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Familial and Self Systems as Contributors to Sexual Decision-making Patterns of Young African American Women

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Familial and Self Systems as Contributors to Sexual Decision-making

Patterns of Young African American Women

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

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I celebrate God's grace for guiding me through this journey. I pray that I have and will continue to make my ancestors proud.

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Dedication

I dedicate this document to any individual who has ever been told, "You will never be able to do that!" or who looks at a task thinking, "Can I overcome this challenge?"

This completed document is proof that with certain key ingredients (realistic objectives, diligence, resilience, faith and sincere support) the response will always be "Yes, I can!"

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Abstract

FAMILIAL AND SELF SYSTEMS AS CONTRIBUTORS TO SEXUAL DECISION-MAKING PATTERNS OF YOUNG AFRICAN AMERICAN WOMEN

Christina M. Grange, M.S.

A dissertation submitted in partial fulfillment of the requirements for the degree Doctor of Philosophy at Virginia Commonwealth University.

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This study utilized a is a two-phase mixed methods design to examine partner-based expectations and perceptions of factors that affecting condom use among African American women recruited at a sexually transmitted infection (STI) clinic. Phase One utilized qualitative methods to analyze interviews from 25 unmarried, African American women between ages 18-26. Interviews explored the following two research questions: (1) How do young adult African American women conceptualize relationships as illustrated by their expectations of their partner and their expectations of themselves in the relationship? (2) What messages do women recall receiving from their family members about sexual opportunities, intercourse, consequences of sex, love, marriage and premarital sex? Data analysis revealed partner-based expectations that

included expectations of trust/honesty, respect from partners, stability of partner's behaviors, interest in women's well-being, partner's ability to be self-reliant, and specific behavioral expectations (e.g., communication, family commitment). Some expectations linked to women's ideas about their sexual health. Women's self-expectations included being emotionally supportive, committed, honest, domestic and independent. Familial messages focused on what to expect from partners, who women should be in relationships, messages stressing respect for and from others, messages emphasizing how to prevent negative outcomes of sex and messages warning about consequences of sexual engagement. Findings related to women's HIV/AIDS prevention behavior included responsibility for their own sexual safety, commitment to assessing partner's history, incorrect education regarding sexual safety, and relationship factors affecting condom use. Findings from interviews were used to develop items for the Relationship Expectation Measure (REM), which tested and used as a mediator for Phase Two Hypotheses. Phase Two of the research tested for the association between family process factors, communication and closeness, relationship expectations and sexual health outcomes. Hierchical Linear regression models were used to test associated hypotheses. Findings did not support the association between family process variables, relationship expectations and sexual health outcomes. Findings from this study illuminate the need for further understanding the degree to which different aspects of expectations and familial processes affect women's history of sexual behavior and partner-based expectations. Inconsistencies between what women expect and accept from partners are also discussed.

Chapter 1

Introduction

At all stages of Acquired Immunodeficiency Syndrome (AIDS) epidemic, African Americans are disproportionately affected when compared to other ethnic groups (CDC, 200b5). As recently as 2002, the CDC documents that HIV/AIDS was the leading cause of death among African American women ages 25-34 (CDC, 2007). For this reason that the sexual health practices of African American women and adolescents continues to be a health concern. This study was conducted to enhance understanding of the context of African American young women's sexual choices and how these choices are shaped.

Engagement in risky sexual behavior has historically been a concern as it places individuals at risk for unplanned pregnancy. Today there continues to be a notable number of youth engaging in premarital sexual behavior. They are doing so at younger ages and with an increased severity of the consequences (Lerner & Simi, 2000). Health consequences include the transmission of sexually transmitted infections (STIs), including HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). While non-marital childbearing and the associated consequences have been

a consistent area of social concern (Beutel, 2000; Coley & Chase-Lansdale, 1998; Danziger, 1995; Furstenberg,1991; Geronimus,1991), the continuing increase in rates of (STIs) and HIV/AIDS infections has heightened the need to more thoroughly understand the context in which sexual decision-making occurs. While it is valuable to assess attitudes and behavior associated with sexual risk, it is necessary to move towards a more comprehensive understanding of complex issues that shape the sexual behavior (Bouton, 1993; Gagnon & Parker, 1994).

Statistics suggest that African Americans are disproportionately affected by HIV/AIDS. Though African Americans are only 13% of the Unites States population, they accounted for 49% of the estimated newly diagnosed HIV/AIDS cases in 2005 (CDC, 2005b). African American women accounted for 68% of reported HIV/AIDS diagnosed cases between 2001 and 2004 (CDC, 2005a). Of young people under 25 who were diagnosed during this period, 61% were African American (CDC, 2005a). Heterosexual transmission accounted for 78% of transmission cases among African American women between 2001 and 2004 (CDC, 2005a).

Although HIV/AIDS is transmittable through various forms of contact with an infected person's body fluids, the current research focuses on heterosexual behavior that can lead to disease transmission. The protective benefits of condom use and delayed sexual engagement have been highly promoted. Unfortunately, a considerable portion of the population still engages in sexual risk behavior. Given the role that heterosexual contact plays in the rate of HIV/AIDS transmission, the need to understand the context of heterosexual relationships is important. Understanding of the dynamics and drives

associated with male-female sexual interactions and relationships is one manner in which sexual-decision making processes can be further understood. There is a growing body of literature indicating that women misperceive their risk of transmitting STIs and HIV/AIDS including factors associated with trust and potentially inaccurate perceptions of their relationship (Crosby, DiClemente, Wingood, Sionean, Cobb & Harrington, 2000; Ellen, Vittinghoff, Bolan, Boyer & Padian, 1998; Kershaw, Eithier, Niccolai, Lewis & Ickovics, 2003; Kusseling, Shapiro, Greenberg & Wenger, 1996).

The goal of the current research is to understand the nature of African American females' relationship conceptualizations and the potential impact of these ideas on decisions made about sex. It is important to consider how women's expectations of self in the context of male interactions and expectations of male partners may contribute to sexual risk-taking behavior. The concern is that risk may increase due to sexual behavior practices associated with beliefs about what it means to be intimately involved with a man.

Efforts to understand females' ideas about sexual intimacy with men and sex may benefit from an understanding of proximal environmental factors, such as parental influences, that impact ideas and decisions about sexual engagement. Familial communication and closeness may serve as processes in which beliefs and values are transmitted to young women (Dazinger, 1995; Fox & Inazu, 1980; Jaccard, Dittus & Gordon, 2000; Jensen, Gaston & Weed, 1994; Miller, 2002; Rodgers, 1999). While there have been efforts to understand the impact of parent communication and closeness

on young women's sexual behavior, the impact of these processes of women's ideas of romantic or sexual interactions with men has not been assessed.

The current research intends to contribute to existing knowledge of individual and familial contributions to sexual decisions of African American women ages 18 to 25. The purpose is to understand women's partner-based expectations, familial factors that may influence these ideas and how these issues relate to sexual choices and the possibility of placing women at risk for HIV/AIDS. The next section provides a foundation for the literature review by providing operational definitions for keywords used in this research. The following section will provide a review of theories that have been associated with efforts to understand sexual behavior and will present the theoretical framework for the current study. Developmental Contextualism is discussed as the theoretical foundation for the research in an effort to understand the formation of ideas and behavior association with sexual health. The review of the literature will then provide empirical and theoretical evidence supporting the need to address sexual practices of individuals in general and African American females in particular as well as individual and familial factors that contribute to such practices. Subsequently presented are the hypotheses, a description of the study methodology, results and discussion of study findings.

Terminology

Recent efforts to understand the complex nature of sexual behavior and sexual risk have looked at the behavior and contexts associated with vaginal intercourse as well as non-coital forms of sexual engagement such as oral and anal sex, mutual

masturbation and fondling (Remez, 2000). For the purposes of the current research, sex is defined as vaginal intercourse that occurs in the context of a heterosexual relationship since this form of contact has a strong impact on the rate of HIV/AIDS transmission among women (CDC, 2007). *Sexual risk-taking behavior* is defined as those sexual behaviors that place individuals at risk for contracting a disease or becoming unintentionally pregnant (Taylor-Seehafer & Rew, 2000). The current research assesses sexual risk-taking behavior according to reports of *condom use* and delayed sexual initiation with partner. Condom use is defined as respondent's estimated use over the past 90 days. Delayed sexual initiation refers to the amount of time the individual is involved in what he or she anticipates to be a romantic relationship (or committed beyond being "just friends") before engaging in sexual intercourse with a man. An objective of this research is to assess whether sexual risk is associated with young women's perception of what it means to be in a romantic relationship. A *Romantic relationship* is defined as an interpersonal interaction between two individuals. This interaction includes a level of involvement and commitment that is greater than what may exist in a purely dating relationship. It is likely that there is sexual activity or the expectation of sexual involvement at some point in the future (Diamond, Savin-Williams & Dube, 1999). A premise of the current research is that ideas about intimate relationships are influenced by familial communication and familial closeness. *Familial communication* is defined as a verbal, bidirectional exchange between the respondent and a family member. *Familial closeness* is defined as the perceived

amount of support and connectedness experienced by the respondent and the identified family member.

Chapter 2

Theoretical Overview

Ranges of perspectives have been used to understand the sexual behavior process, particularly among adolescents. These perspectives include biological, behavioral and developmental theories. Given the complex nature of adolescent sexuality and processes of decision-making, it is necessary to note that none of the theories singularly account for sexual decisions. Yet, it is important to understand the theoretical contributions, the nature in which they are applied and their appropriateness when attempting to understand sexual behavior and relationship ideas maintained by young African American women.

One of the most basic biological traits associated with the initiation of sexual activity is pubertal development (Whitebeck, Yoder, Hoyt & Conger, 1999). Studies have found that puberty is accompanied by increased sexual interest and activity among male adolescents (Udry, 1988; Udry, Talbert & Morris, 1986) and that menarche is associated with earlier sexual behavior among inner city girls (Zabin, Smith, Hirsch and Hardy, 1986). Androgen hormone levels and timing of pubertal development are hereditary factors that have been associated with adolescent sexual behavior by potentially increasing sexual interest and sexual activity (Morris, 1992; Udry & Campbell, 1994). While the contribution of biological factors on sexual initiation is

relevant, some scholars have suggested that the impact of puberty on sexual behavior (e.g., age of sexual onset) is mediated by individual maturation processes, interactions with people and the larger societal context (Lerner, 1992). Although biological, genetic and maturational factors play a role, they are not of central interest in the current study. This study uses Developmental Contextualism to understand the context of African American young women's sexual choices. The following theoretical perspectives are shared to illustrate models that have been used and why Developmental Contextualism is deemed most appropriate for this study.

Behavioral theoretical perspectives of risk taking behavior include the Health Belief Model, the Theory of Reasoned Action, the Transtheoretical Model and the AIDS Risk Reduction Model. The Health Belief Model (HBM; Rosenstock, 1974) presents a framework for understanding why people do or do not engage in a variety of health actions and decision-making processes. There are four components of HBM. *Perceived susceptibility* measures the individual's subjective appraisal of risk for contracting the health condition. *Perceived severity* involves one's opinion of how serious the risk is. *Perceived benefits* assesses the extent to which the individual perceives that the recommended treatment or prevention strategy is effective or has some desirable amount of alternative benefit (e.g., whether condom use will prevent pregnancy, thereby increasing chances of other positive life outcomes). *Perceived barriers* include some degree of cost-benefit analysis wherein the individual weighs the action's effectiveness against potentially less favorable associated outcomes (Strecher & Rosenstock, 1997). There have been mixed findings regarding the utility of the HBM.

Stern & Zak-Place (2004) found no support for the HBM's utility in predicting the HIV and STI prevention behavior among a young adult, college student sample. Other scholars have found that the HBM significantly predicted many current behaviors and behavior changes for European Americans, but few for other ethnic groups (Steers, Elliot, Nemiro, Ditman & Oskamp, 1996). In another study, social support predicted current condom use and susceptibility predicted the number of opposite sex partners among African Americans. The HBM model did not predict any behavior change for African Americans (Steers et al., 1996).

The Theory of Reasoned Action (TRA) proposes that the best predictors that a person will engage in a particular behavior are their intentions. Intentions are shaped by attitudes towards the behavior and by normative standards (Azjen and Fishbein, 1977). The model incorporates some level of social influence by postulating that social norms can shape intentions. The more recent version of the theory, the Theory of Planned Behavior, includes behavioral control as a component (Ajzen, 1985). The TRA has been found to be applicable for majority White homosexual male samples (Cochran, Mays, Ciarletta, Caruso & Mallon, 1992). Elements of the TRA have been linked to African American adolescent sexual behavior, specifically perceived behavioral control (Townsend, Grange, Belgrave, Wilson, Fitzgerald & Owens, 2007). Cochran et al. (1992) found that positive behavioral beliefs about risk reduction predicted attitudes towards lower sexual risk, which were associated with intentions to engage in fewer sexual risk-taking behaviors. These intentions were positively associated with lower risk behaviors as indicated by condom use and less sexual exposure to situations where

HIV could be transmitted. Serovich and Green (1997) found some support for this model in that attitudes towards risk behavior (considered an indication of intentions) predicted condom use among White middle school, high school and college students. While theory components have been found useful in research and interventions with ethnically diverse samples (Koniak-Griffin, Lesser & Nyamathi 2003; Fingerson, 2006), this model was not used as an assessment of all the theory components is beyond the scope and intent of the current study.

The Transtheoretical Model proposes that individuals pass through five stages of change when modifying unhealthy behaviors or acquiring new healthier behaviors (Prochaska & DiClemente, 1984). Stage 1 includes *precontemplation* in which people does not intend to take action towards changing the behavior in the near future. The second stage is *contemplation* wherein there is an intention to change within the next six months. Stage 3 is *preparation* in which the individual intends to take some form of immediate action towards the healthier behavior. Stage 4 is *action* wherein the behavior change has occurred for less than 6 months and stage 5 is *maintenance* in which the behavior change has existed for over 6 months. This model has been applied to various problems including addictive behaviors (Plummer, Velicer, Redding, Prochaska, Rossi, Pallonen, Meier, 2001) and have more recently been assessed for their utility in predicting sexual risk behaviors. Grimely and Lee (1997) investigated condom use among a majority White sample of female adolescents. While findings identified that the majority of participants were furthest along on the continuum of change for the use of male condoms, the study did not report findings supporting the predictive power of

the model. In another study (sample ethnicity not provided), the Transtheoretical Model was useful understanding factors associated with condom use among an inner-city sample (Posner, Bull, Salyers & Ortiz, 2004).

The AIDS Risk Reduction Model (ARRM) proposes that the behavioral change process involves three unidirectional and nonreversible stages including labeling one's behavior as problematic, making the commitment to behavior change and taking action to accomplish that change (Catania, Kegeles & Coates, 1990). This model has been found useful in understanding factors that influence risk avoidance (asking about partner's history, using contraception, HIV testing) among an ethnically mixed group of incarcerated adolescents (Lanier & Gates, 1996). Gillis and colleagues (1998) evaluated sexual risk behavior among a sample of urban, homosexual males. They found that the stages of labeling and commitment were not well predicted by the ARRM Model. The enactment stage yielded more predictive accuracy as related to sexual risk. Findings suggest that the ARRM Model has potential usefulness in understanding and influencing behavior among individuals with secondary partners (individuals with whom the respondent is not involved in a committed relationship). However, the ARRM was less consistent when considering sexual choices made in the context of relationships with primary partners (Coates & Kegeles, 1994). Consequently, this model may be less applicable when trying to understand behavior patterns of women with both primary and secondary partners. Further, the nonreversible stages of the model may be too restrictive for understanding the complexities of HIV/AIDS prevention behaviors.

Each of the behavioral models discussed includes elements that are helpful in the development of prevention and intervention initiatives. Yet, they are not optimal for considering the sexual act within the normative developmental context in which the behaviors occur (Kershaw, Ethier, Niccolai, Lewis & Ickovics, 2003). The understanding of HIV/AIDS risk is limited by a focus on individual level predictors with little consideration for the impact of sociocultural forces on sexual behavior (Amaro, 1995). These theories also do not acknowledge "in the moment" factors that can affect decision-making. Such factors include physical desires as well as emotional investment that may influence a woman's understanding of what it means to be in a relationship, her role in the relationship, her partner-based expectations and her perceptions of how sex is integrated into her interactions with men.

Some scholars suggest that certain models may be less applicable to African Americans due to an emphasis on "an individualistic, direct and mainstream defined rationale for behavioral decisions" (Cochran and Mays, 1993). The link between intentions and behavior may be associated with less successful outcomes because some African Americans may perceive themselves as having less personal control over resources (e.g., money, steady employment, housing, education, mobility) (Cochran and Mays, 1993). Because they focus primarily on the individual, afore mentioned theories do not adequately address the spectrum of factors related to sexual risk behavior (Kusseling, Shapiro, Greenberg, & Wenger, 1996), particularly those associated with the ecological context including social messages and familial influences (e.g., structure, resources, monitoring, modeling, value transmission). In addition, these theories do not

address aspects of female development and relational orientations, as well as culturally specific factors that may contribute to sex-related behavioral outcomes.

A developmental perspective grounded in the ecological framework may provide a more comprehensive theoretical alternative for understanding the circumstances in which the ideas about sexual behavior evolve and are associated with sexual choices. The ecological perspective, as initially proposed by Bronfenbrenner (1977), suggests that different structures are nested together. These structures work to impact individual development throughout the life span. They include the microsystem (immediate environment setting), the mesosystem (interactions among forces in the immediate environment), the exosystem (larger community), and the macrosystem (overarching social framework). The ecological perspective has been used to understand adolescent sexual risk behavior through the development of four categories representing different aspects of adolescent ecology. These include individual characteristics, family factors, extrafamilial factors and microsystem influences such as cultural values (Perkins, Luster, Villarruel & Small, 1998; Small & Luster, 1994).

Kotchick, Shaffer, Forehand and Miller (2001) also utilize the ecological perspective to understand sexual behavior by focusing on the self (i.e., individual qualities, knowledge, and ideas) family, and extrafamilial systems (i.e., peers, neighborhood, and school). Utilizing the ecological perspective in this manner is done with the understanding that higher order macrosystem influences operate through these lower levels to affect behavior. Figure 1 illustrates this conceptualization. This model guides hypotheses tested in the current research with the exception of the exploration of

the extrafamiliar system, which is beyond the scope of this study. While the model was developed for adolescents, the framework can be also generalized to the young adult sample in the current research. First, research suggests that the young adult age range is an "emerging adulthood" period (Arnett, 2000) that is actually an extension of adolescents for youth growing up in the United States. Further, the current research investigates how family factors influence ideas that begin to develop during adolescence.

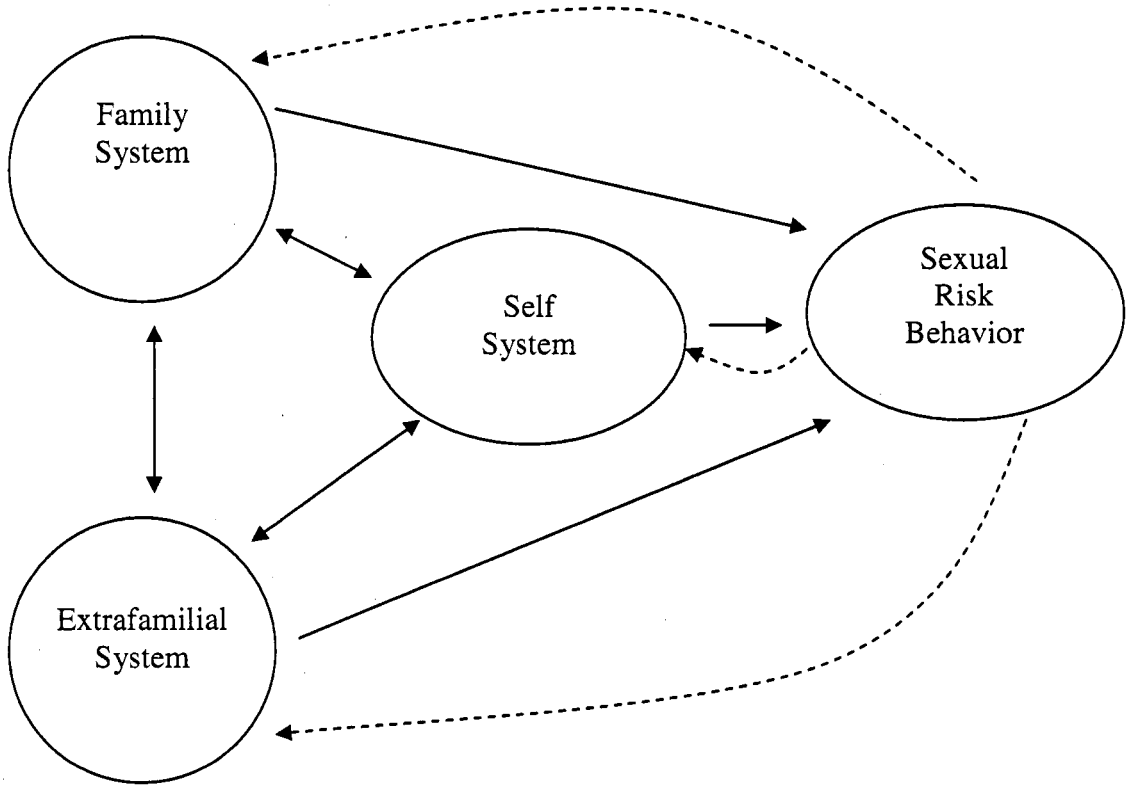


Figure 1. A Multisystemic Perspective on Adolescent Risk Behavior (Kotchick et al., 2001)

Developmental Contextualism is a specific ecological perspective that focuses on the interaction between continuously changing individuals and the ecological context in which they exist. Similar to the Transactional model (Sameroff & Fiese, 2000), the goal of Developmental Contextualism is to understand how variations in the ecological person-context relationship account for variations in an individual's life trajectory (Lerner & Simi, 2000). Developmental Contextualism asserts that experiences or individual characteristics that appear at certain points in one's development are probable in nature depending on the contextual variables that will influence the individual. More specifically, Developmental Contextualism focuses on the effect of continuous, reciprocal bidirectional interactions of individual characteristics and features of their environment.

The idea of continuous bidirectional interactions is helpful in understanding the sexual behaviors and decision-making patterns of young people. According to the Developmental Contextualism model, what it means to be in a relationship can be significantly impacted by the norms of the individual's environment, including their family and community. Sexual behavior may be better understood in terms of the proximal and distal factors that work to shape related ideas and decisions of the individuals engaged in the risk behavior. Proximal factors include opportunities to model adult behaviors, communication with peers and adults about relationships, interpersonal closeness to information sources, and the levels of adult monitoring or supervision that can impact adolescent engagement in sexual behavior. Distal factors include accepted community norms and community opportunity structure that impact

life-course options. It is for this reason that Developmental Contextualism is considered a more comprehensive and appropriate model to use in the effort to understand ideas and behaviors associated with sexual risk among adolescents (Lerner, 1985). The current research is now applying this theory to young African American women in urban environments.

In the current research, Developmental Contextualism is used to explain how family communication and closeness as experienced in adolescents affects African American women's partner-based expectations and ideas about relationships. Familial influences are one of the ecological factors that affect decisions about sexual behavior. This family impact is mediated by ideas that operate in the self-system. It is an extensive initiative to simultaneously measure the impact of all proximal and distal factors. As a result, the current research focuses on proximal factors associated with familial processes (communication and closeness) that affect relationship ideas and associated sexual outcomes. It is also important to point out that while the current research is grounded in the model of Developmental Contextualism, it does not propose to test bidirectional relationships. Instead, the development of ideas about relationships and related behaviors is viewed with a particular sensitivity to distal and proximal factors, outside of the identified familial process variables, that can influence their development.

