
HYPERFEMININITY, HIV RISK BEHAVIOR,
AND VICTIMIZATION AMONG COLLEGE
AGED FEMALES

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ABSTRACT

This study examines hyperfemininity, victimization and HIV risk behavior among college aged females. The hyperfemininity scale is used to measure traditional gender roles. Study participants were 372 females with an average age of 19, who volunteered to participate for the study for research credit as part of their Introductory Psychology class at a medium sized southeastern university. Two groups were examined which included respondents who scored one standard deviation above the mean on the hyperfemininity scale (high hyperfemininity, $n=62$) and those who scored one standard deviation below the mean (low hyperfemininity, $n=54$). Results were that high hyperfeminine women were significantly more likely to have engaged in sexual intercourse in the previous 3 months, significantly more likely to have used drugs or alcohol before and during sex, and had lower condom self-efficacy scores than low hyperfeminine women. Also, high hyperfeminine women had more verbal victimization experiences and sexual coercion experiences, but not forced sexual experiences, than low hyperfeminine women. Results also suggest that high hyperfeminine women were more impulsive and had more favorable attitudes toward

alcohol than low hyperfeminine women. Further, high hyperfeminine women reported more alcohol use than low hyperfeminine women. Overall, differences between high and low hyperfeminine women indicate that a further examination of this construct could be informative for HIV prevention interventions and potentially for preventing victimization.

RESUMEN

Este estudio investiga la hiper-feminidad, la discriminación, y las conductas de riesgo VIH entre mujeres de una edad de universitaria. La escala de la hiper-feminidad se utiliza para medir los papeles (roles) tradicionales de los sexos. Los sujetos eran 372 mujeres con una edad media de 19 años, que se habían ofrecido voluntariamente para participar en el estudio con el fin de obtener un crédito de investigación como parte de su clase de Introducción a la Psicología en una universidad de tamaño medio en el Sureste. Se examinaron dos grupos que incluían participantes que alcanzaron una desviación estándar por encima de la media en la escala de la hiper-feminidad (hiper-feminidad alta, $n=62$) y las que alcanzaron una desviación estándar por debajo de la media (hiper-feminidad baja, $n=54$). Los resultados demostraron que las mujeres de hiper-feminidad alta tenían significativamente más propensión a haber mantenido relaciones sexuales en los tres meses anteriores, significativamente más propensión a haber consumido drogas y alcohol antes y durante las relaciones sexuales, y tenían peor puntuación en auto-eficacia en el uso de preservativos que las mujeres hiper-femininas. Las mujeres de hiper-feminidad alta también presentaron más experiencias de abuso verbal y más experiencias sexuales coercitivas, pero no experiencias sexuales forzadas que las mujeres de baja hiper-feminidad. Los resultados también indican que las mujeres de alta hiper-feminidad eran más impulsivas y tenían actitudes más favorables hacia el alcohol que las mujeres de baja hiper-feminidad. Además las mujeres de alta hiper-feminidad presentaron mayor consumo de alcohol que las mujeres de baja hiper-feminidad.

En general las diferencias entre las mujeres de alta y baja hiper-feminidad indican que una evaluación adicional de este constructo podría proporcionar más información para las intervenciones preventivas en áreas de VIH y posiblemente en la prevención de la discriminación.

HYPERFEMININITY, HIV RISK BEHAVIOR, AND VICTIMIZATION AMONG COLLEGE AGED FEMALES

Among adults and adolescents, the following three HIV exposure categories continue to account for nearly all cases of AIDS: men who have sex with men (35%), injecting drug use (24%), and heterosexual contact with a person who is in a high-risk group or has HIV/AIDS (13%) (CDC, 1997). However, AIDS incidence is increasing more rapidly among heterosexuals than among the other two transmission categories with the estimated AIDS incidence among people infected heterosexually increasing 17% from 1993 to 1994 (CDC, 1996). HIV Awareness has increased with prevention efforts (Feucht, Stephens, & Gibbs, 1991) and needle use seems to have decreased by HIV prevention interventions (Brown & Minichiello, 1994; CDC, 1994; 1997). Sexual behavior, however, has been more difficult to target for prevention interventions, among drug users and college students (Brown & Minichiello, 1994; CDC, 1990; Needle & Coyle, 1997).

