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Intimacy and Infidelity: Using the Theory of Gender and Power to better understand the sexual realities of African American adolescent women

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Intimacy and Infidelity: Using the Theory of Gender and Power to better understand the sexual realities of African American adolescent women

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2008

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An abstract of
a thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

Intimacy and Infidelity: Using the Theory of Gender and Power to better understand the sexual realities of African American adolescent women
By Kelly M. King

African American adolescent women share a disproportionate burden of STI and HIV incidence and prevalence in the United States. Interpersonal and behavioral risk factors associated with the constructs Sexual Division of Power and Structure of Cathexis within the Theory of Gender and Power may contribute to such disparities. A secondary data analysis was conducted, using baseline data from the AFIYA study (N=701) to determine relationships between unbalanced gender and power structures and the outcome variables: infidelity, condom use and self-reported STI status. Results showed that there was a high prevalence of positive STI test results, low prevalence of condom use at last sex and a clear relationship between experiences with infidelity and having contracted an STI, in this sample of African American adolescent women. Male dominant power dynamics within romantic relationships were found to be predictive of experiencing infidelity and failure to use a condom at last sex. In-depth qualitative interviews (N=7) were also conducted with women from this sample to determine what factors contributed to women tolerating male partner infidelity. Here again, results showed that unbalanced power structures within romantic relationships and prevailing cultural norms about appropriate behavior for men and women both directly and indirectly influenced women's decisions to remain in relationships with unfaithful partners. Taken together, the results of this study indicate that future research should evaluate relational power structures as a particularly powerful determinant of behavior and encourage the continued use of societal level theories to better understand the intricate context of individual-level sexual behavior.

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Introduction

Young people are at a disproportionately high risk for sexually transmitted infections (STIs) including HIV. In the United States, adolescents aged 15 to 24 years constitute only 25% of the sexually active population; however, they account for about half of new STI cases (Weinstock, Berman & Cates, 2000). Twenty-five percent of new HIV infections in the United States are estimated to occur among those aged 13 to 20 (Office of AIDS Policy, 1996). Statistically, two young people become infected with HIV every hour of every day; and more than one-third of these new cases are female. Additionally, adolescent females have higher STI rates than any other age or gender group (CDC, 2008). A 2004 study by Chesson, Blandford, Gift, Tao and Irwin reported that the direct monetary cost associated with the 9.1 million STI cases among youth age 15 to 24 in 2000 was $6.5 billion dollars. CDC researchers and economists also tracked lifetime medical costs of HIV, HPV, genital herpes simplex type 2, hepatitis B, chlamydia, gonorrhea, trichomoniasis and syphilis and estimated the "total burden" in financial cost of these diseases among individuals in this population. Results showed that HIV and HPV alone had estimated direct medical costs of $5.9 billion dollars (Chesson et al., 2004). Beyond the financial burden, however, the mental and social “costs” these diseases produce in the lives of the individuals they affect are truly immeasurable. In addition to age, clear disparities exist by race.

Among African American adolescent females (aged 15-19), gonorrhea rates are higher than for any other racial or age group, with approximately 3% of African-

American adolescent females reporting a case of gonorrhea (specifically, 2,814 per 100,000 population)(CDC, 2004a). Further, African American, Hispanic and American Indian youth have rates of gonorrhea and chlamydia that are between two and seven times higher than rates for White youth (CDC, 2004b; Weinstock et al., 2004). Further, African-American and Hispanic females are also most likely to report no contraception use at first sex (29% and 34% respectively) and 78 percent of AIDS cases among females ages 13 to 19, are to African American and Latino adolescent women (CDC, 2002a). It is clear that young people of color share a disproportionate burden of STI and HIV incidence and prevalence.

The root of these racial/ethnic health disparities is complex. Socio-economic status, poverty, discrimination and geography are all deeply intertwined with issues of race and sexual behavior. A 2006 CDC fact sheet on HIV/AIDS among African Americans cited socioeconomic issues associated with poverty, such as limited access to high quality healthcare, housing and HIV prevention education as likely direct or indirect risk factors for HIV infection (CDC 2006; Barrow, Newman & Douglas, 2008). Further, according to the 2002 CDC HIV/AIDS Surveillance Report, deep seeded racial inequities contribute towards weakening the social and economic conditions that are protective against sexual risk-taking among African American teens (CDC, 2002b).