Chapter 3

Review of Literature

Sexual Behavior and Risk among Adolescents and Emerging Adults

Although engaging in risky sexual behavior such as premarital intercourse is not a recent behavioral or social development, the breadth of engagement and severity of consequences has become a heightened concern in the past 20 years. Traditionally, research regarding adolescent sexual behavior has focused on vaginal intercourse largely due to concerns related to consequences of early pregnancy and childbearing (Remez, 2000). Recent initiatives are beginning to broaden the conceptualization of sexual behavior to include anal and oral sex, given that these behaviors are additional means of acquiring and contracting sexually transmitted diseases. Efforts to understand the sexual experiences of young people further expand the conceptualization of sexual engagement to include other forms of non-coital behavior such as mutual masturbation and intimate touching and fondling (Remez, 2000) which have been found to be precursors to vaginal intercourse (Arlington, 1990; Brooks, Balka, Abernathy & Hamburg, 1994). While the current study focuses on vaginal intercourse as reported among a sample of young African American women, it is important to note that sexual risk behavior that leads to disease transmission is usually precipitated by non-coital behavior that can eventually transition to sexual intercourse. An assessment of factors

that impact the sexual risk behaviors among young women aged 18-25 is valuable in identifying strategies to prevent these behaviors.

The current research focuses on sexual behaviors that are associated with heightened levels of negative consequences. Sexual risk-taking behaviors have traditionally referred to those sexual behaviors that increase an individual's likelihood of contracting HIV/AIDS, other sexually transmitted diseases or becoming pregnant (Taylor-Seehafer & Rew, 2000). These behaviors include having an early sexual debut, engaging in unprotected sexual activity, inconsistent use of contraceptives, sex with high-risk partners, and sex with multiple partners. This research specifically focuses on three issues related to sexual health. First, age of sexual onset is an outcome variable due to its association with the number of sexual partners that an individual will experience during her lifetime. Second, condom use (past 90 days) is of interest because of its direct impact on STD transmission. Third, the study investigates delayed sexual initiation given the potential for this behavior to (a) promote opportunities for sexual partners to investigate sexual histories, (b) potentially decrease the number of life-time sexual partners due to spending more time in each relationship or concluding the relationship before engaging in sex and (c) allow time to discuss and promote sexual health (i.e., condom use) in the context of the relationship.

At first glance, national level trends associated with sexual risk are encouraging. The Centers for Disease Control and Prevention (CDC, 2006) reports that across the nation, there has been a decrease in the prevalence of most sexual behaviors. Overall, there was a 13.8% decrease among Black students' reports of having ever been sexually

active (81.4% in 1991 to 67.6% in 2005) and a 7% decrease for White students (50.0% in 1991 to 43.0% in 2005). Among Hispanic students, there was a 2% decrease (53.1% in 1991 to 51.0% in 2005). Among African American female students, 61.2% report having ever had sex (CDC, 2006).

Reports of current sexual activity (in past 3 months) also decreased from 1991 to 2005. Among Black high school students, there was a decrease of approximately 11.7% (59.3% in 1991 to 47.6% in 2005). There was a decrease for reports of current sexual activity among White students (33.9% in 1991 to 32% in 2005) and Hispanic students (37.0% in 1991 to 35% in 2005). Among African American female students, 43.8% reported current sexual activity (CDC, 2006).

Reports of individuals having had equal to or greater than four sexual partners, also showed a decrease across all ethnic groups. Reports among Black high school students decreased by nearly 14.9% (43.1% in 1991 to 28.2% in 2005) and decreased by 3.5% among White students (14.7% in 1991 to 11.2% in 2001). There was a small decrease among Hispanic high school students (16.8% in 1991 to 15.9% in 2005). Eighteen percent of African American female students reported having greater than or equal to four partners in their lifetime.

Condom use during the last sexual experience significantly increased among all ethnic groups. Condom use increased by 20.9% among Black students (48.0% in 1991 to 68.9% in 2005), 16.1% among White students (46.5% 1991 to 62.6% in 2005) and 20.3% among Hispanic students (37.4% in 1991 to 57.7% in 2005) (CDC, 2006). Sixty-two percent of the African American female students reported using a condom at

last intercourse. Though African American youth demonstrated greater levels of risk, overall relative to other groups, condom use increased the most among African American youth.

It is important to note that there are no indicators of socioeconomic status for the sample (i.e., approximate school neighborhood incomes, family income estimates). This information is particularly valuable in identifying the extent to which poverty and low resources impact the sexual choices of adolescents as indicated by the Centers for Disease Control and Prevention (CDC, 2002).

Other research have expanded the understanding of sexual risk taking behaviors to include the frequency of the sexual experience (Billy, Brewster & Grady, 1994) and sex with older partners (Davies, DiClemente, Wingood, Harrington, Crosby & Sionean, 2003; Kaestle, 2002). A comprehensive understanding of sexual risk should also include the early initiation of non-coital behaviors such as mutual masturbation, oral sex and anal intercourse since such behaviors are likely to be "gateway" behaviors leading to other sexual experiences (Remez, 2000). While an exploration of all of these "gateway" behaviors is beyond the scope of this study, they are noted and worthy of future investigation.

Scholars have suggested that efforts to understand the sexual patterns of adolescents should focus on relationship features (Manning, Longmore & Giordano, 2000). A goal of this study is to identify ways that respondents' ideas about romantic or intimate relationships are associated with sexual behavior and sexual risk. While there is research related to adolescent sexual activity, literature addressing the relationship-

based context of such behavior is sparse, particularly relating to African Americans adolescents and young women. The literature that does exist lends support to the assertion that romantic or dating relationships serve as the context for many initial sexual encounters (DeLamater & MacCorquodale, 1979; Gaston, Jensen & Weed, 1995).

DeLamater and MacCorquodale (1979) conducted a study to understand the context and decision-making processes associated with the sexual behavior of collegiate (freshman through senior) and non-collegiate (aged 18-23) men and women in a Midwestern city (race not identified). Findings indicated that between 24.5%-26.5% of the women indicated that they were emotionally attached to their first sexual partners (not "in love") (men, 30.5%-31.5%). An additional 36.5%-47.5% of the women indicated that they were "in-love" with their first sexual partner (men, 26.4%-30.3%). Having held an expectation to marry their first sexual partner was reported by 16.7%-22.3% of the women and 5.2%-6.8% of the men. These findings suggest that women may maintain relationship conceptualizations that involve a slightly higher level of emotional attachment and partner-based expectations than men do. It is also noted that this study was published over 25 years ago and findings may differ today.

A more recent study investigated the relationship-based conceptualizations among adolescents. De-Gaston, Jensen and Weed (1995) found that among middle and high school parochial students who had experienced sexual intercourse (65.5% males, 58.5% females), 54.4% reported that they were involved in a "steady" relationship with their first sexual partner and another 13.7% reported that they were dating their first

partner. Although the majority of the sample was identified as White and Catholic, this study at least suggests that romantic relationships and related ideas may serve as a context for some sexual decision-making and that the association should be further investigated. Nonetheless, findings from these studies cannot necessarily be generalized to include African American women living in urban environments. Given the limitation of existing literature, the current work will investigate the association between romantic relationship ideas and sexual behavior practices among young African American women.

Consequences of Sexual Risk-taking Behavior

The two most evident and problematic consequences associated with sexual risk-taking behavior include pregnancy and the transmission of STIs. The negative implications for these consequences intensify when considering disadvantaged populations.

Rates of teenage childbearing have decreased in a relatively consistent manner over the past decade, though the statistical significance of this decrease is unknown (CDC, 2003). Among mothers between ages 15-19 years of age, rates of childbearing were 59.9/1,000 in 1990 compared to 42.9/1,000 in 2002. Among White adolescent mothers, rates were 50.8/1,000 in 1990 compared to 39.4/1,000 in 2002. Among Latino/Hispanic adolescent mothers, rates were 100.3/1,000 in 1990 compared to 82.9/1,000 in 2002. Rates of pregnancy also decreased among African American adolescent mothers, from 112.8/1,000 in 1990 to 66.2/1,000 in 2002. There is no evidence to suggest that differences in rates of childbearing relate to the rates of legal

abortions. In 1999, African American female abortion rates (52.9/1,000) were more than twice that of the national rate (25.6/1,000) and Hispanic women (26.1/1,000) and more than three times that of White women (17.7/1,000).

The trend data indicating the decrease in nonmarital childbearing are encouraging as they reflect a consistent decrease in rates across all ethnic groups. Yet, African American pregnancy rates are persistently twice as high as the national average and the average for White females. As statistics indicate, this high rate of pregnancy is matched by the high rate of abortions among African American women. These data reinforce the need to understand the factors that contribute to sexual risk-taking behaviors that maintain such rates.

Coley & Chase-Lansdale (1998) suggest that there are social and psychological implications for unplanned, nonmarital, teenage childbearing particularly among already disadvantaged girls. Such consequences are illustrated by young mothers' challenges of solidifying their identity, limited ability to develop autonomy from parents, little time to explore normative aspects of the teen experience, potential depression due to stress, and possibilities of restricted educational attainment (Coley & Chase-Lansdale, 1998; Hogan & Kitawaga, 1985). While adolescent childbearing may appear to be an individual problem, the associated difficulties have implications for society as well, particularly if there is a lack of paternal, parental and financial support.

Various theorists have presented perspectives that support or contrast the perspective suggesting that there are significant negative consequences for teenage childbearing among disadvantaged populations. Geronimus (1991) suggests that

although early childbearing may limit prospects for girls who already exist in disadvantaged states, there are certain benefits that make the endeavor appear to be a viable alternative life course. Geronimus suggests that for women in poverty, health deterioration may begin at an accelerated life course presenting as early as the mid-20s. Given this perspective, she feels that early childbearing may actually serve an adaptive function because of the potential for a higher number of healthy births to mothers who initiate childbearing earlier. The presumption is that babies who are born to teenage mothers will be infants while their young mothers are working or completing school. The assumption is that during this time the grandparents are still very able to care for the infants until they become toddlers. The children of these teenage mothers will presumably start school before their grandparents become physically or mentally unable to provide daily kinship care. According to Geronimus' proposition, the family would avoid financial strain of paying for childcare by maximizing grandparents as resources. Finally, there exists the claim that children born to teenage mothers of lower socioeconomic status can serve as a buffer against hardships such as hunger or homelessness due to their mothers' use of government assistance (Geronimus, 1991).

Yet, in the decade since Geronimus presented this perspective, there have been social and political changes that limit the validity of the proposition that teenage childbearing may be viewed as an adaptive life-course. Research suggests that kinship care is becoming less of a resource for young mothers. Brewster and Padavic (2002) found that between 1977 and 1994 kinship care was used significantly less across all groups of African American mothers, though the difference was less pronounced among

young, single mothers living in the South. Such changes may be related to the fact that more grandmothers are working, which makes them less available for all-day childcare (Brewster and Padavic, 2002). Further, the evolving migration patterns of African Americans may impact their ability to utilize kinship care opportunities if they are not surrounded by extended family (Brewster & Padavic, 2002).

Furstenburg (1991) presents additional concerns about Geronimus's propositions. Furstenberg asserts that there are no existing data suggesting that economically disadvantaged women believe that early childbearing will produce healthier babies, children in economically disadvantaged communities profit from multigenerational childcare, or that the increase in economic resources will outweigh the educational benefits of deferring early parenthood (Furstenberg, 1991). In fact, research suggests that a decline in government benefits may contribute to adolescents having an even lower incentive to engage in sexual activity.

Over the past twenty years, the impact of sexually transmitted diseases and life-threatening issues such as HIV/AIDS have also come to the forefront as consequences of risky sexual behavior among a wider range of African American young women. Efforts to prevent disease transmission are of particular interest since such an effort will simultaneously contribute to pregnancy prevention.

African Americans have the highest STI rates in the nation. African Americans are 24 times more likely to have gonorrhea and eight times more likely to have syphilis as compared to their White counterparts (CDC, 2002c). Because of this increased exposure and rate of STIs, African Americans are at heightened risk for contracting

HIV. This increased vulnerability is partially due to the physical changes caused by STIs, including genital lesions that can serve as an entry point for HIV (Fleming & Wasserheit, 1999).

Urban African American adolescents are at increased risk due to experiencing earlier sexual intercourse and the greater likelihood of residing in poorer neighborhoods with higher rates of infection (Paikoff, 1995). This is supported by reports indicating that the rate of infection for African American females is nearly 24 times the rate of infection for White females (CDC, 2005). Data suggests that risky heterosexual contact accounts for 74% of HIV/AIDS cases among African American women as compared to 48% among African American men (CDC, 2005). Knowing that heterosexual contact accounts for a large portion of STI and HIV transmission and given the percentage of HIV/AIDS cases that are among adolescents, it is necessary to understand the context of such sexual relationships.

The current study suggests that ideas about relationships, partner-based expectations and expectations of self are factors that impact decisions made about sexual engagement. Additionally, other factors have been associated with sexual risk behavior that can affect relationship conceptualizations. An individual's history of sexual abuse is one such issue. According to the CDC, approximately 7.7% of high school students report having engaged in nonconsensual sexual activities (CDC, 2002d). This is relevant given empirical findings that indicate that sexual abuse history is associated with increased reports of sexual risk-taking behaviors (Buzi, Tortolero, Roberts, Ross, Addy & Markham 2003; Langer, Tubman & Duncan, 1998). The

current study does not include sexual abuse history as a primary variable. Background information was obtained to identify (1) the percent of participants who report a history of sexual victimization and (2) the extent to which such background factors are associated with relationship conceptualizations and sexual risk.

Adolescent Involvement in Romantic Relationships: A Developmental Perspective

Research suggests that adolescent engagement in sexual behavior is likely to occur in the context of a romantic relationship (Katchadourian, 1990). While there is no single definition that to represent every individual's understanding of what it means to be in a romantic relationships, there are some distinguishing characteristics. First, romantic relationships are thought to have involved or currently involve dating activities (Miller & Benson, 1999). Second, while the cultural beliefs and defined norms of dating behaviors are constantly being redefined, they are most generally understood as involving a movement away from same-sex or opposite sex group activities to a "pairing off" of individuals who generally have some degree of affection for one another (Dunphy, 1963; Miller & Benson, 1999). Third, romantic relationships are interactions between two people, with a greater expectation of substantiated involvement by both partners than is the case with dating relationships (Diamond, Savin-Williams & Dube, 1999). Fourth, romantic relationships also often involve current sexual activity or the anticipation of sexual relations at some later stage in the relationship (Katchadourian, 1990). This suggests that to understand sexual decision-making patterns in young women, an understanding of how these individuals

conceptualize romantic relationships and how sexual engagement relates to such conceptualizations may be beneficial.

The developmental perspective suggests that the desire for romantic relationships is imbedded in the natural desire to maintain close relationships (MacDonald, 1992). Developmental Contextualism can be used as a foundation for understanding the development of romantic relationships by first learning how relationship ideas are shaped in early stages of life, then how they evolve into peer networks in middle childhood. Following this, there is an assessment of how ideas progress into involvement in romantic relationships and sexual experiences during the adolescent years and beyond. While using existing theories and research to understand the developmental perspective regarding how relationship ideas are shaped, it is important to note that this information should be considered with sensitivity to the fact that the information may not capture the experiences of adolescents from all ethnic and cultural groups.

Several theoretical perspectives exist that explain the evolution of romantic relationships during adolescents. The following discussion initiates with Sullivan's Interpersonal Theory (1953) of relationship development, then progresses to Dunphy's theory of adolescent group formation (1963) and then readdresses the role of attachment in the development of romantic relationships as detailed by Collins and Sroufe (1999). The goal is to obtain a more comprehensive appreciation of how ideas about romantic relationships are formed to understand how ideas about relationships may contribute to sexual decision-making.

Interpersonal Theory. Sullivan's Interpersonal Theory (1953) of development focuses on the mastery of tasks associated with interpersonal skills that influence development from one stage to another. Interpersonal relationships are said to develop by satisfying needs for closeness and then by resolving needs for emotional sharing and emotional support (Bakken & Romig, 1992). In Interpersonal Theory, theoretical implications for adolescent development are considered as they relate to the formation of relationships. The stages are identified as preadolescence, early adolescence and late adolescence.

Preadolescence begins with a change in the individual's social orientation where the individual demonstrates a newly developing need for intimate, one-to-one relationships. During this stage there is a shift from a larger, broader group of playmates to a more focused attention on a single playmate with more extensive sharing of thoughts, feelings and ideas between partners.

During early adolescence, the focus on intimacy with someone similar to self is now redirected towards an intimacy involving a member of the opposite sex among heterosexuals. During such a transitional phase, the individual may experience awkwardness that involves a greater sense of insecurity and unrealistic wishful thinking. This focus on the opposite sex may be more fantasy oriented, as the individual continues to allocate the majority of time to same-sex friends.

Late adolescence involves exploration within which the individual works to establish a pattern for satisfying sexual needs. The culmination of this stage is the emergence of the need for tenderness and steps towards the establishment of full,

personal relationships that often involve sexual intimacy (Sullivan, 1953). The ultimate goal of the process can be viewed as the integration of mature, interpersonal relationships into their lives.

Group Development Theory. Dunphy (1963) conducted field research to gain insight into the internal structural properties of adolescent peer groups in an urban area of Sidney, Australia. The research investigated group dynamic processes related to the roles of crowds, cliques and couples among adolescent peer groups. Outcomes suggest that the formation of heterosexual couples is the final of five stages that were identified to be part of the group development process in adolescents.

Stage 1 is generally composed of large adolescent groups, considered crowds. Crowds involve less purposeful organization than cliques involve. Crowds are generally maintained in early adolescence. They are primarily homogenous as it relates to sexual composition. Stage 2 involves movement towards heterosexuality in-group structure. Unisex cliques form and there is some degree of heterosexual interactions. According to Dunphy, such interaction is experimental and only occurs in the security of a group that includes same-sex supporters. Stage 3 involves an official integration of heterosexual cliques where certain group members (those thought to have a higher status) engage in one-on-one heterosexual interactions. It is in this stage that dating first occurs. Stage 4 involves the reorganization of unisex cliques into heterosexual cliques. Finally, Stage 5 involves the disintegration of the crowd, as it previously existed, with the formation of couples that are now dating or going steady (Dunphy,

1963). Dunphy, as with Sullivan, deliberately does not specify ages associated with the different stages.

Attachment Theory. When evaluating early life relationship formations, social scientists use Attachment Theory to understand how relationships are constructed in infancy. Bowlby (1969) and Ainsworth (1967) were among the first researchers to investigate the process of early attachment relationships between children and their mothers. These studies suggested that from an early age children develop secure or insecure (anxious) attachment patterns associated with the presence or absence of mothers. More recently, this research direction has expanded to suggest the existence of similar bonds between non-maternal caregivers, as well as peers (Field, 1996).

Regarding the development of close relationships in adolescence, Attachment theorists suggest that early relationship experiences have the potential to impact three significant markers in adolescents' experiences of romantic relationships – dating, involvements in perceived committed relationships and becoming sexually active (Collins & Sroufe, 1999). Dating becomes a significant part of the adolescent experience as young people transition from middle to late adolescence and their extensive involvement with large peer groups decreases. This provides the opportunity for securely attached individuals to become involved with smaller groups of friends and romantic partners (Brown, Eicher & Petrie, 1986). One research study indicated that, while adolescents with secure and insecure attachment histories were equally likely to be involved in dating activities at 16, those with secure attachment were more likely to have consistently dated someone for 3 months or more (Collins & Sroufe, 1999).

Involvement in a perceived committed relationship is the second significant marker in adolescents' romantic relationships that can lead to sexual intimacy. Romantic-committed relationships differ from other non-romantic relationships in that these committed relationships involve a relatively greater amount of intimate closeness than that involved in relationships with family and friends (Reis & Shaver, 1988). In parent-child relationships, there is a kinship and legal bond, as well as a traditionally asymmetrical dependency in which the child is more dependent on the caregiver than the caregiver is on the child. In contrast, adolescent committed relationships generally involve a symmetrical dependency in which individuals depend on one another in a reciprocal manner. This is also different from friendship relationships because commitment in romantic relationships generally involves higher amounts of dependency and expected reciprocity (Collins & Sroufe, 1999).

The onset of sexual activity is the third major phenomenon to consider (Collins & Sroufe, 1999). Research findings suggest that the initiation of sexual activity occurs, on average, at around 16 years of age and usually within the context of a steady relationship (Katchadourian, 1990). Adolescents may also experience sexual activity as part of a less committed dating relationship wherein the relationship may be primarily sexual and might involved lower levels of perceived commitment (Diamond, Savin-Williams, Dube, 1999).

While the Attachment Theory provides a life-experience reference that help to understand forces that drive relationship-oriented behaviors, Interpersonal Theory (Sullivan, 1963) and Group Development Theory (Dunphy, 1963) are centered on

stage-related developments and more immediate desires that drive interactions. The Attachment Theory, the Interpersonal Theory nor Group Development Theory presents a perspective regarding the development of romantic relationships that has been thoroughly tested on minority samples. Therefore, efforts to generalize theory assumptions based on these perspectives to sexual minority groups or non-Caucasian groups should be conducted with caution since most findings are relevant to heterosexual, White populations. The current work expands upon existing theories with an emphasis on the perceptions, experiences and ideas of African American women in an emerging adult stage of development as they engage in interactions with men that involve sexual intimacy. The following sections will evaluate empirical findings related to the progression of sexual experimentation and intercourse as it relates to African Americans as compared to other groups.

Sequencing of Sexual Experiences among African American Adolescents

As previously discussed, findings about sexual behavior trends indicate that adolescents as a whole are making healthier sexual choices. African American youth, however, continue to demonstrate a higher percentage of risk behavior when compared to their White counterparts and national averages in most domains (CDC, 2002). Given the differences in sexual experience trends among African American female adolescents, it is useful to assess sexual experience trajectories that lead to sexual intercourse among adolescents in general, and African American female adolescents in particular, to the extent that this information is available.

Recent literature suggests that few studies have specifically assessed the sequencing of sexual experiences that are thought to lead to sexual intercourse among adolescents. Understanding the progression of sex-related behaviors is beneficial given that such information can provide insight into which behaviors are associated with different stages of romantic relationships. In a longitudinal study, Thorton (1990) investigated the causal relationships of sexual behavior with dating, courtship and planning to get married among an all White sample. Findings indicated that participants who began dating earlier: (1) started steady relationships earlier (2) were more likely to have experienced intercourse and (3) had experienced sex with more than one partner and were more likely to have permissive attitudes related to premarital sex (Thorton, 1990). Consistent with Thorton's findings, Leigh, Weddle, and Loewen (1988) found that dating also affected sexual onset in African American youth.

Smith and Udry (1985) investigated the sexual experiences of Black and White adolescents and found that there were significant differences in the sexual trajectories of White and Black teenagers (average age 14.1 years). They found that White female adolescents were more likely to engage in a predictable series of sexual experiences before engaging in sexual intercourse. The behaviors proceeded from necking, then feeling breasts through clothes, feeling breast directly to feeling sex organs then intercourse. In comparison, Black adolescents engaged in a minimal amount of non-coital behaviors (necking and feeling breasts directly), before transitioning to intercourse as illustrated by their greater likelihood of moving directly from kissing to

sexual intercourse (Udry, 1988). These findings suggest that African American girls may have a shorter period of delayed sexual initiation.

Brook and colleagues (1994) conducted research, which resulted in findings notably different from Smith and Udry's research. The findings indicated that both African American and Latino adolescents progressed through a series of non-coital behaviors such as deep kissing and petting before progressing to sexual intercourse. Neither of the studies assessed gender differences, thus limiting the ability to confirm that the sequencing of sexual behaviors is the same among males and females.

Gender and Culturally Centered Perspectives

Behaviors of African American women are likely to be influenced by gender, as well as ethnic cultural factors that influence the formation of ideas and beliefs (Belgrave, 2002). Gilligan (1982) suggests that the females generally demonstrate a caring, relationship orientation whereas males are more likely to demonstrate a hierarchy orientation based on achievement and independence. Gilligan proposes that such different orientations may be related to the manner in which that males and females are socialized from birth. Females' maintenance of such relationship-based orientations at least partially explains gender differences in motivations for engaging in sexual intercourse. For example, research findings suggest that men are more likely to engage in sexual encounters for pleasure, fun and physical stimulation. In contrast, females' motives relate to love, commitment and desires for emotional closeness (Carrol, Volk & Hyde, 1985). This consideration has received minimal attention among African American samples (Belgrave et al., 2000).

