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Cultural Predictors of Asian/Pacific Islander Women's HIV/AIDS Protective Behaviors

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CULTURAL PREDICTORS OF ASIAN/PACIFIC ISLANDER WOMEN'S
HIV/AIDS PROTECTIVE BEHAVIORS

BY

JENNIFER C. HUANG

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Abstract

Understanding the HIV/AIDS risk behaviors among heterosexual Asian/Pacific Islander (API) women requires an examination of the circumstances which place heterosexual women at risk of AIDS, as well as the cultural factors which affect API sexuality. Research has been conducted on samples of women, one of the fastest growing populations to be infected with HIV/AIDS, as well as API populations, who are susceptible to HIV infection as any other ethnic group. There is, however, a paucity of research concerning the sexuality of API women. Previous research regarding HIV/AIDS risk factors for women may not be culturally sensitive. Additionally, research pertaining to APIs may not address gender constructs.

The current study addresses the sexuality of API women by examining sexual attitudes and behaviors, as well as cultural variables in a sample of unmarried, heterosexual, college API women. Standard multiple regressions were performed to examine the relationship among sexual assertiveness, condom self-efficacy, decision-making in relationships and condom frequency, acculturation and individualism/collectivism.

Results suggest that acculturation may have an impact on API sexual behaviors, such as the age of sexual initiation. Once sexually active, however, acculturation does not appear to affect sexual behaviors or attitudes. Sexual behaviors of sexually active APIs in this study are similar to non-Asian female college samples. Additionally, sexual assertiveness – pregnancy/STD prevention emerged as a strong indicator of condom use among women who are sexually active.

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Cultural Predictors of Asian/Pacific Islander Women's HIV/AIDS Protective Behaviors

Despite the popular misconception and prevailing stereotype of Asian and Pacific Islanders (API) as the "model minority" in terms of health, education and economics, APIs are as susceptible to HIV infection as any other ethnic group. Although the number of reported AIDS cases among APIs is significantly lower than in other racial groups - approximately 1% of total cases reported in the US (Centers for Disease Control and Prevention (CDC), 1997) – AIDS in the API population is increasing. A study of one minority community in San Francisco indicated that in 1989 and 1990, the API population had the greatest proportional increase in AIDS cases among all ethnic groups (Mandel & Kitano, 1989, as cited in Cochran et al., 1991). Regardless of the rapid growth of AIDS among this ethnic group, few studies have been conducted among this population.

Understanding the HIV incidence among API heterosexual women requires an examination of the factors which place heterosexual women at risk of AIDS. Women are one the fastest growing populations to be infected with HIV (CDC, 1998). In 1997, women comprised 22% of all AIDS cases in the US (Center for AIDS Prevention Studies (CAPS), 1999) and the incidence of women developing AIDS has continued to increase. Heterosexual intercourse, rather than injection drug use, is the leading risk exposure category for all women (CDC, 1998). Difficulties with asserting sexual and negotiating safer sex practices with men have been suggested to account for the increase in HIV infection among women (Morokoff, Quina, Harlow, et al., 1997; Quina, Harlow, Morokoff, & Saxon, 1997).

Behavioral interventions and risk reduction models have proposed condom-promotion strategies for women, including sexual assertiveness. HIV and AIDS interventions which are based upon and encourage strategies of sexual assertiveness may not consider the cultural and social constructions which encompass sexual interactions (Gómez & Marín, 1996). For the API woman, the current construct of sexual assertiveness may not fully address the cultural norms concerning gender, power, collectivism/individualism, acculturation, sexual attitudes and behaviors. To fully comprehend the psychology of API women, and to further our understanding of the sexuality of API women, their history of proscribed gender roles must be recognized. If API women are to attain their sexual goals and to protect themselves from unwanted or unsafe sexual situations, cultural norms which are involved in the construction of sexuality must be researched to create culturally sensitive interventions.

Asian/ Pacific Islander Sexuality

While the API population nearly doubled during the 1980s and is now the fastest growing minority group in the U.S. (CAPS, 1999), medical models and researchers continue to neglect this population, creating a scarcity of culturally relevant research, education, prevention, and intervention programs. Only California, Hawai'i, New Mexico, the territory of Guam, and local health departments in Los Angeles, San Francisco, Oakland and New York City report AIDS cases among APIs by ethnicity/national origin (CAPS, 1999). As a result of the lack of detailed HIV surveillance among the API population, AIDS cases are grossly underreported, obscuring the true nature of the epidemic.

The diversity among APIs may create barriers to the understanding of API sexuality. APIs comprise over 40 different nationalities that speak over 100 languages and dialects (CAPS, 1999). The "Asian" category consists of 29 different groups and the "Pacific Islander" category comprises 20 distinct ethnic groups (U.S. Bureau of the Census, 1992). More prevalent API heritages include Chinese, Taiwanese, Japanese, Indian, Samoan, Vietnamese, Korean, Hawaiian, and Filipino. The rapidly increasing sizes of, and differences among, the API ethnic groups present difficulties in obtaining health status and behavioral risk information. In addition, data collected for the entire API population may obscure differences among these subgroups (Hou & Basen-Engquist, 1997), such as cultural, socio-economic, geographic, religious, and political differences.

The diverse languages spoken among APIs create additional barriers to research. Although foreign-born APIs may have low or no English skills, few programs provide interventions in non-English languages. Additionally, API languages may not have words that will directly translate from English, increasing difficulties in research (CAPS, 1999).

The lack of understanding of API sexuality may also be due to cultural factors. Culturally sensitive programs and interventions have recently begun to incorporate cultural factors within their frameworks, recognizing problems with the reliance on traditional White male medical models. Studies which have investigated API sexuality have found that API and White populations may view sex differently. Despite the diversity between and within various Asian cultures, particular societal norms have been defined as core characteristics of Asian heritage. Compared with North American

standards, Asian culture places a greater emphasis on the adherence to strict moral and social standards. In Asian cultures, certain topics - - including illness, sexuality, homosexuality and death - - are not openly discussed, especially in public or with strangers, creating barriers for researchers who attempt to collect data (CAPS, 1999). Additionally, HIV/AIDS prevention and education efforts in the API community are challenging because they involve topics of illness, death, sexuality, and homosexuality. Among some Asians, there exists the belief that discussion of illness is bad luck and may even cause the occurrence of illness (Aoki, Ngin, Mo, & Ja, 1989).

A review of the literature suggests that APIs are also conservative in outward expressions of sexuality. In Asian cultures, sexuality is both private and emotional, while control of emotions and feelings are highly valued (Hirayama & Hirayama, 1986). In addition, APIs may be embarrassed when expected to talk about sex, because sex is regarded as a private and personal issue (McCormick, 1993). Research has indicated that APIs are less likely to discuss sex than are Whites, Hispanics/Latinos, or African Americans (Moore & Erickson, 1985). Horan et al., (1993) found that Asian young adults were less likely to discuss sexuality openly and had less ability to communicate with others on issues concerning HIV infection and prevention, when compared to Whites, Hispanic and Black students. Judged by White, North American standards, Asian may appear to be sexually inhibited. There is, however, no empirically-demonstrated relationship between the willingness to talk about sex and sexual behavior (McCormick, 1993).

The few studies which have been conducted on the sexual behaviors of APIs indicate this population is at risk, as any other population. Premarital sexual behavior

has been documented among API adolescents and young adults, and research indicates Asian American college students are no different than their non-Asian counterparts in terms of premarital sexual behavior (Sue, 1982). In addition, heterosexual Asian Americans are engaging in high-risk sexual practices, such as sexual intercourse without a condom. Cochran et al. (1991) conducted a study of the rates of sexual activity and patterns of sexual behavior among 153 young, unmarried, heterosexual Asian Americans, and reported Asian Americans to be significantly less sexually active (47%) than Whites (72%), Blacks (84%), and Hispanics (59%). However, sexual conservatism in the outward expression of one's sexuality should not be confused with the absence of unsafe sexual behavior. While Asian Americans appeared to delay the onset of sexual activity, Cochran reported that once sexually active, sexual behavior appears to be similar to that of the non-Asian population. Asian Americans students who were sexually active practiced risky sexual behaviors, such as low rates of condom use (11%), which did not differ significantly from Whites (11%), Blacks (11%), or Hispanics (10%).

Hou and Basen-Engquist (1997) reported findings similar, to those of Cochran et al. (1991). There were no differences in the age of initiating sex, the proportion of being currently sexually active (having had sex during the past 3 months), number of lifetime partners, or prevalence of condom use among Asian Americans and White college, male and female subjects. Additionally, this study suggests that sexually active Asian Americans have an even greater number of recent partners compared to White subjects. According to these studies, current beliefs of the healthy model minority underestimate the transmission of HIV within the Asian American population.

Women's Sexuality

Behavioral researchers have investigated the factors which influence an individual's ability to use or request condoms, applying existing models of risk reduction to sexual risk behaviors. Examples of such models include: the health belief model (Becker, 1974; Rosenstock, Strecher, & Becker, 1988), theory of reasoned action (Ajzen & Fishbein, 1980), social learning theory (Bandura, 1977), the AIDS risk reduction model (ARRM; Catania, Kegeles, & Coates, 1992), the stages of change model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992) and diffusion theory (Rogers, 1983).

Self-efficacy has often emerged as a significant psychosocial/attitudinal predictor for HIV prevention (Quina et al., 1997). Bandura (1989) has defined self-efficacy as the conviction that one can successfully perform a behavior required to achieve the desired outcome. Social learning theory suggests that the more self-efficacious a woman is regarding the use of contraceptives, the more likely she will be to insist that they will be used (Quina et al., 1997). Several studies have shown relationships between condom self-efficacy and safer, HIV preventive sexual behavior (e.g., Goldman & Harlow, 1993).

Although these theories and studies have provided valuable insights into sexuality and sexual behavior, they are often limited in their understanding of sexuality within cultural contexts which may influence one's sexual interactions (Amaro, 1995; Gómez & Marín, 1996). Amaro (1995) has noted that existing models of sexual risk behavior, which assume that sexual behaviors and encounters are controlled and initiated by the individual, fail to consider broader cultural and social contexts of sexuality, and ignore cultural value and norms which influence and define the behavior of men and women in sexual situations. For example, in order for women who have sex with men to be self-

efficacious concerning the use of condoms, women must often solicit the consent of a male partner. Therefore, conceptualizing self-efficacy as a means of protective HIV/AIDS behavior may not be relevant to condom use, which is often beyond the control of women (Bowleg, Belgrave, & Reisen, 2000; Cochran & Mays, 1993). Overall, the basic ideology of these models:

is devoid of gender as a central determinant of sexual behavior. This is a significant omission because condom use is a sexual behavior that is clearly under the control of men and is embedded in a socially sanctioned inequality between partners. This fact is not captured by these models (Amaro, 1995, p. 440).

Studies based on these theoretical frameworks must utilize gender differences or social factors to comprehend the unique context for risk reduction in women.

Prior to the recent introduction of the female condom, women in sexual encounters with men were limited in their choices in preventing exposure to HIV – to partake in non-penetrative sex, abstain, or negotiate with their male partner for the use of contraceptive protection (Gómez & Marín, 1996; Morokoff et al., 1997). Negotiation with men to use contraceptives, engaging in non-penetrative sex, and abstinence all require women to adopt an active sexual role, negotiating sexual behavior with their partner. Investigating the construct of sexual assertiveness within a cultural context may further the understanding of strategies utilized by women to accomplish safer sex and sexual autonomy.

The construct of sexual assertiveness, as defined by Morokoff et al. (1997): rests on a general conceptualization of assertiveness based on human rights to autonomy. We assume that individuals "own" or have rights over their bodies

and their sexuality and are never under a social obligation to let someone touch their body (except in the social convention of the handshake) or to touch another person sexually. This concept thus implies a basic human right to retain autonomy over sexual experience. We view this basic human right as being expressed through the response classes of initiation and refusal (p. 791).

