She also notes that the application of the precautionary subscale to
women may be limited since women do not decide to wear a condom but may practice safer sex by refusing to participate in unsafe sexual activity.

Sexual efficacy operationalized as "...handling relationships with a partner, sexual relationships in general and new social situations" (Breakwell et al., 1994, p. 198) was directly related to condom use among British 16-20 year olds (n = 63) in a longitudinal study. Contrary to the authors' previous study and expectations, the less confidence an individual had in handling sexual relationships the more likely they were to use condoms contemporaneously and prospectively. Females were slightly less confident than males in their ability to handle sexual relationships. The authors recognize the limitations of generalizations given the small sample and the voluntary participation. Participants were European, a further limitation to generalization to a U.S. population.

Condom use self-efficacy was measured by using a subset of items from Brafford and Beck's CUSES (1991) in Bryan, Aiken, and West's (1996) study of 198 undergraduate females. The researchers utilized Brien and colleagues (1994) factor analysis of the CUSES including three factors (assertiveness, condom use mechanics, partner dissatisfaction) as well as two items from the CUSES regarding obtaining condoms. Condom use self-efficacy was correlated with intentions to use condoms. Perceptions of control over sexual encounter and acceptance of sexuality were significant predictors of condom use self-efficacy. Women may need to feel comfort with being
sexually active and feel a sense of control in sexual encounters prior to learning skills specific to condom use.

The authors conducted a longitudinal study of 238 female undergraduates, 137 from whom follow up data was collected regarding their use of condoms at last instance of intercourse and the percentage of times condoms were used in the follow up period. Self-efficacy for condom use was significantly correlated with intentions for condom use, but not for last instance of intercourse or percentage of times used in follow-up period.

Some item similarities exist between Rosenthal and others (1991) Sexual Self-Efficacy Scale and Bryan and colleagues (1996) factors of “condom use self-efficacy” and “sense of control in the sexual encounter”. The Sexual Self-efficacy Scale assessed a more general sense of perceived sexual behavior capabilities. Bryan and colleagues identified “condom use self-efficacy” and “sense of control in the sexual encounter” as separate constructs.

Summary

Studies exploring the relationship between self-efficacy and condom use/AIDS protective behaviors are all subject to the limitation of self-report. In keeping with gender acceptable behavior, women may under-report their sexual activity, men may over-report sexual activity, and both may misrepresent their safer sex behaviors. Surveys about condom use are frequently retrospective or prospective without follow up to
determine if perceived capability manifested in condom use. Retrospective studies are not only subject to social approval answers but also are subject to recall bias.

The fundamentally flawed (Forsyth & Carey, 1998) operationalization and measurement of the construct of self-efficacy complicates the interpretation and generalization. Although studies do tend to show some relationship of self-efficacy to safer sex behaviors, the measures are sometimes not adequately or accurately addressing the construct.

Despite the high risk of disease through unprotected oral sex and anal intercourse, few studies specifically addressed these behaviors. There is some anecdotal evidence that adolescents assume that oral sex is risk-free and “not real sex” and as such, their rates of oral sex and unprotected oral sex have increased markedly.

Women appear to be more confident in the “gatekeeper” role. They have more confidence about saying “no” to sexual behaviors than men, more self-efficacy in protecting themselves from AIDS, implement more AIDS protective behaviors, and have more confidence in ending a sexual encounter with a partner who objected to condom use than men. Women feel unable to carry condoms with them. There were no significant gender differences in condom use and frequency of condom use was low among both genders.

Although women may feel some confidence about enacting some safer sex behaviors, they still had high perceptions of risk, described as an “amorphous sense of vulnerability” (Goldman & Harlow, 1993, p. 496). It is speculated that women are aware
that the added dimension of context may indeed affect their behavior. They may have good intentions of using condoms and feel quite capable but recognize that this requires negotiation and communication skills in a highly charged situation in which gender roles are particularly salient.

Women's sense of efficacy appears to mirror the contradictory and conflicting societal messages about sexuality and women's role in sexuality. Statistics on the number of women who consent to unwanted sexual intercourse underscores women's situational vulnerability (Walker, 1997). Women may feel capable of safer sex behavior but situational context may make it very difficult to enact the behavior. Responding to verbal or physical coercion, or just responding to their own sexual feeling and emotions put women at risk.

Importance of Relationships

A common and generally accepted gender stereotype is that women are far more interested and capable of engaging in interpersonal relationships than are men. Socialization messages emphasize the importance of relationships to women and the meaning that relationships give to women's lives, particularly their relationships with men (Lerner, 1983; Westkott, 1986). Despite the influences of feminism in the past four decades, an analysis of the predominant themes of popular girls and women's magazines identified "...heterosexual relationships as a defining goal of femininity..." (Durham, 1996; Walker, 1997, p. 161).
Western psychological theories have emphasized the development of "self" through the processes of individuation and separation – psychological health being identified as autonomy and independence. Some feminists, including Chodorow (1978), Miller (1986), and Gilligan (1982) have challenged that premise, instead viewing healthy psychological development as relational. Psychological health then being the ability to develop "reciprocal relations" (Griscom, 1992, p. 400) or interdependence. This perspective reframed women's development. No longer was interdependence perceived as a deficit, but rather a gender differential strength.

Other feminists dispute the relational theories. Women's emphasis on relationship may be an indication of a lack of power, the need to please others and a reflection of social hierarchy, not gender related traits or characteristics (Hare-Mustin & Marecek, 1986). Emphasizing women's difference, even if positive, still identifies women as "the other," a label that can easily be perceived or interpreted as "less than" (Hare-Mustin & Marecek, 1990).

Emphasizing compassion and relatedness versus rationality, rules, and control are indicators of positions of social hierarchy (Hare-Mustin & Marecek, 1990). Males may often take the rational perspective and woman the caring perspective in marital conflict. In a different context, however, women are likely to take the rational disciplinarian and control position with children while children take the caring position. And in another context, white, upper-class females may assume the rational/control perspective in relation to women of color and/or lower socioeconomic status (Griscom, 1992). This
phenomenon is a reflection of social hierarchy and is embedded in the power structure within our society (Hare-Mustin & Marecek, 1990).

**Women and Importance of Relationship**

Contradicting stereotypes and the author's predictions, Hammersla and Freise-McMahan (1990) found that approximately 75% of male and female college students (n = 303) would sacrifice a majority of their life goals for a heterosexual relationship. Both genders prioritized having a heterosexual relationship over such goals as "career", "contribution to society," and being "financially well off". Women rated "relationships" significantly more important than men when asked to rate six types of relationship possibilities (including marriage, close circle of friends, etc.).

Masculine persons (as measured by the BSRI) were the least likely and feminine persons the most likely to choose relationship over life goal choices. Women who indicated having a strong personality were less likely to choose the relationship. Those women who self-rated high in love for their children were more likely to choose a relationship over life goals. These women may perceive the relationship as instrumental to meeting their goals of motherhood. The authors point out that generalization of these results may be limited due to the conservative church-affiliation of the university. However, the BSRI results are similar to other university populations, which may indicate that the responses to the Goals in Life Scale may not differ significantly from other student populations.
Self-esteem is partially a result of one’s ability to adhere to social norms and socio-cultural expectations (Josephs, Markus, & Tafarodi, 1992). For women “being a good woman and being a good person are somewhat different projects and in some situations at odds with each other” (p. 400). In the instance of safer sexual behavior, women who want to be sexually active and practice safer sex, must defy an accepted social/gender norm of female sexual passivity (the good woman) while enacting the “good person” role, protecting themselves and their partner from disease. The likelihood of enacting a behavior to protect yourself (in this instance by using condoms) is significantly diminished if the behavior is a challenging interpersonal process and may have negative short-term ramifications.

