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Unwanted Unprotected Sex
Condom Coercion by Male Partners and Self-silencing of Condom Negotiation Among Adolescent Girls

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This exploratory study used the theory of reasoned action and the theory of gender and power to guide elicitation of partner-related impediments to condom use among 64 adolescent girls living in poor urban areas with high rates of HIV and partner abuse. About 53% indicated that they had experienced unwanted, unprotected vaginal sex and 25% indicated that they were unable to discuss condom use with a partner. Novel qualitative findings related to condom coercion, condom sabotage, and self-silencing of condom negotiation are discussed in the context of connecting partner abuse to interpersonal control over condom use. Implications for intervention design are discussed. **Key words:** *adolescent*, *coercion*, *female*, *HIV*, *prevention*, *sexual behavior*

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HUMAN IMMUNODEFICIENCY VIRUS (HIV)-infection risk remains a bleak fact of life for low-income, urban adolescent girls and black women/adolescent girls who are overrepresented in economically impoverished urban communities.[1] The HIV-infection incidence rate in 2008 for black women was about 20 times the rate for white women and 4 times the rate for Hispanic women/adolescent girls.[2] Younger women are more likely to get HIV infection than older women, and HIV/AIDS is a leading cause of death for women, second only to heart disease and cancer.[3] Given that the latency period from HIV exposure to AIDS symptoms is 8 to 10 years, AIDS cases diagnosed among those 20 to 29 years old are likely because of HIV infection contracted during adolescence. Thus, the development of prevention interventions for urban adolescent girls is an urgent public health priority.

Factors that place adolescent girls at risk for contracting HIV infection include sexual activity without condom use, sexual partners with sexually transmitted infection (STI)/HIV-infection risk factors, and increased physiological susceptibility to HIV and STIs.[4] Salazar

and colleagues[5] discuss the heightened risk for adolescent African American girls engaging in a constellation of sexual behaviors that may increasingly include anal sex. In 2009, 46% of sexually active high school girls reported that their partner did not use a condom the last time they had sex.[6] Lack of knowledge about safer sex, beliefs that condoms reduce sexual enjoyment, and inadequate skills in condom use and condom negotiation often interfere with adolescents' intentions to use condoms.[7] However, adolescent girls who want to use condoms depend, at least in part, on their partner's interest in or resistance to this form of HIV-infection prevention and the amount of influence the partner exerts on their decision making. Empirical findings indicate that partner approval is a significant correlate of condom use.[8] Studies have also revealed an association between lower sexual relationship power (decision-making power in an intimate relationship), physical abuse, and inconsistent condom use.[9,10]

Partner abuse, a known HIV-infection risk factor for adult women, has been shown to account for 12% of the HIV infections among women in the United States,[11] and a growing body of research links adolescent partner abuse with increased risk of HIV infection for adolescent girls as well.[12] Adolescent partner abuse is any attempt to dominate or control a partner, resulting in harm, and includes psychological, emotional, sexual, or physical violence, as well as threats of violence.[13] There are various terms used in the literature for adolescent partner abuse, including teen-dating violence and unhealthy relationships. Low-income, urban girls are particularly vulnerable to partner abuse as they report rates that are more than twice the national average.[14] Higher rates of partner abuse are reported in neighborhoods characterized by poverty, violence, and social disorganization.[1] Several studies have demonstrated a relationship between adolescent partner abuse and HIV-infection risk behaviors, including condom nonuse, having riskier partners, using alcohol before sex, and early initiation of sexual intercourse.[10,15-17] Decker et al[18] found that among sexually active adolescent girls diagnosed with an STI or HIV, 51.6% had experienced either physical or sexual partner violence. Adolescent partner abuse is also associated with depressive symptoms, anxiety, and substance abuse that also increase HIV-infection risk behaviors.[19] Among sexually active girls, it has been shown that adolescent partner abuse is related to several more specific partner-related HIV-infection risk factors, including fear of perceived consequences of negotiating condom use, less-perceived control over their sexuality, and a perceived risk of acquiring an STD.[10] For adolescent girls with an older male partner, the age difference may represent a power imbalance that puts them at a disadvantage in safer-sex negotiations and therefore at greater sexual risk.[20]

Further complicating HIV-infection risk for girls and compounding adolescent partner abuse are the interpersonal phenomena of rejection sensitivity and self-silencing. Rejection sensitivity fosters the fearful expectation of imminent rejection. Edwards and Barber[21] conducted a study among 18- to 25-year-olds, demonstrating that increased rejection sensitivity predicted lower condom use when participants' favorable preference for condom use were at odds with those that they thought their partner held. Furthermore, dating adolescents who possessed a higher degree of rejection sensitivity reported more depression symptoms and higher levels of self-silencing behaviors.[22] Self-silencing, based on attachment theory,[23] is when a heightened concern to preserve a relationship fosters self-sacrifice and compliance and is fueled by gender inequalities.[24] Widman and colleagues[25] found that adolescent girls' (aged 14 to 21 years) self-silencing, as it pertained to the patterns of sexual communication in romantic relationships, indirectly predicted contraceptive use, including condoms. Finally, DeMarco[26] argues for the incorporation of the concept of self-silencing in any gender sensitive and culturally relevant HIV-infection prevention education intervention as a vehicle to attend to giving "voice" to women and girls.

