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Education, Power, & Sex: A qualitative study on the interrelationship of factors that influence the sexual behavior of African American women attending a Historically Black College

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BS
Emory University
2011

Thesis Committee Chair: Ralph DiClemente, PhD

An abstract of
A thesis submitted to the Faculty of the
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Abstract

Education, Power, & Sex: A qualitative study on the interrelationship of factors that influence the sexual behavior of African American women attending a Historically Black College

By Carmen Collins

This qualitative study explored the impact of educational or professional achievement on perceived power in relationships and sexual encounters. Specifically, this study considered how differences in partner educational or professional achievement influenced protective sexual behaviors including condom negotiation and patterns of condom use. African American emerging adult females are disproportionately affected by sexual health risks such as HIV/AIDS and unintended pregnancies. Furthermore, when controlling for condom use rates, African American females in this age group continue to have more deleterious health outcomes when compared to their White counterparts. Thus, it is important to understand the underlying social and behavioral factors contributing to sexual decision-making in this population. This study consisted of 19 semi-structured, in-depth interviews of African American females attending a Historically Black College in the Southeastern United States. The theory of gender and power and the social cognitive theory were used as a framework for thematic analysis of the relationship between perceived power and protective behaviors in a cultural context. Results revealed that college women desired partners who were or would become financially stable so that, in the case of unintended pregnancy, they would have adequate support. Women also described education as a self-efficacy booster for partner communication which was shown to be important in perceived power women felt in their relationships and sexual encounters. Overall, these findings inform current and future multi-level sexual risk reduction interventions and allow college campuses to better align their resources to the African American emerging adult female population.

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Warmest Regards,

Carmen Collins, MPH

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Chapter I: Introduction

Problem Definition

African Americans are disproportionately affected by compromised sexual health including a higher rate of unintended pregnancies, sexually transmitted infections (STIs) and HIV/AIDS (Centers for Disease & Prevention, 2011; Finer & Henshaw, 2006; Gavin et al., 2009; Prevention, 2011). This has been a particularly prominent issue in the African American emerging adult population. Emerging adulthood has been defined as individuals aged 18-25 years, and African American women in this population are at greatest risk for the aforementioned sexual health disparities (Centers for Disease & Prevention, 2011). Some research has suggested that this population is the least likely of all ethnicities to consistently use condoms or successfully negotiate condom use with their partners (Eaton et al., 2010; Finer & Henshaw, 2006; Wingood & DiClemente, 1998b) while other studies have shown that African Americans have similar or higher rates among condom use as their White counterparts (Hou, 2009; Nguyen et al., 2010). Despite the discrepancies in the literature, when controlling for condom use rates, African Americans continue to have more deleterious sexual health outcomes.

Disparities in sexual health are an important issue that needs to be addressed in the African American emerging adult female population. A report by the CDC revealed that approximately 66.7% of pregnancies in African American women aged 15-24 were unwanted or mistimed (Gavin et al., 2009). In addition to unintended pregnancies, African American women have been disproportionately affected by STIs/HIV. Surveillance data from the CDC has shown that, while African American women make up only approximately 14% of the entire US female population, they account for nearly

66% of new cases of HIV infection (Centers for Disease & Prevention, 2010). Furthermore, it was reported in 2009 that 65% of females aged 13-24 living with HIV were Black/African American (Centers for Disease & Prevention, 2010). African American emerging adult women are also at highest risk for gonorrhea and chlamydia with the most at risk populations being 20-24 year olds followed by 15-19 year olds (Centers for Disease & Prevention, 2011).

A recent quantitative study by Nguyen et al. (2010) found that, overall, African American women have high condom negotiation efficacy but largely negative attitudes towards condom use. Some research has speculated that some reasons for negative attitudes toward condom use have included issues of trust and intimate partner violence (Ferguson, Quinn, Eng, & Sandelowski, 2006; Otto-Salaj et al., 2008; Wingood & DiClemente, 1998b). Additionally, African American women have cited the ratio of eligible African American men to women as one of the major contributors to lack of condom use (Ferguson et al., 2006; Wingood & DiClemente, 1998b). Women in this study had the collective belief that lack of condom use was a way to keep an intimate partner in an environment where the number of eligible men was limited; these women feared that if they attempted to negotiate condom use, their partners would leave them for women who were more willing to forgo condom use (Ferguson et al., 2006; Wingood & DiClemente, 1998b).

Problem Justification

Literature has shown that level of education does not decrease the sexual risk behavior of African American emerging adult women (Lewis, Melton, Succop, & Rosenthal, 2000; Wingood & DiClemente, 1998a). However, there have been some

interesting manifestations that set African American college women apart from the rest of the emerging adult population in the Black community. Several studies have shown that interventions targeting African American college students have improved condom use in this population. Specifically, three recent studies have provided evidence that African American college students are more likely to use condoms across all types of intercourse (oral, vaginal, and anal) than their White counterparts (Buhi, Marhefka, & Hoban, 2010; Davis, Sloan, MacMaster, & Kilbourne, 2007; Whaley & Winfield, 2003). This is contrary from other reports that show that the general African American emerging adult population has lower condom use than any other ethnicities. Despite this difference, African American college students are still at higher risk for STIs, unintended pregnancies, and HIV/AIDS in comparison with their White peers (Buhi et al., 2010; Whaley & Winfield, 2003).

African American college women face a unique set of issues related to sexual health and sexual behavior. Women in this population are similar to the general population of African American emerging adult females in that their pool of eligible men is limited due to the small male-to-female ratio within the population. A study by Ferguson et al. (2006) revealed that the decreasing male-to-female ratio of African Americans on college campuses has impacted the dynamics of African American relationships. Those women who continue to explore relationships within their college community may engage in higher sexual risk behaviors in order to maintain their relationships (Ferguson et al., 2006). Contrarily, African American women who explore relationships with African American males outside of their college campuses or with males outside of their race reported a lower likelihood of engaging in high risk behavior

because the reduced fear that their partner would leave them for a woman more willing to accommodate desires for high risk behaviors. (Ferguson et al., 2006).

African American college women are different from their female peers in the general African American population in that they typically live on college campuses and have a meal plan. As a result, African American women may be less likely to be susceptible to direct or indirect financial incentives to engage in high-risk sexual behavior than women of low socioeconomic status. This leaves the question of why African American college women are still at greater risk for sexual health issues. Few studies to date have explored the impact of educational or professional achievement on perceived power and condom negotiation in African American women attending college. Specifically, no known published studies have defined perceived power based on the educational or professional attainment.

Theoretical Framework

This study utilizes the theory of gender and power and the social cognitive theory in combination to analyze the relationship between perceived power and sexual risk behaviors in African American women enrolled in in a Bachelor's degree program. Specifically, the theory of gender and power provides the framework for understanding the relationship between perceived power and protective behaviors in a cultural context. Many of the previous studies utilizing the theory of gender and power have targeted African American women of low socioeconomic status (Wingood & DiClemente, 1998a, 1998b). No study to date has specifically observed the role of differences in academic or professional achievement on the perceived power of African American females and how this impacts sexual risk behaviors. Furthermore, few studies to date have utilized the

theory of gender and power to frame the sexual risk behaviors of African American college women aged 18-25 years.

Using the social cognitive theory in combination with the theory of gender and power is thought to be useful in the development of interventions that decrease sexual risk behaviors in women. The social cognitive theory adds another level to the theory of gender and power by examining the social and cultural factors that help to predict perceived power (Table 1). The SCT has a longstanding history in the development of HIV prevention interventions, and it is often used in combination with the theory of gender and power, especially when assessing sexual risk behaviors of African American females. To date, few studies has used these theories in combination to understand perceived power and sexual behavior of emerging adult females in an educational setting, specifically in African American females attending college. The constructs that were used to guide data analysis in this study are detailed below:

Theory of Gender and Power. The Theory of Gender and Power is a model through which one can understand risk among women (DiClemente, Crosby, & Kegler, 2009). This risk is understood through three interrelated structures that illustrate how gender impacts relationships between men and women (DiClemente et al., 2009). These structures are the sexual division of labor, the sexual division of power, and the structure of cathexis (DiClemente et al., 2009).

Sexual division of labor. The sexual division of labor posits that economic inequality favors men; as a result, women are more dependent on men for financial support (DiClemente et al., 2009; Wingood & DiClemente, 1998b). Women who have more adverse economic exposures (i.e. less than a high school education) and

socioeconomic risk factors (i.e. ethnic minorities) are more burdened by the sexual division of labor and will be more likely to experience poorer sexual health outcomes. Specifically, as economic disparity between men and women increases to favor men, women are more likely to engage in high-risk sex for direct or indirect financial gain (DiClemente et al., 2009; Wingood & DiClemente, 1998b).

Sexual division of power. Power is a fundamental component of intimate heterosexual relationships (Wingood & DiClemente, 1998b). Power has been defined as having the power to act or change or having power over others, and is the foundation that shapes social relationships between men and women (DiClemente et al., 2009). The sexual division of power takes into account issues of hegemonic masculinity which is the expression of male privilege over females (DiClemente et al., 2009). Hegemonic masculinity is often manifested as imbalances in power that favor men. In relationships with unequal power women do not have control or authority and have limited bargaining power for sexual protective behaviors (DiClemente et al., 2009; Wingood & DiClemente, 1998b). This could include women whose sexual partner is resistant to condom use and other factors which increase the probability of women not using condoms (DiClemente et al., 2009; Wingood & DiClemente, 1998b).

