THE INFLUENCE OF SELF-ESTEEM AND SELF-SILENCING ON
SELF-EFFICACY FOR NEGOTIATING SAFER SEX BEHAVIORS IN
URBAN BAHAMIAN WOMEN

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Shane L. Neely-Smith

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DISSERTATION
by
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2003

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DEDICATION

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ABSTRACT

The Influence of Self-Esteem and Self-Silencing on Self-Efficacy for Negotiating Safer Sex Behaviors in Urban Bahamian Women

Shane L. Neely-Smith

Barry University, 2003

Dissertation Chair: Dr. Carol (Pat) Patsdaughter

The rapidly increasing rate of HIV/AIDS among Bahamian women is daunting for the future of Bahamian society. Despite many concerted efforts, scientists are unable to find a cure for HIV disease and are faced with the multiple challenges that treatment and management strategies bring for persons living with AIDS. As a result, there is a major focus on HIV prevention. The purpose of this study was to understand the characteristics that put urban Bahamian women at risk for HIV/AIDS so that gender appropriate and culturally sensitive prevention interventions could be developed and implemented.

A cross-sectional, correlational survey design was used to study the relationships between select demographic variables (i.e., age, income, education), self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors in urban Bahamian women. Data were collected from urban Bahamian women (N = 661) ages 18 to 78 years from a variety of community sites in Nassau, Bahamas. Data were collected using an 80-item anonymous questionnaire which included: (a) The 16-item Taylor’ Self-Esteem Inventory (TSEI) (Taylor & Tomasic, 1996); (b) The 31-item Silencing The Self Scale (STSS) (Jack & Dill, 1992); (c) The 12-
item Self-Efficacy Scale (SES) to measure self-efficacy for negotiating safer sex behaviors (Dilorio et al., 1997); and (d) demographic and background questions.

Hypothesis testing was conducted using Pearson product-moment correlation coefficients (r) and logistic regression analyses, which revealed mixed results. Three of four hypotheses were supported, and the fourth hypothesis was partially supported. Self-esteem and self-silencing were negatively correlated ($r = -.56, p < .01$), self-esteem and self-efficacy for negotiating safer sex behaviors in urban Bahamian women were positively correlated ($r = .22, p < .01$), and self-silencing and self-efficacy for negotiating safer sex behaviors in urban Bahamian women were negatively correlated ($r = .15, p < .01$). Additionally, age ($OR = 1.02, 95\% CI = 1.01-1.04$), education ($OR = 1.10, 95\% CI = 1.00-1.20$), and self-esteem ($OR = 1.03, 95\% CI = 1.02-1.04$) were significant independent and combined predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women.

The results of this study suggest that in addition to being gender appropriate and culturally sensitive, HIV prevention interventions developed and implemented for Bahamian women should also be tailored with respect to age and educational level and address self-esteem enhancement. Future research should include replication of this study with rural Bahamian women, urban and rural Bahamian men, and urban and rural Caribbean adolescents as well as evaluation of theory-based self-esteem and skills building HIV prevention interventions.
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CHAPTER I
INTRODUCTION

Background of the Study

Bahamian women were at risk for acquiring HIV-infection from the time it was first discovered in The Bahamas in 1985 since the virus has primarily been spread through heterosexual transmission in Caribbean countries. In fact, the first case of HIV/AIDS in The Bahamas was discovered during an autopsy of a female cadaver (Gomez, 2002). As in most of the world, women in The Bahamas represent the fastest growing segment of the population with HIV/AIDS. Moreover, HIV/AIDS is the leading cause of death for Bahamian men and women between the ages of 15 and 44 years (American Foundation for AIDS Research [AMFAR], 2001; Campbell, 2001). As of December 31, 2002, The Bahamas had a cumulative number of 9,329 reported cases of HIV/AIDS. Of these cases, 3,120 (34%) have already died, and 4,162 (45%) are women (Health Information and Research Unit, 2003).

Among the hardest hit regions in the world, second only to Sub-Saharan Africa (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2001), The Bahamas has the highest annual incidence of HIV/AIDS in the English Speaking Caribbean (Campbell, 2001). The Bahamas continues to report almost 400 new cases of HIV per year in a population of just over 304,000, of which 51% are women (Department of Statistics, 2001). The large number of new cases, coupled with unreported cases, suggest a daunting future for Bahamian women and Bahamian society at large. Although the Bahamian government responded very early to the threat of HIV/AIDS with the establishment of a National HIV/AIDS
program to address the epidemic through surveillance, public education, blood banking, and research, Bahamian women continue to have an increasing rate of HIV infection (Campbell, 2001).

Unable to find a cure for HIV/AIDS, researchers have focused their attention on prevention efforts by identifying risks factors (Cummings, Battle, Barker, & Krasnovsky, 1999; Deren, Shedlin, & Beardsley, 1996; Kusseling, Shapiro, Greenberg, & Wenger, 1996; Pulerwitz, Gortmaker, & DeJong, 2000) and developing prevention interventions (Card, Benner, Shields, & Feinstein, 2001; Dancy, 1996; John Hopkins AIDS Service, 2002; Morin & Charlebois, 2000). Despite these numerous efforts, HIV rates in women all over the world continue to escalate.

Global health organizations such as UNAIDS, World Health Organization (WHO), and the Centers for Disease Control (CDC) have developed and disseminated social policies and preventive strategies to decrease the HIV acquisition rate and prevent transmission among women in countries around the world. However, these strategies have been found to be unsuccessful in many countries where they were adopted. Scientists soon shifted their efforts to address gender and cultural issues such as those that influence women’s personality and behaviors and increase their risks for HIV/AIDS (Amaro & Raj, 2000).

As a part of the early response in The Bahamas to the HIV/AIDS pandemic, national initiatives to enhance public knowledge concerning HIV/AIDS were established. However, research initiatives have mainly focused on preventing mother to child transmission (MTCT) through the availability of antiretroviral
drugs and discouragement of breastfeeding among HIV-infected mothers. While this prevention initiative has shown success by decreasing the MCTC rate from 30% to 10% (Campbell, 2001), the rate of new HIV infection cases is rapidly rising among Bahamian women.

There has been a paucity of research conducted in The Bahamas related to HIV/AIDS. The few HIV/AIDS studies conducted in The Bahamas have mostly been related to ongoing drug trials (e.g., ACTG 076) (Campbell, 2001) and trends of HIV/AIDS, genital ulcer disease (GUD), and crack cocaine use (Bauwens et al., 2002; Gomez, Bain, & Read, 1992; Gomez et al., 2002). One study assessed the characteristics of HIV-infected pregnant women between 1990 and 1991 to determine associative risk factors for HIV/AIDS (Gomez, Bain, Major, Gray, & Read, 1996). However, few studies have addressed the characteristics of Bahamian women that may or may not put them at risk for HIV/AIDS.

The Bahamas, like most other developing countries, depends on scientific data pertaining to HIV/AIDS gathered from other countries such as Canada, the United Kingdom, and the United States to establish national prevention initiatives. Although Bahamians in general and Bahamian women in particular are usually exposed to a cadre of HIV/AIDS educational programs through church meetings, school meetings, professional clubs, and other social gatherings as well as in the work environment and through media, new cases of HIV among Bahamian women continue to be reported.
Prevention initiatives adopted from other countries are not reducing acquisition and transmission of HIV/AIDS among Bahamians in general or Bahamian women in particular. As a result, the healthcare and social system have suffered the burden caused by escalating numbers of HIV-infected individuals, lack of healthcare and socioeconomic resources, and limited numbers of available healthcare professionals, particularly nurses. As stated by Gomez, Director of the National AIDS program in The Bahamas, “…and unless we stem this disease, there will be severe socioeconomic impacts” (AMFAR, 2001, p. 1).

In addition to childbearing, women have the roles of caregiving and childrearing in The Bahamas. Moreover, the majority of Bahamian children are raised solely by their mothers. Therefore, infection with HIV/AIDS negatively impacts these women’s roles resulting in decreased quality of life not only for infected women but (also) for their children and spouses (Neely-Smith, 2002).

Statement of Purpose

The beliefs that prevention is paramount in the fight against HIV/AIDS and that the most effective ways to prevent HIV are to identify risk behaviors are shared globally by numerous researchers (Amaro & Raj, 2000; Jenkins, 2000; Malow, Cassagnol, McMahon, Jenning, & Roatta, 2000; Quirk & DeCarlo, 1998). However, holistic prevention approaches must be undertaken to include gender and culturally specific strategies to enhance effective interventions (Amaro & Raj, 2000; Centers for Disease Control and Prevention [CDC], 1995).

In an effort to develop and implement gender and culturally specific prevention interventions for Bahamian women, it is imperative to understand the
factors that may enhance or impede their self-efficacy for negotiating safer sex behaviors. Numerous qualitative and quantitative studies from other countries have already addressed women’s risk factors for HIV/AIDS. Most have purported that women’s risk for HIV from heterosexual transmission is directly related to culture, gender, and race/ethnicity factors (Beadnell, Baker, Marrison, & Knox, 2000; Brunswick et al., 1993; Dolcini, Catania, Choi, Thompson Fullilove, & Coates, 1996; Erickson, 1997; Malow et al., 2000; Nyamathi, Flaskerud, & Leake, 1997; Oliva, Rienks, & McDermid, 1999; Roberts, 1999; Rose, 1995; Ruangjiratain & Kenall, 1998; Salgado de Snyder, Diaz Perez, & Maldonado, 1996; Schieman, 1998; Simoni, Walters, & Nero, 2000; Weir, Roddy, Zekeng, Ryan & Wong, 1998; Williams, 1991; Wyatt et al., 2000). Although researchers have been investigating concepts and behaviors such as self-esteem (Anderson, 2000; Fife & Wright, 2000; Oxley, 2001), self-silencing (DeMarco, Johnson, Fukunda, & Deffenbaugh, 2001; DeMarco, Miller, Patsdaughter, Chisholm, & Grindel, 1998; Koutrelakos, Baranchik, & Damato, 1999), and self-efficacy (Lindberg, 2000; McMahon, Malow, Jennings, & Gomez, 2001; Sharts-Hopko, Regan-Kubinski, Lincoln, & Heverly, 1996), no study has specifically addressed the influence of self-esteem and self-silencing on self-efficacy for negotiating safer sex behaviors in women, and more specifically, in Bahamian women.

Research Questions

The following research questions were posed for this study:

1. Is there a relationship between self-esteem and self-silencing in urban Bahamian women?
2. Is there a relationship between self-esteem and self-efficacy for negotiating safer sex behaviors in urban Bahamian women?

3. Is there a relationship between self-silencing and self-efficacy for negotiating safer sex behaviors in urban Bahamian women?

4. What are the relative contributions of select demographic variables (i.e., age, income, education), self-esteem, and self-silencing behaviors to self-efficacy for negotiating safer sex behaviors in urban Bahamian women?

Answers to the above questions will assist nurses and other professionals in The Bahamas and around the world to develop and implement effective gender and culturally specific interventions to reduce the number of HIV/AIDS cases among Bahamian women.

Significance to Nursing

In its position statement, the International Council of Nursing (ICN) (2000) indicated that HIV/AIDS, sexually transmitted diseases (STDs), and women’s health are areas of critical concern for action. Moreover, national nurses’ associations have been urged to participate in sensitizing and educating the public about HIV/AIDS. With over 7 million nurses in the world (Lutzen, 2000), the profession has adopted the framework of “Health for All” by the World Health Organization and, therefore, has been ready to accept the challenges HIV/AIDS has bought upon the global health care system (Hilfinger Messias, 2001).

As a practice of caring (Bishop & Scudder, 1999), professional nursing practice involves the maintenance of health, prevention of illness, restoration of health, and the alleviation of suffering for clients of healthcare. The results of this
study will provide impetus for maintenance of health and prevention of illness (i.e., HIV/AIDS and related illnesses as well as other sexually transmitted diseases) for Bahamian women. Findings from this study will assist nurses and other professionals develop and implement gender and culturally specific interventions for public education and training such as workshops; continuing education for nursing students, nurses, and other healthcare professionals; patient teaching; and social policy development. Indirectly, the results of this study will decrease the stress and strain which exist on the socioeconomic and healthcare system from the overwhelming and increasing numbers of persons living with HIV/AIDS in The Bahamas (AMFAR, 2001).

Since the mid 1980s, nursing has joined other healthcare professions in seeking knowledge about HIV/AIDS through numerous research initiatives (Goldrick, Baigis, Larsen, & Lemert, 2000). Despite these concerted efforts, HIV/AIDS continues to challenge humankind in terms of its diversity in methods of prevention, transmission, and management (UNAIDS/WHO/PAHO, 2000). Although many strides have been made in the international fight against HIV/AIDS, there are still many gaps in the global puzzle of HIV/AIDS. These gaps are mainly due to decreased knowledge concerning personality traits and social behaviors of specific gender and cultural groups and the influence of these variables on HIV risk behaviors. The findings from this study can spawn many other studies related to HIV/AIDS prevention initiative efforts not only in The Bahamas but (also) in other countries around the world. Study findings will fill in a major gap in global HIV/AIDS knowledge and add to the body of nursing
knowledge. Additionally, findings will bring The Bahamas and the rest of the world one step closer to conquering the war against HIV/AIDS.

Theoretical Framework

*Overview*

Although Bahamian women share similarities with other women around the world and Caribbean women in particular, they share only among themselves the unique experience of being Bahamian women. However, even within the Bahamian experience of being a woman, there are differences. Born and raised in a patriarchal society with embedded racism, sexism, colorism, and classism, history has placed upon Bahamian women traditional practices and cultural mores which greatly influence their personality and behaviors related to their gender roles. Historically, the role of Bahamian women was considered insignificant and at best supportive by elite men. Moreover, beside having less social status by virtue of gender, women were only allowed certain privileges based on their social class level and skin shade or color (i.e., white, colored-light, or black). Since the majority of Bahamian women were Black, they basically fell within the lower-class strata of society (Saunders, 1994).

The 1960s bought on a new meaning to being Bahamian. The victory of a new Black party provided equal opportunities for all Bahamians related to educational and employment privileges. Many Bahamians, especially women, took advantage of new equal opportunities and, as a result, the Bahamian nation rapidly prospered and a heightened sense of pride developed among Bahamians (Beardsley Roker, 2000). Although the rapid change in socioeconomic status and
equal opportunity provided a better outlook for Bahamian women, historical baggage of traditional cultural practices of oppression remained dormant within the psyche of these women, which greatly influenced their personality and behaviors, particularly in the areas of intimacy and relationships (Tertullien, 1976).

In an effort to understand Bahamian women’s personalities and behaviors related to their risk for HIV/AIDS, it is important to gaze through the lens of specific concepts as well as cognitive and behavioral theories related to self-esteem, self-silencing, and self-efficacy. These concepts will form the framework for this study and will be used as a guide to measurement of variables, analysis, and interpretation of findings regarding Bahamian women’s risk of acquiring and transmitting HIV/AIDS.

Theory of Self-Esteem

Self-esteem is considered by many clinical scholars to be the evaluative aspect of the self-concept defined as all aspects of the self, including roles and identities (Adler, 1997; Burke & Reitzes, 1981; Cast & Burke, 2002; Coopersmith, 1967; Wylie, 1961). It is believed that self-esteem is a personality trait that is relatively stable over time and is made up of two dimensions: worth-based self-esteem and efficacy-based self-esteem (Adler, 1997; Coopersmith, 1967; Gecas & Schwalbe, 1983). More importantly, self-esteem is conceptualized on a continuum ranging from high to low implying that persons with high self-esteem are happy, self-loving, and competent individuals who are more able to deal with life stressors. Conversely, individuals with low self-esteem
are less competent, less self-satisfied, and less able to deal with life stressors, resulting in such negative outcomes such as depression, anxiety, jealously, and “bad” judgments (Burke & Stets, 1999; Cast & Burk, 2002; Coopersmith, 1967; Gecas & Schwalbe, 1983; Rosenberg, 1965). In its simplest form, Rosenberg (1965) defined self-esteem as “a favorable or unfavorable attitude toward the self” (p. 15).

The importance of self-esteem as a part of the self-concept is supported by the fact that there has been extensive study of self-esteem by many disciplines (Corning, 2002; Fife & Wright, 2000; Flaskerud & Uman, 1996; Geller, Srikameswaran, Cockell, & Zaitoff, 2000; Heatherton & Polivy, 1991; Miyamoto et al., 2001; Peden, Hall, Rayens, & Beebe, 2000; Riccierdelli & McCabe, 2001; Roberts & Kendler, 1999; Stanley & Murphy, 1997). However, it is important to view self-esteem within the context of how an individual develops and maintains self-esteem, which is beneficial to self and society at large.

Expanding on identity theory, defined as “giving meaning to the self in a social role or situation” (Burke & Stets, 1999, p. 348), Cast and Burke (2002) developed a theory of self-esteem by integrating the three conceptual ways it has been investigated: outcome, buffer, and motive. According to Cast and Burke (2000), one gains self-esteem through the process of self-verification. Self-verification occurs when there is a match between meaning in the social situation and one’s identity.

Since self-verification is essential to the production of self-esteem, it is important to understand this process. Cast and Burke (2002) stated that:
There are four main conceptual parts to each identity control system: the identity standard, the comparator, the output, and the input. Identity standards provide an internal reference for the individual about the meanings and expectations that are to be maintained. Inputs into the system are the perceptions of self-relevant meanings in the social environment. The comparator compares these perceptual inputs with meanings contained in the standard. The output of the system is meaningful behavior that works to alter the situation so that a match between self-relevant perceptions and the situation and meanings contained in the standard is maintained. This is the self-verification process. (p. 4)

These authors further elaborated:

That the normal operation of a role-identity (self-verification process) results in behavior that produces a match between self-relevant meanings in the situation and the meanings and expectations held in the identity standard. The actions taken to do this constitute the role behaviors of the person occupying the role, and these behaviors enact/create/sustain the social structure in which the role is embedded. Perception of the behaviors that are relevant to the identity the individual is seeking to verify thus become relevant to the verification of that identity. (p. 5)

Stated another way, an individual’s behavior is based on what she or he has identified as the standard behavior in social situations. However, self-verification is only possible when the behavior that the individual displayed matches what another person or group expects the individual’s behavior to be.
With a view of self-esteem as an outcome, Cast and Burke (2002) contended that the process of verification affects all individuals or groups involved and posited that any disturbances in the process will result in negative emotional responses such as anger, depression, and anxiety. An individual’s self-esteem is a composite of worth-based self-esteem and efficacy-based self-esteem. Self-verification reinforces an individual’s feelings of being accepted and valued, which enhances worth-based self-esteem. Therefore, the less accepted an individual feels, the less worth-based self-esteem she or he may have. Efficacy-based self-esteem, on the other hand, results when the individual realizes his or her successful behaviors.

From the standpoint of self-esteem as a buffer, once an individual is able to verify her or his identity with another individual or group, self-esteem is also elevated. Similarly, when he or she is able to alter or control social situations, self-esteem is enhanced. However, when there is a disruption in the self-verification process, self-esteem developed from previous self-verifications will sustain the individual or will act as a buffer during the times of distress but will become depleted if the individual does not seek social situations to enhance self-verification. Although they agreed that self-esteem is highly stable, Cast and Burke (2002) likened self-esteem to a “reservoir of energy.” It will sustain the individual during disrupted self-verification process but will be depleted without continued successful self-verifications. In other words, the more successful self-verifications an individual has, the more self-esteem he or she will have and the better equipped he or she will be to deal with life stressors.
As a motive, Cast and Burke (2002) contended that individuals search for social situations that will enhance their self-esteem. In other words, individuals will seek social situations that are likely to result in successful self-verification, thus increasing self-esteem.

In essence, self-esteem is a positive and important attribute of self-concept that enhances self-worth and competency and equips the individual to deal with life stressors more effectively. Although considered a relatively stable trait, frequent disruptions in the self-verification process can deplete the reservoir resulting in low levels of self esteem and less self-competence, self-satisfaction, and an inability to effectively deal with life stressors. However, an individual develops self-esteem through frequent successful self-verification and by seeking social interactions that are likely to result in successful self-verification between individuals and groups.

For the purpose of this study, self-esteem will be measured using Taylor’s Self-Esteem Inventory (TSEI). This instrument was specifically developed for Black populations, and initial psychometric evaluations were conducted on a group of predominately \( n = 444, 84\% \) low-income, Black women (Taylor & Tomasic, 1996). According to Taylor and Tomasic (1996), self-esteem is the relative level of rewards and costs a person assigns to his or herself. Moreover, a person is presumed to have a high self-esteem when he or she assigns more rewards than costs. Conversely, assigning more costs than rewards to the self will result in low self-esteem. Social exchange theory, which provided the conceptual framework for the TSEI and was developed by Thibuat and Kelly (1959), is a
form of relational theory that basically explains what motivates a person to act. According to social exchange theory, people act by evaluating a given outcome. In other words, weighing the benefits between costs and rewards of an outcome will determine the behavior of an individual. Social exchange theory better explains interpersonal conflicts and why people chose certain relationships or behaviors over others than it does how an individual develops and maintains self-esteem.

Although social exchange theory will not be included in the theoretical framework for this study, the TSEI will be used to measure self-esteem for the following reasons: (a) it was developed for Black populations and initially tested on Black women; (b) it has highly favorable psychometric properties; (c) according to Barrett (1978), the TSEI correlates high with some of the most popular and well-utilized measures of self-esteem (i.e., Rosenberg and Coopersmith inventories of self-esteem) (Adler, 1997), even higher than these instruments correlated with each other; and (d) although the items are grouped in costs and rewards dimensions, they fit better with Cast and Burke’s (2002) theory of self-esteem that explains how individual develops and maintains self-esteem.

Theory of Silencing The Self

Jack (1991) developed the theory of silencing the self to explain how women’s silencing behaviors contributed to their depressive states. While many studies have linked Jack’s theory with depression in women (Brody, Haaga, Kirk, & Solomon, 1999; Carr, Gilroy, & Sherman, 1996; Hart & Thompson, 1996; Thompson, 1995; Thompson, Whiffen, & Aube, 2001; Vaden Gratch, Bassett, &
Attra, 1995), this theory can also be used to explain how women’s low levels of self-esteem may increase self-silencing which may, in turn, put them at risk for HIV/AIDS.

Expanding upon relational theory (Gilligan, 1982), Jack contended that a relationship is so important to women that they will conform to any situation, in this case silencing, to maintain it. Moreover, Jack purported that dependency and passivity are not why women silence, as suggested by men, but rather that women silence because of the value they place on relationship and the need to preserve it. According to Jack (1991), women have many selves, but the self of intimacy is the most important to women’s self-esteem so that loss of this self can lead to depression.

Historically, cultural mores and traditional practices enforced by social context within the home have been responsible for socializing girls to view themselves as inferior to men and weaker than men. Women also put others before themselves, tend to be submissive to men, hide their true feelings if it means hurting others or expressing anger, and always try to help and please others. According to Jack (1991), these cultural practices are so imbedded in the psyche of women that they become women’s “over eye” (i.e., seeing themselves by social and moral standards set forth by society). Jack contended that the “over eye” has such strong influence on women that it cause them to neglect their own values and standards to conform to those of men’s. This is done through the cognitive process of silencing to secure and maintain relationships. By listening to
the “over eye,” women lose their authentic self which results in feelings of anger, frustration, guilt, decreased self-worth, and depression.

Jack (1991) maintained that a woman may silence herself to maintain a relationship that she depends upon to meet her financial needs. Another reason a woman may silence is to protect the self from abuse and hurt within the relationship. Fear of loss and rejection from partners are yet other reasons women engage in silencing behaviors.

Jack (1991) further maintained that listening to the “over eye” results in two opposing selves—the divided self—which is the main cause of depression. To take it a step further, since listening to the “over eye” results in loss of the authentic self, there will be less favorable situations to enhance self-verification for women. As stated in the theory of self-esteem, low self-esteem can lead to frequent disruption in the self-verification process (i.e., silencing) which will deplete the self-esteem “reservoir” and further lower self-esteem. As a result, the individual may experience feelings of decreased self-worth and competency, leading to increased silencing behavior. It is important to note that while self-esteem can affect self-silencing, self-silencing can, in turn, affect self-esteem. However, the bidirectional effect of self-silencing on self-esteem was not tested in this study.

Theory of Self-Efficacy

Social Cognitive Theory (SCT), formally Social Learning Theory (SLT), explains that human behavior is a triadic continuous reciprocal interaction of personal (i.e., cognitive, affective, and biological), behavioral, and environmental
influences. However, the strength of each factor is dependent upon the individual, the behavior in question, and the situated context in which the behavior occurs. Moreover, the individual’s personal characteristics such as age, gender, ethnicity, thoughts, emotions, goals, beliefs, expectations, self-evaluation, and sociocultural factors also influence his or her behavior. Toward this end, people are seen as both products and producers of their environment (Bandura, 1986; 1989).

Bandura (1989) further asserted that the uniqueness of human beings that allows them to engage in cognitive activities to achieve desired behaviors are due to five basic capabilities: symbolizing, vicarious capability, forethought, self-regulation, and self-reflection. Symbolizing consists of words and images that give meaning to experiences and allows humans to store and retrieve information to guide behaviors. Symbolizing capability also allows humans to think about behaviors and outcomes without acting them out. Vicarious capability allows humans to learn behaviors through observation. However, learning will only take place if one is able to pay attention, retain information, and possess ability and motivation to reproduce the behavior. The ability to self-motivate and guide actions through anticipation is forethought capability. In other words, humans are able to cognitively represent the future using present thoughts. The capability of self-regulation is the internal control that determines which behaviors are performed. However, social, motivational, and moral standards interact with self-producing factors to determine chosen behaviors. Self-reflection allows humans to
think about and analyze their experience while modifying their thoughts to achieve desired outcomes.

Self-efficacy, according to Bandura (1986; 1989), is one of the most important types of self-reflection. Moreover, it is a major determinant of self-regulation. It is defined as the self-belief that one is capable and competent in organizing and performing a desired behavior in a given situation. Bandura (1989) asserted that people need more than just knowledge and skills to perform desired behaviors. They need to have self-belief in their ability to exercise personal control. It is their self-belief that affects what people actually chose to do, the effort they put into doing it, their ability to persevere, their positive or negative thought patterns, and the amount of distress they experience during demanding situations.

Bandura (1986) made a clear distinction between self-efficacy and self-esteem. He contended that self-esteem is the evaluation of self-worth, where self-efficacy is concerned with judging personal capabilities; hence, self-efficacy is task and domain specific. The specificity of self-efficacy is reflected by the amount of research studies conducted to either determine the level of task and domain specific self-efficacy people have (Cerwonka, Isbell, & Hansen, 2000; Faryna & Morales, 2000; Goh, Primavera, & Berralini, 1996; Lindberg, 2000; Wulfert & Choi, 1993) or to determine effective task and domain specific interventions to enhance self-efficacy (Clark & Dodge, 1995; Icard, Schilling, & El-Bassel, 1995; McMahon et al., 2001).
According to Bandura (1989), low self-efficacy will cause an individual to mismanage a situation which may result in negative consequences such as stress and depression. To enhance an individual’s self-efficacy, it is important to understand how one gains and loses self-efficacy. The more a person succeeds at performing the desired behavior, the higher or stronger her or his self-efficacy will be. Conversely, the more a person fails at performing the desired behavior, the lower or weaker his or her self-efficacy will be. However, if a person has strong self-efficacy, occasional failures will not have much effect on judgment of their capabilities. It is important to remember that efficacy is task and domain specific so that a person may have a low or weak self-efficacy in one domain of her or his life while also have a strong or high efficacy in another domain. An individual can also gain or lose self-efficacy vicariously by observing others who are comparable to themselves succeed or fail at performing behaviors. However, observing failure by another person who was perceived as competent could result in low self-efficacy for the observer. Verbal persuasion is another way an individual can gain self-efficacy. The caveat is that unrealistic beliefs of personal ability can lead to failure and loss of self-efficacy. Lastly, an individual’s physical state such as agitation, nervousness, and anxiety can cause dysfunction while performing a behavior, resulting in failure and loss of self-efficacy. Bandura (1989) maintained that successive achievements in the desired behavior, “requires strong self-belief in one’s efficacy to exercise personal control” (p. 26).
**Relationship of Theoretical Framework to Study**

Bahamian women’s personalities are shaped by Bahamian cultural mores and traditional practices sanctioned by society and enforced by strong religious faith and parental up-bringing, particularly by their mothers. Historical customs of racism, colorism, classism, and gender inequality have socialized Bahamian girls to view themselves as being inferior to others; to neglect their needs and ensure the needs of others are met; to nurture and care for the family and keep the house; to suppress their true feelings in order not to hurt others; to please their spouses and ensure their spouses’ happiness; to be submissive to their spouses; and to bear their spouses’ children.

There were numerous times in the history of The Bahamas when men had to leave their families in search for work. While some of them returned, others never came back to their families (Saunders, 1994). Always desiring the best for their children, Bahamian women struggled in a man’s world to ensure a roof over their children’s head and food on the table (Tertullien, 1976). More recently, although there are almost as many men as women in The Bahamas, the availability of men, owing to incarceration and other social problems, leave most women to fend alone for their children (Neely-Smith, 2002). Additionally, given the fact that Bahamian men were socialized to prove their manhood by the number of sexual partners coupled with Bahamian women’s need for intimacy and relationship, Bahamian women succumb to spousal sharing (McCartney, 1971). Moreover, Bahamian women conform to female normative behaviors sanctioned by the Bahamian patriarchal society to secure relationships.
Historical and present social context which helped to shape the demographics of Bahamian women have had direct impact on their levels of self-esteem. However, it is believed that instead of Bahamian women seeking social situations that will lead to successful self-verification and, thus, increased self-esteem, they comply with cultural and societal sanctioned female normative behaviors for fear of losing intimate relationships. As a result, they silence themselves and manipulate their internal cognitive structures in hopes of achieving verification from their spouses. However, these women are never truly self-verified because of the battle between the divided self. They display compliant behaviors with their spouses and gain their approval, but self-verification does not occur in women because the process is faulty. Therefore, repeated faulty self-verification processes lead to depletion of these women’s already low self-esteem reservoir, resulting in even lower levels of self-esteem.

It was hypothesized that self-esteem and silencing behaviors affect Bahamian women’s self-efficacy for negotiating safer sex behaviors. Bandura (1989) asserted that decreased risk for HIV requires a sense of personal power and control over sexual relationships. This means having the ability to manage interpersonal relationships, which is believed to be difficult for Bahamian women. Like many women around the world, Bahamian women probably are not able to control sexual relationships for numerous reasons. First, they were socialized to take a passive role during sexual activities. Additionally, Bahamian women deny men’s ability to be unfaithful, and they develop a false trust in an effort not to “rock the boat.” Sometimes these women are over-powered by men and forced to
engage in sexual activities but do not seek help for fear of embarrassment and loss of relationship. Situational constraints such as depending upon men for finances to meet the needs of self and children also hinder these women’s abilities to negotiate in sexual activities. However, it is mostly Bahamian women’s fear of rejection and loss of relationships that lead to their inability to control sexual relationships.