Amaro (1995) suggests that current prevention models of HIV risk behavior are based on assumptions that limit the usefulness of understanding and changing HIV risk behavior, especially sexual behavior. The main assumptions that Amaro (1995) proposes which are the most detrimental in understanding and changing risk behaviors are: (1) sub-cultural norms, forces, and expectations in the individual's network and specific situational factors are not taken into account; (2) most models are based on the assumption that risk behaviors and encounters are totally under the control of the individual which ignores the possibility that some behaviors are imposed (i.e., victimization); and, (3) gender roles often define the behavior of males and females and the interpersonal relationships in which risk behavior may occur.

The third assumption—gender roles—has been focus ongoing of research. For example, developmental studies suggest that gender roles are defined by socialization or social reinforcement (Ehrhardt & Wasserheit, 1991). Other studies have shown that boys are more likely to use physical dominance than girls; while girls are more likely to use verbal persuasion than boys in conflict situations (Charlesworth & Dzur, 1987; Jacklin & Maccoby, 1978; Maccoby, 1988). These different conflict resolution styles between genders can place girls at a disadvantage in conflictual encounters with boys. Research on gender roles also indicates that traditional gender-role socialization is associated with being dependent

and passive in addition to being sex objects (Weis & Borges, 1973). Research findings indicate that internalizing feminine gender roles may lead women to deal ineffectively with sexually coercive men and to be passive in relationships which can predispose women with traditional gender role beliefs to be susceptible to victimization (Amick & Calhoun, 1987; Muren, Perot, & Byrne, 1989).

A growing number of researchers recognize that gender differences may be a barrier to changing HIV risk behavior. For example, Ehrhardt and Wasserheit (1991) noted that gender roles are important modifiers in how sexual encounters are negotiated and who determines which sexual practices will prevail. For women, protecting themselves from the heterosexual spread of HIV can require negotiating and persuading a male partner to use a condom, which may be more difficult for women who adhere to traditional gender roles (Amaro, 1995). Understanding the values, beliefs, and practices related to gender roles is critical for HIV prevention interventions in order to target behavior change in males and females (Amaro, 1995).

Muren, Perot, and Byrne (1989) reported that women who adhered to traditional gender roles were unable to communicate disinterest in unwanted sex, blamed themselves if they experienced it, and continued in adversarial relationships (Murnen, Perot, & Byrne, 1989). Murnen and Byrne (1991) developed an inventory to measure adherence to stereotypic feminine gender roles, which they called hyperfemininity. The concept was originally developed with the idea that "...the hyperfeminine woman believes that her success is determined by developing and maintaining a relationship with a man and that her primary value in a romantic relationship is her sexuality; hyperfeminine women use their sexuality to obtain the goal of relationship maintenance" (Murnen & Byrne, 1991, p. 481). McKelvie and Gold (1994) hypothesized that a hyperfeminine woman was manipulative and willing to break social rules and norms in order to further their "main" goal of establishing or maintaining a relationship. They also hypothesized that because the hyperfeminine woman believes her sexuality is her primary commodity, she would behave most unconventionally sexually including showing antisocial tendencies, permissible sexual attitudes, early and coercive sexual experiences, and not using nor requesting that her partner use sexual protection. In fact, McKelvie and Gold's (1994) indicated that high hyperfeminine women, when compared to lower hyperfeminine women, were more supportive of traditional feminine gender roles, reported more

acceptance of adversarial sexual behavior (when responding to fictitious scenarios), and were more likely to endorse rape myths. They also reported that higher hyperfeminine women had more non-consensual sexual experiences (i.e. sexual victimization) than lower hyperfeminine women.