Women, Importance of Relationship, and Sexuality

Numerous studies show that women’s sexuality is more closely tied to emotional or relational factors than men’s sexuality (Carroll, Volk, & Hyde, 1985; Mosher & Maclan, 1994; Traeen & Kralem, 1996). Women have more negative and less permissive attitudes towards casual, premarital sex than men according to a meta-analysis of 177 studies from the 1960s to 1990 (Oliver & Hyde, 1993). Amaro (1995) posits that recognition of the importance of relationship is key to understanding women’s sexuality. Holland, Ramazanoglu, Sharpe and Thomson’s (1992) qualitative study of British adolescent girls found that “sexual pleasure was seen as dependent on the quality of the relationship with a man” (p. 666). In addition to the relationship being an important
aspect of female sexuality, college students identify “love” as being the cause of sexual desire for women, while male sexual desire was associated with biological processes, sexual fantasies, and a woman’s physical attractiveness (Regan & Bershead, 1995).

Maintenance of an important relationship may be associated with young women consenting to unwanted sexual activities (Muehlenhard & Cook, 1988). College women ($n = 76$) were asked to respond to a vignette in which a young woman was being coerced into having a sexual relationship. They were asked to write what they thought would happen if the woman refused to get involved, what would happen right away, in the long run, and how the woman and the man would feel about the refusal. Seventy-five percent of the students agreed that the woman would be “concerned that she hurt the man”, 92% of the women thought that the man would be angry by the refusal, and 82% thought that the man would no longer want to see the woman who refused sex. If the woman agreed to the sexual relationship, 55% of the women felt that the man would be afraid that the woman would desire a longer relationship, and that he would lose respect for the woman. (Lewin, 1985).

**Women, Importance of Relationship, and Condom Use**

Among some high risk women the “…relationship with men and families…are the critical forces in their day-to-day reality that provide the context of their sexual decision making (Wyatt & Riederle, 1994, p. 623). Santelli and colleagues (1996), in their study of 17 to 35 year old inner city heterosexual black women, report that those
women who had male partners who supported the use of condoms were more likely to intend to use condoms and to attempt to use them consistently. Consistent condom use seemed to be promoted by beliefs that condom use built trust in the relationship. Not surprisingly, those women who identified as having high emotional closeness in the relationship also seemed to have low intentions to use condoms.

Female and male 10th grade students had less self-efficacy in refusing sex with partners who were more familiar or liked (Kasen, Vaughn, & Walter, 1992). Ninety-two percent of the females felt confident that they could “say no to sex with someone whom they have known for a few days or less.” Only 51% felt confident that they could say “no” to someone that they “wanted to date again” and 48% could say “no” to someone they wanted to fall in love with them. Only 33% of the women in this sample had intercourse in the past year. Respondents may be projecting more confidence than they would be capable of implementing given the young age and inexperience.

College students (Cline, Johnson, & Freeman, 1992) identified a “threat to the relationship” as significantly impeding talk about safer sex practices or AIDS. The authors note that a significant issue confronting college students was “how efforts to ensure their physical health may function to endanger their relationships health” (p. 805). Interpersonal costs of condom use (loss of spontaneity, image of promiscuity, offending the partner) were negatively associated with the intention to use a condom and actual condom use for both males and females (Breakwell et al., 1994).
Hynie and colleagues (1998) explored how socio-sexual norms manifest in sexual behavior and contraceptive use. Initially focusing on sexual scripts, they found that women endorsed a relational role for female sexuality versus the more recreational, pleasure role for male sexual behavior. This relational script is less likely to be associated with condom use and condom use is not well integrated into the relational script.

Women also vary in their endorsement of the relational ideal. Relational ideal implies that sex is an expression of love, that there is relationship commitment and that one should know the person really well before sex. There was no correlation of instrumentality to relational ideal and only marginal correlation of expressiveness to relational ideal. Those women who were more expressive were more likely to endorse the relational ideal. The authors conclude that the endorsement of the relational ideal is not a function of gender-typed personality characteristics, but more specifically tied to sexuality. Furthermore the relational ideal is negatively correlated with condom attitudes. Women who did not use a condom in the last month or the last time they had sex had a stronger endorsement of the relational ideal and less positive attitudes towards condoms.

Monahan, Miller, and Rothspan (1997) interviewed 306 sexually active, heterosexual, non-virgin African American men and women, ages 18 to 40, who were not in long-term committed relationships. Interestingly, those women who’s relationship goals were of “nurturance and acceptance” were significantly more likely to report using
condoms than those women who’s goals were “control and dominance”. Those women who wanted control and dominance also reported more sexual partners, were more likely to lie about their sexual history, feel unable to deny a partner sex, and to perceive that they had poor persuasive skills in influencing their partner to use condoms.

In a study of 102 sexually active college men and women (Galligan & Terry, 1993) both genders reported feeling that initiating a discussion of condom use or using a condom would “destroy the sense of intimacy and trust in a relationship” (p. 1706). Women and men’s discussion of condoms and actual use of condoms with casual or new partners was strongly influenced by fears of negative implications. With casual or new partners women felt that condom use might “partially destroy feelings that their partner was of special significance” (p. 1706). Women’s condom use and discussion of condom use with a regular partner was affected by fear of negative implications contrary to men who were relatively unaffected by these concerns with a regular partner. Women feared the negative implications of condom use and were also less likely than men to discuss or use condoms with their regular partner.

Summary

College students place high priority on heterosexual relationships and wanting to protect the relationship is an obstacle to communication about safer sex and condom use. Both genders acknowledge the negative implications of condom use in more recent
relationships and seem to accept that longer-term relationships imply trustworthy monogamy, consequently eliminating the need for condoms.

By placing importance on the relationship, women are less likely to protect themselves by using condoms, especially if their partner does not support the use, if they are uncomfortable about the negative implications of condom use, and if they have high emotional closeness with their partner.

Women are inclined to associate their sexual pleasure with the quality of their relationship and adopt a sexual role that emphasizes relationship vs. recreation. The socio-sexual norms and the role that relationships play in women's sexuality put women at risk for participating in sexual activities that they may not want and practicing unsafe sexual behaviors. Women who wish to practice safer penetrative sex are in the awkward position of not having direct control over condom use, potentially having to negotiate condom use with a partner while not appearing distrusting, untrustworthy, promiscuous, taking control of the sexual encounter, and alienating their partner.

College Students and Condom Use

Research involving college students finds no relationship between students' knowledge of AIDS and safer sex practices (DiClemente, Forrest, & Mickler, 1990). Although students are knowledgeable about the risks and serious ramifications of HIV/AIDS, they may not be as well informed about other STDs, despite the prevalence
and significant threat to the health of the college population. DiClemente and colleagues (1990) reported in a national survey that nearly 50% of heterosexual college students reported multiple partners, approximately 60% used condoms less than half of the time. Of female college students, 16% reported using condoms all of the time, 43% using a condom on their most recent intercourse (Bryan, Aiken & West, 1997). Of those surveyed, 73% (median age 18.6 years) had more than one sex partner in their lifetime.

**College Women and Condom Use**

In numerous studies of college students women are less likely to use condoms than men. McGuire and colleagues (1992) found in her study that 67% of sexually active females reported using condoms whereas 88% of the men reported condom use. Ninety percent of sexually active males stated that they would use condoms if they perceived that it would decrease their risk of getting AIDS, only 75% of women reported that they would do so. DeBuono, Zinner, Daamen, and McCormack (1990) report that 51% of college women used condoms and Gerrard and Warner (1994) report that 38% of sexually experienced college women used condoms at the most recent intercourse.

A study of Canadian freshmen in post-secondary schools (McDonald et al., 1990) found that only 16% of the women and 25% of the men reported consistent condom use. As an individual’s number of sexual partners increased, the incidence of condom use decreased, confirming a trend identified in other studies (Binson, Dolcini, Pollack & Catania, 1993; Santelli et al., 1997). The Canadian study concluded that women’s’
condom use declined with increased partners but men's did not. Nineteen percent of women with one or two partners always used condoms, whereas only 7.5% of women with ten or more partners always used condoms.

Women's reliance on female controlled contraception is likely to increase as they become more sexually active and involved in a monogamous relationship. This gives them more personal control over contraception and enables them to avoid the feelings of discomfort associated with carrying condoms, keeping condoms at home, and the intentions of purchasing condoms and keeping them at home. Women report considerable more discomfort with these issues than do men (Sacco, Levine, Reed, & Thompson, 1993). Unfortunately, the ramifications of this avoidance can leave women more vulnerable to disease.