These orientations may contribute to relationship-based expectations that are self-imposed by the women and that the women unconsciously impose on men with whom they interact. Several studies have suggested that women feel pressure from their partners to engage in intercourse (Wyatt, 1997; Carrol, Volk & Hyde, 1985; Guggino & Ponzetti, 1997). Women may allow themselves to submit to such pressures due to higher relationship commitment. One study found that college women were significantly more likely to report that their first sexual experience left them feeling less pleasure, satisfaction and excitement than male participants. These women also felt more sadness, guilt, nervousness, tension, embarrassment and fear (Guggino & Ponzetti, 1997). The possibility exists that the presence of such negative affective states after the sexual experience are related to the female's dissatisfaction with self as a result of submitting sexually or due to concern that the partner did not or will not meet the spoken or unspoken relationship-based expectations (i.e., unconditional security, mutual respect).

While literature suggests that gender may affect the decision-making process, culture also influences behaviors across several domains, including the sexual domain (Belgrave, Marin & Chambers, 2000) and relationships (Wyatt, 1997). Among people of African descent the development and maintenance of relationships has traditionally been of central importance (Azibo, 1996). This appreciation for a connectedness with others is evident in platonic interactions, as well as those interpersonal relationships that involve intimacy. While this orientation towards relationships can be generally adaptive when it serves to promote a sense of collectivism with the African American

community, it can have a positive and/or negative impact in the context of romantic, and potentially sexual, relationships. It has been argued that in the African American community there may be a perception that certain behaviors are associated with "belonging" or "non-belonging" to either ethnic or gender group (Cochran & Mays, 1993).

There are various cultural behavioral prescriptions that may further impact the sexual choices of African American women. Wyatt (1997) indicates that there are often externally imposed expectations which suggest that females' sexuality should be expressed in the context of romantic or intimate relationships. If such ideas are internalized by African American women and female adolescents, these expectations may affect decisions about when, why and how (i.e., use of condoms) to engage in sexual intercourse. In addition, a traditional gender-role suggests that the Black female's role in the relationship is to be the supporter and nurturer. Within these role scripts, it is undesirable for women to demonstrate assertive behaviors related to sexual issues, even to promote sexual health (Wyatt, 1997). Frequently African American women may make decisions that focus on pleasing their partner in order to maintain the status associated with being in a relationship (Wyatt, 1997). There may be a fear that by putting their own needs first, the chances of attracting and maintaining a romantic partner may be diminished (Wyatt, 1997). Such gender and culturally based perspectives need to be considered when examining proximal and distal factors that may influence the sexual behavior practices and related ideas of African American females.

Involvement in sexual behaviors at any age is a complex and multifaceted process. While it is an individual-level decision to engage in the sexual act, that decision is shaped by life experiences. This study examines whether sexual decision-making patterns are influenced by individual ideas about relationships. These ideas should be understood with sensitivity to family processing factors that shape them.

Self-system: Romantic Relationship Conceptualizations

The self-system includes a constellation of factors such as individual qualities, knowledge and skills that can influence behavior (Kotchick et al., 2001). The self-system can include variables associated with biological, psychological and behavioral domains. The current research focuses on one element of the self-system – conceptualization about intimate, heterosexual relationships.

Previous literature suggests that many sexual experiences occur in the context of what women may perceive to be monogamous, love-oriented relationships (Impett & Peplau, 2002; O'Sullivan & Allgeier, 1998; Whitebeck, Yoder, Hoyt & Conger, 1999). This suggests that many females may perceive the relationship as a safe place for sexual intimacy. Additionally, women may perceive sexual intimacy as a necessary part of a relationship. For this reason, the manner in which women conceptualize romantic relationships, their role in the relationship and their expectations of their partner should be investigated. Doing so may aid the understanding of how these ideas affects women's choices related to sexual engagement. While not all women may engage in sexual risk behavior because of expectations associated with romantic relationships, the existing literature suggests that sexual behaviors may be influenced by those who do.

Therefore, it is essential that scholars look at African American female conceptualization of relationships with their male partners to understand how these ideas are linked to sexual choices. An exploration of these ideas should occur with sensitivity to contextual factors that may influence relationship conceptualizations.

Adolescents and young adults use a variety of methods to classify relationships with a significant partner. Though there are existing theories that contribute to the understanding of how romantic relationships form, the assumption could be made that strategies for defining romantic relationships evolve over time and have different implications based on the norms for the social environment. In a qualitative study, Eyre, Hoffman, & Millstein (1998) explored how African American adolescents viewed romantic relationships. The mean age for the sample was 17 years of age and 45% of this sample reported having engaged in sexual intercourse. Findings were organized primarily according to behavioral expectations. Relationships generally involved an informal public acknowledgement that the individuals were committed to one another. Partners were expected to be accountable for one another's whereabouts, spend time together and have limited contact with members of the opposite sex. Reports indicate that, within this social climate, relationships often involve sex if both partners agree "the time is right" (Eyre et al., 1998). One might reasonably assume that these types of expectations may persist past the high school years as individuals enter their early twenties since the timing of adolescent transition to adulthood is not fixed. There is also a need to understand exactly how relationships are being defined, how definitions differ and how behaviors may vary across different types of romantic relationship ideas.

When considering the impact that relationship conceptualizations have on the sexual behaviors of women there are two areas of primary concern. First, it is advantageous to investigate the timing of sexual engagement. The time of the sexual engagement and decisions about delaying sexual engagement are relevant to concerns that women who are not active contributors to the decision-making process regarding when to engage in sexual intercourse may also not contribute to decisions about contraception (Bowleg, Lucas and Tschann, 2004). Second, since it is accepted that condom use is one of the most reliable strategies for preventing pregnancy, the transmission of STIs and the transmission of HIV/AIDS, women's reasons for not promoting condom use in their sexual relationships should be understood. The following discussion will begin with a review of literature related to the timing of sexual engagement by assessing the extent to which individuals consent to undesired sexual experiences and reasons for doing so. Literature addressing relationship conceptualizations related to condom use as a protective strategy against STIs and HIV/AIDS will then be reviewed.

Link between Relationship Elements and Sexual Choices

Evidence suggests that individuals consent to sexual intercourse before they are ready or at times that are less desirable, particularly when involved in a dating or romantic relationship (Bowleg, Lucas & Tschann, 2004; Critchlow, 1989; Impett & Peplau, 2002; O'Sullivan & Allgeier, 1998). Impett and Peplau (2002) found that women who were anxiously attached in the context of romantic relationships (as demonstrated by heightened concern about being accepted or rejected by others) were

more likely to consent to unwanted intercourse than those who where not anxiously attached. This finding was not supported when specifically looking at the African American females. In this group, avoidant women (who indicated less relationship-based comfort with closeness and intimacy) were more likely to consent to unwanted sexual intercourse.

In a study using a majority White sample of male and female college students Muehelenhard and Cook (1988) found that 97.5% of the women and 93.5% of the men had consented to unwanted sexual activity (not including intercourse). In addition, 46.3% of the women and 62.7% of the men had experienced unwanted sexual intercourse. In a study using a majority White sample of college students, O'Sullivan and Allgeier (1998) found that nearly twice as many women consented to unwanted sexual intercourse as compared to males (50% and 26%, respectively).

Research suggests that women, and men to a lesser extent, may engage in undesired sexual intercourse with a partner for various reasons including to satisfy their partner's needs. Shotland and Hunter (1995) found that 67% of the women consented to unwanted sexual intercourse because they did not want to disappoint their partner, 56% indicated that they did not want it to seem that they had been leading the partner on, 52% said that they continued because their partner was aroused. These responses suggest that a notable percentage of the women were concerned about disappointing or not satisfying their partner. O'Sullivan and Allgeier (1998) also found that 42% of the women reported engaging in unwanted sexual intercourse in the effort to satisfy their partners' needs and promote intimacy as compared to 38% of the men.

These quantitative findings are supported by qualitative research conducted by Bowleg, Lucas and Tschann (2004). In interviews with 14 African American women, Bowleg et al. (2004) investigated the sample's interpersonal relationships, sexual scripts and condom use with their primary male partner. Nine of the fourteen women indicated that their partners were more likely to initiate sex, decide the type of sexual engagement or control the frequency of sexual engagement. The latter point raises the possibility that women may consent to undesired sexual intercourse. In addition, even if these women desire sexual engagement, their needs are not the priority. This supports the idea that women are willing to sacrifice their own desires to satisfy their partner and sustain the relationship (Bowleg et al., 2004).

Additional research suggests that women may consent to undesired sexual intercourse or decide to not delay sexual engagement due to their perceived responsibility for relationship maintenance (Muehelenhard & Cook, 1988; Shotland & Hunter, 1995). Muehelenhard and Cook (1988) found that women were significantly more likely than males to engage in sexual activity (not including intercourse) due to concerns that their partner would terminate the relationship (56.6% and 43.4%, respectively). Shotland and Hunter (1995) found that twenty-one percent of college women specifically stated that they consented to unwanted sexual activity because they were concerned that their partner would stop going out with them.

As previously stated, the sexual decision-making processes of African American women are a particular concern because this group is disproportionately represented among women and adolescents living with HIV/AIDS. Though the empirical literature

that investigates ethnic differences in consent to unwanted sexual engagement is sparse, there is one study to suggest a notable difference. When assessing college women's consent to unwanted sex with dating partners, Impett and Peplau (2002) found substantial differences between reported experiences of consensual unwanted sex among African American women as compared to other ethnic groups. Among college students, approximately one-half to two-thirds of the White, Asian and Hispanic women reported having engaged in consensual unwanted sex at some point. In contrast, all of the African American women reported that they had done so (Impett & Peplau, 2002). This suggests that African American women may be more at risk for engaging in unwanted sexual intercourse. Beliefs related to the female's role in the relationship may influence sexual choices and place these women at risk for problematic consequences, such as STIs and unwanted pregnancies.

The second issue to address when considering sexual behavior in the context of a romantic relationship is condom use. Several elements have been identified as relating to ideas about relationships and associated contraception-related behaviors. Trust is a reoccurring theme when considering how adolescents conceptualize relationships and make decisions about condom use in the context of a relationship (Crowell & Emmers-Sommer, 2001; Jadack, Fresia, Rompalo, & Zenilman, 1997). Research has found that higher levels of perceived trust actually lower women's condom use, therefore placing them at increased risk for transmitting STIS. Pilkington, Kern and Indest (1994) found that participants who felt more positive about their

partner and relationship, as indicated by level of trust and positive feelings about their partner or relationship, were less concerned about AIDS or STIs.

In another study to identify the most frequent reasons African American women cite for not using a condom, one out of five women (20%) suggested that they did not pursue the issue of condom use because they did not want their partner to think that their relationship lacked trust (Jadack, Fresia, Rompalo, & Zenilman, 1997). While women may be hesitant to pursue the issue of condom use due to partner's concerns about trust, research suggest that by doing so women may actually place themselves at increased risk because they may "trust" too much. One proposed explanation for this trend is that as relationships continue to evolve and trust increases, women's level of concern related to partners' current or previous sexual behaviors decreased (Crowell & Emmers-Sommer, 2001).

Kershaw, Ethier, Niccolai, Lewis and Ickovics (2003) investigated misperceived risk as a factor contributing to sexual risk-taking behavior among African American and Hispanic adolescents between 14 and 19 years old at an STD clinic. Findings suggested that females who have sex with only one partner might not be at risk due to their own behavior, but due to their erroneous beliefs about their partner's behaviors. Fifty percent of these adolescents underestimated their risk for an STD. Females who engaged in unprotected sex assumed that there was a lower risk due to involvement in a long-term relationship (Kershaw, Ethier, Niccolai, Lewis & Ickovics, 2003). This supports the idea that women may equate long-term relationships with sexual intimacy, trust and safety.

Kusseling, Shapiro, Greenberg and Wenger (1996) also identified that low perceived risk was a factor strongly related to risk for an STD between an STD clinic sample (86% African American, 28% females) and a collegiate sample (67% White, 72% female). In an investigation of why safer sex (safer sex was defined as any sexual activity other than vaginal intercourse with a condom) was not practiced, 62% of the sample indicated a fair level of comfort that their partner did not have AIDS, 20% reported that a condom was unavailable, 19% said they did not want to. Women (20%) were significantly more likely to indicate reasons associated with partner influence (e.g., "too embarrassed to talk about it", "my partner didn't want to") than men. In general, low perceived risk was a major factor for non-condom use, although 62% of the sample actually knew little about their partner's sexual history. Findings support the proposal that trust is an issue affecting condom use. Risk may be perceived as low because young women in this sample maintained the expectation that their partners would have told them about problems associated with prior sexual behaviors that could place them at risk. In addition, findings indicate that females from urban communities were more likely to cite partner influence as a reason for not using condoms than the sample of college students. This suggests different conceptualizations about relationships and decision-making (Kusseling, Shapiro, Greenberg, & Wenger, 1996) that should be further investigated and understood when trying to influence the sexual activities of women in urban environments.

Perceived monogamy relates to trust and is another factor that contributes to misperceptions that place people at risk for contracting HIV/AIDS or a STD.

Individuals who believe that they are in a monogamous relationship or who have known the partner for a long time report little or no need for condom use (Crowell & Emmers-Sommer, 2000). The amount of time spent with partner may contribute to belief in the partner's monogamous behavior. Among a sample of African American adolescents, ages 14-18, the average amount of time spent with a boyfriend and length of the relationship were significantly related to unprotected vaginal intercourse among women with steady partners (Crosby et al., 2000). The notion of 'time spent' as a characteristic of one's relationship is consistent with Eyre et al. (1998) findings. Women may assume that time spent with a partner means that her partner is not sexually active with other women. These research findings suggest that trust is a significant factor that contributes to security within a relationship. The perceived security may cause a woman to expect or assume a level of fidelity that would essentially protect the women from risks associated with sexual intercourse with a particular partner. The current study hopes to expand upon this notion by clarifying specific behavioral and emotional expectations associated with trust as an element of romantic and intimate relationships, as well as which sexual behaviors are associated with such ideas.

While faith in one's relationship and trust in one's partner promotes one's sense of security within a relationship, there are data suggesting that people in relationships need to continue to protect themselves regardless of perceived trust issues. Research suggests that approximately 20% of men and women incorrectly believe that their partners are monogamous (Ellen, Vittinghoff, Bolan, Boyer, & Padian, 1998). Additional findings from this research indicate that 85.7% of women incorrectly

perceive that their male partners have never had sex with a man (Ellen et al., 1998). A recent study surveying HIV/AIDS positive men and women found that 40% of these individuals failed to inform their partner of their HIV status and over 30% reported not always using condoms. This is consistent with research suggesting that individuals may withhold information from their partner as a means of promoting trust with intent to increase the likelihood that their partner will consent to sexual intercourse (Cochran & Mays, 1990). The findings present a reality that must be addressed. The objective of the current research is to clarify the extent to which African American women maintain a romanticized view of a relationship and the extent to which ideas are associated with sexual risk. Second, the current research sought to understand how these ideas are shaped. Therefore, current research uses qualitative and quantitative methods to assess how familial variables of closeness and communication impact relationship ideas and subsequent sexual behavior.

Familial System Influences

Research indicates that family dynamics impact female adolescents' engagement in early transitioning to adult behaviors. Scholars have proposed that the family is the most "proximal and fundamental social system" affecting the development of adolescents and has a strong influence on adolescent sexual behavior (Perrino, Gonzalez-Soldevilla, Pantin & Szapocznik, 2000). In line with the Developmental Contextualism model, it is understood that the family strongly impacts decisions adolescents make because the family is the primary context for social, psychological and emotional development (Feldham & Elliot, 1990). While much research has been

conducted to understand familial contributions to adolescent sexual behavior, little is known about the influence of family factors once individuals reach adulthood (Jarmara, Belgrave, Bradford, Young & Honnold, 2007).

Traditional literature on family structure is limited in its consideration of how the African American extended family networks and how non-parental adult influences may support aspects of the family structures that often are viewed as risk factors. Given the alternative influences on many African American family systems, research should be used with caution when considering mainstream White family structure as the model of health in exploring African American families (Horton, Thomas & Herring, 1995). Efforts to understand African American family influences must more carefully assess family process factors that may exist among African American families.

Much of the traditional research literature attempting to understand contributors to sexual behavior among adolescents addresses race, parental education, socioeconomic status and parental constellation as the primary aspects of family structure that contribute to sexual risk behavior. Santelli, Lowry and Brener (2000) conducted a study to explore the relationships among socioeconomic status, family structure and sexual behavior. They found that parental education, family structure, and the family's race had the strongest impact on an adolescent female's virgin status. Adolescent females from single-parent families had the greatest chance of engaging in intercourse. Whitbeck, Simons & Kao (1994) suggest that lower amounts of parental supervision and parents' dating activities may be a factor moderating the relationship between parent's marital status and adolescent sexual behavior. Single parent

households are likely to have less monitoring compared to two-parent households and single parents are more likely to date. Regarding the influence of parental education, female adolescents whose parents had not completed high school were more than twice as likely to have had sex as those whose parents were college graduates. Condom use was lower among females whose parents had less education. Other studies have also found that single-parent household structure impacts sexual behavior attitudes of African American girls (Belgrave, Marin & Chambers, 2000). The above conclusions are a concern because of their association with parallel outcomes such as sexual intercourse (Reitman, St. Lawerence, Jefferson, & Alleyne, 1996).

While providing valuable data, these studies do not suggest that family structure is a more significant contributor to risk behavior than family process variables. In fact, Miller, Forehand and Kotchick (1999) found that family structure variables failed to predict adolescent sexual behavior, while family process variables did. Findings regarding the impact of family structure are relevant and should not be ignored, yet they often represent the impact of higher-order socio-political systems particularly when looking at minority family structure. The current research focuses on family process variables which can be targeted through interventions and which may be strengthened to offset the potential negative influence of certain structural variables.

The impact of family process variables or family structure variables on outcome behaviors of African Americans can better be understood from a historical perspective. Hill (1998) asserts that many of the strengths of the Black family traditionally have been ignored due to a consistent emphasis on the perceived structural weaknesses of the

nuclear Black family. Discussions of such weakness often are influenced by a characterization of many Black families as being "broken" versus "intact" (Hill, 1998). In contrast, Hill proposes a healthy model and definition suggesting that the Black family is a "Constellation of households related by blood or marriage or function that provides basic instrumental and expressive functions of the family members to those networks." He asserts that this definition of the Black family is equivalent to the extended family model.

Scannapieco & Jackson (1996) further explain some of the reasoning behind the complexity in understanding the Black family structure as presented by Hill (1998). As a result of the slave trade, relatives and non-relatives on slave plantations were automatically given the responsibility to support and care for other children. This contributed to the development of the intergenerational links among slave families. This intergenerational link was accompanied by a willing obligation and mutual support. This integrative system was a survival strategy maintained through the 1900s..For example, in some families and communities it has been customary to send frican-American children to live with family members in different areas, not as punishment, but as a means of staying connected to family and close friends even though families may be separated by physical distance or as a means of providing a safe developmental context. This enables African American youth to access safe developmental contexts and extended family support. Scannapieco & Jackson (1996) go on to emphasize that while nuclear families do exist in contemporary African American communities, they are often found within an extended family structure. This

extended family structure can also serve as a support resource for people lack adequate resources.

African American families maintain that extended family care that makes substantial contribution to the family's well-being. In fact, in one study, the majority of African American parents indicated that support from external caregivers and considerable male involvement is significant parenting strengths. It was noted that the male involvement did not necessarily come from the biological father, but from other family members or friends (Hurd, Moore, & Rogers, 1995).

Given a more comprehensive understanding of alternative African American family structural influences and constellations, a discussion of family processes can more appropriately occur. Literature focusing on family processes has addressed issues of closeness, communication, monitoring/supervision (see Miller, Benson & Galbraith, 2001) and conflict (McBride, Paikoff, & Holmbeck, 2003; Barber, 1994). The current research focuses on how perceived adult-child closeness and communication affect ideas about relationships and related sexual behaviors of African American college-aged women. Previously cited literature indicates that relationship ideas can impact decisions about sexual engagement. Therefore, by impacting ideas about relationships, family process variables may have an indirect influence on decisions related to sexual behavior. The premise is that respondents' perceived closeness to familial adults, communication with familial adults about sex-related issues and the content of the communication, impacts relationship ideas and decisions about sexual engagement. Previous research suggests that the quality of the parent-child interaction may be

important in conveying sexual standards to youth (Taris & Semin, 1997). This study extends that premise suggesting that youth may communicate with other familial adults and that the content of "sexual standards" needs further clarification. Supervision/monitoring will not be addressed given the more direct impact on the opportunity to have sex, versus the contribution to the decision-making process. Conflict will not be assessed in this study given negative associations between this construct and familial communication and closeness (Taris & Semin, 1997).

Closeness: Literature regarding the impact of parent-child closeness on sexual decision-making (including the age of onset and contraception use) has yielded mixed results. A portion of the literature suggests that familial closeness and warmth is associated with reductions in adolescent sexual risk behavior whether by the promotion of abstinence, increased use of contraception or decreased number of partners (Miller, 2002). Jensen, Gaston and Weed (1994) conducted research to assess how adolescent behaviors are related to adolescents' concerns about parental feelings. They found that young women's concern for their parents' feelings, which can be considered an indicator of closeness, was an issue that these adolescents considered when making sexual decisions (race not indicated). In a retrospective, qualitative study of family processes among African American families, Danziger (1995) attempted to identify the manner in which family processes impact African American female age of sexual onset. The research findings suggest that 73% of those females who reported close ties to at least one family member delayed sexual onset. Miller and colleagues (1997) found that

among White families, mother-daughter reports of closeness had a modest impact on sexual onset for girls, but not for boys.

Other research has suggested no association between adolescent sexual behavior and parental warmth. Closeness did not predict sexual risk at all or the prediction was only accurate among males. Luster and Small (1994) assessed parental closeness among a large sample of students in the Midwest (race not identified) using three items from the Parent-Adolescent Attachment Inventory (Armsden & Greenberg, 1987). They found that parental support was not a significant predictor of sexual risk-taking. In a longitudinal study in England, research findings indicated a non-significant association between positive parent-child relationships and delayed sexual onset among adolescents (Taris & Semin, 1997). Other findings actually indicated that parental efforts to maintain close relationships with the adolescents increased the likelihood of earlier sexual initiation. Somers and Paulson (2000) found that higher levels of closeness in combination with parental communication did not have a significant impact on adolescent sexuality in a majority White sample. Finally, Whitbeck, Yoder, Hoyt and Conger (1999) conducted research with a majority White sample of rural families. Findings did not suggest that parental support and warmth were predictors of early sexual initiation.

These efforts to assess the impact of parental closeness on adolescent sexual behavior are limited by three significant factors. First, none of the studies referenced clearly define closeness and the studies vary in the manner that closeness is measured. Secondly, samples for studies that suggest that closeness is not a significant contributor

to sexual behavior are restricted to majority White samples and, therefore, findings should not be automatically generalized to other racial/ethnic groups. When ethnicity/race was reported, it revealed a majority or all White samples. Finally, these studies appear to restrict familial influence to parental influences. In the current research, closeness is defined as the perceived amount of support and connectedness demonstrated between two people or among a group. The construct of closeness will focus on the relationship between the respondent and the self-identified adult. In addition, this study assesses the relationship between family closeness and sexual behavior as well as how partner-based expectations affect this association.