This active sexual role contradicts traditional gender role expectations of a sexually passive role for women. The socialization of women as unequal and subordinates to men complicates the task of negotiating safer sex. It has been argued that men's and women's behaviors in heterosexual situations follow traditional, culturally defined gender roles. Traditional gender roles include expectations for men to be more instrumental than women in initiating sexual activities and in aggressively pursuing sexual desires (Lawrance et al., 1996). Adherence to gender-based norms present specific risk and conflicts to women. Women who comply with the traditional role of sexual passivity may be reluctant to refuse unwanted sex, an important aspect of protection from unwanted or unsafe sexual situations (Morokoff et al., 1997). Thus, it may be difficult for young women to request condom use, because they perceive that men are in control and dominate sexual encounters.

A perception of powerlessness over sexual encounters may influence the use of condoms among women. Power differentials existing at various levels of society, including within constructs of gender, race/ethnicity and social class, may be linked to risk of HIV infection for women (Zeirler & Krieger, 1989). Within relationships, interpersonal power and dominance may influence decision-making practices. Relationship power is expressed through decision-making dominance, "the ability to

engage in behaviors against a partner's wishes, or the ability to control a partner's actions" (Pulerwitz, Gortmaker, & DeJong, 2000).

In a study by Soet, Dudley, and Dilorio (1999), women who said that their male partners were more dominant in their relationships were found to be disadvantaged in outcome expectancies, self-efficacy, sexual decision-making, and safer sex discussion, compared to women who stated that they were dominant or shared power equally in their relationships. Interviews conducted with Latinas (Amaro & Gornemann, 1992) and focus groups conducted with African American women (Wingood, Hunter-Gamble, & DiClemente, 1993) revealed an inability to insist on condom use or risk reduction strategies, due to powerlessness in relationships. These findings indicate that relationship power and decision-making in relationships are an essential component to understanding women's HIV/AIDS risk.

Miller (1986) argues that within women's ascribed roles as unequal, there is little room for women's acceptance of their own sexuality. Rather, sex is "given" to men. If women are to be sexually assertive, complications from gender role ideology may place women in direct conflict and challenge with men (Miller, 1986). Fear of a partner's negative response to sexual assertiveness may impede many women from initiating safer sex practices. The presence of physical or sexual violence as well as sexual coerciveness within heterosexual relationships is not uncommon (Gómez & Marín, 1996). Thus, women in this position may relinquish sexual decision-making power to their male partners (Gómez & Marín, 1996).

Asian/Pacific Islander Women's Sexuality

The psychology of API women's sexuality revolves around traditional ideology of both gender sexual norms and cultural norms. A investigation of API women's sexuality is ideal, considering the lack of information on sexuality and the interactions of restrictive gender norms and cultural norms. Currently, the amount of research investigating API women's sexuality is negligible. Certain barriers to the understanding of API women's sexuality are similar to those that affect API men, including cultural standards, language and the diversity among the API population. However, other barriers to the understanding of API women's sexuality concern the multiple oppressions which API women face. As with other women of color, API women are affected by both racism and sexism (McCormick, 1993).

The sexuality of the API woman is complicated by traditional Asian cultural ideology. While acknowledging the diversity among API ethnic groups, characteristic gender roles tend to define API women's identities by their relationship with others, particularly males: father, husband, and then son. The essence of these roles is differential treatment based on gender, which render her a second-class citizen, even within her own family (Root, 1995). As API women's identities are defined by their relationship to others, a lack of general assertiveness and self denial may result (Root, 1995). Additionally, gender constructs of female modesty, invisibility, and passivity are traditionally viewed as ideal behaviors for API women. Women are expected to be sexually submissive, tolerating insensitivity and men's sexual indiscretions for the sake of family honor (McCormick, 1993).

These cultural and social expectations affect the extent of sexual assertiveness characteristic of API women. The presence of physical or sexual violence, as well as

"obligations" to cultural norms of subservience to men, are not uncommon. The strong, culturally prescribed roles of obedience and subservience to men, as well as the fear of a partner's negative response, may impede API women from initiating sex and safer sex practices. At the present, there has been an absence of studies investigating cultural contexts of API women's sexuality. However, a few studies have been conducted on other populations of women of color, including Latinas. Gómez and Marín (1996) investigated the strong cultural gender norms regarding sexual behaviors, and found that these behaviors exacerbate risk for HIV for Latinas. In a traditionally *machista* society, women are typically responsible for pregnancy-prevention methods unless their partner dictates that no contraceptives are to be used. Anthropological observations suggest that the frequency and type of sexual behaviors are most often determined by men. Additionally, women do not typically discuss sex with men, as this is viewed as distasteful and/or suggestive of sexual promiscuity. Although not all Latinas may ascribe to these sexual roles, interviews revealed that these cultural values are significant in their relationships with male sexual partners. Reflecting these sexual roles, the Latino culture will be least likely to provide women with the skills and attitudes needed to negotiate safer sex effectively. Many Latina and non-Latina White women in the study reported that their partners would be angered and even violent if they suggested contraceptive use.

Similar research investigating the intersections of culture, ethnicity, and gender for API women are necessary and fundamental for the understanding of the implications of HIV risk behaviors and behavior change strategies. Current interventions which are based upon increasing women's sexual assertiveness may not address the cultural standards API women may have to contend with in their homes and relationships. Gómez

and Marín (1996) argue that cultures with traditional gender-role norms may not be able to provide women with the skills and attitudes needed to perform sex negotiation behaviors. Without comprehending the spheres of gender ideology, these interventions may create tension and cause danger to API women, and may be of limited use for this population.

The present study is designed to address the paucity of research examining the sexuality of API women, and the underlying cultural factors which may influence patterns of, and barriers to, condom use with partners. For the reasons previously described, sexual assertiveness, powerlessness, frequency of condom use, condom self-efficacy and decision-making variables will be investigated. Cultural factors of collectivism/individualism and acculturation will be investigated in relation to these attitudes and behaviors.

Collectivism. Conceptualizing individualistic and collectivist cultural norms in the context of sexuality may help to understand API women's sexuality and sexual assertiveness. Western cultures subscribe to an individualistic approach, which emphasizes the goals of the individual, assuming responsibility for themselves and their immediate family (Triandis, 1994). Asian cultures emphasize a collectivist approach, integrating the concept of the individual self within group goals over individual goals (Triandis, Leung, Villareal, & Clack, 1985). Collectivist individuals may avoid actions or behaviors which would bring shame to not only the individual, but to the individual's family (Triandis, 1994). Therefore, behaviors may be limited to acceptable gender role expectations, including actions relating to a topic as private and sensitive as sexuality.

In the traditional Asian culture, a person is not viewed as an individual, but as a representative of his or her family. Maintaining "face," the public persona, dignity, or self-esteem, is all important. Loss of face reflects negatively on the individual's entire family and community, not only on the individual. One maintains face by fulfilling culturally appropriate responsibilities and acting in accordance with norms with respect to one's social role (Aoki et al., 1989).

Despite acculturation in many domains, API groups continue to value collectivism, viewing the self as a unit of an in-group rather than as an independent entity; subordinate personal goals to the goals of in-groups; and value interdependence, duty, and in-group harmony over freedom, autonomy and competition (Triandis, 1994).

Several measures have been developed to assess individualism-collectivism, including the Individualism-Collectivism Scale (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988), a self-administered questionnaire (Triandis, & Singelis, 1998) the INDCOL (Hui, 1988) and the Revised INDCOL scale (Hui & Yee, 1994).

The cultural dimension of individualism-collectivism has been widely used, with apparent success, to account for a plenitude of cultural differences (Singelis & Brown, 1995). In a review of cross-cultural social psychology, Triandis (1989) remarked that the concept of individualism-collectivism would be a dominating research in this discipline (Hui & Yee, 1994). Indeed, individualism has been found to be associated with severe forms of social pathology, such as high crime, suicide, divorce, child abuse, emotional stress, physical and mental illness rates (Triandis et al., 1985) and help-seeking attitudes (Tata & Leong, 1994). In collectivist cultures, individuals have been found to have marriages and are more likely to receive social support (Triandis, et al., 1985). Studies

have also examined variations of this dimension in relation to religion, morality, communication, work-related values and modernity (Triandis, et al., 1985).

The interactions between individualism-collectivism and sexuality have not yet been investigated. Based on previous literature concerning these constructs, it is difficult to predict whether strong cultural norms such as collectivism may decrease or exacerbate the risk of contracting HIV. For API women, sexual conservatism may result from traditional Asian values of family unity. Consequences of deviating from the sexual norm may be viewed as loss of face, and violation of the traditional values of family unity. Thus, it may be predicted that collectivism encompasses sexual conservatism and lower HIV risk. Conversely, subscribing to sexually passive and conservative roles may lead to an increase of HIV risk. If women do not feel confident or effective in their sexual choices due to the fear of diverging from cultural norms, their risk of HIV may increase. On the other hand, collectivism may limit sexual risk, as young women adhere to the familial or peer norms of sexual conservatism in general. This study will provide an exploratory investigation into the intersections of collectivism and sexual behaviors and attitudes.

Acculturation. Acculturation to American norms and sexual values remains a variable to be explored when investigating the sexual behaviors of Asian American women. Acculturation is a multidimensional process that can occur when two or more cultures interact (Suinn, 1995). Several outcomes of this process on an individual level have been documented, including *assimilation*, where the individual adopts the host culture's values, attitudes, and behaviors and rejects his/her parent culture; *resistance to assimilation*, where the individual resists the host culture and retains identity with the

parent culture; or *biculturalism*, where the individual adopts characteristics from both the host and the parent cultures. Acculturation has an important role in the comprehension of ethnic minority behaviors, including sexual attitudes and behavior.

With exposure to American attitudes and behaviors, it may be expected that Asian immigrants would adopt, or be influenced by, American sexual values. This hypothesis is supported by previous studies that have indicated that Asian American sexual behaviors may vary as a function of acculturation into the American culture. Huang and Uba (1992) investigated the relation between acculturation and the sexual attitudes and behaviors of 114 male and female Chinese students in American. Acculturation was positively related to having experienced premarital intercourse, and levels of sexual permissiveness, and negatively related to the age of sexual initiation.

As API women's identities are defined by their relationship to others, a lack of general assertiveness and self-denial may result. Separation from the hegemonic, cultural constructs to form positive self-expectancies may evolve through continuous stages of identity formation (Root, 1995). Implicit in these stages is the dimension of acculturation. Studies indicate that as degrees of American acculturation increased, Asian American females adopt certain characteristics of the traditional American male gender role (Campbell & Connolly, 1987). As Asian American women progress to an agentic orientation, the development towards individuality and the self may increase assertiveness, including assertiveness in the sexual domain.

Although research suggests acculturation to the values of American culture may increase the risk of HIV infection among APIs, previous investigations have failed to specifically examine API women. Additionally, previous research regarding

acculturation and sexuality has not considered the gendered nature of sexual behaviors. The relative absence of research on API women's sexuality has severe implications for the health and psychology of API women. Acknowledging the significant ramifications of sexual assertiveness, this dimension must be examined to understand API women's sexual decision making. For API women, an integrative understanding of acculturation and collectivism/individualism is necessary to predict the attainment of sexual assertiveness. Sexual assertiveness may violate collectivist and cultural credence for API women. In addition, API women's sexuality cannot be viewed as a homogeneous construct. Therefore, investigating factors such as acculturation is necessary to comprehend complicated and variant sexual attitudes and behaviors.

Current approaches to HIV and AIDS interventions which encourage women to be sexually assertive may not be culturally sensitive or realistic, and may be even dangerous in terms of violating the cultural norms and ideology which frame Asian American women's psychology and health. Sexuality is contextual, and must be considered within a framework of socio-cultural factors. As suggested by Amaro (1995), HIV-prevention strategies must address social conditions and variables, including sexual gender norms, sexual power imbalances, and disempowerment of women.

Research Hypotheses

Based on the literature presented in regards to API women's sexual roles and behaviors, acculturation, and collectivism/individualism, it was hypothesized that:

1. Higher levels of acculturation, higher individualism, higher peer and family norms, higher condom self-efficacy and higher decision-making relationship scores will be related to higher scores of sexual assertiveness – pregnancy/STD prevention.

