2000

Relationship between sexual empowerment and risky sexual behaviours

MacGillivary, Lana Audrey Marie

Running head: SEXUAL EMPOWERMENT AND RISKY SEXUAL BEHAVIOURS

The Relationship Between Sexual Empowerment and Risky Sexual Behaviours

Lana A.M. MacGillivary ©

M.A. Thesis

Lakehead University

July, 2000

Submitted in partial fulfilment of the degree of Master of Arts, Clinical Psychology

Supervisor: Dr. J. Jamieson

Second Reader: Dr. J. Tan

Abstract

The present study explored the relationship between empowerment and risky sexual behaviours. Participants were 104 University students. All participants individually completed a questionnaire package that included the Scale of Sexual Risk Taking and the Sexual Empowerment Scale. The latter is an instrument developed for this study as a measure of sexual empowerment in undergraduate students. The questionnaires were followed by a 30-minute interview on the determinants of both safe and unsafe sexual behaviours. Students engaging in high-risk behaviour were compared to low-risk students, using both quantitative and qualitative data. The quantitative measures of sexual empowerment failed to predict Risky Sexual Behaviours although a variety of aspects of sexual empowerment emerged in the qualitative data. These findings are interpreted as support for treatment programs which focus on individual needs as opposed to a general increase in sexual empowerment.

Acknowledgements

Many individuals have contributed to the completion of this thesis. My parents, whose patience and support have never failed, I hope this helps make it worthwhile. I express my gratitude to Dr. Josephine Tan, my second reader, for her helpful, supportive feedback and her attention to detail. I thank fellow students Lize Jalbert and Jen Mazur for their insight, interest, and help. Finally, I thank my advisor Dr. John Jamieson for his encouragement and guidance, which made this all possible.

Table of Contents

List of Tables and Figure

Tables

The Relationship Between Sexual Empowerment and Risky Sexual Behaviours

According to UNAIDS (2000), approximately one in every 100 adults aged 15 to 49 is HIV-infected. More than 80 percent of these infections have resulted from heterosexual intercourse (Quinn, 1996). This information is especially relevant for adolescents and women as the incidence of HIV in these two populations is on the rise. In 1999, for example, more than 6,500 young people aged 15 to 24 became infected with HIV every day, that is, about five every minute (UNAIDS). Also, the proportion of all U.S. AIDS cases which were reported in women increased from 7 percent to 23 percent from 1985 to 1999 (CDC, 1999) Understanding why individuals engage in risky sexual behaviour is key in stopping the spread of HIV/AIDS and other STD's. Recently, the concept of empowerment has been proposed as a conceptual framework for modifying risky sexual behaviours in inner-city women (Levine et al., 1993) and gay men (Zimmerman, 1998). The present study explored the relationship between empowerment and sexual behaviours in university students through qualitative data and an instrument measuring sexual empowerment.

Sexual Practices

In an era of HIV and STD's, an understanding of factors that contribute to risky sexual practices is essential, especially for university-aged students. The university years are a time of sexual exploration and experimentation (Uddin, 1996). Undergraduate women may be particularly at risk for contracting HIV or STD's as the transmission of a STD from men to women is more likely than women to men (Uddin, 1996). To protect against such transmission, students must ensure they practice safe sex consistently. An important first step toward intervening effectively to change high-risk behaviours is an assessment of influencing

factors. According to Simkins (1995), the most predominant risky behaviours in university students are having unprotected sex and multiple sex partners. Self-esteem, self-efficacy, culture, and sex-role stereotypes are also possible contributors to sexual behaviours. These and other factors will be reviewed in the following section.

Health Factors. Health-related factors have been recognized as determinants of sexual risk-taking behaviour. Use of alcohol and drugs before sex is associated with more unprotected intercourse (O'Leary, Goodhart, Jemmott, & Boccher-Lattimore, 1992; Simkins, 1995). Epstein, Dusenbury, Botvin, Diaz, and Schnike (1994) found that AIDS knowledge, substance use, decision-making skills, and gender predicted intentions to engage in sexual behaviour in the future.

The purpose of a three-month study by Morrill et al. (1996) was to identify factors that predict the maintenance or initiation of safer sexual behaviour over time. Participants were women from a variety of backgrounds (e.g., educational, ethnicity, and socio-economic status). They were recruited from four urban community based health clinics and were either voluntarily seeking HIV testing or using other clinic services. Using those seeking HIV testing served two purposes: individuals engaging in this health behaviour deemed themselves to be at risk for a STD (i.e., as having unsafe sexual practices) and thus provided an appropriate comparison group for women seeking other services at the clinics. Overall, relationship involvement at follow-up was most closely associated with sexual behaviour: women in committed relationships were more likely to lapse from safer behaviour to risky behaviour over the study period. For women who engaged in unsafe sexual behaviours at the initial testing, participant optimism and HIV counselling and testing were associated with adopting safer sexual behaviour. For women who were safer at the initial testing, outcome efficacy

belief, and change in health locus of control were associated with behavioural maintenance.

Knowledge of HIV transmission and prevention, perceived risk of AIDS, and the sexual behaviour of pregnant, inner-city African American and European American women were investigated by Hobfall, Jackson, Lavin, Britton, and Shepherd (1993). Overall, they found women had poor AIDS knowledge and engaged in sexual behaviour (e.g., unprotected intercourse) which placed them at risk for HIV infection. Additionally, the women did not perceive themselves at risk for the AIDS virus although they did recognize that heterosexuals were at risk.

Psychological Factors. Research on psychological factors has also been fruitful in determining predictors of sexual practices. Rosenthal, Moore, and Flynn (1991), for example, found high self-esteem in adolescents to be associated with increased sexual risk taking in regular relationships. Self-efficacy was also predictive of contraceptive use. Morokoff et al. (1997) found that self-efficacy and experience were consistent predictors of sexual assertiveness.

Using a variety of dependent measures and a longitudinal (one month lag) design, Hardeman, Pierro, and Mannetti (1997) predicted Italian high school and university students' intentions to avoid casual sex and to use condoms. The dependent measures included scales assessing self-efficacy, attitudes, optimistic bias in perceived risk, and AIDS knowledge. Females with a strong intention to avoid casual sex had a relatively low risk for HIV-infection and perceived more benefits from condom use. They also reported more difficulty with talking about sex, but those with higher self-efficacy had higher intention to avoid casual sex.

In social cognitive theory, perceptions of self-efficacy to successfully carry out desired behaviours are key determinants of effective behaviour change (Bandura, 1986). Such

perceptions are found to be predictors and/or moderators of safer sexual behaviours (e.g., Adler-Cohen & Alfonso, 1997; Bakker, Buunk, & Manstead, 1997; Morrill et al., 1996; Otis, Levy, Samson, Pilots, & Fugere, 1997; Seal, Minichiello, & Omodei, 1997). Self-efficacy refers to perceptions of ability as opposed to actual ability. For example, women who know how HIV is transmitted may not take preventative measures unless they perceive themselves as capable of doing so. Several researchers (e.g., Bakker, Buunk, & Manstead, 1997; Uddin, 1996) have developed scales to assess individual levels of sexual-self-efficacy.

Bakker, Buunk, and Manstead (1997) examined whether perceptions of self-efficacy moderated the relationship between anticipated regret after unsafe sex and actual condom use. Students attending a primarily undergraduate institution in The Netherlands were approached on campus and asked to complete a questionnaire on "Opinions about safe sex." Students reported their subsequent sexual behaviour three months later. Results suggest that people are more likely to engage in safer sexual behaviour when they think they can exercise control over the situation, that is, when they have a high sense of self-efficacy. Additionally, participants were most likely to use condoms when they anticipated negative feelings as a result of not doing so (and positive feelings after using condoms).

Uddin (1996) measured self-efficacy as a composite of independent variables consisting of 11 questions pertaining to skills for carrying out safer sex practices. Participants responded on a 7 point Likert scale ranging from *not at all confident* to *extremely confident*. Uddin's (1996) scale provides a quick index of an individual's perceived self-efficacy in sexual situations. Examples of specific items include "I can carry condoms with me when on a date," " I can insist that my partner wear a condom even when he doesn't want to," and "I can refuse intercourse with my partner if no condom is available."

Using this survey, in conjunction with several others, Uddin (1996) found that levels of perceived self-efficacy of undergraduate women were related to dimensions of sexuality that may play a role in decreasing their risky sexual behaviour. Women with higher self-efficacy, for example, were more likely to be assertive with their male partners and insist on the use of contraceptives. They were also more likely to communicate openly about issues of HIV/AIDS, sex, and sexuality.

O'Leary et al. (1992) investigated sexual behaviours of college students in New Jersey. Self-efficacy was measured using two subscales: one assessing self-efficacy to discuss/negotiate sexual encounters (e.g., ask how many sex partners s/he has had) and the other assessed self-efficacy to practice safer sex (e.g., discuss using a condom before having sex). Contrary to their expectations, students who expressed greater confidence in their ability to negotiate and discuss their partners' sexual history engaged in more unsafe behaviours. O'Leary et al. (1992) suggest this is a consequence of students' beliefs that a partners' self-report of a safe history is an accurate one. Self-efficacy to practice safe sex in females, however, significantly predicted safe sex behaviour; but was not a predictor for males.

Self-esteem, one's feelings of high or low self worth, is another psychological factor related to sexual behaviour. Gaynor and Underwood (1995) developed a 35-item measure to assess sexual self-esteem, "the tendency to value, versus devalue, one's own sexuality, thereby being able to approach rather than avoid sexual experiences both with self and others" (p. 334). Examples of items include: "I feel sex is wrong or dirty," "I like and appreciate my body sexually," and "Part of what is good in life is being sexual." General support for the validity of this measure was obtained through three studies. In these studies, sexual self-esteem was related to a variety of factors such as sexual satisfaction with oneself and a sexual partner.

Seal, Minichiello, and Omodei (1997) also investigated the influence of self-esteem on sex practices. They surveyed 331 young women, aged 17-25, attending post secondary institutions, about their sexual risk taking behaviours. Self-efficacy and self-esteem were investigated as influencing factors. Questions were modified to include items specifically referring to perceptions of sexual self-efficacy and sexual self-esteem. Sexual self-efficacy was the perception of one's ability to exert control over sexual situations. Sexual self-esteem was feeling positive about one's own sexuality. Seal, Minichiello, and Omodei (1997) reported that sexual self-efficacy was positively related to sexual risk taking in both regular and casual relationships. That is, women who believed they were able to exert control in sexual situations were more likely to engage in risky behaviours. Sexual self-esteem was positively related to risk taking in regular relationships and negatively related to risk taking in casual relationships. That is, women in regular relationships who felt positively about their sexuality engaged in more unsafe behaviours while their equivalent peers (i.e. those having high self-esteem) in casual relationships engaged in fewer unsafe behaviours. .

These results were unexpected. Seal, Minichiello, and Omodei (1997) hypothesized that high self-esteem and self-efficacy would be directly related to safer sexual practices. Their results indicate the opposite pattern, with the exception of women in causal relationships with high self-esteem (they engaged in less risky behaviour). One possible explanation is that young women who feel more comfortable and confident in their sexual relationships (i.e., have high sexual self-esteem) engage in greater amounts of sexual activity, which leads to higher rates of unsafe sex. Seal, Minichiello, and Omodei (1997) suggest that these young women hold optimistic beliefs about the potential threats of STD's and rely on their own judgements about their partner's risk status, actively choosing not to use condoms. Thus, an intervention

designed at raising levels of self-efficacy may not necessarily lead to safer sex practices among women. Their findings suggest that further research needs to take into account personal and sexual characteristics, together with the type of sexual partners (i.e., casual or regular) to increase our understanding of the influences of self-efficacy and self-esteem on risk-taking behaviours.

Relationships between high self-esteem/self-efficacy and sexual risk taking may not be as simple as was once thought: increasing women's self-esteem or self-efficacy may not necessarily lead to an increase in safer sexual practices. If self-efficacy is influential, it would be expected to be positively related to the practice of safer sex (e.g., Hardeman, Pierro, & Mannetti, 1997; Jemmott et al., 1992; Uddin, 1996). Not all studies have found such a positive straightforward relationship (e.g., Rosenthal, Moore, & Flynn, 1991). Specifically, Gaynor and Underwood (1997) reported both positive and negative relationships with sex practices depending on the nature of the relationship. O'Leary et al. (1992) reported different relationships between two factors: self-efficacy (high versus low) and sexual behaviour (safe versus unsafe). Methodology also differed among studies (e.g., differences in the instruments and populations used and varying sets of dependent factors investigated) which may account for the discrepant results regarding the influence of self-efficacy on sexual behaviour.

External Factors. Socio-cultural experiences across gender, racial, and ethnic groups differentially influence sexual practices. For example, safer sex predictors of inner-city African American teenagers are different from youths in a middle-class rural farming community (e.g., Jemmott, Jemmott, & Fong, 1992; Stevenson et al., 1995; Quina et al., 1997; Zibalese-Crawford, 1997). Parents, peers, perceived social norms, and religion play varying roles, depending on the population of interest.

O'Leary et al. (1992) assessed the influence of perceived social norms on sexual behaviours, hypothesizing that perceptions of positive social norms for safer sex may promote safer behaviour. Their scale consisted of six self-report items on a four-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. Specific examples of items include: "Many students these days are trying to protect themselves using condoms," "Very few students are doing anything differently because of AIDS," and "Many women on campus keep condoms available." Their hypothesis was supported: students who reported that practising safer sex was socially acceptable were more likely to engage in safer behaviours.