Communication. Parent-child communication is a construct related to parent-child closeness, but potentially unique in its contribution to risk behavior. In fact, research suggests that among African American families the quality of the parent-child relationship can be associated with parents' communication with their adolescents regarding sex issues. This relationship may be stronger for mother-daughter dyads and for older adolescents (Jaccard, Dittus & Gordon, 2000). Findings from a sample of Caucasian males suggest that closeness/support can interact with communication to impact sexual behaviors (Rodgers, 1999). This may relate to the fact that the quality of the parent-child interaction may be important in the parents' efforts to convey messages about sex (Taris & Semin, 1997), as well as the way in which the child will receive the information. Yet, it cannot be assumed that because families are close, they necessarily communicate about sexual topics. Parents and children can experience emotional closeness and communicate about a variety of issues unrelated to sex. Research

indicates a noteworthy difference between general adult-adolescent communication, which may occur because of closeness, and the communication that is specific to sexual issues (Jaccard, Dittus & Gordon, 2000). The current study assesses whether parents' communicate about sexual topics as well as the content of this communication. Although research has assessed the extent to which certain sex-related topics are discussed (Dutra, Miller & Forhand, 1999; Somers & Paulson, 2000), there is limited evidence providing information about what specific messages or values are communicated to young people about these topics. Information about what is communicated about sex-related issues is relevant since parents can provide subjective information that reflects family values such as whether or not to engage in premarital intercourse (Taris & Semin, 1997). Both the general quality of communication and the sex-related content of adult-child communication are assessed in the current research. The following discussion related to communication focuses on literature specific to adult-child communication about sex-related issues.

Parents can be a valuable source of information on sex-related issues through the provision of necessary information (such as how to use contraception and the process of procreation). Spanier (1977) found that mothers' communication about sex education issues was associated with less sexual activity among daughters. Research indicates that daughters who delayed sexual intercourse were more likely to have talked to their mothers about sex (Fox & Inazu, 1980; Pick & Palos, 1995). Among Hispanic families, Pick and Palos (1995) also found that mother-daughter communication about sex also increased chances of daughters' contraception use. Research suggests that when parents

are the main source of sex education, suggestive of the presence of communication in the home, children are more likely to abstain from sex (Jensen, De-Gaston and Weed, 1994). Mueller and Powers (1990) found that college students (race/ethnicity not indicated) who perceived that their parents had a more open communication style were more likely to report consistent contraception use. Among a sample of Hispanic and Black student, Miller, Forehand and Kotchick (1999) found that mother-adolescent sexual communication was associated with less frequent intercourse and fewer sexual partners. They found no differences across ethnic groups. The significance of parental communication with daughters is further supported by findings suggesting that maternal communication about birth control was associated with less sexual risk among White and Hispanic teenage girls, though not among boys (Luster & Small, 1994).

The above findings are in contrast to research suggesting the lack of a significant relationship between communication and adolescent sexual risk behavior. Miller, Norton, Fan and Christopherson (1998) conducted longitudinal research assessing the manner in which pubertal development, parental communication and sexual values related sex behavior outcomes ranging from abstinence to fondling to intercourse. They found no effect for the impact of communication on sexual behaviors, but did find that communication positively impacted reports of sexual values among rural, White adolescents (Miller et al., 1998). More recently, Somers and Paulson (2000) found that parent-child communication was related to increased sexual behaviors among their adolescent sample (race/ethnicity not specified). Further investigation suggested that this relationship varied by age. Younger adolescents

reported experiencing less communication and reported less sexual activity. The relationship between communication and sexual activity among older adolescents may be due to the fact that communication occurred after the adolescents started engaging in sexual acts (Somers & Paulson, 2000).

As with the family closeness construct, communication has not been consistently operationally defined in the family process literature. As a result, the current study defines communication as a verbal, bidirectional exchange between the adult-child respondent pertaining to a stated topic.

Discrepancies in the presented findings highlight the value of assessing parental as well as non-parental influences in children's lives as demonstrated through measures of closeness and communication. Moore (2003) sought to identify which types of factors yield different sexual behavior related outcomes among young girls living in similar lower resource conditions. She found that adolescent females who perceived high levels of social support from community adults were more likely to delay sexual onset and pregnancy. However, Moore did not define social support. Yet, it can be inferred that support involves a sense of closeness and opportunities to communicate. Moore's findings also suggest that biological parents are not the only source of information and other adult influences can play a significant role in sexual decision-making processes among African American female adolescents. In line with Moore's findings, the current study provides participants with an opportunity to respond to items according to their perceived level of closeness or communication with their mother, father or another familial adult. While it is important to know whether sex is being

discussed with adolescents and from whom messages are coming, it is also important to know to what degree certain topics are being communicated to the decision-making adolescents (Jaccard, Dittus & Gordon, 2000). Research suggests that the more parents talk about sex, the greater the impact their disapproval will have on sexual behavior (Jaccard & Dittus, 1991). Most research assumes that "disapproval" is the message being relayed and fails to investigate the content of the messages among adolescents. Moore, Peterson and Furstenberg (1986) investigated the impact of traditional versus non-traditional parental attitudes on the sexual onset of White adolescents. They found that adolescent females whose parents expressed traditional attitudes (not defined in the study) about marriage and family life were only half as likely to have had sex as compared to less conservative parents (9% compared to 20%). Miller (1999) assessed the impact of family communication about sex according to maternal reports among a sample of Black and Hispanic families. Findings suggest that as mother-adolescent communication increased and maternal attitudes about sexual behavior became more conservative the frequency of reported lifetime intercourse and the number of sexual partners decreased. Findings did not differ by gender or ethnicity. This indicates that the type of communication about sexual topics does impact outcomes. While it is valuable to know parents' perceptions of communication about certain topics, Miller's study does not report content of communication about certain sexual topics from the child's perspective.

Studies have identified that teenagers and their parents often disagree regarding the extent to which parent-child communication about sexual topics has occurred

(Newcomer & Udry, 1985) and that parents may overestimate the amount of conversation that has occurred about sex related topics (Jaccard, Dittus & Gordon, 2000). Jordan, Price and Fitzgerald (2000) found that almost all of the parents (94%) in their study believe that they had communicated with their adolescent about sex. Data indicates that parents report that they were most likely to have spoken with their children about responsibilities associated with being a young parent (46%), sexually transmitted diseases (40%), dating behavior (37%) and abstinence until marriage (36%). These estimates are limited by a failure to obtain child reports to confirm parent reports. Furthermore, specific messages and values associated with these topics were not assessed. The current research focuses on respondents' perceptions of closeness and communication from the perspective of the women who were sampled. The premise is that women's perception of whether communication about certain relationship-based and sex-based topics occurred and their understanding of what was communicated about such topics may influence subsequent decisions.

Literature related to family process variables and sexual behavior outcomes suggests that there is mixed support for how closeness and communication might be related to sexual outcomes among adolescents. The current study contributes to the understanding of how perceived adult-child closeness and communication may influence ideas about romantic relationships and related sexual behavior of young African American females. The premise is that by affecting ideas about relationships, these constructs have an indirect influence on decisions related to sexual behavior. Developmental literature's suggest that sexual onset usually occurs within the context

of perceived relationships, the current research sought to contribute to existing knowledge by (a) assessing how ideas about romantic relationships mediate the impact that familial variables have on sexual behavior outcomes and (b) provide insight to how such romantic relationship ideas evolve specific to African American, young adult females.

Chapter 4

Overview

There is a paucity of research to clarify ideas related to African American women's sexual behavior. There is also limited information about contextual factors that affect these ideas among young African American women who have a history of sexual risk. Existing research is only beginning to address African American females' expectations of themselves and their partner within the context of sexual relationships. A goal of this study was to further the understanding of how relationship ideas influences the sexual decision-making patterns of young adult African American women with specific consideration of familial influence on relationship conceptualization. The research sought to enhance understanding of the social environment's impact on young African American women's thought processes, with the understanding that these processes impact decisions about sexual behavior. In addition, the study contributes to existing knowledge of familial influences by providing operationalized definitions of constructs. Hypothesized variables related to relationship conceptualization (expectations of partner and of self) include the quality and content of familial communication and respondent perceived closeness to family. Hypothesized variables related to sexual behavior include relationship conceptualizations and the family process variables of closeness and communication. By understanding individual

and familial factors that have contributed to the sexual behaviors of young African American women, more effective prevention initiatives can be devised to support adolescent females in making healthy decisions about sexual behavior and more adaptively shaping their life-course.

Study 1 (Qualitative Analysis)

Question 1 (qualitative). How do young adult African American women conceptualize relationships as illustrated by their expectations of their partner and their expectations of themselves in the relationship?

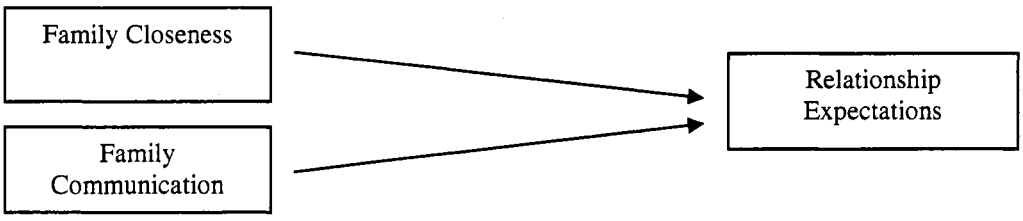
Question 2 (qualitative). What messages do women recall receiving from their family members about sexual opportunities, intercourse, consequences of sex, love, marriage and premarital sex?

Study 2 (Quantitative Analysis)

Question 1. Literature has yielded mixed findings regarding the impact that family communication and family closeness have on adolescent and young adult sexual behavior practices. Few of these studies have focused on the impact of these processes on African American females. In which ways do family process factors[1] impact the ways in which African American young women conceptualize relationships[2]?

Hypothesis 1. Family communication (quality and sex-specific content) will be a stronger predictor of relationship conceptualizations than reports of family warmth and closeness.

Model for Hypothesis 1



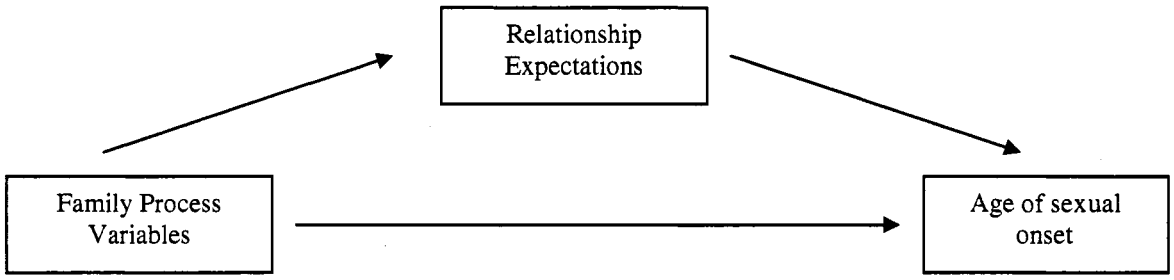
[1] Family process factors (including familial closeness, familial communication and familial sex-related communication were measured through women's reports of earlier relationships with a specific adult family member (over age 21) when respondents were first developing ideas about relationships and sex. This set of variables represents women's recall of childhood or adolescent experiences.

[2] In Phase 2, women's relationship conceptualizations are assessed through women's reports of expectations of their last sexual partner. These represent adult expectations.

Question 2. One central question in the proposed study is the extent to which African American females make decisions about sexual engagement as a result of certain ideas that they maintain about what it means to be in a relationship, their understanding of their role in a relationship and their relationship-based expectations of their partner. How do ideas about romantic relationships contribute to sexual behavior outcomes?

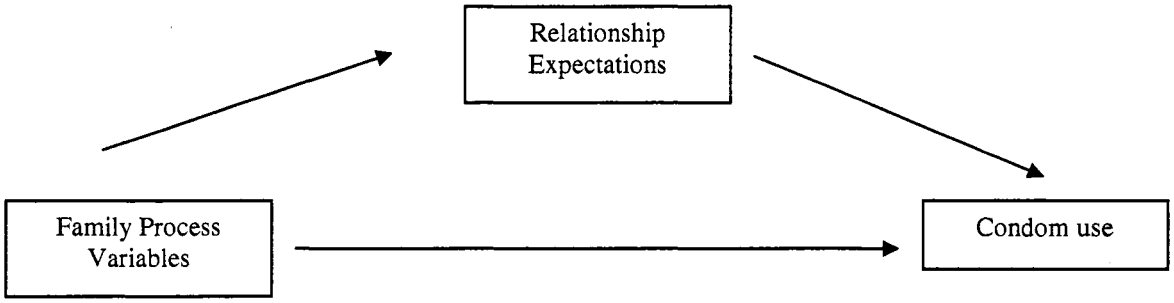
Hypothesis 2. Relationship conceptualizations will mediate the effect of family process variables (family closeness, general communication quality and communication sex-specific content) on the age of sexual onset.

Mediation Model for Hypothesis 2



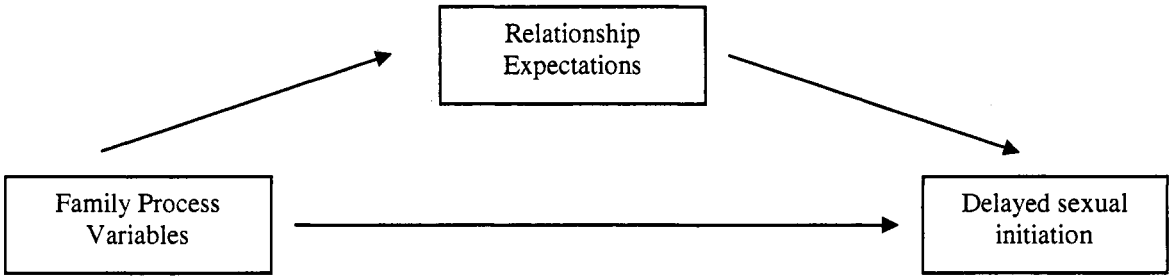
Hypothesis 3. Current adult relationship expectations (of last sexual partner) will mediate the effect of family process variables (family closeness, general communication quality and communication sex-specific content) on condom use.

Mediation Model for Hypothesis 3



Hypothesis 4. Current adult relationship expectations (of last sexual partner) will mediate the effect of family process variables (family closeness, general communication quality and communication sex-specific content) on delayed sexual initiation.

Mediation Model for Hypothesis 4



Mixed Methods Research Design Overview

The research community has limited and mixed empirical evidence about how African American women's ideas about interacting with men relates to decisions about sexual engagement. As a result, the current research utilized a sequentially organized mixed methods research design, which involved qualitative and quantitative data collection (Creswell, 2003). The objective was for with African American women to provide foundational information during the interviews about relationship conceptualizations that could be tested to identify potential contributions to sexual risk behavior.

In Phase 1, qualitative methods were utilized to facilitate an understanding of African American women's ideas and expectations regarding interactions with men. Literature addresses behaviors that contribute to increased HIV/AIDS risk among this population, but the context of such behaviors is not yet fully understood. Consequently, using qualitative methods allowed for an exploration and increased understanding of the

context of sex-related decision-making. In addition, this methodology clarified how African American women's ideas of interacting with men may be affected by familial influences.

Although the initial aim of this phase was to understand women's relationship conceptualization, this construct was found to be too broad for the scope of this study. Information pertinent to partner-based expectations, a component of relationship conceptualizations, was revealed in the interviews and served as the basis for the Relationship Expectation Measure (REM) that was developed for use in Phase 2 of the study. The REM listed various expectations that women have of male partners. Using qualitative methods as the basis for understanding women's expectations of men ultimately facilitated, through the development of the REM, the later exploration of a model tested through quantitative means. During Study 2, the REM was used to collect quantitative data to test a mediation model. The mediation model hypothesized that African American women's relationship expectations would mediate the influence of family process variables (familial communication and closeness) on sexual health outcomes (condom use and delayed sexual initiation).

Chapter 5

Study 1: Methodology

Participants

Twenty-five participants were recruited from a public health clinic treating sexually transmitted infections (STI) within a metropolitan area in the southeastern United States. Participants were heterosexual African American females. The mean age of participants was 22 years (range 18-28, SD = 3.27). The majority of the women indicated that there sexual relationships were usually committed or exclusive relationships (N = 16). Most women were high school graduates (N=23) and had received some higher education. The average age of sexual onset was 15 years old. Women reported having sex with 0-4 sexual partners over the past 3 months (m = 1.52) and 1-25 partners over their lifetime (m = 10)[1]. The modal number of lifetime sexual partners was six. Twenty-eight percent (28%) of the sample (7 women) indicated that they had experienced forced sexual intercourse in their lifetime. Of the 58 women who were approached for the interview, 25 women participated (43%), 17 women declined (29%) and 14 women (27%) were not eligible.

Women were recruited from a community-health clinic during hours dedicated to STI treatments and screenings. Clinic data indicated that typically approximately

64% of the clients at the clinic are male and 36% are female. Women between 18-25 years of age account for over 50% of the female clients. Approximately 90% of the clients at the STD clinic are African American. The clinic offers six free weekly STD screenings for adolescents and adults. The STD clinics are held on Monday, Wednesday and Friday mornings (clients arrive 7:30am) and afternoons (clients arrive at 12:30pm). All clients who receive services at the clinic must be 14 years or older and speak English to be eligible for services. A random review of 35 client charts suggested that the average clinic client was 19.6 years of age, over 50% have more than one child, 97% were single and 60% were unemployed. Chart reviews indicated that 68% of the clients had previously visited the clinic and 87% had at least one prior STD.

The STI clinic was an appropriate recruitment venue given that clients are seeking services (e.g., STI diagnosis or treatment) associated with some level of sexual risk. Utilizing this sample allowed for assessing the association between partner-based expectations among a sample of women who have a strong likelihood of recent involvement in some level of sexual risk.

Measures

Measures are discussed in the order that they were presented to participants.

Structured interview questions. The interview (See Appendix A) addressed the respondents' expectations of sexual partners and messages received from identified family members about sex and relationships. The interviewer was an African American female graduate student familiar with the topics of sexual behavior and factors that

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[3] One woman reported having over 100 sexual partners during her lifetime. This case was considered an

could influence decision-making. The measure initially focused on women's ideas about being in a romantic relationship with a partner. After 5-7 interviews, it became apparent that including the term "relationships" carried an implied meaning and may actually direct women towards a certain type of response. As a result, future interviews tried to focus on interactions with men in place of the term "relationships" when asking about interactions with sexual partners. The term "relationships" continued to be used in certain components of the protocol such as when asking women about their expectations of themselves while involved in a relationship. (See appendix A for a copy of the measure).

Sexual Communication Scale (SCS). The SCS (Somers & Canivez, 2003) was developed to measure the frequency of parent-adolescent communication about a variety of topics. Traditionally, respondents rate perception of the amount of communication that they had experienced with each available parent across 20 sexual topics (e.g.., dating, pregnancy, intercourse) on a five-point Likert system (from 1: Never, to 5: A lot of times). Cronbach Alpha coefficients yielded internal validity of .93 for mother's communication and .92 for father's communication (Somers & Canivez, 2003). The SCS was used as a checklist during the interview process to assess for the specific content of messages related to relationships and sex. Secondly, the protocol directions and language were changed to promote the participant's ability to respond to their communication with a particular adult family member. Participants were directed to provide retrospective accounts of their experiences and interaction with

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outlier and was not included in the mean calculation.

one specific adult, family member (over age 21) when responding to the interviews (See Appendix B).

Demographic Questionnaire. Respondents completed a demographic questionnaire after completing the interview. Items included information pertinent to the following areas: age, county of residence, neighborhood name, whether they have children, age at first childbirth, housing status (with family or independent), perceived neighborhood socioeconomic status, presence of family planning services in neighborhood and perceived household income. Four items pertaining to sexual behavior were included – (1) At what age did you have sex (vaginal) for the first time (CDC, 2003c) (2) How often did you and your partner use a condom over the past 90 days. (2) Approximately how long (weeks) were you intimately/romantically involved with your most recent sexual partner before engaging in sexual intercourse? Respondents' history of sexual abuse was also assessed. (Buzi, Tortolero, Roberts, Ross, Addy & Markham 2003; Langer, Tubman & Duncan, 1998; See Appendix C).

Procedures

Approval for this study was acquired from Virginia Commonwealth University's Institutional Review Board (IRB). Women were recruited from the waiting area of an STI clinic based at a local health department. A convenience sample of women were specifically recruited from an STI clinic since there was a strong likelihood that women had engaged in some form of sexual risk behavior that warranted testing for sexually transmitted diseases. The clinic also provides free services to city

residents, thus increasing the likelihood of targeting women with lower economic resources who are often not represented in research studies.

After the women completed standard clinic registration procedure, the researcher approached women who were waiting in the reception area. The researcher provided more information about the study and asked the women if they would be interested in participating. Women who were interested participated in a 3-minute screening (See Appendix J) to confirm that they met inclusion criteria. To participate in the study women had to identify as African American, be between 18-25 years of age and unmarried, identify as heterosexual, and have engaged in vaginal intercourse at some point in their lives. Approximately 57 women were approached to participate in the study. Of these women, 17 (29%) declined to be interviewed, most often citing time constraints as the cause. Twelve (21%) women were excluded due to age, two (3%) due to sexual orientation and another two (3%) women were excluded because they were currently married.

Women participated in the interview after their clinic visit was over. The interview began after the statement of informed consent was reviewed with participants (Appendix D). Participants were given a $20.00 gift card to a local grocery store as in incentive for their participation. The investigator then conducted the face-to-face, tape-recorded interviews. Interviews ranged in length from 40-60 minutes. After completing interviews, the women completed the background questionnaire.

Research Questions

Question 1. How do college-age African American women conceptualize relationships as illustrated by their expectations of their partner and their expectations of themselves in the relationship?

Question 2. What messages do women recall receiving from their family members about sexual opportunities, intercourse, consequences of sex, love, relationships, marriage and premarital sex?

Explanation of Analytic Approach

The qualitative component of the research utilized the Consensual Qualitative Research strategy (CQR; Hill, Thompson & Williams, 1997) which emphasizes the use of multiple researchers involved in a process of reaching a consensus about findings and examining the representative nature of results across cases (CQR; Hill, Thompson & Williams, 1997). CQR is most influenced by grounded theory (Strauss & Corbin, 1998) which allows for a constant comparative method of data analysis. Constant comparative method allows for making comparisons between the actual data and identified categories. Yet, there are notable differenced between grounded theory and CQR. First, while the grounded theory approach allows a research protocol to evolve or change based on issues that emerge from the data, CQR research utilizes the same protocol throughout the research project to try to ensure consistency of responses. Second, CQR requires a team of researchers to code and an objective researcher to audit whereas grounded theory allows for one coder who may be audited by another individual or team. Third, CQR codes data into domains, then extracts meaning whereas grounded theory first codes into themes (directly in the transcript) then

organizes meaning into core ideas. Fourth, CQR tabulates the number of cases represented in each domain rather than stating general findings

Data Analysis

Audiotaped interviews were transcribed verbatim, and all identifying information was removed. In accordance with the CQR procedure, several phases of data analysis were initiated to ensure the validity and reliability of the analytic process. Each phase involved systematically comparing coding for similarities and differences using the constant comparative method (Strauss & Corbin, 1990). The evaluation team included three researchers who conducted the analyses in a group format and one auditor. The three coders were African American women at different levels in their doctoral training (one working towards her master's degree, one working towards her doctorate and a post-doctoral fellow).

Coders met at least bi-weekly to come to a consensus regarding different domains and categories. Individual transcripts were reviewed weekly (3-5 transcripts per meeting). As researchers reviewed transcripts they independently looked for topics that emerged. Coders also reviewed transcripts for data that dealth with how the data addressed certain research questions including: (1) What do women expect from their partners in relationships? (2) What do they expect from themselves? (3) What have women learned from their family that may influence sexual decisions? (4) How do ideas about sex and relationships influence sexual "safety"?