The majority of effective HIV-infection prevention interventions for youth use social-cognitive theories, such as the theory of reasoned action (TRA) approach, to guide the identification of modifiable mechanisms of risk-associated behaviors.[27] For example, by targeting beliefs about condom use and improving acquisition of condom-use skills, TRA-based interventions have been able to change intentions about condom-use behavior and have led to significant reductions in sexual risk behaviors among adolescents.[28,29] The reasoned action theoretical approach has been shown to account for 50% to 60% of the variance in reported behavioral intentions (eg, to use condoms) and approximately 30% of the variance in reported sexual risk behaviors.[27] Thus, while TRA-based interventions are effective at reducing risk, there is still a need to augment the TRA-informed approach to improve intervention outcomes. According to the TRA approach, specific behavioral intentions are the immediate precursor to behavior, assuming the behavior is under one's volitional control.[27] Willingness and wanting to perform a behavior are considered alternate expressions of intention. The theory further specifies that an intention is determined by attitudes toward the behavior, subjective norms regarding it, and perceived behavioral control or self-efficacy over the action, which in turn are influenced by salient beliefs. Perceived behavioral control, which is akin to the concept of self-efficacy,[30] is contingent on internal and external factors that include skills, barriers, resources, and opportunities. Lack of control to carry out a behavior can lower intentions and/or directly hamper behavior. Partner factors, such as abuse, that interfere with adolescent girls' condom use, may partially explain the alarming and potentially lethal gap between safer sex (eg, condom use) intentions and practice.

However, knowledge is limited about the mechanisms of abusive partner dynamics and how they may influence adolescent girls' ability to use condoms. Uncovering and clarifying these mechanisms may allow for the development of more targeted and focused intervention strategies. While we have made great strides into HIV-infection prevention for youth, partner factors remain an obstacle for STI/HIV-infection prevention, especially for urban adolescent girls living in economically disadvantaged neighborhoods. The goals of this exploratory study were to (1) identify partner factors that may increase girls' risk for condom nonuse in the context when they wanted to use a condom, (2) elicit girls' suggestions for addressing these issues in an HIV-infection prevention program. We sampled from publically supported reproductive health clinics in an urban area with an HIV infection rate 5 times the national average, where heterosexual sex was the highest exposure category.[31] Long-term goals of the study include generating hypotheses about mechanisms of partner abuse and control that limit sexually active urban adolescent girls' ability to use condoms even when they want to use them. Findings will be used to conduct further studies to examine these mechanisms and to develop a uniquely tailored HIV-infection prevention intervention.

METHODS

We conducted focus groups since this method is well suited to the central tenets of health promotion in relation to sensitive topics such as sexual relationships.[27] Furthermore, this method has been used extensively to develop effective HIV-infection prevention interventions, where designs begin with the needs and desires of the target population.[28,29] In addition, we used a brief survey to collect demographic and health information.

We recruited 64 adolescent girls aged 14 to 17 years. The study was approved by the appropriate institutional review boards. All participants were attending family planning or prenatal clinics in a northeastern city, were able to read and write English sufficiently to complete the paper-and-pencil survey, had no recent treatment for a major mental health issue, and reported vaginal intercourse in

the previous 3 months. We initially oversampled those with a history of partner abuse to ensure that they comprised at least half of the sample. After the first focus group, this strategy was no longer necessary, as actual levels of partner abuse in the clinic population were high. Two screening questions about history of verbal and physical abuse were used to determine this eligibility.

Girls were recruited in clinic waiting rooms by a research team member who handed out flyers and asked about interest in being screened for possible study participation. If a girl indicated that she wanted to participate that day, a member of our research team escorted her to a private location within the clinic to conduct the brief eligibility screening. Eligible girls completed self-administered surveys and were invited to participate in focus groups. A second strategy for recruitment entailed placing flyers in clinic waiting and examination rooms so that potential participants could consider the study and later contact a research team member for an appointment to be screened for eligibility. We offered $5 to complete the survey and $20 and refreshments for participation in a focus group.

The 5 systematic elicitation focus groups were based on the TRA approach to behavioral prediction,[27] as described previously. In addition, we drew from the theory of gender and power (TGP) to guide this inquiry.[32] As suggested by the TGP, intersecting structures of power and inequality (based on gender, race, ethnicity, age, sexual orientation, social position, etc) create background (social and material) inequalities that foster susceptibilities to conditions such as sexual risk and violence. The TGP provides a framework for understanding interpersonal power and control dynamics within partner relationships.

Description of survey

The survey included questions on demographic and health information, partner abuse, and sexual risk. To assess verbal, threatening, and physical partner abuse, respectively, we asked 3 closed-ended questions: (1) Has a partner ever called you names or put you down (with words)? (2) Have you ever been threatened by a partner? (3) Have you ever been hit, slapped, punched or kicked by a partner? Participants were asked about their sexual behaviors, including vaginal and anal sex. *Vaginal sex* was defined as penis-in-vagina sex. *Anal sex* was defined as a penis-in-butt/bottom sex. Participants were also asked whether they had ever experienced unwanted vaginal and anal sex and whether condoms were used at last vaginal and anal sex. In addition, participants were asked to report whether they ever had an STI. To assess for unwanted unprotected sex, participants were asked whether they ever had vaginal and anal sex without a condom when they wanted their partner to use one. To assess for silencing about condom negotiation, they were asked whether they ever wanted to talk with their partner about using a condom during vaginal or anal sex, respectively, but were unable to. This question was followed by an open-ended prompt to write an explanation.