Structure of cathexis. The structure of cathexis dictates social norms and cultural beliefs about the sexual behavior of women; specifically, this structure personifies emotional and sexual attachments that women have with their intimate partners (DiClemente et al., 2009). The structure of cathexis looks at the social mechanisms that constrain the daily lives of women; these constraints further delineate gendered expectations of men and women (DiClemente et al., 2009). Societal gender roles call for

women to develop meaningful and long-term relationships with a male partner (DiClemente et al., 2009). Long-term relationships impact the ability for women to negotiate sexual protective behaviors with their partners due to issues of trust and intimacy; as a result, women may find it difficult to place restrictions on partners with increasing length of relationship (DiClemente et al., 2009).

Table l. Domains Framed by Constructs of the Theory of Gender and Power

Construct	Institutional Level	Social Level	Domains
Sexual Division of Labor	Academic Institution	1. Educational Attainment 2. Professional Attainment	Economic Exposures: • Perceived sexual behavior norms • Facilitators/barriers of uptake of safer sex practice
Sexual Division of Power	Relationships & Prevention Messaging	1. Control Imbalances 2. Decision-Making Inequality	Physical Exposures • Perceived authority and bargaining power • Attitudes about partner communication
Structure of Cathexis	Relationships & Culture	1. Social Constraints 2. Norms Inequality	Social Exposure: • Cultural norms and social beliefs about behavior • Cost/benefit analysis for uptake of behavior

Social Cognitive Theory. The Social Cognitive Theory (SCT) has been used as a model for understanding the dynamic interplay of personal, behavioral, and environmental factors that influence a person's health decisions (Glanz, Rimer, & Viswanath, 2008). The SCT allows researchers to evaluate how these factors reciprocally influence one another to create a scenario of optimal health (Glanz et al., 2008). This study will use three specific constructs of the SCT to guide data thematic analysis. These constructs are facilitation, self-efficacy, and outcome expectations (Figure 1).

Facilitation. The facilitation construct of the Social Cognitive Theory involves the provision of tools or resources that enable behavior or improve the ability to perform a behavior (Glanz et al., 2008). Facilitation is an environmental determinant of health which empowers individuals to adapt health behaviors and decrease risk. For example, provision of tools that allow for improvement of sexual health empowers individuals to uptake protective behaviors that will decrease risk for negative outcomes like HIV infection (Glanz et al., 2008).

Self-efficacy. Self-efficacy is an individual's belief about his or her ability to execute behaviors that bring desired outcomes (Glanz et al., 2008). This construct posits that it is important for individuals to believe in their capacity to complete a task in order for them to uptake positive health behaviors (Glanz et al., 2008). For instance, women who have higher self-efficacy in their ability to persuade their partners to use condoms will be more likely to utilize condom negotiation as a sexual protective behavior (Glanz et al., 2008).

Outcome Expectations. In addition to an individual's belief about his or her ability to perform a behavior, an individual must also believe that this behavior will be beneficial; therefore, the outcome expectations construct posits that maximizing benefits and minimizing costs is an important component of human learning (Glanz et al., 2008). Changing someone's beliefs about the outcomes associated with the uptake of a protective sexual behavior will increase the likelihood that this person will uptake that behavior (Glanz et al., 2008). For instance, individuals may be more likely to use condoms if their beliefs about pleasure one feels when using condoms is changed to be viewed in a positive manner (Glanz et al., 2008).

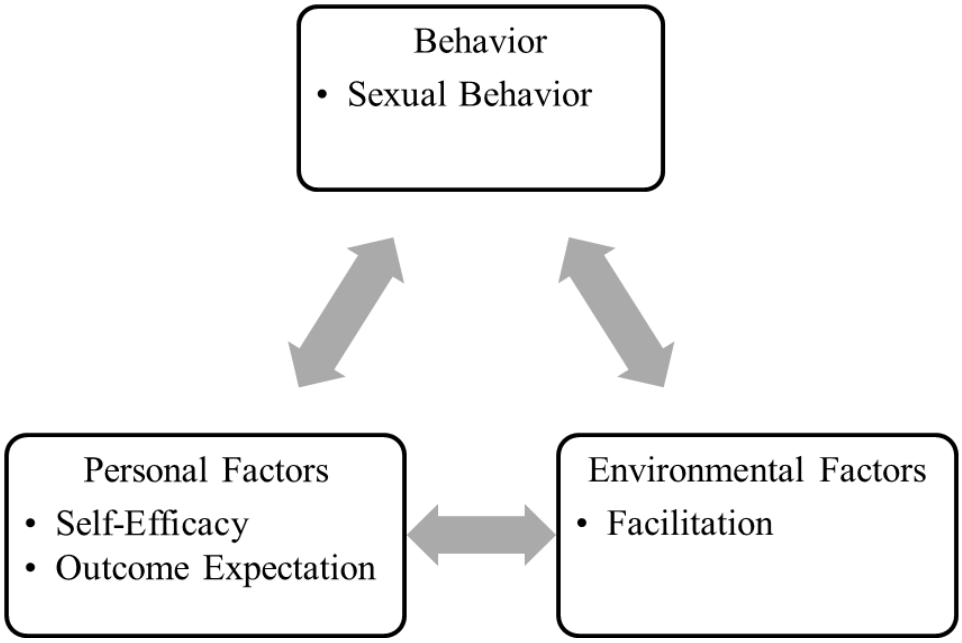

Figure 1 Social Cognitive Theory

Purpose

The purpose of this study was to qualitatively explore perceived power in relationship to educational or professional attainment. Specifically, this study aimed to understand the impact of perceived power on the ability of African American college women to negotiate condom use. HIV incidence rates have been increasing among African American women attending college. Specifically, small sexual networks and the decreasing male-to-female ratio in the African American college population have been shown to be important factors in the decision making of African American emerging adult females. This, in turn, has had a profound effect on sexual risk behaviors including unprotected sex. This study aimed to add an in-depth perspective to the current literature on HIV and sexual behavior. The knowledge gained from this study could inform future sexual health prevention interventions by examining the relationship between sexual protective behaviors and perceived power.

With the above in mind, the specific questions that this study aimed to answer were:

1. **How does educational or professional achievement impact perceived power of African American emerging adult females?**

2. **How does perceived power impact condom negotiation and/or use in relationships of differing educational or professional attainment?**

Chapter II. Literature Review

A total of 14 studies were selected for this review. Some articles had a target population that was not college women aged 18-25 years; however, these articles were kept for the purposes of this review to demonstrate gaps in the literature. Sample sizes in these studies ranged from 40 to 44,165. The majority of the studies (6) were cross-sectional, one study was long-term, another study was a randomized control trial, three studies were qualitative, and two were secondary analyses of survey data. Most studies done on African American college students were done on the campuses of historically black colleges and universities (HBCUs). A total of six studies specifically targeted women while the rest targeted both men and women. Most studies examined factors that influenced sexual protective and/or risk behaviors. Four studies compared African American behaviors to the behaviors of their white counterparts, and one study examined the impact of an intervention emphasizing partner communication.

Articles will be presented by topic area: partner communication in African American couples; impact of condom negotiation & use; the African American Achievement gap; perceived power in African American relationships.

Partner Communication in African American Couples

Partner communication was consistently an important factor in sexual risk behaviors in the emerging adult population. Specifically, partner communication was identified as a significant mediator of increased condom use in Black women aged 15-21 years; women who communicated with their partners more frequently were more likely to have condom-protected sex and consistently use condoms (Sales et al., 2012). Furthermore, women aged 18-29 years who were not sexually assertive were less likely

to use condoms than those who were sexually assertive and able to communicate their desires to their partner (Wingood & DiClemente, 1998b). Nguyen et al. (2010) concluded in their study that women who were very aggressive, very active, very competitive, did not give up easily, and stood up well under pressure were likely to be able to communicate their needs and desires and were not easily persuaded by conflicting requests from their partners.

Black college women are particularly able to better communicate with their partners (Hou, 2009). Specifically, Black women at HBCUs were 3.8 times more likely to ask the HIV/STI status of their partner and 2.9 times more likely be asked their status in comparison with their White counterparts at a traditionally white institution (TWI) (Hou, 2009). Despite the ability of Black college women to communicate with their partners about disease status, factors remain that put this population at greater risk for negative sexual health outcomes.

Ferguson et al. (2006) discussed these risk factors with student focus groups at an HBCU in the South. These students believed that women's lack of condom negotiation may stem from low self-esteem (Ferguson et al., 2006). The HBCU was described as an environment where man-sharing was common; man-sharing was defined as multiple women having sexual partnerships with a single man (Ferguson et al., 2006). It was the belief of the students that women were seeking secure relationships with men in this environment; therefore, these women did not want to jeopardize being rejected because of desires to use condoms (Ferguson et al., 2006). This provides insight into areas of communication that may be driving sexual risk behaviors and is worthy of further exploration.

The Impact of Condom Negotiation and Use

Condom negotiation is an important sexual protective behavior that helps to improve women's risk for sexual health issues including HIV/AIDS, STIs, and unintended pregnancy (Otto-Salaj et al., 2008). Several methods of condom negotiation have been recognized by researchers, and studies have been conducted to determine the success of these strategies in real scenarios (Otto-Salaj et al., 2008). Otto-Salaj et al. (2008) qualitatively explored the success of these strategies to determine which types of negotiation methods were most successful. While there were no universal strategies, a few were revealed to generally be more successful based on gender. For example, men were more responsive to reward strategies in condom negotiation; that is, if men were promised that condom use would enhance the relationship, they were more likely to wear a condom. On the other hand, coercive strategies evoked the worst male response; some men brought up issues of trust while others threatened to leave or became violent when women attempted to coerce them to use condoms (Otto-Salaj et al., 2008). These results were consistent with findings in several other studies where respondents alluded to the fact that their partners may become violent if asked to use a condom in a coercive manner—i.e. "no condom, no sex" (Otto-Salaj et al., 2008; Sales et al., 2012; Wingood & DiClemente, 1998a). Women in these studies also mentioned that their partners may become suspicious of infidelity if they tried to negotiate condom use (Otto-Salaj et al., 2008).