After reviewing individual case data independently, domains were agreed on by coders at the initial meeting. The domains were selected specific to the initial research

questions. Within-case coding was initiated and involved re-reading transcripts to identify information specific to these domains. Researchers then convened to reach consensus regarding coding for each case. A consensus version (in the form of multiple tables containing the main text, an abstract of the text, the proposed associated domain and identifying information linking the text to the specific transcript) was created to reflect the coding. These tables were read by team members independently. At the next meeting, the research team then met to determine consensus regarding domain content and text summaries. An outside auditor then reviewed these within-case summaries. The auditor was familiar with qualitative research (has published using this methodology). She is a faculty member in the university's Sociology department where she continues to be involved in qualitative research. The auditor reviewed the data tables to assess whether each core idea appropriately represented specified categories and whether the category label appropriately captured the essence of the core ideas or text. The research team convened with the auditor to discuss feedback and develop a consensus regarding coding.

Similar methods were employed for across-case analysis efforts. Data from each case were merged, allowing for across-case analysis and a more detailed understanding of categories within domains. The primary research team reviewed these domains, then identified core categories and supporting cases. Team members completed independent review, discussion of these categories, and consensus determination. The auditor subsequently reviewed the analyses for consistency and to ensure that data were coded appropriately. She then shared this feedback with the

research team. The research team and auditor met to discuss differences in coding until 100% agreement was achieved. This process of independent review, consensus meetings and auditor review/feedback occurred consistently over a period of 8 months during which researchers met regularly to come to a consensus and discuss divergent perspectives.

According to CQR, saturation levels are explored by assessing how frequently categories apply to the whole sample. This allows for a discussion of the degree to which findings represent behaviors of people in the general population and for exploration of lesser-endorsed categories that may still have some relevance. Categories that apply to nearly the entire sample are considered *general.* Those applying to 50% to 80% of the sample are described as *typical.* Those applying to a quarter to one-half of the sample are considered *variant.*

Chapter 6

Study 1 Results

Interviews yielded information related to partner-based expectations or scripts, women's expectations of self, and content of familial communication. Women were also asked about their earlier expectations of partners. Pseudonyms are used to ensure confidentiality for women who were open to sharing their stories.

Question 1. How do young adult African American women conceptualize relationships as illustrated by their expectations of their partner and their expectations of themselves in the relationship?

Current Partner-Based Scripts

1. Trust/Honesty. The script of trust and honesty as a partner expectation was represented in 20 (80%) of the interviews at a general level of saturation. While some women were less specific in stating their expectation of trust and honesty, other women's statements were more explicit. Among the concerns about trust were that a partner should (a) share information about his background (e.g., criminal history, sexual history, whether he has children) (b) be honest about what is expected in the interaction with the respondent (e.g., primarily a sexual interaction or a more serious relationship) and (c) be honest about his involvement with other women. Comments from 'Alicia' represent how these categories are integrated into partner scripts. Her response

particularly addresses expectations of honesty about the partner's involvement with her and with other women.

> Just be honest… don't lie and say "I'm going with my friends out" and you at another girl's house. Don't lie and say, "I fell asleep last night" but you didn't call me back. You was on the phone with a girl or something like that... Just don't lie to me. I'm real open and real straight forward and I'll tell you straight up and I'll tell you, "This is what I want. This is what I want from you, are you willing to give me what I want?" And, you know, everybody has their expectations.

2. *Respect.* Women indicated their desire to be respected throughout their interviews. Only those responses that specified the expectation of respect were included in the analysis to assess for saturation. This expectation was directly expressed by 12 (48%) of the women, representing a typical level of saturation. 'Brenda's' comments exemplify women's desires to be respected, even if this expectation is not always met.

> I want you to respect me at the utmost. If your friends come around, don't say well... if I'm your girlfriend, say "this is my girlfriend" or you know and I want you to introduce me as your girlfriend not... don't try to use me... don't try to say well "this is Brenda" and I'm your girlfriend. Before they came you was all in my face you know what I'm saying and then I expect you know …

3. Stability in Behavior. Related to the issue of respect was the idea that male partners should demonstrate a consistency in behaviors shown towards women. This script was revealed in interviews with nine (36%) women and reached a variant degree of saturation. While some women acknowledged that aspects of interactions change over time (e.g., you feel more comfortable with people, you may get into a routine), women indicated a script reflecting that their partner (regardless of whether they were in an "official" relationship) should demonstrate the same quality of behaviors throughout the course of the relationship. 'Carmen's' comments reflect that stability in behavior is important when dealing with a man and how she has been emotionally impacted by changes in partners' behavior after sex becomes part of the relationship.

> O.K. Like the whole one night stand thing. I had a friend that I liked and we moved to the next level...we had sex, then like after that we didn't talk anymore and I was like, I didn't understand why. I was crushed because I was like, "If that was the case then I woulda never did it to begin with you." If that's all he wanted, he should have just let me know in the beginning.

4. Interest in Her Well-being. Several women expressed a need for men they interacted with to demonstrate concern for who they are as women. Within this typically saturated category, themes of the need for emotional support and wanting partners to show interest in her feelings or responsibilities (e.g., asking about her day or mood) were reflected in 14 (56%) interviews. These feelings are evident in 'Doreen's' comments below.

> You need to be there for me. I need to be there for you – no matter what the situation is. Whether it be emotionally, financially. No matter what it is, I need you to be there for me. If you are going to call me your girl then you need to be there for me. Not always sexual, but you need to be there. But, if you are just my friend, then I need to depend on you as my friend. If I am having a bad day, I need to call you up, you know, "You got time now..." It's not a big deal if you don't have time. But, if you my man and I call you up in the middle of the day, then you need to be able to listen to me.

5. Self-reliance. The importance of men being able to take care of themselves was demonstrated in the responses of 12 (48%) women at a typical degree of saturation. This category was reflected in women's expectation that male partners be able to support themselves financially, be employed, dependable, financially stable, or goal oriented. Each of these subcategories was present to a variant degree within the overall category of self-reliance. Education was only expressed as an expectation by one participant. 'Alexia's' statement illustrates how and why issues of self-reliance are so significant.

> They have to be taking care of their stuff, their business. You know... You know, they are paying their own bills. Have a job. That's basically it. As long as I see that they are self-sustained. They don't depend on others to do stuff for them.

6. Physical and Personality Characteristics. The final expectation category to reach saturation includes specific ideas about a man's level of attractiveness and humor. Other personality characteristics were mentioned by women, but humor was the only one to reach saturation at a variant level. Among the seven (28%) women who mentioned this desirable characteristic, humor was not prioritized independently, but was listed among qualities that women would like in their partner. 'Carmen's' comments reflect how humor is part of a list of qualities, as compared to other expectations that were expressed more explicitly. A desired characteristic in a partner: "[He should be] *Charming. Easy to talk to. Confident. Funny. Make me laugh. Make me happy. Stress free."* 'Hamila's' comments speak to the significance of physical characteristics in the context of other qualities when asked about important partner qualities: *"[He should be] a good dresser [laugh]... has to have a neat person... and educated."*

7. Behavioral Expectations. A final category that emerged was specific to the behaviors that women expected their partners to demonstrate. Each of these behaviors reached a variant level of saturation. Expectations included the desire for partners to communicate more (40%), demonstrate interest in or commitment to sharing family and family events with her (32%), contact her regularly by phone or in person (44%), facilitate "going out" activities (e.g., movies, being with friends) or participate in out-of-town outings together (44%).

Earlier Relationship Expectations

To obtain information about the consistency between women's current relationship expectations and recall of expectations from earlier in women's lives when they were first developing ideas about relationships and sex. Women were asked, *"Are these (expectations previously mentioned) the same types of ideas about relationships that you had when you first started being involved in romantic relationships?"* The saturation assessment was based on 16 cases wherein women recalled earlier expectations. Of responses obtained for this question only one reached saturation. At variant levels of saturation, four (25%) women reported that earlier expectations and ideas included having regular contact (on the phone or at school with their partners). Physical attractiveness, popularity and material things were also reported with each category endorsed by the women (not saturated).

Current Expectations of Self

Women expressed various expectations of themselves. Of the expectations reported, five categories saturated. Saturation levels were determined based on responses from 22 participants who responded to the question, "*What expectations do you have for yourself in relationships?"*

1. Emotional support. At typical levels of saturation, nine (41%) women reported that they expected themselves to demonstrate emotional support as manifested by acts such as caring for partners during hard times, reassuring partners, being tolerant and non-judgmental of partners. When asked what she expected of herself in relationships 'Samantha' replied,

> Just to be make and myself him realize that he can trust me. Just be there for him emotionally or just know that they have someone to talk to despite of if the relationship goes bad that he can always come talk to me and its still going to be fine. Let him know that I do care.

2. *Commitment.* At typical levels of saturation, nine (41%) women also expressed expectations of self that included elements of commitment as demonstrated by mutual dedication to one another, willingness to compromise, and accountability. 'Hope' expressed her feelings that relationship involve mutual dedication to one another, "*Like I said, 50/50, have respect for each other. You know...work things out together or sometimes you might work it out by yourself. I mean it should be equal in the relationship.*"

'Brenda's' comments reflected how she expects herself to compromise when involved with her partner and how her standards were affected by her partner's expectations of her.

> I would really ask that person "what do they expect of me"?...But if it's something I say, "I need to cook more," or "I need to wash dishes more," I would do that because that makes that person happier and it would make the relationship better... I would compromise...

3. *Honesty.* At variant levels of saturation, five (23%) of the 22 women

expressed that they should be honest, trustworthy and faithful towards their partners. Such sentiments are reflected in 'Halima's' comments: "*I have to be trustworthy, I have to be honest. I have to be all the things that I expect from a guy.*"

4. Domestic responsibilities. Five (23%) women, at variant levels of saturation, indicated that they expected to care for their partner and complete duties such as washing/ironing clothes, cooking, and washing dishes. Only one woman explicitly stated that she is committed to domestic responsibilities as long as her partner maintains his responsibilities such as contributing to the home income.

> I think everything some things should be 50/50; I don't think that if I can cook and clean you can just sleep and eat... I expect some help sometimes, you know. I'll wash dishes, and I'll iron your clothes, and I'll wash your clothes as long as you doing what you're supposed to do, paying bills...What a man's supposed to do.

5. Self-investment and independence. At typical levels of saturation, 11 (50%) women expressed the importance of knowing and understanding themselves. Two women specifically indicated the need to be financially stable and working, for their individual benefit or to be able to contribute financial security when in relationships with men. 'Olivia's' comments represent elements of sentiments from different women,

> I expect myself to be strong... I would expect myself to stay how I am. Strong and doing for myself and doing what I have to do as far as a woman. ...To take care of myself and, most of for all, to keep my head about water so everything

can be fine. I love to work, so I'll stay working. My mom always told me, independence is the most valuable key in a woman's life.

Women did not explicitly endorse that being sexually active in a relationship is a self-expectation. However, more than 50% of the sample indicated that they have consented to unwanted sex with partners in the past. For most of these women, the reasons for doing so related to desires to satisfy their partner, maintain relationship security (and associated benefits such as money) and pressure.

Question 2

What messages do women recall receiving from their family members about sexual opportunities, intercourse, consequences of sex, love, marriage and premarital sex?

Content of Familial Sex-related Communication

Women recalled receiving several types of messages from their family members about interactions with men, relationships and factors associated with sexual engagement. Interestingly, several categories that reached various levels of saturation included sub-themes reflecting the dynamic nature in which communication about certain topics can occur. Saturated categories that emerged from the data included messages about (1) types of behavior or qualities to expect form male partners (Expecting sex, proper treatment of women, self-sufficiency), (2) messages warning women to be careful and "aware" when in relationships with men, (3) issues around obtaining respect from men as well as self respect, and (4) prevention and consequences messages about having sex with men. This analysis included 24 cases because one

woman did not recall any examples of familial communication and reported that no one discussed sex-related topics with her.

1. Messages about expectations from male partners. Women were asked to share their recollection of what older familial members communicated to them about what to expect from men and in relationships. Major themes within this category included messages suggesting that men/boys definitely want to have sex with women. Family informants also wanted women to be aware that men should be self sufficient (as demonstrated by their ability to care for themselves and female partners).

At variant levels of saturation, six (25%) of the women interviewed recalled messages suggesting that men would desire and pursue sex. 'Alicia's' mother explained that men would desire sex, but that Alicia should be clear on how she wanted to handle it in the context of expecting other things from male partners.

> She [Mother] told me to expect guys to wanna have sex...It's up to you whether or not you want to make that decision." And she told me to expect guys to buy things for you... Expect guys to be there for you and be honest with you and never expect a guy to cheat on you.

'Olivia' recalls her aunt's messages of how men would desire and potentially misuse sexual experiences.

> She [aunt] said some guys are going to want you just for sex. I might fall in love with that person, but don't trust him just yet. You have to know him. She always stressed the issue that guys out here today is trying to see how many girls they can have sex with just so they can go and tell their friend.

Six women (25%), at variant levels of saturation, recalled messages linked to men being economically stable to sustain themselves and or to take care of women. These messages were reflected in communication that Fran experienced with the older women in her family,

> They be like, "you gotta see if... make sure he got a job so that if you don't' have a job, he can take you shopping and take you places and stuff like that. So he can be able to take you out and y'all can go places. Make sure he has a car you know. Just in case, if you want to go out...

There were also messages of how women should expect to be treated. This category nearly reached saturation and was extracted from interviews with five women (21%). 'Alexia's' sister spoke to her directly about sex and how women's desires and comfort level are also important.

> Older sisters would basically tell me, "If I liked it – o.k. If I didn't then they need to get on up." That was the gist of the conversation. And don't let him just be all abusing all over you sexually. If it is too rough, let him know to calm it down. Slow it down. If not he needs to get on up.

'Samantha' received different messages from her grandmother, who suggested that "treating you right" included what a man could do for a woman. Her aunt emphasized respect and equality in the relationship.

> My grandmother, "He suppose to pick you up. He suppose to do this. He suppose to give you money...My auntie ... she said it's 50/50...Once you get

older, you do have to have a 50/50 relationship. Just don't have him pressure you into sex. Don't have it unless you ready. It's ok for you to pick him up. It's ok for you to pay for things and vice versa. … As long as he respect you.

2. *Messages about what women should be in relationships.* At variant levels of saturation, eight (36%) women recalled various messages encouraging them to look out for themselves when interacting with men. 'Brenda' recalled messages from her mother that encouraged her to "not be a fool".

…she you know would tell me, just be yourself and be your own person ... I mean as far as with relationships, just don't (laugh) be aware of the person that you're with, what they're doing. Refuse to be a fool. Like, it's just so many things. But, the main thing was just be yourself.

There was a sense that men would try to take advantage of women either through direct messages such as experienced by 'Fran', "My grandma just always told me to be careful with guys. Like she just told me that guys don't have a conscience." 'Samantha' recalled that her brother and male cousin strongly influenced her through her observations of how they interacted with women.

My brothers, they see girls as toys or "she a family hoe" or they put her on speaker phone and talk to her any kind of way and just disrespect her. If you don't have respect for yourself they will not give you respect. That's what I learned from all of my brothers. You have to respect yourself for them to respect you.

3. Messages stressing respect for self and from others. With warnings of how men may disrespect women, eleven (46%) women (nearly typical) recalled messages that emphasized that women should have respect for themselves or demand respect from men they interact with. 'Irene' recalled details of how messages from her mother affected her early sexual behaviors.

> She [Mother] would always say..., you pretty much don't give it up to anybody that ... ...you're not interested in like... it's not like a one-night thing so pretty much you have to keep it sacred. And that played a big part in my relationship with my high-school sweet heart because we was together like two years before we did ...it was a blessing then because my mom, she prepared me for what to expect as far as sex goes and what to do.

'Alexia' recalled her brother's messages that respect should be demonstrated in what a man was willing to do for her. When asked, "What did your brother tell you?" she replied,

> They need to respect you. They need to do stuff for you...As in anything I ask, they need to do it. And it ain't no if, ands, or buts...he knew how he was and he didn't want us to find a guy that was like that. The way he was, he would tell us to find a guy opposite of that.

Related to the issue of respect, women further recalled messages suggesting that they have to right to choose what they wanted from men and that they should evaluate relationship options. 'Alicia' recalls observations and direct messages from her mother

that emphasized "don't ever – a day in your life, settle for less [than what you desire in a relationship]". Messages from 'Fran's' mother emphasized,

> My mom always, you got to weigh up the good and the bad when you first meet guys. She always told me that weigh out the good and the bad when you meet guys. Like if you talk to someone now and you meet one and his qualities are better than the other one then you...switch it up...

4. Prevention messages. When women were asked about what was communicated to them about sex. Categories that emerged were related to messages of prevention and consequences of sexual behavior. Prevention-related messages emerged from interviews with 14 (58%) women at typical levels of saturation. Themes within these categories centered on disease prevention/condom use (6 women at variant levels of saturation) and abstaining from or delaying sex (11 women at nearly typical levels of saturation). Messages that stressed disease prevention included statements such as this one from 'Olivia's' mother, *"To protect yourself and the next person, use a condom. But, it was mainly like. Use them to protect you"* and from 'Felicia's' sister, *"Always use a condom and always protect yourself. Don't let anybody use you. Don't make anybody do anything you didn't want to do"*. Six respondents recalled messages specific to using a condom. These messages were often limited to telling women to use condoms without any preparations such as how to use them, when to use them, where to get them that could increase the likelihood of condom use.

Secondly, there were messages suggesting abstaining or delaying sexual initiation for various reasons. 'Irene's' mother stressed the importance of her respecting her body and keeping her sexuality sacred.

> My mom, growing up, she would always say... I forget the exact words she said, like, you pretty much don't give it up to anybody that ... you know what I'm saying, you're not intimate... you, you're not interested in like... it's not like a one-night thing so pretty much you have to keep it sacred. And, that played a big part in my relationship with my high-school sweet heart because we were together like two years before we did anything.

'Alexia' indicated that her mother did not talk to her much about relationships specifically, but did stress the importance of not engaging in premarital sex.

> We talked about it [premarital sex], especially my Mama. It's always wrong. Under no circumstances is it ok to have sex outside of marriage. That was one thing she did talk to us about and drill into us. No boys should be touching you down there unless you married.

Additional sex-related messages addressed the consequences of having sex including getting a disease, responsibilities associated with pregnancy and social and emotional implications of sex. 'Elaine' recalled more negative messages from her aunt about what to expect from male partners.

> From my aunt, she want to give you the more negative on it cause if you gonna do it they have this they gonna this and you can get crabs... after they get it, and

> they ain't even gone acknowledge you anymore.... That's how she used to talk to me.

More women recalled messages about the difficulties associated with unplanned pregnancies. These messages focused on emphasizing that women should not come home with children 'Catherine's' mother provided advice based on her own experience of raising five children,

> My mom talked about that like a lot of times. She'll tell me it's a lot of responsibility, it's just not easy, cause she had 5 [children]. She said it's a lot, cause you gotta stop what you doing, put your life on hold, just because one baby's coming to this earth.

5. Consequence-specific messages. Finally, there were consequence-specific warnings addressing the negative emotional and social implications of having sex. At typical levels of saturation (46%) these messages did not include specific information about prevention of negative outcomes. Instead, they were warnings. ,'Claudia's' aunt emphasized that having sex with the wrong type of man may result in different social consequences in that they *"might run and tell what's going on, like if you have sex with them."*

Chapter 7

Study 2 Methodology

Participants

Participants were 154 single, heterosexual African American women at the clinic described in Study 1. This sample size was adequate to obtain a moderate effect size of .15 with a power of .80 ($n=L/f^2 + k + 1$) (Cohen, Cohen, West & Aiken, 2003). The mean age of participants was 22.36 years (range 18-30, SD = 3.22). In total, 290 were approached to participate in the study. Nine percent declined participation and 37% did not meet the inclusion criteria (28% outside of age range, 6% not heterosexual, 3% married). Though 158 women were recruited for the study, analyses included only 154 women because four packets were invalid (due to missing data or random responding).

Eighty-eight percent of the women were high school graduates (N=128) and 46% had completed some college or vocational training. Regarding their housing, 33.3% of women lived alone, 35% lived with their parents or other family members, 13% had a roommate, 15% lived with their boyfriends and 3% did not specify their living arrangements. For household income, 80% of the sample reported a household income of less than $25,000.

Consistent with Study 1, the average age of sexual onset was 15 years old. Forty-five percent of the sample (65 women) had children and 66% of these women had only one child. Another 21% of the sample had two children and 13% had 3 or more children. Women reported having sex with 0-7 sexual partners over the past 3 months (m = 1.49) and 1-47

partners over their lifetime (m = 10.79). Sixty five percent of the sample reported 0-1 partners in the past three months and 63% reported equal to or less than 10 lifetime partners. The modal number lifetime sexual partners were 5 and 6[4]. Twenty-six percent of the sample (39 women) indicated that they had experienced forced sexual intercourse in their lifetime. Fifty-four percent of the sample only engaged in vaginal sex during the past 6-12 months, 28.8% vaginal and oral, 2.4% vaginal and anal and 13.6% all three sex types. The mean for being involved with a partner before having sex was 29 weeks (approximately 7 months). Thirty-six percent of the sample reported using condoms always or almost always during the past 3 months, with 16% of the sample reporting condom use half of the time. See Table 1 for a summary of relevant demographic information.

[4] Multiple modal numbers existed.

Table 1

Demographics of Participants (N= 145)

Variable	Number	Percentage (%)
Age		
18-19 years	28	19.2
20-24 years	68	53.4
25-30 years	40	27.3
Highest Education Completed		
Some high school	18	12.8
Completed high school or GED	61	41.8
Some college	52	35.6
College graduate / Post College / Vocational	15	10.3
Housing Status		
Lived lone	48	33.3
Lived with parents/family	51	35.4
Lived with roommate	19	13.2
Lived with boyfriend	22	15.1
Did not specify	4	2.7
Household Income		
Under $10,000	44	32.4
$10,000 – 15,000	33	22.8
$15,000 – 25,000	21	24.3
$25,000 and over	28	20.5
Age of sexual onset		
13 or younger	26	17.8
14-15	58	39.8
16-17	45	30.8
18 or older	17	11.7

Table 1 (Continued)

Demographics of Participants (N= 145)

Had children	65	44.5
1 child	45	66.2
2 or more children	14	21.6
Number of sexual partners (lifetime)		
1-5	46	31.5
6-10	50	31.5
11-15	24	15.8
16 or more	31	21.4
Type of sexual experience in past 6-12 months		
Only vaginal sex	68	54
Vaginal and oral sex	36	28.8
Vaginal and anal sex	3	2.4
Vaginal, anal and oral sex	17	13.6
Number of sexual partner (past 3 months)		
0-1	95	65.1
2-3	46	31.5
4 or more	5	9.8
Condom use (past 3 months)		
Always to almost always (range from 1-3)	53	36.3
Half the time	24	16.4
Never (range from 5-7)	69	47.3
Experienced forced sex	39	26.9

Measures

Measures are presented in the order that they were given to the participants. Descriptive statistics and internal reliability estimates are presented in Table 2.

Table 2.

Descriptive Statistics for Predictor and Outcome Variables

Variable	*Mean*	*SD*	*Alpha*
NRI (N=142)	2.27	.82	.92
SCS (N=142)	2.89	1.03	.96
PPAI (N=142)	2.52	.762	.83
REM (N=144)	4.14	.68	.91

The Networks of Relationships Inventory (NRI). The NRI (Furman, 1985) was used to measure closeness. The NRI (See Appendix E) was developed to measure individuals' perceptions of their personal relationships (parents, stepparents, siblings, grandparents, peers) according to 10 relationship qualities (companionship, conflict, instrumental aide, antagonism, intimacy, nurturance, affection, and admiration, relative power and reliable alliance). Five subscales from the NRI were used to represent respondent closeness to the identified family member. The following five subscales were used in the current study to represent familial closeness: companionship (alpha = .78), intimacy (alpha = .89), nurturance (alpha = .69), affection (alpha = .88) and reliable alliance (alpha = .89). Cronbach alpha for the sum of all subscales with the current sample was .92. Participants were asked to respond according to their relationship with a single adult familial member to whom they felt close or with whom

they spent substantial time when they were forming their initial ideas about relationships and sex. Participants rate how much each of a particular relationship quality occurs in a relationship using a 5-point Likert scale (1: little or none, 5: the most) for all of the subscales except for the relative power subscale (1: they almost always do, 5: I almost always do).