The surveys were completed before the focus groups to allow participants to report on their own perceptions uninfluenced by the group process. This also gave them time to explore their responses before the group since similar issues were discussed in the focus groups.

Focus groups

All five focus groups were conducted by the principal investigator (PI) and 2 other members of the research team at the participating clinic or in a private room at the university. One of the research staff cofacilitated the group, while the other handled logistics (eg, refreshments and consent forms), took notes, and managed the digital recorders. All participants agreed verbally and in writing to allow audiotaping of the focus group discussions. The groups lasted approximately 2 to 2½ hours. Our intent in the focus groups was to better understand girls' beliefs related to condom use in healthy and unhealthy relationships. The goal was to have

Table 1. Focus Group Interview Guide Synopsis

Topic	Examples of Questions
Warm up	What are common things young people do after school? What are the most important health concerns among girls your age? What do girls your age do to stay healthy?
Definitions of relationships	What do young people your age call it when they are in a relationship with someone? (Probes: What are different types of relationships? What are they called?)
Gender roles	What is the role of a man/woman in a relationship? What happens if those roles aren't followed?
Relationship scenarios	Tasha and Mike: Tasha doesn't answer a call from Mike. What could happen? (When participants identified unhealthy relationship actions) What do girls your age call that?
Condom use: healthy and unhealthy relationships	Do adolescent girls in (their term for unhealthy relationships) use condoms? Why do some use condoms? Why do some not use condoms? Who would approve? Who would disapprove? What makes it easy for adolescent girls your age to use condoms in (their term for unhealthy relationships)? What makes it hard?
Design a program	If someone gave you some money to design a health program that would teach adolescent girls 14-17 years of age like you how to prevent HIV/AIDS and how to have safe and healthy relationship, what would you like it to include?

Abbreviations: AIDS, acquired immunodeficiency syndrome; HIV, human immunodeficiency virus.

participants engage with each other on these topics, and this was stated at the beginning of the group. The first step in proceeding with the focus groups was to collaborate on the establishment of terminology used for different types of partner relationships. In addition, we read aloud short vignettes depicting potentially unhealthy partner relationship circumstances and had the girls provide language to make clear the meaning of the scenario for them. These vignettes were based on individual research interviews with slightly older young women aged 18 to 25 years from the same target population, who were asked to reflect on their partner experiences during their teen years (unpublished data). To protect confidentiality during the group discussions, we asked that the girls not talk about their own personal experiences. Rather, we asked about perceptions of what was occurring among their peers and reminded participants of this throughout the group, as they sometimes spoke in the first person. As indicated in Table 1, the focus group covered several topics in a sequence. It is important to note that although we asked girls about anal sex on the survey, we did not ask them to talk about anal sex in the focus groups; therefore, the participants' quotes about "sex" are in reference to only vaginal sex.

Data analysis

The demographic and health data from the survey were double data entered into an SPSS database (PASW Statistics v18 @ 2010, SPSS, Inc; IBM Chicago), and descriptive statistics were generated. Digital recordings of the focus group discussions were transcribed into a Microsoft Word document by a member of the research team and checked for accuracy by the PI. The PI read through focus group transcripts and identified emerging themes.

The data analysis began after the first focus group was conducted and continued throughout the duration of the study. To increase

the trustworthiness of interpretation, the research project's 2 community advisory boards (CABs) were asked to comment on preliminary analyses and to suggest further areas of inquiry. The teen CAB was composed of adolescent girls from the target demographic affiliated with a youth outreach center. The teen CAB was consulted about the wording of the questions before the data collection and later was asked to provide feedback on the interpretation of the findings. The adult CAB was composed of service providers who directly worked with youth in the areas of teen-dating violence and sexual health. They were selected because they provided health and clinical services to teens about healthy relationships, teen-dating violence prevention or reproductive health in schools, after-school programs, or clinical settings. The role of the adult CAB was to strategize about recruitment procedures, determine whether our findings were consistent with their assessment of the issues they encountered when working with teens in the community, and gather input about the best locations for implementing future intervention to reach vulnerable teens. This process of debriefing with CABs, which included peers, according to Lincoln and Guba,[33] is a technique used to establish credibility in qualitative data analysis, which is an important component of trustworthiness. In this way, the team determined when data saturation was reached and concluded data collection.

Subsequently, a systematic group-coding process was employed by using a team approach. The PI (A.M.T) and 3 other members of the research team read each focus group transcript. During this phase, the research team consisted of an ethnically diverse group, including 2 members who were in their late teens (aged 18-19 years). Multiple coders and continued dialogue among team members from different backgrounds were used to foster reflexivity, which is a way to enhance the confirmability of interpretation, another aspect of trustworthiness.[33,34] The text of the transcripts was double coded, by 2 coders, each using TGP-theory–derived codes, such as partner dynamics/interpersonal power, as well as TRA-derived codes, such as behavioral, normative, and control beliefs about condoms. This deductive coding process was supplemented with inductively derived free coding. Coders also created interpretive and analytic memos, and the 2 coders met to identify and resolve coding discrepancies. A third coder examined the TRA-coded data for more refined coding. The transcripts and coding were also discussed in research team meetings, and notes were taken at these meetings. Then the PI examined coded text, memos, and meeting notes, using cross-case analysis and identified common patterns and themes across focus groups.[35] These patterns and themes were presented to the members of the CAB for discussion, and their input was used to further refine and confirm trustworthiness of the interpretations.