A second factor is support for preventative behaviours from outside sources, such as peers or parents. In their study of African-American women, Jemmott and Jemmott (1991) found that support for condom use from others (e.g., parents and sexual partners) was significantly related to future intentions for condom use. Daugherty and Burger (1984) investigated the attitudes and sexual behaviours of undergraduate students attending a private Baptist university. They reported that females' general attitudes about sexuality tended to resemble the attitudes they believed their peers to hold more than they resembled the views they heard expressed by their parents. Females' sexual behaviour followed a similar pattern.

Sex-Roles. Due to socialization processes, men and women have adopted differential "roles" for sexual behaviour. Traditionally, North American women have been assigned the passive role as receptors of men's sexual advances (Quina, Harlow, Morokoff, & Saxon, 1997). There is evidence supporting the continued existence of these roles. Zellman and Godchild (1983) found that attitudes and expectations of 14-18 year-olds regarding relationships tended to be traditional and non-egalitarian. Both genders indicated that heterosexual relationships "necessitate an unequal power structure" (pp. 55). They generally

expected that the male partner would initiate and control a sexual interaction, that there are occasions where he may use force to have sex, and that the female may be held responsible for outcomes. The teenagers also endorsed the traditional view of relationships: the male as the active, aggressive pursuer who sees sex as separate from love, and the generally passive, uninterested female resistor who sees physical sex as an expression of romantic love.

Further evidence supporting the continued existence of gender-role stereotypes comes from Perper and Weis (1987). They found extensive use of 'proceptive behaviours' among undergraduate women, such as smiling, touching, or gazing into a partner's eyes, behaviours that served to indicate women's interest in sex. A reluctance among women to use direct statements for initiating, refusing, or requiring contraceptive use was also found, reinforcing the traditional "woman as passive/man as aggressor" stereotype. This view can have deleterious effects on women's sexual behaviour. A woman's statements to her partner, that is, her ability to effectively communicate her desire for safer sex has been positively related to condom use (Catina et al., 1990; Edgar, Freimuth, Hammond, McDonald, & Fink, 1992). If a woman is "passive" and does not express her wish to practice safe sex, unprotected sex may ensue. Edgar et al. (1992), for example, reported that few respondents attempted to assess the risk of contracting AIDS or other sexually transmitted diseases with a new partner. However, participants who explicitly communicated their desire for safer sex were successful in ensuring contraceptive use.

Intervention programs

In light of the persistence of AIDS-risk related behaviour, it is evident that research on methods for encouraging widespread behaviour change must remain a priority in the fight against AIDS (Kelly, Kathleen, Sikkema, Kalichman, 1993). To date, there have been

numerous attempts to formulate interventions to reduce risky sexual behaviour within various populations (e.g., African American adolescents, gay men, college students, etc.): these interventions have generally focused on teaching and encouraging the use of cognitive, social, and self-management skills to make risk reduction behaviour changes. Fisher and Fisher (1992), for example, developed the Information-Motivation-Behavioural Skills (IMB) Model to reduce risky sexual behaviours..

The IMB model asserts that HIV prevention information, HIV prevention motivation, and HIV prevention behavioural skills are determinants of HIV preventative behaviour. Thus, engagement in preventative behaviours is contingent upon the extent to which individuals are well informed, motivated to act, and possess the behavioural skills to act effectively. Carey et al. (1997) used this model to guide HIV risk reduction in a sample of primarily African-American, economically disadvantaged, urban women. Success of the four, ninety-minute intervention sessions was evaluated three weeks post treatment: participants were significantly less likely than controls to engage in unprotected intercourse.

Kelly and his colleagues (1989, 1993) found that gay men attending group interventions teaching risk-reduction skills, including condom use, safer sex negotiation, sexual assertiveness when confronted with coercion, and problem-solving strategies exhibited substantial, long term (16 months post-intervention) reductions in high-risk sexual practices. Jemmott, Jemmott, and Fong (1992) noted similar results in their five-hour intervention program for African-American male adolescents. Their intervention focused on AIDS education, risk attitudes and intentions, and training in condom use and risk reduction skills.

Using males and females from the same population, Jemmott, Jemmott, and Fong (1998) also designed and implemented controlled abstinence and safer-sex risk reduction (e.g.,

knowledge of HIV/STD's, the importance of using condoms, and skill development and confidence building regarding condom use) interventions. They reported that while both interventions reduced HIV sexual risk behaviours, the safer sex intervention was especially effective with sexually experienced adolescents and had longer-lasting effects.

St. Lawrence, Brasfield, Shirley, Jefferson, Alleyne, and O'Bannon (1995), in a longitudinal study of sex behaviours, randomly assigned African American adolescents to an educational program or an 8-week intervention that combined education with behaviour skills training. This included correct condom use, sexual assertion, refusal, information provision, self-management, and risk recognition. Results indicated that participants in the skills-training group reduced the frequency of unprotected intercourse, increased condom-protected intercourse, and used more of the behavioural skills taught than did participants who received information alone. Risk reduction was maintained one year post-intervention.

A number of interventions have not been as successful: those with undergraduate or college students appear to have only had modest successes in producing changes in sexual behaviours (Fisher & Fisher, 1992). Gillam and Seltzer (1989), for example, approached university undergraduate students and randomly assigned participants to watch an AIDS information movie or a first-aid movie. Those who did not show up for their assigned viewing formed the control group. From pre to 6-week post-test, participants who had watched the AIDS film showed marginal and inconsistent changes in AIDS information and AIDS attitudes.

Dommeyer, Marquard, Gibson, and Taylor (1989) investigated the effects of an AIDS awareness week campaign at a primarily undergraduate university. The campus was saturated with information on AIDS, including signs and symptoms, contact numbers, and the

importance of using condoms as a preventative measure. Free condoms were also given out to students. From pre-to immediate post-test, small significant effects were shown on students' AIDS knowledge (increase) and AIDS fear (decrease).

Franzini, Sideman, Dexter, and Elder (1990) randomly assigned college students to small groups of AIDS prevention behavioural skills training sessions, an AIDS information session (with participant discussion), or to an AIDS information only condition. Pre- and two-week post intervention testing showed increased assertiveness ability for those in the behavioural skills training condition. No changes in assertiveness were noted for the other two conditions.

In a longitudinal (3-month) study, Sanderson and Jemmott (1996) investigated condom use and mediators of condom use in college students after participating in one of two HIV prevention interventions (communication or technical skills training such as correct condom use) or a control group. Participants who completed either one of the interventions had greater condom use self-efficacy, more positive condom use attitudes, and had stronger intentions to use condoms than did those in the control group. At a three-month follow-up, those who were not in a serious relationship and who had participated in one of the interventions, reported more consistent use of condoms than did those in the control condition.

The majority of intervention studies targeting college/undergraduate students have tested only sex-education programs (e.g., Dommeyer et al., 1989; Gilliam & Seltzer, 1989). This strategy is likely to be ineffective with college students who know how HIV is transmitted but who still engage in risky sexual behaviours (Jemmott & Jemmott, 1992; Sanderson & Jemmott, 1996). Moreover, almost all HIV interventions with this population

are limited by only focusing on one or two aspects of behavioural change (e.g., Franzini et al., 1990; Sanderson & Jemmott, 1996; Tanner & Pollak, 1988), short-term follow-up assessments (e.g., Dommeyer et al., 1989; Gillam & Seltzer; Tanner & Pollack, 1988), or failure to assess behavioural outcomes (Dommeyer et al., 1989; Franzini et al., 1990).

Educators need to develop multifaceted approaches to AIDS prevention. Single strategies, such as enhancing condom availability, although important, will probably be insufficient to alter student behaviour. Predictors of safer sexual behaviour involve psychological factors such as self-efficacy and perceived control: these must not be overlooked when developing interventions. Skills training and awareness of the social norms and influences are also important components to the process of increasing safer sexual practices. These three dimensions, internal (e.g., self-efficacy), external (e.g., perceived societal norms), and behavioural (e.g., actual behaviours), are each components of empowerment.

Psychological Empowerment

Empowerment is generally defined as a process through which people, organizations, and communities gain mastery over issues of concern to them (Rappaport, 1984). It integrates perceptions of control, a proactive approach to life, and a critical understanding of one's environment (Cornell Empowerment Group, 1989; Zimmerman, Israel, Schulz, & Checkoway, 1992). Empowerment is a paradigm challenging notion (Kuhn, 1970). It is a positive concept in which strengths are examined instead of risk factors and environmental influences of social/individual problems are explored instead of blaming victims (Perkins & Zimmerman, 1995).

Many different definitions of empowerment have been posited over the last two

decades. For example, the Cornell Empowerment Group (1989) defines it as "an intentional ongoing process centred in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over these resources" (p. 2). Rappaport (1987) defines it as "a process by which people gain control over their lives, democratic participation in the life of their community." Maton and Salem (1995) define empowerment as "the active participatory process of gaining resources or competencies needed to increase control over one's life and accomplish important life goals" (p. 632). Zimmerman, Israel, Schulz, and Checkoway (1992) further simplify the definition as a "critical understanding of their environment" (p. 708).

While consensus has yet to be attained on a universally accepted definition, several themes are evident across definitions. These include: gaining control over one's life (Rappaport, 1984; Wallerstein, 1992), the belief that actions toward change will be effective (Gutierrez, 1988; Rappaport, 1984), having access to important resources (Lord & Hutchisom, 1993; Maton & Salem, 1995), the importance of self-efficacy (Rappaport, 1988; Rogers et al., 1997), and skill development (Dunst & Trivette, 1987; McWhirter, 1991; Pinderhughes, 1983).

Health service providers are beginning to see how empowerment can help protect individuals from HIV/AIDS and other STD's (Giffin, 1998; Hobfoll, 1998; Levine, Britton, James, Jackson, & Hobfoll, 1993; Zibalese-Crawford, 1997; Zimmerman, Ramizez-Valles, Suarez, de la Rosa, & Castro, 1997). A variety of strategies have been suggested to empower individuals to practice safer sexual behaviours, but few sexual empowerment programs have been actualized to date. One exception however, is the work of Levine et al. (1993). They

provide an example of variables relevant to empowerment theory in sexual practice research.

In their 1993 study, Levin et al. invited low-income women (ages 16 through 29) from obstetrics clinics in a midwestern U.S. city to participate in an empowerment intervention program designed to increase safer sex practices. The project itself was based on an intervention format involving a series of four group sessions. Women were randomly assigned to one of three groups: the HIV prevention group or to one of two control groups (one that received no intervention and one that was similar to the HIV prevention intervention, but the focus was on general health promotion rather than specific HIV-preventative behaviours).

The central theme of the sessions for both the AIDS- prevention and health-promotion groups was to formulate and apply a sound health action plan. To enhance practice of action plans, sessions encouraged "a sense of mastery, positive expectation of success, negotiation skills, assertiveness skills, and fear of negative health consequences for not acting in a healthy manner" (Hobfoll et al., 1994, p. 399). Reinforcing positive actions and past successes in addition to projecting positive expectancies of women's successes helped women experience a sense of mastery. Role-playing illustrated how behaviours could be enacted, to provide feedback, and to share ideas. Cognitive rehearsal helped women learn the specific behaviours necessary (e.g., how to use a condom). Sessions also included aversive-conditioning segments to increase both senses of vulnerability and mastery.

Participants completed questionnaires prior to the intervention, at post-intervention (approximately four months after recruitment), and at a six-month follow-up. A condom credit card allowing participants to obtain free condoms from local pharmacies for one year served as an objective measure of intervention effectiveness. Overall, women attending the HIV intervention demonstrated improvement in HIV knowledge, greater intentions to buy

condoms, and reported more frequent condom use. This group also made more use of the condom credit card than the other two groups.

Four critical points relevant to the translation of HIV prevention knowledge into behavioural change were noted. These included the importance of integrating participants' lives into the program (i.e., tailoring an intervention to the group to meet their specific needs), using a group format to encourage cohesiveness and support, engaging group facilitators to promote mutuality and equality, and promoting ongoing authentic relationships among the participants and staff members (social support).

Zibalese-Crawford (1997) suggested strategies for an empowerment-oriented intervention program for youths in alternative residential or educational settings (e.g., psychiatric hospitals, youth detention centres, etc.). Interviews were conducted with such youths (ages 12- 18) to ascertain their needs, and recommendations for program development were made based on this information. She suggests a peer education program, which would include: prevention, safer sex, skill building, self-esteem enhancement, and would encourage youth to think about their behaviour and values.

The link between empowerment and safer sexual practices is evident. Encouraging skill development (e.g., assertiveness and negotiation skills) and increasing HIV/AIDS awareness were suggested by Levine et al. (1993) as empowering strategies. The importance of self-efficacy, interpersonal relationships, and self-esteem enhancement were also highlighted. Fostering these abilities in young men and women is a positive step towards increasing safer sexual behaviours. However, increasing a woman's confidence in negotiating safer sexual encounters does not mean that she is "empowered." Rather, this is a single component of a larger framework including self-efficacy, resource mobilization, and a critical

awareness of ones' environment, to name a few. A general model of empowerment, encompassing these dimensions, was developed by Zimmerman (1995).