Conversely, in a study of predominantly White participants, female respondents were found to be more likely to convince their partners to use a condom than their Black or Hispanic counterparts (Carter, McNair, Corbin, & Williams, 1999). Specifically,

African American women without a main partner cited the lack of eligible African American men as a reason for negative attitudes towards condom use which was true for both the general population of African American emerging adult females and the subpopulation of African American college females (Ferguson et al., 2006; Wingood & DiClemente, 1998b). These women feared that withholding sex to ensure condom use would make their partner more likely to be unfaithful (Ferguson et al., 2006; Wingood & DiClemente, 1998b).

According to Nguyen et al. (2010), women with a strong need for security and who are seeking their partner's approval were more likely to refrain from being assertive in conversations regarding condom use to avoid conflict or rejection. On the other hand, there are some factors that make African American emerging adult women more likely to use condoms. Reasons that this population of women would choose to use condoms include assertiveness skills, perceived control, being in a non-abusive relationship, avoidance of pregnancy and STIs, and history of STIs (Davis et al., 2007; Nguyen et al., 2010; Whaley & Winfield, 2003; Wingood & DiClemente, 1998a).

Amongst African American college students, Ferguson et al. (2006) found that the gender imbalance was an underlying factor in males having greater number of sexual partners and more control in sexual relationships. Due to the lack of eligible African American men, women were more likely to either knowingly or unknowingly participate in "man-sharing." Furthermore, women were more likely to negotiate *lack* of condom use in exchange for emotional attachment of a male partner; in other words, there was a belief that lack of condom use would help secure the relationship (Ferguson et al., 2006). Despite the potential reasons to forgo condom use, there is evidence in the literature

suggesting that African American college female students are more likely to use condoms than their white counterparts (Buhi et al., 2010; Whaley & Winfield, 2003).

The African American Achievement Gap

Longitudinal studies have shown that the disproportionate ratio of African American male-to-female matriculation in college has been increasing drastically. From 1980-2002, the number of Bachelor's degrees conferred for African American women increased by 41,268 while the number conferred for African American men increased by only 14,683 (US Department of Education, 2004). This increase in African American women attending college has created an environment where women who date within the same race have a smaller pool of eligible African American men from which to choose. As mentioned previously, the gender-ratio imbalance within the Black college community has influenced women to participate in "man-sharing" and lack of condom use (Ferguson et al., 2006). Sexual risk behaviors jeopardize the ability of African American college women to pursue higher education; therefore, it is important to establish consistent condom use as the norm within this population in order to prevent the deleterious health effects associated with lower socioeconomic status (Lewis et al., 2000).

Despite the findings, studies on this population have not examined the educational gap between men and women and how this would impact relationship dynamics. The gender disparity in African American academic achievement increases the likelihood of couples in this population having unequal levels of educational achievement; therefore, it is important to understand how differences in educational achievement may impact women's ability to engage in sexual protective behaviors. The underlying effects of the disparity in educational achievement on African American couples and condom use in the

United States have not been explored in the literature and beckons further research.

Perceived Power in African American Relationships

Several studies reported that perceived relationship power in African American couples was largely equal (Cowdery et al., 2009; Harvey & Bird, 2004; Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002; Nguyen et al., 2010; Otto-Salaj et al., 2008). African American women described respect as an important characteristic in defining a good relationship (Cowdery et al., 2009; Harvey & Bird, 2004) . Specifically, both males and females believed that when a man showed respect for a woman, the woman would feel powerful in the relationship (Harvey & Bird, 2004). Factors that were associated with feelings of power in the relationship among African American women were money, education, and physical attractiveness (Harvey & Bird, 2004). Studies have also shown that African American emerging adult men and women felt that they shared power in sexual and reproductive decision-making (Harvey & Bird, 2004; Harvey et al., 2002). Decisions on when to have sex, when to use condoms, and when to get pregnant were all made jointly (Harvey & Bird, 2004; Harvey et al., 2002).

Previous studies examining power in relationships have not focused on college populations; however, it is important to understand the impact that perceived relationship power has on emerging adult relationships in the African American population. This information can guide future studies that explore relationship power in African American college couples.

Summary

Based on the results of this review, several gaps can be acknowledged. While

evidence has shown conflicting evidence about condom use of African American emerging adult women when compared to their White or Hispanic counterparts, African American emerging adult women are still at increased risk for STIs, unintended pregnancies and HIV/AIDS (Hou, 2009). These findings are applicable to African American college women; however, the characteristics that facilitate the increased risk for STIs, HIV/AIDS and unintended pregnancies in the college women may be different from the characteristics that have been described in the literature for the general population (i.e. poverty and racial segregation). These differences in sexual health risk need to be further explored both qualitatively and quantitatively.

Another gap in the literature has been shown between perceived power and condom negotiation efficacy. While both men and women in the African American emerging adult population indicate equal power in relationships, women still express low efficacy in condom negotiation. Reasons for low efficacy have included: partner trust, intimate partner violence, and the lack of eligible African American men. There is a need for future studies that further delve into differences between perceived relationship power and perceived sexual power to understand the cultural factors that may be at play in determining sexual risk behavior.

Lastly, studies in condom negotiation efficacy and condom attitudes have alluded to the fact that the lack of eligible African American men is a factor in consistent condom use; no studies to date have explored how the increasing gender gap in academic achievement has impacted African American couple dynamics. There is a need to explore how differences in educational level impact perceived power and the ability to negotiate condom use.

As indicated by several studies in this review, future interventions should target couples instead of a single gender. The sexual behavior of African American women is mediated by the influence of their partners; therefore, including partners in future studies and interventions would better improve the sexual health disparities in this population. These studies and interventions could work to further understand and improve partner communication frequency which has been shown to be an important mediator in condom use and consistency. Finally, it is worth exploring the impact that differences in educational achievement has on relationship dynamics. Specifically, it would be interesting to see if and how dynamics change during a sexual encounter.

Overall, this review has revealed that no studies to date have been done that explore perceived power in the African American college student population. Perceived power plays an important role in partner communication, condom negotiation, and condom use. Taking it a step further, no studies were found to show the impact that educational or professional achievement has in relationships, especially when there is a difference in achievement. With the above gaps described, this study used the Theory of Gender and Power and the Social Cognitive Theory to explore perceived power in African American college couples. Specifically, the impact on of the achievement gap on relationship power was explored in the context of partner communication, condom negotiation, and condom use. The results of this literature review support the objectives of this study which are:

1. **How does educational or professional achievement impact perceived power of African American emerging adult females?**
2. **How does perceived power impact condom negotiation and/or use in relationships of differing educational or professional attainment?**

Chapter III: Methodology

Research Design

This research utilized a phenomenological qualitative design. Data for this study was collected from individual, semi-structured interviews. The content obtained from this study will inform future interventions targeting Black/African American college women and provide insight into how differences in academic achievement may impact relationship dynamics and sexual behavior. This study did not meet the criteria for human subjects research and was, therefore, excluded from review by the Emory University Institutional Review Board.

Participants

This is a secondary analysis of a larger study on the sexual health attitudes and beliefs of students attending a historically black college or university (HBCU). Data from the National College Health Assessment (NCHA) revealed that Black/African American women attending an HBCU were disproportionately affected by HIV/AIDS and other STIs (Hou, 2009). Participants for this study, therefore, were selected to represent this population through purposive sampling methods.

Recruitment materials were disseminated throughout the campus of a historically black college via paper and electronic flyers as well as through list-servs. These materials included basic eligibility criteria for participation, incentive information, and contact information for project staff. Approximately 30 women expressed their interest participating in the study. Once participants made initial contact, they received either a follow-up email or phone call from a project staff member who collaborated with these

women to schedule an interview. Of the eligible participants who expressed interest in the study, 63.7% (n=20) were selected to participate. One participant was not interviewed due to scheduling conflicts making the final sample size 19.

Selection criteria for inclusion in the original study included:

- Self-identification as female at birth
- 18-26 years of age
- Enrollment full-time in a Bachelor's degree program

Exclusion criteria for the secondary analysis included participants who did not identify as Black/African American and participants 26 years of age. No participants were excluded from the study as none of them met the exclusion criteria.

Table 2. Demographic Characteristics of the Sample (n=19)

Mean Age (SD)	20.11(1.10)
Classification (n, %):	
First Year	4 (21.1)
Sophomore	6 (31.6)
Junior	5 (26.3)
Senior	4 (21.1)
Race/Ethnicity (n, %):	
Black	11 (57.9)
African American	5 (26.3)
Black/African American	3 (15.8)
Relationship Status (n, %):	
Dating: non-committed relationship	4 (21.1)
Dating: committed relationship	9 (47.4)
Not currently dating	6 (31.6)
Sexual Activity (n, %):	
Sexually Active	13 (68.4)
Oral Sex	16 (84.2)
Penetrative Sex	15 (78.9)
Mean Number of Sexual Partners (SD)	1.47 (2.22)
Sexual Protective Behaviors (n, %):	
Condom Use – Every time	10 (52.6)
Condom Use – Most of the Time	5 (26.3)
Condom Use – Sometimes	1 (5.3)
Condom Use – Never	1 (5.3)
STI Testing	16 (84.2)
Receipt of Test Results	16 (84.2)

Data Collection & Management

All individual, semi-structured interviews were conducted by two, female Rollins MPH graduate research assistants (GRAs), one White and one Black/African American. Both interviewers were trained by Project Ujima staff and were CITI certified. Interview lengths ranged from 40-120 minutes and took take place in private interview rooms near the principal investigator's laboratory. A "Do Not Disturb-Interview in Progress" sign was posted on the door of the interview room to prevent interruptions during the interviews. In case of interruption, interviewers were instructed to pause audio recording and to ensure participant confidentiality was maintained to the best of their abilities.