RESULTS

Sample

All 64 girls in our study were identified as African American and were between the ages of 14 and 17 years, with a mean age of 16 years (SD = 1). All participants reported ever having vaginal sex and 22% (n = 14) of girls reported ever having anal sex. The survey data revealed that indicators for sexual risk were notably high with more than half of the girls reporting that their partners had not used condoms at last vaginal sex, and 67% of those who had anal sex reported that condoms were not used at last anal sex. In addition, more than one-third of the girls had been treated for an STI. A little more than one-third had older partners (aged 19-25 years) at last vaginal or anal sex. For questions pertaining to partner abuse, 59% of our sample experienced at least 1 of the 3 forms of abuse (physical, verbal, and threatening partner abuse types), with approximately 1 of 3 of the total sample experiencing all forms of partner abuse. About 27% of participants reported that they had

Table 2. Description of Sample Total (N = 64)

Variable	Total Sample, N (%)	Ever Experienced Unwanted Unprotected Vaginal Sex, N (%)	
		Yes	No
No condom use last vaginal sex	36 (56.3)	22 (34.4)	14 (21.9)
History of STI[a]	24 (37.5)	18 (28.0)	6 (9.4)
Hx ever pregnant (N = 63)	37 (58.7)	19 (30.2)	18 (28.6)
Hx forced vaginal sex	15 (28.3)	11 (17.5)	4 (6.3)
Hx of partner physical abuse	24 (37.5)	18 (28.0)	6 (9.4)
Hx of partner verbal abuse	34 (53.1)	22 (34.4)	12 (18.8)
Hx of partner threats	24 (37.5)	16 (25.0)	8 (12.5)

Abbreviation: STI, sexually transmitted infection.
[a]None were HIV positive.

ever had vaginal sex when they did not want to, and about 9% of the participants reported that they had ever had anal sex when they did not want to. About 53% of the participants indicated yes (yes/no response choice) that they had experienced vaginal sex without a condom when they wanted their partner to use one, and 6% of the participants reported that they had experienced anal sex without a condom when they wanted their partner to use one. Table 2 summarizes these descriptive findings with comparisons by history of unwanted unprotected vaginal sex. As indicated in Table 2, sexual risk indicators of condom nonuse and STI history were higher among those who had experienced unwanted unprotected sex.

We also explored possible avenues of unwanted unprotected sex in different types of relationships. On the basis of the focus group data and survey questions, we identified 2 categories of partner-related factors that interfered with girls' stated intent in using condoms: condom coercion and silencing of condom negotiation. Within the category of condom coercion, there were 3 types: (1) physical/sexual abuse and threats; (2) emotional manipulation; and (3) condom sabotage. Later, we define and describe each category. However, in the focus groups, we first needed to elicit their definitions of different types of relationships and what terminology they used.

Relationship definitions and terminology

In the focus group, we began the discussion about relationships and partner abuse by asking the participants about their definitions to avoid imposing our own terminology. The most commonly used terms were abusive, violent, disrespecting, and unhealthy. For example: "Verbal abuse is where it starts—can become violent and physically abusive"; "unhealthy relationship; gives you money and still abuses you"; and "most 14-17-year-old girls are in unhealthy relationships, not knowing . . . thinking these older guys is really their boyfriend . . . the guy starts disrespecting them, but the girls are like 'oh he loves me.'"

Participants commonly described partners using various forms of abuse as a way to get a girl to do something he wanted her to do. This included physical abuse, "When your boyfriend hits you when you don't do something that he wants"; threats, "If you don't do this, I'll leave . . . just to scare you into doing stuff but it doesn't always work"; verbal abuse, "When a boy yells at you and makes you do something"; and sexual coercion, "Forcing your partner to have sex when

they don't want to or other sexual acts." Verbal abuse was thought to be more common than physical abuse. Controlling aspects of a relationship, described as being "overprotective" or "thinking they can own you," were generally not defined as abusive, but it was thought that this type of behavior could lead to an abusive relationship.

Condom coercion

One purpose of the focus group discussions was to understand partner barriers to girls' intended condom use in healthy and unhealthy relationships. Girls described situations in which partners were not in agreement with them about using condoms and used various degrees of pressure to get the girls to forgo condom use, which we refer to as condom coercion (Table 3). In several focus groups, girls talked about a gender difference in the impact of condom use on sexual pleasure, noting it was more often the guy than the girl who resisted condom use for this reason. For example:

> lot of guys don't like using condoms because they don't like the way they feel and the guy can pretty much convince them [girls] to not use condoms, and if the girl really likes that person, they won't do it [wear condoms] . . . the girls don't really have a problem with it [wearing condoms] but the guys have a problem with using them so they kinda convince the girls and makes the girl do what they want to do.

Although there were some girls in the focus groups who talked about not wanting to use condoms because they reduced sexual pleasure, our current research question focused on the situations when girls wanted to use condoms and encountered other barriers. The quote above provides an example of the interpersonal dynamics that may ensue in the context when the female partner wanted to use a condom but the male partner did not. There are a variety of ways that a male partner might use to "convince" or "make" a girl to forgo condom use. Forms of condom coercion may differ in degree, and participants identified some personal factors that can make girls more vulnerable to condom coercion. As mentioned in the quote previously, for example, if she had feelings of affection for him, she would be more vulnerable to his pressure. The different forms of condom coercion mentioned by the participants are described next, and specific quotes are provided in Table 3.