2. Higher levels of acculturation, higher individualism, higher peer and family norms and higher decision-making in relationship scores will be related to higher scores of condom self-efficacy.
3. Higher levels of acculturation, higher individualism, higher peer and family norms, higher condom self-efficacy and higher sexual assertiveness – pregnancy/STD prevention will be related to higher degrees of decision-making in relationships.
4. Higher levels of acculturation, higher condom self-efficacy and sexual assertiveness – pregnancy/STD prevention will be related to higher scores of condom frequency for sexually active participants.

Method

Participants

A total of 88 individuals participated in this study. Of these individuals, 80 met the eligibility criteria, requiring participants to be a minimum of 18 years old, single, heterosexual and self-identified as API. Individuals who identified as Indian were not included in the study, as current literature and theory based upon APIs do not include the experiences of individuals of Indian descent. Participants with excessive missing values were deleted from the study, and the final sample included 73 API male and female undergraduate and graduate students. These students attended the University of Rhode Island, Johnson and Wales University or the Community College of Rhode Island – Warwick and Community College of Rhode Island - Lincoln. Of these 73 participants, 60 were female, and 12 were male.

Measures

Ten measures were included in the 123-item questionnaire, including general demographics and background information, cultural factors, sexual attitudes and behaviors.

Demographic Information. Participants responded to a brief series of questions to assess their age, gender, ethnicity, place of birth, length of residency in U.S., religion/spirituality, year in school, sexual preference, relationship, living with partner and other background information. (See Appendix B)

Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA). The SL-ASIA (Suinn et al., 1987) is a 26-item, multiple-choice scale that assesses six content areas of acculturation: language, identity, friendships, behaviors, generational/geographic background and attitudes. Questions on the SL-ASIA are multiple choice, fill in the blank and Likert format, ranging from 1 (do not believe) to 5 (strongly believe). Several questions and responses were altered to include Pacific Islanders. Suinn et al. (1987) identified three levels of acculturation: a) a high Western-identified or assimilated acculturation level, where the individual identifies completely with the dominant culture; b) a bicultural individual, who is thought to accept both Asian and European American culture equally; and c) an Asian-identified, low acculturation individual, who retains identity with his or her ethnic heritage and refuses to become assimilated into the dominant culture. Scores could range from a low of 1.00, indicative of low acculturation (or high Asian/low Western identity) to a high of 5.00, indicative of high acculturation (or low Asian/high Western identity). Suinn et al. (1992) reported Cronbach's alpha to be .91. (See Appendix C)

INDividualism-COLlectivism (INDCOL). The revised INDCOL (Hui & Yee, 1994) is a shortened version of the original INDCOL (Hui, 1988), a 63 item scale developed to measure individualism/collectivism at the individual level. The INDCOL was revised in 1994 to address the length of the instrument, and items were reduced to 33 items. Ratings on the INDCOL are recorded on a 6 point Likert-type scale, ranging from 0 (strongly disagree) to 5 (strongly agree). The INDCOL assess five factors of collectivism and individualism: colleagues and friends/supportive exchanges (alpha = .54), parents/consultation and sharing (alpha = .45), kin and neighbors/susceptibility to influence (alpha=.58), parents and spouse/distinctiveness of personal identity (alpha = .38) and neighbor/social isolation (alpha = .73).

The INDCOL was factor analyzed for this study, which is further discussed in the results section. Five subscales emerged from the factor analysis. Three of these subscales were used for this study: kin and neighbors (alpha = .71), family/parents (alpha = .72) and neighbors (alpha = .65). Higher scores refer to higher levels of collectivism, and lower scores refer to higher levels of individualism. (See Appendix D)

Peer and Family Norms for Condom Use. The Peer Norms for Condom Use Scale (Harlow, Morokoff, & Quina, 1991) was modified to include questions regarding family as well as peers. Respondents were asked what their close friends think about using condoms or latex barriers when having sex. The original five questions were reduced to two, and three questions were added. One question addressed respondents whose close friends are not having sex. Two questions addressed respondents' family norms and sexuality. Examples of questions include "My close friends think that it is important to protect themselves from getting AIDS when they have sex." Answers are

provided on a 5-point Likert-type scale, from Definitely True to Definitely False.

Cronbach's alpha has been assessed at .88 (Harlow, Morokoff, & Quina, 1991). (See Appendix E)

Condom Self-Efficacy. The Condom Self-Efficacy Scale (Prochaska, Redding, Harlow, Rossi, & Velicer, 1994) is a 6 item scale which measures how effective the respondent feels she would be in using condoms in specific situations. Participants answer the question "How sure are you that a condom or latex barrier would be used for sex in these situations?" Examples of situations include "When I am really turned on" and "When I have been drinking or doing drugs." Ratings are recorded on a 5-point Likert-type scale, ranging from "Not at all sure" to "Very sure." Cronbach's alpha has been reported as .88 (Harlow, Morokoff, & Quina, 1991). (See Appendix F)

Sexual Assertiveness Scale (SAS). The SAS (Morokoff et al., 1997) is scale developed to measure factors of sexual assertiveness and communication in women. The SAS assesses three distinct factors of sexual assertiveness: initiation (6 items), refusal (6 items), and pregnancy-sexually transmitted disease prevention assertiveness (6 items). A SAS scale to evaluate assertive communication in sexual situations, the Sexual Assertiveness for Communication of HIV Risk-Related Information (SC-Info), was also included (8 items) (Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000). Responses for the entire scale are recorded on a five point Likert-type scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Items are summed to create a scale score for each subscale. Cronbach's alpha for subscales of Initiation was .77; for Refusal, .74; and for Pregnancy-STD Prevention, .82. Cronbach's alpha was .93 for the SC-Info (Quina et al., 2000). (See Appendix G)

Powerlessness. Adapted from Newcomb and Harlow (1986), this scale measures the respondent's beliefs of power specific to sex life. Example of questions include "I feel I am not in control of my sex life" and "I can change my sex life if I want to." Responses are recorded on a Likert-type scale, ranging from "Never" to "Always." Cronbach's alpha for the scale is .88 (Harlow, Morokoff, & Quina, 1991). (See Appendix H)

Relationship Power - Decision-Making Power. The Sexual Relationship Power Scale (SPRS: Pulerwitz, Gortmaker, & DeJong, 2000) contains two subscales used to measure control and decision-making in relationships. For this study, only the decision-making subscale was utilized. Participants answered questions such as "Who usually has more say about whether you have sex" and respond on a 3 point scale, consisting of "Your Partner", "Both of You Equally", and "You". Pulerwitz et al. (in press) reported Cronbach's alpha for both subscales to be .84 (Pulerwitz, Gortmaker, & DeJong, 2000). (See Appendix I)

Sexual History. Participants answered a brief series of questions regarding their sexual history, including whether they have ever had sex, age of first sexual experience, length of involvement with sex partner, living with sex partner and gender of sex partner. Participants who have never had sex were asked to skip the questions in this section. (See Appendix J)

Condom Frequency. The Condom Frequency Scale (Prochaska et al., 1994) was modified, and only one item was utilized. Condom frequency was assessed with the question "Do you ever use condoms?" Responses ranged from Never to Started always using 6 months ago or longer. Cronbach's alpha for the entire scale has been reported as

.88. Participants who have never had sex were asked to skip this question (Harlow, Morokoff, & Quina, 1991). (See Appendix K)

Procedure

Approximately 100 API men and women were approached and given a survey packet. Each survey packet included a consent form, emphasizing confidentiality and anonymity, and a 123 - item paper-and-pencil survey, measuring general demographics, cultural factors, sexual attitudes, sexual behaviors, and sexual history. Due to the anonymous nature of the survey, consent was implied when participants read the consent form and completed the survey. Confidentiality was further ensured by allowing participants to either complete the survey and return it to the researcher in person, or complete the survey packet in privacy, and mail the packet to the researcher. If participants chose to complete the survey in privacy, a self-addressed stamped envelope was included in the survey packet.

No information was obtained that could identify the participant, and only the researcher would have acquired consent forms and surveys. Completed surveys were returned either to the researcher or mailed to the researcher to ensure anonymity. The survey took an average of 20 minutes to complete.

Participants for this study were recruited through various means, including psychology courses at the University of Rhode Island, Johnson and Wales, student organizations at the University of Rhode Island, and the “snowball” method. Additionally, the researcher approached potential participants in the library of the University of Rhode Island and Community Colleges of Rhode Island (CCRI) at

Warwick and Lincoln. Surveys packets were also left for students at various locations, including the libraries at two CCRI campuses.

API students enrolled in the General Psychology class at the University of Rhode Island were given an opportunity to participate in the study for course credit, provided that they are at least 18 years of age. Participants were given a survey packet, and asked to complete the survey while the researcher waited in another room to allow privacy. The researcher debriefed participants after the completion of the survey.

API students from the University of Rhode Island were also recruited from the Asian Student Association (ASA). After a short presentation of the topic of study to ASA members, the researcher distributed surveys packets. A pre-addressed return envelope was included in the survey packet, and participants were instructed to return surveys via campus mail to the researcher.

API participants were also recruited from the annual Cultural Show, organized by the ASA at the University of Rhode Island. The Cultural Show is an on-campus, social event which presents a variety of skits, poems, cultural dances, and a fashion show of traditional Asian clothing. The researcher attended the event, and prior to the beginning of the show, asked potential participants if they self-identified as API, and were of at least 18 years of age. If students met these requirements and agreed to participate, the researcher provided a brief explanation of the study, and gave students a survey packet with self-addressed stamped envelopes. Participants were encouraged to complete and return the survey to the researcher before the event began, but were also given the option to mail the survey at their discretion.

An instructor for the Talent Development Pre-Matriculation Program at the University of Rhode Island agreed to distribute surveys to her students for course credit during the summer of 2000. Talent Development Pre-Matriculation Program is directed towards providing opportunities for minority and disadvantaged persons to apply to the University of Rhode Island.

Potential participants were also approached at the library and computer labs at the University of Rhode Island. This procedure was similar to the recruitment procedure of the Cultural Show. Participants were encouraged to complete and return the survey to the researcher at the library, while the researcher waited in a separate area to ensure privacy. However, participants could also choose to complete the survey in privacy, and were given a self-addressed stamped envelope.

Survey packets were also distributed to several psychology courses during the 2000 summer term at Johnson and Wales University. Survey packets were distributed to professors of the Arts and Science department, and professors were given the choice to disburse the surveys to their students. Participants mailed completed surveys were to the researcher.

API students were approached during the summer term at CCRI-Lincoln and CCRI-Warwick, given a brief description of the study, and asked if they were willing to participate. This recruitment procedure was similar to the one used at the Cultural Show and the University of Rhode Island library and computer labs. Surveys packets were also left at the bookstores of both CCRI locations for one month, for students to pick up at their own discretion. The return rate for these survey packets was 11%. Additionally, flyers were posted throughout the CCRI locations (See Appendix L).

A “snowball” technique was also utilized as a recruitment strategy. Participants were encouraged by the researcher to take extra survey packets for their friends or family members who might be interested in participating in the study.

Analytic Procedures

Data analyses were performed using the SPSS statistical program, version 8.0 for Windows for all procedures, except for the path analysis. The EQS computer program was used to calculate the path analysis. Data were screened prior to conducting analyses for accuracy of data entry, missing values, fit between distributions and assumptions of multivariate analyses, outliers and correlations among variables. Cronbach’s alpha was calculated for each scale to assess internal reliability.

Confirmatory factor analysis was performed to examine the structure and confirm the factor structure of the INDCOL scale. Cronbach’s alpha was calculated for each final subscale of the INDCOL to assess the internal reliability. This adapted version was assessed for use in the present study.

Standard multiple regression analyses (MRs) were performed to examine the significance of various predictor variables for sexual assertiveness – pregnancy/STD prevention, decision-making in relationships, condom self-efficacy and condom frequency for sexually active females.

Descriptive statistics were computed for means and standard deviations for comparisons between sexually active and not sexually active females across all measures, except for condom frequency, which only sexually active participants completed.

A preliminary path analysis (PA) was conducted to assess associations between acculturation as a predictor for condom self-efficacy and decision-making in

relationships and acculturation, condom self-efficacy, decision-making in relationships as predictors for sexual assertiveness – pregnancy/STD prevention.