It was believed that Bahamian women who have low self-esteem, high self-silencing, and less self-belief that they have the power to control sexual situations would, therefore, comply to sexual demands of their partners in an effort to please them and secure intimate relationships. This compliant behavior is what put Bahamian women at risk for HIV. Additionally, Bahamian women’s inability to succeed in controlling sexual situations leads to decreased self-efficacy for negotiating safer sex behaviors. It is important to note, that because the predominant mode of HIV transmission in The Bahamas is through heterosexual transmission (96.2%) (Gomez et al., 2002), Bahamian women’s risk for HIV basically lies in their efficacy in negotiating sexual activities.

Only when Bahamian women begin to seek out social and sexual situations that will enhance their self-verification process (i.e., relationship change) will they produce self-esteem to refill the reservoir. It was hypothesized that Bahamian women’s increased levels of self-esteem would lead to a decrease in their silencing behaviors which would directly increase their self-efficacy for negotiating safer sex behaviors. Toward this end, this study sought to understand
the influence that self-esteem and self-silencing have on self-efficacy for negotiating safer sex behaviors in urban Bahamian women (Figure 1).

![Figure 1. Theoretical Model: Influence of Select Demographic Variables, Self-esteem, and Self-silencing on Self-efficacy for Negotiating Safer Sex Behaviors.]

**Assumptions**

For the purpose of this study, it was assumed that:

1. Race and gender inequality are subtly embedded in the minds of most Bahamian women.

2. Older Bahamian women are more submissive in their intimate relationships than are younger Bahamian women.

3. Well educated Bahamian women are more assertive in their intimate relationships than are Bahamian women with less education.

4. Bahamian women with low income are very dependent on their spouses for financial support.
5. Bahamian women care more about others than they do about themselves.

6. Bahamian women have a great need for intimacy and relationship.

7. Bahamian women tend to be very competitive with other women for intimate relationships.

8. Bahamian women tend to be assertive in other aspects of their lives except with intimate relationships.

9. Bahamian women generally love their spouses more than they love themselves.

10. Bahamian women tend not to express their true feelings with their spouses.

11. Bahamian women tend to deny that their partners are having affairs despite evidence.

12. Bahamian women generally lack condom negotiation skills or do not like using condoms.

13. Bahamian women would respond honestly to self report measures.

14. Selected study measures are gender as well as culturally appropriate and sensitive.

Definition of Terms

_Urban Bahamian Woman_

_Conceptual definition._ An urban Bahamian woman is conceptually defined as a woman who was born in The Bahamas and resides on the island of Nassau or Freeport, Grand Bahama.

Operational definition. In this study, an Urban Bahamian woman was
measured by a nominal-level item on residence in either Nassau or Freeport, Grand Bahama on the demographic instrument.

Self-Esteem

*Conceptual definition.* Self-esteem is conceptually defined as “the relative level of rewards and costs individuals distribute to themselves. Persons high in self-esteem are presumed to distribute more rewards than costs to themselves than do persons low in self-esteem” (Taylor & Tomasic, 1996, p. 296).

*Operational definition.* In this study, self-esteem was measured by the Taylor’s Self-Esteem Inventory, a 16-item inventory with eight positive and eight negative items. After reverse scoring of negative items, higher total inventory scores indicated higher self-esteem (Taylor & Tomasic, 1996).

Silencing The Self

*Conceptual definition.* Self-silencing is conceptually defined as the ability of a woman to withhold certain feelings, thoughts, and actions in an effort to create and maintain safe, intimate relationships (Jack & Dill, 1992).

*Operational definition.* In this study, self-silencing was measured by the Silencing The Self scale (STSS), a 31-item scale with four subscales (i.e., Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, and The Divided Self) developed to measure types of women’s silencing. The higher the total STSS score, the greater the degree of silencing (Jack & Dill, 1992).

Self-Efficacy for Negotiating Safer Sex Behaviors

*Conceptual definition.* Self-efficacy is conceptually defined as a self-belief that one is capable and competent in organizing and performing desired behavior
in a given situation (Bandura, 1989). More specifically, it is the degree of confidence that urban Bahamian women have in their perceived ability to negotiate safer sex behaviors with intimate partners (i.e., sexual behaviors that will prevent or decrease HIV/AIDS acquisition and transmission).

*Operational definition.* In this study, self-efficacy for negotiating safer sex behaviors was measured by the Self-Efficacy Scale, a 12-item scale with three subscales (i.e., Refusal, Condom Use, and Discussion). The higher the total scale score, the higher the self-efficacy for negotiating safer sex (Dilorio, Maibach, O’Leary, Sanderson, & Celentano, 1997).

**Research Hypotheses**

The sociocultural context of Bahamian women’s lives coupled with theoretical foundations have contributed to the following hypotheses for this study:

1. There will be a negative relationship between urban Bahamian women’s self-esteem and self-silencing behaviors.

2. There will be a positive relationship between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behaviors.

3. There will be a negative relationship between urban Bahamian women’s self-silencing and self-efficacy for negotiating safer sex behaviors.

4. Age, income, education, self-esteem, and self-silencing will make significant independent and combined contributions to self-efficacy for negotiating safer sex behaviors in urban Bahamian women.
Scope and Delimitations of the Study

The sample for this study was drawn from women who were born in The Bahamas or have lived in The Bahamas for more than 10 years and resided on an urbanized island of the Bahamas, where approximately 80% of the population reside (Department of Statistics, 2001). These women were 18 years or older because the legal age in The Bahamas is 18 years and also because the sampling procedure was one of convenience in which participants were recruited at various public sites that Bahamian women visit frequently. Additionally, the sample was drawn from a heterogeneous population with respect to their age, income, education, employment, marital status, number of dependents, and HIV/AIDS status.

Data were collected from urban Bahamian women on the variables of demographic characteristics (i.e., age, income, education) self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors. Bivariate statistical techniques were used to test relationships between and among demographic and major study variables. Multivariate statistical techniques were also used to identify the degree to which individual and combined variables predict self-efficacy for negotiating safer sex behaviors in Bahamian women.

Limitations of the Study

Since convenience sampling was used to collect data for this study, there may have been sampling bias, thus, limiting the ability to generalize findings. Additionally, since data were collected over a three week period in numerous public settings, there was a possibility that some women may have filled out the
Another limitation of the study was the possibility that missing data or inaccuracies on self-report measures may have affected findings.

Summary

The rapidly increasing rate of HIV/AIDS among Bahamian women is daunting for the future of Bahamian society. Despite many concerted efforts, scientists have been unable to find a cure for HIV disease and are faced with the multiple challenges that treatment and management strategies bring for persons living with AIDS. As a result, there is a major focus on HIV prevention. However, many prevention strategies have been ineffective with women and particular cultural groups, and the rates of HIV/AIDS continue to rise around the world.

To enhance effectiveness of prevention strategies, it is imperative to develop interventions that are gender appropriate and culturally sensitive. In essence, by understanding the personal characteristics of Bahamian women such as self-esteem and self-silencing, which may or may not be related to their self-efficacy for negotiating safer sex behaviors, gender and culturally specific preventive measures can be developed and implemented in an effort to reduce acquisition and transmission of the disease.

Chapter two will present a review of the literature to delineate the context with what is known about this area of study. It will begin with a global overview of HIV/AIDS and women in general and Bahamian women in particular from an epidemiological standpoint. Additionally, quantitative and qualitative studies
related to women’s risk factors for HIV/AIDS as they relate to the major variables of this study will be summarized and critiqued.

Chapter three will present the research methodology for the study. The design, sampling techniques, instruments that were used to measure the major variables and their appropriateness to this study, ethical considerations, data gathering procedure, and data analysis techniques will be described and justified.

Chapter four will present the results of the study. Description of the sample including response rate and post hoc power analyses, exploratory data analysis including measurement assessments and descriptive findings, and hypotheses testing will be provided.

Chapter five will present a discussion of findings and conclusions of the study. The results will be interpreted and discussed related to demographic and background characteristics of the participants, the relationship between major study variables, and significant and nonsignificant predictors of self-efficacy. Additionally, limitations of the study and implications for nursing education, practice, and future research will also be discussed.
CHAPTER II

REVIEW AND CRITIQUE OF THE LITERATURE

Introduction

This chapter will address HIV/AIDS epidemiology, risk for acquiring and transmitting HIV/AIDS, and the major variables of the study as they relate to women. First, the epidemiology of HIV/AIDS related to women globally, women in Latin America and the Caribbean, and Women in The Bahamas will be discussed. In addition, this chapter will evaluate factors that increase women’s risk for HIV/AIDS using qualitative and quantitative studies to support the discussion. Lastly, the study major variables, self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors, will be discussed in relation to women in general and specifically to their risk for HIV/AIDS. Qualitative and quantitative studies in these areas will be summarized and critiqued. It is important to note, however, that the small number of studies conducted with Bahamian women related to the major study variables will limit discussion with respect to this specific population.

A literature search was conducted in numerous disciplines to gather information. Databases searched include PsychInfo, Eric, Proquest, Ovid, Medline, MedPub, CINAHL, HAPI, Dissertation Abstracts, and Psychological Abstracts. Additionally, the Internet was explored using Google and Yahoo search engines, authors of instruments used in this study were contacted for bibliographies, and article reference lists were used to obtain appropriate research
studies that helped to provide a rich literature base to support this study. Research studies and theoretical articles as well as books and book chapters written in English were explored using various time frames from 1970 to 2003, depending on whether the title, subject, or author’s names were used to conduct the search. Keywords and phrases used were (a) HIV risk and women, (b) HIV risk and Black women, (c) Bahamas and HIV/AIDS, (d) self-esteem and women, (e) self-esteem and Black women, (f) self-esteem and Bahamian women, (g) self-esteem and risk for HIV/AIDS, (h) self-esteem and self-silencing, (i) self-esteem and self-silencing and women, (j) self-esteem and self-silencing and Black women, (k) self-silencing and risk for HIV/AIDS, (l) self-esteem and self-efficacy for negotiating safer sex behaviors and women, (m) self-esteem and self-efficacy for negotiating safer sex behaviors and Black women, (n) self-silencing and self-efficacy for negotiating safer sex behaviors and women, (o) self-silencing and self-efficacy for negotiating safer sex behaviors and Black women, (p) self-efficacy for negotiating safer sex behaviors and Black women, and (q) self-efficacy and HIV/AIDS. Additionally, names of authors and instruments that were used in this study were also searched. These include Taylor’s Self-Esteem Inventory (Taylor & Tomasic, 1996), Jack and Dill (1992) Silencing The Self Scale, and Dilorio et al.’s (1997) Self-Efficacy Scale. Other keywords used to gather information for this study were, “Bahamian women,” “Black women,” and “Caribbean women.”

HIV/AIDS Epidemiology Related to Women

Global
Declared as the most devastating disease ever to affect humankind, an estimated 42 million persons in the world were living with HIV/AIDS disease by the end of 2002, including 5 million new cases in 2002. In Sub-Saharan Africa alone, over 29 million Africans are living with HIV/AIDS. Moreover, the prevalence rates among pregnant women have exceeded 30% (UNAIDS/WHO, 2002). Most daunting is the fact that the majority of new cases of HIV are seen in women, particularly young women. In Canada, for example, new cases of HIV among women have increased from 8.5% in 1995 to a soaring 20% presently (UNAIDS/WHO, 2002). In the US, Blacks make up 13% of the US population, yet they comprise 38% of the HIV/AIDS cases. For example, although women are the fastest growing population with HIV/AIDS in the US, as in the rest of the world, Black women are disproportionately affected. Black women make up an estimated 64% of new cases of HIV annually compared to their White and Hispanic counterparts who make up only 18% and 18%, respectively (CDC, 2002). As a result of the pervasive effect of HIV/AIDS, countries barely affected by this disease only a decade ago are now reporting escalating numbers. For instance, Indonesia, China, and some Eastern European countries (e.g., Estonia, Russian Federation, and the Ukraine) which reported low rates of HIV/AIDS just a decade ago are now seeing increases in HIV/AIDS cases within the general population and specifically among groups with high risk behaviors such as female sex workers and intravenous drug users (IDUs) (CDC, 2002; UNAIDS/WHO, 2002).

*Regional: Latin America and the Caribbean*
Although only 8% of the world’s population lives in Latin American and the Caribbean, there are approximately 1.8 million people in Latin America and 420,000 people in the Caribbean presently living with HIV/AIDS, and women comprise the majority of new cases. Moreover, the Caribbean is the second most HIV/AIDS affected region in the world, and AIDS is the leading cause of death in some Caribbean countries (UNAIDS, 2002). To take a closer look at the effects of HIV/AIDS on Caribbean women, given that heterosexual transmission is the predominate mode for HIV infection in the Caribbean and that women are at greater risk for acquiring HIV/AIDS than are men, it is no surprise that new cases of HIV/AIDS are escalating among these women. For instance, Haiti, one of the affected countries in the Caribbean, has 6% of the adult population living with HIV/AIDS (AMFAR, 2001). Moreover, it was reported that 1 in every 10 Haitian women living in Haiti may be infected with HIV/AIDS. Other Caribbean and Central American countries such as the Dominican Republic, Barbados, Belize, Guyana, and Honduras have reported HIV prevalence rate of at least 1% (IPS-Inter Press Service, 2001; UNAIDS/WHO, 2002).

Local: The Bahamas

Second only to Haiti with a prevalence of almost 4%, The Bahamas have the highest incidence of HIV/AIDS in the English speaking Caribbean (Campbell, 2001; UNAIDS/WHO, 2002). A small country with just over 304,000 people, of whom 51% are women (Department of Statistics, 2001), The Bahamas has reported a cumulative number of 9,329 cases of HIV/AIDS as of December 31, 2002 (Health Information and Research Unit, 2003). In addition to women being
the fastest growing segment of the population with HIV/AIDS, they make up 45% of the total cases of HIV/AIDS in The Bahamas. Along with such a high rate of HIV/AIDS per capita, The Bahamas continues to report almost 400 new cases of HIV/AIDS per year. Moreover, HIV/AIDS is the leading cause of death for Bahamian women and men between the ages of 15 to 44 years (Campbell, 2001).

What do these soaring HIV/AIDS numbers mean for women in the world in general and women in The Bahamas in particular? The high rates of HIV/AIDS among women mean that unless effective prevention interventions including gender appropriate and culturally sensitive strategies are developed and implemented to reduce the number of women becoming infected, HIV/AIDS rates among women will continue to escalate, more infants will become infected with HIV/AIDS through MTCT, and more women will die leaving an unbearable socioeconomic burden on society due to increasing numbers of orphanages.

However, gender and culturally specific prevention interventions for women cannot be developed without first identifying sociocultural, socioeconomic, and intra- and interpersonal characteristics that put women at risk for HIV/AIDS.

Women’s Risk for HIV/AIDS

In an effort to reduce the number of HIV/AIDS among women, it is imperative to identify factors that put them at risk for this disease. Despite women’s knowledge about risk factors for HIV/AIDS, Black and other ethnic minority women in particular still engage in high risk behaviors for HIV (Dolcini et al., 1996; Malow et al., 2000; Moore, Harrison, & Doll, 1994; Salgado et al., 1996; Ward & Samuel, 1999). Therefore, it is important to determine the factors
that make women vulnerable to HIV-infection and why some women are unable to resist such high risk behaviors.

There are a myriad of behavioral factors that increase women’s risk for HIV/AIDS, some of which will be discussed briefly in this chapter. However, the major focus of discussion will be on major variables of this study: select demographic variables (i.e., age, income, education), self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors.

*Biological Risks*

Women have a greater risk than men for HIV/AIDS by virtue of their biological make-up. For example, women’s increased vaginal surface area coupled with the possibility of contracting sexually transmitted diseases (STDs), which can cause disruption in the integrity of the vaginal mucosa and which are sometimes asymptomatic, place women at greater risk than men for HIV/AIDS (Cochran, 1989; Holmberg, 1997). Moreover, it was estimated that women are eight times more likely to contract HIV/AIDS from a man than for a man to contract HIV/AIDS from a woman (Brunswick et al., 1993; Quirk & DeCarlo, 1998).

*Behavioral Risks*

There are many behavioral factors that put women at risk for HIV/AIDS. However, these behavioral factors are mediated by socioeconomic, sociocultural, intrapersonal, and interpersonal (relational) factors. These factors help explain why women engage in risky sexual behaviors with their male partners. One of the reasons for women’s risky sexual behaviors is that some women trust their
partners to be monogamous and, therefore, do not perceive themselves to be at
risk for HIV/AIDS, especially if they are married or in a long-term relationship.
For instance, a focus group study was conducted in Haiti to determine prevailing
norms and the capacity of Haitian women to negotiate sexual behavior change.
Haitian women in this study admitted to being afraid of contracting HIV/AIDS
but not through unprotected sex. These women were more afraid of becoming
sick and of the possibility of receiving HIV-infected blood in hospitals as a means
of contracting the disease. As a matter of fact, some of these women considered
themselves not only to be in trusting relationships but (also) as having an added
assurance that God will take care of them because of their claim to Christianity
reported on a community-based study conducted in The Bahamas with 236
participants including males (n = 61, 26%) and females (n = 175, 74%) to
determine the socioeconomic factors that make women more vulnerable than men
to HIV/AIDS. Although the average age of first sexual encounter was 16.3 years
and the number of sexual partners in the past year ranged from 0 to 20, almost
three fourths (n = 190) of the sample thought that their risk for HIV/AIDS was
low. The remainder of the sample thought that their risk for HIV/AIDS was either
moderate or high. Consistent with these findings on perceived risk, only 47
women (29%) in the sample stated that they always used condom during sexual
encounters.

Despite women’s trust in their partners or spouses, some partners or spouses
are not honest about their sexual risk factors. For example, Stokes, MCKirnan,
Doll, and Burzette (1996) conducted a study with 350 bisexual men between the ages of 18 to 30 years. These investigators found that up to 71% of the participants’ female partners were unaware of their bisexual behaviors. Similarly, Robins, Dew, Kingsley, and Becker (1997) conducted a study with 525 homosexual men, among whom 156 (29.7%) were HIV positive, and found that regardless of the participants’ HIV status, they reported that they placed others at risk for HIV/AIDS.

From the beginning of the HIV/AIDS epidemic, injecting drug users (IDUs) were classified among the high risk groups (Cochran, 1989). Today, although many women are not IDUs, because the major mode of transmission for HIV/AIDS among women is by heterosexual transmission (UNAIDS/WHO, 2002), women who are sexual partners of IDUs are at risk for HIV/AIDS. For example, in a study conducted in Southern Arizona with 123 female partners of IDUs of whom 80% belonged to ethnic minority groups, Erickson (1997) found that these women predominately engaged in unprotected sexual behaviors with their IDUs partners. These findings are disturbing since more recent empirical studies continue to link intravenous injecting drug use as a predictor of HIV seropositivity (Huba et al., 2000).

Noninjectable drugs such as alcohol, crack cocaine, and marijuana can decrease women’s decision-making capability during sexual encounters and, therefore, can indirectly place them at risk for HIV/AIDS. In a study conducted by Graves and Hines (1997), data were collected from two samples of racially mixed adults. In the first sample, there were 2,247 participants including 804
Whites (35.8%), 737 Blacks (32.8%), and 706 Hispanics (31.4%). In the second sample, there were 583 participants including 177 Whites (30.4%), 189 Blacks (32.4%), and 217 Hispanics (37.2%). The investigators examined the link between alcohol consumption and risky activity with a new sexual partner in these racially mixed samples. Among other findings, the investigators reported that drinking was a predictor of not using condoms with casual partners among women. In contrast, Scheidt and Windle (1996) conducted a study with 802 inpatient participants in five alcohol treatment centers to evaluate the relationships between their personal situation variables and sexual risk behaviors. Although this was a mixed group, of which 331 of the participants were women and 562 were Black (70%), findings from t-tests suggested that although men reported alcohol use during the previous six months with nonprimary partners \([t(148) = 3.68, p < .001]\) with greater frequency than did women \([t(105) = 2.20, p < .05]\), both male and female participants also used condoms more in those situations \([t(148) = 6.23, P < .001\) for men and \(t(105) = 6.70, p < .05\) for women].

Crack cocaine is another noninjecting drug that puts women at risk for HIV/AIDS, mostly because women engage in frequent unprotected sexual behaviors as a result of either decreased cognition or to exchange sex for drugs (Richard, Bell, & Montoya, 2000). In a retrospective case-control study conducted in The Bahamas representing 835 cases from 1985 to 1990, including 304 women (40%), Gomez et al. (2002) assessed the relationships among crack cocaine use, genital ulcer disease (GUD), and HIV infections and concluded that case-control analysis linked crack cocaine use, GUD, and HIV-infections. The odds ratio
between GUD and cocaine use increased from 1.2 (95% CI, 0.7-2.0) to 1.6 (95% CI, 1.0-2.6) and 3.5 (95% CI, 1.9-6.4) in 1988 and 1990, respectively. Additionally, the investigators reported that the highest odds ratio for cocaine use to HIV infection was 8.1 in 1987 but has decreased thereafter. The investigators concluded that the resurgence of increased transshipment of cocaine through the Caribbean islands may be responsible for the present increases in new HIV/AIDS cases in the region.

Abusive relationships are also a factor that put women at risk for HIV/AIDS because women are either given decreased power or perceive themselves as having decreased sexual negotiation powers. Pulerwitz et al. (2000) conducted focus groups with 388 women at a community health clinic to develop an instrument that measures sexual relationship powers and found that the more physical violence these women reported, the less sexual relationship power they had. Similarly, Beadnell et al. (2000) conducted a study that compared nonabused (n = 70, 42%), emotionally abused (n = 70, 42%), and physical abused (n = 27, 16%) women in primary relationships to determine their risk factors for HIV and STDs and concluded that abused women were at greater risk for STDs, were more likely to be raped, and were more likely to engage in sex for pay.

It is important to note, however, that stigma is also among the reasons for women’s risk for HIV/AIDS. According to Schieman (1998), some women might not perceive themselves to be at risk for HIV because of the distance they place between themselves and high risk groups such as homosexuals, prostitutes, and IDUs. As a result, these women may engage in unprotected sex.
Among the cadre of factors that put women at risk for HIV/AIDS are sociocultural and socioeconomic, intrapersonal, and interpersonal factors such as self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors. The major study variables will be the focus for discussion in later sections of this chapter.

*Sociocultural Risks*

Triandis and Suh (2002) stated that the elements of a culture are shared values, standards, assumptions, norms, tools, and habits and that culture develops conventional laws which determine what and to what extent information in the environment is sampled. As one of the conventions, women’s roles are sanctioned by culture and society. Historically, women have held the role of childbearers, childrearers, homemakers, and partner pleasers, although Loo and Thorpe (1998) have reported a significant liberalization in attitudes toward women’s roles in society. The women’s liberation movement of the 1960’s and 1970’s was the impetus for some women taking control over their lives (i.e., reproductive decision-making as well as education and employment opportunities). Despite women’s struggle for liberation, their attitudes, beliefs, and behaviors are still bonded by cultural norms and traditional practices, which in turn affect their risk for HIV/AIDS. Noteworthy is the fact that Black women come from a long history of sexism, racism, colorism, and classism which have led to their oppressive states and put them more at risk for HIV/AIDS than women of other races (Trotman Reid, 2000). This statement is validated by the reported soaring numbers of cases of HIV/AIDS among Black women in the world.
In support of how cultural norms and traditional practices can put women at risk for contracting HIV/AIDS, Ruangjirantain and Kendall (1998) reported that Thai culture affects women’s ability to protect themselves from HIV infection. These authors maintained that extramarital affairs with prostitutes are accepted among men in Thai culture. Despite this practice, Thai culture has forbidden women to refuse to have sex with their husbands, insist that their husbands use condoms, or confront their husbands about their extramarital affairs. Moreover, Thai women are not expected to question the social order in Thailand, but they are expected to accept the patriarchal rules and traditional practices as morally right. Similarly, Ranin and Wilson (2000) reported that African women are at risk for HIV/AIDS because of cultural norms and traditional sexual practices in African regions. Moreover, these authors contended that cultural norms and traditional practices in African society sanctioned a limited status for African women including a lack of control over their bodies.

The effects of cultural norms and traditional practices on women’s risk for HIV were documented by a study conducted in Indonesia by Basuki and colleagues (2002). These investigators collected qualitative data from 204 sex workers and their pimps through focus groups, in-depth interviews, and condom dairies over four weeks to monitor condom use with their clients. Additionally, quantitative data were collected via surveys from sex workers (n = 1,450) related to their knowledge, attitudes, beliefs, and practices (KABP) about HIV/AIDS. Among other findings, the investigators reported that female sex workers in Indonesia engaged in unprotected sex more with Native and regular customers.
and their boyfriends than they did with foreign clients. Moreover, of 5,603 sexual contacts, the majority were with Native Indonesians ($n = 4,292$), resulting in decreased condom use. When the women were asked how they decided which clients should be made to use a condom, some stated that they use condoms with foreign men because foreigners eat different kinds of food than Native Indonesians, and as a result, they have a different type of sweat. Additionally, these women stated that if a man is “clean,” then they are more likely to have unprotected with him. On the other hand, skinny men who are unable to walk straight or a man with red spots on his penis are considered sick and would warrant condom use. These findings explain why the numbers of HIV/AIDS cases in Indonesia among female sex workers have escalated in recent years (UNAIDS/WHO, 2002). In addition, many cultures that promote women to play the submissive role and men the dominant role during sexual intimacy have aided in women’s lack of sexual negotiation powers and increase their risk for HIV/AIDS (Deren et al., 1999; Malow et al., 2000; Salgado de Snyder, Acevedo, Diaz-Perez, & Saldivar-Garduno, 2000; Tertullien, 1976).

Cummings and colleagues (1999) interviewed 142 African American women to determine whether their risk for HIV/AIDS was influenced by their AIDS-related worry status. Although study findings indicated that African American women were worried about getting AIDS for various reasons such as engaging in unprotected sex and lack of trust for partner or spouse, these women still engaged in unprotected sex. As a matter of fact, some women held fatalistic beliefs about
their risk for HIV/AIDS such as “…if I’m gonna get it, I’m gonna get it” or “because what’s meant to happen is gonna happen” (p. 339).

Socioeconomic Risks

Socioeconomic status of women cannot be overlooked in terms of their risk for HIV/AIDS. Investigators have linked low socioeconomic status with increased risk for HIV/AIDS (Trotman Reid, 2000). In some cultures, women carry the brunt of the responsibilities to meet the needs of the family. For instance, in The Bahamas where the majority of Bahamian children are solely raised by their mothers without financial support from their fathers, women struggle to keep a roof over their children’s heads, food on the table, and clothes on their backs (Neely-Smith, 2002). It is understandable why some women, particularly Black women, ignore the threat of HIV/AIDS when these threats are viewed in the context of complex socioeconomic burden they have to bear (Trotman Reid, 2000). More directly, lack of or inadequate income may be responsible for some women’s engagement in risky behaviors such as prostitution (UNAIDS/WHO, 2002).

Oliva and colleagues (1999) conducted focus groups with women (N=63) with high risk behaviors for HIV such as injection drug users, sex with injection drug users, sex workers, and women with a history of sexual transmitted diseases to identify barriers in accessing healthcare. Among their many stated barriers to healthcare, cost related to lack of healthcare coverage took precedence over other
concerns. These women, some of who were at high risk for HIV due to lack of or decreased income, also lacked healthcare access, which suggested lack of preventive care for this vulnerable group of women. However, insufficient income is not considered a risk factor for HIV in every situation. In a study to identify HIV risk behaviors in Latinas, Peragallo (1996) found that women’s income status had no statistically significant relationship to risk for HIV/AIDS.

Other Demographic Variables and Risks

Age may also be a factor that puts a woman at risk for HIV/AIDS. For instance, older women tend to be in stable committed relationships and, as a result, may not see the need to engage in protected sex with their partners. Additionally, some older women are peri-menopausal and may engage in unprotected sex because they have completed their childbearing years and do not consider themselves in need of protection from pregnancy any longer (Wyatt et al., 2000). In a study to determine the relationship between alcohol and HIV risk behaviors, Graves and Hines (1997) also found that older women were more likely to engage in unprotected sex with a new partner than were their younger counterparts.

Lastly, educational level is another variable that may be responsible for women’s risk for HIV/AIDS. In a study conducted with 125 women including non-Latina Black \(n = 59\), White \(n = 9\), Asian \(n = 4\), and Latinas \(n = 52\) to test their HIV/AIDS protective behaviors related to gender roles, relationship power strategies, and precautionary sexual self-efficacy, Bowleg, Belgrave, and Reisen (2000) found that the women’s educational level significantly predicted
expressive gender roles which accounted for 14% of the variance in their model. Similarly, Graves and Hines (1997) found that education was an important predictor of condom use in Hispanic women; the more educated the Hispanic women, the more likely they engaged in safer sex behaviors.

Self-Esteem

Known as the evaluative component of the self-concept and sometimes used synonymously with concepts such as self-worth, self-respect, self-acceptance, and self-regard (Blascovich & Tomaka, 1991), self-esteem is viewed on a continuum from low to high. Low self-esteem is viewed as a correlate of ill-health and the inability to effectively cope with life stressors, whereas high self-esteem is viewed as a correlate of good health and the ability to effectively deal with life stressors (Cast & Burke, 2002; Coopersmith, 1967).

The belief that self-esteem is important to the well-being of an individual is seen in the extent to which it had been studied (Blascovich & Tomaka, 1991). Among numerous self-esteem studies, scientists have investigated self-esteem with other variables such as culture (Heine, Lehman, Markus, & Kitayama, 1999; Tsai, Ying, & Lee, 2001), gender (Kling, Shibley Hyde, Showers, & Buswell, 1999), race (Poindexter-Cameron & Robinson, 1997), acculturation (Flaskerud & Uman, 1996), stigma (Corning, 2002), abuse (Haj-Yahia, 2000), educational level (Abu-Saad, 1999), age (Tsai et al., 2001), parenting (Barrett, 1977; Wilson, 1985), ill-health such as depression (Beeber, 1998; Peden et al., 2000), weight (Cameron et al., 1996; Jambekar, Quinn, & Croker, 2001; Ricciardelli & McCabe, 2001; Schaumberg, Patsdaughter, Selder, & Napholz, 1995), religion (Anderson-
Despite the extensive history of investigations, the pervasive nature of self-esteem continues to warrant investigations (Kling et al., 1999).