Informed Consent. Prior to interviewing, GRAs reviewed the informed consent form with participants. Participants were told the purpose of the study; they were also notified that some of the research questions would be personal in nature. Participants were informed that the study was completely voluntary and if at any time they wanted to stop, they could do so without penalty. If a participant desired to stop interviewing because of the sensitive nature of the topics discussed, all recordings were to be stopped, and the interviewers would provide information for the campus student health and counseling services. If any participants elected to leave prior to completion of the interview, the GRAs were instructed to ask if the data collected could still be used for the purposes of the study. Express permission to audio-record interviews was obtained from all participants prior to initiation of interview. After review, participants were asked to sign the informed consent form and were given a copy to keep for their records.

Demographic Survey. Once consent was obtained, participants were asked to complete a brief screening instrument that assessed demographic characteristics and

sexual behaviors. No identifying information was requested on the screening instrument for confidentiality purposes; however, each screening instrument and interview were given a unique identification number in order to match the document and compare responses. Once completed, the instrument was placed in a sealed envelope and stored in a locked file cabinet in the principal investigator's office after completion of the interview.

Semi-structured Interviews. GRAs used an interview protocol to guide the semi-structured interviews. The interview protocol began with short, less invasive questions, continued to more in-depth questions on the participants' sexual behaviors (i.e. condom negotiation and use), and ended with questions that were short and less invasive. Each question had a set of probes to draw out participant responses; silent probes and follow-up questions were also used to gain more in-depth responses from participants. Interviewers took notes on participant responses as well as their demeanor and perceived level of comfort when answering questions. All interviews were audio-recorded using an Olympus digital voice recorder, and uploaded to a secure, password-protected laptop. Recordings were transcribed verbatim by an outside company, and screening instruments and interviewer notes were scanned to create electronic versions. All transcripts, screening instruments, and interview notes were uploaded to Dropbox for data management and coding. The laptop and paper versions of the screening instrument and interviewer notes were locked in a file cabinet in the principal investigator's office.

After two pilot interviews were completed, the protocol was reviewed by both GRAs and the Project Ujima staff for any repetitive questions and to ensure the items accurately measured the research questions associated with the study. Once the

protocol was finalized, interviewing was initiated.

Data Analysis

Demographics. One GRA was in charge of entering demographic data into IBM SPSS version 20.0.0. Descriptive data analysis was performed on the data generating frequency tables for categorical data and means and standard deviations for continuous data.

Semi-Structured Interviews. Upon completion of all interviews, the GRAs independently read a sample of approximately five transcripts, identified common themes in participant responses, and established with a preliminary list of codes using inductive and deductive coding methods. These codes were discussed and matched to develop a codebook for analysis; codes based on the Theory of Gender and Power and Social Cognitive Theory as well as codes developed by the GRAs were included in this codebook. The preliminary codebook was used to code all other transcripts, and all new codes that arose during the coding process were discussed between the GRAs and added to the codebook. This iterative process continued until the codebook was exhaustive at which point, GRAs read through the transcripts again, updating codes based on the finalized codebook. All transcripts (n=19) were hand-coded, independently by the GRAs. Upon completion of coding, GRAs reconvened to check for consistency of findings and ensure inter-coder reliability; all identified discrepancies in coding were discussed and resolved between the GRAs.

Interview transcripts were used to identify themes and recurring topics that arose in the interviews. Quotes that captured unique perspectives of participants were highlighted and noted for inclusion in the study results.

Chapter IV: Results

Participants

A total of 19 women participated in this study (Table 1). The average age of participants was 20.11(1.10) years, and there was a fairly even distribution of participants across classification with sophomores having the largest cohort (n=6; 31.6%). All participants identified as Black (n=11; 57.9%), African American (n=5; 26.3%) or both (n=3; 15.8%). Nine participants (47.4%) reported being in a committed relationship while six (31.6%) reported that they were not currently dating. The majority of participants indicated that they had oral sex (n=16, 84.2%) and/or penetrative sex (n=15; 78.9%) at some point in their lifetime. Thirteen (68.4%) of the women in the study indicated that they were currently, sexually active. Participants who indicated sexual activity had an average of 1.47 (2.22) partners within the past 3 months. Ten (52.6%) women reported using a condom every time they had sex and the majority of participants had been tested for STIs/HIV/AIDS and received the results for these tests (n=16; 84.2%).

Power Defined

In order to provide context to the research questions raised in this study, it was important to understand how the participants defined power and the factors that contributed to the perception of power in relationships and sexual encounters. Most participants defined power as having respect for one's partner. This included taking the opinion of one's partner into consideration and consulting one's partner when making decisions that affected both parties. One participant summarized the collective belief:

> …it definitely has to go two ways. Like I don't want to try to force something on someone on someone else or make the decisions because I think it's a good idea. So I think it's just kind of respecting both persons' wishes and respecting their decision-making process. If someone says, "This doesn't – I don't think this is right. I don't feel comfortable," then you have to respect that.

While similar themes arose when defining power, the way participants described power was different. Participants either described power from a more positive perspective as the *power to act or change* or from a more negative perspective as having *power over* others.

Power to Act or Change. Participants who described power as the *power to act or change* discussed effective communication as an important contributor to the power they felt in their relationships. Women believed that they had power in a relationship when their partner valued their opinion and outcomes of conversation usually ended in their favor. One participant discussed her positive perspective on power stating, "I think that power in a relationship is when you're able to verbalize your voice or opinion very well and make sure that the other person in the relationship understands it and respects you based off of what you said."

Participants who discussed positive power expected to feel like an equal to their partner and believed that they should have a significant stake in the relationship. One participant described her power expectations as follows, "I would expect for us to conference and make sure that we compromise on how we get with each other before we make any alternate decisions. So I definitely think that power is a balance."

Power Over. Several participants had a negative perception of the term power. When describing the term power, women would refer to dominance and/or control over

another person, and arrogance. It was the belief among these negative perceptions that having power meant partners were not communicating effectively and usually meant that one person did not benefit in the relationship. One participant described her perspective on the negative aspect of power stating, "I believe when…a guy is able to make you do anything without your consent or you're able to… make him do anything without his consent against his will or against your will. That's negative power, I guess."

Participants also discussed negative power as an imbalance of personalities. Women believed that if one partner had low self-esteem or a submissive personality, he/she was more likely to be in a relationship with negative power. Women believed that these types of relationships would be unsuccessful because one partner would not benefit from the relationship dynamics:

> When you think about one person being on top of the other, and the one that's on the bottom, do you really think that person being happy? Somebody ruling them all the time and thinking they run things, you know? I mean I don't really see that as being a relationship and…both of the individuals being happy as partners…

The women who described power in this manner expressed a dislike for the term and a desire for a term that better encompassed a relationship with equal partners.

Gendered Power. Some participants described power based on gender; specifically, these women described gendered power as favoring men. The participants described attributes of men that make them physically more powerful than women. One woman stated "…males are usually taller, they're usually older, you know? Females are usually shorter…I'm just like comparing the physical characteristics and the male always has more power, and usually males are stronger, so they have more power."

In addition to physical power, women also described men as having greater emotional power due to the perception of men being less emotionally involved in the relationship. Participants specifically described how women being more emotionally involved in the relationship made it more likely for them to succumb to their partners' requests.

One woman described how an emotional imbalance could contribute to decreases in relationship length among college students stating, "…in these college relationships that don't really last that long, most of the time the guy has the most power over the female because the female has all her emotions put into it and she just kinda falls into what they guy says or wants." Similar to the collective opinion about power, gendered power relates to the ability to effectively communicate with one's partner and an ability to respect one another despite gender differences such as physical strength and emotional attachment.

Perceived Power and Sexual Relationships

Women had two overarching opinions about perceived power in sexual relationships across partner types; power was either described as alternating dominance or as male dominance. It is important to note that, in the context of sex, *power over* was described in a positive manner. Some women believed that power or dominance shifted from encounter to encounter depending on who initiated the interaction. Women described physical aggression or dominance as a determinant for which partner had more power in a sexual encounter. One participant described the shift in power during sexual encounters with her partner:

> …It's equal… 'cause we both take our turns in dominance. And if there's one day that I'm more aggressive then he'll let me be aggressive or there's days where

> he's aggressive. I'll let him be aggressive. Or if we both, like, push n' pull, it's a push n' pull thing so kind of just feed off each other…

Participants who talked about male dominance described this belief in terms of gender roles; sexual encounters were an opportunity for men to display their masculinity and for women to be more vulnerable and feminine. One woman summarized the collective belief about power and gender roles during a sexual encounter:

> I want him to have the power. That's where the feminine part comes in because I don't want to be the man of the bedroom, I want him to be the man of the bedroom. Our status definitely changes, our roles sexually definitely change. He's more dominant, he's more aggressive and manly -In our sexual encounters than any other part of our relationship - Because I think that's what I prefer.

In both descriptions of sexual power it is interesting to note that there was a common theme of participants "letting" their partner be more aggressive or more dominant during sexual encounter.