Given the intertwined nature of these correlates, causal relationships are difficult to distinguish, however, the unequal weight of disease that this population shares is evident. African American adolescent women report teen birth rates that are between two and three times higher than White youth, earlier initiation of

sexual activity, more sexual partners, older sexual partners and higher levels of failure to use contraception at first sex, all risk factors for STIs/HIV (CDC, 2002).

Study Purpose

The proposed research seeks to better understand the relationship between gender, power, infidelity, condom use and STI status among African American adolescent women. The gender and power factors addressed by this study include adolescent's perceived power within their romantic relationship, ability to communicate with partners (i.e. the ability to talk about sex and resolve conflicts with their partners), ability to refuse sex and feelings of fear around condom negotiation. Cultural factors that contribute to sustaining gendered relational power dynamics are also addressed through qualitative interviews exploring what factors motivate women's tolerance of male partner infidelity. In addition, sexual happiness, self-esteem, pleasure, intimacy, age, level of education and socioeconomic status were examined as individual level factors in this study.

Ultimately, better understanding these relationships, and the contexts in which they exist, could provide crucial information to improve condom negotiation strategies on an individual level and inform societal level STI/HIV prevention initiatives in this and similar populations.

Theoretical Framework

The Theory of Gender and Power (TGP), a macrosocial theory that argues that sexual inequity and unbalanced gender and power dynamics exist fundamentally within society on many levels (DiClemente & Wingood, 2000), serves as the theoretical framework for this study. TGP is useful in acknowledging how

societal norms influence women's sexual health and behavior, specifically in terms of how gender-based risk factors affect women's experiences with male partner infidelity, condom use, STI status.

Assumptions

The following is a list of assumptions made while conducting this study.

(1) Participants understood the language and terminology included in the survey and qualitative interview guide as intended by the researchers.

(2) Participants provided honest and accurate answers throughout the survey and in-person qualitative interviews.

(3) There are societal and institutional forces within the United States that serve to segregate resources, power and assigned social norms on the basis of gender-determined roles (DiClemente & Wingood, 2000).

Definition of Terms

The WHO defines health as, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This definition goes beyond disease outcome to acknowledge the complex social and cultural factors that make up the human experience. Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) are diseases that are inherently transmitted through social contact with huge costs for both physical and mental health. There are intricate relationships between gender and culture that have implications for contraceptive use and ultimately, STI/HIV status. Condom negotiation is the ability to persuade a sexual partner to use a condom. Often this process is made up of a set of skills and may include verbal communication, physical application or a

combination of both. Previous research has shown that condom negotiation outcomes are largely tied to self-efficacy (Baele, Dusseldorp & Maes, 2001), a person's belief in his or her ability to succeed in a particular situation (Bandura, 1986).

The social construction of gender has implications for individual self-efficacy within sexual relationships. Here social construction refers to the idea that gender is created and re-created out of pre-established social norms surrounding conceptions of masculinity and femininity rather than something fixed and inherent to an individual (Lorber, 1991; West & Zimmerman, 1987). For example, the traditional operationalization of feminine as submissive and masculine as dominant influences power structures within relationships, which can impact self-efficacy and, in turn, condom use and sexual health.

Literature Review

Influence of Gender on Condom Use

Previous research suggests that cultural constructions of gender and their effects on condom negotiation may have significant implications for increasing risk factors and corresponding poor sexual health outcomes among African American women. Construction of gender in the African American community has important implications for contraception use, number of sexual partners and relationship dynamics with older partners. A 2002 study by DiClemente and Wingood, et al., of 522 sexually active African American adolescent females found that sixty-two percent of the sample reported that their typical sex partners were at least 2 years

older. Moreover, these women who had older sexual partners were significantly more likely to report not using condoms during their most recent sexual encounters.

Bauermeister, Zimmerman, Xue, Gee and Caldwell (2009) further evaluated the effect of partner age on sexual behavior among 562 African American youth. Results showed that the age of an individual's sexual partner was associated with their total number of partners, condom use and sex frequency, with these associations strongest for females. African American males reported more infrequent condom use if they were older than their sexual partners with larger effects found as the age difference widened. Conversely, African American females reported higher levels of condom use when they were the older partner. Women who were older than their partners reported increased sexual power within the relationship, self-esteem, and self-efficacy to use condoms (Bauermeister et al., 2009).