Self-Esteem and Women

Although some studies have found no gender differences in levels of self-esteem (Baker, Beer, & Beer, 1991; Mullis & Chapman, 2000), the majority of studies have suggested that men have higher levels of self-esteem than do women. Kling and colleagues (1999) conducted a meta-analysis on gender differences in self-esteem which supported what most investigators have found; males tend to have higher levels of self-esteem than do females, although the difference was small as evidenced by consistent small effect sizes. These investigators conducted two analyses to determine gender differences in self-esteem. The first analysis was a composite of computerized search studies ($N = 216$) with an overall effect size of 0.21; the second analysis was with large data set from the National Center for Education Statistics (NCES) with effect sizes ranging from 0.04 to 0.24.

On the other hand, Cremer, Vugt, and Sharp (1999) conducted a study with a small group of British undergraduate female students ($n = 31, 63\%$) and male students ($n = 18, 37\%$) to explore the relationship between gender and collective self-esteem (CSE). Using a one-way analysis of variance, they found that on the average CSE scores were significantly different by gender [$F(1, 47) = 7, p < .05$]. Moreover, they found that women expressed a higher level of CSE than did men ($M = 5.79$ vs $M = 5.30$), although variability in gender scores were not reported. It
is important to note, however, that due to the small sample size and limited geographical area, findings of this study cannot be generalized to wider populations.

Findings from such studies have prompted investigators to study reasons why women tend to have lower levels of self-esteem than do men. Based on previous studies that have found self-esteem levels to be higher in men than in women, one may conclude that women may not be able to overcome life stressors as well as men and as a result suffer many health consequences such as depression and other mental illnesses, obesity, and cardiac conditions. Moreover, women may engage in high risk behaviors as a result of their decreased sense of self-worth.

Cross and Madson (1997) explained that gender differences in self-construals are the basis for documented differences in male and female self-esteem levels. These scholars contended that men tend to operate from an independent self-construal of autonomy, uniqueness, and individuality which are the assumptions from which self-esteem is based. On the other hand, women tend to operate from an interdependent self-construal of relationship with others. Moreover, Cross and Madson (1997) purported that women actually gain self-esteem from their ability to maintain relationships with others. It could be understood why investigators have found men to have higher self-esteem than women when self-esteem, as a concept of the Western world, is defined and measured on the basis of men’s self-construal—autonomy, uniqueness, and individuality (Heine et al., 1999).

Although women around the world have a lot in common in terms of their thinking, motivation, emotions, and social behaviors (Cross & Madson, 1997),
there are differences in terms of culture, race/ethnicity, and socioeconomic status which may impact their level of self-esteem. The type of roles women and girls are sanctioned to perform in a given culture may also impact their level of self-esteem. For example, in some cultures, girls are socialized by parents and teachers to engage in interdependent activities such as group play, nurturance, and caring activities (Jack, 1991), which in turn foster low scores on most self-esteem scales.

Cultural values and trends also foster decreased levels of self-esteem for women. In American culture, for example, the emphasis on being thin may shatter a woman’s self-esteem if she believes that she is overweight (Jambekar et al., 2001). However, the effect of weight on self-esteem might be related more to ethnicity than to gender. Cameron and colleagues (1996) conducted a study with African American ($n = 36, 22\%$) and European American ($n = 96, 78\%$) pregnant inner-city women to determine the relationships among weight, self-esteem, and depressive symptomatology and found that African Americans reported higher levels of self-esteem during their second and third trimesters than did their European American counterparts [$t(130) = 3.30, p < .01$ and $t(130) = 2.82, p = .01$, respectively]. These findings, however, should be viewed with caution since ability to generalize to all African American and European American women is limited due to the relatively small sample size. Furthermore, it may be that among the many worries that inner-city African American women have to face such as abuse, unemployment, and lack of housing, gaining weight is probably not a major concern, especially since it is something they would expect to happen during pregnancy.
Violence against women, which is tolerated in many cultures, is another phenomenon researchers have investigated in relation to low self-esteem in women. For instance, Haj-Yahia (2000) conducted a study in Palestine with 1,334 women using a random home selection procedure to determine the influence of wife abuse and battering on self-esteem, depression, and anxiety. The investigator found that despite the type of abuse (i.e., psychological, physical, sexual, and economical), women showed low levels of self-esteem. Moreover, regression analysis revealed that the more these women suffered abuse from their husbands, the lower was their level of self-esteem: psychologically abused ($\beta = -.342, p < .0001$); physically abused ($\beta = -.038, p < .0001$); sexually abused ($\beta = -.026, p < .0001$); and economically abused ($\beta = -.028, p < .0001$). Conversely, Romans, Martin, and Mullen (1996) conducted a study with a group of women ($N = 477$) to determine if childhood sexual abuse (CSA) was a major determinant of low self-esteem in adulthood. These researchers found no significant difference in psychosocial predictors for low self-esteem between the two groups of women studied, except when the CSA was intrusive. These investigators concluded, however, that childhood temperament, poor mother-child relationship, low qualification attainment, psychiatric morbidity, and CSA in its most intrusive form, are predictors of low self-esteem in women.

Age is another factor that researchers have explored as an influence on self-esteem in women. For example, Block and Robins (1993) suggested that girls tend to lose self-esteem whereas boys tend to gain self-esteem during the adolescent years. This difference may have something to do with cultural trends
and the value placed on body weight, which may be a struggle for many girls during puberty.

Other socioeconomic factors that may not be specific to women yet may impact their level of self-esteem are educational and income levels. According to Wiggins, Schatz, and West (1994), well educated women have higher levels of self-esteem than do less educated women. Similarly, Flaskerud and Uman (1996) conducted a study to determine the effects of acculturation on self-esteem among immigrant Latina women. They found that women from Central/South Americas were more educated than their counterparts, which may have accounted for their higher self-esteem scores. In the study conducted by Haj-Yahia (2000) with Palestinian women, the investigator found that the women’s educational level was a significant contributor to the variance accounting for in self-esteem ($\beta = .088, p < .0001$). However, educational level has been found to have a positive relationship with self-esteem in various racial and ethnic groups. Thompson and Keith (2001) conducted a study with a sample of Black Americans ($N = 1,683$), including 1,043 (62%) women, to determine the degree to which gender socially constructs the importance of skin tone for evaluation of self-worth and self-competence. Using two items from the Rosenberg (1965) Self-Esteem Scale to measure self esteem and using a two-tailed test, the investigators found that education correlated significantly with self-esteem for women ($r = .078, p < .05$). However, education was found to have no interaction effect with skin tone on self-esteem. The investigators also reported that there were different interaction effects between education and other sociodemographic variables and skin tone in
terms of effect on self-esteem. They found that skin tone did not have any effects on self-esteem for women who were attractive or had high incomes, whereas skin tone and education did.

Consistent with other researchers, Francis and Jones (1996) purported that persons with higher social class tend to have higher self-esteem. Abu-Saad (1999) substantiated this view in a study of Arab adolescents in Israel. This researcher found that there was a significant relationship between self-esteem and community type. Using the Rosenberg Self-Esteem Scale to measure self-esteem in this sample, the investigator reported that adolescents who lived in the city reported higher self-esteem scores ($M = 82.03$, $SD = 10.9$) than did adolescents who lived in villages ($M = 80.30$, $SD = 10.13$) and than Bedouins ($M = 75.96$, $SD = 11.07$), respectively. De-Meo (1998) further supported that the higher the socioeconomic status, the greater the self-esteem level in a sample of Italian-American women ($N = 155$) in New York City area. The study was conducted to determine the relationships among ethnic identity, self-esteem, and career attainment in these women. The investigator found that women with higher self-esteem scores had higher career attainment when compared to women with low self-esteem scores.

Lastly, researchers have postulated that race and ethnicity may have an important influence on level of self-esteem. Mixed findings from a meta-analysis conducted by Kling and colleagues (1999) noted that in some studies Whites have been found to have higher self-esteem levels than Blacks, whereas in others the reverse has be documented. However, some researchers have questioned whether
self-esteem instruments are measuring a different concept when Blacks have reported higher self-esteem scores than their White counterparts (Cookson & Persell, 1991; Hoelter, 1983). This alternative explanation is probably what led Taylor and Tomasic (1996) to develop a self-esteem inventory specifically for Black populations. Additionally, some researchers have hypothesized that positive attitudes of Blacks concerning their race and ethnicity might explain, in part, the discrepancy in self-report self-esteem scores between Blacks and Whites. For example, Poindexter-Cameron and Robinson (1997) conducted a study to determine the relationships among racial identity attitudes, womanist identity attitudes, and self-esteem in African American college women from a predominantly white university (n = 46, 54%) and a historically black university (n = 38, 46%). Using the Rosenberg (1965) Self-Esteem Scale to measure self-esteem in these two groups of students, findings revealed that African American women at the predominantly white university had higher self-esteem scores (M = 36.11, SD = 4.01) than did African American women in the historical black university (M = 33.11, SD = 5.30). However, the researchers reported that Chi square analysis showed a significant difference in the number of African American women at the predominantly white university as compared to African American women at the historically black university who engaged in discussions about Black womanhood within the past six months [$\chi^2 (1) = 13.42, p < .0005$], which the researchers thought might have accounted for the difference in self-esteem scores.
Self-Esteem and Bahamian Women

Despite the paucity of scientific data related to self-esteem and Bahamians in general and Bahamian women in particular, much can be learned from the historical and cultural roots of Bahamian women and how these roots may influence their level of self-esteem. As discussed previously, Bahamian women came from a long history of racism, sexism, colorism, and classism in a patriarchal society (Saunders, 1994), which are likely to influence their self-worth. Given the history of the socialization process for Black women and the fact that positive reinforcements enhance and maintain self-esteem (Heine et al., 1999), it can be assumed that Bahamian women who experience perpetuated negative reinforcements related to their gender, skin tone, and class during their up-bringing will probably have low levels of self-esteem.

Additionally, findings from a study conducted with Jamaican adolescents to examine their racial identity, Africentric values, and self-esteem can be related to Bahamian adolescents since The Bahamas and Jamaica share most of the same historical roots of sexism, racism, colorism, and classism. Data were collected from a sample of Jamaican girls ($n = 81, 54\%$) and boys ($n = 73, 46\%$) between the ages of 8 to 13 years ($M = 10.8$ for boys and $M = 11.1$ for girls). Using the Piers-Harris Children’s Self-Concept Scale (PHCSCS) to measure self-esteem, the investigators found that Jamaican female adolescents scored higher on the self-esteem scale ($M = 61.68, SD = 10.78$) and ($M = 58.01, SD = 3.37$) than their Jamaican male counterparts. Moreover, these investigators found that the pride of
being Black was strongly associated with Jamaican female adolescents’ level of self-esteem \((r = .249, p < .01)\) (Akbar, Chambers, Jr., & Sanders Thompson, 2001).

Assuming that these findings can be generalized to Bahamian adolescents, it would mean that Bahamian females have higher self-esteem levels than do Bahamian males and that being Black is strongly associated with Bahamian female adolescent’s level of self-esteem. This assumption, along with the fact that since the 1960’s the people of The Bahamas were sensitized to be proud Bahamians (Beardsley Roker, 2000), suggests the need for investigating self-esteem among Bahamians in general and Bahamian women in particular. Moreover, in an article on Bahamian culture and society featuring Bahamian women, the author reported that there are two types of Bahamian women. The first type of Bahamian women are considered fighters, independent, hard-working, and supporting of self and family, which resemble characteristics of high self esteem. However, the second type of Bahamian women, according to the author, are the ones that are mostly married and will do anything to make their marriages work. The author further maintained that despite the second type of Bahamian women’s level of education, they stay in poor relationships because they feel dependent upon their spouses, insecure, have a low self-esteem, and are afraid of being alone without a partner (Hanna-Ewers, 1999). It is important to note, however, that this report was not empirically based. However, assuming that these attributions about Bahamian women are true, it was interesting to explore these women’s level of self-esteem and the influence on their risks for HIV/AIDS.
Self-Esteem and Women’s Risks for HIV/AIDS

Since self-esteem is considered a feeling of self-worth, self-respect, self-regard, and self-acceptance (Blascovich & Tomaka, 1991), one would assume that women with high self-esteem levels will have a low risk for HIV/AIDS because their self-appreciation and self-respect discourage them from engaging in high risk behaviors. While this may seem evident, there are some conflicting views about self-esteem and risk for HIV/AIDS in the literature.

Mill (1997) conducted a qualitative study using focus groups with eight HIV positive Aboriginal women to determine their HIV risk behaviors prior to them contracting the disease. Among many other factors that contributed to these women’s risk for HIV/AIDS, all of the women reported having low self-esteem before becoming infected. Many of the women stated that they really did not care about themselves and felt that they did not deserve care. Some of the women remembered engaging in high risk behaviors such as unprotected sex, drug use, promiscuity, and prostitution, and they admitted that it was during the times when they hated themselves that they engaged in these behaviors to cope with life stressors. These women believed that if they had high levels of self-esteem, they would have cared more about themselves and would not have put themselves at risk for HIV/AIDS.

Similarly, a community-based study was conducted in The Bahamas to determine socioeconomic factors that make women more vulnerable to HIV/AIDS. It was reported that some of the participants during one of the focus
groups sessions attributed low self-esteem as a reason for Bahamian women’s HIV/AIDS risk. In fact, one of the participants shared with the group that she grew up having low self-esteem and as a result used sex as an avenue to find self fulfillment (Ward & Samuels, 1999).

Nyamathi (1991) conducted a study with homeless and drug-abusing minority women ($N = 581$) of whom 81% were Black and 19% were Hispanic. The purpose of the study was to determine the relationships among self-esteem, sense of coherence, and support availability and emotional distress, somatic complaints, and high risk behaviors including risk for HIV/AIDS. Using a revised version of The Coopersmith (1967) Self-Esteem Inventory to measure self-esteem, findings suggested that women who had high self-esteem and strong sense of coherence reported significantly fewer high risk behaviors. However, self-esteem along with coherence accounted for only 10% of the variance in high risk behaviors in these women. These findings suggest that many other psychosocial variables may influence HIV/AIDS risk for this underserved, disenfranchised group of women.

Contrary results regarding self-esteem and high risk behaviors were documented by a study conducted by Hollar and Snizek (1996) to explore the relationship between knowledge and self-esteem on the sexual practices of college students. The sample consisted of 353 female (49.7%) and male (50.3%). Using the Rosenberg (1965) Self-Esteem Scale, the investigators found that both genders with high levels of self-esteem reported engagement in high risk sexual behaviors. More specifically, students who reported high levels of self-esteem and
high levels of knowledge were more likely to engage in risky behaviors \( M = 4.21, p = .05, df = 2 \) than students with low levels of self-esteem. The investigators concluded that high self-esteem might give students the feeling of invulnerability or that engaging in high risk behaviors may improve students’ level of self esteem.

Similarly, Long-Middleton (2001) conducted a study on a multiracial sample of female adolescents \( N = 224 \) to determine the influence of mastery and self-esteem on their risk reduction behaviors. This researcher found that mastery and self-esteem, as measured by Rosenberg’s (1965) Self-Esteem Scale, did not predict risk reduction behaviors in this multiracial sample. The conclusion reached by Hollar and Snizek (1996) in the previous study may also explain findings of this study.

The majority of study findings that failed to link high self-esteem with low risk behaviors were with adolescent groups (McNair, Carter, & Williams, 1998; Smith et al., 1997), which may lead to the conclusion that adolescents’ developmental levels may be related to their risk taking behaviors (Ponton, 1998). However, studies with adult participants have also produced similar results. Hylton (1999) conducted personal interviews with black women \( N = 30 \) in Washington, D. C., 83% of whom were seropositive to determine the psychosocial factors related to their HIV prevention behaviors. The investigator found that although most of the participants had high self-esteem, self-esteem had no influence on these women’s safer sex practices.
Despite conflicting findings regarding the relationship between self-esteem and risk for HIV/AIDS, it is believed that the higher Bahamian women’s levels of self-esteem, the lower their risk for HIV/AIDS which should be evident by their high levels of self-efficacy for safer sex behaviors. However, although it is believed that self-esteem can affect self-efficacy for safer sex behaviors directly, the influence of this variable may also be mediated by self-silencing behaviors in Bahamian women.

Self-Silencing

According to Amaro and Raj (2000), silencing refers to the loss of voice or the loss of self which is one of three common dynamics of oppression that may interfere with a person’s well-being. The impact of self-silencing on well-being has prompted researchers to investigate self-silencing to determine linkage with many other variables such as gender and cultural differences (Ali & Toner, 2001; Duarte & Thompson, 1999; Koutrelakos et al., 1999; Remen, Chambless, & Rodebaugh, 2002; Thompson, Geher, Stevens, Stem, & Lintz, 2001), personality traits (Witte, Sherman, & Flynn, 2001), coping with illness (Ali et al., 2000; DeMarco et al., 2001; Kayser, Sormanti, & Strainchamps, 1999), depression (Carr et al., 1996; Hart & Thompson, 1996; Jack, 1991, Jack & Dill, 1992; Thompson, 1995), anger (Brody et al., 1999; Jack, 2001), abuse (Whiffen, Thompson, & Aube, 2000), self-esteem (Cracco, 1999; Craver, 2000; Page, Stevens, & Galvin, 1996; Woods, 1999), and risk for HIV/AIDS (Bruner, 1997).
Self-Silencing and Women

Jack (1991) has contended that silencing the self is a gender-specific set of cognitive schemas women use to ensure their performance of society sanctioned normative female behaviors. Moreover, silencing is a way women cope to secure relationships. Because women judge themselves by their ability to maintain relationships (Gilligan, 1993), they silence themselves in an effort not to “rock the boat.” However, in the process of silencing and complying with cultural norms and practices to maintain relationships, women experience a paradox between ideal versus actual self and, thus, loss of the authentic self. As a result, silencing the self can be maladaptive and can lead to depression and decreased well-being in women.

Although the theory of silencing the self was developed to explain why women become depressed (Jack, 1991), the importance of self-silencing related to interpersonal behaviors have encouraged investigators to study gender and cultural differences in silencing behaviors. Scholars have maintained that cultural norms and traditional practices have socialized girls to silence (Cross & Madson, 1997; Jack, 1991), which is manifested in girls’ behaviors when they reach adolescence (Brown & Gilligan, 1992). Although adolescent girls are very outspoken in relationships in some cultures and ethnic groups, the opposite is seen in their relationships with male partners (Way, 1995). This behavior in girls is consistent with that which is seen among Bahamian girls living in The Bahamas (Tertullien, 1976).
Despite the belief that self-silencing is unique to women, investigators have suggested that men also manifest silencing behaviors. Moreover, findings from some studies have suggested that men silence more than do women (Haemmerlie, Montgomery, Williams & Winborn, 2001; Thompson, 1995; Thompson et al., 2001; Vaden Gratch et al., 1995). However, investigators have suggested that men may silence for different reasons than do women. Duarte and Thompson (1999) conducted a study to determine sex differences in self-silencing in a sample of undergraduate students (N = 1,117), including 71% females. Using the Silencing The Self Scale developed by Jack and Dill (1992), the researchers found that men’s global self-silencing scores were significantly higher than those of women (F = 40.3, p < .001, df not specified). The researchers concluded that men may perceive self-silencing differently than women in regard to themselves and their relationships.

Remen and colleagues (2002) may have shed light on why men and women differ in their perception of self-silencing in a study they conducted to determine gender differences in the construct validity of Jack and Dill (1992) Silencing The Self Scale (STSS). The investigators sampled 187 female and 169 male undergraduate students and found gender differences in the scale structure using exploratory and confirmatory factor analyses. While the factor analysis conducted on the female subsample was consistent with Jack and Dill’s (1992) defined four subscales, the same was not found for men. The factor analysis conducted on the subsample of men revealed another factor called Autonomy/Concealment, which did not reflect any of Jack and Dill’s (1992) original subscales. The investigators
concluded that men may silence as a way to maintain control and power in relationships as opposed to women who silence to secure relationships. As a result, the investigators cautioned against using Jack and Dill (1992) STSS with men.

In addition to gender, scholars have maintained that women’s silencing behaviors are related to culture. Koutrelatos and colleagues (1999) conducted a study using two of Jack and Dill’s (1992) four subscales, Divided Self and Care As Self-Sacrifice, to determine cultural and gender differences in a sample of Greeks and Americans. The total sample size was 853, with 480 participants from America (women comprised 65% of this sample) and 373 from Greece (women comprised 85% of this sample). Findings showed that Greeks scored higher than Americans on both subscales ($p < .001$ in each case, no test statistics reported), although Greek men scored higher than Greek women on both subscales ($p < .05$, no test statistic reported). The investigators concluded that the findings were consistent with the practices and values of both American and Greek cultures (i.e., individualism versus collectivism). In other words, individualism is consistent with independence and autonomy, and collectivism is consistent with interdependence and connectedness. Self-silencing, according to Jack (1991), is one’s desire to stay connected and maintain relationships.

Conversely, Ali and Toner (2001) conducted a study with Caribbean-Canadian women ($n = 20$) and Caribbean women living in the Caribbean ($n = 20$) to examine their symptoms of depression, self-silencing, and domains of meaning using both self-report and interviews. Although the sample was homogenous with
respect to sociodemographic status, Caribbean-Canadian women had higher self-silencing scores ($M = 88.3$, $SD = 29.5$) than their Caribbean counterparts ($M = 63.9$, $SD = 19.9$) on Jack and Dill’s (1992) STSS. Moreover, using Roy-Bargman stepdown $F$ analyses to control for meaningfulness, self-silencing, and depressive symptoms in succession, Caribbean-Canadian women still had significantly higher scores on the STSS than Caribbean women living in the Caribbean [$F(1, 37) = 6.5$, $p = .023$]. Additionally, although Caribbean-Canadian women showed their domain of meaning as “self-nurturing” and Caribbean women living in the Caribbean as “relational,” Caribbean women living in the Caribbean still reported less silencing behaviors. However, caution should be used when interpreting these findings since the sample size was small.

Cultural differences may also be seen in the relationship between self-silencing and depression among women from different ethnic groups. In a study conducted with African American ($n = 40$) and Caucasian ($n = 40$) women to determine the relationship between silencing the self and depression after controlling for income and social desirability bias, Carr and colleagues (1996) found that silencing the self was a significant predictor of depression in Caucasian women ($\beta = .61$, $p < .0001$) but not in African American women ($\beta = .17$, ns). Although African American women’s scores on self-silencing ($M = 82.05$, $SD = 18.80$) were not significantly different than Caucasian women’s STSS scores ($M = 80.25$, $SD = 20.75$) and scores on Beck Depression Inventory (BDI) ($M = 11.31$, $SD = 7.31$ versus $M = 10.33$, $SD = 8.68$), African American’s self-silencing behaviors appeared to have no relationship to depression. These findings have
perplexed investigators, especially since many previous studies have linked self-silencing and depression (Hart & Thompson, 1996; Jack, 1991, Jack and Dill, 1992; Thompson, 1995). The investigators concluded that cultural values and differing socialization practices in girls and women may have been responsible for unanticipated findings.

In an attempt to identify areas for intervention, researchers have begun to investigate how self-silencing behavior may impact coping behaviors of women living with chronic diseases. Kayser et al. (1999) conducted a study to understand how women living with cancer cope with this disease ($N = 49$) and used the Jack and Dill’s (1992) Silencing The Self Scale to measure relationship beliefs. Among other findings, the investigators found that silencing the self was a significant predictor of self-care agency as measured by the Exercise of Self-Care Agency Scale ($\beta = -.46, p < .01$), an instrument that taps subconstructs such as attitude of responsibility for self, motivation to care for self, the application of knowledge of self-care, the valuing of health priorities, and self-esteem. This finding indicated that women living with cancer who were more likely to report silencing behaviors scored lower on self-care agency.

To further document the effects on silencing behaviors on coping with chronic illness, DeMarco and colleagues (2001) conducted a study with African American ($n = 10$), White ($n = 4$), and mixed Portuguese/Native American ($n = 1$) women living with HIV/AIDS to explore their silencing and affectivity behaviors. The investigators used data triangulation obtained from responses to Jack and Dill’s (1992) STSS and semi-structured interviews. Findings indicated high
silencing behaviors among women living with HIV/AIDS ($M = 102.40, SD = 15.72$), especially in relation to women putting the needs of others (i.e., children and dependents) before themselves. DeMarco and colleagues (1998) used data from focus groups extracted from secondary analysis obtained from a group of women living with HIV/AIDS ($N = 14$) and explored women’s health care experiences to determine what women needed to maintain their health. The investigators found that although the women’s experiences matched Jack and Dill (1992) four subscales in the STSS, the women broke their silence and mobilized themselves to action for survival. It was suggested that the women mustered up the courage to act as a result of the life-threatening diagnosis of HIV/AIDS as well as support from peers and health care professionals. The investigators concluded that when faced with life-threatening situations, women may overcome their silencing behaviors and “speak up” for their survival.

Given cultural norms and traditional practices in The Bahamas and how they impact women’s roles, it would be interesting to document Bahamian women’s self-silencing behaviors as measured by Jack and Dill (1992) STSS, a concept that has never been explored in Bahamian women living in The Bahamas.

*Self-Silencing and Self-Esteem*

Since self-silencing can lead to depression and decreased well-being (Jack, 1991) and since self-esteem is believed to be lower in women than men (Cast & Burke, 2002; Kling et al., 1999), it is important to explore the connection between self-silencing and self-esteem in women.
Despite the paucity of scientific evidence regarding the relationship between self-silencing and self-esteem, scholars have posited a relationship between these two variables, suggesting that high self-silencing behavior is associated with low self-esteem (DeMarco et al., 2001; Jack, 1991). Woods (1999) conducted a study with a convenience sample of abused (n = 53) and nonabused (n = 52) women to examine their thoughts, feelings, and actions when developing and maintaining an intimate relationship. One of the investigator’s hypothesis was to test the relationship between self-esteem as measured by Rosenberg Self-Esteem Scale (RSE) (1965) and normative beliefs regarding maintenance of intimate relationships as measured by Jack and Dill’s (1992) STSS. Among other findings, the investigator found that there was a strong inverse correlation between RSE scores and STSS scores in the total sample of women (r = -.65, p < .0001). Although findings suggested that women with low self-esteem have high silencing behaviors or vice versa, a causal relationship could not been established. In other words, these findings do not provide evidence to suggest that either one of these variables leads to the other.

However, when Cracco (1999) conducted a study with female (n = 244) and male (n = 199) undergraduate students to determine the relationships between self-silencing across relationship domains and depression and self-esteem, the investigator found that self-silencing predicted a significant proportion of the variance in self-esteem and depression for women but only predicted self-esteem for men.
Although the above study substantiated a relationship between self-silencing and self-esteem, the directionality of the influence between the two variables remains unknown. Freedman (1998) contended that when girls reach adolescence, they experience a drop in self-esteem, which is manifested in three ways: (a) academic decline, (b) diminishing dreams, and (c) self-silencing behaviors. Given that self-silencing is one of the manifestations of low self-esteem seen in adolescent girls, then self-esteem can be viewed as an antecedent to self-silencing, a relationship that was tested in this present study.

To test this hypothesis, Page and colleagues (1996) conducted a study with a sample of men ($n=90$) and women ($n=91$) to explore the relationships among depression, self-esteem, and self-silencing behaviors. Using Jack and Dill’s (1992) STSS to measure self-silencing behaviors and the Multidimensional Self-Esteem Inventory (MSEI) (O’ Brian & Epstein, 1988) to measure global self-esteem (GSE), the investigators found a significant moderate inverse correlation between STSS and GSE ($r = -.54$, $p < .01$). Furthermore, the findings from multiple regression analysis indicated that STSS and GSE accounted for 44% of the variance in depression which was measured by Beck Depression Inventory (BDI), [$F(3, 177) = 47.26$, $p < .001$], and the interaction between STSS and GSE significantly accounted for another 3% of the variance in depression, [$F(3, 177) = 8.70$, $p < .01$]. These results indicated that the effect of self-silencing on depression varies depending on the level of self-esteem. More specifically, self-esteem appeared to moderate the effect of self-silencing on depression. At high and moderate levels of self-esteem, self-silencing had no effect on depression;
only at low levels of self-esteem did self-silencing significantly contribute to depression \((B = .08, p < .05)\).

The above studies have provided evidence that there is a relationship between self-silencing and self-esteem and, more importantly, that there may be a bidirectional relationship between self-silencing and self-esteem. However, in this study, the hypothesis that was tested was derived from a linear model which predicted that self-esteem would influence self-silencing behaviors which in turn, would influence Bahamian women’s self-efficacy for negotiating safer sex behaviors.

**Self-Silencing and Risk for HIV/AIDS**

Given that the predominant mode for HIV/AIDS acquisition and transmission in women is through unprotected sex with infected partners (UNAIDS/WHO, 2002) and that women silence themselves to maintain and secure intimate relationships (Jack, 1991), it may be fair to assume that despite limited scientific evidence, self-silencing behaviors can result in women’s increased risk for HIV/AIDS.

In some countries such as The Bahamas where cultural norms and traditional practices have socialized women to be unassertive and passive during sexual encounters, cases of HIV/AIDS have escalated among women (Gomez & Morin, 1996; UNAIDS, 2001). In other words, less assertive women may exhibit increased silencing behaviors and, thus, increase their risk for HIV/AIDS due to their inability or unwillingness to negotiate condom use. Although limited,
findings from studies have suggested that sexual communication generally results in safer sexual behaviors.

Kelly and Kalichman (1995) have contended that communication between intimate partners regarding safer sex issues can influence safer sex behaviors through the use of condoms. Quina, Harlow, Morokoff, Burkholder, and Deiter (2000) conducted a study with 816 predominately Caucasian women ($n = 646, 79.2\%$) to explore women’s willingness to communicate with their intimate partners. These researchers used two sexual communication scales adapted from Deiter (1994), one scale assessing sexual communication for preference (SC-Pref) and the other for information (SC-Info). Findings revealed that SC-Info was significantly negatively correlated with frequency of unprotected sexual intercourse ($r = -.11, p < .002, df$ not reported). This finding indicated that the more information women gathered from their sexual partners, the less likely they engaged in unprotected sex. However, this significant, but weak correlational finding must be interpreted with caution. Additionally, since Caucasian women comprised almost 80% of the sample and the remainder consisted of various ethnicities, caution must be exercised in generalizing this finding to other ethnic groups.

