College Students Use Implicit Personality Theory Instead of Safer Sex

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Many college students engage in high levels of unsafe sexual behavior that puts them at risk for HIV infection. To better understand the dynamics underlying college students' unsafe behavior, focus group discussions were conducted with 308 students (146 men and 162 women). The results showed that, instead of consistently using condoms, many college students use implicit personality theories to judge the riskiness of potential sexual partners. Specifically, partners whom college students know and like are not perceived to be risky, even if what students know about these individuals is irrelevant to HIV status. The students determine the riskiness of partners they do not know well based on superficial characteristics that are also generally unrelated to HIV status. Therefore, AIDS prevention interventions for college students must expose the ineffectiveness of the students' use of implicit personality theories to determine potential partners' riskiness, and the "know your partner" safer sex guideline should be abandoned.

Health experts are increasingly concerned about HIV infection among college students because students are continuing to engage in high levels of unsafe sexual behavior that puts them at risk for infection (Miller, Turner, & Moses, 1990). J. D. Fisher and W. A. Fisher (1990)

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found that 72% of college students had been sexually active during the previous year; of those who had been sexually active, 75% had not always used condoms during sexual intercourse and 44% had had two or more partners. Other surveys (e.g., Abler & Sedlacek, 1989; DeBuono, Zinner, Daamen, & McCormack, 1990; Fisher & Misovich, 1991) have obtained similar results.

There is evidence that there are already appreciable levels of HIV seroprevalence among college students. An American College Health Association study (Gayle et al., 1990) found that 1 in 500 college student blood samples was HIV+. There was substantial variability among the universities sampled, and because these blood samples are now 3 years old, the incidence of HIV seropositivity may have increased substantially in the interim. Moreover, according to the General Accounting Office/Human Resources Department (1990), the number of AIDS cases among people in their twenties increased 41% during 1989. Because of the long latency period between HIV infection and the development of AIDS, many of those who developed AIDS in their twenties were probably infected through unsafe sexual behavior during their teens or early twenties, which is the average age for college students.

In order to reduce the amount of unsafe sex exhibited by many college students, it is necessary to understand the dynamics associated with their unsafe sexual behavior. While there is a great deal of quantitative research documenting the incidence of risky sexual behavior among students (e.g., Abler & Sedlacek, 1989; DeBuono et al., 1990; Fisher & Fisher, 1990; Fisher & Misovich, 1991), much less work has been directed at identifying the reasons underlying college students’ unsafe sex and the conditions under which it occurs. Nevertheless, such research, which can best be performed using qualitative methods (see Fisher & Fisher, 1992), is necessary both to develop conceptualizations of college students’ unsafe sexual practices and to design interventions to change these practices (Manning, Balson, Barenberg, & Moore, 1989; Parker & Carballo, 1990). To address this need, the present study attempted to gain a better understanding of the dynamics underlying college students’ unsafe sexual behavior.

Method

Overview

This research employed focus group techniques to explore the dynamics of heterosexual college students’ safer and unsafe sexual behavior. Focus groups, which are often used to facilitate understanding of
the psychological underpinnings of behavior (Basch, 1987; Nix, Pasteur, & Servance, 1988) and can also be used to corroborate quantitative findings (Parker & Carballo, 1990; Stewart & Shamdasani, 1990), provide an appropriate means to perform such an analysis. Furthermore, the feasibility of using this technique in the area of sexual behavior and AIDS risk reduction research has been demonstrated by studies conducted with lower income African American women and teenage girls (Fulilove, Fullilove, Haynes, & Gross, 1990), African American teenage boys (Nix et al., 1988), and gay men (Offir, Williams, Fisher, & Fisher, 1991).

In the current research, groups of four to eight college students were asked to discuss their safer and unsafe sexual behavior and their reasons for engaging in those behaviors, as well as the contexts within which safer and unsafe sex occurred. Both same-sex (male-only and female-only) and mixed-sex focus groups were conducted to ensure breadth of results. That is, although mixed-sex groups may have more mundane realism, in that members of both sexes are present, it is possible that college students may disclose more in same-sex groups.3

In addition, both types of groups were conducted because the two types of groups had different purposes. The same-sex groups (in which the discussions lasted about 2 hours) were run solely for the purpose of exploring the dynamics of college students' safer and unsafe sexual behavior. However, the mixed-sex groups (in which the discussions lasted about 1 hour) were conducted for another purpose as well; they were conducted to perform a quantitative analysis to determine the consequences for impression formation of an individual taking a pro- or anti-AIDS prevention stance during the focus group discussion. This latter data will not be addressed here.