One-way Multivariate Analyses of Variance (MANOVAs) were conducted to determine whether group differences exist between sexually active and not sexually active females.

Results

Demographics

Of the final 72 participants, 60 were women (83.3 %) and 12 were men (16.7%). This study was originally designed to investigate the sexual attitudes and behaviors of API women and men. Due to the lack of participation from men in this study, men were excluded from all analyses. Demographic information for both men and women is provided in Table 1 and sexual history information is provided in Table 2.

The mean age of the sample was 19.6 years ($SD = 1.36$, range = 18-22 and older). The mean year in college was at the sophomore level ($SD = 1.20$, range = freshman – graduate student). Twenty-four participants (33.3%) indicated that they were born and have lived in the United States for their entire lives. Thirty-seven participants (52.1%) have lived in the United States for 11-20 years, and twelve participants (16.9%) have lived in the United States for less than 10 years.

Participants were given an open-ended question regarding their racial or cultural group. Twenty-one participants (29.2%) self-identified as Cambodian, fourteen (19.4%) identified as Hmong and twelve (16.7%) identified as Laotian, five identified as Asian (8.3%), five identified as Chinese (8.3%), four identified as Asian American (6.7%), and three Filipino (4.2%). Ethnicities of Marshallese, Korean, South Korean,

Thai/Cambodian, Chinese/Cambodian and Vietnamese, Cambodian/Chinese/Vietnamese and Taiwanese were each represented by one participant (1.4%). The majority of participants denoted Buddhism as their religious or spiritual belief (52.1%).

Sexual History

Of the 60 females who participated in the study, 23 (38.3%) indicated sexual activity, while 36 (60%) did not report sexual activity. One participant did not report whether she had or had not engaged in sexual activity. Of the 12 males, 10 (83.3%) responded that they had engaged in sex, and two (16.7%) indicated that they had not engaged in sex.

The mean age of sexual onset for sexually active females was 16.9 years ($SD = 1.77$) and 17.4 years for males ($SD = 2.22$). Scores from the condom frequency scale indicated that the majority of sexually active females (52.2%) and sexually active males (60%) reported inconsistent or no condom use. Sexual history information separated by gender is provided in Table 2.

Screening of Data

Prior to conducting analyses, data for the SL-ASIA, INDCOL scales, peer norms, family norms, decision-making in relationships, sexual assertiveness – pregnancy/STD prevention, condom self-efficacy and condom frequency were screened and examined for female participants. As recommended by Tabachnick and Fidell (1996), accuracy of data entry, missing values, fit between distributions and assumptions of multivariate analyses, outliers and correlations among variables were examined. Missing values of participants were replaced with the series mean function. All variables were within acceptable limits

of the assumptions of multivariate analyses. Mahalanobis distance at $p < .001$ was performed to identify outliers. No cases of outliers were found in the sample.

Correlations among all variables are presented in Table 3. Cronbach's alpha was calculated for each scale and presented in Table 4. Because of low internal reliability and/or high correlations with other measures, Powerlessness, SAS – initiation, SAS – refusal, and SC-info scales were excluded from analyses. Specifically, the alpha levels for Powerlessness ($\alpha = .56$) and SAS-initiation ($\alpha = .32$) rendered these scales to be inapplicable for further analyses. Upon inspection of the intercorrelation matrix of all scales, it was found that both SAS – refusal and SC-Info were highly correlated with SAS - pregnancy/STD prevention. Due to this overlap, SAS – refusal and SC-info were deleted from further analyses.

Descriptive Data for Scales

Means and standard deviations for all females, sexually active and not active, for the SL-ASIA, INDCOL subscales, peer norms, family norms, decision-making in relationships, sexual assertiveness – pregnancy/STD prevention, condom self-efficacy and condom frequency are presented in Table 5.

Factor Analysis of INDCOL Scale

Due to the reported low alphas of the revised INDCOL subscales (Hui & Yee, 1994), items for the INDCOL subscales were factor analyzed with principal components extraction utilizing the data completed by female participants ($N = 60$).

The five factors originally reported by Hui and Yee (1994) did not remain intact. Rather, five different factors were extracted, accounting for 43.69% of variance. Subscales were developed with items which loaded significantly on one factor with a cut

of $\geq .50$ for inclusion of a variable on a factor. With this criterion, 10 of 32 items did not load on any factor. No complex items were indicated in the analysis. An alpha coefficient for the full scale and each subscale was calculated for determining scale/subscale reliability.

From this analysis, six items were conceptualized as the Kin/Coworkers (alpha = .71) subscale, six items were identified as the Family/Parents factor (alpha = .72), five items were identified as a Neighbors factor (alpha = .65), three items were conceptualized as the Money subscale (alpha = .58), and three items were classified as the Life Advice subscale (alpha = .41).

In light of the theoretical approach in this study, which focused on peers and family as primary collectivist influences and because of the low alphas of the last two scales, only the first three factors, Kin/Coworkers, Family/Parents, and Neighbors were included in analyses. One question from the Family/Parents subscale was dropped ("To go on a trip with friends makes one less free and mobile. As a result, there is less fun") due to the lack of theoretical fit with the factor. These final three factors accounted for 29.74% of the total variance. The theoretical content of these three factors substantially overlapped with the original factors of colleagues and friends/supportive exchanges, kin and neighbors/susceptibility to influence, parents and spouse/distinctiveness of personal identity and neighbor/social isolation, demonstrating theoretical validity for the factor analysis.

Factor loadings of each item and standardized coefficient alphas for all subscales are included in Table 6. Items are ordered according to their factor loadings (from highest to lowest) and grouped according to factor.

Multiple Regression Analyses

The analytic strategy for the hypotheses focused on four standard multiple regressions, which were performed to test the main research questions. These analyses were conducted only on data provided by female participants. Tables 7-10 display the results of these analyses. These tables indicate unstandardized regression coefficient (B), the standard error of B ($SE B$), the standardized regression coefficients (β), and the total amount of variance accounted for in the analyses. All multiple regressions were conducted at an alpha level of .05.

Sexual Assertiveness Scale-Pregnancy/STD Prevention. A standard multiple regression was conducted to examine the relationship between predictors SL-ASIA, INDCOL scales, peer norms, family norms, decision-making in relationships and condom self-efficacy and the dependent variable sexual assertiveness-pregnancy/STD prevention (Table 7). All female participants, including those who identified as sexually active and not sexually active, were reported in this analysis. The overall test of the model was not significant, $F(8, 51) = 1.12, p > .05$. Combined, these variables accounted for 15% of the variance in sexual assertiveness-pregnancy/STD prevention.

Condom Self-Efficacy. A standard multiple regression was performed with SL-ASIA, INDCOL scales, peer norms, family norms, decision-making in relationships, sexual assertiveness – pregnancy/STD prevention, condom self-efficacy as predictor variables and condom self-efficacy as a dependent variable (Table 8). All female participants, including those who identified as sexually active and not sexually active, were accounted for in this analysis. The multiple regression was not significant, $F(8,51)$

= 1.57, $p > .05$. Together, the independent variables accounted for 19.8% of the variance in condom self-efficacy.

Decision-Making in Relationships. A standard multiple regression was performed to assess the relationship between SL-ASIA, INDCOL scales, peer norms, family norms, sexual assertiveness – pregnancy/STD prevention and condom self-efficacy as independent variables, and decision-making in relationships as the dependent variable. The analysis resulted in a non-significant model, $F(8,51) = 1.44$, $p > .05$ (Table 9). Together the independent variables accounted for 18.4% of the variance in decision-making in relationships. All female participants, including those who described themselves as sexually active and not sexually active, were included in this analysis.

Condom Frequency. A standard multiple regression with SL-ASIA, condom self-efficacy, and sexual assertiveness - pregnancy/STD as predictor variables and condom frequency as the dependent variable was performed for female participants who identified as sexually active. The overall test resulted in a significant model, $F(3,19) = 11.20$, $p < .001$, accounting for 63.9% of the variance in condom frequency (Table 10). Subsequent t tests revealed that only the sexual assertiveness - pregnancy/STD prevention scores uniquely contributed to the variance in condom frequency scores ($\beta = .85$, $t(19) = 4.95$, $p = .00$). Thus, women with higher sexual assertiveness - pregnancy/STD prevention scores had higher condom frequency scores.

MANOVA

A one-way MANOVA was to compare sexually active and not sexually active females, in order to assess differences on measures of SL-ASIA, INDCOL scales, peer norms, family norms, decision-making in relationships, sexual assertiveness –

pregnancy/STD prevention, and condom self-efficacy. An alpha level of .05 was used for this analysis to maximize detection of differences. Results from the MANOVA indicated that there were no significant differences between the two groups of sexually active and not sexually active female participants, (Pillai's $F(9, 49) = 1.65, p > .05$). There was a weak association between the IV and combined DVs ($\eta^2 = .23$). Table 11 displays the results of the MANOVA.

Assumptions of differences between these two groups were tested for specific scales, including SL-ASIA, combined INDCOL scales, decision-making in relationships, sexual assertiveness – pregnancy/STD prevention and condom self-efficacy. All t-tests were non-significant.

Preliminary Path Analysis

To further examine the potential interrelationships, a preliminary path analysis was performed on data for the current study, on responses provided by sexually active and not sexually active females ($N = 60$). The hypothesized model assessed the relationship among acculturation, condom self-efficacy, decision-making in relationships and sexual assertiveness – pregnancy/STD prevention. Acculturation served as an indicator for condom self-efficacy and decision-making in relationships. Acculturation, condom self-efficacy and decision-making in relationships all served as indicators for sexual assertiveness – pregnancy/STD prevention.

Analyses were performed through EQS computer program. The fit between the hypothesized model and the empirical data was evaluated by examining the chi-square to degrees of freedom ratio. However, because chi-square is highly dependent upon sample size, several adjunctive fit indices were examined, such as the comparative fit index

(CFI), the average absolute standardized residuals (AASR), parameter estimates and the amount of explained variance (R^2) (Schnoll, Harlow, Stolbach, & Brandt, 1998).

Support was found for the hypothesized model, $\chi^2(1) = 1.65$, $p < .05$. The CFI = .89 and the AASR = .02. Only one of the hypothesized parameters – regression paths from acculturation to decision-making in relationships – was significant. The proportion of explained variance for decision-making in relationships was $R^2 = .07$. The proportion of explained variance for condom self-efficacy was $R^2 = .01$, and $R^2 = .10$ for sexual assertiveness- pregnancy/STD prevention. A Wald test was computed for parameters to be eliminated. No paths were suggested to be dropped from the model. This model is illustrated in Figure 1.

Discussion

The current study underscores the importance of continued research regarding API women and sexual health. This study was designed to test hypotheses relating cultural factors of acculturation, individualism/collectivism and sexual attitudes and behaviors of condom self-efficacy, sexual assertiveness – pregnancy/STD prevention, decision-making in relationships and condom frequency for API women. Several multiple regressions were performed, attempting to predict variables of condom self-efficacy, sexual assertiveness – pregnancy/STD prevention, decision-making in relationships and condom frequency. Although major hypotheses were not supported, the hypothesis that sexual assertiveness – pregnancy/STD prevention would predict condom frequency was confirmed.

Among sexually active women, acculturation, condom self-efficacy, sexual assertiveness – pregnancy/STD prevention as predictors of condom frequency resulted in

a significant model. For this model, however, only sexual assertiveness – pregnancy/STD prevention appeared to be a strong indicator of condom use among women who are sexually active. Additionally, a strong correlation was also found between sexual assertiveness – pregnancy/STD prevention and condom frequency. These findings suggest that the sexual assertiveness – pregnancy/STD prevention subscale is a beneficial measure to predict condom frequency for this sample, but only for sexually active participants. Similarly, in an examination of the relationships between communication and assertiveness in general and sexual contexts, Zamboni, Crawford, and Williams (2000) found that sexual assertiveness was a strong predictor of condom use among a sample of sexually active college students.