Condom coercion: Physical /sexual abuse and threats

One type of condom coercion described by the participants was physical/sexual abuse and threats of these types of abuse. In all 5 focus groups, when we asked participants about the possibility of using condoms in abusive relationships, they described how physical and sexual abuse and the associated fear (implying the threat of abuse or having been abused previously) could limit girls' ability to use and negotiate for condom use. Forced sex without a condom was also described as a barrier to condom use.

Condom coercion: Emotional manipulation

Another type of condom coercion, which participants said was often hard to identify especially for younger girls, was emotional manipulation. There were several forms of this type of condom coercion identified across all 5 focus groups. Participants described how this type of condom coercion may occur along with more overt forms of condom coercion that include physical/sexual abuse and threats or may occur in relationships not otherwise considered abusive. One common form that girls described was partners proclaiming some level of relationship commitment just to get them to have unprotected sex. The girls also indicated that a partner's stated pregnancy desire can also be viewed as a proclamation of relationship commitment and therefore undermine condom use. In 1 group, in particular, participants talked about younger girls (referring to girls aged 12-14 years) who they described as, "they so immature and not wise to the game, anything a boy tell them, they hang on." In response

Table 3. Types of Condom Coercion

Type of Condom Coercion	Quote
Physical/sexual abuse and threats	
Partner physically hurt me	"I think it's harder to use a condom in an unhealthy relationship because he might wanna fight you"
	"When you can't do anything about the situation, he just cheatin', he be hitting you, he just lying, and you can't do anything about it"
	"He can beat her up" or "he can beat her up and she won't be thinking about condoms"
	"He might want to knock her out"
	"The girls are brainwashed and don't want to be beat up"
Feel afraid my partner will hurt me (implied threat)	"It's hard to use condoms because you might be scared that you may get hit and you just want to get through the night and not get beat up"
	"No because they would be scared/fear . . . control comes with abuse"
	"It would be hard [to use condoms] in an abusive relationship, because the guy would do what he wanted to"
Partner forced me to have sex without a condom	Leader: "What would make it hard to use condoms in an abusive relationship?
	Participant: "If she gets beaten and he wants to rape her . . . just forcing her to have sex" "If he's forcing her to have sex, there's nothing . . . you can't make him use a condoms, so the best thing is not put yourself in a situation where he is forcing you to have sex"
Partner forced me to have sex without a condom	"In an abusive relationship, he can just beat her up, she's sitting there crying and he can get on top of her, she's not paying attention because she's so tore up . . . and like he just throw it in there and that's the make-up sex, and she's supposed to be happy?"
	"you're bleeding, you crying but he don't care, 'cause he wants what he wants'"
Emotional manipulation	
Partner proclaimed some level of relationship commitment	"If I guy doesn't want to use it [a condom], girls are unlikely to use them if they really like the guy . . . Guys might say to girls: 'You're the only person that I'm sleeping with'. .. [or] . . . 'I love you' . . . [or] . . . 'We've been together for a long time' . . . [or] . . . 'You my girlfriend and we shouldn't have to use them'"
	"Some men be like . . . no, you mine, you gonna have my babies"
Partner accused me of having sex with someone else	"If you ask him to use a condom, then he's gonna really look at you like you really is a whore! They like, 'oh you want me to use a condom . . . what you like smashin' somebody else'?"
Partner accused me of damaging the relationship because I did not trust him	Leader: "Does it mean something if a girl brings up condoms?"

(*continues*)

Table 3. Types of Condom Coercion (*Continued*)

Type of Condom Coercion	Quote
	Participant: "A guy may think of it as "she doesn't trust me she thinks I'm having sex with other people or she's having sex with other people"
Partner refused to use a condom	"they're going to tell you, 'no, I'm not putting the condom on'"
	"It would be easier to use a condom if my boyfriend stops saying 'no'"
Partner got angry at me for asking to use a condom	"he could get mad . . . boys always get mad when you tell them they can't get none"
Condom sabotage	
Partner slipped condom off without me knowing	"Guys are real sneaky . . . guys slide condoms off . . . but they try to keep you entertained"
Partner got me sexually aroused so I would not notice he was not wearing a condom	"Once you all be getting in the mood, eyes start closin' and then they'll take the condom off"
	"to be honest, if he hit that spot, she gonna do it . . . (give in to have sex without a condom"

to a question about asking guys to use condoms in unhealthy relationship, 1 participant responded: "The girls being young and naïve, they're going to believe whatever the guy says." "Some boys, when they say they love the girls, they be lyin."

Two other forms of emotional manipulation in relation to male-partner condom coercion were to accuse the girl of having sex with someone else or to accuse her of damaging the relationship because she must not trust him if she negotiates for condom use. Establishing or maintaining a relationship was commonly presented by male partners as antithetical to condom use. Setting up such binary choices is a form of manipulation that forces girls to choose between 2 less-than-desirable outcomes, for example, have unprotected sex or lose the relationship. Furthermore, invoking the stigma of promiscuity for girls exerts a powerful form of pressure that is likely to result in condomless sex, as she attempts to "prove" herself otherwise.

The girls described a couple of different ways in which partners resisted their expressed interest in using condoms. Some partners would refuse to use a condom. Because condom use is dependent on the male partner, girls' options were very limited when it came to practicing safe sex when a partner refused to wear a condom. A partner's blatant refusal to use condoms and the girl's inability to safely protect herself highlight the lack of control that girls have over their own safe-sex practices. Another way in which partners resisted condom use was when a partner got angry in response to a girls' request for condom use. The participants expressed that a girl's refusal to have sex without a condom could be met with partner anger, which may in turn cause a girl to give in and have unprotected sex. A potentially dangerous outcome of a girl's continued insistence on condom use was that it might lead her partner to become increasingly angry and resort to using more coercive and abusive actions to get the girl to have unprotected sex.