The goal of the current study was to further clarify the relationship of hyperfemininity to victimization and HIV risk behavior. It was hypothesized that hyperfeminine women would exhibit higher HIV risk behaviors, specifically, that higher hyperfeminine women would report more sexual partners in the previous 3 months, use condoms less often in the previous 3 months, and use more drugs and alcohol during sexual intercourse than lower hyperfeminine women. A second main hypothesis was that hyperfeminine women would report experiencing more victimization experiences, specifically more verbal, physical and sexual victimization experiences than lower hyperfeminine women.

METHOD

Participants

Participants were 372 females with an average age of 19 who volunteered for research credit in their Introductory Psychology class at a medium sized southeastern university. Of the total sample, approximately 97% reported their sexual preference as heterosexual, 32% (n=119) reported never having had sexual intercourse, and of those who reported ever having sex, 79% (n=200) reported having sexual intercourse in the previous 3 months. Also, of those who reported ever having sexual intercourse, 78% had oral sex in the previous 3 months.

MEASURES

Participants were given one of two forms of the questionnaire in order to facilitate privacy. The questionnaire included the following measures: (1) hyperfemininity; (2) verbal and physical victimization; (3) consensual and non-consensual sexual experiences; (4) HIV risk behavior; (5) STDs; (6) condom self-efficacy; (7) alcohol attitudes; (8) alcohol use; and, (9) impulsivity.

The hyperfemininity scale was adapted from Murnen and Byrne (1991). This scale was developed to measure adherence to traditional gender roles. Murnen and Byrne (1991) recommended that one factor was most parsimonious with the hyperfemininity scale. The original scale was forced choice response format. However, Sudman & Bradburn, (1982) indicate likert scales are easier for respondents and provides a more valid response format. Thus, a likert scale response format developed and administered to a separate group of female college students. Results of that pilot study indicated the correlation between the original forced choice and the likert format (1=strongly disagree to 5=strongly agree) of the hyperfemininity scale was .71 for 117 college age females. For the current study the Alpha coefficient of internal consistency for the 51-item likert hyperfemininity scale was .87 which was higher than the Alpha coefficient for the hyperfemininity scale that Murnen and Byrne (1994) reported in the development of the scale which was .76. Specific items included: I like to flirt with men; I would rather be a famous fashion model than a famous scientist; I would agree to have sex with a man if I thought I could get him to do what I want; Sometimes I cry to influence a man; and Sometimes women need to make men feel jealous so they will feel more appreciative.

The Conflict Tactics Scale (Straus, 1990) was developed to assess verbal and physical victimization by asking whether or how often a specific behavior occurred. For the current study, 19 items were included in the questionnaire and were coded as yes or no depending on whether the event occurred in the past year. The items included: Your partner insulted or swore at you; Your partner stomped out of the room; Your partner threw something at you; Your partner pushed, grabbed, or shoved you; Your partner beat you up; and, Your partner threatened you with a knife or gun. Alpha coefficient of internal consistency for the total scale was .77. This scale was divided into two main subscales recommended by Straus and Gelles (1990): verbal and physical abuse.

The Sexual Experiences Survey (Koss, Gidycz, & Wisniewski, 1987; Koss & Oros, 1982) consisted of 13 dichotomous questions about consensual and non-consensual sexual experiences. Items range from asking the person if she had ever been in a situation where she had intercourse with a man even though she didn't want to because he threatened to end the relationship, to asking about rape. If a respondent had encountered the experience since 16 years of age, she was asked to answer yes. The Alpha coefficient for this scale was .80. This scale was also divided into two sub-

scales for analysis: (1) sexual coercion; and, (2) non-consensual or forced sexual experiences.

HIV risk behavior questions included: condom use (1=always or almost always to 5=never), age of first intercourse (1—under 16, 2—16, 3—17, 4—18, 5—19 or older), oral and anal sexual practices in the previous 3 months (yes/no), number of sexual partners in the last 3 months (0=0, 1=1, 2=2, 3=3, 4=3+partners), whether the participant use drugs or alcohol before or during sex (1= never to 5=always or almost always), and if the respondent had ever been treated for: venereal/genital warts, chlamydia, genital herpes, or gonorrhea (yes/no). The STD questions were combined into one overall index. Subjects were also instructed to skip questions that did not apply to them (e.g., if they had never had sexual intercourse).