Conversely, Bruner (1997) conducted a study with undergraduate women ($N = 219$) to determine the relationship between self-silencing and safer sex behaviors. Using Jack and Dill’s (1992) STSS, the investigator found that silencing the self was not significantly related to past condom use. However, women with low silencing scores were significantly more likely to have intentions
to use condoms with their primary partners \((r = - .21, p < .007, df \text{ not reported})\). Again, the weak correlation warrants caution in interpretation. Although Thompson and colleagues (2001) did not measure silencing in their study with male \((n = 91)\) and female \((n = 179)\) undergraduate students to determine psychological predictors of sexual behaviors related to AIDS transmission, they used a Self-Perception of Safe Communication Scale and found through multiple regression analysis that communication was not a significant predictor of risky sexual behaviors \((R^2 = .03, \text{ns})\).

Based on these limited findings related to a relationship between self-silencing and women’s risk for HIV/AIDS, the influence of self-silencing on self-efficacy for negotiating safer sex behaviors in urban Bahamian women was tested in this study.

Self-Efficacy

The belief that one has the ability to perform a behavior is strongly influenced by what Bandura (1986; 1989; 1994) termed self-efficacy. Moreover, Bandura asserted that an individual gains self-efficacy through continual successes in behaviors. Analogous to a feedback mechanism, the higher a person’s self-efficacy, the more likely he or she will repeat the behavior. Unlike other psychosocial correlates such as self-esteem that are global in nature, self-efficacy is conceptualized to be domain-specific. For instance, an individual can have a high level of self-efficacy in one domain (i.e., performing physical exercise) and yet a low level of self-efficacy in another domain (i.e., negotiating safer sex behaviors).
Self-efficacy, as a model for behavioral change, has been studied within many disciplines to determine predictive ability to bring about specific behavioral change. Areas of self-efficacy studied by investigators to predict specific behavioral change include clients’ health management behaviors following surgery (Gardner et al., 1999; Homko & Moran, 2000; Strychacz et al., 1997), exercise performance (McAuley, Talbot, & Martinez, 1999; Vicki, 1998), nutritional adherence (Schwarzer & Renner, 2000), contraceptive use (Levinson, 1995), hormonal therapy (Ali, 1999), and parenting ability of persons living with HIV/AIDS (Dorsey, Klein, Forehand, & Family Health Project Research Group, 1999; Sharts-Hopko et al., 1996). Additionally, investigators have studied other psychosocial factors such as self-esteem to determine the influence on individuals’ levels of self-efficacy (Collins & Lightsey, Jr., 2001; Rosenthal, Moore, & Flynn, 1991; Thompson & Keith, 2001) and self-efficacy in relation to preventing and controlling high risk behaviors for HIV/AIDS such as sexual behaviors (Marin, Tschann, Gomez, & Gregorich, 1998; Organista, Organista, Bola, Garcia de Alba, & Moran, 2000; Trobst, Herbst, Masters, & Costa, 2002).

**Self-Efficacy and Women**

Since self-efficacy is domain-specific, as posited by Bandura (1986), it may be fair to assume that self-efficacy is not generally gender related, although a particular gender may be more efficacious in a given domain and in a given context due to cultural norms and social practices. For example, because women usually perform the role of nurturers, caregivers, and childrearers within most
cultures, they may have more parenting self-efficacy than men given that they may have had more practice and successes in these areas.

Clark and Dodge (1999) conducted a study with women \((N = 570)\) 60 years of age and older to explore their self-efficacy as a predictor of cardiac disease management at 4 months and again at 12 months. Self-efficacy was measured on a scale of 1 (not at all confident) to 10 (very confident) with items related to specific behaviors. The investigators found that self-efficacy predicted disease management at 4 months and again at 12 months in all domains: medication use (parametric estimate at 4 months \(.221, SE .07, p = .002\) and at 12 months \(.809, SE .05, p = .0001\)), following dietary recommendations (parametric estimate at 4 months \(.345, SE .04, p = .0001\) and at 12 months \(.493, SE .05, p = .001\)), exercising (parametric estimates at 4 months \(.388, SE .06, p = .0001\) and at 12 months \(.415, SE .07, p = .0001\)), and stress reduction (parametric estimate at 4 months \(.161, SE .05, p = .001\) and at 12 months \(.111, SE .06, p = .05\)). However, the sample was made up of predominately Caucasian women (87%), and the remainder were of various ethnic backgrounds. Although at four months, race, self-efficacy, and living alone accounted for 7% of the variance in following dietary recommendations and race combined with self-efficacy, living alone, and education accounted for 29% of the variance in stress reduction, the investigators did not specifically report any self-efficacy differences by race. This information may have shed some light on self-efficacy related to health management among women of different racial groups.
Levinson (1995) conducted a study with 11 to 20-year-old adolescent girls from California \( (n = 258) \) and Chicago \( (n = 263) \) to determine the relationships among their contraceptive self-efficacy (CSE), reproduction and contraceptive knowledge (RCK), and sexual behaviors. Using an 18-item CSE instrument with four factors (i.e., assertive communication, physicality of sex, taking control, and prevention of unprotected coitus) to measure CSE, the investigator unexpectedly found that CSE did not influence the relationship between adolescent women’s RCK and their contraceptive behaviors, although CSE did explained 12% of the variance in RCK for the Chicago group and 28% for the California group \( (p < .05) \).

Despite some negative findings, investigators continue to suggest that self-efficacy can predict behaviors. For instance, Dorsey et al. (1999) conducted a longitudinal study with African American mother-child dyads \( (N = 205) \) of whom 32% were mothers were living with HIV/AIDS. The investigators collected data during two occasions separated by 12 to 14 months to explore the difference in parenting self-efficacy and social support between the two groups. Using a parenting self-efficacy scale to measure the mothers’ perception of self in her role as a parent, they found that parenting self-efficacy at baseline was a significant predictor of parenting self-efficacy 12 to 14 months later \( (\beta = .74, p < .01) \). The investigators reported that women living with HIV/AIDS had significantly lower levels of parenting self-efficacy than did women uninfected with HIV disease. Additionally, findings revealed that the relationship between parenting support at baseline and parenting self-efficacy was significant for HIV-uninfected mothers.
[β = .18; $F(1, 134) = 7.85, p < .01$] but not for the HIV-infected mothers [β = -.04; $F(1.61) = .37, ns$]. The investigators concluded that mothers living with HIV/AIDS may view offered support as a failure or perceived inability to deal with their own problems and thus may feel less efficacious as parents.

Similarly, Sharts-Hopko and colleagues (1996) conducted a study with HIV-infected mothers ($N = 41$) to determine the relationships among perceived self-efficacy, uncertainty, social support, psychological distress, and problem-focused coping. The investigators used a visual analog scale with scores ranging from 1 (*most negative*) to 100 (*most affirmative*) to measure two dimensions of perceived self-efficacy (PSE): perceived capability of meeting challenges associated with their HIV infection (PSE-1) and confidence that they could succeed in meeting those challenges (PSE-2). Although the authors could not conduct predictive analysis due to small sample size, they found that PSE was negatively related to psychological distress and duration of an HIV-infected child’s illness ($r = -.40, p < .05$ and $r = -.43, p < .05$, respectively), indicating that the higher the women’s perceived self-efficacy, the lower were their psychological distress and duration of HIV-infected child’s illness. In addition, PSE showed a positive relationship with problem-based coping ($r = .44, p < .05$), indicating that the higher the women PSE level, the more ways they were able to cope. However, causal relationships could not be established so caution should be used when generalizing these findings.

As scholars continue to investigate predictors of behaviors and interventions for effective coping to decrease preventable diseases such as hypertension,
diabetes, and HIV/AIDS, self-efficacy will continue to be among the important variables to predict and bring about behavioral change (Dennis & Goldberg, 1996; Moore, Turner, Park, & Adler, 1996; Strychacz et al., 1997). Additionally, other psychosocial variables such as self-esteem are also being investigated by scientists to determine their influence on individuals’ self-efficacy for domain-specific behaviors.

**Self-Efficacy and Self-Esteem**

Self-efficacy and self-esteem are two psychological concepts that have been widely studied, together and separately, in various disciplines and domains in an effort to predict and/or bring about behavioral changes to improve individuals’ coping abilities with life stressors. However, scholars’ views differ concerning the association and causal relationship between these two concepts. Bandura (1986) asserted that self-efficacy and self-esteem are differing concepts with no important relationship since self-efficacy pertains to perceived capabilities, and self-esteem pertains to perceived self-worth. Bandura (1986) further argued that although both self-efficacy and self-esteem contribute to quality of life, a person who feels inefficacious concerning a given task may do so without losing his or her feeling of self-worth and vise versa. For example, a woman with a high level of self-esteem may perceive herself to be inefficacious in mathematics with no affect on her self-esteem level. Bandura’s (1986) argument may be due to the fact that this theorist viewed self-efficacy as domain and task specific and viewed self-esteem to be a global feeling of self-worth.
In contrast, Gecas and Schwalbe (1983) maintained that there are two sources of self-esteem: (a) efficacy-based self-esteem, which referred to “inner self-esteem” that depends on individual competencies, and (b) esteem, which refer to “outer self-esteem” that is based on the opinions of others. Similarly, Cast and Burke (2002) stated that self-esteem is made up of two dimensions, efficacy-based self-esteem and worth-based self-esteem. Moreover, Cast and Burke (2002) agreed with Gecas and Schwalbe (1983) that efficacy-based self-esteem is the central of the two and may indeed be responsible for maintaining the level of worth-based self-esteem. Findings from a study conducted by these investigators suggested that the efficacy-based part of the self-esteem appeared to be responsible for buffering effects on unsuccessful self-verifications.

Differing views concerning self-esteem and self-efficacy have encouraged scholars to seek answers to the following questions:

1. Is self-efficacy domain and task specific and does self-efficacy differ from self-esteem as posited by Bandura (1986)? Or

2. Is self-efficacy one dimension of self-esteem as posited by Gecas and Schwalbe (1983) and Cast and Burke (2002)?

Woodruff and Cashman (1993) suggested that there might be three levels of self-efficacy: (a) task-specific self-efficacy, (b) domain-specific self-efficacy, and (c) general self-efficacy. To shed more light on this view as it relates to self-esteem, one might argue that self-esteem is indeed a combination of worth-based self-esteem and efficacy-based self-esteem. Further, it is believed that the efficacy-based aspect of self-esteem is tapped whenever scholars use general self-efficacy
instruments to measure self-efficacy. Consistent with Bandura’s (1986) argument, self-efficacy appears to be a combination of task-specific and domain-specific self-efficacy, and self-efficacy as a concept is different from self-esteem. However, it is believed that self-efficacy and self-esteem are related by virtue of the efficacy-based aspect of self-esteem.

Although many studies have found a correlation between self-esteem and self-efficacy (Bernard, Hutchinson, Lavin, & Pennington, 1996; Betz & Klein, 1996; Saracoglu, Minden, & Wilchesky, 1989; Stanley & Murphy, 1997; Timmons, 1999), some findings have supported the notion that they are indeed different constructs. Dickerson and Taylor (2000) conducted a study with female university students ($N = 123$) to determine the impact of task-specific self-efficacy (TSSE) and global self-esteem (GSE) on their choice of leadership task. The investigators found that although TSSE and GSE were significantly correlated ($r = .61, p < .01$), they were not equally strong in predicting leadership task preference among the women (13%, $p < .01$ versus 7%, $p < .05$ of the variance, respectively). Moreover, findings from this study led the investigators to the conclusion that the relationship between TSSE and GSE would only be slightly improved upon by using task-relevant abilities as a moderator ($R^2 = .03, p < .05$).

Conversely, Stanley and Murphy (1997) conducted a study with undergraduate students ($N = 165$) to examine the relationships among general self-efficacy, task-specific self-efficacy, and self-esteem. Using a battery of scales, general self-efficacy and global self-esteem scales, the investigators found
that general self-efficacy and self-esteem overlapped in variance to predict task-specific self-efficacy. For instance, the combined general self-efficacy scales accounted for a significant proportion of variance accounted for (7%, $p < .00$) in task-specific self-efficacy before self-esteem was removed from the equation and accounted for a nonsignificant proportion of variance (1%, ns) after the removal of self-esteem from the equation. Moreover, the investigators found that the correlation between general self-efficacy scales and self-esteem was so high ($r = -.74$, $p < .01$) that they concluded that these variables were measuring the same construct. However, the correlation was negative because high self-esteem scores indicated low self-esteem levels and high self-efficacy score indicated high self-efficacy levels. As a result, one might conclude that general self-efficacy and self-esteem appeared to measure the same construct because general efficacy may actually be measuring the efficacy-based aspect of self-esteem.

Social structures can act as both enhancers and barriers to self-esteem and self-efficacy. Gecas and Schwalbe (1983) contended that life experiences may increase and decrease self-esteem depending on the role one plays in a society. For instance, in some societies where there are inequalities related to race/ethnicity and gender, self-esteem and self-efficacy may have differential predictive capabilities among these groups. Thompson and Keith (2001) conducted a study with Black American men ($n = 637$) and women ($n = 1,036$) to evaluate the influence of gender and skin tone on self-esteem and self-efficacy. The investigators found that although skin tone had a negative effect on self-esteem and self-efficacy, these variables affected different self-domains in men
and women. More specifically, the investigators found that skin tone predicted
12% of the variance in self-efficacy for men and only 3% for women. On the
other hand, skin tone predicted 1% of the variance in self-esteem for men and 9%
for women. The investigators concluded that darker skinned men may feel
inefficacious because of less opportunity to demonstrate competence in a society
where inequality related to racism and colorism are displayed. This lack of
opportunity may cause darker skinned men to have decreased beliefs that they
have the capabilities to perform a task effectively. Similarly, darker skinned
women may have low levels of self-esteem because of their socialization process
in a society embedded with sexism, racism, colorism, and classism. This view was
supported by the fact that the investigators found that the more attractive and the
more income darker skin women had, the higher were their levels self-esteem.

Despite conflicting views as to whether self-efficacy is a part of self-esteem
or whether self-efficacy is an entirely different construct, given that self-esteem is
a feeling of self-worth and self-efficacy is a belief in self-capability, it is
reasonable to assume that a person’s level of self-esteem would impact his or her
self-efficacy for a particular behavior. However, Rosenthal et al. (1991)
conducted a study with students from post-secondary institutions (N = 1,788)
between the ages of 17 to 20 years, of whom 73% were females, to investigate
their sexual self-efficacy and sexual self-esteem on their sexual risk-taking
behaviors. Despite the fact that the investigators found that male students had
higher levels of self-esteem than did female students (F = 14.32, p < .001) and
female students had higher self-efficacy subscale scores than male students (“Say
No” $F = 137.59, p < .001, df$ not reported and “Assertive” $F = 20.62, p < .001, df$ not reported), they found that self-efficacy and self-esteem accounted for less than 10% of the variance in risk-taking behaviors for both genders, suggesting that other mediating and/or moderating factors are also involved in decision to engage in safer sex behaviors.

**Self-Efficacy and Negotiating Safer Sex Behaviors**

Early during the HIV/AIDS epidemic, scientists focused their attention on changing behaviors such as sexual practices and injecting drug use to decrease acquisition and transmission of the virus. In their quest for knowledge, however, scientists quickly found that education alone was insufficient to bring about behavioral change. As a result, they focused their attention on variables that may predict high risk behaviors in an effort to target interventions to reduce such behaviors. One such variable is self-efficacy (Bandura, 1986).

Sexual intimacy is a complex phenomenon which is one human basic need that brings about a pleasurable experience. However, it is the primary mode by which HIV/AIDS is acquired and transmitted (CDC, 2002; UNAIDS, 2002). For instance, although HIV/AIDS can be acquired and transmitted by injecting drugs with contaminated paraphernalia, having sexual intimacy with an HIV-infected IDU could also result in its acquisition and transmission. Additionally, in the case of a woman becoming infected via sexual intimacy, she could pass the HIV virus to her baby, although the same could happen if she became HIV-infected via other routes such as self-injection of drugs or receiving an HIV-infected blood transfusion. Given the primary role of sexual intimacy in the acquisition and
transmission of HIV/AIDS and given that unprotected sexual intimacy between two or more persons may result in HIV infection, it is imperative to focus on self-efficacy for negotiating safer sex behaviors.

Bandura (1986, 1989, 1994) has contended that the higher an individual’s self-efficacy for a particular behavior, the more likely the individual will perform the behavior; conversely, the lower the self-efficacy, the less likely the individual will perform the behavior, which in essence suggest the predictive powers of self-efficacy. Bandura further contended that the more successes an individual has in performing a behavior, the higher his or her self-efficacy for that particular behavior will be, which in essence suggests the diagnostic powers of self-efficacy. Therefore, it may be fair to assume that an individual with a high level of self-efficacy for negotiating safer behaviors has had many successes performing such behaviors.

Investigators have found positive relationships between self-efficacy and safer sex behaviors such as condom use, refusing sex, and sexual discussions (Forsyth, 1999; Goh et al., 1996; Park, Sneed, Morisky, Alvear, & Hearst, 2002). It has also been documented that self-efficacy training is successful in reducing the risk for HIV/AIDS (Icard et al., 1995; Jemmott, Jemmott, Fong, & McCaffree, 1999; Jemmott, Jemmott, Spears, Hewitt, & Cruz-Collins, 1992). Additionally, findings from numerous studies have suggested the predictive powers of self-efficacy with respect to safer sex behaviors. Dilorio et al. (1997) conducted a study with 641 participants ages 18 to 58 years, most of whom were African Americans \((n = 577, 90\%)\) and males \((n = 379, 59.1\%)\) to evaluate the
psychometric properties of two instruments, one being the Condom Use Self-Efficacy Scale. Among other findings, the investigators found that participants who reported no condom use at last intercourse had significantly lower total self-efficacy scores than those who reported use of a condom \(t(584) = 3.81, p < .001\). Similarly, participants who reported no condom use during the past month had significantly lower self-efficacy scores than those who used condom at least one during the last month \(t(593) = 4.91, p < .001\). These findings suggested that the less practice an individual has at performing safer sex behaviors, the less success he or she is likely to encounter and the less efficacious he or she will feel.

Many early studies have investigated self-efficacy in gay men because they were considered a high risk group. However, since women became a high risk group due to biological (Holmberg, 1997) and behavioral (Beadnell et al., 2000; Erickson, 1997; Stokes et al., 1996) factors coupled with the possibility for MTCT, scientists were encouraged to investigate self-efficacy in relation to negotiating safer sex behaviors in women. Lindberg (2000) conducted a study with sexually active urban women \(N = 100\) aged 28 to 45 years to test a model of the relationships among knowledge, self-efficacy, coping, and condom use. Using the Condom Use Self-Efficacy Scale (CUSES) developed by Bragord and Beck (1991) to measure self-efficacy for condom use, the investigator found that condom use knowledge accounted for 28% of the variance in self-efficacy (\(\beta = .28, p = .006\)), but more importantly, that self efficacy for condom use accounted for 64% of the variance in condom use (\(\beta = .64, p < .001\)). Additionally, self-efficacy accounted for 28% of the variance in problem-based coping (\(\beta = .28, p =\)
and the total model accounted for 43% of the variance in condom use behavior ($R^2 = .43, p < .001$).

Similarly, in a study with longitudinal follow-up conducted by Bryan, Aiken, and West (1997) with female undergraduate students to develop, test, and replicate a comprehensive model of the determinants of condom use among young women, the investigators obtained self-report data from 198 women in the first study and 238 women in the follow-up study. Using Brafford and Beck’s (1991) CUSES in study one and a combination of Brafford and Beck’s (1991) CUSES and Brien, Thombs, Mahoney, and Wallnau (1994) CUSES in the follow-up study to measure condom use self-efficacy, the investigators found that in the initial study, self-efficacy showed a significant positive association with intentions to use condoms ($r = .30, p < .001$). In addition, these investigators reported findings from the follow-up study that showed intention to use condoms as a significant positive association with the percentage of time the participants used condoms and their condom use at last intercourse ($r = .69, p < .001$ and $r = .66, p < .001$, respectively). These findings indicate that as women’s self-efficacy increased, so did their safer sex behaviors, further suggesting their ability to negotiate safer sex behaviors with their partners.

Investigators have also studied the ability of self-efficacy to discriminate safer sex behaviors among groups with high risk behaviors. Brien et al. (1994) conducted a study with 362 participants, the majority of whom were women (56.6%), to examine the dimensions of self-efficacy among three distinct groups of condom users: (a) nonusers, (b) sporadic users, and (c) ritualistic users. Using
the revised Condom Use Self-Efficacy Scale initially developed by Brafford and Beck (1991), the authors found that ritualistic condom users had higher scores on all four of the subscales than the sporadic user and nonusers and that three of the subscales scores were significantly different among these groups ("Partner’s disapproval," "Assertive," and "Intoxicants, " $F(2,272) = 3.57, p < .05$; $F(2,272) = 5.76, p < .005$; and $F(2,272) = 6.57, p < .005$, respectively), which further supports the view that the more successes an individual has with safer sex behaviors, the more self-efficacious he or she will be.

Similarly, Trobst and colleagues (2002) conducted a study with African Americans ($N = 201$) to determine if personality characteristics influenced risk for HIV/AIDS. Participants were categorized into groups based upon their HIV risk: (a) low risk ($n = 43, 21.4\%$), medium risk ($n = 96, 47.8\%$), and high risk ($n = 62, 30.8\%$). The investigators reported that personality was, indeed, a predictor of sexual risk. In addition, they reported that thrills and kicks were not predictors of unsafe sex and that the high risk group had decreased opinion of their skills and self-efficacy. However, the investigators did not report if and how self-efficacy was measured in this study, which lends question to the validity of these findings.

In contrast to these findings, St. Lawrence and colleagues (1998) conducted a community-based study with sexually active African American women ($N = 423$), ages 17 to 65 years ($M = 31.3, SD = 9.2$), to examine the differences in their condom use, which was categorized as (a) consistently, (b) inconsistently, and (c) nonusers. Using a 2-item Self-Efficacy Scale based on Bandura’s (1986) Social Cognitive Theory, the investigators found that self-efficacy scores among the
three categories of condom users were not significantly different. However, limited scale items and possibly lack of adequate scale validity may have been responsible for such findings. Similarly, Youmans (2001) found that self-efficacy, as measured by Rosenthal et al.’s (1991) Sexual Self-Efficacy Scale, along with other variables did not predict condom use during sexual intercourse in a group of college women (N = 157) ages 18 to 24 years.

To determine whether differences exist between genders and among ethnic groups for self-efficacy to engage in safer sex behaviors, O’Leary, Goodhart, Jemmott, and Boccher-Lattimore (1992) obtained self-report data from male (n = 372, 40.3%) and female (n = 549, 59.5%) college students, of whom 71.7% were Whites, 9.6% were Black/African Americans, 8.8% were Asian/Pacific Islanders, 5.7% were Hispanics/Latino, and 4.4% were others. Using two self-efficacy scales with items designed to assess self-efficacy for safer sex behaviors as conceptualized in the Health Belief Model (HBM), the investigators found that women reported significantly higher perceived self-efficacy for discussing history/negotiating [t(385) = 2.05, p < .05] and for safer sex behaviors [t(389) = 2.02, p < .05], than did men. Additionally, the investigators found that there was a significant effect for history/negotiating for safer sex behaviors $F(4, 356) = 3.08$, $p < .05$, which was accounted for by Asian/Pacific Island students having significantly lower self-efficacy for discussing history/negotiating for safer sex behaviors scores than did Blacks and Hispanics ($t = 2.0, p < .05$ and $t = 2.10, p < .05$, df not specified).
In further support of ethnic difference in self-efficacy to engage in safer sex behaviors, Soet, Dilorio, and Dudley (1998) conducted a study with sexually active female college students \(N = 762\), ages 18 to 25 years, of whom 46.5% were White and the remainder were African Americans. The purpose of the study was to explore women’s intra- and interpersonal factors affecting their condom use and to determine possible ethnic differences between the two group of women related to intra- and interpersonal factors. Using the 4-item Self-Efficacy Condom Use subscale of the 12-item Self-Efficacy Scale revised by Dilorio and colleagues in 1995 (C. Dilorio, personal communication, September 23, 2002), the investigators found that higher self-efficacy in white women was significantly associated with increased condom use \[F(1, 352) = 17.54, p < .0001\], but not in African American women. Moreover, multiple regression analysis suggested that high self-efficacy was a significant predictor of condom use among White women accounting for 5% of the variance, whereas self-efficacy did not predict condom use in African American women.

Similarly, Gomez and Marin (1996) conducted a study with Latino \(n = 513, 73.6\%\) and non-Latino White \(n = 184, 26.4\%\) women to assess their contraceptive use and condom use with steady male partners and explored ethnic differences in sexual behaviors and psychosocial variables. Using a 4-item self-efficacy scale for condom use to measure condom use self-efficacy, the investigators found that non-Latino White women had significantly higher self-efficacy scores than their Latino counterparts \[t = 5.60, p < .007, df\] not reported. However, these findings must be interpreted with caution because the self-
efficacy scale demonstrated weak internal consistency for both group of women (Latino $\alpha = .52$ and non-Latino Whites $\alpha = .47$), bringing to question the reliability of the scale. Despite the need to use caution when generalizing the findings of this study along with findings from the previous study, race and ethnicity due to cultural norms and female socialization do appear to influence women’s self-efficacy for safer sex behaviors.

Although Bandura (1986, 1989, 1994) maintained that self-efficacy is a major determinant of safer sex behaviors, this theorist also maintained that interpersonal factors may conflict with women’s ability to protect themselves leading to decreased self-efficacy and decreased engagement in safer sex behaviors. For instance, in a study conducted by Soet, Dudley, and Dilorio (1999) to determine the effects of ethnicity and perceived power on women’s sexual behaviors, the investigators surveyed 615 female students (46.2% Whites and 53.8% African Americans) between the ages of 8 to 25 years who were involved in active heterosexual relationships. The researchers categorized the women into three power groups: (a) partner dominant, (b) self dominant, (c) and equal dominant and used a 12-item Self-Efficacy Scale revised by Dilorio et al. in 1995 (C. Dilorio, personal communication, September 23, 2002) to measure the participants’ confidence to perform safer sex practices. Although the investigators found no significant differences in levels of dominance by race, they did find that there were significant differences among dominance groups in all three self-efficacy subscales: refusing sex [$F(2,595) = 11.384, p = .000$], discussing safer sex [$F (2,597) = 10.12, p = .000$], and using a condom [$F(2,599) = 5.82, p =$
In addition, the investigators found that women whose partners dominated the relationship had lower self-efficacy scores on all three subscales than women who equally or self-dominated the relationship. Additionally, the investigators found that African American women reported significantly higher self-efficacy in discussing safer sex than did white women ($M = 36.44, SD = 5.79$ versus $M = 34.55, SD = 6.27, p < .017$). These findings suggest that women who perceive themselves to be in partner dominant relationships may also perceive themselves as less efficacious in negotiating safer sex behaviors with their partners.

Additionally, the investigators concluded that African American women’s high scores on the self-efficacy to discuss safer sex might be related to their comfort level with condom use, which may in turn be due to their prescribed “less traditional” roles (p. 718).

In further support of how power imbalances may impact women’s ability to negotiate safer sex behaviors, Wingood and DiClemente (1997) conducted a study with predominately low socioeconomic African American women ($N = 165$) to examine the consequences of having a physically abusive partner on condom use and negotiating practices. Although the investigators did not measure the women’s self-efficacy for negotiating safer sex behaviors, they found that women in abusive relationships were less likely to use condoms, more likely to be afraid because of possible physical abuse as a result of an attempt to negotiate condom use, may experience more verbal and emotional abuse, were more worried about contracting HIV/AIDS, and may experience more isolation than women in nonabusive relationships.
Conversely, Bowleg and colleagues (2000) conducted a study with women (N = 125) of different ethnic background [i.e., non-Latina Black (n = 59, 47.2%), Latinas (n = 52, 41.6%, White (n = 9, 7.2%), and Asian (n = 4, 3.2%)] to test a model using gender roles, relationship power strategies, and precautionary sexual self-efficacy as predictors of HIV/AIDS protective behaviors. Using the Sexual Self-Efficacy Scale developed by Rosenthal et al. (1991) to measure sexual self-efficacy, the investigators found that the women’s precautionary sexual self-efficacy had a significantly positive relationships with their level of education (r = .36, p < .001), instrumental gender roles (r = .28, p < .01), and direct power strategies (r = .27, p < .01). Additionally, multiple regression revealed that expressive and instrumental gender roles along with the use of direct power accounted for 16% of the variance in precautionary sexual efficacy and that direct power strategies was a significant predictor in the model (β = .22, p < .05).

Despite these findings, the variables in the model did not predict HIV/AIDS protective behaviors in this group of women.

Findings from the majority of the studies presented suggest that self-efficacy is a major predictor of safer sex behaviors. Based on the theoretical assumption that the more success with a specific behavior, the higher the self-efficacy scores (Bandura, 1986), it may be fair to use the diagnostic powers of self-efficacy for negotiating safer sex behaviors as an indirect indicator of urban Bahamian women’s actual engagement in negotiating safer sex behaviors with their partners.
Summary

Based upon the review of the literature, it is evident that women are at increased risk for HIV/AIDS acquisition and transmission. Women’s increased risks are due to their biological make-up (e.g., increased vaginal mucosal surface area and possible asymptomatic STDs) and their behaviors, which are influenced by sociocultural (e.g., cultural norms and traditional practices), socioeconomic (e.g., age, educational, and income levels), intrapersonal (e.g., self-esteem), and interpersonal (e.g., self-silencing and self-efficacy) variables.

Despite the preponderance of studies that have investigated these variables to date, no study was found that has investigated the influence of self-esteem and self-silencing on self-efficacy for negotiating safer sex behaviors in women in general or in urban Bahamian women in particular. Therefore, findings from this study have shed light not only on the relationships among major variables (i.e., self-esteem, self-silencing, and self-efficacy, but (also) how these variables interact in a different culture of women from a country with high rates of HIV/AIDS in women.

To this end, the following hypotheses were tested in this study:

1. There will be a negative relationship between urban Bahamian women’s self-esteem and self-silencing behaviors.

2. There will be a positive relationship between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behaviors.

3. There will be a negative relationship between urban Bahamian women’s self-silencing and self-efficacy for negotiating safer sex behaviors.
4. Age, income, education, self-esteem, and self-silencing will make significant independent and combined contributions to self-efficacy for negotiating safer sex behaviors in urban Bahamian women.
CHAPTER III

METHODOLOGY

Introduction

In this chapter, the quantitative methods used to conduct this study are presented. The design, sampling techniques, instruments used to measure the major variables and their appropriateness to this study, ethical considerations, data gathering procedures, and data analysis techniques are described and justified.

Research Design

The design used in this study was cross-sectional and correlational. The purpose for selecting such a design was to determine the degree and direction of association among the variables in this study and to explore the relative contributions of predictor (independent) variables (i.e., select demographic variables including age, income, and education; self-esteem; and self-silencing) to the criterion (dependent) variable, self-efficacy for negotiating safer sex behaviors. Participants completed a self-administered, 80-item questionnaire containing three instruments and demographic and background questions.