Empirical studies suggest that the measure is appropriately valid. Satisfying relationships, as measured by the NRI, were related to adolescents' perceptions of global worth and positive emotionality (Furman, 1987). In satisfying relationships, female adolescents display more positive affect, share power more equally and are less jealous (Gavin & Furman, 1992.

The Parent-Peer Attachment Inventory (PPAI). The PPAI (Armsden & Greenberg, 1987) was used to measure general communication quality. The PPAI (See Appendix F) addresses the extent to which adolescents trust that the caregiver understands and respects her/his needs and desires, as well as adolescents' perceptions that the caregiver is sensitive and responsive to her/his emotional states. Subscales includes (1) 10 items addressing parental understanding and mutual trust (2) 10 items addressing the quality of verbal communication with parents and (3) and 8 items addressing feelings of alienation and isolation. Respondents indicated the extent to which they agree or disagree with each statement using a five-point Likert response system (1: Never true, 5: Almost or always true).

In the current study, the verbal communication subscale was used to assess the quality of general family communication based on retrospective accounts of their experiences. Participants were asked to respond according to the adult family member to whom they felt closest when growing up. Internal consistency was assessed using Cronbach Alpha and yielded a score of .82.

In earlier work with PPAI, internal consistency was established for the parent scales including trust (alpha = .91), communication (alpha = .91) and alienation (alpha - .87). Convergent validity was obtained through correlation analyses with other indices of family climate. The PPAI significantly correlated with the Tennessee Self-concept Scale subcategories (family self-concept r=.78 and social self-concept r= .46), as well as five of the six Family Environment Scale subcategories (Cohesion r= .56, Expressiveness r= .52, Conflict r= -.36, Independence r= .15, Organization r= .38, Control, r= -.20). Cronbach alpha coefficients indicate the internal consistency of subscales: Trust .91, Communication .91 and Alienation .86 (Armsden & Greenberg, 1987).

Sexual Communication Scale (SCS). The SCS (Somers & Canivez, 2003) was used to assess the content of familial communication specific to sex-related topics. The SCS (See Appendix G) measures the frequency of parent-adolescent communication about a variety of topics. Previously established psychometric properties are presented in Study 1. To obtain more detailed information, additional questions were linked to certain SCS items. For example, for the following question was linked to the topic of "Dating Relationships: What messages were communicated? Based on findings from Phase 1 of the study, questions that are more detailed were also added to the topics of dating, sexual intercourse, STIs, and AIDS. For example, respondents were asked to indicate how much the family member discussed sex. Related supplemental questions asked how much the family member discussed "risks that come with sex" and "avoiding sex." When asked about dating relationships, supplemental content items inquired about communication specific to "what a good relationship *looks like*" and "negative things to expect from interactions with men." (See appendix B for a copy of the measure). Internal validity was assessed using Cronbach Alpha and yielded a score of .96. A

factor analysis for the SCS was conducted to assess for underlying subscales with this study's sample. Only the one factor (specific to whether familial members discussed relationships or dating) included 3 items that did not have greater than a .32 loading on other factors. This data suggests that the SCS should be used as a one factor scale for this study.

Relationship Expectation Measure (*REM:* Grange, in development). The REM (See Appendix H) examined women's partner-based expectations. Items were developed based on results from the qualitative analysis of interviews from Study 1 with 25 African American women. Interviews yielded dimensions of partner-based expectations as described in Study 1. Interviews were conducted to gather detailed information to reflect options and ideas of the target population. This information was analyzed through a rigorous process of qualitative data analysis according to the Consensual Qualitative Research Method.

Behavioral expectations of partners and of women themselves were obtained from the women. Given the broad nature of relationship conceptualizations, only information specific to partner expectations was integrated into the original measure, Items gathered were presented to a group of five scholars familiar with HIV/AIDS sex-related risk behavior. After consultation with this group, 51 items were chosen for inclusion in the measure. Items were rated on a 5-point Likert Scale (1= strongly disagree to 5 = strongly agree). Participants indicated the degree to which certain behaviors were expected from their last sexual partner. While psychometric properties have been assessed and are presented in the results section, this measure is exploratory and further development is needed.

Demographic Questionnaire. Respondents completed a demographic questionnaire (See Appendix I) similar to the measure used in Phase 1. Sex-related outcome measures were included that addressed age of sexual onset, condom use over the past 90 days and an

estimation of how long women were in their last relationship before having sex. A final question addressing a history of sexual abuse stated: *Have you ever been forced to have sexual intercourse when you did not want to?* The response option was dichotomous (yes/no).

Procedures

A separate IRB approval was obtained for Study 2. Women were recruited from the same community-based health clinic used in Study 1. During the STI Clinic screening and treatment hours (8:30am-11:00am) women between the ages of 18 and 30 years of age were asked to volunteer for the research study. They were then given a brief summary of the project's goals, information about how the data would be used, and information about the incentive (a $10 gift card to a local grocery store). Women where individually screened (See Appendix J) for inclusion.

The researcher reviewed the information document (See Appendix K) describing the study with eligible participants. Women who indicated willingness to participate were given the opportunity to ask questions and the questionnaire was distributed. The participants had the option of completing the questionnaires in the clinic's waiting area or in a private room. Almost all participants chose to complete the measures in the reception area to ensure they would hear when the receptionist called their number to see the medical provider. No participant indicated a need for assistance while reading the document. Participants were asked not to discuss survey items with anyone (e.g., male or female companions) until the survey was returned to the researcher. After women turned in a completed survey packet, gift cards were individually distributed.

Chapter 8

Study 2 Results

Preliminary analyses

Upon completion of data entry, the data were reviewed to check for out of range variables. Twenty percent of the data was screened for random errors by the primary researcher and an objective researcher not involved with the project. Errors were corrected. Frequency distribution analyses were conducted to assess for normality among variables. Eight cases were deleted because they contained outliers. Skewed variables were transformed in the effort to meet normality assumptions. Descriptive analyses including means, standard deviation, range, and alpha levels for all predictors are presented in Table 2.

REM Scale Development.

Factor analysis was conducted to determine underlying factors for the Relationship Expectation Measure (REM). Principal axis analysis was conducted utilizing a varimax rotation since the goal of the factor analysis was to obtain underlying factors that are uncorrelated (Mertler & Vannatta, 2001). The analysis produced an eleven-component solution, which was evaluated according to the following criteria: eigenvalue (only retained values greater than 1), variance (retain factors that additively account for approximately 70% of total variance), scree plot and loading values. After evaluating outcomes according to criteria, a four-component solution was identified.

After rotation, the first factor accounted for 36.4% of the total variance for the REM. The second component accounted for 6.0%, the third component for 4.9%, the fourth component accounted for 3.9% and the fifth for 3.5% of the variance. Though 11 factors were necessary to account for 70% of the variance, factors 5 thru 11 were not retained because less than three items loaded on these factors or because they included items that cross loaded at .32 or higher with other factors (Tabachnick & Fidell, 2001). Variables were considered reliably associated with a factor if the loading was > .50 (absolute value) and did not exceed a .32 or higher loading with any other factors. After evaluating all criteria, four factors were identified for the REM. Final factors were named "emotional connectedness" (6 items), "intimacy perspective" (3 items), "trust" (6 items) and "economic stability" (3 items). Factor loadings and subscale means are presented in Table 3. Table 4 includes correlations among the REM subscales.

Table 3.

Subscale means, factor loadings and alpha coefficients for Relationship Expectation Measure (REM).

	Factor Loadings	Alpha Coefficients
Emotional Connectedness (m = 4.06)		.88
Talk to me about his feelings.	.634	
Provide emotional support for me when I needed it.	.742	
Talk to me about things in his life (e.g., family, work)	.685	
Talk to me about things he is dealing with (e.g., work, family, professional).	.685	
Look forward to being in a committed relationship with me.	.547	
Express his emotions.	.690	
Intimacy Perspective (m = 4.29)		.73
Act the same way towards me after we started having sex as he did before we were having sex.	.513	
Understand if I do not want to have sex.	.513	
Spend quality time with me in private.	.705	
Trustworthiness (m = 3.96)		.86
Be honest about who he was spending his time with.	.672	
Be honest about where he was going (e.g., When leaving the house).	.581	
Be faithful to me.	.652	
Only have sex with me.	.581	
Be trustworthy.	.517	
Be faithful to me even if we are not having sex.	.590	
Economic Self Sufficiency (m = 4.24)		.83
Be able to take care of himself (financially).	.834	
Make enough money to be able to take care of all of his responsibilities.	.737	
Show me that he can make money to take care of himself.	.620	

Table 4.

Correlations among REM Subscales and Total REM.

Variable	Emotional Connectedness	Interpersonal Sensitivity	Trust	Economic Self-sufficiency	REM Total
Emotional Connectedness (N=144)	-	..514**	.647**	.451**	.829**
Interpersonal Sensitivity (N=144)		-	.549**	.433**	.779**
Trust (N=144)			-	.342**	.815**
Economic Self-sufficiency (N=144)				-	.717**
REM Total (N=144)					-

Construct Validity: Construct validity was evaluated by assessing correlation coefficients from REM and two other measures. The Perceived Relationship Quality Components Inventory (PRQC; Fletcher, Simpson & Thomas, 2000) examined participants' feelings of trust and intimacy towards their most recent sexual partner. The PRQC (Appendix L) total score was significantly correlated with the REM total score (r=.550, p = .00). The Multidimensional Relationship Questionnaire (MDQ; Snell, 1998) assesses the degree to which respondents feel that they are responsible for their relationship (Interpersonal Relationship Control subscale) and respondent's motivation for being in intimate relationships (Relationship Motivation Subscale). The MDQ (Appendix M)total score was significantly correlated with the REM total score (r= .27, p = .001).

Testing of Hypotheses

Hierarchical multiple regression analyses were conducted to test Hypothesis 1.

Hypothesis 1. It was hypothesized that familial communication would be a stronger predictor of current adult relationship expectations than familial closeness. Three blocks of variables were entered to examine their unique contributions. Control variables (age, education, age of sexual onset) were entered on Step 1. To test for the predicted association, familial closeness (NRI) was entered on Step 2. Familial communication (PPAI-C and SCS entered in the sample block respectively) was entered on Step 3. Contrary to the hypothesis, results indicated that neither earlier familial closeness [$F (2, 135) = 3.99$, $p > .05$, $R^2 = .057$)] or communication [$F (2, 133) = .821$, $p > .05$, $R^2 = .068$] predicted current adult relationship expectations. See Table 5 for a summary of regression findings.

Table 5

Summary of Hierarchical Regression Analysis for the Family Closeness and Communication as predictors of Relationship Expectations (Hypothesis 1)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.029	.029	1.339			
Age				-.005	.019	-.024
Education				.118	.060	.175
Age of sexual onset				-.011	.027	-.034
2. Family Closeness	.057	.028	3.998			
NRI				-.140	.070	.168
3. Family Communication	.068	.012	.821			
PPAI-C				-.019	.105	-.021
SCS				-.075	.068	-.112

R^2 represents the squared multiple correlation.
$R^2\Delta$ represents a change in the squared multiple correlation with the addition of new variables to a model.
FΔ represents change in the F-test value. (*) indicates model significance
B represents the unstandardized regression coefficient.
SEB represents the standard error of Beta.
B represents the standardized regression coefficient.

Hypothesis 2[6]. Current adult relationship expectations were predicted to mediate the relation between family process variables and age of sexual onset. This hypothesis was not tested given findings from the qualitative interviews (Study 1) which produced responses that focused primarily on current as opposed to past relationship expectation. Conceptually, using current relationship expectations (REM) to predict past behavior (age of sexual onset as originally proposed) would have been inappropriate so these analyses were not conducted.

Additional series of regressions were conducted for the mediation models proposed in Hypothesis 3 and 4 (Barron & Kenny, 1986). Criteria for a valid mediation model include: (1) The independent variable must be significantly associated with the mediating variable (2) the mediating variable must be significantly associated with the dependent variable (3) the independent variable must be significantly associated with the dependent variable (4) the variance accounted for by the independent variable is significantly decreased after controlling for the mediator.

As recommended by Baron and Kenny (1989), bivariate correlation analyses were conducted to assess the relationship between predictor and outcome variables before the hierarchical regression hypotheses are tested (see Table 6). Predictors were assessed for multicollinearity by assessing the strength of correlations and the tolerance index. Multicollinearity was not present among predictors.

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[6] To capture relationship expectations women were asked to indicate expectations of their last sexual partner (representing most recent expectations). For family process variables women were asked to provide a retrospective account of a relationship with a familial adult member.

Table 6.

Correlations among predictors, outcomes and demographics.

Variable	NRI	SCS	PPAI-C	REM	Partners past 3 months	Condom use past 3 months	Delayed sex – last partner	Age	Education	Income
NRI (N=142)	-	.385**	.625**	-.178*	-.032	-.076	-.063	-.004	-.081	-.071
SCS (N=142)		-	.520**	-.173*	-.097	-.040	-.096	.190*	-.034	.021
PPAI-C (N=142)			-	-.157	-.092	-.088	-.124	.063	-.067	-.041
REM (N=144)				-	-.086	-.023	.047	.022	.164*	.120
Partners past 3 months					-	-.089*	-.066	-.054	.073	.008
Condom use past 3 months						-	.001	.122	.006	.206*
Delayed sex – last partner							-	.038	-.075	.056
Age								-	.277**	.090
Education									-	.123

Hypothesis 3. Relationship expectations (REM) were predicted to mediate the effect of family process variables of familial closeness (NRI) and familial communication (SCS and PPAI-C) on condom use over the past 3 months. A series of three regression analyses were conducted to test for mediation. For the first step of the mediation model, the independent variables (family process variables including NRI, PPAI-C and SCS) needed to significantly predict the mediating variable (REM). Results indicated that family process variables did not significantly predict women's relationship expectations [$F(3,133) = 1.877$, $p > .05$, $R^2 = .068$]. The second step was for the mediating variable (REM) to significantly predict the dependent variable (condom use). REM did not significantly predict condom use [$F(1, 139) = .067$, $p > .05$, $R^2 = .017$]. The final step was for the independent variable (family process variables including NRI, PPAI-C and SCS) to significantly predict condom use. Family process variables did not significantly predict condom use over the past 3 months [$F(3,135) = .493$, $p > .05$, $R^2 = .027$]. These data indicate that contrary to the hypothesis, REM could not mediate the relationship between family process factors and condom use for this sample. Given that initial mediation criteria were not met, the full mediation model was not tested. See Tables 7-9 for a summary of these regression findings.

Table 7

Summary of Hierarchical Regression Analysis for the Mediation of Family Process Variables (PPAI-C, SCS and NRI) on Relationship Expectations (REM) (Hypothesis 3a)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.029	.029	1.339			
Age				-.005	.019	-.024
Education				.118	.060	.175
Age of sexual onset				-.011	.027	-.034
2. Family Process Variables	.068	.039	1.877			
NRI				-.093	.090	-.112
PPAI-C				-.019	.105	-.021
SCS				-.075	.068	-.112

Table 8.

Summary of Hierarchical Regression Analysis for the Mediation of Relationship Expectations (REM) on Condom Use (Hypothesis 3b)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.010	.010	.436			
Age				1.110	1.564	.063
Education				-5.186	4.971	-.094
Age of sexual onset				.339	2.217	.016
2. Relationship Expectations (REM)	.017	.000	..067	-.076	.293	-.022

Table 9.

Summary of Hierarchical Regression Analysis for the Mediation of Family Process Variables (PPAI-C, SCS and NRI) on Condom Use (Hypothesis 3c)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.016	.016	.760			
Age				-.096	.064	-.131
Education				-.064	.205	-.027
Age of sexual onset				-.025	.091	-.023
2. Family Process Variables	.027	.011	.493			
NRI				-.075	.315	-.026
PPAI-C				-.234	.366	-.076
SCS				-.039	.236	-.017

Hypothesis 4. Relationship expectations (REM) were predicted to mediate the effect of family process variables of familial closeness (NRI) and familial communication (SCS and PPAI-C) on delayed sexual initiation with the respondent's last sexual partner. As with Hypothesis 3, a series of three regressions were conducted to test for mediation. For the first step of the mediation model, the independent variables (family process variables including NRI, PPAI-C and SCS) needed to significantly predict the mediating variable (REM). Results indicated that family process variables did not significantly contribute to women's relationship expectations [$F(3,133) = 1.877$, $p > .05$, $R^2 = .068$]. The second step was for the mediating variable (REM) to predict the dependent variable (delayed sexual initiation). REM did not significantly predict delayed sexual initiation [$F(1, 134) = .518$, $p > .05$, $R^2 = .013$]. The final step was for the independent variable (family process variables including NRI, PPAI-C and SCS) to significantly predict condom use. Family process variables did not significantly predict delayed sexual initiation [$F(3,130) = .962$, $p > .05$, $R^2 = .031$]. Contrary to the hypothesis, REM could not mediate the relationship between family process factors and delayed sexual initiation for this sample. Since the initial mediation criterion was not met, the full mediation model was not tested. See Tables 10-12 for a summary of these regression findings.

Table 10.

Summary of Hierarchical Regression Analysis for the Mediation of Family Process Variables (PPAI-C, SCS and NRI) on Relationship Expectations (REM) (Hypothesis 4a)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.029	.029	1.339			
Age				-.005	.019	-.024
Education				.118	.060	.175
Age of sexual onset				-.011	.027	-.034
2. Family Process Variables	.068	.026	1.877			
NRI				-.093	.090	-.112
PPAI-C				-.019	.105	-.021
SCS				-.075	.068	-.112

Table 11.

Summary of Hierarchical Regression Analysis for the Mediation of Relationship Expectations (REM) on Delayed Sexual Initiation (Hypothesis 4b)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.016	.016	.771			
Age				-.096	.064	-.131
Education				-.064	.203	-.027
Age of sexual onset				-.025	.091	-.023
2. Relationship Expectations (REM)	.017	.000	.067	-.076	.293	-.022

Table 12

Summary of Hierarchical Regression Analysis for the Mediation of Family Process Variables (PPAI-C, SCS and NRI) on Delayed Sexual Initiation (Hypothesis 4c)

Step and Variable	R^2	$R^2\Delta$	F Δ	B	SEB	β
1. Controls	.010	.010	.429			
Age				1.110	1.564	.063
Education				-5.186	4.971	-.094
Age of sexual onset				.339	2.217	.016
2. Family Process Variables	.031	.022	.962			
NRI				2.113	7.597	.278
PPAI-C				-8.869	8.833	-1.004
SCS				-3.652	5.694	-6.41

Subsequent analyses were conducted to clarify associations between REM subscales and target variables, as well as to test for suppression effects. None of the four REM subscales were significantly associated with sexual risk outcome variables. In the suppression analyses, the goal was to assess whether the effects of other independent variables masked the effects of other predictor or independent variables. Analyses tested for suppression effects, wherein the association between the predictor variable and outcome variables is assessed independent of the influence of other predictor variables. To do so, different regression analyses were conducted (Tabachnick & Fidell, 2001). In each analysis, the independent variable that would have acted as the suppressor variable was isolated in a separate block while other independent variables were entered in one block. Results reflected none of the analyses contributed unique independent variance to the models.

Chapter 9

Discussion

The current study investigated the association between African American women's relationship ideas, family process variables (including communication and closeness) and sexual risk behavior. The study involved two phases. Phase 1 was a qualitative study, which led to the development of the Relationship Expectation Measure (REM). Using quantitative methods in Phase 2, it was predicted that the REM would mediate the effect of family process variables on sexual outcomes. Current research used both methodologies to better elucidate contextual factors that may affect African American women's sexual choices. Developmental Contextualism (Lerner & Simi, 2000) was the theoretical framework used to understand the complexity of sexual decision-making. Previous literature suggested that certain ideas about relationships (Bowleg et al., 2004; Shotland & Hunter, 1995) and family influences (Miller et al., 2001; Donenberg, Paikoff & Pequegnat, 2006) affect sexual outcomes. The current research investigated women's recall about familial messages and current relationship ideas to understand the manner in which these variables may relate to the sexual choices of a high-risk sample of African American women.

There were specific issues explored in Phase 1. First, how do young African American women conceptualize relationships as illustrated by their expectations of partner and self? Regarding partner expectations, the women's responses frequently addressed

personality characteristics. These elements address more of the desired qualities of a partner rather than expectations.

Consistent with previous literature's findings about the link between trust issues and sex (Crosby et al., 2000; Crowell & Emmers-Sommer, 2001; Jadack et al., 1997), a dominant theme for the women was the expectation that partners would be honest and trustworthy. Expectations about relationship qualities and the desire for stable commitment, reflected by some of the respondents' reciprocal expectations (maintained for self and for partner) have been associated with sexual risk-taking (Foreman, 2003).

Findings revealed that women expect men to be economically self-sufficient. This concept, expressed by 48% of the sample, may be particularly functional for African American young women living in an environment with fewer economically stable and single, heterosexual, African American men. Research has suggested that the sex-ratio imbalance within the African American community may affect women's sexual choices (Wingood & DiClemente, 1992). While the interviews do not explicitly link the expectation of self-reliance to risky behavior, the degree to which this issue is prioritized may factor into the women's partner selection process. It may also affect decisions to make seemingly small sacrifices (e.g., avoiding the inconvenience of wearing a condom or delaying sex) that can facilitate the development of a relationship.

Other elements of women's expectations were endorsed at variant levels and highlighted expectations that could have an indirect effect on sexual health. For example, the women expected that men would be stable and consistent in their behaviors as well as maintain and demonstrate interest in their well-being. The importance of emotional support is underscored in other qualitative works with African American women (Jarama, et al.,

2007). These are broader level expectations that may affect the degree to which women feel that their relationship context is a "safe place" for sexual engagement.

The women were less explicit in describing expectations that were linked to behavioral standards and physical/personality characteristics. Some women did mention current expectations suggesting that, for example, it was important for partners to be funny, attractive or do things for or with them. These expectations were much more prevalent in women's recall of romantic relationships that they experienced when first developing an attraction for the opposite sex.

While certain expectations are maintained, the women's comments suggest that partners in the past may not have met their standards. Among a portion of the sample, there appeared to be an inconsistency between what the women expected in a relationship and what they had actually allowed in their previous interactions with their partners. Research from other disciples suggests that this paradox is evident in other areas of human behavior. For example, Mickelson (1990) addresses the perceived inconsistency between African American youth's favorable attitudes about education and the general levels of academic underperformance among this group. Mickelson pointed out that while many youth maintain abstract attitudes (reflecting societal attitudes that education is the vehicle to success) about education, their concrete attitudes are more predictive of academic performance. In this context, concrete attitudes reflect the realities that individuals experience versus a societal reality or norm imposed on people.

Findings from this study may indicate a broader societal level of expectations with the women's concrete and more individual level experiences and perspectives demonstrated to a lesser degree. The women's responses to the REM demonstrated high partner expectations, but personal experiences shared in the interviews support the idea that women

may modify these standards. For example, if relationship maintenance is a high personal priority then the women may adapt or increase their tolerance regarding other behaviors their partner may demonstrate. Decisions to modify or lower expectations may be affected by the male-female relationships that women observe in their immediate environments, such as among older family or community members. The issue of relationship norms and attempts to clarify women's models for interacting with men was not explored in this research, but is noteworthy for future research assessing the degree to which women enforce certain expectations.

The inconsistency between what women actually expect and experience in their interactions with men also extends to the expressed expectation of trust. Efforts to decrease risk for HIV/AIDS are challenged by the conflict between promoting relationships that have trust, while also reminding women that their expectations may not always be met. This issue is further complicated by familial messages suggesting the need to be skeptical or mistrustful of men. (Jarama et al., 2007). This strong desire to be in a trusting relationship can undermine condom use. Since only 20% of the sample reported consistently using a condom in the past 3 months, having faith in ones partner (possibly represented by not using a condom) may have certain psychological benefits despite the women's awareness that their partners may not have been faithful.