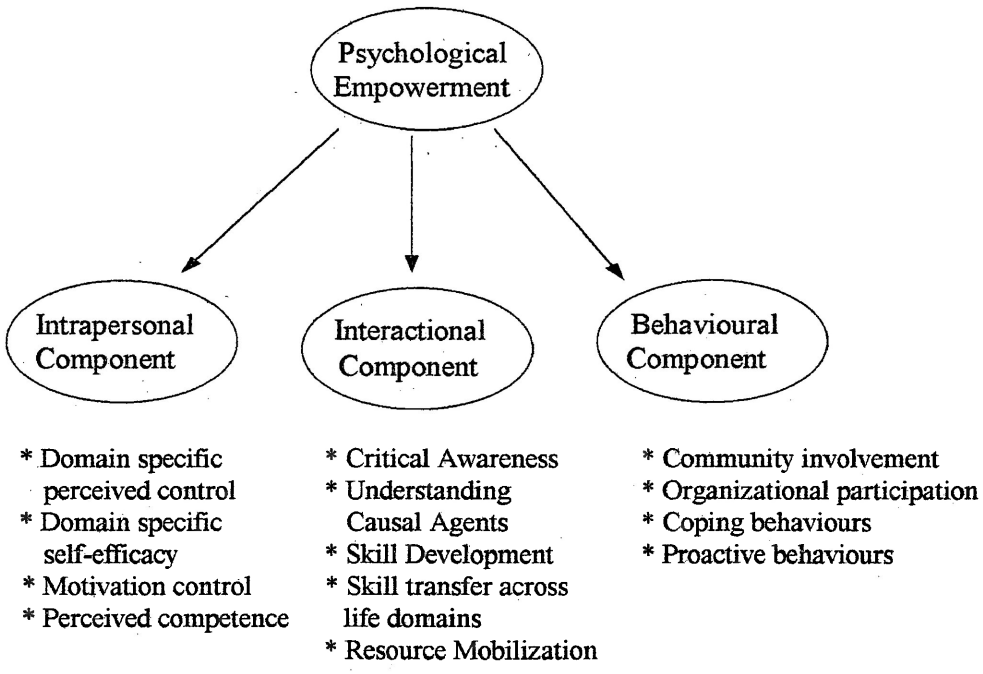
Zimmerman (1995) posits that psychological empowerment (PE), the study of empowerment at the individual level, differs across contexts, populations, and time (Rappaport, 1984; Zimmerman, 1995). For example, the behaviours necessary for a 40-year old unemployed blue collar worker to become empowered are different from a 20-year old engaging in unprotected sexual encounters. Empowerment takes on different forms for different people in different contexts: PE is dependent on the specific population under investigation.

According to Zimmerman (1995), an empowered individual might be expected to exhibit a sense of personal control, a critical awareness of one's environment, and the behaviours necessary to exert control. In this light, individuals who are sexually empowered are able to decide when and if to have sex, are aware of the factors that may influence this decision (e.g., relationship status, parents, peers), and act based on well-thought-out decisions. These different dimensions are the Intrapersonal, Interactional, and Behavioural components of PE (See Figure 1).

The Intrapersonal component includes personality (e.g., control), cognitive (e.g., self-efficacy), and motivational aspects of perceived control (Zimmerman & Rappaport, 1988). It specifically includes domain-specific perceived control, domain-specific self-efficacy, motivation control, and perceived competence. Domain-specific perceived control refers to beliefs about one's ability to exert influence in specific areas of life -- work, home, social life, etc. Perceived competence refers to one's beliefs about their competency to engage in certain behaviours. The emphasis on perceptions is important because perceptions influence

behaviour. For example, it is unlikely that a woman who does not feel she has control over a sexual encounter will exert control and/or if she does, it is unlikely that she will be efficacious in doing so. Domain-specific self-efficacy refers to one's beliefs about their ability to influence outcomes in specific areas. Motivation control refers to how motivated one is to control various sexual situations.

Figure 1: Nomological network for Psychological Empowerment



The Interactional component of PE is the vehicle through which the interpersonal component works (Zimmerman, 1995). It includes the capacity to analyze and understand one's environment (i.e., Critical Awareness), the ability to understand Causal Agents (i.e., those with power), their connection to the issue of concern, and an awareness of factors that influence decision making. The ability to transfer learned skills across environments (i.e., Skill Development) and to mobilize resources (i.e., Resource Mobilization) are also included in this component. Thus, a woman who is sexually empowered is aware of the factors that influence

her sexual decisions, knows where and how to access resources relating to her sexuality (e.g., physicians, birth control), and is able to transfer learned skills (e.g., communication, assertiveness, negotiation, etc.) to sexual situations.

The Behavioural component refers to actions taken directly to influence behaviours. This can include proactive behaviours, and stress and coping behaviours. For example, sexually empowered individuals will not rely on stereotypes about who is "clean" and who is not: they may not engage in sexual relations until they are certain that the partner is clean via STD testing or alternatively, they may consistently practice safer sex.

These three components of PE combine to form a picture of people who believe they are capable of influencing an outcome (Intrapersonal component), have an understanding of the factors that influence this ability (Interactional component), and are able to engage in behaviours necessary to elicit a desired outcome (Behavioural component). All three dimensions must be measured to fully capture sexual empowerment.

Zimmerman et al. (1997) employed this framework to develop a community-based intervention to prevent the spread of HIV/AIDS among homosexual Mexican males living on the United States/Mexico border. The intervention used an empowering process whereby participants were involved in developing, implementing, and evaluating the intervention. Participants took over leadership of the project by setting the agenda for topics covered, developing resources for the intervention, planning strategies to distribute condoms, providing assistance to people with HIV/AIDS, and conducting community education campaigns. Evaluation of the intervention included an assessment of attitudes, knowledge, and behaviour related to HIV/AIDS prevention. Results indicated that participants engaged in more preventative behaviours than non-participants did. However, the evaluation did not assess

individual empowerment outcomes (i.e., psychological empowerment).

In summary, research to date has identified a host of psychosocial predictors of sexual behaviour. Interventions, mostly behavioural or informational in nature, have been developed to increase safer sex practices. Empowerment has been posited as a predictor of sexual risk-taking behaviour in inner-city women and with gay men. Its role in determining the practices of undergraduate students, however, is unknown. As empowerment is population, context, and time specific, developing successful interventions for undergraduate students will be dependent on understanding individual needs. Conducting interviews and developing an instrument to measure levels of empowerment are two methods through which this may be achieved.

Present Study

The present study explored the relationship between psychological empowerment and sexual practices. A specific issue of concern is the relevance of the three theoretical dimensions of empowerment (described by Zimmerman, 1995) as determinants of risky sexual behaviour. This study attempted to measure these three dimensions of sexual empowerment using psychometric instruments. As well, interview data from sexually active women was used to evaluate the importance of empowerment.

Method

Participants

Participants were recruited from two populations. The first one was Lakehead University students seeking either STD treatment or testing at the student Health Services Center. They were given a cover letter (Appendix A) describing the nature of the study and the required involvement. They were asked to phone to schedule an interview. A lottery draw

for $100 was offered as an incentive for those participants recruited from the Health Services Centre. The second population was Lakehead University students recruited from Introductory Psychology courses. All participants drawn from this source received one bonus point towards their final mark in the course.

A sample of 132 participants from Introductory Psychology class (n=121) and from the Health Services Clinic at Lakehead University (n=11), having a mean age of 21.05 (SD = 4.77), participated in the present study. As only eleven individuals using the Health Services Center participated in the study, their responses were combined with those from Introductory Psychology participants. Only data from sexually active participants was analyzed. The final sample consisted of 104 participants: 83 females and 21 males with a mean age of 21.61 (SD=5.23).

The majority of participants (78.8%) were in their first year of university and either lived with their parents (35.6%) or in a University residence (26.9%). Others lived with roommates (12.5%), a partner or spouse (12.5%), alone (7.9%) or in a University townhouse (1.9%). The majority of students (76%) were involved in a steady relationship (M = 13.10 months, SD = 10.8) and 70.2% of those individuals were involved in a steady sexual relationship (M length = 9.78 months, SD = 8.83). The average number of different sexual partners was 4.42 (SD = 6.03). A Demographics section was used to obtain this information (see Table B).

Measures

Sexual Empowerment. Sexual Empowerment Scales measured the three different dimensions of empowerment (Zimmerman, 1995): the Intrapersonal, Interactional, and Behavioural dimensions.

Intrapersonal. Rosenthal, Moore, and Flynn's (1991) scale of sexual self-efficacy was used to measure the Interpersonal component of sexual empowerment. The Competence sub-scale (9 items) was concerned with taking the initiative and being assertive in achieving sexual satisfaction (e.g., refusing unwanted sexual advances and determining the extent of sexual encounters). The Control sub-scale (7 items) consisted of items relating to being responsible about and taking the initiative in saying no to sex. All items were assessed on a 5-point Likert scale ranging from *Very Uncertain* (1) to *Very Certain* (5). A total score was obtained by summing all responses.

Interactional. The Interactional component of sexual empowerment was measured by developing items assessing four areas. These areas were: Resource Mobilization (e.g., "Would you obtain sexual information through these services? The: Internet? Health Services Clinic on campus?), Critical Awareness (e.g., "Most students at the university practice safer sex" and "Most students at the university discuss methods of protection before engaging in sex"), Causal Agents (e.g., "My sexual practices are influenced by my religious beliefs" and "My sexual practices are influenced by my desire to be popular"), and Skill Development (e.g., "I've learned from past sexual experiences" and "I'm more comfortable negotiating the use of condoms than I have been in the past"). All items were assessed using a 5-point Likert scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (5), with the exception of the Resource Mobilization scale. It was assessed using a yes/no dichotomy. For each scale, a total score was obtained by summing participants' responses.

Behavioural. Seven items were generated from discussions and from the literature to measure the behavioural dimension of sexual empowerment. These questions addressed the extent of agreement with the following behaviours: always having protection available, going

for regular STD testing, delaying sexually gratifying experiences in anticipation of future outcomes, communicating their desire for sex, remaining in control when using drugs or alcohol, relying on friends when in vulnerable situations (e.g., drinking at a party), and never accepting drinks from strangers. All items were assessed using a 5-point Likert scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (5).

The items designed to measure the Interactional and Behavioural dimensions were examined by two graduate and one undergraduate students to ensure they were unambiguous and appropriate measures of these concepts. Based on their feedback, a number of items were deleted or reworded. After this process, the Interactional scales consisted of 40 items and the Behavioural scale had 7 items (Appendix C).

Scale of Sexual Risk-Taking (SSRT). The SSRT is an 11-item self-report scale designed by Metzler, Noell, and Biglan (1992) to assess high-risk sexual behaviour in heterosexual adolescents. It consists of six items measuring specific heterosexual behaviours reported to be significant risk factors for AIDS: number of different sexual partners in the past year, number of sexual contacts in the past year with partners that the person did not know well, number of sexual contacts in the past year with partners known to be having sex with other partners, number of sexual contacts in the past year with partners who have used intravenous drugs, frequency of intercourse without the use of condoms, and a history of ever having anal sex. Additional items include questions pertaining to frequency of sexual intercourse, contraceptive use, and use of alcohol or drugs during sexual activity (Appendix D).

Items are answered using a 5-point likert scale or a yes/no dichotomy. Responses are then added to obtain a composite score of risky sexual behaviour with higher scores meaning

greater engagement in risk taking activities. The point value for six items are doubled: Metzler et al. (1990) argued that not all sexual behaviours represent equal risk, some could arguable be of greater or lesser importance. For example, scores from the two items "Have you ever had anal sex?" and "When you have sexual intercourse, how often do you or your partner (s) wear a condom?" are doubled. Scores from items "Have you ever had sexual intercourse with someone of the opposite sex?" and "When you have heterosexual sex, how often do you or your partner (s) use some kind of birth control?" are not doubled.

Sexual Self-Esteem. The tendency to value, versus de-value one's sexuality, is the core concept of sexual self-esteem. Gaynor and Underwood (1995) proposed seven dimensions of this in a 35-item Likert type questionnaire: Safety (the tendency to feel safe and secure during sexual activity), Body (the tendency to value one's body, sexual body parts, and appearance), General (the tendency to value one's sex life), Pleasuring Self (the tendency to enjoy multi-sensory, external stimuli), Fantasy (the tendency to enjoy sexuality through healthy fantasy and imagination), Receiving (the tendency to enjoy receiving sensual, sexual attention and stimulation from a partner), and Giving (the tendency to enjoy giving sensual, sexual attention to a partner) (Appendix D). The items reflect both positive (n=18) and negative (n=17) poles of each dimension. Items were summed to obtain a total score for each dimension with higher scores representing higher levels of sexual-self esteem.

Self-Esteem. The short form (10 Likert items) of Rosenberg's (1979) Self-Esteem scale was used to assess self-esteem. The ten items were summed to obtain a measure of participants' level of self-esteem (Appendix F).

Interpersonal Adjectives Scale – Revised (IAS-R). Developed by Wiggins, Trapnell, and Phillips (1988), the IAS-R consists of 64 adjectives describing 8 different personality

dimensions. It includes assuming, unassuming, arrogant, unassured, warm, cold, aloof, and gregarious personality dimensions (Appendix G). Eight adjectives are used to describe each dimension. Participants rate themselves on each adjective using an eight-point likert scale ranging from *Extremely Inaccurate (1)* to *Extremely Accurate (8)*. Scores for each dimension are then totalled with the higher scores reflecting personality characteristics and vice versa.

Procedure

The present study involved individual fifty-minute sessions per participant in which they completed the questionnaires and interview. Participants were given a package that included a consent form, and the aforementioned questionnaires. After signing the consent form (Appendix G) to indicate their willingness to participate in the study, participants completed the questionnaires. Responses were recorded on a computer scanner sheet.