Subjects

The subjects were 308 University of Connecticut undergraduate students (146 men and 162 women) who were recruited both through an advertisement in the campus newspaper and through the university subject pool to ensure a representative sample. The individuals received either $10 or course experimental credits for their participation. Based on focus group availability, the subjects were assigned to same- or mixed-sex groups of four to eight subjects each. Only previously unacquainted

3In the present research, differences in focus group discussion content among mixed-sex, male-only, and female-only groups were minimal. Therefore, the results for the same- and mixed-sex groups were combined.
people were assigned to the same group, and there were at least two men and two women assigned to each mixed-sex group. Overall, there were 169 subjects (80 men and 89 women) in 25 mixed-sex groups, 66 men in 13 male-only groups, and 73 women in 13 female-only groups.4

Procedure

The protocols for the focus group discussions were developed in accordance with established guidelines for focus group research (Basch, 1987; Krueger, 1988). The discussion sessions were conducted by trained moderators who followed a prepared, semi-structured outline. The moderators for the mixed-sex groups were female, whereas those for the same-sex groups were of the same sex as the group members. The participants and the moderator were seated comfortably in a circle, and a multidirectional microphone was used to record the session.

Before the discussion began, the subjects were asked to read and sign an informed consent form. They were told that the discussion was being audiotaped for later review by the research team, but were assured that their responses were confidential. It was also stressed that the purpose of the discussion was to find out what college students think and feel about sex and AIDS and that subjects should state their opinions whether or not they agreed with other group members. Furthermore, the participants were told that they did not have to answer any questions that made them uncomfortable and that they could withdraw from the study at any point without loss of either monetary remuneration or experimental credit.

After brief self-introductions, the discussion began. The questions focused on situations in which the participants may have had or refused to have unsafe sex, the number and types of sexual relationships the participants had experienced, what methods of sexual protection the participants currently used and why, what they liked and disliked about using condoms, and whether the participants thought that AIDS was a

4AIDS risk behavior data that was collected only on subjects in the mixed-sex focus groups suggests that those in our sample were engaging in high levels of unsafe sexual behavior comparable to those found in other college student samples (e.g., Abler & Sedlacek, 1989; DeBuono et al., 1990; Fisher & Fisher, 1990; Fisher & Misovich, 1991). Specifically, 87% of those in the mixed-sex sample had been sexually active during the previous year. Of those who had been sexually active, 67% had not always used condoms during sexual intercourse (although only 23% had ever had an HIV blood test), 57% had had two or more sexual partners, and 14% had had anal sex.
Data Analysis

Because focus group data is collected in group settings, it is inappropriate to analyze the data by conducting frequency counts of responses within fixed content categories (Basch, 1987; Krueger, 1988). Instead, focus group discussions should be analyzed using a systematic process to extract and interpret descriptive statements from audiotapes or transcripts (Krueger, 1988). Basch suggests analyzing such data by creating categories of ideas to generate themes and backing these themes with illustrative quotes from the discussion participants. The data analytic procedures for the present study followed the above guidelines. Focus group discussion audiotapes were analyzed by having several research assistants listen to each tape. Only viewpoints raised in the majority of groups and by more than one person in the group were considered. Each listener generated several perceived themes and extracted descriptive statements and quotes in support of those themes. The research assistants then discussed their individual findings with one another in order to develop consensually validated conclusions.

Findings

The results from these analysis techniques are presented in four subsections which deal with (a) how students make judgments of the riskiness of their sexual partners, (b) their assessments of their own personal risk, (c) their reasons for specific incidents of unsafe sex, and (d) their beliefs about condoms. These four subsections represent the major categories of findings. As noted above, these categories originated from what the subjects said, rather than from the protocol questions per se. In other words, the categories were data-driven. Because the categories were data-driven and so few subjects were abstinent or practiced noninsertive sex (only 13% of those in the mixed-sex groups had abstained from insertive sex during the previous year), the results emphasize condom use as the primary AIDS prevention method.