Condom Negotiation

Committed Relationship. Nine (47.4%) of the women in this study were in a committed relationship which, for the purposes of this study, is defined as being monogamous or exclusive. Participants in a committed relationship self-reported relationship length as at least one year or longer. Women gave varying accounts about condom negotiation and patterns of condom use with their serious partners. Furthermore, when discussing the conversations they had with their partners about condom use, participants cited testing as important alternative to noncondom use. One participant

described her experience bargaining protective behaviors with her serious partner:

> …First we did have sex with condoms because I was still like, oh my God, he's trying to kill me...But after a while, we started having sex a lot and we used all the condoms and it's kind of getting to the point where I was getting comfortable without having them. And I felt like it's okay now. I made a deal like alright, if you are negative again for all these STD's and I'm negative because I got tested again, and then I'll have raw sex with you forever…

Despite imploring alternative protective behaviors, women in serious relationships cited varying frequencies of HIV/STI testing ranging from once before initiation of unprotected sex to once every three months. Negotiating protective behaviors, however, brought up issues of trust and intimacy. Specifically, women discussed having to justify their reasons for wanting to test regularly. One participant expressed her frustration with her partner stating:

> I mean, just me saying that I didn't feel comfortable with not using condoms, and then it kind of like brings up the whole, "You don't trust me," type thing, which is not even about trust…When I said it, it wasn't even about STDs, because we both get tested regularly, so we know each other's status.

Women in committed relationships also used birth control as a form of prevention against unintended pregnancies. These women had high efficacy in their ability to negotiate condom use despite being on birth control. Women felt that sexual risk was still an issue despite using contraceptives, so they felt it was still important to negotiate condom use with their partners. While women did not necessarily use condom

consistently, they did express the importance of condom use as an extra level of protection beyond birth control. One participant provided an example of how she negotiated condom use with her serious partner after having unprotected sex:

> …I know the birth control is not 100 percent, so I definitely get very worried like for the next couple of weeks or whatever, just because I know that we did that. That's another reason why I want us to use condoms, because I don't want to feel that worry. I'm like as a male you never really have to feel it. You can say, "Oh, no, we're in this together," but really, no, it's kind of just me, and I didn't think that that was fair…

Women in committed relationships who were not on birth control were adamant about condom use with their sexual partners. These women explained to their partners a desire to avoid unintended pregnancies as their primary reason for using condoms. One woman described her agreement with her partner:

> …we had an understanding, so he knows that I want us to stay on that. Even if you don't have anything, we're just gonna keep it like that and you don't want kids right now, so I'm not gonna try and force you to do without, and accidents happen…

Participants cited various levels of resistance from their serious partners. Some women had no opposition from their partners stating, "it's already understood," while others dealt with issues of trust and intimacy. Despite the variety, women overall felt they had high bargaining power for negotiating condom use in their serious relationships.

Non-committed Relationships and Casual Encounters. For this study, non-

committed relationships were relationships where the couples were not monogamous or exclusive. Casual encounters were described as sexual encounters with non-main partners including hook-ups, one night stands sex buddies, etc. Women who had sexual encounters in these types of relationships had high efficacy for negotiating condom use. Women cited lack of monogamy or exclusivity and fear of sexual risk as the primary reasons for wanting to use condoms with these types of sexual partners. One woman described her thought process for negotiating condom use with her sex buddy:

> …I feel like he's in it for the same reason I am, and he's trying to protect himself. So it's like since we're buddies, you don't know if I'm buddies with somebody else, so I feel it's more of a conscious decision like okay…

Women stated that condom negotiation was not difficult in this type of relationship because both parties wanted to avoid negative sexual health outcomes, especially unintended pregnancy. One participant described how avoidance of pregnancy was her motivation to negotiate condom use with a casual sex partner:

> …when I think of condom use, I think of pregnancy and whatnot. Then you have to think about it financially a kid costs—I mean having a child costs money, you know? And you're not ready, you're not really committed and you don't know that person long enough to have a child, you know?

Overall, women in non-committed relationships felt greater efficacy in their ability to negotiate condom use in non-committed relationships to 1) prevent sexual risk due to broader sexual networks and 2) prevent impedance of future orientation due to financial costs of negative sexual health comes.

Impact of Perceived Power on Negotiation

When discussing partners in non-committed relationships or for casual sex, women had high efficacy in negotiating condom use. Women felt that in these types of relationships, they had a significant amount power because the men in these relationships wanted to have sex with them. Women described these types of sexual relationships as being in their favor stating, "It'd just have to be on my terms about what I wanted and if you don't want what I wanted you can leave or whatever." With this perceived power, women had no difficulty negotiating condom use with their partners to protect their sexual health. Their beliefs about sexual risk associated with non-monogamous relationships gave them higher self-efficacy in expressing their desires:

> I would be more likely to use a condom during a one night stand. Because if I'm planning on it being a one night thing I don't want anything to happen where it would have to last longer than one night. Where I'd have to catch something or think about the memory or get pregnant and… yeah, I'd just – we'd just have to leave it at that one night and it'd be over once he takes that condom off.

For serious relationships, the level of perceived power a woman felt impacted the efficacy she felt in her ability to negotiate condom use. One participant described how power was dependent on who was more confident and forceful in what they wanted stating, "In the bedroom I think it plays out that the person with more power is more like forceful with what they want and condom use might be up to that..." Women who had higher perceived power had a greater efficacy in their ability to persuade their partners to use condoms during a sexual encounter. Specifically, they were confident in their ability

to communicate to their partners that they would not have sex if condoms were not used stating, “At the end of the day, if you’re saying, ‘I’m not gonna have sex if you’re not wearing a condom,’ then they’re gonna get a condom.”

Additionally, women felt that they had the power and confidence to tell their partner no in order to protect their sexual health. One woman described her efficacy in negotiating sexual protective behaviors with her serious partner stating, “Well, for me, sexual power is ‘no, I'm not going to do that. I don't care if you want it, or you think you deserve it, I'm not going to do it…’”

Despite any resistance women may have felt from their partners about condom use in their serious relationships, all participants demonstrated high perceived power and high self-efficacy in their ability to negotiate condom use or some form of sexual protective behavior (i.e. testing or birth control) with their serious partners.

Educational & Professional Achievement

Participants discussed the role of educational and/or professional achievement in their selection of relationship partners as well as sexual partners. When discussing relationship partners, future orientation was an important characteristic of potential partners. Women discussed a desire for their partners to have goals for their future whether academically or professionally (i.e. military career or entrepreneurship):

> I’ve always wanted someone who kind of matches me intellectually, and usually when someone matches you intellectually…they usually have, I don’t know, they actually have goals, or, a sense of what they want to do with their lives. Like even if they don’t make like 6 figures…“do you want to do something? …do you want to do something with your life?”

The participants felt that being oriented towards the future meant stability which is a trait they desired in their potential partners. Participant descriptions of stability included financial stability where several of participants talked about their partners being significant financial contributors in future familial settings. One participant described the financial stability she desired in her future partner:

> I feel as though if you make $80,000.00, $90,000.00 a year, you have a good job… if you're somewhere around there then, yeah, we can still be together but I just can't be with you if you're making less than the poverty line 'cause then it's like I'm supporting you and you're not bringing anything into the relationship ... 'cause then I might as well just be a single parent or be alone.

Stability could also include emotional stability. Women cited the desire for their partners to have a stable lifestyle and to be emotionally sound. Women who desired partners who were emotionally stable believed they were more focused which was reflective of the partner's ability to achieve future goals. One woman talked about how financial stability can lead to other forms of stability desired by women in this study stating:

> I feel like being financially stable, you're also stable in other ways, like you're emotionally stable, because you don't have to worry about the economy or you don't have to worry about the stresses and the pressures of being homeless and that sort of thing.

Women desired long-term partners who matched them as intellectuals oriented towards the future and had the ability to provide financial and emotional stability for a family.

Women had differing opinions about educational or professional achievement when selecting sexual partners (i.e. a hook-up, one night stand, casual sex partner, etc).

The majority of participants believed that educational or professional achievement did not matter for a sexual partner. For hook-ups and one night stands, participants believed that it was a one-time event and that it would not happen again, so future orientation was not important.

> …I feel like sex is just physical activity. When you're playin' basketball you don't – or when you're playin' softball you don't really care what the other person is going through or doing at the time, you're just in that game in that time and I feel like sex is the same way. You - what you do outside of the bedroom or how much money you make, well… we're not really talkin' about that...Sexual I just feel like you don't even need to know anything – you don't even need to know their last name in a sexual hookup or encounter.

Women also discussed how purely sexual relationships were more in the moment and less about building lasting relationships. Women did not see a future with sex partners; therefore, they did not take professional or educational achievement into consideration. One participant summed up the collective belief in one sentence, "…if it's a one night stand then I don't really think that all other characteristics of this guy matters."

While not the majority, several participants had opposing opinions about educational or professional achievement when selecting a sexual partner. In these cases, fear of sexual risk played a prominent role in women's desire to know the educational or professional achievement of their sexual partners. Women specifically cited the risk of pregnancy as a reason for wanting to know their casual sexual partner's level of achievement. These women were concerned about financial stability and support in the case that a child was the result of a random sexual encounter. One participant described

the collective opinion:

> …it would matter because if something happens out of this one night stand such as a baby being produced or if there is something that is transmitted through that, activity…then I would just want that person to understand like hey you have to take responsibility, um, without education you're not going to be able to help me out with anything. Um, without a job, I mean, what can you do for me? Without a legal job what can you do for me?

It is worth noting that all the women who discussed the importance of educational or professional achievement in a casual sex partner had never been involved in a casual sex encounter in their lifetime.