DiOrio, Parsons, Lehr, Adame, and Carlone (1993) studied several factors, including perceived susceptibility and future time perspective, associated with safer sex practices among college freshmen. Although sexually active white women perceived more susceptibility to AIDS than non-sexually active white females, they had a more extended future time perspective, and they were not using safer sex practices. White males who had a similar future time perspective tended to choose abstinence. Black males with a more extended future time perspective were more likely to practice safer sex. There were too few black females to include in analysis. White women were the only group that defied prediction.
Risk Factors

Having multiple partners, engaging in unprotected vaginal, anal, or oral sex puts individuals at high risk of contracting STDs. The women who report a history of more partners frequently engage in more risky sexual practices and use condom protection less frequently. Women are two times as likely as men to contact STDs, including HIV/AIDS, through heterosexual contract and have more significant ramifications from STDs, but still continue to report less safer sex.

Condom use studies rely on self-report and it is highly likely that men over-report and women under-report the number of sex partners and their sexual activity. This is a limitation of all condom use studies. Most of the studies assume that condoms are being used properly, although this is not necessarily occurring. Most studies do not explore the use of condoms with oral sex despite the associated risk of oral transmission of both viral (herpes, hepatitis B, human papillomavirus) and bacterial (gonorrhea, syphilis, chlamydia, chancroid) STDs. Anecdotal evidence suggests that teenagers are engaging in unprotected oral sex more frequently with the mistaken belief that it is not risky and is not really having sex (Remez, 2000).

Women who have more sexual partners and women who are involved in a monogamous relationship will frequently switch to female controlled contraception. Many college students practice “serial” monogamy and although they may not be sexually active outside of their present relationship, unprotected sex is still risky due to the potential of unprotected sex with prior partners. College students are reluctant to ask
about previous sexual history for fear of entering an element of distrust into the relationship (Williams, Kimble, Covell, Weiss, Newton, Fisher, & Fisher, 1992).

Reliance on self-report of previous sexual activity assumes that sex partners or potential sex partners will be truthful about their history.

Cochrane and Mays’ (1990) study on 18 to 25 year old university students underscores the error of relying on self-reported sexual history. Thirty-four percent of males and 10% of females admitted having told a lie to have sex. Sixty-eight percent of males and 59% of females have been involved with more than one person, the primary partner being unaware of that fact. Sixty percent of women and 47% of men believed that they had been lied to for the purpose of sex. Forty-seven percent of men and 42% of women would understate the number of previous partners and 20% of men and 4% of women would lie about having an HIV test.

Summary

Despite public health efforts, condom use by college students remains inconsistent. The threat of HIV/AIDS may be perceived as too remote for most college students, the disruption of relationships, sexual pleasure and the discomfort of having to negotiate the use of condoms being more relevant to their current lives.

Those women who’s sexual behavior places them at high risk for STDs, tend to opt for contraceptive methods that do not provide protection from disease but offer more privacy and personal control. Students are reluctant to ask about sexual history and may
view serial monogamy as a protective behavior. The unreliability of self-report about sexual behavior may render asking about sexual history useless at best, and misleading at worst.

Literature Review Summary

Condom use remains inconsistent and unpredictable in spite of the well-publicized health risks due to unsafe sexual behaviors. The relationship of one’s individual traits, sense of efficacy and life priorities to condom use has, when investigated, been contradictory and sometimes unexpected. Because the subtexts to condom use in heterosex are so complex, it is to be expected that research would be equally as complex and challenging.

Sexual behaviors are generally expected to conform with gender-role appropriate behavior. If contradicting one’s gender role expectations is not socially reinforcing in the short-term, it is unlikely that the long-term risks of the behavior will take precedence.

This study investigates women’s condom use during oral, anal, and vaginal sex. Prior research has investigated gender-related traits and condom use with no conclusive findings. Self-efficacy, has been utilized in numerous studies, often utilizing a construct that is not measuring self-efficacy. Sexual self-efficacy in relationship to condom use has mixed results. The association of relationship importance to condom use has not been assessed previously. Given the results of qualitative research and the relational theorists perspective on women’s development this is an area that needs to be investigated. If
women's use of condoms has less to do with individual traits and priorities than the context of the behavior needs to be more fully addressed.
CHAPTER III

Methodology

Female undergraduate students ($N = 157$) from a medium-sized, private, Catholic university in an urban setting in the Northeast participated in the study. Demographic and descriptive information were collected from the entire sample. Four women were excluded from analyses of the hypotheses, three because they were married and one because of incomplete data. Criteria for inclusion in analyses of the hypotheses included being female, between the ages of 18 to 25, heterosexually active (defined as having vaginal intercourse, oral sex, or anal sex) in the past 12 months, and single.

Demographics

Demographic information was chosen to assess other relevant variables that may increase a woman’s STD risk based on previous research. The majority (67%, $n = 105$) of the sample were white (non-latina), 12% ($n = 19$) were black or African-American (non-Latina) and 11% were Latina. The ages of the women ranged from 18-24 years old ($M = 19.5$, $SD = 1.2$) and the majority (65%, $n = 101$) were freshmen or sophomores. Ninety-eight percent of the women in the sample were not married; those women who were married were excluded from analyses of hypotheses (See Table 1).
Of the never married women, 47% (n = 74) reported currently being in a monogamous heterosexual relationship from 1-64 months duration (M = 17.7, SD = 16.26).

Seventy-one percent (n = 112) of the women in the sample indicated that they had been sexually active (defined as engaging in oral, anal or vaginal sex within the past 12 months). Responding to a separate survey item related to sexual activity and condom use in the past 12 months, 63% (n = 99) reported having engaged in vaginal sex, 66% (n = 103) engaged in oral sex and 11% (n = 17) reported engaging in anal sex.
Table 1

Demographic Characteristics  (N = 157)

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Range</th>
<th>M or %</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>156</td>
<td>18-24</td>
<td>19.5</td>
<td>1.2</td>
</tr>
<tr>
<td>Year in school</td>
<td>156</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freshman</td>
<td></td>
<td></td>
<td>31.8%</td>
<td></td>
</tr>
<tr>
<td>Sophomore</td>
<td></td>
<td></td>
<td>32.5%</td>
<td></td>
</tr>
<tr>
<td>Junior</td>
<td></td>
<td></td>
<td>19.7%</td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td></td>
<td></td>
<td>14.0%</td>
<td></td>
</tr>
<tr>
<td>Graduate student</td>
<td></td>
<td></td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>156</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single, never married</td>
<td></td>
<td></td>
<td>97.5%</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>156</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African-American</td>
<td></td>
<td></td>
<td>12.1%</td>
<td></td>
</tr>
<tr>
<td>White (non-Latina)</td>
<td></td>
<td></td>
<td>66.9%</td>
<td></td>
</tr>
<tr>
<td>Latina or Hispanic</td>
<td></td>
<td></td>
<td>10.8%</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian-American</td>
<td></td>
<td></td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td></td>
<td></td>
<td>.6%</td>
<td></td>
</tr>
<tr>
<td>Middle Eastern</td>
<td></td>
<td></td>
<td>.6%</td>
<td></td>
</tr>
<tr>
<td>Bi or multi-racial</td>
<td></td>
<td></td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Relationship status</td>
<td>156</td>
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<tr>
<td>Currently in a monogamous</td>
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<td></td>
<td>47%</td>
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<tr>
<td>Heterosexual relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months in relationship</td>
<td>1-64</td>
<td></td>
<td>17.7</td>
<td>16.26</td>
</tr>
<tr>
<td>Currently in monogamous</td>
<td></td>
<td></td>
<td>.6%</td>
<td></td>
</tr>
<tr>
<td>Lesbian relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have more than one male sexual partner</td>
<td></td>
<td>9.6%</td>
<td></td>
<td></td>
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<tr>
<td>Have both male and female sexual partners</td>
<td></td>
<td>.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of first vaginal intercourse</td>
<td>109</td>
<td>12-21</td>
<td>16.6</td>
<td>1.59</td>
</tr>
<tr>
<td>Partners age</td>
<td></td>
<td>13-29</td>
<td>18.3</td>
<td>2.67</td>
</tr>
<tr>
<td>Condom used</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>
Instruments

Participants were asked to provide demographic information, indicating their age, year in college, marital status, and racial/ethnic backgrounds. Respondents were also asked to provide information regarding their relationship status, sexual history, method(s) of birth control, and STD history.