The condom self-efficacy scale was adapted from Brafford & Beck (1991) and had 26 items with an Alpha coefficient of .92. The condom self-efficacy scale was developed to measure expectations in all the various aspects of obtaining, using, disposing of, and negotiating the condom use with a sexual partner. The 5-point response scale ranged from 1=strongly disagree to 5=strongly agree. This scale included the following items: I would feel embarrassed to put a condom on my partner; If I were to suggest using a condom to a partner; I would feel afraid that he would reject me; I feel confident in my ability to put a condom on a partner quickly; I feel confident that I would remember to use a condom even if I were high; and, I feel confident in my ability to discuss condom usage with any partner I might have.

The alcohol attitudes scale was adapted from Harrington, Brigham, & Clayton (1997) and was originally used to assess alcohol attitudes and beliefs for college age males and females in sororities and fraternities. There are 33 items and the Alpha coefficient was .86. The Alpha coefficient for the alcohol attitudes subscale was .92 and the Alpha coefficient for the alcohol beliefs subscale was .62. The items included: It is never o.k. to get drunk, even to celebrate something special; I believe that getting drunk for kicks is just a part of being young; A person who doesn't drink at all is not fun to be with; People become alcoholic because they cannot deal with problems; Alcoholism is caused by moral weakness; Alcoholism is caused by heredity; and, Having a few drinks is a good way to calm down when a person is angry. Response categories ranged from strongly disagree to strongly agree (1-5).

Alcohol use was adapted from Harrington et al. (1997) and consisted of 4 items. The first question asked how much a person typically drinks

when they drink alcohol (1-- 1-3 drinks at a time; 2-- 4-6 drinks at a time; 3-- 7-12 drinks at a time; 4-- 13 or more drinks at a time). The second question asked how many days in the previous month they drank the amount of alcohol they reported in the first question (0-- did not drink in the previous 30 days; 1-- on 1 to 4 days; 2-- on 5 to 9 days; 3-- on 10-19 days; 4-- on 20+ days). The third question asked how many times in the previous month they got very drunk (0—drank but did not get drunk in the previous 30 days; 1—daily, 2— just one or two times in the previous month, 3—1 or 2 days a week, 4 —almost daily). And, the fourth question asked at what age they were when they began drinking alcoholic beverages once a month or more often (0—don't drink once a month or more, 1—under 16, 2—16, 3—17, 4—18 or older).

The Impulsivity scale was adapted from Eysenck & Eysenck (1977,1978). The Alpha coefficient for this scale was .84 and there were 19 yes/no items. This scale was developed to measure how impulsive a person typically is. Specific items included: Do you often buy things on impulse; Are you an impulsive person; Do you often get involved in things you later wish you could get out of; and, Do you mostly speak before thinking things out.

PROCEDURE

After the study was described, participants were asked to read, sign, and date an informed consent form if they wished to participate in the study. The consent forms were then returned. After the consent forms were collected, the questionnaires were distributed. After each person completed their questionnaire, she was given a debriefing sheet and a referral sheet listing various professional organizations to contact for more information or support if needed. All questionnaires were administered in a group setting. However, because of the sensitive nature of the questions, participants were asked to sit with at least one seat between them. Also, two forms of the questionnaire were used in order to facilitate privacy.

RESULTS

Initial correlations for the total sample variables were computed. Base rates for the total sample and group differences were then examined for

higher hyperfeminine women and lower hyperfeminine women on: individual difference variables, alcohol use, HIV risk behavior, and victimization.

Correlations

Table 1 presents the correlations for hyperfemininity, HIV risk behavior, and victimization for the total sample ($n=371$). Hyperfemininity was significantly related to a composite HIV risk behavior variable which included the number of different sexual partners in the previous 3 months, condom use, STDs, and using drugs or alcohol before having sex. Hyperfemininity was also significantly correlated with verbal and physical victimization and sexual coercion. And, each of the victimization measures were significantly correlated with the composite HIV risk behavior measure except forced sexual victimization and verbal victimization.

