



Are there gender differences in perceived sexual self-efficacy among African-American adolescents?

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Abstract

Background: African American adolescents accounted for more than half of all HIV/AIDS cases in 2009. Behavioral Strategies are needed to help lessen the incidence of HIV/AIDS among this population.

Purpose: The aim of his study was to examine sexual self-efficacy practices and beliefs among African American adolescents. We also examined gender differences between African American adolescents to better understand their perceptions of sexual self-efficacy, condom use intention, and other safer sex practices and beliefs.

Methods: A cross-sectional study was conducted with 214 African American adolescents using survey instruments to examine their beliefs, perception and intentions on the use of condoms, sexual self-efficacy and safe sex practices. Participants were recruited through a mass media campaign and local youth serving organizations within Sedgwick County, KS.

Results: Our findings indicate significant differences exist between genders in perception of sexual self-efficacy among African American adolescents. Females were found to have higher perceived sexual self-efficacy compared to males. Having high negotiation skills and a sexual partner who approved of condom use were significant predictors for high perceived sexual self-efficacy.

Conclusions: African American adolescent females were more likely to have higher perceived sexual self-efficacy than African American male adolescents. Because of the dynamics that exist in male and female relationships and the mediating role sexual self-efficacy might play in engaging in safe sex practices, it is important to design gender specific interventions in order to curb the spread of HIV/AIDS and other STDS/STI's.

Keywords

African American adolescents; HIV/AIDS; self-efficacy; self-concept; gender; prevention

Cover Page Footnote

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Among African-American Adolescents?**

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ABSTRACT

Background: African American adolescents accounted for more than half of all HIV/AIDS cases in 2009. Behavioral Strategies are needed to help lessen the incidence of HIV/AIDS among this population.

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Keywords: Community Health, Community Health Preventative Medicien, Health Psychology, Public Health, Women's Health, Sexual Health, African American Health,

INTRODUCTION

African American youth are disproportionately represented in HIV/AIDS cases (CDC, 2011; Colon Wiatrek, & Evans, 2000). African American adolescents (13-24 years) accounted for 65% of all HIV cases in 2009 (CDC, 2011). The incidence of HIV has steadily increased among adolescents over the past several years (CDC, 2003, 2011). Many adolescents do not know they are infected with HIV, which increases the risk of infecting others through risky behaviors (i.e. unsafe sex, multiple partners, and injection drug use) (CDC, 2012a). Because African American adolescents are most at-risk, particularly females, it is important to provide them with prevention risk behavior tools like sexual self-efficacy that can lessen the likelihood of being infected with HIV.

With the insurmountable number of new cases each year and the cost of this illness socially, mentally, and economically, there is ample reason to provide prevention and intervention programs for high risk populations. Researchers have focused on the role of psychosocial variables in the prevention of risky behaviors that lead to HIV infection (Bachanas et al., 2002; Colon et al., 2000; Wingood & DiClemente, 1992). One of the major risk factors for HIV infection is unprotected sexual contact or lack of using a male latex condom (CDC, 2001). Having the confidence to negotiate safer sex practices with a partner, as well as the ability to practice those skills consistently, is the very essence of sexual self-efficacious behavior. In this study we will focus on self-efficacy, which has proven to be a mediating factor in reducing risky sexual behaviors that can lead to HIV transmission in certain populations (Jemmott & Jemmott, 1992; Jemmott, Jemmott, Spears, Hewitt, & Collins, 1992).

Perceived Sexual Self-efficacy

Self-efficacy is the capacity to believe in the ability to overcome obstacles, challenges, and adversities in one's life (Creer & Wigal, 1993). Higher perceived self-efficacy can increase confidence in one's ability to accomplish certain behaviors, as well as the belief that they have control of certain situations in their environment (Bandura, 1997; 2001; Rimal, 2001). Self-efficacy is effective as a protective factor against risky sexual behaviors such as inconsistent condom use. Several prevention studies have demonstrated that increasing adolescent's self-efficacy for intended condom use and partner negotiation skills can help them maintain consistent protective behaviors, thus reducing their risk of HIV infection (Burns & Dillon, 2005; Colon et al., 2000; Goh, Primavera & Bartalini, 1996; Jemmott, Jemmott, Spears, Hewitt, & Collins, 1992; Zak-Place & Stern, 2004). While self-efficacy is an effective protective tool, it can also be enhanced or attenuated by social, cultural, or environmental factors. These factors can influence how adolescents perceive health promoting and health risk behaviors (Cooper & Guthrie, 2007). It is important to consider how these factors can influence the ability to execute improved sexual self-efficacious behaviors for HIV risk behaviors (Betty, Wheeler, & Galter, 2004).