The ordering of the questionnaire was designed to present the most non-threatening scales first since some of the information gathered asks for very personal information and some of the questions are quite explicit. Each scale was preceded by a short introduction and detailed instructions. Because of the personal nature of some of the questions, efforts were made to normalize the range of sexual behaviors presented and to underscore the confidentiality and anonymity of the survey.

Instrumentality/Expressiveness

The 24-item short form of the Personal Attributes Questionnaire (Spence, Helmreich, & Stapp, 1974) was utilized in this study to measure the gender-related traits of instrumentality and expressiveness. The measurement was originally identified as assessing masculine and feminine traits. Spence and Buckner (1995) noted that the labels instrumental and expressive were more appropriate labels for gender-related traits as they are “empirically accurate and without unwanted theoretical overtones” (p. 116).
This instrument was chosen because it specifically addresses socially desirable
gender-related traits devoid of context and domain, thus addressing the relationship of
one’s dispositional or trait instrumentality/expressiveness to condom use.

The 8-item M scale consists exclusively of self-assertive, instrumental traits that
have been judged to be socially desirable to some degree for both genders, but more
characteristic of men than women. The 8-item F scale consists of desirable socially-
oriented and expressive traits judged to be more characteristic of women than men. The
8-item M-F scale consists of items that address characteristics whose desirability appears
to vary in the two sexes.

Respondents use a five-point Likert scale to indicate their perceived position on a
particular trait (e.g., 0 = not at all emotional to 4 = very emotional on the expressiveness
scale and 0 = not at all independent to 4 = very independent on the instrumentality scale).
Scores range from 0 – 32, with high scores on the M and M-F scales indicating an
extreme masculine response and high scales on the F scale indicating an extreme
feminine response.

Reliability analyses using Chronbach alpha scores have yielded results of .85,
.82, and .78 for M, F, and M-F respectively among a sample of male and female college
students (Spence & Helmreich, 1978). The short form of the PAQ has yielded moderate
scores for internal consistency.

For the purposes of this study the M and F subscales were used as independent,
continuous scales and composite scores were calculated. One hundred and fifty-five
women completed the instrumental scale and 157 completed the expressiveness scale. Chronbach alphas were .58 and .80, respectively. The reliability of the measurement of instrumentality is perplexing and contrasts with two other studies with Chronbach alphas of .75 (Fritz, 2000) and .76 (Bowleg, 1997).

Sexual Self-Efficacy

The 20-item Sexual Self-Efficacy Scale (SSE; Rosenthal, Moore, & Flynn, 1991) used in this study was derived from Libman, Rothenberg, Fichten, and Amsel's (1985) Sexual Self-Efficacy Scale, supplemented with additional items for their study. The scale was originally tested on 1,788 Australian college students (17 – 20 years old, 73% female). Race and ethnicity were not identified in the study. The scale measures the confidence respondents have in their capability to engage in behaviors related to sexuality (i.e., initiate sexual activities). Participants identify if they have confidence in their capability to enact a specific behavior and then rate the degree of confidence they have in doing so on a 5-point Likert scale from 1 (Very Uncertain) to 5 (Very Certain). A sample item asks the respondent to check if they could “Tell your partner how to treat you sexually”. If they indicated that they could enact that behavior, they were then asked to rate their level of confidence. References to contraceptives in item five, “Discuss using condoms and/or other contraceptives with a potential partner” and item fourteen,
“Be able to buy condoms/contraceptives” were deleted in order to identify behavior related specifically to condom use.

Reliability analyses using Cronbach alphas scores yielded correlations of .75 for the “Say No” scale, .77 for the “Assertive” scale, and .69 for the “Precautions” scale. SSE factors were moderately correlated but reflect different behavioral domains.

One hundred percent of the respondents (N = 157) completed the Sexual Self-efficacy Scale. The overall Sexual Self-efficacy score for this study was determined by the mean level of confidence respondents indicated in their ability to engage in all twenty behaviors. Composite scores were computed. Respondents who reported not having the ability to engage in a particular behavior (i.e., Refuse a sexual advance by your partner) were given a zero level of confidence for that item. Individual subscales were not included in the analysis.

**Importance of Heterosexual Relationship vs. life Goals**

The Goals in Life Scale (Frease-McMahan, 1989) was utilized in this study to measure the “importance of relationships, the importance of achievement goals, and the willingness to sacrifice goals for an opposite sex relationship” (Hammersla & Frease-McMahan, 1990, p. 4). Participants were asked to rate the importance of 7 life goals, for example, being “physically fit”, “owning your own home” on a 7-point Likert scale. This study has eliminated one item from the original scale (“missions or work in the ministry”) because it was more applicable to the original assessed population than the current
population of this study. Respondents were also given the option to fill in their own goal by checking “other” and identifying that goal.

Participants were then asked to choose between a life goal and a relationship with a man. Each forced-choice item was preceded by the phrase “Suppose that a relationship with a man developed…” followed by the question, e.g., “if you had to choose between being physically fit or the relationship which would you choose?” Respondents receive a score of 1 if they choose the relationship and 2 if they choose a life goal.

Finally, participants were asked to rate six relational possibilities according to the importance to the individual “in the course of their life”. They were asked to rate on a 7-point Likert scale such items as “marriage” or “close circle of friends.” The scale yielded a satisfactory test-retest (two week interval) reliability estimate of \( r = .67 \) in a previous sample (Frease-McMahan, 1989).

Because this study investigated the importance of a heterosexual relationship versus life goals, only the forced-choice subscale was analyzed. One hundred and fifty-four women completed this scale. Results were determined by using a composite relationship score. A continuous variable was calculated to reflect the degree to which the participant chose relationship goals over life goals. This was done by determining the mean response to the eight forced choice items.
Condom Use

Condom use specifically refers to the male-controlled condom and condom use was assessed for vaginal, oral, and anal sex. Participants were asked to respond to the following questions “How often have you and your partner used a condom in the past 12 months during vaginal sex, oral sex, and anal sex?” indicating frequency of condom use on a Likert scale ranging from 1 (Never) to 5 (Always). Participants were given one additional response to each condom use question – “NA” (Does not apply to me). This will account for those individuals who did not participate in a particular sexual activity versus those who did, but never used a condom.

Procedures

Approximately one third (n = 58) of the participants were recruited from an introductory psychology classes in which extra credit was offered from the professor. Another third (n = 51) of the students were recruited in the school dining hall and coffee shop and offered $2 to complete the questionnaire. Students (n = 48) were also recruited by a graduate assistant through her office in the Freshmen studies program.

Female students were asked if they were willing to participate in a study about college women traits, sexual attitudes and behaviors, and attitudes about relationships. Students were informed in writing and verbally that they could discontinue with the survey if the information was too personal and/or made them too uncomfortable. They were assured that this would not effect their extra credit status or the monetary reward.
The University Counseling Center’s phone number was included in the Letter of Informed Consent (see Appendix A & Appendix B) in the event that questions provoked some emotional discomfort. Those who were willing to participate were assured of their confidentiality and anonymity. Time was allotted for the students to ask questions before the survey and questions were answered during the survey. Students were asked to return their anonymous surveys by placing them in a sealed envelope or for those recruited in class, to place them in a box provided for them as they exited the classroom.

Statistical Analysis

Range, means, and standard deviations were computed for each scale. Reliability was computed for only the PAQ, since the SSE measured different domains of behavior and only the forced-choice subscale of the Life Goals Scale was analyzed. Simultaneous multiple regression was utilized to evaluate the predictive ability of the variables with condom use. Pearson correlation coefficient was used to determine the relationship between gender-related traits and sexual self-efficacy as well as gender-related traits and the importance of relationship versus life goals.
CHAPTER IV

Analysis of the Data

In addition to demographic and descriptive information, all participants were asked to complete the Personal Attributes Questionnaire (PAQ), Sexual Self-Efficacy Scale (SSE), and The Goals in Life Scale. Composite scores for these measures were computed (see Table 2).