Differences for Higher and Lower Hyperfemininity Women

To further examine the relationship of hyperfemininity and HIV risk behavior as well as victimization. Participants were partitioned into two groups: (1) those who scored one standard deviation above the mean on the hyperfemininity scale (high hyperfemininity, $n=62$); and, (2) those who scored one standard deviation below the mean on the hyperfemininity scale (low hyperfemininity, $n=54$). Hyperfemininity scale scores ranged from 69 to 193, the scale mean was 128 with a standard deviation of 19. A series of Analysis of Variance (ANOVAs) were used to assess group differences. Results of the ANOVAs are presented below for individual differences, HIV risk behavior, alcohol use, and victimization.

Individual Differences

The overall mean on the impulsivity scale was 6.92 with a standard deviation of 3.95. The overall mean for alcohol attitudes was 41.8 ($SD=12.96$); alcohol beliefs ($M=40.1$, $SD=5.85$); and condom self-efficacy ($M=101.18$, $SD=15.94$). Women who scored high on the hyperfemininity scale were significantly more impulsive and reported significantly more favorable attitudes toward alcohol as well as endorsed more traditional alcohol beliefs than women who scored lower on the hyperfemininity

scale (see Table 2). High hyperfeminine women also had significantly lower condom self-efficacy than lower hyperfeminine women.

Alcohol Use

Total sample means for alcohol use were: alcohol quantity ($M=1.7$, $SD=.74$); alcohol frequency ($M=1.35$, $SD=.92$); get drunk ($M=4.15$, $SD=.73$); and, age began drinking once a month or more ($M=1.82$, $SD=1.4$). Table 2 presents the univariate F tests, means, and standard deviations by group for alcohol quantity, frequency, how often they get drunk, and age they began drinking once a month or more. High hyperfeminine women were significantly more likely to report using more alcohol when drank and used alcohol more frequently than lower hyperfeminine women. However, lower hyperfeminine women reported getting drunk significantly more often than higher hyperfeminine women. Both groups of women began regularly drinking alcohol at about the same age (16 years old).

HIV Risk Behavior

High hyperfeminine women were significantly more likely to report ever having had sexual intercourse (89% vs. 57%, $X^2(1)=15.3$, $p<.001$) than lower hyperfeminine women. Of those who reported having had sexual intercourse, high hyperfeminine women were also significantly more likely to report having engaged in heterosexual oral sex in the previous 3 months (84% vs. 57%, $X^2(1)=7.9$, $p<.01$) than lower hyperfeminine women. However, there were no differences between the two groups in anal sex in the previous 3 months (14% vs. 10%).

Group means and standard deviations overall for HIV risk behavior include: number of different sexual partners last 3 months ($M=1$, $SD=.85$); condom use ($M=2.92$, $SD=1.79$); age of first sexual intercourse ($M=2.4$, $SD=1.23$); and, using drugs and/or alcohol before and during sexual intercourse ($M=1.87$, $SD=1.04$). Group means, standard deviations, and univariate F values are presented in Table 3 for: the number of different partners in the last 3 months, condom use, using drugs or alcohol during sex, and age of first sexual intercourse. Both groups were as likely to report having had only one sexual partner in the previous 3 months, as likely to report using condoms about half the time when having sex in the previous 3 months, and to have initiated sexual intercourse

when they were about 16 years old. However, women who scored higher on the hyperfemininity scale were significantly more likely to report using drugs or alcohol before or during sex than women who scored lower on the hyperfemininity scale.

Victimization Experience

Overall victimization rates for the total sample were: 35% (n=130) report at least one physically violent experience (M=.7, SD=1.39); 84% (n=279) reported at least one verbal abuse incident during the relationship (M=2.32, SD=1.44); 33% (n=119) reported at least one incident of sexual coercion (M=.54, SD=.92); and, 21% (n=75) report at least one incident of forced sexual contact (M=.59, SD=1.41).