This study also suggests that acculturation should be further examined as a cultural predictor for sexual attitudes and behaviors of API women. Although this construct did not contribute highly to the hypothesized regressions, acculturation should not be considered irrelevant to HIV/AIDS prevention models. Huang and Uba (1992) have found that acculturation was positively related to having experienced premarital intercourse and levels of sexual permissiveness, and negatively related to the age of sexual initiation. Levels of acculturation have also been found to affect HIV risk among the Latino population (CAPS, 2001). In a study by Galaif, Stein, and Nyamathi (1999), greater acculturation among Latinas predicted higher levels of risky sexual behaviors.

Results of this study reflect previous investigations concerning sexual behaviors of APIs. Cochran et al. (1991) found that age of sexual initiation by non-APIs was greater compared to API peers. Harlow, Quina, Morokoff, Rose and Grimley (1993) reported that in a predominately non-API, female, college sample the majority of women

(72%) had engaged in intercourse by 17 years of age. The percentage of women who had engaged in intercourse by 17 years of age in the current study was lower (27%).

Based upon the preliminary path analysis, results suggested that a higher level of acculturation to United States cultural norms was related to a higher level of condom self-efficacy, decision-making in relationships, and sexual assertiveness – pregnancy/STD prevention. It must be emphasized, however, that this finding is based upon a small sample, and results must be interpreted with caution. Nevertheless, these results, and results of previously mentioned studies indicate that future investigations should focus and incorporate the acculturation process into their contextual models. Cochran et al. (1991) also reported that among sexually active participants, those born in the United States, and thus more acculturated, were significantly younger than their foreign-born peers when they initiated sexual activity.

Once sexually active, however, sexual behavior appears to be similar to that of non-API peers, including low rates of condom use (Cochran, et al., 1991). Comparable findings have also been reported in other studies. For example, in a comparison of sexual behaviors of White and API high school students, Hou and Basen-Engquist (1997) found that once APIs are sexually active, their behaviors are as high a risk for contracting HIV/AIDS as White students.

These results are also evident in the present study. Although acculturation may have an impact on API sexual behaviors, such as the age of sexual initiation, once sexually active, acculturation did not appear to impact sexual behaviors or attitudes. Instead, these behaviors appear to be similar to those of their non-API peers. In a study of the development and validation of the SAS scale, Morokoff et al. (1997) utilized a

predominantly non-API community and college sample and reported comparable findings to the current study. Means and standard deviations of the sexual assertiveness/pregnancy – STD subscale indicate that this sample of API women ($X = 23.99$; $SD = 5.48$) are very similar to non-API women ($X = 21.63$; $SD = 5.88$) in their decision making regarding sex and sexual behavior.

Although no hypotheses were made *a priori*, sexual attitudes were examined with sexually active and not active females. Examining means and standard deviations of sexual assertiveness/pregnancy – STD scores across sexually active and non-sexually active females, non-sexually active females appear to be overconfident in their ability to refuse unwanted sex and their sexual assertiveness. This finding has also been indicated elsewhere. In a qualitative and quantitative analyses of adolescent HIV-risk predictors, Lang (1996) found that sexually non-active young women appear to be significantly more confident in their future sexual assertiveness skills and condom use, but the reverse held true once becoming active.

Despite the above findings, there were not many differences among sexually active and non-active females in this sample. A MANOVA to assess differences on all variables across sexually active and non-sexually active females was not significant.

The INDCOL scale was found not to be psychometrically sound. Due to the low internal reliability reported by Hui and Yee (1984), INDCOL subscales were factor analyzed with principal components extraction. The original five-factor structure was abandoned for a factor structure supported by the factor analysis. Three factors that emerged from the analysis were used in this study. Subscales for Kin/Coworkers, Family/Parents and Neighbors, held high internal reliability, and factor loading for items

was .50 or greater. Ten of 32 items which did not load on any factors were eliminated. Failure of numerous items on the INDCOL to load on a factor reflects heterogeneity of items from the original scale, which likely contributed to its low internal reliability in the original study. The resulting items utilized in this study reflect a sound measure of individualism-collectivism for this sample, and may offer a stronger alternative to the original scale for future research.

Limitations

There are several limitations to the present study, which may explain the lack of support for the main research hypotheses. Participants of this study primarily college students, which may limit the degree to which the study can be generalized. Additionally, the cultural heterogeneity of the sample may explain the lack of support for the hypotheses. Despite the fact that ethnic group differences were not examined, it should not be assumed that API participants in this study are homogeneous. Although all research participants were classified as API, they self-identified as members of 13 ethnic/cultural groups.

Relative to the number of predictors used in analyses, the sample size may have been insufficient, affecting the power to detect differences in this study. Failure to achieve an adequate level of power in a statistical test increases the danger of needlessly rejecting an experimental hypothesis (Clark-Carter, 1997). A power analysis *a priori* may aid in the determination of the necessary sample size to detect an effect of the phenomenon.

Although the multiple regression predicted an association between acculturation, condom self-efficacy, and sexual assertiveness - pregnancy/STD with condom frequency

for sexually active females, a substantial amount of this variance remained unexplained. This result may indicate that variables chosen may not fully explain the sexual attitudes and behaviors of API women. For example, acculturation and individualism/collectivism are only two of multiple factors interrelated to the construction of culture. Class, gender roles, and relationship status may also be salient in the development of sexual attitudes and behaviors of this sample. These constructs have been previously examined in other populations of women of color, including Latina samples (Gómez & Marín, 1996), Black adolescent women (Jemmott & Jemmott, 1992), and Black and Latina heterosexual community samples (Bowleg et al., 2000). Therefore, in addition to acculturation and individualism/collectivism, future research examining API sexuality should include measures of other potential cultural factors.

The measure used to assess individualism/collectivism may have also negatively affected the findings. Although the measure was designed to assess cross-cultural levels of individualism/collectivism, the measure did not replicate the original findings by Hui and Yee (1994). Their shortened individualism/collectivism scale used here was based upon findings conducted with a Chinese sample. Thus, this measure may not have been appropriate for this more diverse sample.

In light of the findings of previous studies that those who are not sexually active are overconfident in their ability to refuse unwanted sex and insist on condom use, this study may be limited by the inclusion of both sexually active and not sexually active females. Examining only sexually active participants may ensure a more accurate representation of API women's sexual attitudes and behaviors. It should be noted, however, that the MANOVA examining differences between sexually and not sexually

active females was not significant for this study, and that sexual attitudes, behaviors, and cultural factors for both groups may be the same. Conversely, as previously mentioned, the power to detect statistical differences in this study may be limited by sample size, explaining the lack of statistical significance between the two groups of women.

Strong relationships between condom self-efficacy and sexual assertiveness – pregnancy/STD prevention have been documented elsewhere (e.g., Morokoff et al., 1997). In this study, however, the correlation between condom self-efficacy and sexual assertiveness – pregnancy/STD prevention was low ($r = .11$). There may be several reasons for this unexpected finding. The instructions for completing the survey may have not been clear for participants who are not sexually active. The wording of the survey may have inadvertently led the participant to assume that he/she was to answer according to his/her sexual experiences, rather than what he/she might do in a future sexual situation. This may have been confusing for participants who are not sexually active. Additionally, the low correlation may indicate that the condom self-efficacy measure does not work equally well with both sexually active and non-active women. This may be due to the nature of the questions in the measure concerning condom use, which presume the participant to be sexually active.

The study is also limited by the focus on females. Unfortunately, despite efforts to recruit men for this study, the number of males who agreed to participate was not sufficient to conduct analyses. The impact of males' sexual attitudes and behaviors are imperative towards our development of protective HIV/AIDS interventions, particularly since condom use is often controlled by men (Bowleg et al., 2000; Cochran & Mays, 1993). Thus, future research should also investigate males' sexual attitudes and

behaviors, including sexual assertiveness, condom frequency and condom self-efficacy. Research and interventions should also emphasize the responsibility that males have toward HIV/AIDS prevention for themselves and their partners.

Implications

This study has several implications for future research regarding API women's sexual attitudes and behaviors. Theoretical models predicting sexual behaviors should consider cultural constructs, such as acculturation and class, as well as how these constructs influence circumstances surrounding sexual behaviors. Additionally, it is imperative for researchers to reflect upon their own racial, gender and class biases, and acknowledge how these biases may influence interventions, policy, and research. For example, researchers and policy makers who presume APIs are the "model minority" may not consider or acknowledge the unsafe sexual practices of sexually active APIs, despite the findings that this population is at risk for HIV/AIDS. This bias may affect the development and implementation of appropriate HIV/AIDS prevention strategies.

Qualitative methodologies may provide key insight to the cultural factors involved in the development of sexual attitudes and behaviors for women and people of color. It is imperative that researchers in the field of HIV/AIDS prevention listen to API women to learn about the factors and conditions that encompass their sexual situations. Rather than assuming and defining issues of power, sexual negotiation, and cultural contexts for API women, and imposing these constructs on API women through theoretical frameworks and survey research, researchers must listen to API women's own accounts of sexual negotiations and experiences. Researchers need to listen for these issues within API women's contexts, in conversations, personal relations and interactions

with others. Fine (1997) elucidates the importance of qualitative methodology, and simply listening to participants speak of their life experiences:

When researchers listen to participants, we learn new things. Participants become more than transmitters of raw data to be refined by statistical procedures. They come to be active agents, the creators of the worlds they inhabit and the interpreters of their experiences. At the same time, researchers come to be witnesses, a word whose root means knowledge. In bringing their knowledge – of theory, of interpretive methods, and of their own intellectual, political, and personal commitments – to participants' stories, researchers become active agents as well (p. 637).

From qualitative research, frameworks may be developed to accurately represent the constructs surrounding API women's sexual attitudes and behaviors. From these frameworks, culturally sensitive interventions and programs may be implemented, creating change in the status of API women and HIV/AIDS risk.

Table 1

Demographic Characteristics of Participants

Characteristic	Females		Males	
	<u>n</u>	%	<u>n</u>	%
Age At Time Of Survey				
18	14	23.3	1	8.3
19	21	35	4	33.3
20	12	20	3	25
21	3	5	1	8.3
22 or older	10	16.7	3	25
Year in college at time of survey				
Freshman	23	38.3	1	8.3
Sophomore	16	26.7	7	58.3
Junior	12	20	2	16.7
Senior	6	10	2	16.7
Grad Student	3	5	0	0
Race or cultural group				
Cambodian	20	33.3	1	8.3
Hmong	11	18.3	3	25
Laotian	11	18.3	1	8.3
Asian	5	8.3	0	0
Chinese	5	8.3	0	0

(Table 1 Continues)

Characteristic	<u>n</u>	%
Marshallese	1	1.4
Korean	1	1.4
Thai/Cambodian	1	1.4
Chinese/Cambodian	1	1.4
Vietnamese	1	1.4
Cambodian/Chinese/Vietnamese	1	1.4
Taiwanese	1	1.4
South Korean	1	1.4
Religion or Spiritual Belief (<u>N</u> = 65)		
Buddhist	34	52.3
Christianity	10	13.9
None	7	9.7
Catholic	5	6.9
Atheist	2	2.8
God	1	1.4
Shamanism	1	1.4
Jehovah's Witness	1	1.4
Baptist	1	1.4
Mormon	1	1.4
Other	1	1.4
Not Sure	1	1.4
Number of years in U.S. (<u>N</u> = 71)		

(Table 1 continues)

(Table 1 Continued)

Characteristic	Females		Males	
	<u>N</u>	%	<u>n</u>	%
Baptist	1	0	0	0
Mormon	1	0	0	0
Other	1	0	0	0
Not Sure	0	0	1	10
Number of years in U.S.				
Entire Life	19	31.7	5	41.7
16-20 Years	18	30.5	5	41.7
11-15 Years	12	20.3	0	0
6-10 Years	8	13.6	1	8.3
Less than 5 Years	2	3.4	1	8.3