Because of the extremely small sample size, hypotheses concerning condom use during anal sex were not tested in this sample. Hypotheses concerning use of condoms during oral sex were not tested due to the high invariability of responses. The hypotheses tested included only the unmarried women who had vaginal sex in the past 12 months and completed the condom use items (n = 96).

Table 2

Ranges, Means, and Standard Deviations of the Predictor Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumentality</td>
<td>155*</td>
<td>7-32</td>
<td>24.4</td>
<td>4.76</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>157</td>
<td>10-31</td>
<td>20.4</td>
<td>3.81</td>
</tr>
<tr>
<td>Sexual Self-efficacy</td>
<td>157</td>
<td>0-5</td>
<td>3.45</td>
<td>.92</td>
</tr>
<tr>
<td>Life Goals</td>
<td>154*</td>
<td>1-2</td>
<td>1.51</td>
<td>.22</td>
</tr>
</tbody>
</table>

Note. *Missing Data
Each of the predictor variables as well as the outcome variable (frequency of condom use during vaginal intercourse) was examined to determine if the assumption of normality required for multiple regression analyses had been met (Tabachnick & Fidell, 2001). If the assumption was violated for any of the variables, an appropriate transformation of the variable was made so that the assumption of normality would be satisfied.

The Expressiveness composite score was found to be significantly negatively skewed, $z = 3.49, p < .001$. Based on suggestions given by Tabachnick and Fidell (2001) the Expressiveness score was logarithmically transformed. The Sexual Self-Efficacy scores were also significantly negatively skewed, $z = 6.43, p < .0001$, as well as leptokurtic, $z = 6.12, p < .0001$. A logarithmic transformation of this score was also performed. The outcome variable of frequency of condom use during vaginal sex was also significantly negatively skewed, $z = 2.90, p < .002$. A logarithmic transformation of this variable was performed to satisfy the assumptions of normality necessary for regression analyses.

**Data Analysis Results**

Seventy-one percent of the participants reported being sexually active in the last 12 months. "Sexually active" in this study refers to having engaged in anal, oral, or vaginal sex and is inclusive of heterosexual and bisexual activity. Sixty-three percent ($n = 96$) of the women reported engaging in vaginal intercourse in the past 12 months. Sixty-nine
percent (n = 109) of the sample had experienced at least one instance of vaginal intercourse in their lifetime. The ages of these women when they first had vaginal intercourse ranged from 12 to 21 (M = 16.6, SD = 1.59), the age range of their partners ranged from 13 to 29 (M = 18.3, SD = 2.67). Fifty-six percent (n = 88) of the women reported condom use at the first instance of vaginal intercourse.

The reader should note that references to condom use in this section will refer to condom use in the last twelve months only, unless otherwise specified. The three married respondents as well as a respondent who provided incomplete information were eliminated from analysis of condom use. Of the unmarried women who responded to the condom use during specific sexual activities items, 35% (n = 34) reported always using condoms during vaginal sex. Thirty percent (n = 29) reported usually using condoms. Only 8% (n = 8) of the sample never using condoms during vaginal sex. Only 16% (n = 16) of the women engaged in anal sex, and of those, 12 reported never using condoms and none always used condoms. One hundred women reported engaging in oral sex, 95% (n = 95) never using condoms (see Table 2).

Twenty-five percent (n = 39) of the women reported using birth control pills, 54% (n = 21) of these women also reported using condoms (See Table 3). Fifty-one percent (n = 81) reported having ever bought condoms and 36.9% (n = 58) reported that they had bought condoms is the past 12 months. Only 3.8% (n = 6) of the sample reported ever having a sexually transmitted disease.
Table 3

Frequency of Condom Use During Vaginal, Oral, and Anal Sex in the Past 12 Months

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Vaginal</th>
<th>Oral</th>
<th>Anal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 96</td>
<td>n = 100</td>
<td>n = 16</td>
</tr>
<tr>
<td>Never</td>
<td>8</td>
<td>95</td>
<td>12</td>
</tr>
<tr>
<td>Rarely</td>
<td>11</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Usually</td>
<td>29</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Always</td>
<td>34</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>57</td>
<td>53</td>
<td>137</td>
</tr>
</tbody>
</table>

Note. Married participants (n = 3) and one participant who did complete the survey were eliminated from this analysis.
Table 4

Percent Using Birth Control and Type of Contraceptive Used

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using birth control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>65</td>
<td>41.4</td>
</tr>
<tr>
<td>No</td>
<td>83</td>
<td>52.9</td>
</tr>
<tr>
<td>Type of contraceptive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Birth control pill</td>
<td>39</td>
<td>24.8</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>Male condom</td>
<td>44</td>
<td>28.0</td>
</tr>
<tr>
<td>Female condom</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Contraceptive sponge</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Note. *Missing data; Some women used more than one type of contraceptive

Hypothesis 1

Instrumentality and expressiveness will predict heterosexually active college women's use of condoms in the past 12 months during anal, oral, and vaginal sex.

Because of the small number of participants who reported engaging in anal sex and the relative invariability in responses to frequency of condom use during oral sex, hypotheses concerning these outcome variables were not examined. A simultaneous multiple regression was used to examine the predictive ability of Instrumentality and
Expressiveness on the frequency of condom use during vaginal intercourse in the past 12 months. The transformed Expressiveness score and the Instrumentality score were regressed onto the transformed frequency of condom use during vaginal intercourse score. This multiple regression was not statistically significant, $F(2, 91) = .33, p = .73$, $R^2 = .01$. Neither instrumentality nor expressiveness predicted women’s use of condoms during the past 12 months.

**Hypothesis 2**

Instrumentality will be positively correlated with sexual self-efficacy and expressiveness will be negatively correlated with sexual self-efficacy among heterosexually active female college students: Instrumentality was positively correlated with sexual self-efficacy, $r = .14, p < .04$ (1-tailed). The more instrumental one was, the more they reported being sexually self-efficacious. The expectation of a negative correlation between expressiveness and sexual self-efficacy was not supported, $r = -.10, p < .13$ (1-tailed).

**Hypothesis 3**

Placing importance on heterosexual relationships versus other life goals will predict heterosexually active college women’s condom use in the past 12 months during anal, oral, and vaginal sex and will account for more of the variance of heterosexually active college women’s condom use than instrumentality, expressiveness, and sexual self-
efficacy: This finding was not supported by this study. Using a simultaneous multiple regression with a respondents instrumentality score, transformed expressiveness score, relationship score, and transformed sexual self-efficacy score regressed on the transformed frequency of condom use during vaginal intercourse yielded no significant results, \( F(4, 90) = .28, p < .93, R^2 = .01 \).

**Hypothesis 4**

Among heterosexually active college women instrumentality will be negatively correlated with placing importance on heterosexual relationships versus life goals and expressiveness will be positively related to placing importance on heterosexual relationships versus life goals: This hypothesis was partially supported. Expressiveness was positively correlated with one’s relationship score. Those with higher levels of expressiveness tended to place more importance on relationships over life goals, \( r = .19 \), \( p < .01 \). Instrumentality, however, was not negatively correlated with importance of relationships versus life goals, \( r = .004 \), \( p < .97 \) (2-tailed).

**Summary of Results**

There was only partial support for the hypotheses. Instrumentality was positively correlated with Sexual Self-efficacy and Expressiveness was positively correlated with an individual’s tendency to emphasize relationship over life goals. However, one’s frequency of condom use when engaging in vaginal intercourse during the past 12
months could not be predicted from level of Expressiveness, Instrumentality, Sexual Self-efficacy, or tendency to place importance on heterosexual relationships versus life goals.
CHAPTER V

Discussion

The purpose of this study was to investigate the predictive ability of gender-related traits, sexual self-efficacy, and the importance of relationship versus life goals on heterosexually active college women’s condom use. Analysis of the relationship between gender-related traits and sexual self-efficacy as well gender-related traits and importance of heterosexual relationships versus life goals were also examined.