Judgments of the riskiness of sexual partners. The data strongly indicated that our respondents appeared to have a well-developed and generally accepted set of ideas regarding which potential sexual partners are risky for HIV infection and which are not. We found consistently that partners...
whom students *know* and *like* (including monogamous partners who have not been tested for HIV infection) are perceived as *not* being risky. One subject summed up this view by saying, "When you get to know the person...as soon as you begin trusting the person...you don't really have to use a condom." In effect, such partners appeared to be considered not to be risky, regardless of the objective safeness or unsafeness of their past or present sexual behavior, and actual HIV status was almost never known. As one man said, "I knew my partner really well before we had sex, so I didn't have to worry about her sexual history." These and many other similar statements make it clear that students do not use condoms with partners whom they know and like.

Our impression is that the tendency for students not to practice safer sex with partners they know and like (and whom they invariably trust) is based on their reluctance to link risk or disease with loving or caring. As one student put it, "Because I love her...it's kind of hard to think that [about AIDS]." Furthermore, it is our impression that students generally do not have sex at all with people they do not like. Interestingly, therefore, the only situation in which students are likely to use condoms is with partners they feel they do not know well enough to eschew condom use.

When judging the riskiness of previously unknown potential partners, our focus group data indicated that students often seem to rely on simple rules to label someone as risky for HIV infection (and therefore, to decide either to use a condom or not to have sex with that person). They tend to assume that risky people are those who dress provocatively, whom one met in bars, who were older than most college students, who are from large cities, or who are overly anxious for sex. As one student explained, "If they're...24, they've been around 6 more years than someone...who's 18....If they're dressed up like a slut...they're usually a slut." Another subject summed up this reliance on superficial cues by saying, "If I [were] in the bar-hopping, New York scene and meeting stray women...then I'd worry about getting AIDS." In addition to using the above cues, many men appear to perceive women they have just met who use oral contraceptives to be risky. As one man said, "You don't want to trust someone who just went on the pill." Offir et al. (1991) found a similar reliance on superficial cues in judging the riskiness of potential partners among gay men.

Because of their confidence in their abilities to assess a partner's riskiness, most subjects indicated that they would only consider using condoms during sex with partners they feel they do not know well enough and whom they perceive might be risky. A typical response was, "If you just met them, you use a condom...if it's long-term, you aren't
Going to worry." Therefore, the subjects sometimes indicated that they would use condoms at the beginning of a relationship, before they feel that they know the partner sufficiently. One subject explained, "It's important [to use condoms] for...either one-night stands or the beginning of relationships where you just really don't know enough about the person yet." Another summed up the prevailing view by saying, "At first you should use a condom. Then, once you get to know her, you should discuss other means of birth control." The students reported that once they feel that they know their partners, usually in ways unrelated to HIV status, they almost invariably cease using condoms. A typical response was, "I'm mostly using the pill since my relationship, but if it's a new partner...[I would] definitely use a condom." When asked what he would need to know about a partner to decide to stop using condoms, one man said he would want to "know how she lives, know her friends, [talk] to her about her life."

From these findings, it is clear that college students appear to judge the riskiness of sexual partners based on characteristics that are not related objectively to HIV status—specifically, whether they know and like the partner and whether a previously unknown partner has certain superficial traits. Perceived relationships among characteristics, such as the perception that a partner whom one knows or who is from a small town is not risky, are called implicit personality theories (e.g., Schneider, Hastorf, & Ellsworth, 1979). Clearly, college students are using an implicit personality theory to determine the riskiness of sexual partners, rather than consistently practicing safer sex.

Implicit personality theories are often adaptive, even if they are not entirely accurate, because they allow people to interpret their social world. However, the use of an implicit personality theory for ascertaining a partner's AIDS risk is extremely unreliable and potentially fatal. Because the only way to accurately determine someone's AIDS risk is through knowledge of that person's HIV status, the use of any other cues to assess risk will often provide a dangerous, false sense of security. Therefore, health education efforts to reduce AIDS risk behavior among college students (and perhaps others as well) must expose the ineffectiveness of their use of implicit personality theories to assess the riskiness of partners or potential partners. Furthermore, it must be emphasized that, in the absence of specific knowledge regarding the partner's HIV status, knowing one's partner and being monogamous do not constitute safer sex.