Following questionnaire completion, participants were individually asked four questions related to their sexual practices (Appendix H). They were asked to describe the reasons why they have engaged in safe or unsafe sex during the past year, outside influencing factors, and engagement in proactive behaviours (e.g., buying condoms, discussing sexual practices before engaging in sex, etc.). Students were also asked what they feel would be appropriate in terms of an intervention designed to increase undergraduate students' safer sex practices. Responses were typed into a laptop computer. Upon completion, participants were given a debriefing form (Appendix I). Quantitative and qualitative analyses were then completed, the theory and method behind the latter is presented below.

Qualitative Analysis. Qualitative analysis began with a cross-case analysis, wherein answers from different participants were grouped by themes. The themes were then compared with Zimmerman's (1995) theoretical model of empowerment. Two techniques were used to

help achieve this. A process-outcome matrix (Patton, 1990) describes "linkages, patterns, themes, experiences, content, or actual activities that help us understand the relationship between processes and outcomes" (p. 416). It is a way of organizing, thinking about, and presenting the connections between the construct being investigated and the outcome. Next, Guba's (1978) proposed classification system was utilized to help focus the qualitative data. Guba suggested two major criteria against which data should be evaluated to help identify "reoccurring regularities" (p. 53): internal and external homogeneity. Internal homogeneity, that is, the extent to which data in each category "dovetail" (p. 53) in a meaningful way, is the first criterion. External homogeneity, the extent to which the differences between categories are clear, is the second criterion against which data are judged. If a large number of data are un-assignable or overlap with other categories, the validity of the category is questionable (Guba, 1978). Categories are then to be prioritized based on the "credibility, uniqueness, heuristic value, feasibility, special interests, and materiality of the classification schemas" (p. 55). After the data have been classified and divided, they should be re-evaluated through four means. First, the data should seem to be internally and externally plausible such that the internal categories appear consistent and viewed externally; the categories seem to comprise a whole picture. Second, there should be few un-assignable pieces of data. Third, a second observer should be able to verify that "a) the categories make sense in the view of the data which are available and, b) the data have been appropriately arranged in the category system" (p. 73). In the present study, the second observer was a PhD clinical psychology student who was knowledgeable about risky sexual behaviour. Four, the categories developed should be credible to the persons who provided the data, that is, the participants involved in the investigation. The latter criterion was the only one not met due to time constraints.

Results

Risky Sexual Behaviours

Two definitions were used to identify individuals who engaged in risky sexual behaviours. First, those who answered yes to the questions "Have you had sex with someone you did not know well?" were classified as High Risk #1. Second, those who were not in a steady relationship and who did not always use a condom were defined as High Risk #2. Most individuals were deemed to be low risk by both definitions. That is, they had not engaged in sex with an unfamiliar person or, for those not in steady relationships, they reported always using a condom. There were no significant gender differences (see Table 1). The two high-risk measures were significantly related, χ^2 (1, N=104) = 5.12, $p < .05$.

Table 1

Responses to High Risk Measures by Gender

Gender	Risk Measure				χ^2
	High Risk #1		High Risk #2		
	Low	High	Low	High	
Male	62%	38%	81%	19%	1.67
Female	76%	24%	86%	14%	.27

Responses to the SSRT had a mean of 30.96 (SD = 4.23) and a range of 21 to 43. There was no significant difference between males (M = 31.23, SD = 5.58) and females (M = 30.89, SD = 3.85) (see Tables 2, 3 and 4). Because of the similarities between males and females, their responses were combined for the rest of the analyses. Those identified as High Risk #1 scored significantly higher (M = 32.79, SD = 4.59) on the SSRT than those identified as Low Risk (M = 30.29, SD = 3.91), t (102) = -2.75, $p < .01$. Those identified as High Risk #2 (M = 29.94, SD = 5.31) did not score significantly higher than those identified as Low Risk (M = 31.15, SD = 4.01).

Table 2

Responses (Percentage) to Risky Sexual Behaviour Items

Item	Yes	No
1. Have you ever had sexual intercourse with someone of the opposite sex?	100%	0%
2. Have you had sex in the past year with a partner who you knew was having sex with someone else?	13.5%	86.5%
3. Have you ever had anal sex?	26.9%	73.1%
4. Have you ever had a STD?	8.7%	91.3%

Table 3

Frequency of Engagement in Risky Sexual Behaviours

Item	Never	Occas-ionally	Half the Time	Often	Always
5. Generally, in the past year, how often has alcohol been part of your sexual activities?	40.4%	47.1%	5.8%	6.7%	0%
6. Generally, in the past year, how often have marijuana or drugs other than alcohol been part of your sexual activities?	81.7%	12.5%	3.8%	1%	1%
7. When you have heterosexual sex, how often you do use some kind of birth control?	6.7%	2.9%	2.9%	14.4%	73.1%
8. When you have sexual intercourse, how often do you or your partner (s) wear a condom?	18.3%	19.2%	5.8%	17.3%	39.4%

Table 4

Frequency (Percentage) of Engagement in Risky Sexual Behaviours

Item	Never	Once	Twice	Three Times +
9. In the past 12 months, how many times have you had intercourse with someone you didn't know well?	73.1%	18.3%	6.7%	2.0%
10. Have you had sex in the past year with someone who injects drugs?	96.2%	1.9%	1.1%	1.0%
11. How many times in the last year have you had sexual intercourse with someone of the opposite sex?	14.4%	3.8%	4.8%	76.9%

Psychometric Properties of the Sexual Empowerment Scale

The three dimensions of the Sexual Empowerment Scale (SES) were subjected to a reliability analysis to determine whether they were measuring internally consistent dimensions of sexual empowerment. Items having total item correlations greater than .30 were included in the final scale. Scales were constructed from these items (see Table 5).

Two scales (Control and Competence) derived from Rosenthal et al.'s (1991) scale of sexual self-efficacy were used to measure the Interpersonal component. Each had acceptable alphas (> .70) as did the total score. The Competence sub-scale (9 items) was concerned with taking the initiative and being assertive in achieving sexual satisfaction (e.g., refusing unwanted sexual advances and determining the extent of sexual encounters). The Control sub-scale (7 items) consisted of items relating to being responsible about, and taking the initiative in saying no, to sex.

Table 5

Reliability Analysis for Sexual Empowerment Measures

Scale	Number of Original Items	Number of Final Items	Alpha
Intrapersonal Component			
Control	7	7	.75
Competence	9	9	.73
Total	16	16	.84
Interactional Component			
Resource Mobilization	13	12	.74
Critical Awareness	13	12	.77
Causal Agents	9	5	.58
Skill Development	5	5	.58
Total	40	34	.67
Behavioural Component	7	5	.75

Of the four sub-scales designed to measure the Interactional component, two (Causal Agents and Skill Development) had low internal consistency (< .60) and the total score also had a somewhat low alpha (< .70). Resource Mobilization (12 items), was being aware of the places where sexual information can be obtained (e.g., the Internet, library, physicians, TV programs) and the likelihood that one would use such resources. The second 12-item sub-scale, Critical Awareness, was the perception of sexual norms and values for their university-aged peer group (e.g., with regard to discussing methods of protection, having sex, etc.). Causal Agents (9 items), the third Interactional scale, was awareness of the factors influencing

sexual behaviour (e.g., religion, peers, parents). The fourth scale, Skill Development (5 items), was the recognition that one's skills (e.g., negotiation, communication) have improved as a result of previous experiences.

The 5-item scale designed to measure the Behavioural dimension had acceptable internal consistency (>.70). It consisted of items relating to behaviours encouraging safer sexual practices (e.g., always having protection available, delaying immediately gratifying sexual experiences, communicating sexual intentions to partners, etc).

Pearson correlations showed that the Intrapersonal and Interactional components were highly correlated ($r = .643$, $p < .001$). The Behavioural scale was significantly correlated with the Interactional components, $r = .263$, $p < .01$, but not with the Interpersonal component, $r = .001$. While the inconsistent correlations raise questions about the validity of these scales, it also suggests that they should be examined separately, rather than combined to form a general measure of sexual empowerment. Thus, given the exploratory nature of this study, the scales will be examined individually in the following analyses. There was a significant gender difference only on the Behavioural scale, with males having lower scores than females. Examination of individual items on this scale showed that females scored significantly higher on the items "I always have protection available, just in case", "I go for regular STD testing", "I don't accept drinks from strangers" and "I am able to communicate to a partner that I want to have sex."

Relationship of Empowerment Scales to Risky Sex Practices

There were no significant correlations between the SSRT and either the Interpersonal ($r = .15$), Interactional ($r = .11$) or Behavioural ($r = -.03$) scales. Comparing the high and low risk groups on the three measures yielded only one significant finding (see Table 6). Those in

High Risk group #1 (having sex with a person they did not know well) scored lower in the Behavioural component ($\underline{M}$ = 16.15, $\underline{SD}$ = 4.05) than those in the Low Risk group ($\underline{M}$ = 18.22, $\underline{SD}$ = 4.33), $\underline{t}$ (102) = 2.13, $\underline{p} < .05$. Examination of individual items showed that the High Risk #1 group scored significantly lower in "I go for regular STD testing", "I never let myself lose control when using drugs or alcohol" and "I don't accept drinks from strangers."

Table 6

Correlations between Sexual Empowerment Scales and Risky Sexual Measures

Component	High Risk #1**	High Risk #2**	SSRT
Control	.11	.15	.13
Competence	.004	.06	.13
Resource Mobilization	-.07	-.02	-.05
Critical Awareness	.10	.14	.19
Causal Agents	.10	.05	.12
Skill Development	.10	.09	-.02
Behavioural	-.21*	.002	-.03

* $\underline{p} < 0.05$ level
** Point bisceral correlations

Other Psychometric Measures

Three other scales were included in this study, both to evaluate whether they predicted risky sexual behaviour and to establish concurrent validity for the Sexual Empowerment Scales. The IAS-R provided eight personality dimensions, the Sexual Self-Esteem Scale (Gaynor & Underwood, 1995) yielded seven dimensions, and Rosenberg et al.'s (1991) self-esteem scale yielded a single score. Appendix J shows the correlations of these measures with

the sexual empowerment scales. The correlations with the measures of risky sexual behaviour are presented in Appendix K. While a few correlations were significant, the overall picture is that these measures are not strongly related to either the sexual empowerment scales or the measures of risky sexual behaviour. In contrast, these measures showed much higher correlations with each other (Appendix M).

Alcohol Use

The perceived effect of alcohol on sexual behaviour was also investigated. When asked if they are able to control their sexual urges while under the influence of alcohol, 47.4% of males and 39.9% of females were unsure or disagreed if they could. A comparable percentage of students (47.4% and 31.5% respectively) disagreed or strongly disagreed with the statement "I never let myself lose control when using drugs or alcohol." When asked if their sexual practices are influenced by alcohol use, 57.9% of males and 77.2% of females agreed or strongly agreed that they were. Many males (42.1%) and females (48.6%) reported that alcohol was part of their sexual practices at least occasionally. Thus, a sizeable proportion of participants reported that not only is alcohol a part of their sexual practices and they lose control when drinking, but that it also inhibits their ability to control their sexual urges and hence their sexual practices.

Qualitative Data

Analysis of qualitative began by dividing participant's responses into two categories: engagement in safer and unsafe sexual behaviours. A process-outcome matrix was created to synthesize the data in two dimensions: process and outcome dimensions. The process dimension reflects the decision to engage in safer or unsafe sex while the outcome dimension describe the feelings, beliefs, attitudes, values, and behaviours associated with engaging in

safer and unsafe sexual behaviours. Each safer and unsafe sex behaviour are categorized into positive and negative outcomes. The resulting matrix and themes are presented in Table 7.

Safe Sex, Positive Outcome. Thematic analysis revealed many positive and common outcomes of engaging in safer sexual behaviours. They are:

1. Awareness of Risks

Both male and female participants (67) made comments indicating they are able to successfully refuse unsafe sexual activities, most often out of fear of STD's and pregnancy. When asked if he had ever refused to engage in unsafe sex, one male participant commented, "She just wanted to have sex and it was early in the relationship and so I said no. I looked for a condom frantically and so we had sex. I needed to use a condom because I was nervous about stuff like that. [Like that?] - The risk of her getting pregnant or me getting diseases." Similarly, a woman responded "...If a person refuses to wear a condom, I just refuse. I don't know where that person has been. It's easy for me to refuse"

2. Critical Evaluation of Potential Partner

Participants (21) reporting a healthy sense of scepticism towards sex partners engaged in safer sexual practices or chose to abstain from sex. When asked why she engaged in safer sex, one participant stated, "To be safe from pregnancy and you never know people's past experiences here – you hope they are telling the truth but just to be on the safe side I use condoms." It also appears that men are discriminatory too: e.g., "...she totally wanted to just do it, and I was like "Look Jen, we don't have anything!" and it also helped that she didn't have a great reputation, I knew a bunch of the guys she had been with. That was probably the biggest thing – that would have definitely been a factor influencing my decision. So it was not only pregnancy, it was she might have had something I didn't want to get."