Univariate Fs and means for each of the victimization variables are presented in Table 4. The univariate Fs indicate that high hyperfeminine women experienced more verbal victimization and more sexual coercion than low hyperfeminine women (e.g., had sex with a man when she didn't really want to because he threatened to end their relationship or because he pressured her with continual arguments). However, physical victimization and sexual victimization (i.e., being raped or forced to perform other sexual behavior) was not different by hyperfemininity group.

DISCUSSION

The literature suggests that gender roles are critical in understanding and changing HIV risk behavior (Amaro, 1995). The current study used a previously constructed scale to measure adherence to traditional gender roles. It was hypothesized that hyperfeminine women would exhibit higher HIV risk behaviors. Specifically, higher hyperfeminine women would report more sexual partners in the previous 3 months, use condoms less often in the previous 3 months, and use more drugs and alcohol during sexual intercourse than lower hyperfeminine women. Results of differences between higher and lower hyperfeminine women and HIV risk behavior were somewhat complex. Results from this study indicate that hyperfeminine women were more likely to have ever engaged in sexual intercourse, more likely to have engaged in oral sex in the previous 3 months, and were more likely to have used drugs or alcohol before sexual intercourse than lower hyperfeminine women. However, the

number of sexual partners in the previous 3 months and condom use in the previous 3 months were not significantly different for higher and lower hyperfemininity women. Also, both groups of women initiated sexual intercourse at similar ages and, there were no differences in the incidence of STDs between groups.

One possible reason for not finding differences between higher and lower hyperfeminine women for the number of sexual partners and condom use in the previous 3 months, is that the time frame may not have been long enough to capture more than one sex partner for this age group. The number of lifetime partners was not assessed in this study. Knowing the number of lifetime partners could have clarified HIV risk behavior differences. Further, both groups of women reported using condoms about half the number times they had sex. At least one study has suggested that it is not a norm among the college aged heterosexual population to use condoms (Lear, 1996). Further, because both groups of women reported having about one partner in the recent past, respondents may not have perceived the need for protected sexual intercourse. Regardless, results from this study indicate that high hyperfeminine women may have the potential of engaging in higher risk behaviors over their lifetime, particularly considering that higher hyperfeminine women were more likely to have ever had sex, and more likely to have used drugs or alcohol before sexual intercourse. The use of drugs and alcohol before sex has been associated with having more sexual partners and unprotected sex (Jemmott & Jemmott, 1993; Simkins, 1995).

Results also indicate that higher hyperfeminine women were more impulsive and had more favorable attitudes and beliefs toward alcohol than lower hyperfeminine women. In addition, higher hyperfeminine women reported drinking more alcohol and drinking more often than lower hyperfeminine women. However, high hyperfeminine women did not report getting drunk more often than lower hyperfeminine women. This might suggest that high hyperfeminine women might feel they have more control over their drinking than lower hyperfeminine women. Consequently, these attitudes may dispose higher hyperfeminine women to riskier behaviors after transitioning out of college and suggests that hyperfemininity may be important to consider across the lifecourse. Future research could also examine hyperfemininity with other risk behaviors such as drug use and delinquency, as well as, with other constructs such as sensation seeking to further clarify the hyperfemininity construct and differences among those with high and low hyperfemininity.

The second main study hypothesis was that hyperfeminine women would experience more victimization specifically more verbal, physical and sexual victimization experiences than lower hyperfeminine women. Previous research reported hyperfeminine women were more likely to have non-consensual sexual experiences (McKelvie & Gold, 1994). The current study expanded the type of victimization examined with hyperfemininity by including verbal, physical, and sexual victimization as well as sexual coercion measures. Results from this study indicate that high hyperfeminine women reported more verbal victimization and sexual coercion experiences, but not physical victimization or forced sexual experiences. McKelvie and Gold (1994) indicated that hyperfeminine women were more likely to be attracted to hypermasculine men, and that attraction may put them at more risk for victimization experiences. Mosher & Sirkin, (1984) hypothesized that hypermasculine men have more callused attitudes toward sex and that sexual intercourse with women establishes their masculine power and female submission. If the high hyperfeminine women are more likely to date hypermasculine men, then victimization experiences, like those found in this study to be higher for hyperfeminine women--verbal and sexual coercion, may be attributed to the type of males they date. Because this study did not include information about partners the women in the study dated, it is difficult to discuss this hypothesis.