These finding suggest first, that gendered, male dominant, power structures exist within sexual relationships with clear implications for condom use and second, that age may act to mediate these power dynamics. Although the Bauermeister et al (2009) study found an effect between age and increased condom use in African American females with younger male partners, it failed to explain why this was the case. It is possible that being older allowed women to feel more confident in their ability to negotiate condom use, however, further research into the exact nature of this heightened confidence is necessary in order to truly understand the effect of age on condom use and how this confidence may be modified and extended to women with older sexual partners.

Influence of Gender on Condom Negotiation

Adopted gender roles also have important implications for women's ability to negotiate condom use. A study of 713 young African American women examined the roles that sexual agency and relationship dynamics played in determining whether or not these women engaged in unprotected vaginal sex. Results showed that fear of negotiating condom use with male partners, and beliefs that stopping to use condoms "takes the fun out of sex" had implications for condom use (Crosby et al., 2008). Reported apprehensions about negotiating condom use and negative attitudes toward condoms' effect on sexual pleasure suggest male-dominated power imbalances, which place young African American women at high-risk for STI/HIV.

A cross-sectional study of 522 African American female adolescents also evaluated relationship dynamics and their implications for unprotected vaginal sex. Results showed that women who held stronger normative beliefs of male dominance within relationships reported increased levels unprotected sex. The perception that condoms detract from sexual pleasure and romance were also associated with more frequent unprotected sex acts among adolescents with casual partners (Crosby et al., 2001). Again, these findings imply a clear gendered power structure within romantic and sexual relationships and beg the question of how women understand both pleasure and commitment in this context.

Acceptance of Partner Infidelity

Messages normalizing male infidelity have become increasingly common among African American adolescents (Stephens and Phillips, 2005). Although a "double standard" for sexual behavior by gender occurs across many cultures, this

may be particularly relevant for African American females. African American males are encouraged to engage in multiple, casual sexual relationships, including sex outside of committed relationships, while women are encouraged to "stand by their man." This discrepancy places African American woman at increased risk for contracting STIs/HIV, even from main partners (Harper, Gannon, Watson, Catania & Dolcini, 2004).

A qualitative study of 14 African American women attempted to identify the association between the roles women play in relationships and condom use with primary partners. In order to do so, the authors investigated the interpersonal relationship and sexual scripts these women held. For the purpose of this study, scripts were defined as culturally shared social norms that guide relationship and sexual behavior (Bowleg et al., 2004; Simon & Gagnon, 1986), which may have direct or indirect implications for sexual risk. Results revealed, "infidelity is normative" as a main interpersonal script held by the women in this study.

Although this study provided information about the type of sexual scripts African American women hold, it failed to explain how these scripts are created and maintained in relationships. As a result, more research is needed to understand how both external and internal factors shape these scripts surrounding infidelity acceptance, which, in turn, have implications for women's sexual health. Moreover, the women in this study were age 22-39 and, as a result, findings may not be generalizable to adolescent women. Additional research should be done, with larger sample sizes, to determine the types of interpersonal and sexual scripts that exist in this younger age group, how they are formed and how they impact sexual choices.

A qualitative study by Eyre, Hoffman and Fraser used a cultural model approach to explore cognitive representations of infidelity in African American late adolescents (Eyre et al., 2010). A total of 145 African Americans ages 19-22 were interviewed to identify important representations of infidelity that may have implications for sexual behavior in this group. Results showed that several representations of infidelity existed in this population, including ideas of infidelity as wrong, sex is superior with side partners, side partners needed to be managed to sustain main relationships, unfaithful partners should be tracked and confronted and strategies must be used to protect against STIs/HIV when infidelity has occurred. This study, however, failed to explore how these representations differed by gender or women's motivations for remaining in relationships where infidelity was normative. Although this study highlights the complex social nature of infidelity, it fails to examine how traditional gender roles and power structures influence these representations. Ultimately, male partner infidelity has serious implications for women's sexual health and HIV status yet factors influencing its acceptance are largely overlooked in the literature.