Acknowledging the slightest potential for infidelity may undermine the decision the women made regarding partner selection (Sobo, 1995). The women may have a certain level of faith and trust in their partners that decreases the focus on consistent condom use. Socialization earlier in life (e.g., during preadolescents and adolescents) can better prepare the women to deal appropriately with situations where desired qualities are absent or there

are reasons to question a partner's honesty. With such preparation, they can also develop a more realistic and adaptive conceptualization of trust.

Few women shared expectations that their partner would demonstrate concerns regarding sexual health. Though the women were at an STI clinic, results suggest that this issue was not a priority when discussing partners and relationships. This may be attributed to several factors that are worth consideration. First, it is possible that the women are not use to discussing issues of sexual health in the context of conversations about heterosexual relationships. While issues of sexual health (e.g., HIV/AIDS risk) are often presented in media, the extent to which these topics have permeated daily casual conversation about relationships is not known. Second, the women may feel that these issues are still more appropriate for men to discuss candidly and women may continue to defer decisions about condom use to men. As a result, women may not expect men to discuss issues of sexual health and may not think it is appropriate to bring it up in unfamiliar situation such as research interviews. Third, it is possible that prompting the women to think of relationships, versus specific sexual health issues, prime the women to respond from a more natural relational orientation. This relational orientation, which prioritizes the needs of other people in one's life, may contradict the HIV-prevention messages that promote considering one's own wellness before prioritizing others (Wyatt, Forge & Guthrie, 1998).

Findings pertaining to consent to unwanted sexual intercourse are consistent with previous work and highlight the need to continue to empower women to prioritize their own sexual needs and desires. Empowerment efforts should include supporting the women to feel comfortable enough to decline sexual intercourse at a given time. Approximately half of the sample indicated that they have consented to unwanted sex for reasons associated with relationship maintenance, partner satisfaction and love. It will be important for future

research to determine connections between this behavior and actual sexual risk. The women's acquiescence to unwanted sex may parallel their compliance with risk behaviors such as not having an HIV or STI test before having sex with a new partner or inconsistent condom use.

Compared to adult expectations, recall of earlier expectations (when they first started liking boys) were much more concrete, but less diverse. The women recalled that at younger ages priority expectations were for boys to call them and want to hang out with them. Based on these reports, it is understandable that women's expectations evolved as they experienced more complex interactions with men. When interpreting the data, it is essential to consider the role of delayed recall given that these earlier expectations are likely to be remembered with less detail than adult expectations. Note that the women's recall of earlier expectations were explored with less depth than current recall because of the difficulty that women experienced remembering concrete examples of partner expectations from the time period when they first realized their interest in boys. Finally, the participants' level of cognitive development during preadolescents may have limited their understanding of constructs like "relationships" or "expectations" during this early period. The women's retrospective recount of a period when they were trying to figure out the social phenomena in question may have been affected.

While some literature addressed women's ideas about men and partner-factors that may affect the women's sexual choices (Bowleg, Lucas and Tschann, 2004; Wingood & DiClemente, 1998), the field knows less about how the women view themselves in interactions with men. Of interest is the fact that the women's expectations were reciprocal. The women expected honesty, interest in her well-being and partner self-reliance, as well as parallel self-expectations. If the women expect themselves to be honest and committed, and

are relatively stable in these behaviors, then they may expect their partners to demonstrate behaviors that are also consistent with these standards. Therefore, promoting condom use, questioning their partners' sexual past and assessing current sexual health becomes less of a priority. The women's responses indicate that sexual risk-taking may be part of the intimacy and the reciprocal nature of interacting with men. This is consistent with qualitative findings from interviews with African American college women wherein the women recognized that risk-taking was sometimes a strategy for securing or maintaining relationships (Foreman, 2003).

There were two differences in what the women expected of themselves as compared to their expectation of partners. Responses suggested that women themselves expect to be committed to a relationship as demonstrated by being accountable and able to compromise. A smaller number of women provided expectations of self linked to domestic responsibilities. For this segment of women, their ideas about interacting with men may be linked to more traditional, relationship contexts with longer-term goals in mind. These participants varied in age (18-26) and half of the women who responded in each of these domains had children. Further research in this area should explore how traditional gender-role endorsements or ideas affect women's expectations of men in general, and be specific to HIV/AIDS reduction.

There are limitations to the expectation-related findings. Though the interviewer used "expectations of partner" in most of the interviews, many of the responses suggest that the women may have reported expectations of committed or trusted relationships. Few women commented on expectations of someone that was a "sex only" partner. It is possible that the women's expectations of someone they were having a "sex only" interaction with would be different. The women may have been primed to think about committed relationships due to

the use of the term "relationship" at various points in the script. For example, one question states, "What types of feelings are linked to being in a CLOSE relationship with a guy" as compared to another question asking, "What helps you know that you are ready to have sex with a guy?"

The second research question asked, "What messages do women recall receiving from their family members about sexual opportunities, intercourse, consequences of sex, love, marriage and premarital sex?" This question was framed around messages received when women were younger and first developing an interest in boys and/or sex. The majority of women recalled messages about avoiding sexual engagement. These messages were conveyed with warnings that men will definitely pursue sex, misuse women in the context of a sexual relationship, and women should "not be a fool." These findings are consistent with previous literature indicating that over 50% of an African American adolescent sample recalled maternal communication about sex and pressure to have sex (Miller et al., 1998). Similarly, Jarama and colleagues (2007) recalled messages that "Men are sneaky" and "Men are no" good that often came from male figures, though there were also messages about the emotional and qualitative nature of relationships that came from caregivers. Ashcraft (2004) found that most African American mothers encouraged daughters to "be aware" of guys who would want sex and to avoid "the wrong boy". Consistent with findings from the current work, there was relatively less information about how girls should learn to select the "right" partner (Ashcraft, 2004).

The women also recalled messages indicating that men should be self-sufficient. This is consistent with other qualitative work that described mothers' advice that partners should be financially able to provide for women (Ashcraft, 2004). The fact that this theme also emerged in expectations of self and partner suggests that the women are trying to hold

themselves to standards asserted by familial information sources. Further, the commonalities between women's expectations and family messages of respect suggest that women have integrated this expectation into how they believe they should be treated when interacting with men.

Women's responses to family messages about sex and sex-related topics were divided into two broad categories – prevention messages and consequences of having sex. Nearly half of the sample recalled messages about prevention to some degree or another. While the women recalled familial messages about sexual health, this issue was not a reliable category that emerged in data about partner or self-expectations. Though women were in an STI clinic, this venue did not serve as a primer for talking about sex-related issues specifically in this study. However, expectations of trust and honesty are linked to concerns that men may have sex with other partners but the women did not self-initiate the link between that concern and their own risk for STIs or HIV/AIDS.

Findings present a challenge in that more messages are focused on pregnancy prevention than disease prevention. This issue is being addressed for future generations through the development of interventions focused on familial communication about HIV/AIDS disease prevention through the family and individual level programs to promote sexual health (Jemmott, Jemmott & Fong, 1998; McBride, Baptiste, Traube, Paikoff, Madison-Boyd, Coleman, Bell, & McKay, in press) and substance use prevention (Belgrave, Reed, Plybon, Butler, Allison, & Davis, 2004).

Consistent with other research findings (Miller et al., 1998), data suggest that mothers continue to be the primary source of sex-related information. However, the substantial information received from siblings and extended family members should not be understated.

These findings further support the need for interventions targeting families as well as same-age peer groups that may include family members (e.g., cousins or siblings) of similar age.

Many of the findings regarding familial communication reached only a variant level of saturation. Two considerations can help with understanding this finding. First, respondents' recall about messages was relatively limited. In the interviews, 11 women initially suggested that no communication was received, but were later able to provide limited information when probed. This may relate to the difficulty of recalling earlier messages conveyed during a developmental stage when the women may have been less receptive to participating in sensitive conversations with family members. Sociocultural context may also have affected recall. Though the data was not collected, it would be of interest to determine how family composition factors (e.g., being a raised by a single parent versus a two-parent household) may have affected the quality and quantity of information provided. The culture of a more conservative city that may not promote sexual communication (evidenced by no sex education in public schools) can become integrated into community and family norms regarding sexual communication. It is also important to consider that familial communication was the last portion of the interview and may have affected the information context. Towards the end of the interview, participants were often ready to complete the interview or had to leave quickly due to other constraints such as a partner was waiting for them or they needed to get to work.

Phase 2 included several research questions. Hypothesis 1 proposed that general family communication and sex-specific family communication would be a stronger predictor of current relationship expectations than familial closeness. The two family process variables were correlated, but neither predicted sexual health outcomes. In fact, predictors were negatively associated (not statistically significant) with indicators of sexual risk. Lack

of an association between either variable is not unusual given existing literature's mixed findings about the influence of parental closeness and communication on adolescent sexual outcomes. More interesting is that neither variable was associated. Findings suggest the need to consider the long-term influence of familial communication and closeness for this sample. The women's responses for familial process variables were at moderate levels (means of 2.27 to 2.89 of 5.0). This suggests that higher levels of influence maybe required to yield a lasting impact. Retrospective accounts have limitations. Nonetheless, reports are still noteworthy since what the women actually remember, particularly about sexual communication, might have the greatest impact on choices and behaviors.

Hypotheses 3 and 4 predicted that women's relationship expectations of their last sexual partner would mediate the influence of family process variables on sexual outcomes of condom use (hypothesis 3) and delayed sexual initiation (hypothesis 4). Results did not support these hypotheses. Correlation analyses indicated that the REM, representing women's expectations of their last sexual partner, was negatively associated with the family predictor variables. As with sexual health outcomes, moderate levels of familial general communication, sex-specific communication and closeness (means of 2.27 to 2.89 of 5.0) may not have been substantial enough to affect relationship expectations (4.14 of 5.0). This issue is supported or emphasized by qualitative findings from Phase 1, wherein few messages about what to expect from partners or relationships with men were discussed and low levels of saturation were achieved for the issues that were discussed.

The lack of an association between REM and outcome variables may have been complicated by the fact that the women were in the STI clinic and possibly sensitive to their past behaviors. The women's responses regarding expectations of partners could be inflated due to their intention to do things differently in future interactions with men. Their partner

expectations may have changed after the potentially difficult or emotional experience of receiving services at the clinic. If a portion of the sample failed to focus on their last sexual experience, the model may be limited by using future expectations to predict behavior with the last sexual partner (delayed sexual initiation) or over the past three months (condom use).

Another complicating factor deals with items selection for the REM. The Relationship Expectation Measure (REM) was developed based on findings regarding partner-based expectations. The initial REM measure included 51 items. After the factor analysis was completed, there were 16 items included in analyses of proposed models. These 16 items represented emotional connectedness, intimacy perspective (ideas about being physically close or affectionate), trust and economic stability. Because of narrowing of items to these subscales to satisfy psychometric standards (e.g., avoiding single item scales), some data may have been lost. Themes used in the final analyses are consistent with categories that reached saturation in Phase 1.

Further exploration to understand hypothesis findings assessed participants' responses to the REM. There was little variance in the women's expectations of their last sexual partner. Results indicate that the women have relatively high levels of partner-based expectations, many of which are consistent with qualitative findings. The women may state these expectations because to do otherwise would undermine their perceived ability to select "good" partners particularly among economically disadvantaged women (Sobo, 1995). As a result, responses suggest the women expected just about everything from their last partner. Further, though women were told (verbally and in written directions) to consider the relationship with their last sexual partner, the degree of their expectations suggest that some women may have considered men in general. In addition, there may be a notable difference between what the women expected and what they accepted in relationships before delaying

sexual initiation or deciding not to use a condom since only approximately half of the sample reported using condoms 50% of the time.

Limitations

There are limitations to the current study. The women being in the clinic may have affected responses in the interview or on surveys. They may have been more likely to provide socially desirable responses to compensate for negative feelings associated with being at the clinic. This sensitivity may have affected their self-report due to desires to see self and for others to see them more favorably. This limitation is a risk associated with data collection among more high-risk samples (as demonstrated by the initiation of services), given challenges associated with accessing this population otherwise.

There are limitations specific to the qualitative methods. The protocol questions were developed to understand women's relationship ideas. By utilizing the construct of "relationship" before having it operationally defined by the target group, the researcher may have brought to the study ideas and values not necessarily representative of the sample. The use of questions more explicitly linked to actual sexual behavior, versus a pure focus on the interpersonal aspects of relating to sexual partners may have generated more HIV/AIDS risk information. The particular qualitative strategy may have affected the results. Utilizing the CQR restricted the researcher from modifying the interview protocol, thus allowing the researcher to target additional issues, based on feedback from participants. By not changing questions, reliable categories were more appropriately established. However, by not changing protocol based on feedback useful information may not have been obtained. For example, why women may or may not have listened to familial advice. Are expectations different when relationships involve sex? Additionally, there were no qualitative differences in responses according to parenting status (being a mother versus having no children). If the

protocol had been adapted, there may have been opportunities to explore whether having children affected women's partner selection. Finally, it would have been ideal for the interviewer to be absent from the data analysis team. Frequently, qualitative methodology is criticized for being subjective. Having a purely objective research team can increase the validity of research findings. However, financial constraints of the project made doing so beyond the scope of this study.

There were also methodological limitations. Recruitment occurred at a STI clinic that provides services such as initial testing, follow-up visits and medication management for sexually transmitted diseases. Participants may have expectations that differ from women recruited from a general medical clinic and/or the general population. The setting itself may have primed women to think more negatively (or positively) about sexual health due to having experienced the consequences of sexual risk-taking behaviors.

The homogeneity of this sample is a strength and limitation of the study. The strength is that the research community now has additional insight into the background factors (e.g., family) and self-concepts (e.g., personal expectations) that may affect this particular population's sexual decision-making. Data below show that this community sample of women have increased levels of sexual risk. The behaviors and ideas expressed by study participants cannot be generalized to all African American women of all ages and backgrounds. When compared to a sample of African American college women (Grange, 2003) with a mean age of age 20.2 there are substantial differences in sexual behavior. This research sample had sexual onset at a much earlier age. More than twice as many women in this community sample reported sexual onset prior to age 15 (57% compared to 27% for college aged women). More than twice as many women in the community sample reported 5 or more lifetime partners (80% compared to 38%) and nearly three-times as many sexual

partners in the past 3 months (13% compared to 5%). These data shows differences in sexual behaviors that may coincide with differences in partner expectations and contextual influences on sexual choices. The differences in behaviors between these two sample may also be linked to differences in cognitive styles that may affect the STI clinic sample's planning and expectations regarding relationships, as well as recall regarding previous relationships or communication with family members. For example, Attention Deficit Disorder has been associated with increased sexual risk behavior among young adults (Flory, Molina, Pelham, Gnagy & Smith, 2006). Though this sample did not participate in a mental health screening, it is possible that elevated levels of risk make be associated with increased levels of impulsivity or other cognitive factors. Thus, while findings are relevant to this more high risk sample, inferring applicability to women of other demographics would be premature.

Limitations also exist with use of the REM, a new measure designed within the context of this study. Ideally, new measures are piloted before integration into a model. The current study was essentially the pilot for the REM and helped to establish internal reliability and construct validity. Yet, the measure should be revised to increase its predictive validity before further use in models. In addition, the sample size should be doubled (N = 300) to establish a good reliability estimate (Tabachnick & Fidell, 1996).

Another limitation of the REM is that findings specific to expectations are the basis for REM content. While interviews revealed various expectations, only those reaching saturation were prioritized. Further narrowing the subscales, only those items that were loaded on one of the identified subscales were included in the final analysis. Thus, certain expectations relevant to sexual behavior outcomes may have been excluded due to efforts to strengthen the internal reliability of the REM.

A final limitation of the study became apparent with the construct of delayed sexual initiation. At inception, delayed sexual initiation reflected the amount of time the individual is involved in what they anticipate to be a romantic or committed relationship before engaging in sexual intercourse. Early responses from women suggested that asking them how long they were "in a relationship" before having sex was confusing because women define "relationship" in different ways. To address this issue, women were asked to respond according to how long they liked their last sexual partner in a "more than friends way" before having sex. This broadened and complicated the range of responses. For example, women who have lived in the same community for the majority of their lives could know their partner for several years, and even be romantically attracted to them, before initiating sexual intercourse. A better understanding of women's sexual relationship context can facilitate an operational definition of this construct.

Future Research

Several questions developed based on findings from the current research. Is it possible that women's expectations from men are so high that they cannot really hold men accountable to those standards? If women's expectations are unrealistically high, they may unconsciously compromise in a variety of ways, including sexual safety, when they are interacting with their partner. Future research can clarify this issue by further exploring African American women's ideas about sexual interactions. Findings from this study suggest a benefit in actually understanding the context of women's previous sex-related experiences and their use of condoms in those contexts. Efforts to determine the distinction between what women expected and what they experienced in interactions with men could be useful. Other research may need to explore why the women did not maintain certain standards and at what

point decisions about sex, such as when to have sex or use a condom, were actually integrated into their sexual choices.

What factors contribute to delayed sexual initiation and what is the impact of delayed sexual initiation on HIV/AIDS risk? This study represents an initial effort to explore the construct of delayed sexual initiation. Given complexities in defining the construct, a more detailed assessment is necessary. An exploration of factors that contribute to a woman's decision to delay having sex with a potential partner and criteria that affect that decision can reduce women's risk of STIs and HIV/AIDS in two distinct ways. First, delaying sex decreases the number of sexual partners a woman will have in her lifetime. With maturity and increased exposure, women may learn valuable information that affect their decision delay sex with a particular partner. It is also possible that waiting an average of 6 weeks to have sex can decrease the number of partners a woman has in a single year. Second, delaying sex provides an increased opportunity for women to explore partners' sexual histories. In the current study, few women expected themselves or their partner to formally (STI testing) or informally (detailed discussions) investigate sexual health status or history. An exploration of factors affecting delayed sexual initiation allows for a better understanding of cognitive and emotional contextual issues (Brown, DiClemente, Donenberg, Lescano, Crosby, McBride, 2002). The potential role of affect regulation in sexual risk (particularly condom use) among adolescents has been assessed. More empirical evidence is necessary to understanding factors that affect the timing of sexual initiation, particularly among African American females.

What are the longitudinal effects of family efforts to communicate about sex-related topics? Women in this sample recalled moderate levels of familial communication. Several studies cited note the immediate impact of familial communication among adolescents. Yet,

research is still needed to clarify how these values affect African American women's choices as young adults when familial influences are more distal than proximal. It is important that families do not underestimate which messages will have an effect on their child's behavior. Data from this study suggest that some messages, such as "Wait until you are married to have sex", may be heard though not integrated into sexual choices. However, other messages can be more fully integrated especially when coming from multiple family or community sources such as "treat women right." Differentiating among the long-term versus shorter-term messages can help shape the understanding of how families affect HIV/AIDS risk. Such information can complement existing family-based interventions.

In summary, this study helps to explain the complexity of understanding African American young women's self and family systems as contributors to HIV/AIDS and STI risk. Qualitative findings are rich in revealing self and partner expectations as well as familial communication that can affect sexual outcomes, but they are still preliminary. Efforts to assess associated models using quantitative methods require greater focus on sexual interactions that may or may not be in the context of "relationships". Further, findings regarding the diverse prevention and risk messages included in familial communication are encouraging. The challenge is to build on this strength and the quality of messages about relational aspects of having sex (e.g., what to look for in partners versus only scare tactics about what to avoid). Though media messages are strong in their effort to promote condom use, sexual risk data from this sample suggests that this is not enough. Study findings can be used to inform program development and scientific effort to assess the complex contributors to sexual decision-making.

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Appendix A

Interview Questions

- Welcomes and thanks for your willingness to participate. The interview will focus on your ideas about romantic relationships. At the end of the interview, you will be given $____ for your participation.
- *Review Consent form*
- *Have them complete a brief demographic form (brief pg 2) that includes brief sexual history – it will be helpful so that I don't make assumptions during the interview.*
- *I am going to ask you about ideas related to what it means to be involved in a relationship with a man.*

As you are today,

1. What is your understanding of what it means to be in a RELATIONSHIP with a guy?

2. Are there certain things that are important to you when in a relationship with a man?
(IF SO) What are these things?

3. Do think you have expectations of the guy when involved in a close relationship?
What expectations do you have of your partner (that may or may not involve sex)?
– Behavioral, emotional, financial?

Do expectations differ depending on your relationship with the guy? How?

- Have these expectations been met in the context of any one relationship?

-Given what you said about your expectations, has anything been lacking so far in relationships that you have been in?

-Would you consider relationships that you are generally part of to be ROMANTIC relationships? Why or why not?

-How does DATING play into you ideas/expectations associated with relationships? How are DATING relationships different from *more serious relationships* with a guy?

4. What expectations do you have of yourself in a relationship
- Emotionally? Behaviorally (is sex part of the expectation)?

5. Who is more likely to initiate sex?

Does condom use or birth control come up?

Who is more likely to bring it up?

6. Is sexual activity generally a part of the woman's role in a relationship?
-If yes, why do you think this is?

-Are women likely to have sex in a relationship, even if she is not really satisfied with that relationship?

-Why do you think that is?

7. Once sex is part of a relationship, are there any other expectations or desires that you may have regarding the relationship?
a. Short-term (immediately after sex has become part of the relationship)
b. Long-term (further down the line as you think about your future)

8. Are you satisfied with the way that sex has been a part of your past relationships?
   - Why or why not?
   - What would make you more satisfied?

- Is INTIMACY in a relationship different from SEXUAL ACTIVITY?

We are going to switch directions a little bit and ask you about your earlier ideas regarding relationships (retrospective information).

9. How old were you when you decided to start being involved with guys/males in a "more than friends" way?

10. *(if woman indicates that she has been sexually active)* You mentioned that (responses to earlier items for accuracy) are important aspects of your relationship. Are these the same types of ideas about relationships that you had when you first started being involved in romantic relationships?

11. Did your family discuss relationship issues with you – i.e., what to expect, what was acceptable?

-What were the messages that your family gave you about relationships and sex?
Assess content associated with the following points
-expectations from a partner

-what may be expected of you

-issues around sexual engagement

Did anyone else talk to you?

12. Who was most influential in your thinking about romantic relationships?
Who influenced your ideas about sex?

13. (if it was discussed) Who in your family talked to you about these topics?

Appendix B

Sexual Communication Scale

Who do you think influences your ideas about relationships and sex the most? _____

I am going to ask you some questions about topics that this specific person may or may not have discussed with you. Using this card (present the card to the respondent) tell me how much you think the topics were discussed. I am also going to ask you to tell me what was discussed about certain topics. If you do not understand what a word means, just tell me and I will explain it to you. Don't be embarrassed because it may be a word you are unfamiliar with.

When I say ***"Communication"*** *I mean a discussion that occurred, versus someone just telling you their ideas about something. Even if you did not say anything, communication may have occurred if you felt that you could but just did not have anything to say.*

_____ 1. Sexual reproductive system ("where babies come from")
_____ 2. The father's part in conception ("getting pregnant")
_____ 3. Menstruation ("periods")
_____ 4. Nocturnal emissions ("wet dreams")
_____ 5. Masturbation
_____ 6. Dating relationships

_____ *7. Petting ("feeling up", "being touched in a sexual way", "foreplay")*

_____ *8. Sexual intercourse*
_____ 9. Birth control in general
_____ 10. Whether you personally are using birth control
_____ 11. Consequences of teen pregnancy (other than AIDS)

_____ 12. Sexual transmitted diseases
_____ 13. Love and/or marriage

_____ 14. Whether pre-marital sex is right or wrong

_____ 15. Abortion and related legal issues
_____ 16. Prostitution

_____ 17. Homosexuality
_____ 18. AIDS
_____ 19. Sexual abuse
_____ 20. Rape

Rating Card

1	2	3	4	5
never		a few times		a lot

Appendix C

Demographic Questionnaire

What is your age?:

Which county do you live in? *(Circle one)*:
Richmond Henrico Chesterfield Hanover Other

Highest level of education completed:

- ☐ Some high school
- ☐ High school/GED
- ☐ Some college
- ☐ College - Associates BS Graduate
- ☐ Vocational training

Do you have children? Yes No

If so, what is the age of your oldest child? _____

Who do you live with (circle one)?
Alone with family with a roommate

husband boyfriend other _____

Please respond by circling one of the options.