Ironically, one of the safer sex guidelines that has been widely promoted in many large circulation pamphlets such as the Surgeon General's Report on Acquired Immune Deficiency Syndrome (U.S.
Department of Heath and Human Services, 1986) is the exhortation to “know your partner.” Although this guideline is intended to refer to knowing one’s partner’s sexual history (and, of course, acting on that knowledge), college students, and probably many others as well, appear to have misinterpreted it. In effect, they are using the guideline to strengthen their beliefs that they are not being unsafe if they know their partners, even if the ways in which they know them are entirely irrelevant to AIDS risk. Furthermore, even if one does consider one’s partner’s sexual history, it is dangerous to infer a negative HIV status from a nonpromiscuous sexual history. Clearly, the “know your partner” guideline has backfired and should be abandoned.

Even less cryptic safer sex guidelines such as the advice to “take precautions whenever you have sex outside a long-term monogamous relationship” (e.g., American College Health Association, 1987) create problems. College students seem to misinterpret such advice to mean that monogamy itself constitutes safer sex, even serial monogamy in the absence of objective knowledge regarding one’s partner’s HIV status. Therefore, students often appear to be using such advice to bolster their beliefs that they need to use condoms only with partners whom they do not know. Unfortunately, pamphlets containing the “know your partner” and “take precautions outside a long-term monogamous relationship” guidelines are still being distributed.

Assessments of personal risk. While they judge their partners’ riskiness based on implicit personality theories, our respondents do not generally seem to consider themselves to be at risk for HIV infection, regardless of whether or not they engage in safer sex. For example, one subject said, “I’m not involved with one-night stands, so I don’t worry about it [AIDS] too much.” Another said, “I’d worry if I [currently] had multiple partners.” Some do not even feel that AIDS should be a concern on a college campus. As one subject summed it up, “Personally, I’m not really worried about AIDS on this campus....I’d be willing to bet that there aren’t too many cases outside homosexuals.”

However, even those who may feel that AIDS should be a concern on campus do not seem to feel personally vulnerable because they do not really believe that heterosexual college students are at risk. As one student said, “I don’t know anybody [who has] AIDS, I’ve never seen anybody [who has] AIDS, I’m not gay, and it seems, regardless [of] what the facts are...like it’s mostly gay guys that get it.” Another explained, “I’ve always felt that it wasn’t something that was going to affect me...It happened to drug users and it happened to gay people, but it would never happen to me.” Clearly, most students perceive themselves to be very socially distant from the typical person with AIDS. According to
Weinstein (1980, 1988), the greater the perceived social distance between oneself and the typical victim of a particular misfortune, the less personally vulnerable one will feel to that misfortune, regardless of objective risk.

The major practical implication of this finding is that AIDS prevention efforts must emphasize students' personal vulnerability to HIV infection. To increase perceived vulnerability, students may need to be confronted with cases of heterosexually transmitted HIV infection among college students. In addition, one could present students with statistics regarding the alarming incidence of sexually transmitted diseases (STDs) and unwanted pregnancy on their own campuses, coupled with the reminder that AIDS is transmitted in the same way. This could be followed by a personal risk audit to emphasize that the students are engaging in behavior that puts them at risk for HIV/AIDS.

For most of our respondents, the risk of pregnancy is far more salient than the risk of AIDS or other STD. In this context, a typical response among those who use condoms was, "I use condoms...for birth control. That's what I'm worried about." Another subject admitted, "I think more about pregnancy than I do about it [AIDS]." Because their primary concern is pregnancy, most students are not likely to use condoms in the context of a relationship if the female partner is on the pill. As one man said, "Before she was on the pill, we used condoms; now we don't." A woman explained, "I know that if I'm on it [the pill] that I tend to think less...[about] protection against disease." Unfortunately, use of oral contraceptives appears to be antithetical to condom use. Therefore, AIDS prevention interventions must highlight the fact that the pill does not provide protection from HIV infection or other STD, and campus health professionals should advise individuals who receive prescriptions for oral contraceptives to use condoms as well.