There was a relatively high rate of intimate violence reported by study participants, which is alarming. In addition, each of the victimization measures were significantly correlated with each other, and were correlated with HIV risk behavior as well as with hyperfemininity (except for forced sexual experiences). This is an area that needs further examination, primarily because this finding suggests that hyperfeminine women may be at more risk of encountering future physical and sexual victimization. In other words, the finding that higher hyperfeminine women experience more verbal abuse and more sexual coercion experiences combined with more positive attitudes toward alcohol, more overall alcohol use, and the use of more alcohol before sex may predispose these women to riskier situations including victimization, in the future as they encounter more sexual partners. Differences between higher and lower hyperfeminine women indicate a further examination of hyperfemininity could be informative for HIV prevention interventions, and potentially for preventing victimization. For example, it could be informative to examine whether high hyperfeminine women are more likely to experi-

ence other types of victimization such as sexual harassment and/or stalking than lower hyperfemine women.

IMPLICATIONS

One implication from this study is that HIV prevention interventions should target women with traditional gender roles because these women may be at greater risk of HIV as well as victimization, and, that HIV risk behavior may be related to victimization experiences. However, examining or understanding that individuals differ in adherence to traditional gender roles provides little information about changing HIV risk behavior or other behavior. In other words, developmental studies suggest that women are more passive in relationships while men are more aggressive (Charlesworth & Dzur, 1987; Jacklin & Maccoby, 1978; Maccoby, 1988). For women, protection from HIV during sexual encounters requires communication and negotiation skills to convince their partners to use condoms (Amaro, 1995). Thus, many HIV prevention interventions focus on communication skills, assertiveness, and AIDS education (Kelly, 1995). However, several studies suggest that even when women learn to communicate effectively, are assertive, have a high sense of condom self-efficacy, and understand why it is critical to use condoms; they still do not change their behavior (Institute of Medicine, 1994; Hankins & Handley, 1992).

This study suggests that targeting subgroups of individuals is important, but understanding why subgroups engage in certain behavior may be critical to facilitate behavior change. It may not be enough to simply understand that hyperfeminine women are more at risk of engaging in riskier sexual behavior or more victimization experiences, but understanding why hyperfeminine women are different may be a key to developing behavior change approaches. For example, one hypothesizes that could be examined is that hyperfemininity is associated with gender roles, but it is also related to sexual motivation. When hyperfemininity is examined carefully, the construct appears like it may also be a measure of sexual "goals" as well as adherence to traditional gender "roles". Hill and Preston (1996) suggest there are eight motives a person may have for engaging in sex: (1) feeling valued by one's partner; (2) showing value for one's partner; (3) obtaining relief from stress; (4) providing nurturance to one's partner; (5) enhancing

feelings of personal power; (6) experiencing the power of one's partner; (7) experiencing pleasure; and, (8) procreation. If protected or unprotected sex is driven by sexual motives and gender roles, this could have major implications for HIV prevention interventions. For example, if a woman's primary sexual motive is gaining power; power may be lost when she asks her partner to use a condom since it is primarily the male decision whether to use a condom (Amaro, 1995). Likewise, if a woman's main goal of sex is to establish and/or maintain a relationship, asking her partner to use a condom may not be perceived by her as facilitating that goal. Thus, if sexual motives drive sexual behavior, an alternative focus for HIV prevention intervention could be to examine dispositional sexual motives that determine sexual behavior and how to target and change motives so that the goals are accomplished safely without expecting a person to give up adherence to traditional gender roles. The implications for prevention interventions would be to focus on motives for using condoms during sex and how these motives be can targeted and changed to become more important within specific gender roles, or at least equally as important, as sexual motives.