Table 7

Process-Outcome Matrix of Sexual Behaviours and Positive and Negative Outcomes

	Outcome	
Process	Positive Outcome	Negative Outcome
Engaging in Safe sex	1. Awareness of Risks 2. Critical Evaluation of Potential Partner 3. Critical Evaluation of the Media 4. Perceived Control 5. Positive Messages from Others 6. Ability to Communicate Needs 7. Learned from Previous Experiences 8. Proactive Behaviours 9. Self-Worth 10. Focus on the Future	1. End of Relationships 2. Multiple/Unknown Partners
Engaging in Unsafe Sex	1. Perceived Acceptance by Partner/Peers	1. Succumb to Pressure 2. Sex for Intimacy 3. Passive Attitudes and Behaviours 4. Inability to Communicate Sexual Needs 5. Blind Trust 6. Spontaneous 7. Influence from Others 8. Denial of Risk 9. Passive Acceptance of Media Messages 10. Alcohol as a disinhibitor

3. Critical Evaluation of the Media

The media also appeared to influence sexual behaviour for 15 participants both in terms of the decision to have sex and expectations in sexual encounters. Critically evaluating these messages helped contribute to positive sexual practices. One participant stated "When I was young, naïve and sway-able, I used to succumb to the attitudes of my peers and the media. I started looking at things differently and started noticing how morally decrepit society is especially in terms of sexual attitudes. I'm more careful now." The fear-evoking safe-sex message campaigns were also noted as reasons why participants engaged in safer sexual practices: e.g., "It just scares people. It tries to get the point across that unprotected sex isn't safe and that you should know who your partner is and who they've slept with before... Well, its influenced me as in I haven't experienced unprotected sex..."

4. Perceived Control

Participants (25) spoke proudly of their ability to control the extent and type of sexual activity within relationships, resulting in safer sexual behaviours. One woman stated "Most of the guys I'm with, I'm more domineering in it... I've never been pressured into sex, it's always been me, if I'm comfortable with it. If I don't like something they suggest, I just say no." Another participant, when asked if she ever refused to engage in an unsafe sexual activity stated, "I refuse if we don't have a condom. It's not a decision that I would think about changing. I know that I don't want to have a baby and there's no question about my decision." Thus refusal to have sex without a condom is indicative of perceptions of power to control situation outcomes.

5. Positive Messages from Others

When asked about the influence that peers have on their sexual behaviour, many individuals (54) reported the influence was positive (e.g., they learned from their peers' mistakes in an open, supportive environment). For example, one participant stated, "We're all fairly open with each other and I guess they have influenced me. I learned from their experiences and we all share their input. They've influenced me in a positive way." A similar pattern emerged regarding the influence that parents had: those who discussed sexuality (including sexual practices) felt this had helped shape their positive attitudes toward safe sex: e.g., "Mom influenced my decision because she gave me knowledge on what's out there... So I learned about the diseases way before I had sex. She wanted me to think about it – she said it was up to me but she gave me all the information I needed to know."

6. Ability to Communicate Needs

Participants (26) stated that they talked about their sexual needs and wants with their partner. Success, that is, engagement in safer sexual behaviours, was related to being able to communicate sexual needs and feeling comfortable doing so. Two examples of this include "I didn't really know the person very well and I didn't want to take any risks so I said we would have to use protection" and "I don't have a problem with assertiveness, for example, buying condoms, saying what I want."

7. Learned from previous experiences

Participants (13) noted that past successes and failures helped shape their sexual practices. Feeling able to integrate past learning experiences with future expectations resulted in safer behaviours. One participant stated:

> I've had a one night stand and after I did that I realized that I don't want to do that anymore and I became more conscious of my behaviours 'cause my friends always tell me that I tend to flirt with guys and I don't think I do. So I watch my behaviours, not wanting to make that same mistake over again. From that experience, I've learned to be more careful.

Past experiences also helped improve participant's comfort level when communicating about their sexual needs. For example, one woman commented, "I'm very comfortable talking to my partner about what I like and don't like. I haven't always been comfortable – I guess the experience with a lot of partners and getting influenced from partners on their behaviours and attitudes towards sex makes it easier."

8. Proactive behaviours

Engaging in behaviours that either increase the likelihood of practicing safe sex or decrease the likelihood of unsafe sex, were also noted by 23 participants. Regular STD testing for both the person and their partner, having a 'buddy' system with friends at parties (e.g., you must leave with a friend), purchasing condoms, and limiting alcohol consumption were some proactive behaviours mentioned by participants. For example, one participant commented "When I first started dating my boyfriend, I knew his history but we still hadn't had testing done for STD's and we felt that we would be safer using condoms until we got the results back."

9. Self-Worth

Participants (17) proudly stated that they valued themselves too much to compromise their sexual health by engaging in unprotected intercourse. One participant stated, "I think I have a pretty high self-esteem. I have been raised that way and I don't want to diminish that by

hurting myself by getting a disease or getting pregnant. I have a high respect for myself and don't want to put myself in a bad position." Similarly, another commented:

> I view my body as my temple and even if it were with my present partner and I said "no" for whatever reason – if I wasn't on birth control or if I didn't want to get pregnant – I don't find any problem with it whatsoever. It's my body. It's my decision.

10. Focus on the Future

Another theme that emerged in the relationship between safe sex and positive outcomes was the emphasis on the future in determining sexual experiences, that is, delaying immediately gratifying experiences for longer-term ones (9 participants). One participant commented, "Refusing it [unprotected sex] is better than maybe having a bad sexual experience. That would be worse than dealing with flack for refusing." Another stated that she did not want to engage in an activity she might regret later, adding, " It's hard to say no because you resist something that might feel nice but, I think that resisting in the long term makes you feel a lot better. It probably wouldn't have been beneficial and may have caused you a lot of stress even if nothing happened."

Safer Sex, Negative Outcome.

1. End of relationships

Attempting to ensure physical health, either by deciding to abstain from intercourse or demanding that condoms be utilized, ended relationships for 12 participants (e.g., "When I was in a relationship, the guy didn't like wearing condoms but I told him that I wasn't ready to deal with pregnancy or diseases. It strained and actually ended our relationship"). In the following two quotes, participants recognized the value in their decisions: "Well, it was a let

down because the guy was pretty hot but...it felt good and bad at the same time. Good that I was being smart enough to protect myself and bad because he was such a putz and said "forget you!" and,

> It was eye-opening in the sense that when I said "no, sorry I can't do it" [without a condom] he said he would take me home. So I was there for his convenience and when he couldn't get his 'wham bam thank-you mam', he took me home. There are just times when you don't want to take the risk because you think – "what's it for?"

2. Multiple/Unknown partners

Several participants (6) reporting safe sexual behaviours had multiple partners (e.g., "It's insane to have multiple partners and not be protected. You can't trust guys – they could tell you they've never had sex before and they could be carrying some disgusting diseases") and sexual encounters with people they did not know well. For example, one participant stated, "That was the time when I had sex with a partner that I didn't know that well. So, I told him that we had to use protection." Similarly, another commented, "...It wasn't relationship sex - it was just sex. Cause I didn't know much about him - where he'd been or who he'd been with."

Unsafe Sex, Positive Outcome.

1. Perceived acceptance by partner/peers

Some participants reporting engaging in unsafe sexual activities to please their partner. This overemphasis on others' expectations relative to their own was noted in comments such as "I had sex for the first time and then the partnership broke up, and another guy took an interest me and I just slept with him – I though that's what he wanted" and "It was a maturing

thing – I thought that's what people do. I thought it would be cool to do [unprotected sex]."

Unsafe Sex, Negative Outcome.

1. Succumb to Pressure

Unsuccessfully coping with pressure from one's partner was associated with engaging in unprotected intercourse. This theme emerged in women who did not see the value in refuting the request, noting the effort required doing so. One participant stated,

> I've actually had a lot of experiences where I knew the guy wanted to have sex so I did even if I didn't particularly want to. I wouldn't even bother to say why –I'd just to do. I could have been just not in the mood or I wouldn't feel like it then, I'd rarely say. Sometimes I'd say no but it was an exercise in futility. I'd have to spend more time explaining why I didn't want to have sex as opposed to just having sex so I just copped out a lot.

Others were more apt to engage in unprotected activity to pacify and/or please their partner. As one participant explains, "I guess it was difficult but, um, sometimes you're just not in the mood and you don't want to. I would just say 'no' but they'd say "oh come'on, it's just this once", or "it'll be ok." It makes me feel like shit, just terrible and sometimes I probably end up giving in, just to make him happy."

2. Sex for Intimacy

Some participants reported engaging in unprotected sex in the hopes of establishing a relationship with the person or feeling a sense of connection/intimacy with them. One participant explained unprotected one night stands were "a cry for intimacy, not for sex." Fear of jeopardizing this connection was a reason why participants engaged in unprotected

intercourse. As one participant stated, "I don't want to hurt their feelings or I don't want them to be disappointed in me. I'm insecure – I don't want them to not like me."

3. Passive Attitudes and Behaviour

Some participants engaging in unsafe sexual behaviours did not feel a sense of responsibility for ensuring their own physical health. The philosophy "it's the guy's responsibility" emerged in reference to comfort in communicating sexual needs and in providing contraceptives. One participant explained her inability to purchase condoms as "stereotypical," further stating, "I'm a shy person and I don't think I have the guts to go in and buy them."

4. Inability to communicate sexual needs

The difficulty of discussing their sexual needs and wants, noting feeling uncomfortable and/or embarrassment, was another theme that emerged. This difficulty often resulted in engagement in unprotected intercourse. As one participant explains,

> It's not that I'm not comfortable with it [discussing sexual practices] ... Maybe after we've been together longer. I just can't see myself as the type of person to do that. [What type of person would?] Really kinky chicks who know exactly what they want. Maybe, more assertive people but I'm pretty assertive too, but maybe in a different way.

Another stated, "Relationships for me have started on the basis of sex and I guess I'm just not comfortable discussing it."

5. Blind trust

Being able to critically evaluate a sexual situation before proceeding also influenced sex practices. Blindly trusting sex partners was associated with negative practices. For

example, one participant stated: "If I'm not comfortable or I have a bad feeling in my stomach. But if none of that's there and I feel right I'll go ahead – condom or no condom." Another commented, "It's not consistent [condom use] and unfortunately it's based on, if I look at the guy and I think he's been sleeping with other people, I use a condom. But if I think he's safe, I don't." A third stated, "I guess I just assumed that they did not have anything or that they would tell me if they did."

6. Spontaneous

Unplanned intercourse was, according to many participants, unprotected because they were "hot and heavy" and "caught up in the heat of the moment." When asked why she engaged in unprotected sex, one woman stated: "It was spontaneous; it just happened it was not thought through or planned and it just happened. It was just something that happened spontaneously in a car and I didn't know that person this well. I don't know why it happened."

7. Influence from Others

Listening to others influenced some participants' sexual activity. For example, one female participant commented, "My friend, the one that had it first, when she told us we all wanted to go have sex. So them saying it was OK, and hearing it from someone else, it was cool, and did influence me." Similarly, a male commented:

> My cousin told me about all the women he had slept with and what it was like. So it was me being in a situation where I was looking for a role model and um, him being it. Therefore, I learned and I took him seriously rather than deciding for myself, in a way.

Thus, perceived norms and values for peer groups helped shape participants sexual practices. Partners were also noted as having a negative influence on sexual practices, for example, "Most of the people I've gone out with or slept with, didn't care to practice safe sex so it didn't influence me in a good way."

11. Denial of risk

Several participants did not report needing to seek out information on STD's, for example, "It just hasn't been an issue with me for any of my boyfriends." Others stated they did not go for regular STD testing. As one participant explained, "I'd like to think that I shouldn't have to worry about it."

12. Passive Acceptance of Media Messages

Failure to critically evaluate messages portrayed in the media resulted in permissive attitudes towards unsafe sexual practices. One participant stated: "Well, if you watch a movie and you see that a couple has a relationship or a one night stand it makes you think 'well it's OK for me to do it.'" Another commented on the role that the 1980's movie "Porkies" had in shaping his sexual behaviour:

> I guess 80's Porkies movies influenced me the most. The whole purpose was to have sex and get laid. That shaped my mindset from an early age - that sex was a conquest and that you wanted to get as much as possible from as early an age as possible. I wanted to emulate the guys.

13. Alcohol as a Disinhibitor

Alcohol consumption emerged as a determinant of sexual behaviour. Participants reported engaging in causal, often unprotected intercourse when under the influence of alcohol. One

woman commented: "I was drunk and really didn't care – it didn't seem like a big deal not to use one" and "I've just gone ahead. I guess the first time I had sex was with somebody that I didn't even really know. I was just drunk at the time – we didn't even bother to use protection." A male participant stated: "It was with someone that I had just met...And we were drunk " and "It just got kinda heated. It felt safe. It wasn't the best thing to do but we were young and stupid."

The themes emerging from the qualitative data correspond to the dimensions of sexual empowerment (See Table 8). Twelve themes corresponded to the sexual empowerment dimensions. Four were somewhat related and four others were unrelated. These findings will be dealt with in more detail in the Discussion.

Table 8

Correspondence between the Dimensions of Sexual Empowerment and Qualitative Themes

Component	Qualitative Theme	
	Positive Outcome	Negative Outcome
Intrapersonal		
Control	• Perceived Control	• Passive Attitudes and Behaviours
Competence	• Ability to Communicate Needs	• Succumb to Pressure • Inability to Communicate Sexual Needs
Interactional		
Resource Mobil.	• None	• None
Causal Agents	• Critical Evaluation of the Media • Critical Evaluation of Potential Partners	• Passive Acceptance of Media Messages • Blind Trust
Critical Awareness	• Positive Influence from Others	• Negative Influence from Others
Skill Development	• Learned from Past Experiences	• None
Behavioural	• Proactive Behaviours	• None
Themes Perhaps Related	• Awareness of Risks • Multiple/Unknown Partners	• Spontaneous • Denial of Risk
Themes Not Related	• Perceived Acceptance by Partner/Peers	• End of Relationships • Sex for Intimacy • Alcohol as a Disinhibitor

Discussion

The purpose of the present study was to explore the relationship between sexual empowerment and risky sexual behaviours. The scales used to measure the three dimensions of sexual empowerment were not strongly related to the three measures of risky sexual behaviours. Qualitative analyses of the interview data identified a number of reasons why people either did or did not engage in risky sexual behaviours. Many of these corresponded to aspects of sexual empowerment. Possible reasons for these discrepant findings are presented below.