1. Have you ever had sexual intercourse?
   A. Yes **(skip the following items and go to page ___)**
   B. No

2. How old were you when you had sexual intercourse for the first time? _____

3. During your life, with how many people have you had sexual intercourse? _____

4. During the past 3 months, with how many people did you have sexual intercourse?
   A. _____ (number of people)

B. I have not had sex in the past 3 months

_____

5. Did you drink alcohol or use drugs before you had sexual intercourse the last time?
a. No
b. Yes

6. The last time you had sexual intercourse, did your partner use a condom?
   a. No
   b. Yes

7. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy (select only one response)?
   a. I have never had sexual intercourse
   b. No method was used to prevent pregnancy
   c. Birth control pills
   d. Condoms
   e. Dep-Provera (injectable birth control)
   f. Withdrawal
   g. Some other method
   h. Not Sure

8. How many times have you been pregnant? _____

How many children do you have? _____
Have you been in a heterosexual relationship in the past 6-12 months?
a. Yes
b. No

Were you having sex in this relationship?
a. Yes
b. No

Did you engage in:
☐ Vaginal Intercourse
☐ Anal intercourse
☐ Oral intercourse

How long did your longest romantic relationship last? _____

Which term(s) would best classify your relationships that involve sexual engagement (generally)?
More than one term can be selected.
☐ Committed
☐ Exclusive
☐ Dating
☐ Casual friends

☐ Other term(s) _____

Have you ever been forced to have sexual intercourse when you did not want to?

☐ Yes

☐ No **(skip the following items and go to page ___)**

If so, how old were you?

Did the experience occur with a family member or non-family member?

☐ Family member

☐ Non-family member

Note: If the experiences occurred with a family member and you were 18 years old or younger, we can assist you if you would like to report the incident to the police. If the incident occurred when you were 18 years or younger and you provide the individual's name, I am legally required to report the incident to legal authorities.

Appendix D

Statement of Informed Consent

RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: Relationship Conceptualizations and Familial Factors as Contributors to Sexual Decision-making Patterns of Young African-American Women

VCU IRB NO.:

If there is anything in this consent form that you do not understand, please ask the study staff to explain. If you have questions or concerns after completing this survey or at a later time, please notify the office indicated on the final page.

Purpose of the Study:
The purpose of this research study is to find out about how African-American young women view romantic/intimate heterosexual relationships with men and ideas or experiences related to such views.

You are being asked to be part of this study because you a have identified yourself as an African-American woman between 18 and 25 years of age who has experienced voluntary sexual intercourse at some point during your life.

Description of the Study and Your Involvement:
In this study you will be asked to participate in a one-on-one interview with a trained interviewer. The interview will last approximately 30-40 minutes. During the interview you will be asked to answer questions about your ideas of romantic/intimate male-female relationships, and the impact that your family has had on these ideas. At the end of the interview, you will complete a brief form including questions about where you grew up, your current housing situation, previous sexual behavior and drug use. The interview will be audio-tape recorded to be sure to get all of your ideas, but your name will not be used.

Risks and Discomforts:
It is not expected that any issues addressed will be particularly stressful. Yet, sometimes talking about personal issues and ideas can cause people to feel uncomfortable. Several questions will be asked about your ideas about relationships and where you got these ideas. You do not have to talk about any subjects you do not want to talk about, and you may leave the interview at any time. If you become upset, the study staff will give you a name of a counselor to contact so you can get help in dealing with these issues.

Benefits:
You may not get any direct benefit from this study, but, the information we learn from people in this study may help us design better programs to work with minority women and girls to help them understand male/female and family relationships.

Costs:
There are no costs for participating in this study other than the time you will spend in the interviews and completing the brief questionnaire.

Payment for Participation:

You will receive a $20.00 gift card for your participation in the interview. The gift card will be given to you at the beginning of the interview process.

Alternatives:
The alternative is to not participate in the study.

Confidentiality:

We will not tell anyone the answers that you provide, unless you provide information that suggests that (1) you may be a danger to yourself or someone else or (2) there is reason to suspect abuse of a child or adult. In such a case, the law says that I have to let people in authority know so that you or other involved individuals can be protected. If you provide the name of a person who abused you when you were 18 years or younger, I am legally required to report that information to legal authorities. Information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. What we find from this study may be presented at meetings or published in papers, but names will not be used in these presentations or papers.

The interview will be audio taped. During the interview, the interviewer will refer to you by your initials or a name other than your own so that your name will not be associated with any information recorded. The tapes and the notes will be stored in a locked cabinet. At the completion of this study, the tapes will be destroyed.

Voluntary Participation and Withdrawal

You do not have to participate in this study. If you choose to participate you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. Your participation in this study will have no effect on the services you receive at the clinic.

Questions

In the future, you may have questions about your participation in this study. If you have any questions, contact: Dr. Kevin Allison or Christina Grange at (804) 828-1203.

If you have any questions about your rights as a participant in this study, you may contact:

Office for Research Subjects Protection
Virginia Commonwealth University
800 East Leigh Street, Suite 111
P.O. Box 980568
Richmond, VA 23298
Telephone: 804-828-0868

Consent:

I have been given the chance to read this consent form. I understand the information about this study. Questions I wanted to ask about the study have been answered.

Appendix E

Network of Relationships Inventory (NRI)

Respond to these questions in terms of your relationship with the adult family or non-family member (over 21 years old) who you felt/feel closest to with during the time that you were forming your initial ideas about romantic/relationships and sex.

Mother	Father	Aunt	Uncle
Grandmother	Grandfather	Older sister (age _)	Older brother (age _)
Older female cousin (age _)	Older male cousin (age _)	Other adult - relationship _____	

1. How much free time did you spend with this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

2. How much did you talk about everything with this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

3. How much did you help this person with things she/he can't do by her/himself?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

4. How much did this person like or love you?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

5. How sure were you that this relationship will last no matter what?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

6. How much did you play around and have fun with this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

7. How much did you share your secrets and private feelings with this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

8. How much did you protect and look out for this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

9. How much did this person really care about you?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

10. How sure were you that your relationship will last in spite of fights?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

11. How often did you go places and do enjoyable things with this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

12. How much did you talk to this person about things that you don't want others to know?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

13. How much did you take care of this person?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

14. How much did this person have a strong feeling of affection (loving or liking) toward you?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

15. How sure were you that your relationship would continue in the years to come?

Little or None	Somewhat	Very Much	Extremely Much	As much as possible
1	2	3	4	5

Appendix F

Parent Peer Attachment Inventory (PPAI)

Respond to these questions in terms of your relationship with the adult family or non-family member (over 21 years old) who you felt/feel closest to with during the time that you were forming your initial ideas about romantic/relationships and sex.

1. I like to get this person's point of view on things I am concerned about.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

2. Talking over my problems with this person makes me feel ashamed or foolish.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

3. When we discuss things, I consider this person's point of view.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

4. This person has their own problems so I don't bother them with mine.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

5. This person helps me to understand myself better.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

6. I tell this person about my problems or troubles.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

7. This person encourages me to talk about my difficulties.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

8. When I am angry about something, this person tries to understand.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

9. I can count on this person when I need to get something off my chest.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

10. If this person knows something is bothering me, they ask me about it.

1	2	3	4	5
almost never/ never true	*seldom true*	*sometimes true*	*often true*	*almost/ always true*

Appendix G

Sexual Communication Scale

Who do you think influences your ideas about relationships and sex the most? _____

Look at the list below. Please circle the number that indicates how much _____ (person above) communicated with you about the different topics.

If you do not understand what a word means, just tell me and I will explain it to you. Don't be embarrassed because it may be a word you are unfamiliar with.

When I say ***"Communication"*** *I mean a discussion that occurred, versus someone just telling you their ideas about something. Communication may have occurred if you felt that you could but just did not have anything to say.*

		Never		A few times		A lot
1.	Sexual reproductive system ("where babies come from")	1	2	3	4	5
2.	The father's part in conception ("getting pregnant")	1	2	3	4	5
3.	Menstruation ("periods")	1	2	3	4	5
4.	Nocturnal emissions ("wet dreams")	1	2	3	4	5
5.	Masturbation	1	2	3	4	5
6.	Dating relationships	1	2	3	4	5
7.	*Petting ("feeling up", "being touched in a sexual way", "foreplay")*	1	2	3	4	5
8.	*Sexual intercourse*	1	2	3	4	5
9.	Birth control in general	1	2	3	4	5
10.	Whether you personally are using birth control	1	2	3	4	5
11.	Consequences of teen pregnancy (other than AIDS)	1	2	3	4	5
12.	Sexual transmitted diseases	1	2	3	4	5
13.	Love and/or marriage	1	2	3	4	5
14.	Whether pre-marital sex is right or wrong	1	2	3	4	5

15.	Abortion and related legal issues	1	2	3	4	5
16.	Prostitution	1	2	3	4	5
17.	Homosexuality	1	2	3	4	5
18.	AIDS	1	2	3	4	5
19.	Sexual abuse	1	2	3	4	5
20.	Rape	1	2	3	4	5

Appendix H

Relationship Expectation Measure

Directions: Think about your most recent sexual experience with a man. Think about the types of expectations (spoken or unspoken) you had of him at that time.

Read the following statements. Circle the number that reflects how much you think the statement reflects what you expected from the last man you had sex with. Please try to be as honest as possible and focus on ***THE LAST MAN YOU WERE INTIMATE WITH.***

During the time period that I was with this person, I expected that he would...		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
1.	Talk to me about his feelings.	1	2	3	4	5
2.	Provide emotional support for me when I needed it.	1	2	3	4	5
3.	Be dependable (Do what he says he is going to do).	1	2	3	4	5
4.	Get tested for STDs and/or HIV/AIDS.	1	2	3	4	5
5.	Go to college, school or a training program.	1	2	3	4	5
6.	Be honest about who he was spending his time with.	1	2	3	4	5
7.	Come see me regularly.	1	2	3	4	5
8.	Think about future goals with me.	1	2	3	4	5
9.	Talk to me about things in his life (e.g., family, work)	1	2	3	4	5
10.	Be romantic (bring me flowers, show affection, give compliments).	1	2	3	4	5
11.	Act the same way towards me after we started having sex as he did before we were having sex.	1	2	3	4	5
12.	Understand if I do not want to have sex.	1	2	3	4	5

13.	Be working towards his professional goals.	1	2	3	4	5
14.	Be honest about where he was going.	1	2	3	4	5
15.	Keep in contact with me by calling me.	1	2	3	4	5
16.	Look forward to being in a committed relationship with me.	1	2	3	4	5

During the time period that I was with this person, I expected that he would...		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
17.	Talk to me about things he is dealing with.	1	2	3	4	5
18.	Defend me with other people (i.e., If they are saying bad things about me).	1	2	3	4	5
19.	Make the first move to have sex with me.	1	2	3	4	5
20.	Be able to take care of himself (financially).	1	2	3	4	5
21.	Be interested in doing activities with family (mine or his)	1	2	3	4	5
22.	Consider marrying me one day.	1	2	3	4	5
23.	Be prepared to use a condom during sex.	1	2	3	4	5
24.	Express his emotions.	1	2	3	4	5
25.	Be able to take care of me (financially).	1	2	3	4	5
26.	Be faithful to me.	1	2	3	4	5
27.	Become emotionally closer to me after we start having sex.	1	2	3	4	5
28.	Take me out in public.	1	2	3	4	5
29.	Show an effort to make himself better by working toward his goals.	1	2	3	4	5
30.	To only have sex with me.	1	2	3	4	5
31.	Be willing to talk through issues when we have tough decisions to make.	1	2	3	4	5
32.	Stay with me if I got pregnant.	1	2	3	4	5
33.	Make enough money to be able to take care of all of his responsibilities.	1	2	3	4	5
34.	Be trustworthy.	1	2	3	4	5

35.	Keep our sexual life private.	1	2	3	4	5
36.	Take me out with him and his friends.	1	2	3	4	5
37.	Show me how much he loves me by having sex.	1	2	3	4	5
38.	Spend quality time with me in private.	1	2	3	4	5
39.	Show me that he can make money to take care of himself.	1	2	3	4	5
40.	Be willing to change his mind to agree with me.	1	2	3	4	5

During the time period that I was with this person, I expected that he would...		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
41.	Become more romantic once we start having sex.	1	2	3	4	5
42.	Take me on trips.	1	2	3	4	5
43.	Want to take our relationship to the "next level".	1	2	3	4	5
44.	Expect sex regularly.	1	2	3	4	5
45.	Spend money on me to show that he cares.	1	2	3	4	5
46.	Spend time with me to show that he cares.	1	2	3	4	5
47.	Consider our relationship "official" once sex became a part of the relationship.	1	2	3	4	5
48.	Provide me with money when I needed it.	1	2	3	4	5
49.	Be faithful to me even if we were not having sex.	1	2	3	4	5
50.	Have fun together.	1	2	3	4	5
51.	Go out regularly.	1	2	3	4	5

Appendix I

Demographic Form

Please answer the following questions as honestly as possible. Remember that all information is confidential and your name is not associated with any of this information.

1. What is your age? _____

2. Which county do you live in? (***Circle one***):
City of Richmond Henrico Chesterfield Hanover Other

3. In school, what is the highest grade you ever completed?

- ❑ Some high school
- ❑ High school graduate/GED
- ❑ Some college
- ❑ College graduate
- ❑ Post-college graduate
- ❑ Vocational training

4. Do you have children? Yes No **[If no, skip to #5]**
   - o How many children do you have? _____
   - o What is the age of your oldest child? _____

5. Who do you live with (circle one)?
Alone with family with a roommate

husband boyfriend other _____

6. Which of the following categories best represents your estimated household income?
- ❑ Less than $10,000
- ❑ $10,000-15,000
- ❑ $15,000-$25,000
- ❑ $25,000-$50,000
- ❑ $50,000-$75,000
- ❑ Over $75,000

Please respond by circling one of the options.
1. Have you ever had sexual intercourse?
   C. Yes

D. No **[skip to #_____]**

2. During your life, with how many people have you had voluntary sexual intercourse? _____

3. How old were you when you had sexual intercourse for the first time? _____

4. When you had sex the first time, voluntarily, did you and your partner use a condom?
Yes **No**

5. How long were you interacting/dealing with him (in a "more than friends" way) before you had sex? *Respond according to days, weeks or months.*

_____days OR ____ weeks OR ___ months

When answering the following questions, please focus on behaviors during the past **3 MONTHS.**

14. During the past 3 months, with how many people did you have sexual intercourse?
_____ (number of people)

15. During the past 3 months, did you ever have sex with someone you had just met (i.e., within the past week or so)? **Yes** **No**

16. How often did you and/or your partner use condoms during sex over the past 3 months?

1	2	3	4	5	6	7
Always			About half the time			never

17. How often did you use birth control during the past 3 months?

1	2	3	4	5	6	7
Always			About half the time			never

If so, which form of birth control did you use most often?

i. No method was used to prevent pregnancy
j. Birth control pills
k. Condoms
l. Depo-Provera (injectable birth control)
m. Withdrawal
n. Some other method
o. Not Sure

18. How many times have you been pregnant? _____

How many children do you have? _____

19. Have you been in a heterosexual relationship in the past 6-12 months?
c. Yes
d. No

12. Were you having sex in this relationship?
c. Yes
d. No **[skip to #10]**

Did you engage in this relationship?
- ☐ Vaginal Intercourse
- ☐ Anal intercourse
- ☐ Oral intercourse
- ☐ Wasn't having sex

13. How long did your longest romantic relationship last? _____
14. With <u>your</u> **LAST** sexual partner, how long were you interacting/dealing with him (in a "more than friends" way) before you had sex? *Respond according to days, weeks or months.*

_____days OR ____ weeks OR ___ months

15. Which term(s) would best classify your relationships that involve sexual engagement (generally)?
More than one term can be selected.
- ☐ Committed
- ☐ Exclusive
- ☐ Dating
- ☐ Casual friends
- ☐ Other term(s) _____

Please take answer the following questions as honestly as possible.

16. How likely are you to use a condom the next time you have sex?

Very likely	Somewhat likely	A little Likely	Not at all likely
1	2	3	4

17. How likely are you to use some form of birth control the next time you have sex?

Very likely	Somewhat likely	A little Likely	Not at all likely
1	2	3	4

18. In the next 3 months, how likely are you to have more than one sexual partner?

Very likely	Somewhat likely	A little Likely	Not at all likely
1	2	3	4

19. How likely are you to avoid having sex with your partner if he does not where a condom?

Very likely	Somewhat likely	A little Likely	Not at all likely

1 2 3 4

20. How likely are you to have your next sexual partner get tested before you have sex with him?

Very likely	Somewhat likely	A little Likely	Not at all likely
1	2	3	4

Note: The following question asks about any potential sexual abuse. If the experiences occurred with a family member and you were 18 years old or younger, we can assist you if you would like to report the incident to the police. If the incident occurred when you were 18 years or younger and you provide the individual's name, I am legally required to report the incident to legal authorities.

Have you ever been forced to have sexual intercourse when you did not want to?

- ☐ Yes
- ☐ No

If so, how old were you? _____
Did the experience occur with a family member or non-family member?

- ☐ Family member
- ☐ Non-family member

Appendix J

Screening Form

Informed consent: This is information about the project, your role and how information will be used. I am going to review this form with you before we do anything else to make sure that the purpose of the project if clear. You will receive a copy of the form to take home so that you can contact us if you have any questions after leaving.

I am going to start by asking you some basic background questions.

1. How old are you? _____

2. Most people think of themselves as belonging to a particular ethnic or racial group. Which group do you most identify with?
   a. Black/African-American
   b. Asian (Which country or ethnic group? _____)
   c. Hispanic/Latino (Which country or ethnic group? _____)
   d. White/ Caucasian
   e. American Indian
   f. Other _____

3. What country were you born in? _____
   (If another country) How long have you been living in the U.S.? _____

4. Do you think of yourself as:
   a. Heterosexual
   b. Homosexual
   c. Lesbian
   d. Bisexual
   e. Don't know
   f. Something else

5. In general, are you sexually attracted to:
   a. Only men
   b. Mostly men
   c. Both men and women
   d. Mostly women
   e. Only women
   f. Something else

6. In your most recent, intimate/romantic relationship, was your partner a **M** **F**

7. Have you ever been sexually active (vaginal, anal or oral)? **Yes** **No**

8. Do you have sex with women? **Yes** **No**

9. What is your current relationship status?
   a. Now married
   b. Member of unmarried couple
   c. Divorces
   d. Separated
   e. Widowed
   f. Never marries

Because I want to keep your identity private, what would you like for me to call you (another name, initials)?

Appendix K

Informed Consent Document

RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: Relationship Conceptualizations and Familial Factors as Contributors to Sexual Decision-making Patterns of Young African-American Women

VCU IRB NO.:

If there is anything in this consent form that you do not understand, please ask the study staff to explain. If you have questions or concerns after completing this survey or at a later time, please notify the office indicated on the final page.

Purpose of the Study:
The purpose of this research study is to find out about how African-American young women's ideas about interactions with men affect sexual choices, and types of family issues that affect how women interact with men.

You are being asked to be part of this study because you have identified yourself as an African-American woman between 18 and 30 years of age who has experienced voluntary sexual intercourse at some point during your life.

Description of the Study and Your Involvement:
In this study you will be asked to participate complete a survey packet. It should take about 20 minutes to complete this packet. At the end of the survey, you will complete a brief form including questions about where you grew up, your current housing situation, previous sexual behavior. Afterwards you will receive a $10.00 gift card.

Risks and Discomforts:
It is not expected that any issues addressed will be particularly stressful. Yet, sometimes thinking about personal issues and ideas can cause people to feel uncomfortable. Several questions will be asked about your ideas about interacting with men and where you got these ideas. You can stop completing the survey at any time. If you become upset, the study staff will give you a name of a mental health agency to contact so you can get help in dealing with these issues.

Benefits:
You may not get any direct benefit from this study, but, the information we learn from people in this study may help us design better programs for minority women and girls to help them understand male/female and family relationships.

Costs:
There are no costs for participating in this study other than the time you will spend completing the questionnaire packet.

Payment for Participation:

You will receive a $10.00 gift card for completing the survey.

Alternatives:
The alternative is to not participate in the study.

Confidentiality:

We will not tell anyone the answers that you provide, unless you provide information that suggests that (1) you may be a danger to yourself or someone else or (2) there is reason to suspect abuse of a child or adult. In such a case, the law says that I have to let people in authority know so that you or other involved individuals can be protected. If you complete the survey and provide the name of a person who abused you when you were 18 years or younger, I am legally required to report that information to legal authorities. Information from the study may be looked at or copied for research or legal purposes by Virginia Commonwealth University. What we find from this study may be presented at meetings or published in papers, but names will not be used in these presentations or papers.

During the survey process, the researcher will refer to you by your initials or a name other than your own so that your name will not be associated with any information recorded. The survey paperwork will be stored in a locked cabinet. At the completion of this study, this paperwork will be destroyed.

Voluntary Participation and Withdrawal

You do not have to participate in this study. If you choose to participate you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. Your participation in this study will have no effect on the services you receive at the clinic.

Questions

In the future, you may have questions about your participation in this study. If you have any questions, contact: Dr. Kevin Allison or Christina Grange at (804)828-1674.

If you have any questions about your rights as a participant in this study, you may contact:

Office for Research Subjects Protection
Virginia Commonwealth University
800 East Leigh Street, Suite 111
P.O. Box 980568
Richmond, VA 23298
Telephone: 804-828-0868

Appendix L

Perceived Relationship Quality Components Inventory

Please answer the following questions. Circle the number that best represents your response. Answer based on your interaction with your most recent sexual partner. Take all of the time that you need.

1. How much do you trust your partner?

1	2	3	4	5	6	7
Not at all			Average			Extremely

2. How much can you count on your partner?

1	2	3	4	5	6	7
Not at all			Average			Extremely

3. How dependable is your partner?

1	2	3	4	5	6	7
Not at all			Average			Extremely

4. How committed are you to your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

5. How content are you with your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

6. How happy are you with your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

7. How intimate is your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

8. How close is your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

9. How connected are you to your relationship?

1	2	3	4	5	6	7
Not at all			Average			Extremely

Appendix M

Multidemensional Relationship Questionnaire

Please answer the following questions honestly. Take time to think about what you have thought in the past, not what your thoughts are for the future. Circle the response that represents your feelings. Take all of the time that you need.

1. My intimate relationships are something I am largely responsible for.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

2. My intimate relationships are determined, in large part, by my own behavior.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

3. I exert a great deal of control over my intimate relationships.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

4. The main thing that affects my intimate relationships is what I myself do.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

5. My intimate relationships are something I am in charge of myself.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

6. I'm very motivated to be involved in an intimate relationship.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

7. I am strongly motivated to devote time and effort to my intimate relationships.

1	2	3	4	5
Not at all like me		Somewhat like me		Very much like me

8. I have a strong desire to be involved in intimate relationships.

1	2	3	4	5

Not at all like me Somewhat like me Very much like me

9. It is really important to me that I involve myself in an intimate relationship.

1 2 3 4 5
Not at all like me Somewhat like me Very much like me

10. I strive to keep myself involved in an intimate relationship.

1 2 3 4 5
Not at all like me Somewhat like me Very much like me

VITA

Christina Grange was born on August 21, 1977 in Miami, Florida. She is an American citizen. She graduated from Henderson High School, Chamblee, Georgia in 1995. She received her Bachelors of Arts in English Education/Psychology from Florida Agricultural and Mechanical University in 2000. She proceeded to received her Master of Science in Community Psychology from Florida Agricultural and Mechanical University in 2002. She received her Doctorate in Clinical Psychology from Virginia Commonwealth University in 2007.