Female Conceptions of Sexual Pleasure

Bowleg et al (2004) found that failure to use condoms was not always driven by men. Many women in this study reported not wanting to use condoms because of perceptions that they diminished sexual pleasure and disrupted intimacy. A qualitative study further explored the relationship between condom use and intimacy in 50 inner city African American adolescents (ref here). Results showed that young women were more likely to desire one monogamous romantic partner

over several more casual sexual partners. Interestingly, however, women were willing to engage in sexual relationships with nonmonogamous partners in order to fulfill desires for emotional intimacy. These studies both demonstrated adolescent females' need for intimacy but failed to explore the social contexts that may have motivated this desire.

A qualitative study with 50 African-American adolescents expanded on these previous studies by exploring the psychosocial context surrounding the formation of gender ideologies and their relationship to condom use and HIV/STI prevention (Kerrigan et al., 2007). Results of this study suggested that adherence to traditional female gender ideologies related to emotional strength and caretaking may be linked to an increased desire for male intimacy and tolerance of male sexual risk behavior. Women in this study who took on a heightened amount of economic and emotional responsibility for others at a young age often prioritized relationship intimacy over safer sex behaviors (Kerrigan et al., 2007). Although this study gives context to female desire for intimacy, it does not place this desire within a broader understanding of female sexual pleasure. Throughout the literature, women consistently report not using condoms because they do not “feel good.” It is important to understand whether the “feeling” referred to here, pertains to physical pleasure, emotional pleasure or a combination of both. Future research is needed to better understand the relationship between gender roles, intimacy and female sexual pleasure, in motivating women use condoms and decreasing STI prevalence.

Summary of Limitations

Each of the above studies works to establish relationships between risk factors and condom use. Often they acknowledge male dominant power structures and resulting fear of condom negotiation or decreased condom use, however, the majority of studies fall short in addressing how these gendered realities are culturally constructed and sustained. Through the review of the literature, two main areas emerge as requiring future research for improving sexual health outcomes in this population: women's acceptance of infidelity within the context of committed relationships and understanding of female pleasure and intimacy as they are related to behavioral outcomes like condom use and STI status. Acceptance of partner infidelity has serious implications for sexual health and HIV status but there is a large gap in understanding what motivates this norm, especially in an adolescent population. Further, clear relationships have been demonstrated between women's' negative attitudes toward condoms in regards to sexual pleasure and higher rates of unprotected sex, however, the literature fails to explore what factors shape these attitudes.

The rationale for the proposed study is to fill these gaps in the literature two important ways. First, by going beyond merely establishing relationships between risk factors and condom use outcomes to better understand what is at the root of beliefs that influence behavior. Second, by exploring a relevant and previously under researched area, in this case, infidelity, to gain better insight into specific cultural and gendered power structures in this population with their serious implications for STI/HIV acquisition. Ultimately, answering to previous limitations

in these ways provides crucial information to improve condom negotiation strategies on an individual level and inform societal level STI/HIV prevention initiatives grounded in female empowerment and "re-learning" gender roles. Further, many of the studies reviewed in the literature were cross-sectional or exclusively qualitative in nature.

The proposed study used baseline data from 701 African American adolescent women surrounding various aspects of sexual behavior over a 5-year longitudinal study. In addition to this quantitative data, a select sample of women who participated in baseline assessment were re-contacted for in-person qualitative interviews to give necessary context to findings that were not fully captured quantitatively. Specifically, this mixed methods approach used quantitative data to evaluate relationships between sexual happiness, self esteem, condom negotiation abilities, partner communication, power within relationships, sexual pleasure and intimacy with the outcome variables: infidelity, STI status and condom use at last sex. In-depth qualitative interviews then served to provide rich context to these findings by seeking to better understand how gender and power dynamics, as well as individual and cultural factors, influence tolerance of male partner infidelity.

Specific Aims/Hypotheses

Quantitative

Specific Aim#1 Analyzing individual and interpersonal factors related to the constructs Sexual Division of Power and Structure of Cathexis within the Theory of Gender and Power to determine how they are related to experiencing male partner infidelity.

Hypothesis #1 Women who report low levels of power within their relationships will be significantly more likely to have experienced male partner infidelity.

Specific Aim#2 Analyzing individual and interpersonal factors related to the constructs Sexual Division of Power and Structure of Cathexis within the Theory of Gender and Power to determine how they are related to self - reported condom use at last sex.