Condom coercion: Condom sabotage

Participants talked about condom sabotage as another type of condom coercion. In 2 focus groups, girls described male partners surreptitiously removing the condom. An example of this is when a male partner puts a condom on at the beginning of sexual intercourse

but secretly takes it off during intercourse. The participants indicated that often girls may not notice that the guy is not wearing a condom anymore, especially if they are sexually distracted. Condom sabotage undermines any discussion about condom use. Thus, this action avoids confrontation and effectively circumvents any condom negotiations.

Silencing of condom negotiation

> If we talk about just STI's and HIV, we're not addressing the whole picture . . . I'm easily pressured into doing things that I don't want to do and it's hard to sit back at that time and ask myself, "is this something that I really want to do?" . . . oftentimes it's what he wants, but what I want . . . you don't' want a baby, you don't want a STD, you don't want HIV . . . do you want him to beat you up? . . . Don't let anybody tell you its not about what you want, and he's going to be telling you that. There's always a way out of things, always.

In contrast to condom coercion, this quote insightfully describes how, when faced with pressure from partners trying to dissuade them from using condoms, girls may also feel pressures that silence them from even bringing up the topic of condom use even when they wanted to negotiate condom use. In the survey, we captured data about self-silencing of condom negotiation for both vaginal and anal sex. In response to the question that we presented in the survey, "Have you ever wanted to talk with your sexual partner about using a condom during vaginal sex, but were not able to?" 25% responded in the affirmative. In a follow-up open-ended question on the survey, to expand on these affirmative responses, participants wrote their reasons as follows:

Because I was scared*

Because I thought maybe he knew more that I did

Because I didn't want to bother him

Because I knew he didn't want to wear one*

Because it happened too fast*

Because I thought he wouldn't like me anymore

Because he wouldn't listen*

Because I didn't know how to tell him I wanted to use a condom

Because really nobody talks about it

Because I was not able to speak up about condoms

*Endorsed by multiple participants

In response to the question, "Have you ever wanted to talk with your sexual partner about using a condom during anal sex, but were not able to?" 21% of those who had anal sex answered in the affirmative. In a follow-up open-ended question on the survey, to expand on these affirmative responses, participants wrote their reasons as follows:

Because I wanted him to like me

Because there was nobody to talk to

Because I was raped

Given that participants provided only brief answers, there might be several possible interpretations of why they gave the reasons they did. Reasons for self-silencing may be due to interpersonal factors (eg, lack of communication skills and rejection sensitivity), an internalized response from prior social experiences (eg, partner abuse, including threats), a lack of control over the situation (eg, rape) or a combination. For example, in the response "I was scared to talk about it," we do not know the reason why she was scared. However, the girls' written responses were echoed in the focus groups. When we were discussing barriers to condom use in unhealthy relationships, it was said that a girl might not even bring up the topic because, "She's scared and doesn't want to lose the guy" or "She will just do it [have sex without a condom] and say okay next time we will use one." "He can go out and cheat and he will get it (condomless sex) from somewhere else." In light of the prior discussion on condom coercion, she might also be scared of physical or sexual abuse. In another example, 1 girl indicated that she did not feel that she could talk about condoms "because it happened too fast." We do not know whether there was some purposeful attempt on the part of the partner to distract her from bringing up condoms as she was carried away by the moment. Yet, given that partners would sometimes try to sexually

distract girls as they sabotaged condom use, this could be possible. Lastly, the response, "because he wouldn't listen," suggests that she may have been self-silencing because she had tried to discuss condoms in the past and was ignored, which may be another form of condom coercion.

Strategies young women used and/or recommended

In the last part of the focus groups, we asked girls what they thought should be included in an intervention to address the issues of unhealthy relationships and condom use. One major theme was that girls indicated the need to know how to get out of abusive relationships, especially situations in which the girl had no control over condom use.

> Before talking about how not to do it or how to do it and how to use condoms, there's a few girls out there in abusive relationships who's boyfriends say they don't want to use a condom and there's nothing that they can do . . . here or there, that's rape but girls don't see it that way. it's unwanted sex . . . tackle the problem of how to get out of the relationship and then how to protect yourselves because you can't protect yourself if you can't move—you're trapped in a box.

More specifically, girls provided several strategies to prevent and/or manage situations of condom coercion ranging from individual to group strategies. One way was to link relationship quality or commitment with condom use, for example, "if you love me, you'll use it [a condom]." Another girl suggested that talking with a partner about specific consequences of unsafe sex could enhance condom use; "My boyfriend always talking about AIDS and STD's . . . When we do have sex, we do use condoms though." Others said that they would insist on condom use and tell their partners ahead of time: "Set limits ahead of time, no condoms, no sex!" or "wear condoms- if he doesn't want to, just pack up and leave," otherwise "they keep asking and asking and then you say yeah." If the partner is being abusive, "set some rules like, 'I'm not going to have sex with you because you're treating me this way." To address condom sabotage, girls suggested ways to make sure that the condom was still in place: "I do checks now when I have sex . . . I make him stop to feel it to see if the condom popped or something, because that's common—condom popping . . . I check to make sure the condom is still there."