Sociocultural Influences on HIV Risk Behaviors

African American adolescent's attitudes or intentions about HIV risk behaviors can be easily influenced by peer norms, communication with parent, cultural or religious beliefs, and socioeconomic factors (Belgrave, Marin, Chambers, 2000; DiClemente et al., 2001; Kapungu et al., 2010; Newman & Zimmerman, 2000; Townsend, Grange, Belgrave, Wilson, Fitzgerald, & Owens 2006). Townsend et al. (2006) found cultural or Afrocentric values to be associated with less risky behaviors tied to HIV infection. They believed Afrocentric values to be an important protective factor for safer sex practices because they give adolescents a stronger sense of

perceived behavioral control. This is particularly true if they have strong familial, community, and peer based support that enhances this belief system. Kapungu et al. (2010) found adolescents who communicated with their mothers about sexual behaviors were less likely to engage in HIV risk behaviors. Newman and Zimmerman (2000) indicated that environmental conditions, as well as socioeconomic conditions, also influence an adolescent's intention to practice safer sex behaviors. Characteristically, youth from a lower socioeconomic status may practice fewer safe sex behaviors and have more risk behavior patterns (Woods-Jaeger, Sparks, Turner, Griffith, Jackson, & Lightfoot, 2013). Adolescents from neighborhoods with significant violence and poverty may also be less inclined to practice safer sex practices, engage in sexual behavior at a younger age, and have multiple sex partners (Lightfoot & Milburn, 2009). Aside from the environmental and social factors that influence risk behaviors among African American adolescents, there is also the issue of their own health beliefs. Woods-Jaeger et al. (2013) found African American adolescents felt powerless over certain risky behaviors because of their environmental and social situation. Thus, social determinants (environmental and social situations) of HIV risk can impact behavioral decisions by African American adolescents (Woods-Jaeger et al., 2013).

Gender Differences on HIV Risk Behaviors

There is a paucity of research on gender differences in perceived sexual self-efficacy for HIV prevention, particularly among non-sexually active youth. Most studies indicate females have higher perceived sexual self-efficacy in comparison to their male counterparts (Rostosky, Dekhtyar, Cupp, & Anderman, 2008; Stevenson, Davis, Weber, Weiman, & Abdul-Kabir, 1995). However, some of these studies also found that African American females with high perceived self-efficacy were not consistently engaging in condom use or safer sex practices. Consequently, unprotected sexual contact is also one of the leading causes of HIV infection for African American women; which makes it a potential power differential in interpersonal relationships with a male partner (Bowleg, Belgrave, & Reisen, 2000; CDC 2013). There is a sparse amount of prevention research that even touches on the question of sexual self-efficacy for African American adolescent males. Glenn, Demi, & Kimble (2007), found that a father's communication about safe sex standards and his perception of his son's self-efficacy was a good predictor of the son's self-efficacy. This is the only recent study that looks specifically at African American adolescent male sexual self-efficacy. This is an area of research that needs to be further explored in the context of what gender differences exist between African American male and female adolescents sexual self-efficacy beliefs.

In this study, we wanted to examine the role of gender and perceived sexual self-efficacy in African American adolescents. Sexual self-efficacy is an important factor in HIV prevention messages with adolescents. We want to better understand how African American male and female adolescents perceive their sexual self-efficacy and if there are indeed gender differences in their attitudes about perceived sexual self-efficacy.

METHODS

Participants and Procedures

Two hundred and fourteen African American adolescents were surveyed about their attitudes and beliefs about HIV/AIDS and substance abuse. There were 127 females and 87 males who participated in the study and ranged in age from 11 to 18 ($M=14.07$ years, $SD=1.55$). Approximately 93% of participants were currently attending middle or high school. Most

participants indicated no previous attendance of HIV or substance abuse classes during the past year. Participants were recruited to take part in the study through an intensive media campaign (radio, television, newspaper ads, and flyers) aimed at the entire metropolitan area of Sedgwick County, Kansas.

The administration of the Jemmott HIV/AIDS & Substance Abuse survey took place on Saturdays at a local university. Participants were given consent forms to sign and those under the age of 18 were required to have parental consent in order to participate in the study. Participants were informed that they could withdraw from the study at any time. Because the measure was self-reported and contained sensitive information, participants were given a behavioral contract to sign. The behavioral contract was designed to increase truthfulness in responding to the survey and assure personal identification and survey responses would be kept confidential. Project staff helped administer the survey to program participants.