Table 2

Sexual History of Female and Male Participants

Female Participants		% of Sexually Active Females (N = 23)	% Of All Females (N = 59)
Characteristic	n		
Age of Sexual Initiation			
15	7	29.2	11.9
16	5	20.8	8.5
17	4	16.7	6.8
18	3	12.5	5.1
19	3	12.5	5.1
20	1	4.2	1.7
21	1	4.2	1.7
Someone you regularly have sex with			
No	3	12.5	5.1
Yes	20	87	33.9
Living With a Sex Partner			
No	16	69.6	27.1
Sometimes, at least several days a month	2	8.7	3.4
Yes, all the time	5	8.3	8.5
Who did you have sex with in the past 5 years			
Always with men	22	95.7	51.7

(Table 2 continues)

(Table 2 continued)

Characteristic	<u>n</u>	% Of Sexually Active Females (<u>N</u> = 23)	% Of All Females (<u>N</u> = 59)
Mostly with men	1	4.2	1.7
Do you use condoms			
Never	1	4.2	1.7
Sometimes, but not always	11	47.8	18.6
Started always using 1 month ago	1	4.2	1.7
Started always using 3-5 months ago	1	4.2	1.7
Started always using 6 months ago or longer	9	39.1	15.3

Male Participants

Characteristic	<u>n</u>	% Of Sexually Active Males (<u>N</u> = 10)	% Of All Males (<u>N</u> = 12)
Age of Sexual Initiation			
15	3	30	25
16	1	10	10.4
17	2	20	16.7
19	2	20	16.7
20	1	10	10.4
21	1	10	10.4
Someone you regularly have sex with			
No	0	0	0

(Table 2 continues)

(Table 2 continued)

Characteristic	<u>n</u>	% Of Sexually Active Males (<u>N</u> = 10)	% Of All Males (<u>N</u> = 12)
Yes	10	100	83.3
Living With a Sex Partner			
No	9	90	75
Sometimes, at least several days a month	0	0	0
Yes	1	10	10.4
Who did you have sex with in the past 5 years			
Always with women	10	100	83.3
Mostly with women	0	0	0
Do you use condoms?			
Never	1	10	10.4
Sometimes, but not always	5	50	41.7
Started always using 1 month ago	0	0	0
Started always using 3-5 months ago	0	0	0
Started always using 6 months ago or longer	4	40	33.3

Table 3.

Intercorrelations for Cultural, Sexual Attitude and Behavior Measures

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	--													
2	-.10	--												
3	.06	.07	--											
4	.33*	.06	-.07	--										
5	-.09	-.19	.22	-.07	--									
6	.17	-.11	.24	-.02	.44*	--								
7	.09	.80	-.00	.12	.22	.30*	--							
8	.26*	.16	.09	.22	-.04	.09	-.15	--						
9	.25	.12	.04	.25	.11	.12	.11	.18	--					
10	.20	.17	.11	.10	.11	.19	-.02	.34*	.57*	--				
11	.08	-.16	-.08	-.08	-.09	-.00	.03	-.05	.23	.17	--			
12	.20	-.03	.21	.16	.16	.27*	.06	.12	.41*	.31*	.25	--		
13	.15	.63*	.53*	.59*	-.04	.04	.13	.28*	.23	.20	-.22	.16	--	
14	-.13	.29	-.07	-.07	-.14	-.03	.20	-.10	.78*	.64*	.40	.20	.11	--

Note. N = 60. * $p < .05$ level.

1 = SL-ASIA; 2 = Individualism-Collectivism (INDCOL) neighbors; 3 = INDCOL friends/parents; 4 = INDCOL kin/coworkers; 5 = peer norms; 6 = family norms; 7 = condom self-efficacy; 8 = decision-making in relationships; 9 = sexual assertiveness – pregnancy/STD prevention; 10 = sexual assertiveness – refusal; 11 = sexual assertiveness – initiation; 12 = sexual assertiveness for communication of HIV risk-related information; 13 = powerlessness; 14 = condom frequency.

Table 4

Cronbach's Alpha for Cultural, Sexual Attitude and Behavior Measures

	Cronbach's Alpha
SL-ASIA	.81
Neighbors	.65
Friends/Parents	.69
Kin/Coworkers	.71
Peer Norms	.65
Condom Self-Efficacy	.88
Decision-Making in Relationships	.71
SAS – Pregnancy/STD Prevention	.88
SAS – Refusal	.67
SAS – Initiation	.32
SAS - For Communication of HIV Risk-Related Information	.67
Powerlessness	.56

Table 5

Means and Standard Deviations of Cultural, Sexual Attitude and Behavior Measures
for Sexually Active Females and Non-Sexually Active Females

Sexual Status	SL	NE	FP	KC	PN	FN	CS	DM	SAS – PS	CF
Sexually Active Females										
<u>M</u>	2.71	11.65	24.02	22.19	10.83	4.17	25.07	25.83	22.35	3.26
<u>SD</u>	.43	4.53	4.65	3.52	3.11	1.23	5.59	5.00	5.89	1.51
<u>n</u>	23	23	23	23	23	23	23	23	23	23
Non- Sexually Active Females										
<u>M</u>	2.49	12.64	23.49	20.39	10.94	3.83	23.05	25.79	24.87	
<u>SD</u>	.44	3.44	4.28	4.52	2.12	1.11	7.35	4.66	5.01	
<u>n</u>	36	36	36	36	36	36	36	36	36	

Note. SL = SL-ASIA; NE = Individualism-Collectivism (INDCOL) neighbors; FP = INDCOL friends/parents; KC = INDCOL kin/coworkers; PN = peer norms; FN = family norms; CS = condom self-efficacy; DM = decision- making in relationships; SAS-PS = Sexual Assertiveness – Pregnancy/STD prevention; CF = condom frequency. Non-sexually active females did not complete the condom frequency scale.

Table 6

Factor Loadings for Varimax Orthogonal Three-Factor Solution of Individualism-Collectivism Scale

Item	Factor loading
Factor 1: Kin and Coworkers $\alpha = .71$	
52. I can count on my relatives for help if I find myself in any kind of trouble.	.65
53. When deciding what kind of education to have, I would pay attention to the views of relatives of my generation	.63
37. There is everything to gain and nothing to lost for coworkers to group themselves to help each other.	.59
34. The motto "sharing in both blessing and calamity" still applies even if one's friend is clumsy, dumb, and causes a lot of trouble.	.55
35. I would help if a colleague at work told me that he/she needed money to pay utility bills.	.54
Factor 2: Family and Parents $\alpha = .69$	
57. Children should not feel honored even if the father were highly praised and given an award for his contribution and service to the community. (R)	.72
56. Even if their child won the Nobel prize, parents should not feel honored in any way. (R)	.70
58. In these days parents are too stringent with their kids, stunting the development of initiative.	.65
42. I would not let my parents use my car, whether they are good drivers or not. (R)	.54
43. I would not let my needy mother use the money that I have saved by living a less than luxurious life. (R)	.52
8. To go on a trip with friends makes one less free and mobile.	.52
Factor 3: Neighbors $\alpha = .65$	

(Table 6 continues)

(Table 6 continued)

65. I have never chatted with my neighbors about the political future of this country. (R)	.68
64. I am not interested in knowing what my neighbors are really like. (R)	.63
63. My neighbors have never borrowed anything from me or my family. (R)	.61
67. I enjoy meeting and talking to my neighbors every day. (R)	.54

Factor 4: Money $\alpha = .58$

40. It is a personal matter whether I worship money or not, it is not necessarily for my friends to give any counsel. (R)	.75
48. Whether one spends an income extravagantly or stingily is of no concern to one's relatives (cousins, uncles). (R)	.61
44. I would not share my ideas and newly acquired knowledge with my parents.	.57

Factor 5: Life Advice $\alpha = .41$

60. If a husband is a sports fan, a wife should cultivate an interest in sports. If the husband is a stockbroker, the wife should be aware of the current market conditions.	.65
45. Teenagers should listen to their parents' advice on dating.	.53
59. The decision of where one is to work should be jointly made with one's spouse, if one is married.	.53

Note. $N = 60$. (R) denotes reversed scored items.

Only Factors 1-3 were used in the current study and $\alpha = .58$ for the entire measure.

Table 7

Regression Analysis Summary for Variables Predicting Sexual Assertiveness -
Pregnancy/STD Prevention Among Sexually Active and Not Sexually Active
Female Participants

Variable	B	SEB	β
SL-ASIA	2.50	1.80	.20
Neighbor	.22	.20	.15
Family/Parents	-.05	.19	-.03
Kin/Coworkers	.22	.18	.17
Peer Norms	.35	.33	.16
Family Norms	.14	.73	.03
Condom Self-Efficacy	.02	.12	.03
Decision-Making in Relationship	.09	.17	.08

Note. $R^2 = .15$ ($N = 60$, $p > .05$).

Table 8

Regression Analysis Summary for Variables Predicting Condom Self-Efficacy
Among Sexually Active and Not Sexually Active Female Participants

Variable	B	SEB	β
SL-ASIA	1.35	2.19	.09
Neighbor	.31	.23	.18
Family/Parents	-.08	.23	-.05
Kin/Coworkers	.23	.22	.14
Peer Norms	.42	.39	.16
Family Norms	1.53	.85	.26
Decision-Making in Relationships	-.35	.19	-.25
SAS – Pregnancy/STD	.03	.17	.03

Note. $R^2 = .19$ ($N = 60$, $p > .05$).

Table 9

Regression Analysis Summary for Variables Predicting Decision-Making in
Relationships Among Sexually Active and Not Sexually Active Female
Participants

Variable	B	SEB	β
SL-ASIA	2.19	1.52	.21
Neighbor	.23	.16	.19
Family/Parents	.09	.16	.07
Kin/Coworkers	.18	.15	.16
Peer Norms	.01	.28	.01
Family Norms	.51	.61	.12
Condom Self-Efficacy	-.18	.10	-.25
SAS – Pregnancy/STD	.06	.12	.07

Note. $R^2 = .19$ ($N = 60$, $p > .05$).

Table 10

Regression Analysis Summary for Variables Predicting Condom Frequency
Among Sexually Active and Not Sexually Active Female Participants

Variable	B	SEB	β
SL-ASIA	-.49	.49	-.14
Condom Self-Efficacy	-.04	.04	-.14
SAS – Pregnancy/STD	.22	.04	.85*

Note. $R^2 = .64$ ($N = 23$, $p < .05$).

* $p < .05$.

Table 11

Multivariate and Univariate Analysis of Variance F Ratios for Sexually Active and Not Sexually Active Females on Cultural, Sexual Attitude and Behavior Measures

Variable	ANOVA									
	MANOVA	SL	NE	FP	KC	PN	FN	CS	DM	SAS-PS
Sexual Status	F(9,49)	F(1,57)	F(1,57)	F(1,57)	F(1,57)	F(1,57)	F(1,57)	F(1,57)	F(1,57)	F(1,57)
	1.65	3.68	.91	.00	2.64	.03	1.22	1.26	.00	3.10

Note. MANOVA = multivariate analysis of variance; ANOVA = univariate analysis of variance.

SL = SL-ASIA; NE = Individualism-Collectivism (INDCOL) neighbors; FP = INDCOL friends/parents; KC = INDCOL kin/coworkers; PN = peer norms; FN = family norms; CS = condom self-efficacy; DM = decision- making in relationships; SAS-PS = Sexual Assertiveness – Pregnancy/STD prevention.

Figure 1. Standardized Coefficients for Acculturation, Sexual Attitudes and Behavior Model.

$\chi^2(1) = 1.65$
CFI = .89
AASR = .02
*p < .05

Appendix A

Consent Form

KEEP THIS FORM FOR YOURSELF

Dear Participant:

You have been asked to take part in the research project described below. If you have any questions, please feel free to call Jennifer Huang (401-268-9871), or Kathryn Quina (401-277-5164), the people mainly responsible for this study.

The purpose of this research is to gain knowledge regarding Asian American's sexuality within a cultural context. Responses will be collected using this survey. You can be assured full confidentiality of the information provided, as we will have no way of identifying you as a participant in this study.

YOU MUST BE AT LEAST 18 YEARS OLD to participate in this research project.

If you decide to take part in this study, you will anonymously complete questionnaires concerning culture and sexuality.

The possible risks or discomforts of the study are minimal, although you may feel some embarrassment answering questions about private matters.

Although there are no direct benefits of this study, your answers will help increase the knowledge regarding Asian American's sexuality.