Education and Perceived Power

Differences or similarities in educational or professional achievement had varying impact on the power women felt in their relationships. As seen with the definitions of power, women felt that communication and respect were important, especially in relationships where there were differences in level of educational or professional achievement.

Imbalances in achievement. Participants felt that when a partner had higher levels of achievement, that partner had greater capacity to make decisions regarding both parties involved in the relationship. Women thought it was important to trust and respect their partners' opinions and that, while levels of achievement may be different, both parties should be involved in decision-making. Similarly, many women felt that power should be equal despite variance in educational or professional achievement:

> [Power is] about equal...'Cause respect for each other. Um, I know I have higher

> education. I don't try to degrade. Um, he's better at doing things than me and he don't try to put me down… so we work with each other to kinda encourage the other to do better, or even to encourage the other to improve our own skills...

For these participants, having equal power when levels of achievement differed was essential to the relationship dynamics and their ability to effectively communicate with their partners.

Additionally, education was described as an important factor in the level of self-efficacy participants had in communicating with their partners. Women felt that the partner with lower education would have lower self-efficacy due to lack of confidence in their ability to effectively relay their thoughts and opinions to their partners:

> I feel like the more educated a person will have power over the less educated person because it becomes a self-esteem issue and once you, once you establish that 'I have – I have this over you' then, you know that person will automatically be forsaken by their own self-esteem or somethin' like that I guess...

Conversely, women believed having higher achievement than a partner would increase self-efficacy in the ability to communicate with that partner. Women were more confident that they would have desired outcomes in a relationship where they had higher achievement. One participant compared how she felt when she had a higher achievement than her partner and when she had lower achievement, in both instances the ability to communicate played a major role in her perceived power:

> Well, I definitely feel a lot more powerful if I'm talking to someone I think isn't as intelligent as I am, which is why I would never want to be with that person...but I

> don't want to be with somebody who's a genius, and…I have no idea what you're talking about. It definitely can go both ways. I do feel a lot more powerful when I'm talking with someone who's just not there, not on the same level.

Level of education in comparison to one's partner played a significant role in level of perceived power and the efficacy women felt when communicating their desires. Specifically, participants believed that education improved level of understanding; therefore, when partners had differing levels of education, that level of understanding between partners was diminished.

Equal achievement. Most of the participants in the study were paired with partners with equal levels of academic achievement. In these relationships, women felt that power was on a more "even playing field" because they were able to have intelligent conversations with their partner. When educational achievement was equal, women felt they were better able to communicate with their partners about what they wanted and how to find compromise when making decisions. One participant described her desire to have an equal level of achievement with her partner stating, "I think that's good, though, because if you both could come to an agreement, a good decision, then I feel like people at this level would make rational decisions about what's more important, and they have each other in mind." Having a partner with equal education or professional status made it easier for women to express their desires and gain respect from their partners.

No Impact. A few participants believed that education did not and should not play a role in their relationship dynamics. These participants believed that power had more to do with personality traits than level of education. One woman summarized the thoughts of the collective:

> … I would… not associate education with power because I wanted to say that I would have the power but why would I have the power? Because I have a higher education than you? You could be more dominant or controlling because you're younger or you just have a high school diploma…

Unlike the majority of the women who believed that education played a role in their perceived power and ability to communicate, these women believed that personal characteristics like high self-esteem facilitated the power they felt.

Achievement and Condom Negotiation

When asked how condom negotiation was impacted by educational or professional achievement, participants cited their ability to communicate with their partners as the most important factor. Women believed that having equal levels of achievement as their partners made it easier to communicate. Women seemed to have increased self-efficacy in communicating a desire to use condoms if their partners had lower or equal levels of education. One participant described how having equal levels of education would decrease her partner's persuasive power:

> …if we have the same educational status, then that would in our minds put us on the same level even away from education. So you couldn't really play games with trying to persuade me to not wear a condom or to do other things that I probably wouldn't be comfortable with or whatever. So it puts you on their level I guess I would have to say when it comes to sexual activity.

Women felt their partners had less persuasive ability when discussing condom use. Conversely, some women described how a lower level of achievement could decrease the efficacy they felt in their ability to negotiate condom use. One participant described her

opinion on the impact of differences in achievement:

> I could see how it could…because if you're not – I feel like conversations about sexual health definitely take a level of confidence, and so if…you don't feel confident in the relationship…if you feel like you're being demeaned or you're less than the person or there is unequal or whatever, then you may not feel comfortable talking about it and asking all the questions that you should be asking…

Education was seemed to boost the confidence women felt in their ability to express their desires to protect their sexual health. Specifically, having higher education than their partner increase the efficacy women had in their ability to negotiate condom use. Women believed that men with lower education could not afford condoms or "wouldn't care about using condoms" due to lack of future orientation. Specifically, they thought that men with lower achievement would care more about pleasure from a sexual encounter than the consequences associated with unprotected sex. As a result, women felt they should be more forceful and more confident in their desires to practice safe sex. One participant described the efficacy she felt in her ability to not have sex with a partner if he did not have condoms:

> They would probably not have a condom. That's why they say sometimes it's good for females to carry condoms, too. But for me, I don't want to have sex that bad. If you don't have a condom, then we just not doing it...It's not that serious for me. So, it's like, no, I don't carry around condoms and if you don't have a condom then we're not doing anything.

When a partner had higher achievement, women believed that future orientation played a role in their ability to negotiate condom use. Some women felt that it would be easier to negotiate condom use with a partner who had a higher education. They felt that men with higher education would not want unintended pregnancies or disease to disrupt their pursuit of goals. One woman described how future orientation aided condom negotiation with her partner:

> Because he has more education…he has goals, more likely you don't want those goals to be interrupted by a disease or a pregnancy so you're more willing to be cautious and protect yourself...I just feel like when you have more education you know the risk that could – or basically the consequences of not doin' what you have to do in order to reach your goals. And so, in my relationship, that's not a question so condoms will be used. That's my – that's my decision and his.

Some women expressed high self-efficacy in their ability to negotiate condom use with their partners despite differences in educational or professional achievement. They believed that the ability to negotiate condom use had more to do with upbringing and knowledge about sexual risk than level of education:

> I think it more depends on someone's upbringing and how they're raised as well as how much their high school looked into sex education. Someone at home who didn't have a chance to go to college that I graduated with might want to use condoms just as much as someone who's in a college institution.

Women believed that men across educational levels, men knew what was "right or wrong" in sexual decision-making, and they believed that women should have high

efficacy regardless of the differences or similarities in level of education in order to protect their sexual health:

> …you have some intelligent people who just don't wanna use condoms and don't wanna hear about condoms…education has nothing to do with it. Like, a boy from the hood versus a guy [in college], they both might not wanna hear nothing about you talk about condoms, because they're just trying to get them…

Similar to the opinions seen when discussing partnerships where the male partner had lower or equal educational level, women felt the need to be forceful in communicating their desires to use condoms regardless of differences or similarities in achievement.

Chapter V: Discussion

While a significant amount of research has been conducted on sexual risk behaviors and the factors influencing those behaviors, no studies to date have examined the role of differences in educational or professional achievement on sexual protective behaviors such as partner communication, condom negotiation, and condom use. The purpose of this study, therefore, was to explore the impact of educational and professional achievement on perceived power in relationships as well as during sexual encounters. Specifically, this study examined the influence of differences in achievement on women's efficacy in their ability to effectively communicate with their partner and to negotiate condom use. Partner communication and condom negotiation are important sexual protective behaviors shown to be effective in increasing condom use and decreasing sexual risk.

Results from this qualitative study revealed that educational or professional achievement positively impacted women's perceived power when they had equal or higher education than their partner. Specifically, women felt they were better able to communicate their thoughts and opinions to their partner. Even when a partner had higher education, these women felt they had a role in relationship decision making. Future orientation was a common theme when discussing perceived power and condom negotiation. Women had higher perceived power in sexual situations if their partner had lower or equal education levels. Women cited greater self-efficacy in their ability to communicate with their partners about their desires to use condoms for fear of sexual risk (i.e. unintended pregnancies and STIs). This study adds to current knowledge about the role of similarities or differences in educational or professional achievement in women's

uptake of positive sexual health behaviors (i.e. partner communication, condom negotiation, etc.). Furthermore, this study uses a combined theoretical framework, Theory of Gender and Power (TGP) and Social Cognitive Theory (SCT), to understand sexual risk of the college female population within a social and cultural context.

The sexual division of labor construct of the TGP posits that women are economically dependent on their male partners; furthermore, this theory suggests that women who did not graduate high school would be more burdened by economic inequities between men and women than women who have achieved higher education (DiClemente et al., 2009). The facilitation construct of SCT takes the sexual division of labor a step further by providing insight into how resources (i.e. financial stability) play a role sexual risk. Consistent with the sexual division of labor, women in this study desired partners who were or would become economically stable. They specifically desired partners with equal or greater educational or professional attainment for long-term relationships because they desired partners who would become significant contributors to future family economic status.

For non-committed or casual sex relationships, participants desired a partner with equal or higher achievement as a form of financial security in case of unintended pregnancy. Women particularly wanted assurance that they would have the support necessary for childbearing and rearing of children if pregnancy were to result from a sexual encounter. Despite the desire for economically stable partners, future orientation served an important tool of empowerment for the uptake of sexual protective behaviors (i.e. condom negotiation and testing) in women pursuing higher education. Women in this study often discussed how not using condoms or birth control could disrupt their or

their partner's achievement of future career goals. As a result, this sample placed a high priority on condom use and was comfortable in their ability to negotiate condom use with their partners.