None of the variables investigated in this study (i.e., gender-related traits, sexual self-efficacy, importance of relationships) predicted heterosexually active college women’s condom use in the past 12 months. Instrumentality was positively correlated with sexual self-efficacy but expectations that expressiveness would be negatively correlated with sexual self-efficacy were not supported. As predicted, expressiveness was significantly positively correlated with the importance of relationship, however, contrary to expectations, instrumentality was not related to relationship importance.

Sex educators, public health officials, and parents express concern about the health behaviors of children. Given the high profile that HIV/AIDS has attained in the past decade, the younger age at which adolescents become sexually active and, until recently, the upward trend in pregnancy in teenagers, adolescents’ sexual behavior has become a primary concern. Approaches that seemed to reduce risky sexual behaviors in
white, gay men have not necessarily been effective with other populations. The epidemic of HIV/AIDS and other STDs among the non-IV drug using, young, heterosexual population presents a significant challenge the public health professionals.

Any interactive sexual encounters involve a number of variables that are likely to test the resolve of the most rational-minded, much less those caught up in the throes of love, passion, and hormonal overdrive. Because safer penetrative sex, by definition, must include condom use, safer sex must include planning for sex, an image avoided by both genders. Condom use is controlled by males so that women are relegated to the less powerful position of negotiating their use. This study investigated the possibility that gender-related traits, domain specific self-efficacy, and personal priorities regarding heterosexual relationships versus life goals may decrease or increase a woman’s vulnerability to unsafe heterosexual behavior, and consequently to STDs.

Integration of Findings

Research indicates that the percentage of students who consistently use condoms varies significantly (Boyd & Wandersman, 1991; Brien et al., 1994; Dekin, 1996; Gerrard & Warner, 1994; Boyd & Wandersman, 1991; McDonald et al., 1990). Although 35% of the unmarried women in this study who reported engaging in vaginal sex in the past 12 months (n = 96) used condoms consistently during vaginal sex, 30% (n = 29) reported that they usually used them and only 8% (n = 8) of the students never used condoms. Few condom use studies investigate the rate of use with incidents of oral and anal sex.
There was a low frequency of anal sex and low frequency of condom use during anal sex among women in this study, although this is a relatively high-risk sexual behavior. Condom use during oral sex generally is very low, although the incidence of oral sex is rather high (Dekin, 1996), findings confirmed by this investigation.

Oral sex is often incorrectly considered “safe sex” – disease-free and contraceptively effective. A marked increase in oral sex among adolescents and very young adolescents has been reported in the past decade partially because of the misconception that it is a disease-free behavior (Remez, 2000) and that it is not “real sex” – “real sex” involves penetration. This topic received exposure during the Clinton White House sex scandal but was unfortunately overlooked as an opportunity to expand the public discourse about sexuality. The equation that penetrative sex is “real sex” actually may be a barrier to safer sex behaviors since it confines sexuality to a behavior that exposes one to more risk (Richardson, 1990). By expanding the definition of “real sex”, individuals can expand their sexual repertoire without feeling they are “missing something” while practicing behaviors that are less risky.

Although the popular press has written extensively about the increase in oral sex among adolescents, because so few sexuality studies specifically address oral sex, much of the reported increase in oral sex is anecdotal (Remez, 2000). Government restrictions on sexual behavior research of those under 15 years old have also limited making reliable information accessible.
Only slightly over half of the thirty-nine women using oral contraceptives also reported using condoms. Frequency of condom use tends to decline when women use oral contraceptives (Maticka-Tyndale, 1991) and research suggests that young men and women tend to use condoms primarily as a method of contraception not disease prevention (Santelli et al., 1997). These researchers also found that increased time in a relationship tends to correspond with a decline in condom use and utilization of more female controlled contraceptive methods.

Instrumentality/Expressiveness

These gender-related traits were expected to predict condom use among this sample, however, this hypothesis was not supported. Women’s dispositional gender-related traits were not related to condom use. Bowleg (1997) using the same measurement found no significant predictive relationship to condom use with her sample which consisted primarily of women of color with a much wider age range than this study’s sample.

Contraceptive use has been negatively related to traditional gender role attitudes (Whitely & Schofield, 1986) and nontraditional attitudes toward women’s roles have significantly predicted women having a more positive attitude towards requesting one’s partner to use a condom (Koblinsky & Palmeter, 1984). It is tempting to equate instrumentality with nontraditional attitudes towards women’s gender roles and
expressiveness with traditional attitudes towards women's gender roles, however, research does not support this extrapolation.

Instrumentality/expressiveness as measured by the PAQ (Spence et al., 1974) assess global gender-related traits. The inability of these variables to predict condom use may underscore the salience of context on condom use. What we may glean from these results is that condom use is not necessarily predicted by global traits generally associated with gender, such as those measured by the PAQ. An area that was not addressed in this study is the relationship of instrumentality/expressiveness to female-controlled contraceptive methods. Women may take control of their reproductive life but avoid the discomforts related to negotiating and using condoms. This may be an area for future research.

Instrumentality was positively correlated with Sexual Self-efficacy. Women who identified as globally assertive and direct tended to have confidence in their abilities to enact and resist sexual behaviors. Perhaps if a woman is comfortable contradicting traditional gender expectations in general, she may be more comfortable with the ramifications related to nontraditional gender behavior in heterosex. However, women may be dispositionally assertive (instrumental) and feel confident and capable of engaging in or resisting from sexual behaviors (sexually self-efficacious) but they may still prefer that men be more instrumental in sexual situations then they themselves are (Lawrence et al., 1996). The context then overrides the individual traits.
The lack of relationship between an individual's agentic traits and condom use may be a partial reflection of attempts at image control, a ceding of power to avoid the ramifications of appearing more instrumental/less feminine then is socially acceptable (Klein & Willerman, 1979; Lawrence et al., 1996; Stake et al., 1996), or an indication of the strength of interpersonal dynamics in heterosex, and more than likely all of the above. The added effects of passion, not wanting to ruin "the moment", spontaneity, unavailability of condoms, coercion, and intoxication thwart a simple explanation of these results.

It was expected that Expressiveness would be negatively related to Sexual Self-Efficacy so that those women who were more expressive and "traditionally" female would have less confidence in their capabilities to "engage in" or "resist" some sexual behaviors. This hypothesized relationship was not supported by these results, perhaps due to the range of behaviors addressed, since this study did not assess the predictive ability of the individual scales. Expressive women may feel a level of confidence in "saying no", a traditional sexual role for women, but lack confidence in asserting their own sexual needs, a differential not necessarily represented by a composite score.

Sexual Self-Efficacy

Sexual Self-Efficacy, as measured by the Sexual Self-Efficacy Scale, did not predict condom use in this sample. Previous studies have found a significant relationship between condom use and self-efficacy (Basen-Enquist & Parcel, 1992;
Wufert & Wan, 1993; Wufert et al., 1994), using a variety of measurements of the construct. Of particular interest to this study was the construct of Sexual Self-Efficacy – a more inclusive measurement of a variety of aspects of sexuality. A subset of items from the SSE pertaining to “precautionary” behavior predicted women’s condom use in a prior study although there was no predictive ability of the entire scale (Bowleg, 1997). A more general measurement of sexual self-efficacy yielded unexpected results, that women who had less sexual self-efficacy reported more condom use and condom use intentions (Breakwell et al., 1994).

Gender differences in safer sex behaviors frequently emerge in self-efficacy studies. Women express more confidence in “saying no”, refusing sex with a partner who will not use a condom, protecting themselves from AIDS and enacting safer sex behaviors (i.e., fewer partners) than men. Two glaring contradictions regarding the safer sex/AIDS protective self-efficacy beliefs of women surface is the lack of gender differential in condom use and women’s “amorphous sense of vulnerability” in heterosex.