Empowerment

Empowerment theory was originally conceptualized as a mechanism through which individuals gain control over their socio-political environment: for example, the lobbying action of a group of individuals attempting to persuade the government to promote safer sexual practices in the education system. Sexual empowerment, as conceptualized in the present study, was an individualistic concept wherein a person believes they are able to influence a sexual situation (Intrapersonal), they understand what influences the situation/outcome (Interactional), and they possess the skills necessary to achieve a desired outcome (Behavioural).

Intrapersonal component. The Intrapersonal component included feelings of perceived control and competence. The two scales measuring this component of empowerment, the control and competence scales (Rosenthal et al., 1991), had adequate internal consistency as did the overall scale. The Intrapersonal scales did not predict any of the three measures of risky sexual behaviour. However, a number of themes that emerged from the qualitative data reflected this component. These included both Positive outcomes of engaging in safe sex and

Negative outcomes of not engaging in safer sex. The Ability to Communicate Needs and Perceived Control, core concepts of the Intrapersonal construct, reflected high levels of both competence and control in sexual situations and engagement in safer practices. These were the Positive Outcomes.

Themes emerging from the Negative outcomes of not engaging in safe sex also reflected this construct. Succumbing to Pressure indicates a failure to refuse unsafe sex and reflects low feelings of competence in the Intrapersonal component. As well, Passive Attitudes and Behaviours towards controlling sexual situations reflect low perceptions of control and competence. Inability to Communicate Sexual Needs is the converse of the ability to communicate needs described in the preceding paragraph. It appears that individuals who believe they have the capacity to achieve certain outcomes do what it takes to accomplish them. Those engaging in safe sex reported comfort and confidence in their ability to control sexual situations while those who engaged in risky sexual behaviours reported a lack in competence in intrapersonal aspects of sexual empowerment.

Interactional component. The Interactional component refers to the understanding that people have about their environment and how it affects their decisions and subsequent behaviours. Four scales were originally developed to assess this component: two (Resource Mobilization and Critical Awareness) had adequate reliability. The reliability of the total scale was also low. This scale did not correlate with the measures of sexual behaviours. A number of themes that emerged from the qualitative data reflected this dimension of sexual empowerment. These themes can be viewed within the four sub-dimension framework.

The themes of Critical Evaluation of the Media and its converse, Passive Acceptance of Media Messages, reflects the sub-dimensions of Causal Agents. When asked about the

media's influence, many participants were able to articulate one, if not more (e.g., fear-evoking, norm referencing, a source of ideas, etc.). For example, norm referencing, or using the media to help one determine what's "normal" for their age group was mentioned. One participant, in reference to sitcoms and pop music videos, noted that "everyone is with someone" and "they're always changing partners." She went on to state "I think I should be getting more when I see that!" It appears that the media influences sexual behaviour both in terms of the decision to have sex and expectations in sexual encounters. Critically evaluating these messages, as well as messages from partners also appears to be a key component in shaping safe sexual practices.

Critical Evaluation of Potential Partners and its converse, Blind Trust, also reflect the concept of Causal Agents since this concept includes an understanding of how a partner influences sexual behaviours, either positively or negatively. Overall, several external sources were identified as influential, suggesting the importance of a 'Causal Agents' dimension in sexual empowerment. However, given that there does not appear to be a single common source, it may be useful to ascertain people's general susceptibility to external influences. These findings are consistent with other research, which suggests that we model the behaviour of others. Biglan et al. (1990), for example, reported that individuals who engaged in risky sexual practices had friends who engaged in "problem" behaviour (e.g., low levels of pro-social behaviour, smoking, alcohol use, and academic difficulties).

Positive and Negative Influence from Others reflects the Critical Awareness sub-dimension. This sub-dimension includes the understanding people have of the norms and values of their peers and the values of their parents. Individuals having such awareness, specifically those believing their peers engage in safer practices, were more likely to report

safer practices, and vice versa.

The Skill Development scale did not have good internal consistency. This may have been a function of the target population. They may have lacked the sexual experiences required to develop their sexual negotiation skills: 62 participants had three or fewer sexual partners. In the interview data, however, many participants noted that their past sexual successes and failures helped shape their sexual practices. This was in the Learned from Past Experiences theme.

In summary, those with good Interactional skills critically evaluated the media and their partners, perceived their peers as engaging in safe sex, and have learned from experiences. These individuals were more likely to have reported engaging in safer sexual practices.

Several other themes were similar to the Interactional component, but less tightly linked. Awareness of Risks involves an understanding of the mechanisms of STD transmission, which is similar to the sub-dimensions of Causal Agents. Spontaneous and Denial of Risk reflect a failure to critically evaluate the environment and associated risk factors. Multiple/Unknown Partners reflect an understanding that engaging in safe sex is important when the partner is not known.

Behavioural component. The Behavioural component of empowerment, assessed by the Behavioural scale, refers to actions taken to directly influence outcomes. This scale was significantly related to only one measure of risky sexual behaviour (having sex with strangers). Those who reported having sex with a stranger were less likely to undergo regular STD testing, more likely to lose control when using drugs or alcohol, and more likely to accept drinks from strangers. This was the only scale to show a gender difference, with females more

likely to have protection available, go for regular STD testing, not accept drinks from strangers, and feel able to communicate they want to have sex.

The theme of Proactive Behaviours reflects the Behavioural dimension of sexual empowerment, as does the theme of Focus on the Future. Proactive behaviours were behaviours participants engaged in that increased the likelihood of practising safer sex. Refusing to engage in unplanned sexual activities, having a 'buddy' system with friends at parties (e.g., you must leave with a friend), and limiting alcohol consumption were some proactive behaviours mentioned by participants. Women who did not employ such techniques reported engaging in more unsafe sexual practices. Focus on the Future included behaviours such as refusing unsafe sex in anticipation of future consequences.

There were several significant differences between men and women on engagement in proactive behaviours, suggesting the possibility of gender-biased items. For example, when asked, "I don't accept drinks from strangers," significantly more women than men agreed. Considering the nature of the question (i.e., the likelihood of men versus women being offered drinks), the question may be gender-biased. The item, "I go for regular STD testing" is also potentially gender-biased as women may have STD testing as part of a larger physical health examination (e.g., to obtain birth control) whereas men may not feel the need to engage in comparative health behaviours.

The results indicate that students experience sexual empowerment in a manner that is consistent with the key components of empowerment as described by Zimmerman (1995). Those engaging in safer sex behaviours perceived themselves as empowered, that is, they had a sense of control and expressed comfort and confidence in their ability to state their need for

protected sex. They also engaged in behaviours (e.g., carrying condoms, discussing sexuality) that promoted safer practices (Behavioural component). While critically evaluating one's environment, learning from previous sexual experiences, and perceived peer norms and values, reflections of the Interactional component of empowerment, were not quantitatively associated with sexual practices, they were in the qualitative data. The three components of sexual empowerment merge to form a picture of a person who believes that he or she has the capacity to influence sexual situations (Intrapersonal component), understands how the environment influences their behaviour (Interactional component), and engages in the behaviours necessary to exert control (Behavioural component).

Other themes that emerged from the qualitative data. A number of additional themes emerged from the qualitative data, which did not directly reflect the concept of sexual empowerment. The theme of Self-Worth emerged in the qualitative data and describes individuals who engage in safe sex behaviours because they value themselves and their body. Quantitatively, as assessed by Rosenberg's Self-Esteem Scale (1979), however, it did not appear to influence sexual practices Analgous to self-esteem, its influence on sexual behaviour is unclear: previous research has been mixed (e.g., O'Leary et al., 1992; Rosenthal, Moore, & Flynn, 1991; Seal, Minichiello, & Omodei, 1997).. Perhaps there is a select subset of individuals who would benefit from self-esteem enhancement: research to delineate this population is needed before firm conclusions can be drawn.

Alcohol consumption emerged as a major determinant of unsafe sex behaviours. Substance use can interfere with people's ability to take responsibility for their sexual safety. The present study found that people who reported alcohol use as a component of their sexual activities were more likely to engage in high-risk sexual behaviours. Comments ranging from

"makes me a little more daring" to "I've had sex that I wouldn't have had otherwise if I were sober" suggest that alcohol use does impair judgements. Alcohol also lowers inhibitions and consequently participants were more likely to engage in unplanned sexual activities. This finding is congruent with previous research indicating that alcohol lowers their inhibitions (e.g., Simkins, 1995).

Implications

The most striking finding of the present study is the failure of the sexual empowerment scales to predict risky sexual behaviour at the same time that most of the themes associated with safer sex behaviour, which emerged from the qualitative data, reflected aspects of sexual empowerment. The reason for this difference in unclear. First, it is possible that the measures used to operationalize the concept of sexual empowerment were not suitable. The fact that the Interactional scale had poor internal consistency and that the Behavioural and Intrapersonal scales were not significantly correlated supports the possibility that these scales are not good measures of sexual empowerment. Given that the qualitative data support the importance of sexual empowerment in safer sexual behaviours, it may be useful to refine the quantitative measures. For example, it seems logical to hypothesize that participants engaging in one form of unsafe sexual activity would be more likely to be engaging in other unsafe sexual activities, and or unhealthy behaviours such as smoking and drinking (e.g., Biglan, 1990). However, factors influencing sexual behaviour (e.g. religion, popularity, need for intimacy) may not necessarily be related. A measure assessing how easily others influence individuals may be more practical, with additional questions assessing specific influencing factors.

Second, it is also important to ask whether it is reasonable to view sexual empowerment as a single dimension. The study was undertaken under the assumption that a

holistic measure of empowerment was necessary to increase engagement in safer sexual practices. Developing credible health education programs requires consideration of both the perception of one's own ability to control sexual situations, the understanding individuals have about their environment (e.g., subjective norms and values), and engagement in specific proactive behaviours. While individuals may feel a sense of control in sexual situations, they may lack the ability to critically evaluate their environment and/or engage in behaviours necessary to elicit the desired safe sex outcome. The qualitative data revealed that different individuals reported quite different reasons for engaging or not engaging in safer sex behaviours. Rather than focusing on a common dimension with many components, it may be more important to identify the unique strengths and weaknesses of each individual. Finally, additional consideration should be given to gender. In the present study, 34% of the sample were males as compared to 66% females. External validity may also be enhanced in future research by including an equal number of male and female participants.

In conclusion, the present study failed to develop a reliable and valid quantitative measure of sexual empowerment. However, the reasons students gave for practising or not practising safe sex generally correspond to the dimensions of sexual empowerment. Future research should include attempts to operationalize sexual empowerment using improved measuring instruments. As well, it is important to explore the possibility that the various aspects of sexual empowerment will differentially impact on each individual. Thus, interventions designed to increase all aspects of sexual empowerment may be less valuable than ones targeted to each individual's areas of greatest need. Using the model to develop specific programs (e.g., to increase feelings of control and to develop critical thinking skills) may be more appropriate than a common intervention based on the empowerment model.

References

Adler-Cohn, M .A., & Alfonso, C. A. (1997). Women, sex, and AIDS. International Journal of Mental Health, 26(1), 99-106.

Bakker, A. B., Buunk, B. P., Manstead, A. S. (1997). The moderating role of self-efficacy beliefs in the relationship between anticipated feelings of regret and condom use. Journal of Applied Social Psychology, 27(22), 2001-2014.

Bandura, A. (1986). Social Foundations of Thought and Action: A Social Cognitive Theory. Englewood, NJ: Prentice-Hall.

Biglan, A., Metzler, C. W., Wirt, R., Ary, D., Noell, J., Ochs, L., French, C., & Hood, D. (1990). Social and behavioural factors associated with high-risk sexual behaviour among adolescents. Journal of Behavioural Medicine, 13, 245-262.

Centers for Disease Control and Prevention (CDC). Data presented at the 1999 National HIV Prevention Conference, Atlanta, Georgia, Aug. 29 - Sept. 1, 1999

Catina, J. A., Gibson, D. R., Chitwood, D. D., & Coates, T. J. (1990). Methodological problems in AIDS behavioural research: Influences on measurement error and participation bias in studies of sexual behaviour. Psychological Bulletin, 108(3), 339-362.

Cornell Empowerment Group. (1989). Empowerment through family support. Networking Bulletin: Empowerment and Family Support, 1(1), 2-21.

Dommeyer, C. J., Marquard, J. L., Gibson, J. E., & Taylor, R. L. (1989). The effectiveness of an AIDS education campaign on a college campus. Journal of American College Health, 38, 131-135.

Edgar, T., Freimuth, V. S., Hammond, S. L., McDonald, D. A., & Fink, E. L. (1992). Strategic sexual communication: Condom use resistance and response. Health

Communication, 4(2), 83-104.

Epstein, J. A., Dusenbury, L., Botvin, G. J., Diaz, T., & Schnike, S. P. (1994). Determinants of intentions of junior high school students to become sexually active and use condoms: Implications for risk reduction and prevention of AIDS risk. Psychological Reports, 75, 1043-1053.