Setting

The setting for this study was a variety of community sites in Nassau that Bahamian women frequently visit (i.e., laundromats, beauty salons, clinic waiting rooms, churches, work-places, adult education settings). Owners of these establishments were contacted via a formal letter to ask their permission to collect data from women at their establishments (see Appendix A). Additionally, the owners were asked to post flyers at their establishments to advertise the study (see
Appendix B), and the researcher negotiated appropriate dates and times for data collection with the owners.

Sample

Power Analysis and Sample Size

In order to determine an adequate and appropriate sample size for this study for the number of variables and proposed statistical analyses techniques, a priori power analyses were conducted using the G* POWER 2.1.1 (Buchner, Faul, & Erdfekder, 1997). The software package has received favorable ratings for accuracy and precision and is available, at no charge, on the Internet (Goldstein, 1989). Estimated sample size for this study using G* POWER were comparable with those listed in Cohen’s (1988) sample size tables. The hypotheses for this study included five predictor variables and one criterion variable. Power analyses were conducted for bivariate correlational [i.e., Pearson product-moment correlation(r)] and multiple regression analyses.

Although the initial plans for this study included use of multiple regression, exploratory analysis of the data revealed a very negatively skewed distribution of the dependent variable, which was in violation of one of the first assumptions of multiple regression analysis. As a result, the dependent variable was dichotomized using a median split for binary logistic regression. However, there are no known statistical packages presently available to conduct a power analysis for logistic regression (Munro, 2001); hence, multiple regression power analysis was used both to provide an a priori estimate of sample size and for post hoc power determination.
In view of the relative seriousness of consequences for committing a type I or type II errors in this survey study, alpha (\(\alpha\)) was set at the conventional level of 0.05, and beta (\(\beta\)) was set at the conventional level of 0.20, or four times alpha. As a result, the desired power was calculated as 1 - \(\beta\) = 0.80.

Since psychological instruments were used to measure the major variables in this study, which according to Cohen (1988) are likely to have small effect sizes (ES), and since these instruments have not previously been used with Bahamian women, a conventional small effect size was chosen to calculate the appropriate a priori sample size for the study (e.g., ES = 0.10 for correlations (\(r\)) and 0.02 for multiple regression analyses). In order to detect a small effect, or the degree to which the phenomenon is present in Bahamian women, with a power of 0.80, a sample size of 614 was needed for a one-tailed bivariate correlation (\(r\)) and a sample size of 647 was needed for multiple regression [note: if medium effect sizes of 0.30 for correlations and 0.15 for multiple regression were used, necessary sample sizes decreased to 64 and 92, respectively].

Given the estimated sample size and accommodating for the possibility that some returned questionnaires would be unusable for analyses, the desired sample size for this study was 650. There was no doubt that the desired sample size was obtainable since data collection was open to all available Bahamian women in Nassau who were 18 years or older and wanted to participate in the study.

Using the same estimates as the initial power analysis with the inclusion of the actual obtained sample size of 661, post hoc power analyses using G*POWER revealed actual power achieved for this study was 1.0 for bivariate
correlation \((r)\) for both small and medium effect sizes. Further analyses for multiple regression showed a power of .81 for small effect size and 1.0 for medium effect size, respectively. The power values indicated that the obtained study sample size was more than adequate to detect associations between major study variables if they existed as well as to have a reasonable level of confidence in the predictive value of variables in logistic regression analysis.

**Inclusion and Exclusion Criteria**

A convenience sample of volunteer Bahamian women, ages 18 years or older, living in Nassau or Freeport, Grand Bahama was recruited for this study. The inclusion criteria of women being ages 18 years or older was set because 18 is the legal adult age in The Bahamas. Additionally, residence in either Nassau or Freeport, Grand Bahama was specified as in inclusion criteria because these are the two cities in The Bahamas that are considered urban areas, which was the scope of this study. Although data collection was not conducted in Freeport, Grand Bahama, there were some Bahamian women who lived in Freeport, Grand Bahama visiting Nassau during the time of data collection and who completed the survey. These urban women were included in analyses. There were only two Bahamian women who lived on the Family Islands of The Bahamas (i.e., rural areas) visiting Nassau during the time of data collection who completed the survey. However, these rural women were excluded from analyses since they did not meet the inclusion criteria of residence in an urban area.

Additionally, all foreign born Bahamian women who completed the survey lived in The Bahamas for 10 years or more. Since findings of studies have
suggested that the longer the time spent in a host country, the more acculturated the individual becomes (McCarcken, 1988), it is reasonable to assume that foreign born Bahamian women who have spent 10 years or more in The Bahamas have had adequate time to become acculturated and assimilated into Bahamian culture. Therefore, these women were also included in data analyses.

Although the majority of the participants were able to read English, a few questionnaires were unusable since some women were unable to read English. Almost all of the participants (95%) who were unable to read English were Haitian Bahamians. Due to questionable validity, these questionnaires were excluded from data analyses.

Since the sample was drawn from various community sites in Nassau, Bahamas where women frequent, a heterogeneous sample of urban women most suited for correlational design studies was obtained (Cone & Foster, 2001). The demographic and background characteristics of the participants were measured using a culturally sensitive set of demographic questions (see Appendix C).

**Recruitment Procedures**

A variety of strategies including word of mouth, posted flyers, letters requesting support from governmental leaders, and media advertisements were used to recruit Bahamian women for this study. The researcher used a variety of opportunities during public and private speaking engagements (i.e., during church meetings, community service organization meetings, radio talk shows) to encourage participation of urban Bahamian women in the study.
Additionally, permission was obtained from community owners to post flyers in their establishments (e.g., laundromats, beauty salons, clinic waiting rooms, churches, adult education settings, and professional clubs), which described the study and welcome volunteers. Benefits of the study to The Bahamas in general and women in particular were described. A small incentive (i.e., mugs, photo albums, bath brushes, make-up brushes, calculators, pen sets) valued at $1 each were offered to the women to encourage their participation in the study and to show appreciation for their time (Patsdaughter, Christensen, Kelley, Masters, & Ndiwane, 2001).

A letter was sent to the Executive Director of HIV/AIDS Department, a governmental department that coordinates HIV/AIDS-related activities in terms of prevention, care, and support in The Bahamas (see Appendix D) and the Minister of Health (see Appendix E) to gain their support and assistance in public recruitment of Bahamian women for the study.

The study was advertised via a local radio station during a 1-hour call-in talk show and a 5-minute morning talk show approximately two days prior to data collection. Additionally, advertisements were made via the local television station for two consecutive weeks during the time before and during data collection (see Appendix B).

Instrumentation

Measurement of Sample Demographic Characteristics

Since convenience sampling was used, special efforts were made to enhance the generalizability of study findings through adequate and appropriate
description of the participants’ characteristics (Gall, Borg, & Gall, 1996). A 21-item demographic questionnaire was carefully developed. Items were reviewed by a group of 10 Bahamian registered nurses living in South Florida to ensure that questions were socially and culturally sensitive to Bahamian women (see Appendix C).

The first item on the demographic instrument (i.e., Where do you presently live?) was assumed to be a non-threatening item in Bahamian culture and was used to differentiate which participants’ data would be included in data analyses. The second question (i.e., How many times per month do you attend your place of worship?) helped to describe the participants in terms of their religiosity. However, religious denomination was not asked since churches were a part of the study settings, and it was anticipated that participants might have been reluctant to answer sexual questions due to fear that responses may be linked to their particular religion. Item three (i.e., How many years of school have you completed?) and four (i.e., How many years of college have you completed?) were summed to create an interval-level educational variable. Item five was a dichotomous item about employment (i.e., unemployed vs. employed).

Item six (i.e., What is your monthly household income?) was an ordinal level item in $500 increments, and item seven asked how many persons are supported by this income to help achieve an estimated per capita income. However, exploratory data analyses revealed that per capita income could not be accurately estimated due to the u-shaped distribution of income variable. Although it was recognized that it might have been better from a measurement perspective to ask
raw monthly income, it was thought that Bahamian women would be more likely to respond to income brackets rather than report a monthly dollar amount. Since income revealed a u-shaped distribution, the decision was made based on examination of the frequency distribution of the income variable to dichotomized income into below $18,000 per year and $18,000 and above per year. Since income was measured in brackets of monthly increments of $500 beginning with less than $1000 and ending with $3500 or more, the mean and median could not be used to dichotomize income since neither the floor nor ceiling could be accurately determined for this variable.

Items 8 through 12 and 14 through 19, which addressed marital status, hobbies, number of children, ethnicity, sexual preference, and HIV/AIDS history, yielded additional data to describe participants’ demographic and background characteristics. Item 13 and 14 (i.e., Where were you born? If born in another country, how long have you been living in The Bahamas?) differentiated which participants were included in data analyses, as specified above in the inclusion and exclusion criteria.

Item 21 (i.e., What year were you born?) was a proxy measure for age, which was among the select demographic predictor variables. Age was deemed to be very personal and sensitive to Bahamian women. The item was formatted as a result of findings from an informal survey of 60 Bahamian women who were given two choices of how they preferred to be asked a question concerning their ages (i.e., How old are you? vs. What year were you born? 19_ _). The results of this pilot survey suggested an even preference between the two choices. As a
result, birth year rather than age was asked on the demographic questionnaire. Age was computed by subtracting birth year from 2003 prior to analyses.

Items on the demographic instrument were measured using nominal (categorical), ordinal, and interval levels of measurement. Some items yielded dichotomous data, which were coded as zero and one (i.e., no = 0 and yes = 1 or unemployment = 0 and employment = 1). Other categorical items were coded numerically (i.e., Freeport = 1, Nassau = 2, Other = 3). Qualitative responses to items 10 (i.e., What two hobbies do you engage in most?) and 17 (i.e., relationship of person personally known with HIV/AIDS) were qualitatively summarized and categorized and used to further describe the participants.

An expansive review of the literature related to risk for HIV/AIDS and related variables revealed comparable demographic data to variables that were measured in this study. However, there were some differences in the way the items were phrased and the categories offered for responses in an effort to ensure social and cultural sensitivity of items for this study. The demographic items were relevant for this study and have produced data that adequately described the participants and, thus, have enhanced generalizability of study findings to the target population (Gall et al., 1996).

Measurement of Independent Variables

Selected demographic variables. Age, income, and education were included in the hypotheses for this study as predictor variables and were measured by items on the demographic questionnaire. Age, income, and education are among the most widely reported demographic variables in the literature related to the major
variables of this study (i.e., self-esteem, self-silencing, and self-efficacy) and risk for HIV/AIDS. For example, findings from some studies have suggested that older women tend to engage in unprotected sex more than younger women do (Graves & Hines, 1997). UNAIDS/WHO (2002) have reported that lack of or inadequate income may be responsible for women’s risk for HIV/AIDS. Additionally, education was found to be an important predictor of condom use in a study conducted in The Bahamas between 1990 and 1991 where data were collected from pregnant women \( n = 3,914 \), of whom 79% were Bahamians. More specifically, these researchers found that 4.3% of the women with no formal education used condoms compared to 29.8% of women with high-school education and 28.8% of women with postsecondary education (Gomez et al., 1996). Therefore, it was interesting to assess how much these selected demographic variables (i.e., age, income, and education), individually and in combination, accounted for Bahamian women’s self-efficacy for negotiating safer sex behaviors. The variables of age, income, and education were computed as described in the section, Measurement of Sample Demographic Characteristics, and entered as block one in binary logistic regression analysis.

*Self-esteem.* Self-esteem was measured using Taylor’s Self-Esteem Inventory (TSEI) which was developed by Taylor and Tomasic (1996) and based on social exchange theory (Thibuat & Kelly, 1959) (see Appendix F for permission to use TSEI). This inventory is comprised of 16 self-report items; eight items measure rewards, or positive self-esteem, and eight items measure costs, or negative self-esteem. Odd numbered items assessed the rewards Bahamian women assigned to
themselves such as “I am satisfied with the kind of person that I am”; “I feel happy inside”; “I am proud of the way I do things”; and “I follow through on decisions I make.” Even numbered assessed the costs Bahamian women assigned to themselves such as “I dwell on my faults”; “I distrust my judgment”; “I feel ashamed of things I do”; and “I later regret things I’ve said” (see Appendix C).

Taylor’s Self-Esteem Inventory consists of two subscales, rewards and costs and also produces a total scale score. Each item is rated on a 0 (never) to 8 (always) scale resulting in a possible subscale range of 0 to 64 for each subscale and a total scale range of 0 to 128. To obtain the total self-esteem scores, the costs or negative items were reverse coded and summed with the reward or positive items. Higher total self-esteem scores indicated higher levels of self-esteem.

Initial psychometric estimates for this inventory were obtained from a sample of low-income mothers (N = 444), 84% of whom were Black. Normative measures of central tendency and variability were reported for subscales and the total scale and were as follows: Reward - $M = 47.41$, $SD = 9.55$, range 18 to 64; Costs - $M = 25.41$, $SD = 10.97$, range 0 to 57; and total scale - $M = 86.03$, $SD = 17.13$, range 33-128. Additionally, the Spearman-Brown split-half reliabilities were .81, .82, and .84 for reward and cost subscales and total scale, respectively. Criterion (concurrent) validity for this inventory was tested by Barrett (1977) in a study with 42 families and their infants to examine the relationship between maternal self-esteem, caregiving behavior, and interpersonal disclosure within the family unit. Using the TSEI and Rosenberg’s (1965) Self-Esteem Scale (SES) to measure self-esteem, Barrett found that TSEI correlated higher with Rosenberg
SES than Rosenberg and Coopersmith Self-Esteem Scales correlated with each other (i.e., $r = .62, p < .05$ versus $r = .29, p < .05$). It is important to note that the Rosenberg and the Coppersmith Self-Esteem Scales are two of the most popular and well-utilized measures of self-esteem (Blascovich & Tomaka, 1991).

Construct validity was reported by Asbury (1985) from a study with 63 predominately black (80%) and low-income (70%) families to evaluate a theory-based intervention model of self-esteem enhancement. Entering all 16 items of TSEI into regression equation, the investigator found that the eight Reward items accounted for 99% of the variance in the Reward subscale and similarly, the eight Cost items accounted for 97% of the variance in the Cost subscale. Moreover, as would be expected, there was a negative correlation between the two subscales ($r = -.52, p < .0001$).

Wilson (1985) conducted two studies with primarily black, low income, urban mother-child pairs ($N=147$) to determine the influence of depression, self-esteem, and perceptions on parenting behaviors. Using TSEI to measure self-esteem, the analyses revealed a Cronbach’s alpha coefficient of .82.

Although Taylor’s Self-Esteem Inventory has not been widely used, it was selected over more popular and well-utilized self-esteem measures (i.e., Rosenberg and Coopersmith SES) to measure self-esteem in this study because it was developed for black populations and initially tested on black women. The items appeared to be more gender specific and culturally sensitive and seemed better suited for Bahamian women than items on the other self-esteem measures. However, given limited use of the TSEI in empirical studies, one major
contribution of this study was to provide additional normative and psychometric data for this instrument. Additionally, TSEI had previously been found to have highly favorable psychometric properties and was short and easy to administer and score.

*Self-silencing.* Self-silencing was measured by the Silencing The Self Scale (STSS) developed by Jack and Dill (1992) and based on Silencing The Self theory (see Appendix G for permission to use STSS). This theory posits that women use cognitive schemas to ensure their adherence to gender normative behaviors sanctioned by society in an effort to preserve intimate relationships. The STSS consist of 31 items designed to tap the feelings, thoughts, and actions that women use to preserve intimate relationships. The STSS consists of four subscales (see Appendix C) confirmed using factor analysis by Stevens and Galvin (1995). The first subscale is Externalized Self-Perception, which taps how respondents negatively judge themselves by the standards of others. This subscale consists of six items such as “I tend to judge myself by how I think other people see me”; “I often feel responsible for other people’s feelings”; and “I never seem to measure up to the standards I set for myself.” The second subscale is Care as Self-Sacrifice, which taps schemas governing interpersonal behaviors. This subscale consists of nine items such as “I think it is best to put myself first because no one else will look out for me”; “In a close relationship, my responsibility is to make the other person happy”; and “Doing things just for myself is selfish.” The third subscale, which also taps schemas governing interpersonal behaviors, is Silencing the Self. This subscale consists of nine items such as “When my partner’s needs
and feelings conflict with my own, I always state mine clearly; “I rarely express my anger at those close to me”; and “I try to bury my feelings when I think they will cause trouble in close relationship(s).” The Divided Self, which is the experience of presenting an outer compliant self to adhere to feminine normative roles while feeling anger and hostility inside, is the forth subscale of the STSS. This subscale consists of seven items such as “I feel I have to act in a certain way to please my partner”; “My partner loves and appreciates me for who I am”; and “I feel that my partner does not know my real self.”

The 31 items of the STSS are scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items 1, 8, 11, 15, and 21 were reverse scored, and the second part of item 31 was excluded from statistical analyses because it was intended to yield qualitative data for descriptive and exploratory purposes. Total STSS scores can range from 31 to 155, with higher scores indicating greater silencing behaviors. However, “higher scores should not necessarily indicate poorer functioning but should reflect greater pressure to fulfill the norms of the ‘good woman’” (Jack & Dill, 1992, p. 99).

The initial psychometric data for the STSS were obtained from three samples in a study conducted by Jack and Dill (1992). The three samples consisted of predominately white, female college students (N = 63), predominately white (83.5%) women living in battered shelters (N = 140), and Caucasian mothers who abused cocaine during pregnancy (N = 270). The Beck Depression Inventory (BDI) was administered to women in each sample along with the STSS. Internal consistency (alpha) for the total STSS scores among the three samples of women
ranged from .86 through .94. Satisfactory Crombach’s alpha coefficients were reported for subscales ranging from .60 through .90, inclusive of marginal alphas reported on the Care as Self-Sacrifice Subscale.

Spearman-Brown coefficients of equivalence for two of the samples yielded reliability estimates which was .89 and .93. Items for the STSS were developed from interview data for 12 clinically depressed women and were reviewed and approved by nine clinical psychologists to provide face validity. Additionally, construct validity was obtained by testing two hypotheses derived from the Silencing The Self theory:

(1) the STSS would significantly correlate with depression scores (BDI) within groups of women in different social/relational contexts, and (2) mean STSS scores would significantly differ in the expected direction across groups of women whose social contexts varied in the demand of behaviors measured by the STSS, with STSS scores and BDI scores covarying (Jack & Dill, 1992, p. 102).

As hypothesized, BDI scores correlated significantly with STSS scores for female college students ($r = .52, p < .0001$), women living in battered shelters ($r = .50, p < .0001$), and mothers who abused cocaine during pregnancy ($r = .51, p < .0001$). Significant differences in means among the three groups were verified using analysis of variance (ANOVA). The lowest mean score was reported for the female college student group ($M = 78, SD = 15$), and the highest mean score was reported in the women living in battered shelters group ($M = 100, SD = 26$). Group means for the BDI revealed similar results: the lowest mean score was
reported for the group of college students \( M = 7, SD = 5 \), and the highest mean score was reported for the group of women living in battered shelters \( M = 21, SD = 11 \).

Findings from numerous studies have supported the initial psychometric properties reported for the STSS (Carr et al., 1996; Hart & Thompson, 1996; Thompson, 1995). Noteworthy is the fact that although the STSS has been predominately tested with Caucasian women, it continued to yield high internal consistencies even when tested in Caribbean women. For example, in a study conducted by Ali and Toner (2001) with a sample of Caribbean-Canadian women \((n = 20)\) and a sample of Caribbean women living in the Caribbean \((n = 20)\) to compare their dominant domains of meaning, self-silencing, and depressive symptoms, the investigators reported high Cronbach’s alpha coefficients for both groups: .89 for the Caribbean-Canadian sample and .86 for the Caribbean sample.

Based on the theory of Silencing The Self coupled with culturally sanctioned roles of Bahamian women, it was hypothesized that silencing behaviors would increase Bahamian women’s risk for HIV/AIDS as evidence by a significant negative relationship between their STSS scores and self-efficacy for negotiating safer sex behaviors scores. Furthermore, since this scale has never been used with Bahamian women, this study provided additional psychometric testing of the STSS. It is important to note that the STSS was selected to measure self-silencing behaviors in Bahamian women because the items reflect women’s silencing behaviors in an effort to preserve intimate relationships at any cost, a behavior that could shed some light on Bahamian women’s risk for HIV/AIDS.
Additionally, the STSS was the only instrument found in the literature to measure silencing behaviors, it is easy to administer and score, and it has satisfactory documented psychometric properties. However, the STSS consists of 31 items, which is somewhat lengthy, and two of the items (i.e., items 1 and 11) have shown zero to negative item-total correlations in several studies (Stevens & Galvin, 1995).

**Measurement of The Dependent Variable**

*Self-efficacy for negotiating safer sex behaviors.* Self-efficacy for negotiating safer sex behaviors was measured by the Self-Efficacy Scale. This scale is a revision of an instrument developed by Dilorio et al. (1997) and was based on Bandura’s (1986) self-efficacy theory (see Appendix H for permission to use Self-Efficacy Scale). The initial scale consisted of 21 items and four subscales (e.g., Refusal to Have Sex, Self-Efficacy for Condom Use, Self-Efficacy to Say No To Sex When Under the Influence of Drugs and Alcohol, and Self-Efficacy for Discussion) designed to measure self-efficacy for safer sex practices. The 21-item scale was revised to delete weaker items and to obtain a shorter instrument. As a result, the third subscale, Self-Efficacy to Say No to Sex When Under the Influence of Drugs and Alcohol, was eliminated (C. Dilorio, personal communication, June 18, 2002). The revised scale contains 12 items and three subscales. The first subscale is Refusal, which consist of four items such as “I always say no to someone who is pressuring me to have sex” and “I can always say no to someone even if I have had sex with them before.” The second subscale is Condom Use, which consist of four items such as “I can always put a condom
on (myself/partner) so that it will not slip or break” and “I can always use a condom without fumbling around.” The third subscale is Discussion, which also consist of four items such as “I can always discuss preventing AIDS and other STDs with my sex partner” and “I can always convince my sex partner to use a condom with me.”

Each of the 12-item statements of the Self-Efficacy Scale is rated on a 10-point scale ranging from 1 (not at all sure I can) to 10 (completely sure I can). Total Self-Efficacy Scale scores can range from 12 to 120 with higher scores indicating high levels of self-efficacy.

Content validity for the initial 21-item scale was established by a panel of judges familiar with social cognitive theory, and the initial psychometric properties were estimated from a group of college students (N = 1,380), ages 18 to 25 years, of whom 63% were female and 42.5% were black. The internal consistency for the total scale with this sample was α = .91 (Dilorio et al., 2000).

The revised 12-item Self-Efficacy Scale has also yielded good internal consistency across other samples. Soet et al. (1999) conducted a study with a group of female college student (N = 615), of whom 46.2% were white and 53.8% were black, with a mean age of 20.97 (SD = 1.63) to explore the influence of perceived dominance and ethnicity on women’s safer sex behavior. Using the 12-item Self-Efficacy Scale revised by Dilorio et al. in 1995 (C. Dilorio, personal communication, September 23, 2002) to measure the participants’ confidence in performing safer sex practices, Cronbach’s alphas for the three subscales were reported to be .74 for Refused, .93 for Condom Use, and .87 for Discussion.
Additionally, the 12-item Self-Efficacy Scale yielded a total scale alpha of .89 (F. McCarty, personal communication, July 25, 2002).

Although numerous self-efficacy scales related to condom use and sexuality were found in the literature, the Self-Efficacy Scale revised by Dilorio et al. in 1995 (C. Dilorio, personal communication, September 23, 2002) appeared to be most appropriate for Bahamian women. Some self-efficacy scales in the literature were noted to have too many items like the Rosenthal et al. (1991) 20-item Sexual Self-Efficacy (SSE) and Brafford and Beck’s (1991) 28-item Condom Use Self-Efficacy Scale (CUSES). On the other hand, some self-efficacy scales were too short and might not have captured the negotiating abilities of Bahamian women adequately [i.e., self-efficacy scales cited in Gomez and Morin (1996) and St. Lawrence and colleagues (1998)].

As a result of an extensive evaluation of numerous instruments to measure women’s self-efficacy for negotiating safer sex behaviors, the Self-Efficacy Scale revised by Dilorio et al. in 1995 (C. Dilorio, personal communication, September 23, 2002) was selected to measure this concept with urban Bahamian women for the following reasons:

1. The items were judged to be clear and succinct and spoke appropriately to Bahamian women’s sexual behaviors.
2. The items were judged to be least offensive than other self-efficacy instrument items and were thought to be more likely to be answered by Bahamian women.
3. The scale is short and yet covers appropriate areas needed to negotiate safer sex behaviors.

4. The scale and subscales have demonstrated favorable internal consistency reliability estimates.

5. The scale is easy to administer and score.

However, there are limited reported psychometric data on this scale and since this instrument has not been previously used with Bahamian women, this study provided additional psychometric estimates for the Self-Efficacy Scale with this particular cultural group.

Data Collection Procedure

*Collection of Data*

After gaining approval from Barry University’s Institutional Review Board (IRB) for the protection of human subjects (see Appendix I), data collection began and lasted over a period of three weeks. Bahamian women were invited to participate in the study individually and in groups. For instance, participants at the beauty salons and laundromats were approached individually to solicit their participation in the study. However, timing of approach became very important for their participation in the study. It quickly became clear that the most appropriate time to solicit Bahamian women’s participation in the study at the laundromats was while they were sitting and waiting for their clothes to wash and/or dry. If these women were approached while they were preparing their wash or folding their clothing, they almost always refused their participation. The same principle applied for the women in the beauty salons. They were best approached
while waiting to get their hair started or while they were sitting under the dryer. If they were at the final stage of having their hair styled, they refused participation in the study.

Additionally, aggregates of Bahamian women (i.e., clinic waiting rooms, church groups, and adult educational settings) were approached in groups to solicit participation in the study. The majority of women in these types of settings volunteered their participation in the study. Some women were reluctant to participate at first until they had assessed the data collection process and saw that it went as promised. At that point, women were asking to participate in the study. Although the small gifts were noted to be an incentive for women’s participation in the study, as some of them expressed verbally, the main reason for Bahamian women’s participation appeared to be the fact that they were waiting for a service and had nothing to lose at that time. For example, whenever a participant had to leave, she gave the questionnaire back to the researcher despite the fact that she might only have had one or two more questions to complete the survey.

Whether recruited individually or in groups, the participants were given the same instructions regarding the purpose of the study, consent to participate, benefits and risks related to participation, directions for completing the questionnaire, an explanation and assurance of anonymity, and plans for dissemination of findings, all of which are discussed in the following section.

Once the women agreed to participate in the study, they were each given a questionnaire attached to a clipboard, a pen, and an envelope. These convenience items greatly facilitated data collection because almost all participants did not
have a pen readily available to complete the survey. The participants were instructed to ensure that no personal identifiers (i.e., names, addresses, telephone contacts) were written on the questionnaires or on the envelope. They were instructed to place the completed questionnaire in the envelope, seal the envelope, and drop it in the closed box on the researcher’s table.

After the questionnaires were secured in the box, the researcher was available for questions from participants. Additionally, each participant received a small incentive (e.g., mug, bath brush, photo albums, make-up brushes, calculator, or pen set) in appreciation for their participation in the study. The box was taken away by the researcher, and all sealed envelopes with questionnaires were secured in a locked file cabinet in the researcher’s office until the data were entered into the data files, which occurred on a weekly basis. After data entry, the questionnaires were stored in a locked cabinet and will be kept for seven years, which is a policy requirement of the Barry University IRB.

Protection of Human Subjects

Every effort was made to ensure that ethical principles were adhered to in this study. Potential participants were informed about the study verbally and via a cover letter that accompanied the questionnaire (see Appendix J). The participants were informed about the purpose of the study; the voluntary nature of their participation; anonymity of the data; possible risks and benefits; plans for dissemination of findings; how to contact the researcher and supervisor; instructions for completing the questionnaire; and the incentive for their participation in the study.
The participants were approached face-to-face by the researcher to solicit their participation in the study. They were told that the purpose of the study was to identify and explain sociocultural, socioeconomic, intrapersonal, and interpersonal factors that may influence Bahamian women’s risk for HIV/AIDS so that gender specific and culturally sensitive prevention strategies could be developed and implemented to reduce the numbers of Bahamian women becoming infected with the virus. Additionally, the participants were told that their consent to participate was strictly voluntary and that they could decide to stop participating at anytime without penalty. They were told that by completing the questionnaire, they were giving their voluntary consent to participate in the study.

The participants were assured of the anonymity of their responses. They were told that only the researcher and her supervisor would have access to the data and that identification numbers (i.e., 001, 002, 003…) would be used for data entry. They were told that their information would be reported in group form only (i.e., reflecting Bahamian women in general), further ensuring privacy of their responses.

The participants were told that the risks related to their participation in this study were minimal; however, there was a possibility that some questions might have produced some psychological discomfort or bought back unpleasant memories. They were assured that if this happened and they wished to talk with a counselor, they could talk with any church counselor, which is usually free of charge. Alternatively, participants were provided a list with the names and
telephone contacts of private counselors in Nassau, Bahamas (see Appendix K). However, participants were told that any fees incurred from counseling would be their own responsibility. In the event that the participants expressed an interest in knowing more about HIV/AIDS including testing and care, they were provided with a list of places in Nassau where they could receive these services (Appendix L). Additionally, participants were told that although there were no immediate and direct benefits from their participation in this study, findings from this study would help health and social service professionals understand the characteristics of Bahamian women that may put them at risk for HIV/AIDS as well as to develop and implement effective prevention strategies to reduce the spread of the disease among them.

The participants were told that findings of the study would be summarized in local newspapers and radio stations, presented at local and international conferences, and be submitted to professional journals to add to global HIV/AIDS knowledge. In addition, participants were given the telephone numbers of the researcher and her supervisor in the event that they had additional questions or comments concerning the study.

Once urban Bahamian women had decided to participate in the study, they were given a questionnaire containing a cover letter and 80 items that were simply and clearly written to elicit quick responses (see Appendix C). The participants were asked to read the instructions and questions carefully before responding. They were told that the questionnaire would take approximately 20 to 30 minutes to complete and that they should answer each question completely and honestly.
Again, they were reminded not to put their names on the questionnaires or the envelope provided and that by completing the questionnaire, they had given their permission to participate in this study.

Lastly, the participants were told that they would receive a small incentive for their participation in the study. They were also informed that if they wished to discontinue their participation in the study at any time, they would still receive the incentive.