Feeling confident in one’s own ability to enact or refuse sexual behaviors is not a guarantee that the behavior will or will not occur, particularly behaviors that involve the cooperation of another person in combination with the emotional and physical stimulation involved in sexual activity. Women may be sensitive to, and recognize the complicated dynamics involved in heterosex and feel a sense of powerlessness in negotiating condom use (lacking the skills, feeling that they might be pressured, or forced into unwanted sexual activity).
Male and female college students who consistently use condoms have more confidence in using them under a variety of conditions, dealing with conflict with a partner regarding condom use, have less fear about rejection, are more assertive and have more confidence in their ability to insist on the use of condoms (Brien et al., 1994). The authors conclude that obstacles to condom use are more related to one's confidence in addressing the interpersonal issues. The questions that remain are—how did these students gain this confidence, are these individual traits that are evident in other domains of their life, and finally, how do health educators utilize this information to structure effective interventions?

**Importance of Relationship**

Placing importance on heterosexual relationships versus life goals did not predict condom use. Indications that relationship factors may influence or be associated to women's safer sex behavior are abundant. Women will consent to unwanted sex to maintain a relationship (Muehlenhard & Cook, 1988), link sexual pleasure to the quality of the relationship (Holland, 1992), have less confidence refusing sex with someone whom they want to have fall in love with them (Kasen, Vaughn & Walter, 1992) and are more likely to use condoms if their partner supports their use (Santelli et al., 1996).

The relationship measurement used in this study simply asked students to make the choice between a heterosexual relationship versus a specific life goal. The Goals in Life Scale does not specifically identify the type (i.e., serious vs. short-term) of
heterosexual relationship. A measurement that discriminates between a "serious" relationship and a "casual" relationship might yield more interesting and substantive results. Hammersla and Frease-McMahan (1990) found that those students in their sample who were in a monogamous relationship tended to make more relationship choices, this increasing with the duration of the relationship. Although this relationship was not investigated in this dissertation, it may have interesting implications for condom use.

Choosing a life goal over a relationship, while calmly sitting taking a survey is a relatively easy intellectual exercise. Turning the emotional volume up by specifying the choice between a "serious relationship with someone you are in love with" and a life goal may yield different results. It would be interesting to investigate if assessing an individual's emotional dependency, when the need for relationship is more visceral than intellectual, is related to women's condom use.

An expected outcome that was supported by the results of this study (although modestly), was the positive relationship between expressiveness and importance of a heterosexual relationship versus life goals. More expressive women are more likely to choose a relationship over a life goal. Women were responding to a generic "heterosexual relationship", versus a "serious" relationship, which may have diminished the significance of the results.
Implications of the Study

Practice Implications

Only about one-third of these college women consistently use condoms during vaginal sex. Few women report condom use during oral or anal sex. The population studied has matured into adolescence during a time in which HIV/AIDS is a world epidemic. Public health messages have underscored the risks of unprotected sex while school systems grapple with the appropriate way to educate children about the risks related to unprotected sex. Abstinence programs, correctly claiming that abstinence is the only safe sex, have been developed and sometimes touted as the only way to approach this serious public health problem. This is a generation whose concerns about sexual activity go beyond unplanned pregnancy.

Despite the abstinence message, sexual activity among U.S. adolescents continues and risky sexual behavior has resulted in the highest STD rate in the developed world (Eng & Butler, 1997). College women perhaps feel some protection against HIV/AIDS, a disease often associated with gay males or promiscuous sex with high-risk partners (e.g., IV drug users). Safer sex interventions may be more successful if they focus on the more prevalent STDs (i.e., chlamydia, gonorrhea) that may be perceived as more relevant and immediate to the college population (Bryan et al., 1996).

Although many women seem to have a sense of vulnerability related to sexual risk they also express confidence in their ability to enact safer sex behaviors. Contradicting the sense of efficacy are reports of significant percentages of women
consenting to unwanted sex, the low frequency of condom use and evidence that women do not buy, carry or have condoms available, making them dependent on the male to practice safer sex. The complexity of women’s condom use and the contradictions associated with women’s sexuality cannot be underestimated. Clearly, there are no simple conclusions to draw about women’s condom use – a situation that makes the planning and design of interventions more complex and challenging.

As is evident from this study, having a sense of personal agency (instrumentality) as well as a sense of efficacy in the domain of sexual behavior may have no influence on condom use. Interventions focusing on increasing women’s sexual assertiveness skills with the expectation of increasing condom use may do no harm but may be ineffective in meeting the objective.

If women are not protected from risky sexual behavior by personal instrumental traits (the bad news) they also do not seem to be more vulnerable with expressive traits (the good news). If women are not protected from risky sexual behavior by having a sense of sexual self-efficacy, they also do not seem to be more vulnerable without it. Although these results belie common sense, they may be a reflection on the measurement of the constructs, the complexity of protective sexual behaviors, and/or other limitations of the study.

Widening the field of inquiry by attempting to assess the possible influences of the interpersonal aspect of condom use, this study addressed the variable of importance of relationship on condom use. Placing importance on relationship, although not related to
condom use, was however, related to expressive traits. The expectation that this combination of traits would increase the individual's vulnerability to engage in risky sexual behavior by not using condoms was not supported. Ruling out the influence of relationship variables on women's condom use based on the results of this study needs to be done cautiously, if at all. It may be that the importance of relationship measurement did not adequately address this variable by not specifying the degree of commitment to the relationship. This dimension of condom use behavior needs more thorough investigation.

Women's condom use does not occur in a social or cultural vacuum. If individual factors and even interpersonal factors do not tell the whole story about condom use, perhaps the net needs to be widened. The influence of social, gender, cultural expectations regarding sexuality is a subtext to heterosexual behavior. We may be guilty of treating the symptoms and not the disease. In other words, we may be attempting to respond to behavior that is an outgrowth of much larger issues – the cultural discourses about sexuality and gender and sexuality. A recent United Nations report addressing the AIDS epidemic concluded with a quote from Secretary General Kofi Annan "The gender dynamics of the epidemic are far-reaching due to women's weaker ability to negotiate safe (sic) sex, and their general lower social and economic status" (Crossette, 2001, p. 49). Equating the social conditions of college women in the United States to impoverished women in developing countries does a gross disservice to the challenges and hardships they encounter. However, a recommended intervention for some women
of South Asia, who are considered by international measurement to have the lowest status in the world (Crossette, 2001), is to focus sex education not only on the biological aspects of sexuality but to include and emphasize "...gender equality, and power relations and sexuality more broadly..." (p. 49). This approach may be beneficial for our own intervention planning and design.

Research Implications

Assessing and changing the cultural discourses regarding sex and gender is obviously a long, arduous process. The effects on women's condom use/safer sex behaviors will be far from immediate. But since sexual behavior is here for the "long haul" efforts need to continue to reduce risky behaviors. Research should be aimed at early identification of individuals who may be prone to risky health behavior. Public health efforts and education focused on HIV/AIDS and the STDs more prevalent in the college population should continue as there is some indication that the immediacy of STDs may have some potential for increasing safer sex behaviors (Bryan et al., 1996). And finally, pharmaceutical research aimed at producing more effective, female-friendly, sexual protection that offers privacy, personal control and the ability to be prepared without appearing to be prepared (as oral contraceptive methods do) for sex, may encourage more women to take a more active role in their own sexual health.
Limitations of the Study

Self-report measures are subject to social desirability influences as well as recall bias. Women may choose to under-report their sexual activity due to social/sexual gender expectations. People may also tend to over-report their protective behaviors. The respondents in this study reported a very low frequency of condom use during oral and anal sex in contrast to their condom use during vaginal intercourse. One might think that individuals interested in projecting a responsible image might over-report their condom use in all sexual activity, which might be an indication of the accuracy of the responses to condom use during vaginal sex.

Students who filled out the surveys in a classroom situation may have been affected by the close proximity of their peers, who may have been sitting next to them. Although it was suggested that they move away from each other due to the personal nature of the questionnaire, no one chose to, and doing so would given the appearance that there was something to hide, certainly a disincentive to do so. The lack of privacy may have effected some participant's responses.

Approximately one third of the sample was recruited by the researcher in the coffee shop and the cafeteria. Results may be biased by whom the researcher chose to approach to fill out the survey and by the sample of students who would be in the coffee shop versus studying or involved in extra-curricular activities. Another third of the students were recruited by a graduate assistant and the students who worked for her.
Recruitment was by word-of-mouth and among a social network which may have skewed participation.