In terms of condom use, 1 view expressed was how the condom use practices of 2 people have implications for a wider circle of girls. This quote suggests that if guys get used to not using a condom with 1 girl, he will continue to expect to have sex without condoms with others as well.

> If you cut the supply, the demand won't come, [otherwise] they'll start wanting more, the more you give it to them and you let them not put the condom on, they gonna be looking forward to all the time and then they'll go to the next girl and they get used to having sex raw, and then they'll wanna smash our rule.

Her suggestion, to "cut the supply" implies that girls as a group should insist on condom use, and this would lead to a decreased expectation from male partners to have sex without condoms. In this example of a suggested intervention strategy, girls are interested in ways to intervene not only at a personal level but also to involve their social network of peers, to change group norms.

DISCUSSION

In this exploratory study, adolescent girls who are at high risk for STIs/HIV infection described mechanisms that link partner abuse, interpersonal control over condom use, and nonusage of condom. Specifically, they identified several forms of condom coercion and provided more detailed descriptions of the phenomena of silencing of condom negotiation. These mechanisms are critical to include in HIV-infection prevention interventions to more fully address partner factors that can interfere with condom use, especially for girls in abusive relationships. Previous studies have outlined associations between sexual relationship power, partner abuse, and condom use among adolescent girls and have identified

some of the mechanisms.[9-10,36,37] However, this study illuminates several forms of condom coercion that may further explain these links and thereby points the way to more tailored prevention intervention activities for adolescent girls at high risk for HIV infection/STIs.

Unwanted unprotected sex

We found high rates of unwanted unprotected sex, with more than half of the sample indicating that they had had unprotected vaginal and/or anal sex when they wanted their male partner to use a condom. Participants with a history of forced sex or physical partner violence disproportionately experienced unwanted unprotected sex. Other research has also found that unwanted sex is associated with lower rates of condom among adolescent girls.[38] One explanation, as suggested by the focus group findings, is that girls in an abusive relationship may have unprotected sex to avoid physical harm or because they have limited or no control over condom decision making. Yet, among girls who reported unwanted unprotected sex on the survey, a little less than a third of them reported no history of any of the 3 types of partner abuse that we assessed (physical, verbal, and threats). Thus, unwanted unprotected sex can occur in relationships without these other forms of abuse, although it may occur less commonly in the absence of a physical/verbal abuse history. This pattern of results is similar to the findings in which young women with no history of physical or sexual intimate partner violence experienced reproductive control in relationships but at lower rates than those with no intimate partner violence history.[36] This has important implications for designing and targeting interventions for adolescent girls, suggesting that interventions addressing the various reasons for unwanted unprotected sex targeted to adolescent girls need to include girls regardless of their history of partner violence.

Other sexual risk factors

Research on the prevalence of anal sex in adolescence reveals that it is not uncommon practice, ranging from 9% for young adolescents (13-15 years old) to at least 38% for older adolescents (19-21 years old).[5] Our study found that 22% of the participants reported anal sex, which was consistent with earlier reports. Adolescent girls who engage in both anal and vaginal sex have been found to engage in other sexual risk behaviors.[5] Thus, anal sex may be viewed as a marker for greater STIs/HIV-infection risk and needs to be addressed in future interventions.

In addition, we found that more than one-third of the girls in this sample had male partners who were at least 2 years older the last time they had sex. Adolescent girls who have male partners who are older by at least 2 years have been found to be less likely to use condoms during sex, have greater fear of negative partner reactions to discussing condoms, and indicate that they faced greater partner-related barriers to condom use.[20] In a study by DiClemente et al,[20] partner-related barriers were assessed by using a 7-item scale and included items that may be consistent with condom coercion such as "might get angry" or might think . . . "I was cheating on him," or "I didn't trust him," or "I was accusing him of cheating." Having an older partner may reflect a heightened power imbalance, favoring the male partner, and contribute to the risk of experiencing condom coercion.

Condom coercion

Three specific types of condom coercion were identified by participants across focus groups as possible ways a male partner might use to "convince" girls to forgo condom use, including various forms of physical/sexual abuse and threats, emotional manipulation, and condom sabotage. In a related study, slightly older young women (aged 18-25 years) commonly encountered a gender norm of condom nonuse and those who resisted this norm and expressed an interest in using condoms were typically confronted with condom coercion by a male partner.[39] Furthermore, compared with nonabusers, male partners who are physically abusive are at greater risk for HIV infection/

STIs and more likely to practice coercive condoms practices, such as responding with anger or refusal to female partners' condom use requests.[40] The present study extends these findings to identify several additional forms of condom coercion that can put girls at increased risk for HIV infection/STIs in abusive relationships and in relationships that were not otherwise considered abusive.

Silencing of condom negotiation

Some girls who want to use a condom may not negotiate for condom use because they lack knowledge or communication skills, as suggested by some of the responses in our sample, findings consistent with prior research.[41] Therefore, providing knowledge and fostering condom-negotiation skills are integral to promoting effective HIV-infection prevention communication strategies among girls.[7] In our findings, there were several other reasons that girls provided for silencing their condom negotiations that reflected a partner's resistance to condom use, for example, "I knew he did not want to wear one," or "because he wouldn't listen," or an internalization of norms that others do not talk about condoms. Given that expressing an interest in using condoms runs counter to the prevailing sexual gender norms for girls, and may be met with condom coercion, girls may be especially reluctant to voice an interest in condom use and risk losing the relationship and thus self-silence their condom negotiations for the fear of facing negative consequences.[39] Jones[42] found that adult women were more likely to be pressured to engage in unprotected sex when they adopted stereotypical sexual norms and felt obliged to please their partner, and this type of subtle coercion is more common than overt coercion (eg, threats of abuse) by a partner. According to Amaro and Raj,[43] women and girls may self-silence their condom negotiations if they fear being stigmatized for transgressing accepted gender norms. Thus, silencing of condom negotiations can reflect gender power imbalances that favor men, more widespread in violent and economically challenged communities[44] and magnified in the context of partner violence.[43] Thus, to more fundamentally address both sexual risk and partner abuse, it would be important to address inequitable gender norms in future interventions with urban adolescent girls.