Data Analysis

The Statistical Package for the Social Sciences (SPSS) version 11.0 for Windows NT (SPSS, 2001) was used to analyze study data. The data file was set up to minimize data entry error. As an additional security to data accuracy, data were printed out and crosschecked for error, with particular attention paid to out-of-range values and missing data. Individual scale means were used to substitute for missing data, and questionnaires with more than 30% missing data were excluded from further data analyses. However, there were minimal missing data. Additionally, transformations and computations of variables were conducted (i.e., reverse scores, computations). Four data backup files were maintained (i.e., two floppy, one zip, and one hardcopy) and carefully stored for safekeeping (Burns & Grove, 1997).

Exploratory and Descriptive Analyses

To examine patterns in individual item scores, exploratory data analysis consisted of inspection of frequency distributions and histograms for all demographic variables as well as measures of central tendency (i.e., means,
medians) and measures of variability (i.e., standard deviations, ranges). Additionally, frequency distributions and histograms with superimposed normal curves were run for all items, subscales, and total scale scores to determine outliers, skewness, kurtosis, and missing values. The type of descriptive statistic conducted for each variable was dependent on the level of measurement as well as the distribution of responses (i.e., skewness, kurtosis). Reliability estimates for measures used in this study (i.e., Cronbach’s alpha, Spearman-Brown split-half) were estimated for the study sample and compared with estimates from previous studies. Items were not deleted from subscales and scales since “alpha if item deleted” values identified that deleting items would not have improved the internal consistency of subscales and total scales.

**Hypotheses Testing**

Drawing from an extensive review of the literature, the theoretical foundation that formed the framework for this study, and the historical and cultural socialization of women in The Bahamas, four hypotheses were proposed which were tested in this study. The first three hypotheses were:

H1. There will be a negative relationship between urban Bahamian women’s self-esteem and self-silencing behaviors.

H2. There will be a positive relationship between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behaviors.

H3. There will be a negative relationship between urban Bahamian women’s self-silencing and self-efficacy for negotiating safer sex behaviors.
Since the variables in all three hypotheses were interval-level, hypotheses 1 through 3 were tested using a one-tailed Person product-moment correlation coefficient \((r)\), since it was verified that assumptions of the test were not violated (Munro, 2001) for almost all of the variables involved. However, due to a grossly negatively skewed distribution, self-efficacy for negotiating safer sex behaviors was dichotomized using a median split; the dichotomous variable was then treated as an interval variable for correlational analysis since several sources have argued that the values of 0 and 1 represent an equal interval (Burns & Grove, 1997; Gall et al., 1996; Wood & Catanzaro, 1988).

The fourth hypothesis, which initially stated that age, income, education, self-esteem, and self-silencing will make significant independent and combined contributions to self-efficacy for negotiating safer sex behaviors in urban Bahamian women, was to be tested using hierarchical multiple regression analysis. As noted previously, total scores for the Self-Efficacy Scale resulted in a dependent variable which did not even approximate a normal distribution (index of skewness = -1.721, index of kurtosis = 2.869). Since one of the major assumptions of multiple regression analysis is normality, the decision was made to dichotomize the variable using a median split into 0 (low self-efficacy) and 1 (high self-efficacy) to permit use of binary logistic regression as an alternative analysis technique. The new hypothesis four then became: Age, income, education, self-esteem, and self-silencing will significantly predict urban Bahamian women’s self-efficacy level (i.e., low or high) for negotiating safer sex behaviors.
The regression of several variables (independent) into another (dependent) as seen in multiple regression also holds true for logistic regression. However, in logistic regression, the independent variables can be continuous, discrete, dichotomous, or a mixture of all these levels of measurement, while the dependent variable must be dichotomous. Additionally, the regression equation of logistic regression is different from that of multiple regression. The goal of logistic regression is to accurately predict the category of outcome for individual cases using the most parsimonious model. This is done by creating a model that includes all predictor (i.e., independent) variables useful in predicting the outcome (i.e., dependent) variable by assigning values (i.e., probabilities) (Field, 1999; Dallal, 2001; Mentler & Vannatta, 2001; Munro, 2001).

Although logistic regression has less stringent assumptions than multiple regression, there are several important conditions which must be satisfied for the technique to be appropriately used and results to be interpretable. First, several problems can result if there are too few cases for the number of predictor variables in a logistic regression model. In the present study, there were 661 cases and 5 predictor variables, which allows for 132 cases per predictor. This ratio far exceeded Woods and Catanzaro’s (1988) general recommendation of 15 participants per variable, or a total sample size of at least 50 more than the number of variables for advanced statistical techniques. Furthermore, although Munro (2001) has indicated that “computer software and books such as Cohen (1987) do not cover logistic regression” (p. 289), post hoc power analyses conducted with parameters of this study for bivariate correlations and multiple
regression strongly suggested that there were more than enough cases for the number of predictor variables to be entered into a logistic regression model.

A second assumption of logistic regression, which is based on a goodness-of-fit test, is that expected frequencies in all cells of crosstabulations of dichotomous or discrete variables are sufficiently large, typically defined as greater than five per cell. In the present study, there were only two dichotomous variables, income (i.e., < $18,000 and $18,000 and over) and self efficacy (i.e., low self-efficacy and high self-efficacy). When crosstabulations were run between these two variables, the smallest expected value in any of the four cells was 137, supporting the level of power for the analysis and inclusion of these variables in the model.

Similar to multiple regression, an assumption of logistic regression is that there are not overly high correlations or redundancies among predictor variables in the model. Two methods were used to check for multicollinearity. First, the bivariate correlation matrix for study variables was inspected. Although some correlations between pairs of variables were significant, they ranged from .11 to -.56 and did not approach the recommended cutoff levels ($r = .80 - .85$) for eliminating variables from regression analysis (Berry & Feldman, 1985; Munro, 2001). Second, inspection of collinearity statistics revealed that tolerance for all variables ranged from .65 to .95; since tolerance for all variables exceeded .1, multicollinearity was further ruled out as a potential problem with major variables of this study (Mentler & Vannatta, 2001; Munro, 2001).

As a final check for violation of logistic regression assumptions, an exploratory procedure using Mahalanobis Distance was used to check for and
eliminate outliers since logistic regression is particularly sensitive to extreme values, which may result in a model with an extremely poor fit. Using a critical value of \( \chi^2(5) = 20.251, p < .001 \) (Mentler & Vannatta, 2001, p. 338), three outliers with higher chi-square values were eliminated from subsequent analyses.

Logistic regression was conducted to determine whether age, income, education, self-esteem, and self-silencing can predict self-efficacy for negotiating safer sex behaviors status (i.e., low self-efficacy vs. high self-efficacy) in urban Bahamian women. The first approach used a forced entry procedure based on the conceptual model of this study. Demographic variables (i.e., age, education, and income) were entered in block one, followed by self-esteem in block two and self-silencing in block three. A confirmatory approach used allowed SPSS to apply a stepwise forward logistic regression procedure, which added and deleted variables based on their likelihood ratios. These approaches were used to determine the percentage of cases correctly classified, how accurate the predictor variables can predict urban Bahamian women’s self-efficacy for negotiating safer sex behaviors status, and goodness-of-fit of the model.

Summary

In summary, a cross-sectional, correlational survey design was used to study the relationships between select demographic variables (i.e., age, income, education), self-esteem, self-silencing (independent variables), and self-efficacy for negotiating safer sex behaviors (dependent variable) in urban Bahamian women as well as the value of independent variables in predicting self-efficacy. Data were collected via self-report questionnaires from urban Bahamian women,
ages 18 years or older, at various community sites in Nassau, Bahamas, over a three-week period. Data were analyzed using SPSS 11.0 for Windows, and hypotheses testing were conducted using Pearson product-moment correlation coefficients ($r$) and binary logistic regression analyses.
CHAPTER IV

RESULTS

Introduction

The purpose of this study was to determine the influence of select demographic variables (i.e., age, income, education), self-esteem, and self-silencing on self-efficacy for negotiating safer sex behaviors in urban Bahamian women so that gender specific and culturally sensitive prevention strategies could be developed and implemented to reduce the numbers of Bahamian women becoming infected with HIV. A cross-sectional, correlational design was used, and data were collected from Bahamian women 18 years of age or older who resided in Freeport, Grand Bahama and Nassau, Bahamas. Convenience sampling strategies were used to recruit participants at community settings in Nassau (i.e., churches, laundromats, beauty salons, health clinics, adult educational settings, workplaces) that Bahamian women frequently visit.

Data were collected over a period of three weeks using an 80-item questionnaire, which consisted of three standardized instruments as well as demographic and background questions. Data were analyzed using SPSS 11.0 for Windows (SPSS, 2001). Descriptive statistics were computed, and reliability estimates were obtained for all subscales and scales. Hypotheses testing were conducted using Pearson product-moment correlation coefficients (r) and logistic regression analysis.
Description of the Sample

Response Rate and Post Hoc Power Analyses

Through the use of convenience sampling strategies, a total of 708 questionnaires were distributed, and 699 were returned. However, only 661 questionnaires were useable since 38 contained considerable amounts of missing data. Thus, the response rate for this study was 93.4%, which was remarkably high even for surveys distributed on a face-to-face basis (Fowler, 2001).

Using the same parameters as the initial power analysis conducted for this study (see Chapter III), post hoc power analyses using G* POWER (Buchner et al., 1997) revealed that the actual power achieved was 1.0 for bivariate correlation ($r$) for both small and medium effect sizes. Further analysis for multiple regression with five predictor variables, alpha set at .05, and a sample size of 661 showed a power of .81 for small effect size and 1.0 for medium effect size, respectively. These power values indicated that the obtained study sample size was more than adequate to detect associations between major study variables if they existed as well as to have a reasonable level of confidence in the predictive value of variables in logistic regression analysis since Munro (2001) indicated that there are currently no power analysis sources for logistic regression.

Demographic and Background Characteristics

Ninety-eight percent of the participants ($n = 645$) were born in The Bahamas, and almost 99% ($n = 651$) lived in Nassau at the time of the study. Ninety-five percent ($n = 628$) reported that they were Black Bahamians; Haitian Bahamians,
White Bahamians, and “Others” comprised 2.3%, .5%, and 2% of the sample, respectively. To compute an age variable, the year in which participants reported that they were born was subtracted from 2003. Examination of the frequency distribution and histogram with superimposed normal curve for the age variable revealed a quasi-normal distribution. The average age of the participants was 34.31 years ($SD = 9.97$), and the sample ranged in age from 18 to 78 years. The majority ($n = 575, 81\%$) of the participants completed at least 12 years of school, and only 3.3% ($n = 21$) of the participants completed less than 10 years of school. Over half ($n = 351, 56\%$) of the participants had a monthly income of $1,500 or greater. Four fifths ($n = 531, 80.3\%$) of the participants were employed (see Table 1).

On the average, the participants attended their place of worship five ($SD = 5.07$) times per month, but church attendance ranged from 0 to 30 times per month. The majority of the participants were either married ($n = 232, 35.1\%$) or single ($n = 229, 34.6\%$), with only a few women who reported that they were separated ($n = 27, 4.1\%$), divorced ($n = 27, 4.1\%$), or widowed ($n = 14, 2.1\%$). While a majority ($n = 429, 64.9\%$) of the participants reported that they were heterosexuals, almost 27% ($n = 177$) of the participants did not respond to this item either because they did not understand the terminology or did not want to disclose their sexual orientation. The majority of the participants ($n = 448, 67.8\%$) reported having fewer than five children, while over a fifth ($n = 143, 21.6\%$) of the participants reported having no children (see Table 2).
It is noteworthy that only 3.3% (n = 22) of the participants reported being a virgin. The participants had a mean of 4.75 (SD = 8.39) sexual partners in their lifetime, but there was considerable variability for this variable; almost 70% of the participants reported having between 1 and 7 lifetime sexual partners.

Most of the participants (n = 469, 71%) reported personally knowing someone with HIV/AIDS, many of whom were reported as being family members and friends. Additionally, almost 85% (n = 560) of the participants reported having been tested for HIV/AIDS, and most of these HIV tests were reportedly conducted during the year 2002. While the majority (n = 529, 94%) of women tested for HIV reported negative results, almost 2% (n = 11) of the participants reported having received positive HIV test results (see Table 3).

To further describe the sample, participants were asked to report the two hobbies in which they engaged in most. Reading (n = 271) and singing (n = 110) were the two hobbies they reported most frequently. Other frequently reported hobbies included sports, cooking, meeting people, dancing, traveling, and watching television. Additionally, participants were asked to report three standards that they had set for themselves but had not yet attained. Although the majority of the participants did not respond to this item, career goal attainment (n = 24), educational achievement (n = 22), and Christianity (n = 17) were the three standards reported most frequently by the participants in this sample. Other frequently reported standards were ability to speak true feelings, personal appearance, state of happiness, and being responsible.

Exploratory Data Analyses for Measurements
Frequency distributions and histograms with superimposed normal curves were run for all scale items to determine outliers, skewness, kurtosis, and missing

Table 1

Demographic and Background Characteristics of Sample ($N = 661$)

<table>
<thead>
<tr>
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<th>$M$</th>
<th>$SD$</th>
<th>Range</th>
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<tr>
<td>Age in Years</td>
<td>34.31</td>
<td>9.97</td>
<td>18 − 78</td>
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<tr>
<td>Education in Years</td>
<td>13.15</td>
<td>2.06</td>
<td>4 − 20</td>
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<table>
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<tr>
<th>Monthly Income</th>
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<tr>
<td>Less Than $1,000</td>
<td>139</td>
<td>21.0</td>
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<tr>
<td>$1,000 – $1,499</td>
<td>139</td>
<td>21.0</td>
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</tr>
<tr>
<td>$1,500 – $1,999</td>
<td>122</td>
<td>18.5</td>
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<td>$2,000 – $2,499</td>
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<td>$3,500 or More</td>
<td>89</td>
<td>13.5</td>
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<tr>
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<table>
<thead>
<tr>
<th>Employment</th>
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<tbody>
<tr>
<td>Employed</td>
<td>531</td>
<td>80.3</td>
<td></td>
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<tr>
<td>Unemployed</td>
<td>127</td>
<td>19.2</td>
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<tr>
<td>Not Reported</td>
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Table 2

Additional Demographic and Background Characteristics of Sample ($N = 661$)

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<tbody>
<tr>
<td>Times Per Month Attended</td>
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<td>Place of Worship</td>
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<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
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<tr>
<td>Single</td>
<td>229</td>
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<tr>
<td>Married</td>
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<td>Living With Partner/Common Law Marriage</td>
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<td></td>
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<tr>
<td>Partnered But Not Living Together</td>
<td>54</td>
<td>8.2</td>
<td></td>
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<tr>
<td>Separated</td>
<td>27</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>27</td>
<td>4.1</td>
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<tr>
<td>Widowed</td>
<td>14</td>
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</tr>
<tr>
<td>Not Reported</td>
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<td>.5</td>
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</tr>
<tr>
<td>Sexual Preference</td>
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<tr>
<td>Heterosexual</td>
<td>429</td>
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<tr>
<td>Bisexual</td>
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<td>7.7</td>
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<tr>
<td>Lesbian</td>
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<td>.6</td>
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<tr>
<td>Not Reported</td>
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<tr>
<td>Number of Children</td>
<td>1.93</td>
<td>1.64</td>
<td>0 – 10</td>
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Table 3

Additional Demographic and Background Characteristics of Sample (N = 661)

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<tr>
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<tbody>
<tr>
<td>Number of Sexual Partners in Lifetime</td>
<td>4.75</td>
<td>8.39</td>
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<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Know or Have Known Someone with HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>183</td>
<td>27.7</td>
</tr>
<tr>
<td>Yes</td>
<td>469</td>
<td>71.0</td>
</tr>
<tr>
<td>Not Reported</td>
<td>9</td>
<td>1.4</td>
</tr>
<tr>
<td>Ever Been Tested For HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>96</td>
<td>14.5</td>
</tr>
<tr>
<td>Yes</td>
<td>560</td>
<td>84.7</td>
</tr>
<tr>
<td>Not Reported</td>
<td>5</td>
<td>.8</td>
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<tr>
<td>Result of HIV/AIDS Test</td>
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<td></td>
</tr>
<tr>
<td>Negative</td>
<td>529</td>
<td>80.0</td>
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<tr>
<td>Positive</td>
<td>11</td>
<td>1.7</td>
</tr>
<tr>
<td>Never Tested/Not Reported</td>
<td>121</td>
<td>18.3</td>
</tr>
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</table>

values. Remarkably, there were minimal missing data for all three instruments used in this study. Some variables were recoded, and subscales and total scale scores were computed. Additionally, reliability estimates (Cronbach’s alpha,
Spearman-Brown split-half coefficients) for subscales and scales were computed for the study sample and compared with estimates from previous studies. Items were not deleted from any subscales or scales since “alpha if items deleted” values indicated that deleting items would not have improved subscale and total scale reliabilities.

Taylor’s Self-Esteem Inventory (TSEI) was used in this study to measure self-esteem. This instrument consisted of two subscales and contains a total of 16 items including 8 Reward (i.e., positive) and 8 Costs (i.e., negative) items. Each item was rated on a 0 (never) to 8 (always) scale resulting in possible subscale ranges of 0 to 64 and a total scale range of 0 to 128. The negative, or cost, items were reverse coded and summed with the reward or positive items for a total self-esteem score. Higher self-esteem scores indicated higher levels of self-esteem. An index of skewness (-.315) and histogram with superimposed normal curve indicated that TSEI scores were slightly negatively skewed with this sample. However, visualization of the histogram with superimposed normal curve showed that the distribution of the TSEI scores was quasi-normal.

The Silencing The Self Scale (STSS) was used in this study to measure self-silencing. The STSS consists of 31 items and 4 subscales (i.e., Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, Divided Self). Each item was rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Total STSS scores can range from 31 to 155, with higher scores indicating greater silencing behaviors. Items 1, 8, 11, 15, and 21 were reversed coded, and all items were summed to compute a total STSS score. An index of
skewness (.235) and histogram with superimposed normal curve indicated that the STSS scores for this sample produced a normally distributed variable. Additionally, visualization of the histogram with superimposed normal curve suggested that STSS scores were, indeed, normally distributed.

The Self-Efficacy Scale (SES) was used in this study to measure self-efficacy for negotiating safer sex behaviors in urban Bahamian women. The scale consists of 12 items and 3 subscales (i.e., Refusal, Condom Use, Discussion). Each item was rated on a 10-point scale ranging from 1 (not at all sure I can) to 10 (completely sure I can). Total self-efficacy scores can range from 12 to 120, with higher scores indicating high levels of self-efficacy. Items were summed together to compute a total self-efficacy score. An index of skewness (-1.721) and histogram with superimposed normal curve indicated that SES scores for this sample produced a very negatively skewed variable. Accordingly, visualization of the histogram with superimposed normal curve suggested that SES scores could not be considered to be quasi-normal. Hence, the decision was made to dichotomize this variable into low or high categories for self-efficacy levels using a median split for this sample.

Measurement Assessments

*Taylor’s Self-Esteem Inventory (TSEI)*

The TSEI was used to measure self-esteem in this study and demonstrated high reliability estimates with this sample of Bahamian women. The internal consistency estimate (Cronbach’s alpha) for the total scale was .80, and the Spearman-Brown split-half coefficient was .82. Subscales demonstrated
moderately high reliability estimates given the relatively small number of items in each (see Table 4). These estimates were consistent with other estimates reported in the literature. Wilson (1985) reported a Cronbach’s alpha of .82, and Taylor and Tomasic (1996) reported a Spearman-Brown split-half coefficient of .84 for the total TSEI.

Silencing The Self Scale (STSS)

The STSS was used to measure self-silencing in this sample of urban Bahamian women. Although the total STSS demonstrated high internal consistency reliability estimates (Cronbach’s alpha = .85; Spearman-Brown split-half coefficient = .81) with this sample, the Care as Self-Sacrifice subscale demonstrated weak reliability estimates (Cronbach’s alpha = .40; Spearman-Brown split-half coefficient = .34) (see Table 4). Cronbach’s alphas for the subscale Care as Self-Sacrifice reported in the literature were lower than estimates reported for the other three subscales (Duarte & Thompson, 1999; Jack & Dill, 1992; Koutrelakos et al., 1999; Remen et al., 2002; Thompson & Hart, 1996). However, scores on this subscale from use with urban Bahamian women were even lower than those previously reported for other samples. Reliability estimates reported in the literature have ranged from .86 to .94 for total STSS and .60 to .90 for subscales. Spearman-Brown split-half coefficients reported in the literature for two samples of women were .89 and .93 for the total STSS, which were higher than the estimates obtained from the sample of urban Bahamian women (Jack & Dill, 1992). However, in this study, items 1 and 11 did not show zero to negative item-total correlation as reported by Jack (1992). Item-total correlation for items 1
and 11 were .16 in this study, suggesting that these two items were not as problematic with the sample of Bahamian women as they were with other samples.

**Self-Efficacy Scale (SES)**

The SES was used to measure urban Bahamian women’s self-efficacy for negotiating safer sex behaviors. High reliability estimates were obtained from use of this scale with the study sample of urban Bahamian women (Cronbach’s alpha = .90; Spearman-Brown split-half coefficient = .88). Additionally, subscales of this instrument also showed high reliability estimates (see Table 4). These assessments were consistent with those reported previously in the literature. McCarty (personal communication, July 25, 2002) reported a total Cronbach’s alpha of .89, and Soet et al. (1999) reported Cronbach’s alphas of .74, .93, .87, for the Refusal, Condom Use, and Discussion subscales, respectively.

**Descriptive Findings for Major Study Variables**

**Taylor’s Self-Esteem Inventory (TSEI)**

The TSEI consists of two subscales and contains a total of 16 items including 8 Reward (i.e., positive) and 8 Costs (i.e., negative) items. Since each item is rated on an 8 point Likert scale, the possible range for each subscale is 0 to 64 and the possible total scale range is 0 to 128. Higher self-esteem scores indicate higher levels of self-esteem. The total TSEI scores in this study ranged from 22 to 124 ($M = 88.06$, $SD = 15.81$). These results indicate that, on the average, urban Bahamian women have moderately high levels of self-esteem (see Table 5).
Table 4

Reliability Estimates: Internal Consistency (Cronbach’s Alpha and Spearman-Brown Split-Half) Coefficients for Study Measures \((N = 661)\)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Number of Items</th>
<th>Cronbach’s Alpha</th>
<th>Spearman-Brown Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taylor’s Self-Esteem Inventory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>16</td>
<td>.80</td>
<td>.82</td>
</tr>
<tr>
<td>Rewards Subscale</td>
<td>8</td>
<td>.79</td>
<td>.79</td>
</tr>
<tr>
<td>Costs Subscale</td>
<td>8</td>
<td>.74</td>
<td>.67</td>
</tr>
<tr>
<td><strong>Silencing The Self Scale</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>31</td>
<td>.85</td>
<td>.81</td>
</tr>
<tr>
<td>Externalized Self-Perception Subscale</td>
<td>6</td>
<td>.74</td>
<td>.68</td>
</tr>
<tr>
<td>Care as Self-Sacrifice Subscale</td>
<td>9</td>
<td>.40</td>
<td>.34</td>
</tr>
<tr>
<td>Silencing the Self Subscale</td>
<td>9</td>
<td>.70</td>
<td>.73</td>
</tr>
<tr>
<td>Divided Self Subscale</td>
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<td>.73</td>
<td>.72</td>
</tr>
<tr>
<td><strong>Self-Efficacy Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>12</td>
<td>.90</td>
<td>.88</td>
</tr>
<tr>
<td>Refusal Subscale</td>
<td>4</td>
<td>.79</td>
<td>.77</td>
</tr>
<tr>
<td>Condom Use Subscale</td>
<td>4</td>
<td>.85</td>
<td>.81</td>
</tr>
<tr>
<td>Discussion Subscale</td>
<td>4</td>
<td>.83</td>
<td>.83</td>
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</table>
Urban Bahamian women’s scores on TSEI were comparable with those reported in the literature. For instance, Wilson (1985) reported a total TSEI mean score of 87.51 ($SD = 14.56$) with primarily black, low-income, urban mother-child pairs, and Taylor and Tomasic (1996) reported a total TSEI mean score of 86.03 ($SD = 17.13$) with a sample of black, low-income mothers.

Self-esteem items with which urban Bahamian women were most likely to agree were reward (i.e., positive) items and included (a) “I am satisfied with the kind of person I am” ($M = 6.86$, $SD = 1.60$), (b) “I think of things I’ve done well” ($M = 6.61$, $SD = 1.78$), (c) “I have a sense of purpose” ($M = 6.55$, $SD = 1.90$), and (d) “I feel proud of the way I do things” ($M = 6.51$, $SD = 1.63$). Conversely, items with which urban Bahamian were most likely to disagree were cost (i.e., negative) items and included (a) “I dwell on my faults” ($M = 3.02$, $SD = 2.18$), (b) “My problems get the best of me” ($M = 2.73$, $SD = 2.21$), (c) “I feel ashamed of the things I do” ($M = 2.69$, $SD = 2.04$), and (d) “I distrust my judgment” ($M = 2.65$, $SD = 2.19$).

Silencing The Self Scale (STSS)

The STSS consists of 31 items and 4 subscales (i.e., Externalized Self-Perception, Care as Self-Sacrifice, Silencing the Self, Divided Self). Each item is rated on a 5-point Likert scale so that total STSS scores can range from 31 to 155, with higher scores indicating greater silencing behaviors. Urban Bahamian women’s scores on the STSS ranged from 36 to 139 ($M = 78.07$, $SD = 18.80$) (see Table 5). These results indicate that, in general, urban Bahamian women tend to silence themselves in intimate relationships. Urban Bahamian women’s scores
on the STSS were comparable with some reported in the literature. For example, Jack and Dill (1992) reported a mean STSS score of 78.4 ($SD = 15.0$) with a sample of undergraduate women, and Stevens and Galvin (1995) reported mean STSS scores of 76.8 ($SD = 18.2$), 82.2 ($SD = 18.1$), and 80.7 ($SD = 15.7$) for Sophomore, Junior, and Senior female college students ages 17 to 45 years, respectively. Conversely, urban Bahamian women scores were higher than some previously reported in the literature. With samples of undergraduate females, Remen et al. (2002) reported a mean STSS score of 73.17 ($SD = 14.62$), and Bruner (1997) reported a mean STSS score of 70.1 ($SD = 18.5$). However, Ali and Toner (2001) reported a mean score of 63.9 ($SD = 19.7$) on the STSS for Caribbean women ages 25 to 54 years living in the Caribbean.

Silencing The Self items with which urban Bahamian were most likely to agree included (a) “My partner loves and appreciates me for who I am” ($M = 4.33$, $SD = 1.13$), (b) “I speak my feeling with my partner, even when it leads to problems or disagreements” ($M = 4.03$, $SD = 1.23$), (c) “In order to feel good about myself, I need to feel independent and self-sufficient” ($M = 3.90$, $SD = 1.30$), and (d) “I think it is best to put myself first because no one else will look out for me” ($M = 3.81$, $SD = 1.34$). Conversely, items with which urban Bahamian were most likely to disagree included (a) “When it looks as though certain of my needs can’t be met in a relationship, I realize that they weren’t very important anyway” ($M = 2.19$, $SD = 1.35$), (b) “When I make decisions, other people’s thoughts and opinions influence me more than my own thoughts and opinions” ($M = 2.18$, $SD = 1.31$), (c) “In order for my partner to love me, I cannot reveal certain
things about myself to him/her” ($M = 2.14, SD = 1.42$), and (d) “When I am in a close relationship, I lose my sense of who I am” ($M = 1.83, SD = 1.27$).

It is important to note, however, that items with which urban Bahamian women were most likely to agree came from all of the subscales except Externalized Self-Perception, and items with which urban Bahamian women were most likely to disagree came from all of the subscales except Care as Self-Sacrifice, the subscale with the weakest internal consistency estimate obtained from this sample.

**Self-Efficacy Scale (SES)**

The SES consists of 12 items and 3 subscales (i.e., Refusal, Condom Use, Discussion). Each item is rated on 10-point scale. Total self-efficacy scores can range from 12 to 120 with higher scores indicating high levels of self-efficacy. Urban Bahamian women’s scores on the SES ranged form 12 to 120 ($M = 102.94, SD = 20.61$) (see Table 5). The distribution of scores indicated that urban Bahamian women have very high self-reported self-efficacy for negotiating safer sex behaviors. Comparison of urban Bahamian women’s SES subscale scores (Refusal [$M = 35.91, SD = 6.96$]; Condom Use [$M = 31.46, SD = 9.68$]; and Discussion [$M = 35.56, SD = 7.32$], respectively) with those reported in the literature suggest that urban Bahamian women were comparable to other cultural groups of women with respect to self-efficacy for negotiating safer sex behavior. For instance, Soet et al. (1999) reported mean self-efficacy subscale scores from a sample of African American women of 36.31 ($SD = 5.71$), 31.25 ($SD = 10.06$), and 36.44 ($SD = 5.79$), for the Refusal, Condom Use, and Discussion subscales,
respectively. Similarly, these researchers reported mean self-efficacy subscale scores from a sample of White women of 35.86 ($SD = 4.97$), 30.39 ($SD = 9.10$), 34.55 ($SD = 6.26$), for the Refusal, Condom Use, and Discussion subscales, respectively.

Self-efficacy items with which urban Bahamian were most likely to agree included (a) “I can always say no to sexual intercourse with someone I have just met even if I am attracted to that person” ($M = 9.16$, $SD = 2.01$), (b) “I can always discuss preventing AIDS and STDs with my sex partner” ($M = 9.06$, $SD = 2.11$), (c) “I can always discuss the importance of using a condom” ($M = 8.97$, $SD = 2.22$), and (d) “I can always say no to sex with someone even if I have had sex with them before” ($M = 8.96$, $SD = 2.17$). Conversely, items with which urban Bahamian women were most likely to disagree included (a) “I can always be the one to put the condom on even if I’m with a new partner” ($M = 8.04$, $SD = 2.84$), (b) “I can always put a condom on (myself/my partner) so that it will not slip or break” ($M = 7.96$, $SD = 2.91$), (c) “I can always use a condom without fumbling around” ($M = 7.89$, $SD = 2.92$), and (d) “I can always put a condom on (myself/my partner) even if the room is dark” ($M = 7.57$, $SD = 3.01$).