This survey was taken at a conservative Catholic University in the northeast, which diminishes generalization of the results to other secular or nonsecular universities. Students were primarily white, freshmen, and sophomores which further limits generalizability. Participants who volunteer to fill out surveys that assess sexual behavior may have less inhibition about sexuality then the average person, again possibly skewing the results. Additionally, the use of a convenience sample limits generalizability.

Future Research

Quantitative research gives a "sketch" of the participant's behavior, and maybe not a very accurate one at that. Qualitative research, although subject to some of the same limitations as quantitative sexual behavior research, may yield a richer, more complete picture of the issues that individual's face in their sexual decision making. For example, women may feel confident in their capability to resist engaging in vaginal intercourse without the use of a condom, but in certain circumstances and situations may not have engaged in this behavior. It might be enlightening and useful to identify those circumstances in which the best of intentions get overruled.

Individuals may misrepresent their sexual behavior in an individual interview, fearing judgment and disapproval or, on occasion, misrepresenting their behavior for shock value. Group sessions are subject to the same weaknesses and also may be
influenced by group social pressure. Despite these weaknesses, additional information about sexual behavior from women making the decisions might help researchers identify the specific issues that need to be addressed.

Since this survey was conducted at a religious institution, the research may have been enhanced by inclusion of items that evaluate the relationship between religious affiliation, religious commitment, the individual’s religious denomination’s beliefs regarding sexual behavior, and sexual behavior. If premarital sex and condom use are considered immoral by their professed religious tenets, does this further obfuscate the individual’s decision-making process about their own sexual behavior? Does grappling with the gender role contradictions of being sexually active and the moral dilemma of being pre-maritally sexually active and using condoms make women more vulnerable to risky sexual behavior?

Further inquiry into the role of relationship in women’s condom use behavior would be beneficial to identify and clarify variables that this study did not fully address. This is a factor that might be more adequately addressed by using a combination of quantitative and qualitative research methods. As previously mentioned, the “Goals in Life Scale” did not differentiate between a “special” heterosexual relationship and a “casual” heterosexual relationship, thus making it rather easy to choose a life goal. A more effective measure might be to specifically identify the type (i.e., serious, casual) of heterosexual relationship.
Gender-related traits, sexual self-efficacy, and the importance of a heterosexual relationship versus life goals did not predict condom use with this sample. Over 70% of the women surveyed reported being sexually active in the past 12 months. Consistent condom use during vaginal sex was reported by 35% of the women, while frequency of condom use during oral and anal sex was very low. Clearly this is a population at risk for STDs, despite the public health efforts in the past decade. Future research needs to creatively address the individual and interpersonal factors related to women's condom use as well as the influence of culture, gender, power, and socioeconomic status.
References


Rezez, L. (2000). Oral sex among adolescents: Is it sex or is it abstinence?

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Appendix A

Informed Consent – Classroom
Dear Potential Research Participant:

I am a Doctoral Candidate in Counseling Psychology. I am collecting data for my dissertation and would appreciate your assistance. My research focuses on college student's self-perceptions, perceptions about sexuality, their feelings about relationships and their safer sex behaviors. Your voluntary participation will be greatly appreciated.

If you are at least 18 years of age, I invite you to take the next 15-20 minutes to complete the following self-report inventories: 1) demographic measures (4 items); 2) The Personal Attributes Questionnaire (24 items); 3) Goals in Life Scale (21 items); 4) Sexual Self-Efficacy Scale (20 items); 5) Relationship Status, Condom use, Sexual History questions.

If you decide to participate in the present study, I ask that you complete all of the brief questionnaires and place the anonymous survey materials in the box provided in the classroom. You are free to ask questions or to discontinue participating without penalty at any time. In return for participating and returning your survey packet, your instructor may provide you with extra credit towards your coursework.

If you are under the age of 18 or if you freely decide not to participate in the study for any reason, your instructor will provide you with alternative means of earning extra credit under no penalty. There is no penalty for choosing not to participate.

Your confidentiality and anonymity will be protected in the following ways:
1) Please do not place your name or any other identifying information on the survey materials.
2) Your anonymous survey will be in a sealed envelope and returned to the researcher.
3) Your responses and demographic data will be consolidated with other students and will be analyzed as an anonymous group. Summaries or conclusions will be reported in aggregate form only.
4) Your anonymous survey will be kept confidential by the researcher.

Should you experience any distress during or after participating in this study, I strongly encourage you to contact Seton Hall's Counseling Services (973-275-9500) to help you address any of your concerns.

If you have any questions about this study or would like a copy of the results please contact me at 732- or by e-mail at If you have
any questions about the rights of research participants, you may contact The Chairperson of the IRB, Office of Grants and Research Services (973-378-9809).

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 378-9809.

I have read the material above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

Thank you very much for considering participating in my study. Your informed consent is implied if you decide to complete and return your survey.

Sincerely,

Beth Youmans, LCSW
Ph.D. Candidate
Counseling Psychology
Informed Consent Form

I understand that:

I am being asked by Beth Youmans, a Ph.D. counseling psychology student at Seton Hall University to participate in research for a dissertation. This study investigates college student’s self-perceptions, perceptions about their sexuality, their feelings about relationships and their safer sex behaviors. I will complete four questionnaires about these issues, which will take me approximately 15-20 minutes.

Participation will not involve any physical risk. If at any time I feel uncomfortable I am free to withdraw my participation in the study without prejudice or penalty. Some of the questions may be of a sensitive nature; if I feel that the questions are too personal and/or offensive I may discontinue participation by closing the questionnaire packet and handing in the incomplete survey; if I am uncomfortable with any of the issues raised in the questionnaires, I should contact the University Counseling Services (973-761-9500).

Participation in this study is entirely voluntary. There will be no monetary compensation for my participation in the study, but extra credit may be awarded for participation, at the discretion of my instructor.

The information that I will provide on the questionnaires will be kept entirely confidential and can in no way be identified by my name.

Any questions about this study can be answered in person by the researcher, Beth Youmans, or by email.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject’s privacy, welfare, civil liberties and rights. The chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 378-9809.

I have read the material above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without penalty at any time.

Participant's signature

Participant's name printed

Instructor's name
Appendix B

Informed Consent – Voluntary
Dear Potential Research Participant:

I am a Doctoral Candidate in Counseling Psychology. I am collecting data for my dissertation and would appreciate your assistance. My research focuses on college student's self-perceptions, perceptions about sexuality, their feelings about relationships and their safer sex behaviors. Your voluntary participation will be greatly appreciated.

If you are at least 18 years of age, I invite you to take the next 15-20 minutes to complete the following self-report inventories: 1) demographic measures (4 items); 2) The Personal Attributes Questionnaire (24 items); 3) Goals in Life Scale (21 items); 4) Sexual Self-Efficacy Scale (20 items); 5) Relationship Status, Condom use, Sexual History questions.

If you decide to participate in the present study, I ask that you complete all of the brief questionnaires and place the anonymous survey materials in the envelope provided and seal it. You are free to ask questions or to discontinue participating without penalty at any time.

Your confidentiality and anonymity will be protected in the following ways:
1) Please do not place your name or any other identifying information on the survey materials.
2) Your anonymous survey will be in a sealed envelope and returned to the researcher.
3) Your responses and demographic data will be consolidated with other students and will be analyzed as an anonymous group. Summaries or conclusions will be reported in aggregate form only.
4) Your anonymous survey will be kept confidential by the researcher.

Should you experience any distress during or after participating in this study, I strongly encourage you to contact Seton Hall's Counseling Services (973-275-9500) to help you address any of your concerns.

If you have any questions about this study or would like a copy of the results please contact me at 732- or by e-mail at . If you have any questions about the rights of research participants, you may contact The Chairperson of the IRB, Office of Grants and Research Services (973-378-9809):

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that
the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 378-9809.

I have read the material above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

Thank you very much for considering participating in my study. Your informed consent is implied if you decide to complete and return your survey.

Sincerely,

Beth Youmans, LCSW
Ph.D. Candidate
Counseling Psychology