Instruments

This study used the survey developed by Drs. John and Loretta Jemmott (Jemmott, Jemmott & Fong, 1992; 1998; Jemmott, Jemmott, Fong & McCaffree, 1999) to solicit responses from participants. The survey consisted of 274 questions that address health behaviors, self-efficacy, sexual behavior, sexual attitudes, HIV/AIDS knowledge, background information, educational information, parent's occupation and marital status. Self-efficacy was measured using a 4-item scale with an adequate internal reliability ($\alpha=.78$) based on a Likert scale response ranging from 1- "very difficult" to 5-"very easy". The specific questions on the scale asked participants how hard it would be to perform a certain behavior, such as "how easy or difficult would it be to talk with your partner about preventing HIV/AIDS" (see table 1). Higher scores on this scale indicated greater levels of self-efficacy to perform the task. In this study, an examination of participants' perceived sexual self-efficacy was determined.

Table 1. Sexual Self-efficacy Scale Questions

1-Very Difficult	2-Difficult	3- In the middle	4-Easy	5-Very Easy
1. How easy or hard would it be to get your sexual partner to not have sex with you, even if your partner wanted to?				
2. How easy or hard would it be for you to get your sexual partner to talk to you about preventing sexually transmitted disease (STDs) even if your partner did not want to?				
3. How easy or hard would it be for you to get your sexual partner to talk with you about ways to prevent AIDS, even if your partner did not want to?				
4. How easy or hard would it be for you to use condoms when you have sex?				

Statistical Analysis

Data were analyzed using Predictive Analysis Software, Version 18.0 (SPSS, Inc., Chicago, IL). The "Descriptive Statistics" procedure was used to analyze demographic variables such as age, gender, education level, and sex education classes. The "Analysis of variance"

procedure was used to analyze group difference on perceived sexual self-efficacy for gender and age. Chi-square statistics were calculated to determine associations between condom use intention and behaviors and gender and sexual activity (see tables 2 and 4). Logistic regression analyses were used to construct models of high perceived sexual self-efficacy. The constructed models were assessed using the Hosmer and Lemeshow (2000) goodness-of-fit test.

RESULTS

Descriptive Findings

Table 2 reports the study's sample characteristics. We found no statistically significant association between gender and sexual activity, $X^2(1, N=205) = 3.29, p = .07$. However, female participants reported a higher percentage of no sexual activity (72.4%) compared to male participants (59.3%). As far as previous knowledge on HIV/AIDS or STIs, 93% of the participants reported previously attending classes on HIV/AIDS prevention (See table 2). The general purpose of this study was to examine the differences in attitudes about perceived sexual self-efficacy among male and female adolescents. Our findings indicate significant differences exist between genders in perception of sexual self-efficacy among African American adolescents.

Table 2. Sample Characteristics

	Males (n=87) n (%) [□]	Females (n=127) n (%) [‡]
Age (mean) (SD)	13.9 (1.49)	13.9 (1.49)
Sexually Active	33 (40.7)	35 (27.6)
Non-Sexually Active	48 (59.3)	92 (72.4)
Previous AIDS Classes*	34 (45.3)	60 (47.6)

* measured by questions on the YEP survey

□ percent is equal to total number of males in program

‡ percent is equal to total number of females in program

* significant at $p < .05$ level

Differences in Perceived Self-efficacy

Table 3 provides an assessment of differences between genders and age groups on perceived sexual self-efficacy. Our findings indicated there were significant differences between genders on levels of perceived sexual self-efficacy. Female adolescent participants were found to have significantly higher perceived sexual self-efficacy scores than their male counterparts. On average African American female adolescent's mean self-efficacy was higher than African American male adolescent's mean self-efficacy score, indicating African American female adolescents endorsed stronger attitudes about their ability to carry out safer sex practices and partner negotiation skills. There are however, no differences between genders or any interaction between gender and age when looking at levels of perceived sexual self-efficacy.

Table 3. Analysis of Variance for Perceived Sexual Self-efficacy

Differences Between Groups	203				
	N	df	F	p	n ²
Gender		1	12.89	.000*	0.06
Age		1	2.790	0.096	
Age * Gender		1	0.969	0.326	

*significant at p<.05

Differences in Condom Use Intention and Beliefs

Table 4 examines differences in condom use intention and beliefs among genders. Significant differences existed between males and females intention to use condoms if their sexual partners approved of condom use. More female adolescents intended to use condoms if their sexual partners approved of condom use compared to their male counterparts. No differences existed between genders on embarrassment of condom use or belief about condoms ability to protect from AIDS or STIs.