It is noteworthy that items with which urban Bahamian women were most likely to agree came from only two of the three subscales of this instrument, Refusal and Discussion. More importantly, items with which urban Bahamian women were most likely to disagree came from only one subscale, Condom Use.
Table 5
Descriptive Statistics for Major Study Variables (N = 661)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taylor’s Self-Esteem Inventory</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>88.06</td>
<td>15.81</td>
<td>22 – 124</td>
</tr>
<tr>
<td>Costs Subscale</td>
<td>26.66</td>
<td>10.27</td>
<td>0 – 58</td>
</tr>
<tr>
<td>Rewards Subscale</td>
<td>50.72</td>
<td>9.16</td>
<td>0 – 64</td>
</tr>
<tr>
<td><strong>Silencing The Self Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>78.07</td>
<td>18.80</td>
<td>36 – 139</td>
</tr>
<tr>
<td>Externalized Self-Perception Subscale</td>
<td>14.24</td>
<td>5.55</td>
<td>6 – 30</td>
</tr>
<tr>
<td>Care as Self-Sacrifice Subscale</td>
<td>25.61</td>
<td>5.37</td>
<td>11 – 41</td>
</tr>
<tr>
<td>Silencing the Self Subscale</td>
<td>22.16</td>
<td>6.96</td>
<td>9 – 41</td>
</tr>
<tr>
<td>Divided Self Subscale</td>
<td>16.05</td>
<td>6.07</td>
<td>7 – 35</td>
</tr>
<tr>
<td><strong>Self-Efficacy Scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Scale</td>
<td>102.94</td>
<td>20.61</td>
<td>12 – 120</td>
</tr>
<tr>
<td>Refusal Subscale</td>
<td>35.91</td>
<td>6.96</td>
<td>4 – 40</td>
</tr>
<tr>
<td>Condom Use Subscale</td>
<td>31.46</td>
<td>9.68</td>
<td>4 – 40</td>
</tr>
<tr>
<td>Discussion Subscale</td>
<td>35.57</td>
<td>7.32</td>
<td>4 – 40</td>
</tr>
</tbody>
</table>
Hypotheses Testing

Hypothesis 1

The first hypothesis for this study stated that there will be a negative relationship between urban Bahamian women’s self-esteem and self-silencing behavior scores. Findings from a one-tailed Pearson product-moment correlation coefficient \((r)\) supported this hypothesis \((r = -.56, \ p < .01)\) (see Table 6). There was a significant, moderate (Munro, 2001) negative correlation between urban Bahamian women’s self-esteem scores and their self-silencing behavior scores. This finding suggests that urban Bahamian women with higher levels of self-esteem are less likely to silence themselves in intimate relationships than are urban Bahamian with lower levels of self-esteem.

Hypothesis 2

The second hypothesis for this study stated that there will be a positive relationship between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behavior scores. This hypothesis was also supported using a one-tailed Pearson product-moment correlation coefficient \((r)\) \((r = .22, \ p < .01)\) (see Table 6). There was a modest (Munroe, 2001), but significant correlation between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behavior scores. This finding suggests that urban Bahamian women with higher levels of self-esteem are more likely to negotiate safer sex behaviors than are urban Bahamian with lower levels of self-esteem.
Table 6
Bivariate Correlations Between Major Study Variables (N = 661)

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Education</th>
<th>Income</th>
<th>Self-Esteem</th>
<th>Silencing</th>
<th>Self-Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>.11**</td>
<td>.25**</td>
<td>.25**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>.07</td>
<td>.29**</td>
<td>.20**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Silencing</td>
<td>.09*</td>
<td>-.25**</td>
<td>-.21**</td>
<td>-.56**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>.10*</td>
<td>.13**</td>
<td>.11**</td>
<td>.22**</td>
<td>-.15**</td>
<td>-</td>
</tr>
</tbody>
</table>

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

Hypothesis 3

The third hypothesis for this study stated that there will be a negative relationship between urban Bahamian women’s self-silencing and self-efficacy for negotiating safer sex behavior scores. Using a one-tailed Person product-moment correlation coefficient (r), this hypothesis was supported (r = -.15, p < .01) (see Table 6). There was a small (Gall et al., 1996), but significant negative correlation between self-silencing and self-efficacy for negotiating safer sex behavior scores. This finding suggests that urban Bahamian women who demonstrate higher levels of self-silencing in intimate relationships are less likely
to engage in negotiating safer sex behaviors than are urban Bahamian women who demonstrate lower levels of self-silencing in intimate relationships.

**Hypothesis 4**

The fourth hypothesis stated that age, income, education, self-esteem, and self-silencing will significantly predict urban Bahamian women’s self-efficacy levels (i.e., low or high) for negotiating safer sex behaviors. Two models were used to test this hypothesis. The first model (see Table 7) was based on the conceptual model of study (see Figure 1), which was a forced entry approach to logistic regression with demographic variables entered on block one, self-esteem scores entered on block two, and self-silencing scores entered on block three. The results of this three-block model revealed that only age (odds ratio $[OR] = 1.02$, 95% CI = 1.01-1.04) and self-esteem ($OR = 1.02$, 95% CI = 1.01-1.04) were significant independent predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women. Although education was a significant predictor up to block two ($OR = 1.09$, 95% CI = 1.00-1.19), this variable no longer demonstrated significance (although the $p$-value of .07 was close to being significant) when self-silencing was entered into the equation. The model correctly classified 62% of urban Bahamian in regard to their levels (i.e., low vs. high) of self-efficacy for negotiating safer sex behavior ($\chi^2 = 845.697$, Hosmer-Lemeshow goodness-of-fit, $\chi^2 = 8.73$, df = 8).

For confirmatory purposes and to obtain the best model fit, a second model (see Table 8) was tested using forward stepwise logistic regression, which allowed the statistical software to empirically specify the best fitting model for the
study variables. The results of this three-step model revealed that age ($OR = 1.02$, $95\% \text{ CI} = 1.01-1.04$), education ($OR = 1.10$, $95\% \text{ CI} = 1.00-1.20$), and self-esteem ($OR = 1.03$, $95\% \text{ CI}$) were significant independent predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women. The model correctly classified 61% of urban Bahamian in regard to their levels (i.e., low vs. high) of self-efficacy for negotiating safer sex behavior (-2 Log Likelihood = 847.825, Hosmer-Lemeshow goodness-of-fit, $\chi^2 = 10.84$, $df = 8$).

Hypothesis four was partially supported since only three (i.e., age, education, and self-esteem) of five predictors were significantly associated with urban Bahamian women’s levels (i.e., low vs. high) of self-efficacy for negotiating safer sex behaviors. However, goodness-of-fit of the overall models were questionable (Mertler & Vannatta, 2001) as evident by –2 Log Likelihood and Hosmer-Lemeshow goodness-of-fit results, although the models were statistically reliable in distinguishing between urban Bahamian women’s level of self-efficacy for
negotiating safer sex behaviors ($\chi^2 = 45.427, p < .0001$ for model 1 and $\chi^2 = 43.299, p < .0001$) for model 2), respectively.

Table 8

Forward Stepwise Logistic Regression for Variables Predicting Self-Efficacy for Negotiating Safer Sex Behaviors (Model 2)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>OR</th>
<th>95% CI for OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.021</td>
<td>6.183</td>
<td>1</td>
<td>.01</td>
<td>1.021</td>
<td>1.00 – 1.04</td>
</tr>
<tr>
<td>Education</td>
<td>.095</td>
<td>4.801</td>
<td>1</td>
<td>.03</td>
<td>1.099</td>
<td>1.01 – 1.20</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>.025</td>
<td>21.195</td>
<td>1</td>
<td>.00</td>
<td>1.026</td>
<td>1.02 – 1.04</td>
</tr>
</tbody>
</table>

Odd Ratio (OR)

These findings suggest that older urban Bahamian women with higher education and higher levels of self-esteem are more likely to engage in negotiating safer sex behaviors with their partners than are younger urban Bahamian women with less education and lower levels of self-esteem.

Summary

Six hundred and sixty-one urban Bahamian women ages 18 to 78 years provided data for this study. The majority of the participants completed at least 12 years of school (81%, $n = 575$), almost 56% ($n = 351$) of the participants had a monthly income of $1,500 or greater, and more than 80% ($n = 531$) of the participants were employed. The participants attended their place of worship on an average of five ($SD = 5.07$) times per month. The majority of the participants
were either married \((n = 232)\) or single \((n = 229)\), and most 65\% \((n = 429)\) of the participants identified themselves as heterosexuals. The majority of the participants \((n = 448)\) reported having fewer than five children, and almost 70\% of the participants reported having between 1 and 7 sexual partners in their lifetime. Most of the participants \((n = 469)\) reported personally knowing someone with HIV/AIDS, most of whom were reported to be family members and friends. Almost 85\% \((n = 560)\) of the participants reported having been tested for HIV/AIDS, and the majority of HIV tests were reportedly conducted during the year 2002. The majority \((80\%, n = 529)\) of women tested reported negative HIV/AIDS test results, and almost 2\% \((n = 11)\) of the participants reported having positive HIV/AIDS test results.

Hypotheses one through three were supported by study data. Bivariate correlational analyses revealed a negative relationship between self-esteem and self-silencing scores, a positive relationship between self-esteem and self-efficacy for negotiating safer sex behavior scores, and a negative relationship between self-silencing and self-efficacy for negotiating safer sex behavior scores in urban Bahamian women scores. Additionally, age, education, and self-esteem were found to be significant independent and combined predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women.
CHAPTER V
DISCUSSION and CONCLUSION

Introduction

This chapter summarizes the study and discusses the findings related to demographic and background characteristics of the participants; relationship between major study variables such as select demographic variables (i.e., age, income, education), self-esteem, self-silencing, and self-efficacy; and significant and nonsignificant predictor variables of urban Bahamian women’s levels of self-efficacy for negotiating safer sex behaviors. Limitations of the study and implications for nursing education, practice, social policy, and future research are also addressed.

Summary of the Study

The rapidly increasing rate of HIV/AIDS among Bahamian women is daunting for the future of Bahamian society. Despite many concerted efforts, scientists have been unable to find a cure for HIV disease and are faced with the multiple challenges that treatment and management strategies bring for persons living with AIDS. As a result, there is a major focus on HIV prevention. However, many prevention strategies have been ineffective with women and particular cultural groups, and the rates of HIV/AIDS continue to rise around the world.

To enhance effectiveness of prevention strategies, it is imperative to develop interventions that are gender appropriate and culturally sensitive. In essence, by understanding the personal characteristics of Bahamian women such as self-
estee and self-silencing, which may or may not be related to their self-efficacy for negotiating safer sex behaviors, gender appropriate and culturally specific preventive measures can be developed and implemented in an effort to reduce acquisition and transmission of the disease.

Based upon review of the literature, it is evident that women are at increased risk for HIV/AIDS acquisition and transmission. Women’s increased risks are due to their biological make-up (e.g., increased vaginal mucosal surface area and possible asymptomatic STDs) and their behaviors, which are influenced by sociocultural (e.g., cultural norms and traditional practices), socioeconomic (e.g., age, education, and income levels), intrapersonal (e.g., self-esteem), and interpersonal (e.g., self-silencing and self-efficacy) factors.

Despite the preponderance of studies that have investigated these variables to date, no study was found that has investigated the influence of self-esteem and self-silencing on self-efficacy for negotiating safer sex behaviors in women in general or in urban Bahamian women in particular. Therefore, findings from this study have shed light not only on the relationships among major variables (i.e., self-esteem, self-silencing, and self-efficacy) but (also) on how these variables interact in women of a different culture from a country with high rates of HIV/AIDS.

Based upon the history of Bahamian women, several theories formed the conceptual framework for this study: Self-Esteem Theory; Silencing The Self Theory; and Self-Efficacy Theory. As a result, the following hypotheses were tested in this study:
1. There will be a negative relationship between urban Bahamian women’s self-esteem and self-silencing behaviors.

2. There will be a positive relationship between urban Bahamian women’s self-esteem and self-efficacy for negotiating safer sex behaviors.

3. There will be a negative relationship between urban Bahamian women’s self-silencing and self-efficacy for negotiating safer sex behaviors.

4. Age, income, education, self-esteem, and self-silencing will significantly predict urban Bahamian women’s self-efficacy level (i.e., low or high) for negotiating safer sex behaviors.

A cross-sectional, correlational survey design was used to study the relationships between select demographic variables (i.e., age, income, education), self-esteem, self-silencing (i.e., independent variables), and self-efficacy for negotiating safer sex behaviors (i.e., dependent variable) in urban Bahamian women as well as the likelihood of independent variables predicting self-efficacy. Data were collected via anonymous self-report questionnaires from urban Bahamian women ($N = 661$) at various community sites in Nassau, Bahamas over a three-week period. Data were analyzed using SPSS 11.0 for Windows (SPSS, 2001), and hypotheses were tested using Pearson product-moment correlation coefficients ($r$) and binary logistic regression analyses.

Urban Bahamian women ages 18 to 78 years provided data for this study. The majority of the participants had completed at least 12 years of school, over half of the participants had a monthly income of $1,500 or greater, and more than 80% of the participants were employed. The participants attended their place of worship
on an average of five times per month, or on a weekly basis. The majority of the participants were either married or single, and most participants reported that they were heterosexuals. The majority of the participants reported having fewer than five children, and almost 70% of the participants reported having between 1 and 7 sexual partners in their lifetime. Most of the participants reported personally knowing someone with HIV/AIDS, many of whom were reported as being family members and friends. Almost 85% of the participants reported having been tested for HIV/AIDS, and the majority of HIV tests were reportedly conducted during the year 2002; thus, most tests were recent. The majority of women who were tested for HIV reported negative test results, yet almost 2% of the participants reported having received positive test results. The participants reported that reading and singing were the two hobbies in which they engaged the most. In addition, career goal attainment, educational achievement, and Christianity were the three most frequent standards participants set for themselves but had not yet attained.

Data supported hypotheses one, two, and three and partially supported hypothesis four. There was a negative relationship between self-esteem and self-silencing, a positive relationship between self-esteem and self-efficacy for negotiating safer sex behaviors, and a negative relationship between self-silencing and self-efficacy for negotiating safer sex behaviors. Additionally, age, education, and self-esteem were found to be significant independent predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women. When all of the predictors (i.e., select demographic variables, self-esteem, and self-
silencing) were included in combination in a model tested, over three fifths of the women were correctly classified as having low versus high self-efficacy for negotiating safer sex behaviors.

Discussion of Findings

Demographics and Background Characteristics

Due to the fact that a convenience sampling strategy was used to gather data from urban Bahamian women, it is important to compare the demographic and background characteristics of women in the sample with those of urban Bahamian women in general. Comparisons will be made with other study findings and with demographic statistics for Nassau because data for The Bahamas includes the Family Islands and data for Freeport are mixed with those of other settlements in Grand Bahama.

Since The Bahamas is considered by the majority of Bahamians to be a Christian nation, it was not surprising that urban Bahamian women reported attending their place of worship on an average of five times per month. This finding was consistent with those reported by Ward and Samuels (1999) who found that 74% of women living in Nassau and Freeport attended their place of worship on an average of about six times per month. Further, this finding suggests that, in general, urban Bahamian women attend their place of worship frequently, which further supports the importance they place on religion and Christianity.

Urban Bahamian women who participated in the study ranged in age from 18 to 78 years with an average age of 34 years. The largest numbers of participants’ were between 20 and 44 years of age. This trend is evident in reported statistics of
Bahamian women’s ages in Nassau, except that their ages extended to 95 years and over (Department of Statistic, 2001). Since the majority of older Bahamian women tend to stay at home, it was not surprising that the upper age range of urban Bahamian women who participated in the study was 78 years. In fact, it was remarkable that almost 2% of the participants were age 60 or older.

A u-shaped distribution was found for income in this study sample. This finding was unlike those reported for women in Nassau, which showed women’s income to be positively skewed (Department of Statistic, 2001). However, it could not be determined if upper-class urban Bahamian women were represented in this study or to what extend they were represented, since there was no ceiling for the income item with the highest category being $3,500 or more per month. Moreover, middle-class urban Bahamian women may not have been well represented in this study. Additionally, there is a possibility that some of the participants might have misunderstood the income item and might have responded based on their single income as opposed to household income, which was asked by the income item. Nevertheless, findings from this study revealed that 80% of the participants were employed, which was higher than 74% reported for Bahamian women in Nassau (Department of Statistics, 2002). The high employment rate reported by the participants in this study may have been due to the fact that the majority of Bahamian women fend alone for their children (Neely-Smith, 2002), and the majority of participants in this study had children.

Urban Bahamian women in this study reported an average of 12 years of education. This finding was not surprising since the majority of primary and
secondary schools in The Bahamas are funded by the Bahamian government and are free of charge to all children living in The Bahamas. Moreover, school attendance from grades 1 through 12 is mandatory in The Bahamas. In further support of this finding, Ward and Samuels (1999) reported that more than 71% of the female participants in their study had completed a high school education. Additionally, due to the fact that only a few participants in the current study were unable to read English, 95% whom were Haitian Bahamian, coupled with the fact that 85% of Bahamians are reported as being literate (Dupuch Jr., 1999), it may be fair to say that an average of 12 years of education is representative of Bahamian women living in Nassau.

Participants in this study reported having an average of two children, which is comparable to the average of three children reported for Bahamian women living in Nassau (Department of Statistics, 2001) and two children reported from the study by Ward and Samuels (1999). Additionally, national statistics showed that the rate of marriages in The Bahamas has decreased from 14.9% in 1997 to 7.8% in 2000. This decline in marriages might have been evident in this study since only 35% of the participants in this study reported being married, while almost 55% reported being unmarried excluding those who reported being separated, divorced, or widowed. This trend was also shown in findings reported by Ward and Samuels (1999) since only 25% of the participants in their study were married and 73% were in single relationships. Although the average number of children reported was only two, the finding that only slightly more than a third of the
participants were married may suggest that most urban Bahamian children may be born out of wedlock.

While it was expected that the majority of urban Bahamian women would report heterosexuality as their sexual preference, it was surprising that almost 8% of the participants reported being bisexual, especially since Bahamian culture tends to oppose sexual orientations other than heterosexuality. However, it is possible that some participants may not have understood the meaning of “heterosexual” (i.e., mistaking it for “homosexual”) and knowing that they did not considered themselves lesbians chose the only other response choice provided (i.e., bisexual). In fact, this was the item that required clarification by participants from the researcher the most, and almost 27% of the participants did not respond to this item perhaps because either they did not understand or viewed their sexual preference as too private to share with others.

Although the average number of lifetime sexual partners reported by urban Bahamian women was five, almost 13% of the participants did not respond to this item. Again, urban Bahamian women may have considered this information too private to share with others. For instance, some participants gave qualitative responses to this item such as “I am too ashamed to say”, “I cannot remember the amount”, “this is confidential”, “a lot”, and “too many.” These findings further highlight the need for interventions to enhance self-esteem and foster self-efficacy for negotiating safer sex behaviors in urban Bahamian women.

It was not surprising that almost all participants personally knew someone infected with HIV/AIDS since the rate of HIV/AIDS in The Bahamas is reported
as escalating in a population of about 304,000. In further support of this finding, almost 70% of the participants in a study conducted to identify socioeconomic factors that make women more vulnerable to HIV/AIDS in The Bahamas also reported knowing family members and friends with AIDS (Ward & Samuels, 1999). Participants in the current study identified mothers, fathers, sons, daughters, aunts, uncles, grand parents, cousins, friends, neighbours, coworkers, and church members as having HIV/AIDS. These findings further suggest the pervasiveness of HIV/AIDS in the lives of Bahamians in general and urban Bahamian women in particular and the need to prevent the spread of the epidemic.

Since a majority of participants in this study were urban Bahamian women who were in their childbearing years and since the majority of physicians in The Bahamas usually test pregnant women for HIV/AIDS, it was not surprising that almost 85% of the participants reported having been tested for HIV/AIDS. Additionally, the majority of the participants (48%) who responded to this item reported being tested in 2002 compared to only 13% of the participants in 2001 and 6% of the participants in 2000. These findings suggest that there has been an increase in the number of persons being tested for HIV/AIDS, which supports the national decrease in mother-to-child-transmission (MTCT) rate from 30% to 10% reported in The Bahamas as a result of HIV/AIDS identification and treatment (Health Information Coordinating Services, 2001).

Two percent of the participants in this study reported testing positive for HIV/AIDS, which is lower than seroprevalence rates reported by Gomez et al. (1996) in a study conducted in The Bahamas between 1990 and 1991 with
pregnant women, where 2.5% of Bahamian women tested positive for HIV/AIDS. However, given the fact that 4% of the participants in the present study did not respond to this item coupled with the possibility that some of the participants responded based on remote knowledge and may not have been aware of their present HIV status (i.e., participants reported being tested in 2002, 2001, 2000, 1999…, 1986), seroprevalence rate in the current study sample may have been higher than reported. Moreover, this finding suggest that 1 in every 60 urban Bahamian women in the current study were HIV positive which supports the view that the rate of HIV/AIDS is high among Bahamian women and highlights the critical need for gender appropriate and culturally sensitive prevention interventions to decrease the rate.

Urban Bahamian reported reading and singing as the two hobbies they engaged in most. This finding was not surprising since reading and singing are the two major activities that occur in most places of worship in The Bahamas, which these women reported frequently visiting. However, this finding is important because these hobbies could be incorporated into the development and implementation of prevention intervention strategies to decrease the rates of HIV/AIDS in women in The Bahamas. In addition to their hobbies, career goal attainment, educational achievement, and Christianity were the most frequently reported standards that urban Bahamian women set for themselves but had not yet attained. This finding suggests urban Bahamian women’s desire to excel in Bahamian society and their need to be guided by moral principles. Moreover, this
finding reflected the fact that a majority of Bahamian women fend alone for their children and desired better and stable careers.

**Relationships Between Major Study Variables**

The results of statistical analysis conducted to test hypothesis one in this study indicated that there was a negative relationship between urban Bahamian women’s levels of self-esteem and their self-silencing behaviors. This finding supported findings of other studies (Page et al., 1996; Woods, 1999) in which self-esteem was found to have moderate to high negative correlation with self-silencing. This finding suggests that urban Bahamian women with high levels of self-esteem are more likely to speak their minds in intimate relationships than are urban Bahamian women with low levels of self-esteem. Although a causal relationship cannot be established, it can be concluded that urban Bahamian women could benefit from skills building in areas such as self-esteem enhancement and clear, open communication, which may improve their sexual negotiation powers and decrease their risk for HIV/AIDS.

The results of statistical analysis conducted to test the second hypothesis of this study revealed a significant positive relationship between urban Bahamian women’s levels of self-esteem and their self-efficacy for negotiating safer sex behaviors. Although findings from some studies have indicated that as an individual’s level of self-esteem increases, so does his or her practice of safer sex behaviors (Mill, 1997; Nyamathi, 1991; Ward & Samuel, 1999), other study findings have suggested the contrary. For instance, some studies have found that self-esteem had no influence on women’s safer sex practices (Hylton, 1999) and
that persons with high self-esteem actually reported engaging in high risk sexual behaviors (Hollar & Snizek, 1996; Long-Middleton, 2001). However, it is important to note that the majority of the studies that failed to link self-esteem with safer sex behaviors were conducted with adolescents who tend to engage in risky behaviors more than do adults (Long-Middleton, 2001; Ponton, 1998).

Findings from statistical analysis conducted to test hypothesis three revealed that there was a significant negative relationship between urban Bahamian women’s self-silencing behaviors and their self-efficacy for negotiating safer sex behaviors. This finding suggests that urban Bahamian women who silence during intimate relationships are less likely to engage in negotiating safer sex behaviors with their partners, a conclusion that has also been drawn from other studies (Quinta et al., 2000; Thompson et al., 2001).

To further understand urban Bahamian women in relation to the major variables of this study, the significant correlations between the major study variables suggested that older urban Bahamian women had higher income, silenced more in intimate relationships, but had higher self-efficacy for negotiating safer sex behaviors than younger urban Bahamian women. Likewise, more educated urban Bahamian women had higher income, had higher levels of self-esteem, silenced less in intimate relationships, and had higher levels of self-efficacy for negotiating safer sex behaviors than less educated urban Bahamian women. Urban Bahamian women with higher income were more educated, had higher levels of self-esteem, silenced less in intimate relationships, and had higher
self-efficacy for negotiating safer sex behaviors than urban Bahamian women with less income.

Accordingly, the correlation between age and education was found to be nonsignificant. This finding may have reflected the fact that participants in the study had passed high school age (i.e., ages 18 years or older), and more than 80% had completed high school, which is up to grade 12 in The Bahamas. Thus, it may have been difficult to detect a relationship or association between these variables. Similarly, the relationship between age and self-esteem was also found to be nonsignificant. This finding might have reflected the fact that self-esteem is a personality trait that is relatively stable over-time (Cast & Burke, 2002). Since participants were all adults by Bahamian standards (Dupuch Jr. 1999), they may have lived with a stable level of self-esteem for a while. Another interpretation for this finding may be that participants’ behaviors, attitudes, and environments that may influence their levels of self-esteem may be stable and do not fluctuate with age.

**Significant Predictors of Self-Efficacy**

Findings partially supported hypothesis four of this study and revealed that age, education, and self-esteem were significant predictors of urban Bahamian women’s level (i.e., low or high) of self-efficacy for negotiating safer sex behaviors. In essence, this finding indicates that older, more educated urban Bahamian women with higher levels of self-esteem are more likely to engage in negotiating safer sex behaviors than their younger, less educated counterparts with lower levels of self-esteem.
It was interesting to find that older urban Bahamian women were more likely to engage in negotiating safer sex behaviors since older women are viewed as being in more stable relationships and, thus, thought to be more likely to have unprotected sex than their younger counterparts. Moreover, completion of their childbearing years has resulted in discontinuation of contraception use by older women, which may have led some of them to engage in unprotected sex with their partners (Wyatt et al., 2000). This finding refutes the notion that younger urban Bahamian women would have had more experience with condom use and would be more outspoken with their sexual partners and, thus, would be more likely to negotiate safer sex behaviors than older urban Bahamian women.

However, given that the largest numbers of women infected with HIV in The Bahamas are between the ages of 15 and 44 years with the largest group being between the ages of 25 to 29 years, and in view of the fact that the number of older women infected with HIV/AIDS drops considerably after age 44 (Health Information and Research Unit, 2002), older Bahamian women may, indeed, be more likely to negotiate safer sex behaviors than their younger counterparts. Age as a significant predictor for urban Bahamian women’s level of self-efficacy for negotiating safer sex behaviors has shed some light on urban Bahamian women’s HIV risk behaviors. Major attention should be given to age when developing and implementing prevention intervention strategies to decrease the risk of HIV/AIDS in urban Bahamian women.

It was not surprising that education significantly predicted urban Bahamian women’s levels (i.e., low or high) of self-efficacy for negotiating safer sex
behaviors, since education was also found to be a significant predictor of HIV infections in a seroprevalence study of pregnant women of whom 79.2% were women born in The Bahamas (Gomez et al., 1996). Moreover, Graves and Hines (1997) found that education was a significant predictor for condom use in a sample of Hispanic women. However, education as a significant predictor for urban Bahamian women’s levels of self-efficacy for negotiating safer sex behaviors warrant answers to two questions:

1. Are educated urban Bahamian women more likely to seek HIV/AIDS knowledge through reading (i.e., one of the hobbies they reported as engaging in most) related to HIV/AIDS prevention, and is this knowledge a precursor to their ability to engage in negotiating safer sex behaviors? Or

2. Since findings from studies have also suggested that education is significantly correlated with self-esteem (Flaskerud & Uman, 1996; Wiggins et al., 1994) and is a significant predictor of self-esteem (Romans et al., 1996), do educated urban Bahamian women have high levels of self-esteem and, as a result, have more self-worth, self-respect, self-belief, and assertiveness and thus, are more likely to engage in negotiating safer behaviors? Despite the reason(s), education should play a major role in developing and implementing prevention strategies to decrease urban Bahamian women’s risk for HIV/AIDS.

As theorized, self-esteem was found to significantly predict urban Bahamian women’s levels of self-efficacy for negotiating safer sex behaviors, a finding that has also been reported from other studies (Mills, 1997; Nyamathi, 1991). On the average, urban Bahamian women tend to have moderately high levels of self-
esteem. Comparable levels of self-esteem have been reported for other cultural groups, mainly low-income African American women (Asbury, 1985; Taylor & Tomasic, 1996; Wilson, 1985). However, given the history of Bahamian women related to racism, classism, sexism, and colorism coupled with the fact that self-esteem is considered a personality trait that is relatively stable overtime (Adler, 1997; Coopersmith, 1967; Gecas & Schwalbe, 1983), it could logically have been expected that, on the average, urban Bahamian women would have demonstrated lower levels of self-esteem.

However, given the fact that in the 1960s the people of the Bahamas were sensitized to be proud Bahamians (Beardsley Roker, 2000), a view in which women took great advantage, may account for urban Bahamian women’s relatively high self-esteem scores. In further support of this notion, Knowles (1999) found that Bahamian children had higher social self-esteem scores than their Jamaican counterparts, although Jamaican children had higher academic self-esteem scores than did Bahamian children in the study. More importantly, there was a significant difference by country for social and academic self-esteem scores between Jamaican and Bahamian children.

The frequency with which urban Bahamian women attended their place of worship, where they are taught self-worth and self-love, may also be responsible for their high self-esteem scores. Urban Bahamian women’s high self-esteem scores were evident by the type of positive items with which they were most likely to agree such as “I am satisfied with the kind of person that I am” and “I feel a sense of purpose”. On the other hand, items with which they were most
likely to disagree were negative items such as “I dwell on my faults’ and “I am ashamed of the things I do”. As a result of these findings, self-esteem should be a major concept in the development and implementation of prevention interventions for urban Bahamian women in order to decrease their risk for HIV/AIDS.

Urban Bahamian women’s levels of self-efficacy for negotiating safer sex behaviors scores were remarkably high although comparable to those of African American and White women reported in the literature (Soet et al., 1999). Noteworthy were the findings that urban Bahamian women’s scores were higher for the Refusal and Discussion subscales and lower for the Condom Use subscale. These subscale trends have also been documented for other cultural groups of women (Soet et al., 1999). This finding indicates that training in actual condom use may be warranted for urban Bahamian women.

However, this finding may raise the question as to why the rate of HIV/AIDS continues to escalate in Bahamian women when findings suggest that urban Bahamian women generally have high level of self-efficacy for negotiating safer sex behaviors. This finding is conflicting since Bandura (1986; 1989) posited that the more practice a person has performing a certain skill, the higher his or her level of self-efficacy will be. Assuming that this theory is applicable to urban Bahamian women, it would mean that these women have had considerable practice in negotiating safer sex behaviors and, thus, high self-efficacy. If this is the case, some may question why the rate of HIV/AIDS continues to escalate in Bahamian women when heterosexual transmission is the predominant (96.2%) mode of transmission in The Bahamas. However, it is important to emphasize that
this study only used a self-report measure of self-efficacy rather than a measure of actual sexual behaviors.