In summary, Amaro (1995) believes that current models of HIV risk behavior prevention interventions are based on assumptions that limit the usefulness of understanding and changing HIV risk behavior, especially sexual behavior. These assumptions include the socialization of women to traditional gender roles. Consequently women are more vulnerable to victimization which could impact HIV risk behavior (e.g., rape), norms, and expectations consistent with socialized gender roles that render women less powerful in negotiating protected sex. By incorporating gender role information and targeting gender role beliefs, HIV prevention interventions could better target behavior change. However, hyperfemininity in this study has a complex relationship to HIV risk behavior, was highly related to impulsivity and alcohol use, and was related to verbal victimization and to sexual coercion. Examining the relationship between hyperfemininity with both college age and working women may be critical for understanding hyperfemininity over time. Further, examining hyperfemininity with other individual difference constructs such as sensation seeking, as well as behavior differences is an area for future research. Hyperfeminine women could be more susceptible to HIV risk behavior and victimization as reported in this study.

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TABLE 1
HYPERFEMININITY, HIV RISK BEHAVIOR, AND VICTIMIZATION
CORRELATIONS

	1	2	3	4	5	6
1. Hyperfemininity	1					
2. HIV Risk Behavior	.14*	1				
3. Verbal Victimization	.18**	.21**	1			
4. Physical Victimization	.15**	.23**	.43**	1		
5. Sexual Coercion	.23**	.25**	.31**	.28**	1	
6. Forced Sexual Victimization	.05	.20**	.09	.18**	.41**	1

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

TABLE 2
INDIVIDUAL DIFFERENCES, ALCOHOL ATTITUDES, AND ALCOHOL USE

	MEANS (STANDARD DEVIATIONS)		DF	F
	HIGH	LOW		
	HYPERFEMININE (N=62)	HYPERFEMININE (N=54)		
Impulsivity	9.4 (4.4)	5.8 (3.9)	1,114	21.3***
Condom				
Self-Efficacy	100.7 (16.2)	106 (16.1)	1,103	3.1*
Alcohol Attitudes	50.9 (13.2)	31.9 (11.1)	1,114	69.3***
Alcohol Beliefs	40.7 (6)	37.3 (6.1)	1,114	9.3***
Quantity of				
Alcohol Use	1.93 (.78)	1.58 (.73)	1,100	5.3*
Frequency of				
Alcohol Use	1.58 (1)	1.14 (1)	1,99	4.6*
Drunk	3.94 (.76)	4.31 (.86)	1,88	4.4*
Age of Regular				
Alcohol Use	2.2 (1.4)	1.65 (1.5)	1,97	2.9

* $p < .10$ ** $p < .05$ *** $p < .001$

TABLE 3
HIV RISK BEHAVIOR

	MEANS (STANDARD DEVIATIONS)		DF	F
	HIGH	LOW		
	HYPERFEMININE (N=62)	HYPERFEMININE (N=54)		
# of Different Partners Last 3 Months	1.3 (.99)	1 (.87)	1,83	2.5
Use Drugs or Alcohol During Sex	2.24 (1.2)	1.57 (.73)	1,72	6*
Use Condoms	3.1 (1.8)	3.1 (1.97)	1,69	.05
Age of First Sexual Intercourse	2.27 (1.2)	2.24(1.2)	1,88	.02

*p<.05

TABLE 4
VICTIMIZATION EXPERIENCE

	MEANS (STANDARD DEVIATIONS)		DF	F
	HIGH	LOW		
	HYPERFEMININE (N=62)	HYPERFEMININE (N=54)		
Verbal Victimization	2.78 (1.2)	2.1 (1.6)	1,99	5.7*
Physical Victimization	1 (1.5)	.65 (1.2)	1,110	.05
Sexual Manipulation	.77 (1)	.38 (.81)	1,110	4.7*
Sexual Victimization	1 (1.87)	1.1 (1.75)	1,103	1.96

*p<.05