Your part in this study is anonymous. This means that your answers to all questions are private. No one else can know if you participated in this study and no one else can find out what your answers were. Scientific reports will be based on group data and will not identify you or any individual as being in this project.

The decision to participate in this research is up to you. You do not have to participate and you can refuse to answer any question.

Participation in this study is not expected to be harmful or injurious to you. However, if this study causes you any injury, you should write or call Jennifer Huang (401-268-9871), or Kathryn Quina (401-277-5164) at the University of Rhode Island.

If you have any more questions or concerns about this study, you may contact the University of Rhode Island's Vice Provost for Graduate Studies, Research and Outreach, 10 Lower College Road, Suite 2, URI Kingston, RI, (401) 874-4576.

You are at least 18 years old. You have read the consent form and your questions have been answered to your satisfaction. Your filling out the survey implies your consent to participate in the study.

If these questions are disturbing and you would like to talk, please contact the University of Rhode Island Counseling Center at (401) 874-2288.

Thank you for your time,
Jennifer Huang

Appendix B

Background – Part I

Please circle the answer that is best for you or fill in the blanks. If you have comments or anything you would like to add, please feel free to write them down next to the question.

1. What is your gender?
  - A. Female
  - B. Male

2. How old are you?
  - A. 18
  - B. 19
  - C. 20
  - D. 21
  - E. 22 or older

3. What year are you in school?
  - A. Freshman
  - B. Sophomore
  - C. Junior
  - D. Senior
  - E. Graduate student

4. What is your race or cultural group?
_____ (fill in the blank)

5. What is your sexual identity?
  - A. Heterosexual
  - B. Gay
  - C. Lesbian
  - D. Bisexual
  - E. Other

6. What is your religion or spiritual belief?
_____ (fill in the blank)

7. How long have you been in the United States?

A. All of my life.

B. _____ (fill in the blank)

Appendix C

Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)

The questions which follow are for the purpose of collecting information about your historical background as well as more recent behaviors which may be related to your cultural identity. Please circle the response that BEST describes you.

1. What language can you speak?
  - A. Asian or Pacific Islander only (for example, Chinese, Japanese, Vietnamese, etc.)
  - B. Mostly Asian or Pacific Islander, some English
  - C. Asian or Pacific Islander and English about equally well (bilingual)
  - D. Mostly English, some Asian or Pacific Islander
  - E. Only English
2. What language do you prefer?
  - A. Asian or Pacific Islander only (for example, Chinese, Japanese, Vietnamese, etc.)
  - B. Mostly Asian or Pacific Islander, some English
  - C. Asian or Pacific Islander and English about equally well (bilingual)
  - D. Mostly English, some Asian or Pacific Islander
  - E. Only English
3. How do you identify yourself?
  - A. Oriental
  - B. Asian or Pacific Islander
  - C. Asian American or Pacific Islander American
  - D. Chinese American, Japanese American, Korean American, Filipino American etc.
  - E. American
4. Which identification does (did) your mother use?
  - A. Oriental
  - B. Asian or Pacific Islander
  - C. Asian American or Pacific Islander American
  - D. Chinese American, Japanese American, Korean American, Filipino American etc.
  - E. American
5. Which identification does (did) your father use?
  - A. Oriental
  - B. Asian or Pacific Islander
  - C. Asian American or Pacific Islander American

- D. Chinese American, Japanese American, Korean American, Filipino American etc.
  - E. American
6. What was the ethnic origin of the friends and peers you had, as a child up to age 6?
    - A. Almost exclusively Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - B. Mostly Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - C. About equally Asian or Pacific Islander groups and Anglo groups
    - D. Mostly Anglos, Black, Hispanics, or other non-Asian ethnic groups
    - E. Almost exclusively Anglos, Black, Hispanics or other non-Asian ethnic groups
  7. What was the ethnic origin of the friends and peers you had, as a child from 6 to 18?
    - A. Almost exclusively Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - B. Mostly Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - C. About equally Asian or Pacific Islander groups and Anglo groups
    - D. Mostly Anglos, Black, Hispanics, or other non-Asian ethnic groups
    - E. Almost exclusively Anglos, Black, Hispanics or other non-Asian ethnic groups
  8. Whom do you now associate with in the community?
    - A. Almost exclusively Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - B. Mostly Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - C. About equally Asian or Pacific Islander groups and Anglo groups
    - D. Mostly Anglos, Black, Hispanics, or other non-Asian ethnic groups
    - E. Almost exclusively Anglos, Black, Hispanics or other non-Asian ethnic groups
  9. If you could pick, who would you prefer to associate with in the community?
    - A. Almost exclusively Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - B. Mostly Asians, Pacific Islanders, Asian Americans, Pacific Islander Americans
    - C. About equally Asian or Pacific Islander groups and Anglo groups
    - D. Mostly Anglos, Black, Hispanics, or other non-Asian ethnic groups
    - E. Almost exclusively Anglos, Black, Hispanics or other non-Asian ethnic groups
  10. What is your music preference?
    - A. Only Asian or Pacific Islander (for example, Chinese, Japanese, Filipino etc.)
    - B. Mostly Asian or Pacific Islander
    - C. Equally Asian and English
    - D. Mostly English
    - E. English only

11. What is your movie preference?

- A. Asian language or Pacific Islander language movies only
- B. Asian language or Pacific Islander language movies mostly
- C. Equally Asian/Pacific Islander/English language
- D. English-language movies mostly
- E. English-language movies only

12. Where were you born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____

Where was your father born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____
- D. Don't know

Where was your mother born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____
- D. Don't know

Where was your father's father born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____
- D. Don't know

Where was your father's mother born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____
- D. Don't know

Where was your mother's father born?

- A. U.S.
- B. Asia or Pacific Islands
- C. Other – Where _____
- D. Don't know

Where was your mother's mother born?

- A. U.S.
- B. Asia or Pacific Islands

- C. Other – Where _____
- D. Don't know

On the basis of the above answers, circle the generation that best applies to you:

- A. 1st Generation = I was born in Asia or Pacific Islands or other
- B. 2nd Generation = I was born in U.S., either parent was born in Asia or Pacific Islands or other
- C. 3rd Generation = I was born in U.S., both parents were born in U.S., and all grandparents born in Asia or Pacific Islands or other
- D. 4th Generation = I was born in U.S., both parents born in U.S., and at least one grandparent born in Asia or Pacific Islands or other and one grandparent born in U.S.
- E. 5th Generation = I was born in U.S., both parents and all grandparents also born in U.S.
- F. Don't know what generation best fits since I lack some information.

13. Where were you raised?

- A. In Asia or the Pacific Islands mostly
- B. Mostly in Asia or the Pacific Islands, some in U.S.
- C. Equally in Asia or Pacific Islands and U.S.
- D. Mostly in U.S., some in Asia or Pacific Islands
- E. In U.S. only

14. What contact have you had with Asia or the Pacific Islands?

- A. Raised one year or more in Asia or Pacific Islands
- B. Lived for less than one year in Asia or Pacific Islands
- C. Occasional visits to Asia or Pacific Islands
- D. Occasional communications (letters, phone calls, etc.) with people in Asia or Pacific Islands
- E. No exposure or communications with people in Asia or Pacific Islands

15. What is your food preference at home?

- A. Exclusively Asian or Pacific Islander food
- B. Mostly Asian or Pacific Islander food, some American
- C. About equally Asian or Pacific Islander and American
- D. Mostly American food
- E. Exclusively American food

16. What is your food preference in restaurants?

- A. Exclusively Asian or Pacific Islander food
- B. Mostly Asian or Pacific Islander food, some American
- C. About equally Asian or Pacific Islander and American
- D. Mostly American food
- E. Exclusively American food

17. Do you:
- A. read only an Asian or Pacific Islander language
  - B. read an Asian or Pacific Islander language better than English
  - C. read both Asian or Pacific Islander language and English equally well
  - D. read English better than an Asian or Pacific Islander language
  - E. read only English
18. Do you:
- A. write only an Asian or Pacific Islander language
  - B. write an Asian or Pacific Islander language better than English
  - C. write both Asian or Pacific Islander language and English equally well
  - D. write English better than an Asian or Pacific Islander language
  - E. write only English
19. If you consider yourself a member of the Asian or Pacific Islander group (Asian, Asian American, Filipino American, etc., whatever group you prefer), how much pride do you have in this group?
- A. Extremely proud
  - B. Moderately proud
  - C. Little pride
  - D. No pride but do not feel negative toward group
  - E. No pride but do fee negative toward group
20. How would you rate yourself?
- A. Very Asian or Pacific Islander
  - B. Mostly Asian or Pacific Islander
  - C. Bicultural
  - D. Mostly Westernized
  - E. Very Westernized
21. Do you participate in Asian or Pacific Islander occasions, holidays, traditions, etc.?
- A. Nearly all
  - B. Most of them
  - C. Some of them
  - D. A few of them
  - E. None at all
22. Rate yourself on how much you believe in Asian or Pacific Islander values (e.g., about marriage, families, education, work):

1	2	3	4	5
do not believe				strongly
believe				

23. Rate yourself on how much you believe in American (Western) values:

1	2	3	4	5
do not believe				strongly
believe				

24. Rate yourself on how well you fit when you are with other Asians or Pacific Islanders of the same ethnicity:

1	2	3	4	5
do not fit				strongly fit

25. Rate yourself on how well you fit when with other Americans who are non-Asian or non-Pacific Islander (Westerners):

1	2	3	4	5
do not believe				strongly
believe				

26. There are many different ways in which people think of themselves. Which ONE of the following most closely describes how you view yourself?

- A. I consider myself basically an Asian or Pacific Islander person. Even though I live and work in America, I still view myself basically as an Asian or Pacific Islander person.
- B. I consider myself basically as an American. Even though I have an Asian or Pacific Islander background and characteristics, I still view myself basically as an American.
- C. I consider myself as an Asian American or Pacific Islander American although deep down I always know I am an Asian or Pacific Islander.
- D. I consider myself as an Asian American or Pacific Islander American, although deep down, I view myself as an American first.
- E. I consider myself as an Asian American or Pacific Islander American. I have both Asian or Pacific Islander and American characteristics, and I view myself as a blend of both.

Appendix D

INDividualism-COLlectivism (INDCOL) Scale

For the following questions, please rate how you feel about the statements according to the scale provided.

For the questions which ask about your "neighbor" think of your neighbor at your family's home.

1. The motto "sharing in both blessing and calamity" still applies even if one's friend is clumsy, dumb, and causes a lot of trouble.

0	1	2	3	4	5
strongly disagree					strongly agree

2. I would help if a colleague at work told me that he/she needed money to pay utility bills.

0	1	2	3	4	5
strongly disagree					strongly agree

3. If a colleague lends a helping hand, one needs to return the favor.

0	1	2	3	4	5
strongly disagree					strongly agree

4. There is everything to gain and nothing to lose for co-workers to group themselves to help each other.

0	1	2	3	4	5
strongly disagree					strongly agree

5. Colleagues' assistance is indispensable to good performance at work.

0	1	2	3	4	5
strongly disagree					strongly agree

6. I like to live close to my good friends.

0	1	2	3	4	5

strongly disagree

strongly agree

7. It is a personal matter whether I worship money or not. Therefore it is not necessary for my friends to give any counsel.

0	1	2	3	4	5
strongly disagree					strongly agree

8. To go on a trip with friends makes one less free and mobile. As a result, there is less fun.

0	1	2	3	4	5
strongly disagree					strongly agree

9. I would not let my parents use my car (if I have one), whether they are good drivers or not.

0	1	2	3	4	5
strongly disagree					strongly agree

10. I would not let my needy mother use the money that I have saved by living a less than luxurious life.

0	1	2	3	4	5
strongly disagree					strongly agree

11. I would not share my ideas and newly acquired knowledge with my parents.

0	1	2	3	4	5
strongly disagree					strongly agree

12. Teenagers should listen to their parents' advice on dating.

0	1	2	3	4	5
strongly disagree					strongly agree

13. Young people should take into consideration their parents' advice when making education/career plans.

0	1	2	3	4	5
strongly disagree					strongly agree

14. Each family has its own problems unique to itself. It does not help to tell relatives about one's problem.

0	1	2	3	4	5
strongly disagree					strongly agree

15. Whether one spends an income extravagantly or stingily is of no concern to one's relatives (cousins, uncles).

0	1	2	3	4	5
strongly disagree					strongly agree

16. One need not worry about what the neighbors say about whom one should marry.

0	1	2	3	4	5
strongly disagree					strongly agree

17. When deciding what kind of education to have, I would pay absolutely no attention to my uncles' advice.

0	1	2	3	4	5
strongly disagree					strongly agree

18. If possible, I would like co-owning a car with my close friends, so that it wouldn't be necessary for them to spend much money to buy their own cars.