Finally, some girls' voices in negotiating condom use were effectively silenced by limited control, as suggested by the quotes: "I was scared," "I was raped," or the rhetorical "Do you want him to beat you up?" In such situations, condom negotiation may recede as a priority, when facing the greater need for basic self-protection. This provides further evidence for the need for nuanced approaches to integrate partner abuse prevention with HIV-infection/STI prevention.

LIMITATIONS

The findings here are relevant to African American adolescent girls who attend publicly funded urban reproductive health clinics and may not apply to a broader range of adolescents. However, these findings are important for developing tailored safer-sex interventions for this target group. Although the sample size is relatively small, it is appropriate for eliciting beliefs and identifying contextual information to guide intervention development.[27] Further studies are needed to determine whether the various forms of condom coercion and silencing of condom negotiations identified in this exploratory study occur more broadly in the population. Also, given that we only sampled at 1 point in time, we do not know, for example, if male partner condom coercion precedes other forms of partner abuse and can be an early warning sign; thus, longitudinal studies are needed to assess for patterns of abuse and control that develop over time in adolescent relationships. Also, we ascertained only the views of adolescent girls and not those of adolescent boys; however, recent research on condom use among adolescent male

perpetrators of partner abuse are compatible with our findings.[45]

Implications for interventions

Findings from this study suggest HIV-infection/STI prevention interventions for urban adolescent girls attending publicly funded reproductive health clinics should address the various types of condom coercion and foster ways for girls to safely and/or selectively negotiate for condom use in relationships when encountering partner resistance that could range from subtle manipulation to overt abuse. Such interventions should also cover identifying types of partner abuse and how to safely end a controlling or abusive relationship. Getting out of an abusive relationship should be considered a necessary HIV-infection/STI prevention strategy when these situations limit girls' ability to exercise control over their safer-sex practices. Girls would also benefit from opportunities to reflect on their views of healthy and unhealthy qualities in relationships, because an enhanced understanding of both the joys and pitfalls within relationships would allow them to better navigate the landscape of strong emotions this journey often entails. Interventions for urban girls should foster greater understanding of common sexual gender norms and how they may influence the silencing of condom negotiation. Creating safe spaces for girls to discuss and reflect on gender norms would be an important component, especially if linked with social actions to enhance their efficacy as a group. Clinic-based interventions, such as one being developed from these findings, should target all girls, not just those with a history of abuse, for several reasons. Condom coercion can occur in relationships that are not typically considered abusive. Furthermore, few teens who experience abuse seek assistance from health care providers.[46] Also, given that adolescent girls who attend reproductive health clinics have high rates of partner abuse,[18] intervention programs may offer primary as well as secondary prevention.

In keeping with the TRA approach, it is important to carefully assess the underlying issues surrounding limited behavioral control. Interventions based on social-cognitive theories, such as the reasoned action approach, have limited application when intentions to carry out the behavior are present but circumstances restrict enactment or when a realization of limited power over a particular behavior leads to a reduction in intention. Such lack of behavioral control requires another layer of intervention that focuses on promoting less-restrictive circumstances, so that the TRA-identified determinants can be effectively addressed in an intervention. Intervention approaches, based on feminist and critical theories that address power and control dynamics at various social levels, are needed to augment prevailing behavioral interventions theory when behavioral control is constrained.[32,47,48] Furthermore, interventions based on these theories would be incomplete without the meaningful incorporation of the behavioral predicting constructs of rejection sensitivity and self-silencing behaviors.[24,26]

Finding ways to reach male partners with similar information is also a high priority. Community-wide interventions that foster discussion of healthy/unhealthy partner relationship qualities would complement such individual and small-group HIV-infection/STI prevention programs. Schools may be 1 important site for prevention interventions, but other venues are needed for high-risk youth who are not in school, such as detention centers. To develop relationships of mutual trust and respect, adolescents need to find or create alternative community perspectives that challenge conventional gender attitudes. This is especially important in violent urban neighborhoods where gender-based violence and traditional gender norms are highly prevalent.[44] According to Pinderhughes, school and other community institutions could support youth in these efforts by embracing a critical approach to the study of society, community, and self "that would

incorporate an examination of the dimensions of power that affect relationships, definitions, representations and interactions."[49(p159)] Promoting healthy relationships among youth and preventing partner abuse in adolescent relationships should become a public health priority. This is necessary for primary prevention of the dual and intersecting epidemics of partner abuse and HIV/STIs. Finally, we need social policies that support comprehensive sexual health education for young people, in schools and wherever they can be reached in communities, that include relationship issues and understanding gender norms. A comprehensive HIV-infection prevention plan for urban adolescent girls must therefore take into account a variety of individual and social factors, promoting individual and collective efficacy,[50] and requires a multifaceted approach.

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