Hypothesis #2 Women who report low levels of power within their relationships and who place high importance on sexual pleasure and intimacy will be significantly less likely to report using a condom at last sex.

Specific Aim #3 Analyzing individual and interpersonal factors related to the constructs Sexual Division of Power and Structure of Cathexis within the Theory of Gender and Power to determine how they are related to self reported STI status.

Hypothesis #3 Women who report low levels of power within their relationships and who place high importance on sexual pleasure and intimacy will be significantly more likely to report having received a positive STI test result at some point in their lives.

Qualitative

Specific Aim #1 What factors motivate women to tolerate male partner infidelity?

Hypothesis #1 Women will cite a variety of personal and cultural factors that contribute to the tolerance of male partner infidelity; this behavior will be most accepted among women who describe reduced power in their romantic relationships and women who hold conventional male dominant social norms about sexual behavior.

Theoretical Framework

The Theory of Gender and Power (TGP) is a macrosocial theory that argues that sexual inequity and unbalanced gender and power dynamics exist fundamentally within society on many levels (DiClemente & Wingood, 2000). Specifically, TGP states that gender based inequalities arise from three major social structures: the sexual division of labor, the sexual division of power, and the structure of cathexis (social norms/affective relationships). Moreover, these structures exist and interact at two different levels, the societal level and the institutional level. The societal level is the highest level at which these structures exist and TGP suggests that certain gender dynamics have been historically rooted in society through various sociopolitical forces. As a result, societal forces continually act to segregate resources, power and assigned social norms on the basis of gender-determined roles. These three structures also exist at the institutional level, i.e. schools, the workplace, families, marriages and other

relationships, religious institutions, the medical system, communities and the media (DiClemente & Wingood, 2000).

At the institutional level, social mechanisms serve to maintain these three structures. These social mechanisms may include discriminatory practices at school or in the workplace, disparities in control between men and women within romantic and family relationships, culturally based power imbalances within religious institutions or the medical system and overarching stereotypes about women propagated through the media. These social mechanisms restrict women's opportunities and daily lifestyle practices by producing gender-based inequalities in women's economic potential, generated from the division of labor, inequities in women's control of resources generated from the division of power and disparities in expectations about women's role in society generated from the structure of cathexis. Ultimately, these inequalities affect women's physical and emotional health by manifesting as risk factors that increase women's vulnerability to disease (DiClemente & Wingood, 2000).

The present study will focus specifically on the sexual division of power and the structure of cathexis. The sexual division of power refers to inequalities in power and control that exist between sexes and favor males or persons of higher power. This may include discrepancies in the power to act, change or make important life decisions. Disparities in power may be maintained through social mechanisms such as abuse of control in romantic relationships or messages in the media that serve to dis-empower women (DiClemente & Wingood, 2000). Social mechanisms associated with the sexual division of power materialize as both