0	1	2	3	4	5
strongly disagree					strongly agree

19. I can count on my relatives for help if I find myself in any kind of trouble.

0	1	2	3	4	5
strongly disagree					strongly agree

20. When deciding what kind of education to have, I would definitely pay attention to the views of relatives of my generation.

0	1	2	3	4	5
strongly disagree					strongly agree

21. I am often influenced by the moods of my neighbors.

0	1	2	3	4	5
strongly disagree					strongly agree

22. My neighbors always tell me interesting stories that have happened around them.

0	1	2	3	4	5
strongly disagree					strongly agree

23. Even if the child won the Nobel prize, the parents should not feel honored in any way.

0	1	2	3	4	5
strongly disagree					strongly agree

24. Children should not feel honored even if the father were highly praised and given an award for his contribution and service to the community.

0	1	2	3	4	5
strongly disagree					strongly agree

25. In these days parents are too stringent with their kids, stunting the development of initiative.

0	1	2	3	4	5
strongly disagree					strongly agree

26. The decision of where one is to work should be jointly made with one's spouse, if one is married.

0	1	2	3	4	5
strongly disagree					strongly agree

27. If a husband is a sports fan, a wife should also cultivate an interest in sports. If the husband is a stock broker, the wife should also be aware of the current market conditions.

0	1	2	3	4	5
strongly disagree					strongly agree

28. If a wife is a music fan, a husband should also cultivate an interest in music. If the wife is a physician, the husband should also be aware of the current medical conditions.

0	1	2	3	4	5
strongly disagree					strongly agree

29. I don't really know how to befriend my neighbors

0	1	2	3	4	5
strongly disagree					strongly agree

30. My neighbors have never borrowed anything from me or my family.

0	1	2	3	4	5
strongly disagree					strongly agree

31. I am not interested in knowing what my neighbors are really like.

0	1	2	3	4	5
strongly disagree					strongly agree

32. I have never chatted with my neighbors about the political future of this country.

0	1	2	3	4	5
strongly disagree					strongly agree

33. One needs to be cautious when talking with neighbors, otherwise others might think you are nosy.

0	1	2	3	4	5
strongly disagree					strongly agree

34. I enjoy meeting and talking to my neighbors every day.

0 1 2 3 4 5
strongly disagree strongly agree

Appendix E

Peer and Family Norms for Condom Use

In this survey, a "sex partner" is any person you have done any of these things with:

Oral sex – your mouth on your partner's genitals or your partner's mouth on your genitals

Vaginal sex – a man putting his penis in a woman's vagina

Orgasm – a peak or climax sex experience

"Having sex" is doing any of these things with a sex partner.

Please circle the answer that is your best guess.

1. My close friends are not having sex.
  - A. Definitely true
  - B. Probably true
  - C. Probably false
  - D. Definitely false
  - E. I do not know.

The next 2 questions ask about what your friends or parents think about using condoms or latex barriers when they have sex. Please circle the answer that is your best guess.

2. My close friends think that it is important to protect themselves from getting AIDS when they have sex. This is:
  - A. Definitely true
  - B. Probably true
  - C. Probably false
  - D. Definitely false
  - E. I do not know what my friends think.
3. My close friends would ask a partner to use a condom or latex barrier when they had sex. This is:
  - A. Definitely true
  - B. Probably true
  - C. Probably false
  - D. Definitely false
  - E. I do not know what my friends think.

4. My parents think it is important for me to protect myself from getting AIDS when and if I have sex. This is:
- A. Definitely true
  - B. Probably true
  - C. Probably false
  - D. Definitely false
  - E. I do not know what my parents think.
5. My parents think it is important for me to use condoms when and if I have sex. This is:
- A. Definitely true
  - B. Probably true
  - C. Probably false
  - D. Definitely false
  - E. I do not know what my parents think.

Appendix F

Condom Self-efficacy

How much do you agree with these statements? Circle the answer closest to your opinion.

1. I would use a condom or latex barrier when I am really turned on.

Agree a lot   Agree some   Disagree some   Disagree a lot

2. I would use a condom or latex barrier even if my partner gets mad about it.

Agree a lot   Agree some   Disagree some   Disagree a lot

3. I would use a condom or latex barrier when I am depressed.

Agree a lot   Agree some   Disagree some   Disagree a lot

4. I would use a condom or latex barrier when I have been drinking or doing drugs.

Agree a lot   Agree some   Disagree some   Disagree a lot

5. I would use a condom or latex barrier when I'm angry.

Agree a lot   Agree some   Disagree some   Disagree a lot

6. I would use a condom or latex barrier when I'm afraid I might get AIDS.

Agree a lot   Agree some   Disagree some   Disagree a lot

Appendix G

Sexual Assertiveness Scale (SAS)

Think about a person YOU USUALLY HAVE SEX WITH or SOMEONE YOU USED TO HAVE SEX WITH REGULARLY. Answer the next questions with that person in mind. Think about what you would do even if you have not done some of these things. Circle your best answer.

1. I let my partner know if I want my partner to touch my genitals.

Never   Sometimes   About half of the time   Usually   Always

2. I would ask if I want to know if my partner ever had an HIV test.

Never   Sometimes   About half of the time   Usually   Always

3. I refuse to put my mouth on my partner's genitals if I don't want to, even if my partner insists.

Never   Sometimes   About half of the time   Usually   Always

4. I have sex without a condom or latex barrier if my partner doesn't like them, even if I want to use one.

Never   Sometimes   About half of the time   Usually   Always

5. I begin sex with my partner if I want to.

Never   Sometimes   About half of the time   Usually   Always

6. I would ask my partner about the AIDS risk of his or her past partners, if I want to know.

Never   Sometimes   About half of the time   Usually   Always

7. I put my mouth on my partner's genitals if my partner wants me to, even if I don't want to.

Never	Sometimes	About half of the time	Usually	Always

8. I let my partner know what I do not like in sex.

Never	Sometimes	About half of the time	Usually	Always

9. I make sure my partner and I use a condom or latex barrier when we have sex.

Never	Sometimes	About half of the time	Usually	Always

10. I let my partner know how I like to be touched.

Never	Sometimes	About half of the time	Usually	Always

11. I give in and kiss if my partner pressures me, even if I already said no.

Never	Sometimes	About half of the time	Usually	Always

12. I wait for my partner to touch me sexually instead of letting my partner know that's what I want.

Never	Sometimes	About half of the time	Usually	Always

13. I let my partner kiss my genitals if my partner wants to, even if I don't want to.

Never	Sometimes	About half of the time	Usually	Always

14. I wait for my partner to touch my genitals instead of letting my partner know that's what I want.

Never	Sometimes	About half of the time	Usually	Always

15. Women should wait for men to start things like breast touching.

Never	Sometimes	About half of the time	Usually	Always

16. I let my partner know if I want to have my genitals kissed.

Never   Sometimes   About half of the time   Usually   Always

17. I would ask if I want to know if my partner never had a sexually transmitted disease (STD).

Never   Sometimes   About half of the time   Usually   Always

18. I insist on using a condom or latex barrier if I want to, even if my partner doesn't like them.

Never   Sometimes   About half of the time   Usually   Always

19. If I want to know, I would ask my partner if he or she ever had sex with someone of the same sex.

Never   Sometimes   About half of the time   Usually   Always

20. I would ask if I want to know if my partner ever had sex with someone who shoots drugs with a needle.

Never   Sometimes   About half of the time   Usually   Always

21. I have sex without using a condom or latex barrier if my partner insists, even if I don't want to.

Never   Sometimes   About half of the time   Usually   Always

22. I would ask if I want to know if my partner ever used needles to take drugs.

Never   Sometimes   About half of the time   Usually   Always

23. If I said no, I won't let my partner kiss my genitals even if my partner pressures me.

Never   Sometimes   About half of the time   Usually   Always

24. I have sex without using a condom or latex barrier if my partner wants.

Never   Sometimes   About half of the time   Usually   Always

25. I refuse to have sex, if my partner refuses to use a condom or latex barrier.

Never   Sometimes   About half of the time   Usually   Always

26. I refuse to let my partner touch me sexually if I don't want that, even if my partner insists.

Never   Sometimes   About half of the time   Usually   Always

Appendix H

Powerlessness

Think about what you would do even if you have not had sex. Circle your best answer.

1. I feel I am not in control of my sex life.

Never   Rarely   Sometimes   Often   Always

2. I have a say in my sex life.

Never   Rarely   Sometimes   Often   Always

3. I feel that others are running my sex life.

Never   Rarely   Sometimes   Often   Always

4. I can change my sex life if I want to.

Never   Rarely   Sometimes   Often   Always

5. Things just happen to me in my sex life.

Never   Rarely   Sometimes   Often   Always

Appendix I

Relationship Power - Decision-Making

Think about your current (or most recent) sexual partner. Please answer the following questions according to the following scale.

1. Who usually has more say about whose friends to go out with?
  - A. Your partner
  - B. Both of you Equally
  - C. You
2. Who usually has more say about whether you have sex?
  - A. Your partner
  - B. Both of you Equally
  - C. You
3. Who usually has more say about what you do together?
  - A. Your partner
  - B. Both of you Equally
  - C. You
4. Who usually has more say about how often you see one another?
  - A. Your partner
  - B. Both of you Equally
  - C. You
5. Who usually has more say about when you talk about serious things?
  - A. Your partner
  - B. Both of you Equally
  - C. You
6. In general, who do you think has more power in the relationship?
  - A. Your partner
  - B. Both of you Equally
  - C. You
7. Who usually has more say about whether you use condoms?
  - A. Your partner
  - B. Both of you Equally
  - C. You
8. Who usually has more say about what types of sexual acts you do?

- . A. Your partner
- B. Both of you Equally
- C. You

Appendix J

Sexual History

For the next questions, please circle the answer that is best for you or fill in the blanks. If you have comments or anything you would like to add, please feel free to write them down next to the question.

In this survey, a "sex partner" is any person you have done any of these things with:

Oral sex – your mouth on your partner's genitals or your partner's mouth on your genitals

Vaginal sex – a man putting his penis in a woman's vagina

Orgasm – a peak or climax sex experience

"Having sex" is doing any of these things with a sex partner.

1. Have you ever had sex?

A. Yes

B. No

If you have not had sex, please skip the following questions. You have completed the survey. Thanks for your participation.

2. What was your age when you first had sex?

_____ years

3. Is there someone you regularly have sex with (husband, wife or steady partner)?

A. No

B. Yes

4. About how long have you been involved with your most recent sex partner? (fill in the blanks)

_____ years

_____ months

(If less than a month) _____ weeks

5. Are you living with a sex partner now?

A. No

B. Sometimes, at least several days a month

C. Yes, all the time

6. In the past 5 years, when you had sex was it:
- A. Always with men?
  - B. Mostly with men?
  - C. About half the time with men?
  - D. Mostly with women?
  - E. Always with women?

Appendix K

Condom Frequency

1. Do you use condoms?
  - A. Never
  - B. Sometimes, but not always
  - C. Started always using 1 month ago
  - D. Started always using 3-5 months ago
  - E. Started always using 6 months ago or longer

You have completed the survey. Your participation is appreciated. Thank You!

Appendix L

If you are an Asian American or Pacific Islander American over 18 years old

Please complete a brief survey concerning sexual attitudes and behaviors.

Please contact Jennifer Huang at 401-874-4230 or email jhua0544@postoffice.uri.edu for surveys or more information concerning this study.

Thanks!

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