Table 4. Gender differences in intention and beliefs about condom use

	Males n=81 [†]	Females n=120 [‡]	p-value
Embarrassed to use condoms	52.9%	47.1%	> .05
Believes condoms prevent AIDS	34.3%	65.7%	>.05
Believes condoms prevent STDS	36.5%	63.5%	>.05
Sexual partner approves of condom use	35.9%	64.1%	0.04

[†]Note N for male equals 81 due to missing data

[‡]Note N for female equals 120 due to missing data

Predictors of High Perceived Sexual Self-Efficacy

Table 5 provides results of predictors of high perceived sexual self-efficacy. Two variables were significantly associated with high perceived sexual self-efficacy among African American adolescents. Participants whose sexual partner approved of using condoms were more likely to have high perceived sexual self-efficacy compared to those whose partners did not approve (OR=2.83; 95% CI= 1.03-7.82). Adolescents who scored high on negotiation skills were more likely to have high perceived sexual self-efficacy compared to those who scored low on negotiation skills (OR=21.03; 95% CI=8.34-53.01).

Other variables that measured condom use intention, education on HIV/AIDS, embarrassment in using condoms, and intentions to have sexual intercourse were not significant predictors of high perceived sexual self-efficacy.

Table 5. Odds Ratio (OR) and 95% Confidence Intervals (CI) for Predictors of High Perceived Sexual Self-efficacy	Adjusted OR*	95% CI
Gender		
Female	0.94	(.382, 2.32)
Male	1	
Age		
≤ 14 years	1.67	(.583, 4.77)
≥ 15 years	1	
Condoms can prevent AIDS		
No	1.09	(.388, 3.07)
Yes	1	
Embarrassed to use condoms		
No	0.247	(.058, 1.05)
Yes	1	
Negotiate		
No	21.03	(8.34, 53.01)*
Yes	1	
Plan to have sex in the next 3 months		
No	0.534	(.174, 1.64)
Yes	1	
Condoms can prevent STDS		
No	1.68	(.549, 5.11)
Yes	1	
Had HIV/AIDS classes		
No	1.19	(.502, 2.85)
Yes	1	
Ever been sexually active		
No	0.499	(.160, 1.56)
Yes	1	
Sexual partner approves of condoms		
No	2.83	(1.03, 7.82)*
Yes	1	

Computed using binary logistic regression.

*Significant at the $p < .05$ level.

OR, odds ratio.

CI, confidence interval.

DISCUSSION

Our findings indicate that there are significant differences between sexual self-efficacy among African American adolescents. African American female adolescents were more confident in their perceived ability to carry out safer sex practices, to discuss risk behavior with a partner, and to use or discuss condoms with a sexual partner. This finding is important because of the significance of self-efficacy as a mediating factor in prevention of HIV/AIDS, particularly for adolescent females (Jemmott & Jemmott, 1992). What follows is a discussion of the findings and future research directions.

Gender Differences

In our findings, females had stronger perceptions of sexual self-efficacy compared to males. While there is a dearth of research on perceived sexual self-efficacy for adolescents, particularly African American adolescents, our results are similar to previous studies. Rostosky et al. (2008) surveyed male and female adolescents about their sexual self-concepts and sexual self-efficacy. They found female adolescents had stronger self-concepts and sexual self-efficacy compared to their male counterparts. Stevenson et al. (1995) found similar results in terms of female perceived sexual self-efficacy. Stevenson et al. (1995) found that female participants were more likely to endorse higher self-efficacious behaviors and self-control compared to male counterparts who endorsed more culturally suspicious beliefs about HIV prevention. This may have credence in terms of tailoring prevention programs that deal with specific gender related bias related to HIV preventive behaviors. As Stevenson et al. (1995) points out, there could be a culture of teenagers that supports a pseudo-confidence which prevents them from actively protecting themselves from HIV and other STIs. The fact that male participants seem more likely to report lower perceived sexual self-efficacy is not a definitive indication that they are less confident in their ability to protect themselves. It may be they are subconsciously unwilling to practice these behaviors for the belief that they are invincible from HIV infection. Previous studies have indicated that males tend to engage in more risky sexual behaviors that are tied to their self-esteem, meaning, adolescent males may engage in risky behaviors because of expectations, peer influence, bragging, or relationship control. It is also possible adolescent males believe risky sexual behaviors are acceptable to practice, thus expressing their sexual freedom (Newman, & Zimmerman, 2000; Robinson, Holmbeck & Paikoff, 2007). This can be a problem when considering partner negotiation with females who do want to practice HIV-preventive behaviors. More work must be done in the area of self-efficacy to fully understand the theoretical and cultural linkages this has in helping African American adolescent females protect themselves against HIV infection.