The sexual division of power construct of the TGP postulates that women are socially, economically, and psychologically dependent on men because men tend to bring more assets to the relationship like money and security (DiClemente et al., 2009). Furthermore, this dependence on men makes it difficult for women to negotiate condom use with their partners, especially when a partner is resistant to using condoms (DiClemente et al., 2009). Women in power-imbalanced relationships often perceive themselves as having little control over their partner's condom use (DiClemente et al., 2009). As stated previously, the self-efficacy construct of the SCT is the belief about one's ability to execute behaviors that bring desired outcomes (Glanz et al., 2008). This is particularly important in the sexual division of power construct because it speaks to women's ability to execute sexual protective behaviors like condom negotiation.

The women in this study perceived power in their relationships as either equal or in their favor. Specifically, the women in this study cited having equal or higher education than their partner as a buffer for the self-efficacy they felt in their ability to communicate their desire to engage in safer sex practices. Women in this study were assertive in negotiating positive sexual behavior with their partners, and many of them demonstrated high bargaining power stating that they would not have sex with their partners if condoms were not used. The ability of these women to coerce their partners into using condoms is different from the literature which stated that men reacted more negatively, and at times violently, to coercive negotiation strategies (Otto-Salaj et al.,

2010).

Conversely, women felt that if their partner had higher educational or professional attainment, their bargaining power was reduced because these men had the economic stability to handle unexpected sexual health outcomes like pregnancy. Women still had high self-efficacy in their ability to negotiate condom use and believed that their partners took their desires into consideration; however, the final decision about sexual protective behavior was made by their partners.

The structure of cathexis suggests that women are constrained by societal roles for men and women (DiClemente et al., 2009). Specifically, society calls for women to develop meaningful, long-term relationships with a male partner (DiClemente et al., 2009). Issues of trust and intimacy become a major sexual health issue for women in long-term relationships (DiClemente et al., 2009). In the SCT, the outcome expectations construct posits that maximizing benefits and minimizing costs is important in the uptake of positive health behavior (Glanz et al., 2008).

In terms of sexual health, outcome expectations would involve a cost-benefit analysis of negotiating sexual protective behaviors with a long-term partner. In this study, some women in long-term relationships had partners who were resistant to condom use. These partners attempted to persuade women that condom use was not necessary because they had been loyal and could be trusted to not put them at risk. Women in this situation were able to negotiate frequent HIV/AIDS and STI testing and/or birth control as alternatives to condom use in these situations. For these women, fear of the impact of pregnancy and STIs on their future gave them the confidence to communicate their desire to engage in positive sexual health behaviors with their partners.

Public Health Implications

The public health agenda involves developing prevention intervention programs that will protect the health of the general populations before health issues arise. One major problem in public health is the sexual health in the emerging adult population (18-25 years) (Centers for Disease & Prevention, 2011; Finer & Henshaw, 2006; Gavin et al., 2009; Prevention, 2011). This age group is at highest risk for HIV/AIDS, STIs, and unintended pregnancies than any other age group in the US (Centers for Disease & Prevention, 2011). Specifically, Black women in this age group bear greater risk when compared to their White counterparts despite likelihood of condom use in this population (Hou, 2009).

This study has allowed for more insight into the factors that influence practice of sexual protective behaviors of Black college women on historically black college (HBC) campuses. Specifically, interventions that teach women in long-term relationships how to negotiate alternative protective behaviors such as frequent testing and use of birth control may be effective in reducing sexual risk in the population. Additionally, interventions that focus on pregnancy prevention would be a good fit for this population as many women in this study described unintended pregnancy as their primary concern when discussing sexual health. Finally, Women in this study were oriented towards their future and wanted to prevent any sexual risk that may impede achievement of their goals. Interventions that focus on future orientation as a protective behavior may also be successful in the emerging adult population. Specifically, interventions that express the importance of sexual protective behaviors in achieving future goals may help to improve the sexual health of the population at risk.

Implications for Future Research

The findings in this study indicate a need for future research on the factors that impact sexual risk for HIV/AIDS, STIs, and unintended pregnancies in the Black/African American female college population. In order assess the generalizability of the results; this study should be replicated in a wider variety of academic settings including other historically black colleges (HBCs) as well as predominantly white institutions (PWIs). Future studies could also test and validate other health behavior theories, including the Theory of Reasoned action, as the guiding theoretical framework for understanding the impact of educational or professional achievement on perceived power and the uptake and use of sexual protective behaviors. This would improve the literature on perceived power as well as partner communication and the role it plays in sexual risk behavior of African American college women.

Assessing the male perspective on education and how it plays a role in partner communication, condom negotiation, and condom use would provide further insight in to the validity of the findings from this study. Lastly, conducting this study with couples would also provide a unique perspective and would allow for researchers to also assess the dynamics of the relationship as couples respond to questions concerning power and sexual decision-making.

Strengths & Limitations

Qualitative Studies. Qualitative studies provide excellent opportunities for researchers to gain in-depth answers to the research questions they raise. These studies often provide a way to form hypotheses about the population being studied; however, qualitative methods are limited due to the inability to generalize findings. Despite this

limitation, data obtained from qualitative studies could be used for the development of survey instruments for more general dissemination; information obtained from these surveys could then be generalized. Another benefit of qualitative studies was that the protocol could be adjusted as necessary throughout the interview process to better draw out themes that arose during data analysis.

Social Desirability. Face-to-face, semi-structured interviews are method of data collection that allows the researcher to gain immediate clarification of responses given by participants as well as explain questions for the participant; however, there are limitations. One limitation of this method of data collection is social desirability. Because the items in this study asked personal questions about the participants sexual risk behaviors, the participants may have given inaccurate responses because they were embarrassed, they wanted to give answers that they thought were expected, etc. To further assess participant responses, the GRAs were instructed to take notes on the participants' level of comfort, their demeanor, and their facial expressions when answering questions.

Additionally, these interviews were conducted by one Black and one White, female graduate research assistants. The ethnic characteristics of the interviewers may have impacted social desirability and inherently affected the responses given by the participants.

Lastly, sex is often a difficult and highly stigmatized topic. Because of this the interview guide was designed in such a manner that GRAs began by asking basic information of the participants; they then then moved into the more personal questions about their sexual risk behaviors (i.e. condom use). The interview ended with more basic

questions about the participant's knowledge of sexual health resources available to them. This strategy allowed the participant the opportunity to get comfortable with the interviewer and not immediately be bombarded with questions that were intrusive. It also allowed the emotional level to be reduced after asking such personal questions.

Sample Size. The sample range of interviews was chosen based on previous qualitative studies on sexual attitudes and behaviors. This range has been shown to gain adequate information to reach saturation of information about topics being covered in the study.

Study Location. This study was limited by the fact that it was conducted on a HBC campus; Black women attending a PWI were not included in the study sample. Because the participants in this study were a part of a HBC campus, their sexual risk behaviors may be different from a similar population that is a part of a PWI campus. Previous literature assessing sexual risk behaviors in both types of institutions revealed that students on HBC campuses are at greater risk for sexual health issues (Hou, 2009), so conducting the study on an HBC campus was merited.

Conclusion

The participants in this study provided data demonstrating that education played an important role in perceived power. Findings suggest that women who had equal or higher education than their partner felt that they were better able to communicate with their partners. This higher efficacy in the ability to communicate carried over into sexual relationships and gave women the confidence to negotiate sexual protective behaviors like condom use, HIV/AIDS and STI testing, and/or birth control. Future research should further explore other factors that put African American college women at increased risk

for negative sexual health outcomes like HIV/AIDS, STIs, and unintended pregnancies despite positive sexual health behaviors. This information could then be used to design or improve prevention interventions to better target this at-risk population and will increase the likelihood of uptake of information disseminated and sexual protective strategies shown to be effective in preventing sexual risk.

References

Buhi, E. R., Marhefka, S. L., & Hoban, M. T. (2010). The State of the union: sexual health disparities in a national sample of US college students. [Comparative Study]. *J Am Coll Health, 58*(4), 337-346. doi: 10.1080/07448480903501780

Carter, J. A., McNair, L. D., Corbin, W. R., & Williams, M. (1999). Gender differences related to heterosexual condom use: the influence of negotiation styles. *J Sex Marital Ther, 25*(3), 217-225. doi: 10.1080/00926239908403996

Centers for Disease, C., & Prevention. (2010). Vital signs: HIV testing and diagnosis among adults--United States, 2001-2009. *MMWR Morb Mortal Wkly Rep, 59*(47), 1550-1555.

Centers for Disease, C., & Prevention. (2011). Sexually Transmitted Disease Surveillance 2010. Atlanta, GA: US Department of Health & Human Services.

Cowdery, R. S., Scarborough, N., Knudson-Martin, C., Seshadri, G., Lewis, M. E., & Mahoney, A. R. (2009). Gendered power in cultural contexts: Part II. Middle class African American heterosexual couples with young children. *Fam Process, 48*(1), 25-39.

Davis, C., Sloan, M., MacMaster, S., & Kilbourne, B. (2007). HIV/AIDS knowledge and sexual activity: an examination of racial differences in a college sample. [Comparative Study]. *Health Soc Work, 32*(3), 211-218.

DiClemente, R. J., Crosby, R. A., & Kegler, M. C. (2009). *Emerging theories in health promotion practice and research* (2nd ed.). San Francisco, CA: Jossey-Bass.

Eaton, D. K., Kann, L., Kinchen, S., Shanklin, S., Ross, J., Hawkins, J., . . . Prevention. (2010). Youth risk behavior surveillance - United States, 2009. *MMWR Surveill Summ, 59*(5), 1-142.