Fisher, J. D., & Fisher, W. A. (1992). Changing AIDS-risk behaviour. Psychological Bulletin, 11(91), 27-54.

Franzini, L. R., Sideman, L. M., Dexter, K. E., & Elder, J. P. (1990). Promoting AIDS risk reduction via behavioural training. AIDS Education and Prevention, 2, 313-321.

Gaynor, P. A., & Underwood, J. K. (1995). Conceptualizing and measuring sexual self-esteem. In P. E. Shrout & S. T. Fiske (Eds.), Personality Research, Methods, and Theory (pp. 333-347). Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Giffin, K. (1998). Beyond empowerment: Heterosexualities and the prevention of AIDS. Social Science Medicine, 46(2), 151-156.

Gilliam, A., & Seltzer, R. (1989). The efficacy of educational movies on AIDS knowledge and attitudes among college students. Journal of American College Health, 37, 261-265.

Grimley, D.M., Gabrielle, E.R., Bellis, J.M., & Prochasks, J.O. (1993) Assessing the stages of change and decision-making for contraceptive use for the prevention of pregnancy, STDs and AIDS. Health Education Quarterly, 20, 455-470.

Hardeman, W., Pierro, A., & Mannetti, L. (1997). Determinants of intentions to practice safe sex. Journal of Community and Applied Social Psychology, 7, 345-360.

Hendrick, S., & Hendrick, C. (1987). Mulidimensionality of sexual attitudes. The

Journal of Sex Research, 23, 502-526.

Hobfoll, S. E. (1998). Ecology, community, and AIDS prevention. American Journal of Community Psychology, 26(1), 133-144.

Hobfoll, S. E., Jackson, A. P., Lavin, J., Britton, P. J., & Shepherd, J. B. (1993). Safer sex knowledge, behaviour, and attitudes of inner-city women. Health Psychology, 12(6), 481-488.

Hobfoll, S. E., Jackson, A. P., Lavin, J., Britton, P. J., & Shepherd, J. B. (1994). Reducing inner-city women's' AIDS risk activities: A study of single, pregnant women. Health Psychology, 13(5), 397-403.

Initini, J. (2000). Sex on Campus. Campus, 16(4), 12-14.

Jemmott, L. S., & Jemmott, J. B. (1991). Applying the theory of reasoned action to AIDS risk behaviour: Condom use among Black women. Nursing Research, 40, 228-34.

Jemmott, J. B., Jemmott, L. S., & Fong, G. T. (1992). Reductions in HIV-risk-associated sexual behaviours among Black male adolescents: Effects of an AIDS prevention intervention. American Journal of Public Health, 82, 372-377.

Jemmott, J. B., Jemmott, L. S., & Fong, G. T. (1998). Abstinence and safer sex HIV risk reduction interventions for African American Adolescents. The Journal of the American Medical Association, 279, 1529-1536.

Jemmott, J. B., Jemmott, L. S., Spears, H., Hewitt, N., & Cruz-Collins, M. (1992). Self-efficacy, hedonistic expectancies, and condom-use intentions among inner-city Black adolescent women: A social cognitive approach to AIDS risk behaviour. Journal of Adolescent Health, 13, 512-519.

Kelly, J. A., Murphy, D. A., Sikkema, K. J., & Kalichman, S. C. (1993). Psychological

interventions to prevent HIV infection are urgently needed: New priorities for behavioural research in the second decade of AIDS. American Psychologist, 48, 1023-1034.

Kelly, J. A., St. Lawrence, J. S., Hood, H. V., & Brasfied, T. L. (1989). Behavioural interventions to reduce AIDS risk activities. Journal of Consulting and Clinical Psychology, 57, 60-67.

Kieffer, C. H. (1984). Citizen empowerment: A developmental perspective. Prevention in Human Services, 3, 9-36.

Levine, O. H., Britton, P. J., James, T. C., Jackson, A. P., Hobfoll, S. E., & Lavin, J. P. (1993). The study of empowerment: A key to HIV prevention. Journal of Community Psychology, 21, 320-334.

Lord, J., & Hutchison, P. (1992). The process of empowerment: Implications for theory and practice. Canadian Journal of Community Mental Health, 12(1), 5-22.

Maton, K. I., & Salem, D. A. (1995). Organizational characteristics of empowerment in community settings: A multiple case study approach. American Journal of Community Psychology, 23, 631-656.

McDonald, N. E., Wells, G. A., Fiser, W. A., Warren, W. K., King, M. A., & Bowie, W. (1990). High risk STD/HIV behaviour among college students. Journal of the American Medical Association, 263, 3155-3259.

Metzler, C. A., Noell, J., & Biglan, A. (1992). The validation of a construct of high-risk sexual behaviour in heterosexual adolescents. Journal of Adolescent Research, 7(2), 23.

Morokoff, P. J., Quina, K., Harlow, L. L., Whitmire, L., Grimley, D. M., Gibson, P. R., & Burkholder, G. J. (1997). Sexual Assertiveness Scale for women: Development and validation. Journal of Personality and Social Psychology, 73(4), 790-804.

Morrill, A. C., Ickovics, J. R., Golubchikov, V. V., Beren, S. E., & Rodin, J. (1996). Safer sex: Social and psychological predictors of behavioural maintenance and change among heterosexual women. Journal of Consulting and Clinical Psychology, 64(4), 819-828.

O'Leary, A., Goodhart, F., Jemmott, L. S., & Boccher-Lattimire, D. (1992). Predictors of safer sex on the college campus: A social sognitive theory analysis. Journal of American College Health, 40, 254-263.

Otis, J., Levy, J., Samson, J., Pilote, F., & Fugere, A. (1997). Gender differences in sexuality and interpersonal power relations among French-speaking young adults from Quebec: A province-wide study. The Canadian Journal of Human Sexuality, 6(1), 17-28.

Perkins, D. D., & Zimmerman, M. A. (1995). Empowerment theory: Research and applications. American Journal of Community Psychology, 15, 121-148.

Perper, T., & Weis, D. L. (1987). Proceptive and rejective strategies of U.S. and Canadian college women. The Journal of Sex Research, 23, 455-480.

Quina, K,. Harlow, L. L., Morokoff, P. J., & Saxon, S. E. (1997). Interpersonal power and women's HIV risk. In J. Manlow & N. Goldstein (Eds.), Gender and the Politics of HIV (pp. 188-206). New York: New York University Press.

Quinn, T. (1996). Global burden of the HIV pandemic. Lancet, 348, 99-106.

Rappaport, J. (1984). Studies in empowerment: Introduction to the issues. Prevention of Human Services, 3, 1-7.

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. American Journal of Community Psychology, 15(2), 121-148.

Rogers, E. S., Chamberlin, J. E., Ellison, M. L., & Crean, T. (1997). A consumer-

constructed scale to measure empowerment among users of mental health services. Psychiatric-Services, 48(8), 1042-1047.

Rosenthal, D., Moore, S., & Flynn, I. (1991). Adolescent self-efficacy, self-esteem, and sexual risk-taking. Journal of Community and Applied Social Psychology, 1, 77-88.

Sanderson, C. A., & Jemmott, J. B. (1996). Moderation and edition of HIV prevention interventions: Relationship status, intentions, and condom use among college students. Journal of Applied Social Psychology, 26(23), 2076-2099.

Seal, A., Minichiello, V., & Omodei, M. (1997). Young women's sexual risk taking behaviour: Re-visiting the influences of sexual self-efficacy and sexual self-esteem. International Journal of STD's and AIDS, 8, 159-165.

Simkins, L. (1995). Risk of HIV transmission in sexual behaviours of college students. Psychological Reports, 76, 787-799.

Stevenson, H. C., Davis, G., Webber, E., Weiman, S., & Abdul-Kabir, A. (1995). HIV prevention beliefs among urban African American youth. Journal of Adolescent Health, 16, 316-323.

Swift, C., & Levine, C. (1987). Empowerment: An emerging mental technology. Journal of Primary Prevention, 71-94.

Tanner, W. M., & Pollack, R. H. (1988). The effect of condom use and erotic instruction on attitudes toward condoms. Journal of Sex Research, 25, 537-541.

Uddin, M. (1996). College women's sexuality in an era of AIDS. Journal of American College Health, 44, 252-261.

UNAIDS (2000). Report on the global HIV/AIDS epidemic.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for

health promotion programs. American Journal of Health Promotion, 6(3), 197-205.

Wiggins, J.S., Trapnell, P., & Phillips, N. (1988). Psychometric and geometric characteristics of the Revised Interpersonal Adjective Scales (IAS-R). Multivariate Behavioural Research, 23, 517-530.

Zibalese-Crawford, M. (1997). A creative approach to HIV/AIDS programs for adolescents. Social Work in Health Care, 25(1/2), 73-88.

Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. American Journal of Community Psychology, 23(5), 581-599.

Zimmerman, M. A. (1998). Empowerment theory: Psychological, organizational, and community levels of analysis. In Rappaport, J., & Seidman, E. (Eds.). The Handbook of Community Psychology (pp. 4-24). Plenum Press: New York.

Zimmerman, M. A., Israel, B. A., Schulz, A., & Checkoway, B. (1992). Further explorations in empowerment theory: An empirical analysis of psychological empowerment. American Journal of Community Psychology, 20, 707-727.

Zimmerman, M. A., Ramirez-Valles, J., Suarez, E., de la Rosa, G., & Castro, M. A. (1997). An HIV/AIDS prevention project for Mexican homosexual men: An empowerment approach. Health Education and Behaviour, 24(2), 177-190.

Zimmerman, M. A., & Rappaport, J. (1988). Citizen participation, perceived control and psychological empowerment. American Journal of Community Psychology, 16, 725-750.

Zimmerman, M. A., & Warschausky, S. (1998). Empowerment theory for rehabilitation research: Conceptual and methodological issues. Rehabilitation Psychology, 43(1), 3-16.

Appendix A: Cover Letter

Dear Participant:

I am conducting a study on determinants of sexual behaviours in female undergraduate students at Lakehead University. Very little is known about their sexual behaviours.

The intent of this research project is (a) to investigate the relationship between attitudes towards sexual behaviour and actual sexual behaviour, and (b) to develop a better measurement scale to assess students' sexual behaviours. To accomplish these goals, I would like you to participate in an interview and fill in a few questionnaires concerning sexual behaviours. This will involve answering questions about both safe and unsafe sex practices.

For your participation, which will take approximately 50 minutes of your time, your name will be entered in a lottery draw for $100.

All information you provide will remain confidential and securely stored at Lakehead University for seven years. However, the findings of this project will be made available to you at your request upon completion of the project.

Please contact Lana MacGillivary, M.A. Clinical Psychology Candidate, at 767-0490 (please leave a message on the voice mail if I am not home), or via email at lammacgi@ice.lakeheadu.ca if you are interested in participating in this project.

Thank-you for your co-operation.

Sincerely,

_____

Lana MacGilliary, BScH.

Appendix B: General Information

Please answer these questions honestly. Circle the correct responses where indicated. **DO NOT LEAVE ANY IDENTIFYING MARKS** as this survey will not be analyzed individually.

1. Gender: (please circle) ***Male*** ***Female***

2. Age: _____

3. What year of university are you in? _____

4. What program are you in? _____

5. What is your ethnic background: (please circle)

Caucasian ***Aboriginal*** ***Hispanic*** ***Asian*** ***Other***

6. What is your parent's approximate yearly income? (please circle)

under 15,000 ***15,001-25,000*** ***25,001-40,000*** ***40,001-55,000*** ***55,001-70,000*** ***70,001+***

7. Where do you live? (please circle)

With parent(s) ***With partner/spouse*** ***LU Residence***

LU Townhouse ***Alone in an apartment*** ***In an apartment/house with roommates***

8. Sexual Orientation: (please circle)

Heterosexual ***Gay/Lesbian*** ***Bisexual*** ***Unsure***

9. Are you currently involved in a *casual* sexual relationship? (please circle) ***No*** ***Yes***

10. Are you currently involved in a *steady* relationship? (please circle)

No ***Yes, for _____ months***

11. Are you currently involved in a *steady sexual* relationship? ***No*** ***Yes, for _____ months***

12. How many sexual partners have you had? _____

Appendix C: Sexual Empowerment Scales

How **certain** are you that you could do the following:

Very Uncertain	Uncertain	Unsure	Certain	Very Certain
1	2	3	4	5

11. Refuse a sexual advance by my partner.
12. Have a sexual encounter without feeling obliged to have intercourse.
13. Correctly put a condom on an erect penis.
14. Initiate sexual activities.
15. Discuss using condoms and/or other contraceptives with a potential partner.
16. Ask a potential partner to wait if precautions are not available at the time.
17. Carry condoms with you "in case."
18. Control you sex urges while under the influence of alcohol or drugs.
19. Discuss with a partner use of condoms for AIDS protection when other means of contraception are already being used.
20. Choose when and with whom to have sex.
21. Tell your partner how to treat you sexually.
22. Refuse to do something sexually which you don't feel comfortable with.
23. Buy condoms/contraceptives.
24. Admit being inexperienced to your sexually experienced peers.
25. Reject an unwanted sexual advance from someone other than you partner, e.g. an acquaintance.
26. Ask your partner to provide the sexual stimulation you require.

Please mark the number that **best** describes your behaviour, using the following scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

62. Most students at the university think it's important to have safe sex.
63. Most students at the university think it's important to discuss methods of protection before engaging in sex.
64. Most students at the university think that if you aren't having sex there is something wrong with you.