Bandura (1986; 1989) asserted that self-efficacy is a belief that one can successfully perform a skill. Therefore, it is possible that urban Bahamian women might hold the belief that they could negotiate safer sex behaviors but may be unable to perform safer sex behaviors successfully when in the actual situation. Additionally, urban Bahamian women may have responded to this self-report measure with culturally and socially acceptable answers. Based on Bahamian cultural norms and traditional practices, urban Bahamian women are expected to always say no to sexual intercourse with someone they have just met or may be attracted to, they are expected to always be able to discuss the importance of safer sex, and they are expected to always be able to say no to sex with someone even if they may have had sex with them before. The increasing rates of HIV/AIDS in Bahamian women, however, suggest that urban Bahamian women do not generally practice what is culturally and socially expected of them. Inclusion of a measure of these women’s actual sexual behaviors would have shed more light on this matter.

Findings from this study suggest that older, more educate urban Bahamian women with high level of self-esteem are more likely to engage in negotiating safer sex behaviors than are younger and less educated urban Bahamian women with low level of self-esteem. Moreover, age, education, and self-esteem should definitely be taken into consideration in the development and implementation of
prevention interventions strategies to decrease the risk of HIV/AIDS in urban Bahamian women.

*Nonsignificant Predictors of Self-Efficacy*

The results of logistic regression conducted to test hypothesis four in this study indicated that income and self-silencing were not significant predictors of urban Bahamian women’s level (i.e., low or high) of self-efficacy for negotiating safer sex behaviors. Although there is global agreement that lack of adequate income is responsible for some women’s engagement in risky behaviors (UNAIDS/WHO, 2001), income was not found to be a significant predictor for urban Bahamian women’s level of self-efficacy for negotiating safer sex behaviors. Had income been measured on an interval level in this study, this proxy for financial resources may have been a stronger predictor of self-efficacy for negotiating safer sex behaviors in urban Bahamian women. Alternatively, since income was found to be associated with both age and education, perhaps those other variables masked the influence of income on self-efficacy for negotiating safer sex behaviors. However, Peragallo (1996) also found that women’s income level was not significantly related to their risk for HIV/AIDS.

Forty-two percent of the participants in this study reported an income less than $18,000 per year. Although there is no established poverty level for The Bahamas (Department of Statistics, 2002), income levels in The Bahamas are reportedly higher than those reported for comparable groups in other Caribbean countries (Spadoni, 1977). Thus, Bahamian women may not feel the same financial constraints as women in other cultures.
Although the majority of Bahamian children are raised solely by their mothers (Neely-Smith, 2002), urban Bahamian women may be more financially independent and less dependent upon men than might be thought. Urban Bahamian women’s financial independence may be the reason why the findings from this study failed to support urban Bahamian women’s level of income as a significant predictor of their level of self-efficacy (i.e., low or high) for negotiating safer sex behaviors. However, had the sample of this study included urban Bahamian female adolescents, income might have significantly predicted their level of self-efficacy (i.e., low or high) for negotiating safer sex behaviors since younger women tend to have sex with older men for money (UNAIDS/WHO, 2002). Knowledge gained from this finding is important for the development and implementation of prevention interventions to decrease the rate of HIV/AIDS among urban Bahamian women, indicating that income may not be a constraint or motivator in efforts to improve their level of self-efficacy for negotiating safer sex behaviors.

Self-silencing, a concept not previously studied in urban Bahamian women, was also not found to be a significant predictor of urban Bahamian women’s level (i.e., low or high) of self-efficacy for negotiating safer sex behaviors. This finding is interesting since self-silencing significantly correlated with all other major study variables. Urban Bahamian women who silenced more in intimate relationships were older, less educated, had lower incomes, had lower levels of self-esteem, and had lower levels of self-efficacy for negotiating safer sex behaviors than urban Bahamian women who silenced less in intimate
relationships. Further, urban Bahamian women’s scores on STSS were comparable with those reported in the literature for other cultural groups of women in the U.S. (Bruner, 1997; Jack & Dill, 1992; Remen et al., 2002), although found to be much higher when compared with STSS scores measured in Caribbean women living in the Caribbean (Ali & Toner, 2001). These findings indicate that, on the average, urban Bahamian women tend to silence themselves more in intimate relationships than their Caribbean counterparts.

The literature has presented conflicting findings regarding silencing and sexual behaviors. Findings from some studies have suggested that the more women gathered information from their sexual partners, the less likely they engaged in unprotected sex (Quina et al., 2000). However, findings from other studies have suggested that silencing was not significantly related to past condom use with a group of undergraduate college women, although silencing was related to their intent to use condoms (Bruner, 1997). Moreover, Thompson et al. (2001) found in their study with undergraduate students that communication was not a significant predictor of risky sexual behaviors. The finding that urban Bahamian women’s self-silencing behaviors was not a predictor of their level of self-efficacy for negotiating safer sex behaviors is interesting because it indicates that whether or not urban Bahamian women are outspoken with their sexual partners, they may believe that they can engage in safer sex behaviors. However, the extent to which urban Bahamian women actually do engage in safer sex behaviors is yet to be determined.
Limitations of Study

Findings from this study have provided insight regarding variables that significantly predict urban Bahamian women’s level of self-efficacy for negotiations safer sex behaviors, which can be used to decrease their risk for HIV/AIDS. However, there were limitations to this study, which are as follows:

1. A cross-sectional, correlational survey design was used in this study. Therefore, generalization cannot be made regarding changes or trends over time, directionality of influence, or cause-and-effect relationships.

2. A convenience sampling strategy was used to collect data for this study. Therefore, there may have been sampling bias, thus limiting the ability to generalize findings.

3. Data were collected within one month, and responses might have been different if data were collected during a different time of year (i.e., summer, fall).

4. Self-report questionnaires were used to collect data that might have resulted in response bias, social desirability bias, and inaccuracies that could have affected findings.

5. Some of proposed data collection sites were not used (i.e., professional women’s groups, malls, supermarkets), which might have allowed access to a more diverse sample of urban Bahamian women.

6. Data collection was only conducted in Nassau. Data collection in Freeport, Grand Bahama might have provided a more diverse sample of urban Bahamian women.
7. The researcher was present during data collection, which could have caused some participants to respond in a culturally and socially acceptable manner.

8. The researcher ran out of monies for gifts and questionnaires, which could have provided a larger sample size and increased generalizability of findings.

9. The settings for data collection were community sites that might not have allowed access to older urban Bahamian women who usually tend to stay at home or who do not frequent such places as laundromats and clinics.

Nursing Implications

Although many strides have been made in the global fight against HIV/AIDS including the advent of numerous antiretroviral drugs, HIV/AIDS continues to challenge humankind and the global healthcare system in terms of methods of prevention, care, and support. In the absence of a cure, prevention is paramount in the fight against HIV/AIDS. Therefore, findings from this study provide impetus for maintenance of health and prevention of HIV/AIDS for urban Bahamian women by nursing and other helping professions.

The awareness that older and more educated urban Bahamian women with higher levels of self-esteem were more likely to report confidence in negotiating safer sex behaviors than younger and less educated urban Bahamian women with lower level of self-esteem is very important. Critical attention should be paid to age, education, and self-esteem in planning and implementing HIV prevention efforts for urban Bahamian women. This important piece of knowledge should be shared with local, regional, and international communities through publications, various forms of media (i.e., radio, television, pamphlets), and teaching/learning
sessions to influence nursing education, practice, social policy, and future research.

Education

The characteristics of urban Bahamian women which put them at risk for HIV/AIDS and prevention strategies such as skills building (i.e., condom use) should be included in HIV/AIDS course content in nursing curricula, continuing education, workshops, and conferences to ensure that nursing students and practicing nurses are aware of the areas where they should direct attention in the prevention of HIV/AIDS. For instance, nurses should attend continuing education courses and workshops that will teach them how to design theory-based prevention programs based on findings from this study. Additionally, nurses should be taught how to seek and apply for program funding as well as how to implement programs based on research findings as well as evaluate the programs to determine effectiveness. Lastly, nurses should be adequately trained in HIV/AIDS counseling in order to provide individual prevention interventions tailored to Bahamians women based on age, education, and level of self-esteem.

Practice

Nurses should develop prevention programs that specifically target female adolescents and young women. Peer support groups should be a major focus for prevention intervention strategies with young women. Younger women within the same age group should be allowed to share their sexual experiences with their peers so that others could benefit from their experience and avoid pitfalls. Moreover, peer support could give young women the assurance that they are not
alone and that there is hope for decreasing their risk for HIV/AIDS. Interventions should include educational assessment of participants to ensure that they have completed at least a high school education. When participants have not completed high school, they should be encouraged to attend evening classes to achieve at least a high school education. Additionally, participants should be encouraged to strive for career goal attainments by becoming educationally equipped through vocational and/or college education programs.

Prevention intervention strategies for young Bahamian women should enhance education and foster self-esteem among peers. Although written materials should be provided for participants to inform them about self-esteem enhancement, condom use, assertiveness, communication, and negotiating skills, information should also be provided through demonstrations, role-playing, skits, and videotape that depicts culturally appropriate and gender specific sexual roles. Moreover, young women with educational limitations can also benefit from these types of prevention intervention approaches.

At the community level, nurses should train prominent community leaders in the Bahamas such as pastors, women’s group leaders, radio disc jockeys, and sports heroes (i.e., Bahamian Olympic gold medallists, “The Golden Girls”) about the importance of safer sex behaviors, education promotion, and self-esteem enhancement. These influential persons should be encouraged to diffuse these sediments into the community to impact social norms related to decreasing the risk for HIV/AIDS among their followers and admirers (Holtgrave, 1997). Additionally, nurses should include community stakeholders in planning and
implementing prevention intervention programs for Bahamian women in an effort to maximize their support and benefit from their contributions. Such persons should not only include political, social, and community leaders but (also) Bahamian women of various ages including those that are living with HIV/AIDS.

While many organizations and community sites that Bahamian women frequently visit should be targeted for small-group HIV/AIDS prevention interventions, churches and healthcare facilities (i.e., clinics) may be the most appropriate settings to ensure maximum participation. Since Bahamian women attend church on a regular basis, it may be beneficial to develop prevention interventions with women’s group leaders so that the interventions can be incorporated into group meetings. Likewise, nurses should design prevention interventions programs at healthcare facilities in such a way that women can attend sessions during their clinic appointments.

The main goals of prevention intervention strategies should be to improve knowledge, change beliefs and attitudes, and enhance skills for safer sex behaviors in Bahamian women. Since reading was reported as one of the hobbies Bahamian women engage in most, written materials such as brochures, posters, newsletters, pamphlets should be written in simple, clear, succinct language that is culturally appropriate and should be readily available and accessible to these women. These materials should include information about HIV/AIDS myths, where to obtain information about HIV/AIDS, how to be tested for HIV/AIDS, and the meaning of HIV results as well as information on skills building (i.e., condom use, assertiveness and communication skills, and self-esteem
enhancement). However, since education alone does not guarantee change in attitude and behaviors, interventions should include group discussions about sex roles and negotiating skills including condom use.

Additionally, skills building related to condom use, negotiating powers, communication, assertiveness, and self-esteem enhancement should be fostered through demonstrations from videotapes as well as live instruction, role-playing, and group interactions. Role modeling or a buddy system should also be incorporated in intervention strategies for Bahaman women. Older women should be encouraged to buddy with younger women and to teach them skills building, offer advice about safer sex behaviors based on their experiences, and act as role models for their younger counterparts (DeMarco & Norris, 2002).

Lastly, practicing nurses should identify female patients and clients who are at risk for HIV/AIDS, teach them prevention methods, and make appropriate referrals to intervention programs for additional education and skills building to prevent HIV/AIDS. Nurses should provide a nonjudgmental healthcare environment that encourages assertiveness, promotes education, and enhances self-esteem for patients, staff, and their peers.

Social Policy

Nurses should be involved in all levels of prevention interventions designed to decrease the rates of HIV/AIDS in Bahamian women. From a societal standpoint, nurses should influence social policies to ensure development of national prevention intervention strategies that are gender appropriate and culturally sensitive and designed based on age and educational level. A major
focus of these prevention strategies should be on urban Bahamian female children and young women to promote their level of education, improve their sexual negotiating powers, and provide skills building opportunities such as in the areas of condom use, assertiveness skills, communication skills, and self-esteem enhancement (Porche & Swayzer, 2003).

Nurses should take an active role to ensure that social policies related to self-esteem enhancement activities in schools are developed and implemented. Preschool teachers could be trained in early childhood education so that they will be aware of growth and development issues and learn how to adequately teach and interact with children to enhance their self-esteem, assertiveness, and communication skills as well as enforce the importance of education. Bahamian girls should not only be taught interdependent roles but they should (also) be taught independent and autonomous roles to enhance their levels of self-esteem (Cross & Madson, 1997).

Self-esteem enhancement activities such as “I am Special” day which is carried out every year by Grade 2 students in one of the private schools in Nassau, Bahamas should be adopted by every school in The Bahamas beginning in the first grade. During this special day, students are allowed to wear t-shirts with the logo “I am Special” while they perform on stage for teachers, parents, and friends using poems and plays that enhance self-esteem (Y. Foulkes, personal communications, March 19, 2003). Activities such as “I am Special” day should be a stepping-stone from preschool activities to further promote self-esteem and education in Bahamian children in general and girls in particular.
Additionally, nurses should influence social policies to ensure that Focus on Youth, a program adapted from the Focus on Kids, a CDC identified program that works, which was pilot in The Bahamas since 1998 and has revealed positive changes in the lives of participants is incorporated in every school in the Bahamas. The program trains teachers to educate youth in strategies to prevent pregnancy and sexually transmitted infections (STIs) including HIV/AIDS. Fun, creativity, and interactions are used to teach youths how to develop and build self-esteem, confidence, and negotiation skills (C. Campbell, AIDS Secretariat, personal communication, July 15, 2002).

Nurses should influence social policies that will encourage Bahamian artists to write songs that are culturally appropriate and promote education, self-esteem, and safer sex practices. These songs should be tailored to various age groups (i.e., children, adolescents, young adults, middle-aged, and older adults) and educational levels. Bahamian girls and women should be encouraged to sing these songs during school activities and social gatherings to keep aware of the need to reduce their risk for HIV/AIDS. Additionally, these songs should be played on local radio and television stations in The Bahamas to keep Bahamians aware of the importance of education and practicing safer sex while enhancing their levels of self-esteem. Moreover, these songs can be incorporated in prevention intervention programs for Bahamian women particularly since singing was one of the hobbies they reported as engaging in most.

Nurses should influence social policies related to condom use, availability, and accessibility to persons living in The Bahamas particularly women in an
effort to decrease the stigma attached to condom and increase its use. For instance, Bahamian adolescents and women should be sensitized and educated about the advantages and proper use of condoms. Nurses should ensure that information about condom is appropriately disseminated in the local schools, community sites (i.e., clinics, churches where condom use does not conflict with religious beliefs), and on local television and incorporate demonstrations about the proper use of condoms.

Lastly, nurses should influence social policies to ensure condoms are affordable and accessible. For instance, Bahamian women should be able to obtain free condoms from strategic community sites in The Bahamas. Additionally, condoms should be readily available and could be purchased at a reasonable price in the supermarkets, drug stores, clubs, bars, hotels, and places that women frequently visits. In fact, there should be condom vending machines in strategic places in The Bahamas such as shopping malls, sports gyms, movie theatres, sports centers (i.e., places that house indoor and outdoor sports).

Future Research

Although findings from this study added to national, regional, and global HIV/AIDS knowledge as well as to the body of nursing knowledge, they have filled just a small gap in the global puzzle of HIV/AIDS. However, this study has provided impetus for future studies related to HIV/AIDS prevention in The Bahamas and around the world. First, this study should be replicated with Bahamian women living on the Family Islands (i.e., rural), Bahamian adolescents (i.e., rural and urban), Bahamian men (i.e., rural and urban) as well as Caribbean
adolescents, women, and men (i.e., rural and urban) to determine influence on self-efficacy for negotiating safer sex behaviors, which can then be compared and contrasted with those of urban Bahamian women. Additionally, other predictor and criterion variables such as condom use (i.e., consistent users, inconsistent users, none users), perceived condom use, perceived risk for HIV/AIDS, type of relationships (i.e., self-dominated, partner-dominated, equal dominance), and alcohol and drug abuse (i.e., crack cocaine) should be studied with Bahamian women (i.e., rural and urban) to further identify the characteristics that may put them at risk for HIV/AIDS.

Longitudinal studies should be conducted with urban Bahamian women to identify changes and trends overtime. Additionally, methodological triangulation should be used to enhance data collection, analyses, and interpretation as well as increase generalizability of findings. For instance, inclusion of sexual diaries and focus groups discussions and condom use demonstrations can be included as means of data collection to compare actual sexual practices with self report self-efficacy for negotiating safer sex behaviors. Qualitative methodologies such as phenomenology and ethnography should be used to identify additional characteristics (i.e., indicators) of Bahamian women that may influence their levels of self-efficacy for negotiating safer sex behavior, which could then be tested in quantitative designs.

Lastly, research efforts should include evaluation of theory-based skills building interventions that are gender appropriate and culturally sensitive as well as tailored to age group and educational level. Experimental designs such as
factorial designs (Gall et al., 1996) should be used to evaluate interventions to identify which components individually and in combination work. Such interventions should address condom use, safer sex negotiations, assertiveness, communication skills, and self-esteem enhancement to determine their effectiveness in preventing HIV/AIDS in Bahamians in general and Bahamian women in particular.

Summary

The purpose of this study was to understand the characteristics that put urban Bahamian women at risk for HIV/AIDS so that gender appropriate and culturally sensitive prevention interventions could be developed and implemented to decrease the rate of HIV/AIDS with this vulnerable group. A cross-sectional, correlational survey design was used to study the relationships between select demographic variables (i.e., age, income, education), self-esteem, self-silencing, and self-efficacy for negotiating safer sex behaviors in urban Bahamian women. Data were collected from urban Bahamian women \( N = 661 \) ages 18 to 78 years from a variety of community sites in Nassau, Bahamas. Data were collected using an 80-item anonymous questionnaire which included: (a) 16-item Taylor’s self-esteem inventory (TSEI) to measure self-esteem (Taylor & Tomasic, 1996); (b) 31-item Silencing The Self Scale (STSS) to measure self-silencing (Jack & Dill, 1992); (c) 12-item Self-Efficacy Scale (SES) to measure self-efficacy for negotiating safer sex behaviors (Dilorio et al., 1997); and (d) demographic and background questions.
Hypotheses were tested using Pearson product-moment correlation coefficients (r) and logistic regression analyses, which revealed mixed results. Three of four hypotheses were supported, and the fourth hypothesis was partially supported. There was a negative relationship between self-esteem and self-silencing, there was a positive relationship between self-esteem and self-efficacy for negotiating safer sex behaviors, and there was a negative relationship between self-silencing and self-efficacy for negotiating safer sex behaviors in urban Bahamian women. Additionally, age, education, and self-esteem were significant predictors of self-efficacy for negotiating safer sex behaviors in urban Bahamian women.

The results of this study provided information needed to understand the characteristics of urban Bahamian women which put them at risk for HIV/AIDS and provided impetus for the development and implementation of gender appropriate and culturally sensitive prevention interventions to decrease the rate of HIV/AIDS among this vulnerable group. Future research initiatives should include replication of this study with rural Bahamian women, urban and rural Bahamian adolescents and men, and urban and rural Caribbean adolescents, women, and men as well as evaluation of specific theory-based skills building HIV prevention interventions.
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Appendix C

Participants’ Survey

Please read each statement completely, carefully, and thoughtfully and indicate the frequency with which the thoughts or feelings indicated below apply to you.

Here is an example of a completed item.

<table>
<thead>
<tr>
<th>Always</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>EX: I feel sad inside.</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Always</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am satisfied with the kind of person I am.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I later regret things I’ve said.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. I feel happy inside.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. My behavior is inconsistent with my values.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I tackle my problems head on.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. I criticize myself over the least little thing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. I defend my opinions.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I feel ashamed of the things I do.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I feel proud of the way I do things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. I distrust my judgment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. I think about things I’ve done well.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. My problems get the best of me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. I have a sense of purpose.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Scores</td>
<td></td>
<td></td>
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<tr>
<td>----</td>
<td>--------------------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I worry.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I follow through on decisions I make.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I dwell on my faults.</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please circle the number that best describes how you feel about each of the statements listed below. Here is an example of a completed item:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Agree</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

EX: I am able to ask for directions when I’m lost. 1 2 3 4 5

<p>| | | | | | | | | |</p>
<table>
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<th></th>
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<th></th>
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</thead>
<tbody>
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<td>1</td>
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<td>4</td>
<td>5</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1. I think it is best to put myself first because no one else will look out for me.

2. I don’t speak my feelings in an intimate relationship when I know they will cause disagreement.

3. Caring means putting the other person’s needs in front of my own.

4. Considering my needs to be as important as those of the people I love is selfish.

5. I find it is harder to be myself when I am in a close relationship than when I am on my own.

6. I tend to judge myself by how I think other people will see me.
Please circle the number that best describes how you feel about each of the statements listed below. Here is an example of a completed item:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>EX: I am able to ask for directions when I'm lost.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.

8. When my partner’s needs and feelings conflict with my own, I always state mine clearly.

9. In a close relationship, my responsibility is to make the other person happy.

10. Caring means choosing to do what the other person wants, even when I want to do something different.

11. In order to feel good about myself, I need to feel independent and self-sufficient.
12. One of the worst things I can do is to be selfish.

13. I feel I have to act in a certain to please my partner.

---

Please circle the number that best describes how you feel about each of the statements listed below. Here is an example of a completed item:

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Somewhat</th>
<th>Neither Agree</th>
<th>Somewhat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>Disagree</td>
<td>nor Disagree</td>
<td>Agree</td>
</tr>
</tbody>
</table>

**EX:** I am able to ask for directions when I’m lost.

1 2 3 4 5

---

14. Instead of risking confrontations in relationships, I would rather not rock the boat.

1 2 3 4 5

15. I speak my feeling with my partner, even when it leads to problems or disagreements.

1 2 3 4 5

16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.

1 2 3 4 5

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.

1 2 3 4 5

18. When my partner’s needs
or opinions conflict with mind, rather than asserting my own point of view I usually end up agreeing with him/her.

19. When I am in a close relationship I lose my sense of who I am.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
</table>

Copyright © 1991 by Dana Crowley Jack

Please circle the number that best describes how you feel about each of the statements listed below. Here is an example of a completed item:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree</th>
<th>Agree</th>
</tr>
</thead>
</table>

EX: I am able to ask for directions when I'm lost.  1  2  3  5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.

21. My partner loves and appreciates me for who I am.

22. Doing things just for myself is selfish.

23. When I make decisions,
other people’s thoughts and opinions influence me more than my own thoughts and opinions.

24. I rarely express my anger at those close to me.
   1  2  3  4  5

25. I feel that my partner does not know my real self.
   1  2  3  4  5

26. I think it is better to keep my feelings to myself when they do conflict with my partner.
   1  2  3  4  5

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Please circle the number that best describes how you feel about each of the statements listed below. Here is an example of a completed item:

**EX:** I am able to ask for directions when I’m lost.

1  2  3  4  5

27. I often feel responsible for other people’s feelings.
   1  2  3  4  5

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.
   1  2  3  4  5

29. In a close relationship I
   1  2  3  4  5
don’t usually care what we do, as long as the other person is happy.

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).

31. I never seem to measure up to the standards I set for myself.

If you answered the last question with a 4 or 5, please list up to three of the standards you feel you don’t measure up to:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
<table>
<thead>
<tr>
<th>Completely Not Sure I Can At Sure I Can</th>
<th>All Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Can</td>
<td></td>
</tr>
<tr>
<td>1. I can always say no to sex with someone who is pressuring me to have sex.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>2. I can always put a condom on (myself/my partner) so that it will not slip and break.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>3. I can always talk to any potential sex partner to make him/her understand why we should use a condom.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>4. I can always put a condom on (myself/my partner) even if the room is dark.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
</tbody>
</table>

Please rate how confident you are that you could perform each activity on a regular basis by circling the appropriate number.

Remember: 1. Please answer all items as they apply to your current situation.
2. If you have not had experience in the given situation, answer how you might feel or act.
3. The word condom means a condom or any other protective barrier such as a dental dam or a piece of latex.

Here is an example of a completed item.

<table>
<thead>
<tr>
<th>Completely</th>
<th>Not At All</th>
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<tbody>
<tr>
<td>Sure I Can</td>
<td>Not At All</td>
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</table>

EX: I can ask for help when I need it.

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<th>Not</th>
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<td>&quot;</td>
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</table>

5. I can always discuss preventing AIDS and other STDS with my sex partner.

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<th>Not</th>
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<td>7</td>
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</table>

6. I can always say no to sex without a condom, even if it is with someone new who I really want to have a relationship with.

<table>
<thead>
<tr>
<th>Not</th>
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<th>All</th>
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7. I can always discuss the importance of using condom with any sex partner.

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</table>
Please rate how confident you are that you could perform each activity on a regular basis by circling the appropriate number.

Remember:  
1. Please answer all items as they apply to your current situation.  
2. If you have not had experience in the given situation, answer how you might feel or act.  
3. The word condom means a condom or any other protective barrier such as a dental dam or a piece of latex.

Here is an example of a completed item.

<table>
<thead>
<tr>
<th>Completely Sure I Can</th>
<th>Not At All</th>
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<tbody>
<tr>
<td>EX: I can ask for help when I need it.</td>
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<tbody>
<tr>
<td>Completely Sure I Can</td>
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8. I can always say no to sex with someone even if I have had sex with them before.  

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9. I can always use a condom without fumbling around.  

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10. I can always say no to sexual intercourse with someone I have just met even if I am attracted to that person.  

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<th>7</th>
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</tbody>
</table>
Please answer the following items as completely and honestly as possible. If any answer does not exactly fit your experience, use the answer choice that best represents you. Also, please feel free to add any information that you feel is necessary after any question.

Again, you are not being asked to write your name anywhere in this booklet so your responses will remain anonymous.

Thank you for participating in this project!

1. Where do you presently live?
   - Freeport ........................................1
   - Nassau .........................................2
   - Other ...........................................3
     (specify)----------------------------------

2. How many times per month do you attend your place of worship? _______

3. What was your highest grade completed in school? ________________

4. How many years of college have you completed? ________________

5. What is your employment status?

11. I can always be the one to put the condom on even if I’m with a new partner. 1 2 3 4 5 6 7 8 9

12. I can always convince any sex partner to use a condom with me. 1 2 3 4 5 6 7 8 9
Unemployed ........................................ 0
Employed ........................................ 1

6. What is your monthly household income?
   Less then $1,000.00 ..................................... 1
   $1,000.00 to $1,499.00 ................................. 2
   $1,500.00 to $1,999.00 ................................. 3
   $2,000.00 to $2,499.00 ................................. 4
   $3,000.00 to $3,499.00 ................................. 5
   $3,500.00 or more ..................................... 6

7. How many persons are supported by this income?
   ______________________________

8. What is your marital status?
   Common law marriage ............................... 1
   Divorced ............................................... 2
   Living with partner ................................. 3
   Married ............................................... 4
   Partnered but not living together ............... 5
   Separated ............................................. 6
   Single ............................................... 7
   Widow ............................................... 8

9. How many sexual partners have you had in your lifetime?
   ______________________________

10. What two hobbies do you engage in most?
   ____________________________________________________________________
   ____________________________________________________________________
11. How many children do you have? ______________________________________

12. What is your ethnicity?

- Black Bahamian ........................................... 1
- Haitian Bahamian ....................................... 2
- White Bahamian ......................................... 3
- Other ......................................................... 4

(specify) ________________________________

13. Where were you born?

- The Bahamas ............................................... 1
- Other ......................................................... 2

(specify) ________________________________

14. If born in another country, how long have you been living in The Bahamas?

________________________________________________________________________

15. What is your sexual preference?

- Bisexual ...................................................... 1
- Heterosexual ............................................... 2
- Lesbian ...................................................... 3

16. Do you personally know or have known anyone with HIV/AIDS?

  ______ No                     ______ Yes

17. If yes, what is/was their relationship to you?

________________________________________________________________________

18. Have you ever been tested for HIV/AIDS?

  ______ No                     ______ Yes

19. If yes, when? ___________________________________________________________
20. What was the result?

________ Negative _________ Positive

21. What year were you born? 19_________

Thank you for your participation in this Study!
Dear Bahamian Woman:

Your participation in a research project is requested. The research is being conducted by Mrs. Shane Neely-Smith, RN, MSN, a doctoral student in the School of Nursing at Barry University in Miami Shores, Florida. This study is seeking information about cultural, economic, personal, and relationship factors that might influence Bahamian women’s risk for HIV and be useful in the fields of nursing and health care. In accordance with these aims, the following procedures will be used: An anonymous survey will be distributed in various community sites to adult Bahamian women. I anticipate that the number of Bahamian women who would participate in this study to be approximately 650.

If you decide to participate in this study, you will be asked to complete an anonymous questionnaire that consists of three short sections as well as some questions about your background and yourself. Once you finish, please place the completed questionnaire in the envelope provided, seal it, and then drop it in the box on the table. The questionnaire will take approximately 20 to 30 minutes to complete.

If you decide to participate in this study, please give your best responses to the questions completely and honestly. **DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRE NOR ON THE ENVELOPE.** Your consent to participate is strictly voluntary, and you can decide to stop participating at anytime, if you wish, without penalty.
The risks or potential harm to you for participating in this study are minimal. However, it is possible that some questions might make you uncomfortable or bring back unpleasant memories. Although complete information is important, you may choose not to answer any particular question(s) with which you are not comfortable. If you want to talk with a counselor, you can talk with a church counselor free of charge. If you wish to see a private counselor, a list of counselors in Nassau will be provided. However, any charges incurred with private counseling will be your responsibility. If you desire, a list of HIV education, counseling, and testing resources will also be made available to you. Although there is no immediate and direct benefit to you for your participation, findings from this study will help our understanding of the characteristics of Bahamian women and their risk for HIV infection. Findings will also be used to develop and implement effective gender-appropriate and culturally-sensitive preventive strategies to reduce the rate of HIV in Bahamian women.

As stated above, you should NOT write your name or any other identifier on the questionnaire nor envelope, so your responses cannot be linked back to you. Findings from this study will be reported only in group form, not individually. Additionally, questionnaires will be kept within a locked file cabinet and destroyed after five years, as a requirement of Barry University. Only myself and my supervisor will have access to the questionnaires.

Should you have additional comments or questions you can contact me at (242) 364-4424 or my supervisor, Carol A. (“Pat”) Patsdaughter, PhD, RN, ACRN at (305) 899-3804 or (800)-695-2279.

Thank you for your participation in this study. Your contributions are valued!

Sincerely,

Shane Neely-Smith, RN, MSN