Ferguson, Y. O., Quinn, S. C., Eng, E., & Sandelowski, M. (2006). The gender ratio imbalance and its relationship to risk of HIV/AIDS among African American women at historically black colleges and universities. *AIDS Care, 18*(4), 323-331. doi: 10.1080/09540120500162122

Finer, L. B., & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. [Research Support, N.I.H., Extramural]. *Perspect Sex Reprod Health, 38*(2), 90-96. doi: 10.1363/psrh.38.090.06

Gavin, L., MacKay, A. P., Brown, K., Harrier, S., Ventura, S. J., Kann, L., . . . Prevention. (2009). Sexual and reproductive health of persons aged 10-24 years - United States, 2002-2007. *MMWR Surveill Summ, 58*(6), 1-58.

Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behavior and health education : theory, research, and practice* (4th ed.). San Francisco, CA: Jossey-Bass.

Harvey, S. M., & Bird, S. T. (2004). What makes women feel powerful? An exploratory study of relationship power and sexual decision-making with African Americans at risk for HIV/STDs. [Research Support, U.S. Gov't, P.H.S.]. *Women Health, 39*(3), 1-18. doi: 10.1300/J013v39n03_01

Harvey, S. M., Bird, S. T., Galavotti, C., Duncan, E. A., & Greenberg, D. (2002). Relationship power, sexual decision making and condom use among women at

risk for HIV/STDS. [Research Support, U.S. Gov't, P.H.S.]. *Women Health, 36*(4), 69-84. doi: 10.1300/J013v36n04_06

Hou, S. I. (2009). HIV-related behaviors among black students attending Historically Black Colleges and Universities (HBCUs) versus white students attending a traditionally white institution (TWI). [Comparative Study

Multicenter Study]. *AIDS Care, 21*(8), 1050-1057. doi: 10.1080/09540120802626196

Lewis, L. M., Melton, R. S., Succop, P. A., & Rosenthal, S. L. (2000). Factors influencing condom use and STD acquisition among African American college women. [Research Support, U.S. Gov't, P.H.S.]. *J Am Coll Health, 49*(1), 19-23. doi: 10.1080/07448480009596278

Nguyen, A. B., Clark, T. T., Hood, K. B., Corneille, M. A., Fitzgerald, A. Y., & Belgrave, F. Z. (2010). Beyond traditional gender roles and identity: does reconceptualisation better predict condom-related outcomes for African-American women? *Cult Health Sex, 12*(6), 603-617. doi: 10.1080/13691051003658127

Otto-Salaj, L., Reed, B., Brondino, M. J., Gore-Felton, C., Kelly, J. A., & Stevenson, L. Y. (2008). Condom use negotiation in heterosexual African American adults: responses to types of social power-based strategies. [Research Support, N.I.H., Extramural]. *J Sex Res, 45*(2), 150-163. doi: 10.1080/00224490801987440

Otto-Salaj, L., Traxel, N., Brondino, M. J., Reed, B., Gore-Felton, C., Kelly, J. A., & Stevenson, L. Y. (2010). Reactions of heterosexual African American men to women's condom negotiation strategies. [Research Support, N.I.H., Extramural]. *J Sex Res, 47*(6), 539-551. doi: 10.1080/00224490903216763

Prevention, C. f. D. C. a. (2011). Sexually Transmitted Disease Surveillance 2010 (D. o. H. a. H. Services, Trans.). Atlanta, GA.

Sales, J. M., Lang, D. L., DiClemente, R. J., Latham, T. P., Wingood, G. M., Hardin, J. W., & Rose, E. S. (2012). The mediating role of partner communication frequency on condom use among African American adolescent females participating in an HIV prevention intervention. [Research Support, N.I.H., Extramural]. *Health Psychol, 31*(1), 63-69. doi: 10.1037/a0025073

Whaley, A. L., & Winfield, E. B. (2003). Correlates of African American college students' condom use to prevent pregnancy, STDs, or both outcomes. [Comparative Study]. *J Natl Med Assoc, 95*(8), 702-709.

Wingood, G. M., & DiClemente, R. J. (1998a). Gender-related correlates and predictors of consistent condom use among young adult African-American women: a prospective analysis. *Int J STD AIDS, 9*(3), 139-145.

Wingood, G. M., & DiClemente, R. J. (1998b). Partner influences and gender-related factors associated with noncondom use among young adult African American women. *Am J Community Psychol, 26*(1), 29-51.

Appendix A

Questions from the Original Interview Protocol

Main Questions	Follow-up Questions & Probes
How do you define "power" in a relationship?	• What does it mean to you to have "power" when interacting with a partner?
How does educational level or professional status impact the power you feel in your dating relationships in general? (during a sexual encounter?)	• How is condom use and/or negotiation impacted in intimate encounters where a partner has higher educational level or professional status than you? • If educational level is equal (or professional status is similar to yours) how is condom use impacted? • If partner's educational level (or professional status) is lower than yours, how is condom use impacted? **NOTE**: whichever education level is applicable
Does educational level (or professional development/status) matter to you when choosing a sexual partner (i.e. hook-up, one night stand, etc.)?	• *If yes: Please explain how. • *If does not matter: Why does educational level (or professional status) matter less when choosing a sexual partner vs. a dating partner?
Now let's think about your most recent or current dating experience: Was this person a student?	• *If yes: Where? • *If the person was not a student: What does the person do? (i.e. education, work, professional development)
What is your general pattern of condom use?	• How does the type of relationship influence your pattern of condom use (or non-use)?

Appendix B

Coding Tree and Codebook

Education, Power, & Sex
Coding Tree

(1) Partner
    (1 1) Professional Status
        (1 1 1) Stability
    (1 2) Comfort
    (1 3) Safe
(2) Power
    (2 1) Definition
        (2 1 1) Empowerment
        (2 1 2) Social Psychological
    (2 2) Relationship
    (2 3) Sexual Encounter
        (2 3 1) Casual Sex
        (2 3 2) Serious Relationship
    (2 4) Respect
(3) Educational/Professional Achievement
    (3 1) Partner Selection
        (3 1 1) Random Sexual Encounter
        (3 1 2) Dating/Serious Relationship
    (3 2) Differences in Achievement
    (3 3) Future Orientation
(4) Communication
    (4 1) Sex
    (4 2) Relationships
(5) Protective Behaviors
    (5 1) Contraceptives
    (5 2) Condom Use
        (5 2 1) Pattern of Condom Use
    (5 3) Condom Negotiation
        (5 3 1) Serious Relationship
        (5 3 2) Dating
        (5 3 3) Casual Sex
    (5 4) Testing
    (5 5) Fear of Sexual Risk

Education, Power, & Sex
Codebook

1. Partner – description of characteristics of current partner or desired characteristics for perspective intimate partner
    a. Professional Status – description of expectations for educational or professional achievement in partner based on relationship type (i.e. casual relationship vs. serious relationship)
        i. Stability – descriptions of having a partner who is goal-oriented, future-oriented, and financially sound.
    b. Comfort – descriptions of how one feels with an intimate partner in general and/or during a sexual encounter
    c. Safe – descriptions of characteristics that make one feel they are not at risk with an intimate partner.
2. Power – description of what it means to feel powerful in a relationship and how perceived power impacts relationship dynamics
    a. Definition – description of what it means to have power
        i. Empowerment – having the ability to act or change in a desired direction
        ii. Social Psychological – having the capacity to influence the action of others
    b. Relationship – description of perceived power in current or perspective relationships
    c. Sexual Encounter – description of perceived power in sexual encounters
        i. Casual Sex – description of perceived power in sexual encounters with a non-serious partner (non-monogamous/not exclusive)
        ii. Serious Relationship – description of perceived power in sexual encounters with a serious partner (monogamous/exclusive)
    d. Respect - being able to have an opinion without being pressured to change one's mind; being mindful of differences in opinion
3. Educational/Professional Achievement – impact of status on partner selection, relationship dynamics, and sexual encounter
    a. Partner Selection – impact of educational/professional achievement on choice of partner
        i. Random Sexual Encounter – importance of achievement in selection of partners for singular sexual encounters (i.e. one night stand)
        ii. Dating/Serious Relationship – importance of achievement in selection of partners for more long-term relationships
    b. Differences in Achievement – the impact of unequal achievement on relationship and sexual dynamics
    c. Future Orientation – desires to select a partner who is goal-oriented and focused toward future success
4. Communication – descriptions of conversations and/or discussions with partners.
    a. Sex – descriptions of the feasibility of communicating with others about matters of sexual health

   b. Relationships – descriptions of the feasibility of communicating with one's partner about relationship issues
5. Protective Behaviors – descriptions of behaviors that prevent sexual risk
   a. Contraceptives – explanation of use as a form of protection against pregnancy
   b. Condom Use – explanation of use as a form of protection against pregnancy, HIV/AIDS, and/or STI
      i. Pattern of Condom Use – frequency of condom use during sexual encounters
   c. Condom Negotiation – descriptions of discussions about condom use and the efficacy women felt in negotiating condom use
      i. Serious Relationship – descriptions of discussions about condom use when in a committed (monogamous/exclusive) relationship
      ii. Dating – descriptions of discussions about condom use with a casual partner (non-monogamous/not exclusive)
      iii. Casual Sex – descriptions of discussions about condom use with a random partner (i.e. one night stand)
   d. Testing – explanations of when and under what circumstances women get tested for HIV/AIDS or STIs
   e. Fear of Sexual Risk – descriptions of how fear of pregnancy, HIV/AIDS, or STI infection influences sexual protective behaviors