65. Most students at the university think it's important to practice safe sex to avoid pregnancy.
66. Most students at the university think it's important to practice safe sex to avoid STD's.
67. Most students at the university practice safe sex.
68. Most students at the university discuss methods of protection before engaging in sex.
69. Most students at the university practice safe sex to avoid pregnancy.
70. Most students at the university practice safe sex to avoid STD's.
71. I've educated myself on safe sex practices (e.g. through sex education classes, books)
72. My sex practices are safer now than they have been in the past.
73. I've learned from past sexual experiences.
74. I am more comfortable negotiating the use of condoms than I have been in the past.
75. As I become more sexually experienced, I find it easier to talk about my sexual practices.
76. My sexual practices are influenced by my religious beliefs.
77. My sexual practices are influenced by my access to protection (e.g. condoms, birth control).
78. My sexual practices are influenced by my alcohol use.
79. My sexual practices are influenced by my drug use.
80. My sexual practices are influenced by my desire to be popular.
81. My sexual practices are influenced by my access to a safe place to have sex.
82. My sexual practices are influenced by my desire for intimacy.
83. My sexual practices are influenced by the media (e.g. music videos, magazines, tv).
84. If I want information on sexual practices, I know where to get it.

Please mark the number that best describes you behaviour, using the following scale:

Yes	No
1	2

Please answer the following questions using the stem: **I am aware that sexual information can be obtained through the:**

85. Internet
86. Library
87. Physicians
88. Health Services Clinic on campus
89. Gender Issues Center
90. TV programs (e.g. Sunday Night Sex Talk Show with Sue Johanson)
91. Thunder bay District Health Unit

Please mark the number that best describes your behaviour, using the following scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Would you obtain sexual information through these services? The:

92. Internet
93. Library
94. Physicians
95. Health Services Clinic on campus
96. Gender Issues Center
97. TV programs (e.g. Sunday Night Sex Show with Sue Johanson)

98. I always have protection available, just in case.
99. I go for regular STD testing.
100. I never let myself lose control when using drugs or alcohol.
101. I count on my friends to watch out for me when I'm in vulnerable situations (e.g. drunk at a party).
102. I don't accept drinks from strangers.
103. I am able to delay sexually gratifying experiences in anticipation of future outcomes.
104. I am able to communicate to a partner that I want to have sex.

Appendix D: Sexual Behaviour Scale

The following statements reflect different sexual behaviours. For each, fill in the response that best indicates your behaviours over the past year.

Please mark the number that best describes you behaviour, using the following scale:

Yes	No
1	2

29. Have you ever had sexual intercourse with someone of the opposite sex?
30. Have you had sex in the past year with a partner who you knew was having sex with someone else?
31. Have you ever had anal sex?
32. Have you ever had a sexually transmitted disease such as gonorrhoea (clap), syphilis, or chlamydia?

Please mark the number that best describes your behaviour, using the following scale:

Never	Occasionally	Half the Time	Often	Always
1	2	3	4	5

33. Generally, in the past year, how often has alcohol been part of your sexual activities?
34. Generally, in the past year, how often have marijuana or drugs other than alcohol been part of your sexual activities?
35. When you have heterosexual sex, how often do you use some kind of birth control?
36. When you have sexual intercourse, how often does your partner(s) wear a condom?

Please mark the number that best describes your behaviour, using the following scale:

Never	Once	Twice	Three times	4 or more times
1	2	3	4	5

37. In the past 12 months, how many times have you had intercourse with someone you didn't know very well?
38. Have you had sex in the past year with someone who injects drugs?
39. How many times in the last year have you had sexual intercourse with someone of the opposite sex?
40. How many times have you had sex in the past year with a partner who you knew was having sex with someone else?

Appendix E: Sexual Self-Esteem

Please mark the number that **best** describes your behaviour, using the following scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

27. I feel safe when I am in a sexual situation.
28. I tend to feel uncomfortable and anxious when I am in a sexual situation.
29. I feel present and tuned into my body when I am in a sexual situation.
30. I feel guilty and anxious about sex.
31. I have no painful memories during sex.
32. When I look in the mirror, I criticize every little thing that seems wrong.
33. I like and appreciate my body sexually.
34. I dislike my genitals, legs, buttocks, or face.
35. Overall, I like my body a lot.
36. I find it easy for me to find fault with my looks.
37. I love to listen to sensuous music and feel sensuous touch.
38. I dislike the smells and tastes involved with sex.
39. I like to be thrilled with how things look during sex.
40. Avoiding the feelings of sexuality suits me just fine.
41. I love the body tingles and thrills involved with sex.
42. Unless I am in a sexual situation, sex is absent from my mind.
43. I have delicious fantasies about sexual encounters.
44. I think about sex all the time; it's too much.
45. It's easy for me to imagine good sex with an attractive partner.
46. I have painful or sadistic fantasies about sex.
47. I love to have my body stroked and cuddled by a partner.
48. I liked to be touched as little as possible during sex.
49. I love to relax and relish the pleasure my partner gives me.
50. I dislike being stimulated by my partner.
51. I like to receive my partner's sexual attention.
52. I feel uncomfortable doing things that give pleasure to a partner.

53. One of my delights in sex is the pleasure I give to my partner.
54. I dislike touching my sexual partner.
55. It is very important to me to feel like I am giving sexually.
56. I feel inhibited about touching my partner.
57. I love the sensations I feel when I am in a sexual situation.
58. I feel sex is wrong or dirty.
59. Part of what is good in life is being sexual.
60. The sooner sex is over, the better it is for me.
61. I have high sexual self-esteem.

Appendix F: Self-Esteem

Please answer these questions honestly according to the way you **usually feel.** Please mark the number that best describes your behaviour, using the following scale:

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

1. I feel that I'm a person of worth, at least on an equal basis with others.
2. I feel that I have a number of good qualities.
3. All in all, I am inclined to feel that I am a failure.
4. I am able to do things as well as most people.
5. I feel I do not have much to be proud of.
6. I take a positive attitude toward myself.
7. On the whole, I am satisfied with myself.
8. I wish I could have more respect for myself.
9. I certainly feel useless at times.
10. At times I think I am no good at all.

Appendix G: Interpersonal Adjectives Scale-Revised

Please mark the number in each space beside each adjective that best describe you.

1	2	3	4	5	6	7	8
Extremely Inaccurate	Very Inaccurate	Quite Inaccurate	Slightly Inaccurate	Slightly Accurate	Quite Accurate	Very Accurate	Extremely Accurate

_____forceful	_____calculating	_____un-crafty	_____tender
_____self-assured	_____wily	_____introverted	_____meek
_____hard-hearted	_____assertive	_____extraverted	_____crafty
_____soft-hearted	_____tender-hearted	_____domineering	_____cruel
_____persistent	_____unsympathetic	_____neighbourly	_____unaggressive
_____cocky	_____unsly	_____shy	_____unargumentative
_____dominant	_____tricky	_____cunning	_____forceless
_____boastless	_____un-cheery	_____timid	_____cheerful
_____boastful	_____un-sociable	_____kind	_____un-charitable
_____friendly	_____charitable	_____sly	_____perky
_____bashful	_____un-authoritative	_____unbold	_____warmthless
_____un-demanding	_____ruthless	_____ironhearted	_____un-sparkling
_____cold-hearted	_____outgoing	_____accommodating	_____gentle-hearted
_____enthusiastic	_____un-calculating	_____firm	_____un-wily
_____un-cunning	_____sympathetic	_____self-confident	_____un-neighbourly
_____distant	_____dissocial	_____jovial	_____antisocial

Appendix H

CONSENT FORM

My signature on this sheet indicates I agree to participate in a study by Lana MacGillivary, M.A. Clinical Psychology Candidate, on DETERMINANTS OF SEXUAL BEHAVIOUR, which will involve answering questions about safe and unsafe sex practices. It also indicates that I understand the following:

1. I am a volunteer and can withdraw at any time from the study and/or choose not to answer any questions.
2. There is no apparent risk of physical or psychological harm.
3. The data I provide will be confidential and securely stored at Lakehead University for seven years.
4. I will receive a summary of the project, upon request, following the completion of the project.

I have received explanations about the nature of the study, its purpose, and procedures.

_____

Signature of Participant Date

Appendix I: Interview Questions

I want to understand why people engage in both safe and unsafe sexual behaviours. That is the purpose of this interview. Specific sexual details are not required, rather, the focus is on the reasons behind your actions. Any questions before we begin?

1. Have you engaged in unprotected sex within the past year?
   A. YES – describe the reasons why.
   B. NO - Have you engaged in protected sex (i.e., using a condom) within the past year?
      YES - describe the reasons why.

2. Is your sexual behaviour influenced by any of the following? - Peers, parents, partners, church, physicians, and society at large. Explain.

3. Do you do any of the following? - Buy condoms, discuss sexual practices before engaging in sex, get tested for STD's, refuse to engage in unsafe sex, and seek out information on HIV and other STD's.)

4. One purpose of this interview is to look at ideas that students have that they think would be useful for an intervention program for increasing safe sex behaviours among female students at LU. What do you think would be beneficial for students, for you?

Appendix J

DETERMINANTS OF SEXUAL BEHAVIOUR
DEBRIEFING FORM: SESSION 1

The purpose of the present study is to identify determinants of sexual behaviour in undergraduate female students.

The session in which you have just participated was designed for two purposes:

1. To obtain normative data for a new psychometric instrument assessing sexual behaviour. Such information allows us to evaluate the reliability and validity of these scales ad provides normative scores for which we can compare other individuals in the future.

2. To identify students reasons for engaging in both safe and unsafe sexual practices.

Thank you for participating in this study. If you have any questions about the study, please contact Lana MacGillivary (767-0490), Clinical Psychology M.A. Candidate.

If completing these questionnaires has caused you distress or has raised issues that you would like to discuss with someone, the following organizations are available: LU Health Centre (343-8361), Peer Support Line (343-8255), Chaplain (343-8018), and Career Counselling Services (343-8018).

Appendix K

Relationship between Personality, Sexual Self-Esteem, and Esteem Measures and Sexual Empowerment Measures

	Control	Compe-tence	Critical Aware	Re-source	Causal Agents	Skill Dev	Beh.
			Personality				
Assured	.11	.16	.08	-.02	-.05	.18	.06
Unassured	-.04	-.02	-.06	-.03	.23*	-.06	-.17
Arrogant	.08	.16	.16	.02	.20*	.07	-.17
Unassume	-.23*	-.23*	-.27**	.03	-.04	-.11	.007
Cold	.17	-.003	.16	-.07	.02	.04	-.12
Warm	-.02	.12	-.04	.04	-.03	.12	.15
Aloof	-.07	-.20*	-.16	-.13	.14	-.05	-.06
Gregarious	.14	.22*	.18	.10	.004	.15	.03
			Sexual Self-Esteem				
Safety	-.11	-.16	-.11	.15	-.19*	-.01	.28**
Body	-.10	-.08	-.11	.19	-.002	.02	-.02
Pleasure	-.09	-.02	-.21*	.01	.07	.18	.12
Fantasy	-.09	-.10	-.23*	.05	.09	.21*	-.04
Receive	-.08	-.07	-.08	-.003	-.21*	.03	.07
Giving	-.04	.04	-.08	.01	-.05	.10	.28**
General	-.04	-.07	-.09	.03	-.06	.12	.14
			Self-Esteem				
Esteem	-.07	-.05	-.10	.19	-.09	.08	.06

* $p < 0.05$

** $p < 0.01$ level

Appendix L

Relationship between Personality, Sexual Self-Esteem and Esteem Measures and Risky Sexual Practices

	High Risk #1	High Risk #2	SSRT
	Personality		
Assured	.10	-.05	-.01
Unassured	-.11	.01	.07
Arrogant	.19	-.06	.08
Unassume	-.14	-.09	-.07
Cold	.02	-.01	-.08
Warm	-.02	-.08	.000
Aloof	-.01	.03	.003
Gregarious	.09	-.02	.02
	Sexual Self-Esteem		
Safety	-.10	-.20*	-.11
Body	.03	-.02	-.08
Pleasure	.12	-.08	-.11
Fantasy	.09	-.11	-.14
Receive	.03	-.24*	-.05
Give	-.001	-.22*	-.15
General	.05	-.23*	-.18
	Self-Esteem		
Esteem	.03	.06	-.004

* $p < 0.05$

Appendix M

Correlations between Personality Measures

	Unass-ume	Arrogant	Unass-ume	Cold	Warm	Aloof	Gregar
Assure	-.57*	.35*	-.40*	.31*	-.15	.03	.18
Unassured		-.08	.40*	.002	.08	.28*	-.24*
Arrogant			-.58*	.48*	-.34*	.27*	.06
Unassume				-.24*	.15	.03	-.17
Cold					-.66*	.57*	-.29*
Warm						-.54*	.48*
Aloof							-.73*

* $p < .05$
** $p < .01$

Correlations between Personality, Sexual Self-Esteem, and Self-Esteem Measures

	Body	Physical	Fantasy	Receive	Give	General	Esteem
Safety	.37**	.40**	.35**	.48**	.39**	.600**	.31**
Body		.22**	.31**	.06	.13	.340**	.64**
Physical			.58**	.49**	.48**	.61**	.22*
Fantasy				.51**	.53**	.63**	.29**
Receive					.40**	.58**	.21*
Give						.57**	.19
General							.26**

* $p < .05$
** $p < .01$