Intention and beliefs about condom use

African American adolescent males and females held similar beliefs about the effectiveness of condoms in preventing HIV/AIDS and other STIs. We found no significant differences between genders on intention and beliefs about condom use, however, female adolescents consistently held stronger beliefs about the effectiveness of condoms in preventing HIV and STIs. This is important when considering prevention messages must be believed by the recipient. Not only must they believe they can use condoms and talk to their partner about safe sex practices, they need to believe that condoms will actually protect them from disease. Our findings indicate African American male adolescents may need more instruction on the importance of condom use and disease protection. Both genders seem to have some embarrassment with condom use. This may be due to the young age of participants as well as the fact that most were not yet sexually active.

Predictors of High Sexual Self-efficacy

In this sample of African American adolescents, predictors of high perceived sexual self-efficacy are directly tied to behaviors and beliefs held by a sexual partner. High partner negotiation skills and belief a sexual partner approves of using condoms were predictors of high perceived sexual self-efficacy.

Limitations

Two of the most poignant limitations in this study were the use of personally sensitive self-report data and the issue of selection bias. With the issue of selection bias, perhaps the most at-risk youth were not participating in this survey. The study sample had a relatively low base rate of sexual behavior (36%) compared to the national average where 47.7% of adolescents report being sexually active (CDC, 2012b). This makes it difficult to generalize to other populations that are older or perhaps more sexually active. This study was a needed and overdue snapshot of how African American adolescents in a Midwestern population view sexual self-efficacy and requires further investigation before making definitive conclusions about perceived sexual self-efficacy in other populations of African American adolescents. There are certain social determinants of HIV that we did not consider in this study. Our findings would benefit from understanding additional contextual factors that may have influenced participant's decisions about their ability to perform certain behaviors.

Future Research

Future HIV prevention research must focus on understanding the vast gender differences among adolescent populations, particularly how we study mediating protective factors such as self-efficacy. Given that female participants reported higher self-efficacy in this study, it is worthwhile to further investigate ways of tailoring interventions that promote more self-efficacious behaviors. Because African American females are disproportionately affected by HIV, a study that is tailored to understand female sexual self-efficacy and the contextual factors that may attenuate or benefit higher self-efficacious behaviors would be beneficial (Wingood & DiClemente, 1992).

In addition, future HIV prevention research must focus on the issue of tailoring when creating programs with varying levels of sexually active adolescents. Figuring out how to use self-efficacy to build confidence in non-sexually active adolescents that is effective in terms of their intent to practice safer sex behaviors is needed and proposes a real challenge for prevention researchers.

CONCLUSION

Research on male and female adolescent's perception of sexual self-efficacy is sparse. Nevertheless, our finding of higher perceived sexual self-efficacy among African American female adolescents is important, and adds to the growing body of literature in this area. Past HIV prevention research has shown that even if female adolescents carry condoms and know about safer sex behaviors, they still must have the confidence to talk with their partner and use safer sex negotiation skills (DiClemente, et. al., 2001). While this particular study only focused on intent and perceived sexual self-efficacy, more work is needed to better understand how to move African American adolescents into the next level of stronger sexual self-efficacious behaviors.

In closing, after 30 years of HIV prevention and intervention efforts, African American young adults continue to have a higher incidence of infection (CDC, 2011). Sexual self-efficacy can be beneficial in preventing risky behaviors but there is more to uncover about how it affects intentions and decisions among African American adolescents. In addition to tailoring interventions, researchers must try to understand the social, cultural, and environmental context of how sexual self-efficacy functions for African American adolescents. As stated earlier there are several contextual factors that can influence decisions about safer sex practices for African

American adolescents (Woods-Jaeger et al., 2013). Knowledge of how these contextual factors influence perceived sexual self-efficacy for African American adolescents is missing from the current HIV/AIDS prevention literature. Figuring out how these factors influence an adolescent's ability to exercise safer sex practices will help improve future HIV interventions.

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