Reasons for incidents of unsafe sex. Because most college students do not really believe that they are at risk for HIV infection, many often engage in sexual behavior that they acknowledge is objectively unsafe. There are two major reasons our respondents gave for engaging in specific instances of unsafe sex.

One of the most frequently mentioned reasons for engaging in unsafe behavior was alcohol impairment. One frank response was, "I guess there...[are] episodes where you get really, really [drunk], and things happen, and you forget about consequences." Another student said, "Most times, yes, I use a rubber, but it's happened that I didn't use anything when I [was drunk]." College students need to be taught techniques to prevent the unsafe combination of sex and alcohol intoxication. For example, students could be encouraged to choose not to drink or to
drink less when they anticipate the possibility of having sex. Alternatively, if they are drunk or anticipate becoming drunk, they could be encouraged to ask friends to not allow them to leave a social event with a potential sexual partner.

Another frequently mentioned reason for being unsafe is overwhelming lust. As one student admitted, "There's been a couple of times...that you do give in because it's like the moment." Another explained that, "In the heat of the moment you don't think about it [AIDS]." It must be emphasized to college students that, if they make condom use habitual and they carry condoms with them, they will be far less likely to forget to use them in the heat of passion. Offir et al. (1991) found the same tendency among gay men to attribute specific incidents of unsafe sex to passion.

Beliefs about condoms. In order for college students to use condoms consistently, regardless of the temptations offered by particular situations or their beliefs about their partners' riskiness, they must have positive feelings about condom use. Unfortunately, students reported almost unanimously that they do not like using condoms and believe that using them interferes with their enjoyment of sex. One subject summed up this view by saying, "I think condoms really suck....When I finally thought about maybe getting AIDS I began to pseudo [sometimes] use them. I don't like them, though."

Overall, college students reported feeling that condoms are unpleasant to use, primarily because they decrease sensation and spontaneity. A typical response was, "I don't like condoms at all. I hate them. I can tell the difference, and I don't like it." More specifically, one subject explained, "I can't stand—the spontaneity—how it's ruined, and the smell of condoms...makes me sick." Even students who reported always using condoms often reported not especially enjoying them. Furthermore, many students reported feeling that condoms are inconvenient, because one must remember to buy them and have them available. As one subject explained, "You get sick of taking a condom everywhere; it's a real hassle." Clearly, college students need to be taught ways to be more comfortable with condom use and to have pleasurable sex with condoms. Offir et al. (1991) found that gay men expressed a similarly strong dislike of condoms.

In addition to feeling that condoms are unpleasant to use, many students seem to feel that the use of condoms has undesirable social implications. Many respondents indicated that requesting that a condom be used may imply that one distrusts one's partner; that is, that one believes the partner has been promiscuous or will not be monogamous. One subject summed up this view by saying, "If it's someone [with
whom] I have to use a condom, it's someone I don’t trust." Furthermore, discussing condom use prior to having sex with someone for the first time might imply that one expected to have sex, which might be perceived as socially inappropriate. As one subject put it, "[If] I was going to have sex and I pulled out a condom, it would look bad." These findings suggest that AIDS prevention interventions should seek to alter perceived social norms regarding condom use, so that requesting condom use would not carry undesirable implications regarding one's trust of one's partner or one's social appropriateness (cf. Fisher, 1988).

Conclusions

The main theme that emerged from the results was that college students' judgments of a particular partner's riskiness are not based on the relevant objective criterion of HIV status. Instead, students use an implicit personality theory to determine a partner's riskiness. In addition, students do not believe that they themselves are at risk for HIV infection. Therefore, they often engage in behavior that is unsafe, because they do not perceive the need for using condoms (which they do not like), except when having sex with a partner whom they feel they do not know well enough and perceive may be risky. Future research should confirm these qualitative findings with more rigorous quantitative methods. For example, one could experimentally examine the influence of various characteristics of a stimulus person on subject judgments of the riskiness of that person for transmitting HIV. Finally, the main findings of this study have several practical implications for AIDS prevention with college students, which have been discussed throughout the Findings section. In conclusion, college students need to understand that they are vulnerable to HIV infection and can drastically reduce their HIV risk by abandoning their biased judgments of partners' riskiness and, instead, engaging in pleasurable safer sex.

References