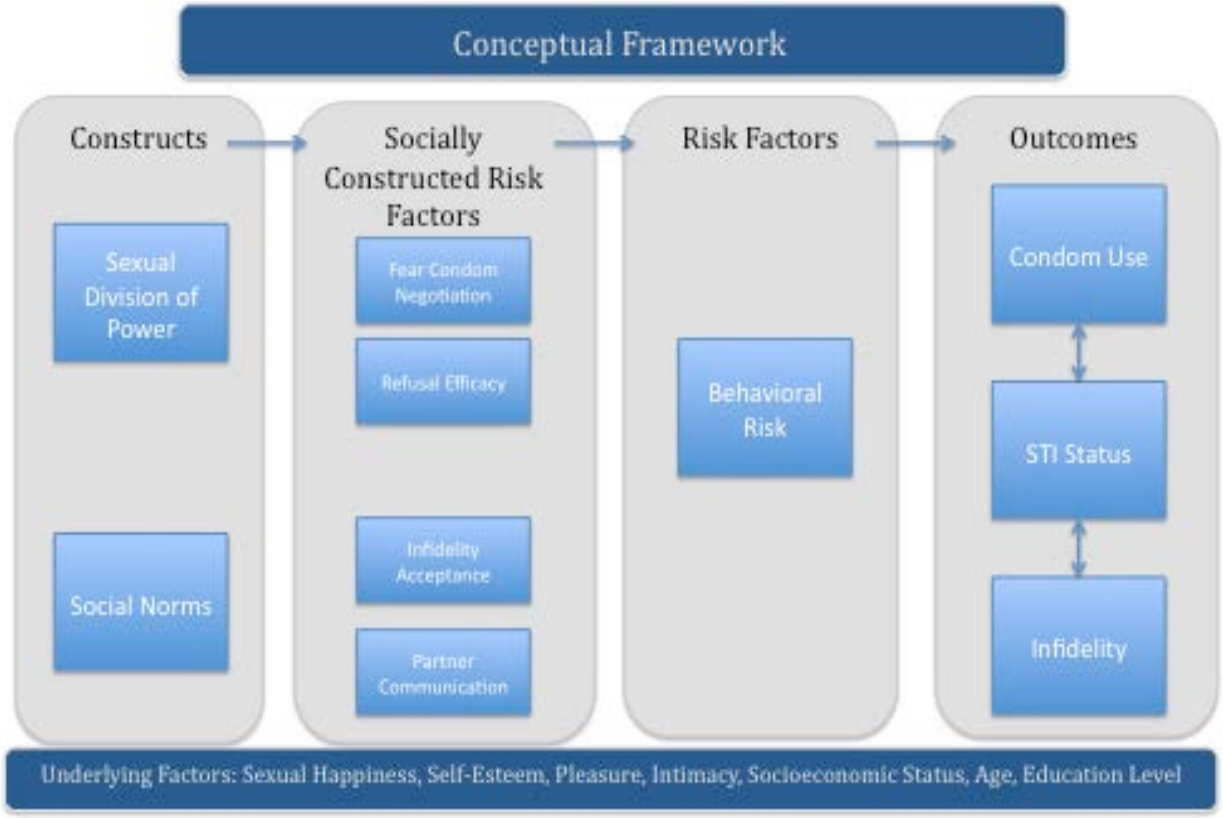
physical and behavioral risk factors. For example, women in unbalanced romantic relationships may be more likely to have a high-risk partner (i.e. disapproves of practicing safe sex, has multiple concurrent partners), which serves as a physical risk factor for STIs/HIV. These women may also be susceptible to behavioral risk factors, such as inability to communicate with their partner (especially around issues of sexuality), low-efficacy to refuse sex/avoid STIs, fear of negotiating condom use with their partner and diminished perceived control within relationships, placing them at even higher risk (DiClemente & Wingood, 2000).

The TGP structure of cathexis, which is also referred to as the structure of social norms and affective attachments, refers to inequalities in norms that exist around "appropriate" behavior for men and women. Disparities in norms may be maintained through social mechanisms such as social constraints in appropriate roles and behavior that favor males (i.e. gender roles, emotions, and stereotypical beliefs for what women and men can do). These social mechanisms associated with the structure of cathexis materialize as social exposures and also have implications for physical health and behavioral risk. For example, women who are more accepting of conventional, male dominant social norms and beliefs may be more likely to have diminished potential for sexual communication (have been told that women should be passive not assertive) or hold conservative norms (acceptable for men to have multiple sex partners) (DiClemente & Wingood, 2000).

These social exposures may also present as personal risk factors such as limited knowledge or low self-esteem/history of depression or psychological distress. As a result, TGP states that women who adopt conventional social norms

will be more likely to experience adverse health outcomes. Moreover, division of power and structure of cathexis interact such that women with pre-existing risk factors are more likely to be burdened with the structure of social norms than women without risk factors (DiClemente & Wingood, 2000). Using TGP as a theoretical framework for the present study allows the researcher to acknowledge how social/societal norms may influence women's sexual health and behavior, specifically in terms of how gender-based risk factors affect women's experiences with male partner infidelity, condom use, and STI status. Ultimately, applying this sociological theory to public health addresses gender-based disparities and asks new broader questions about public health to inform interventions, which address the social environment.

Conceptual Framework



Methodology

The research design for the present study consists of semi-structured qualitative interviews and quantitative secondary data analysis, with the content of the quantitative analysis determining areas that require further exploration in qualitative interviews.

Participants

African American adolescent women who participated at baseline in the AFIYA longitudinal study were the target population for the present study. AFIYA is a 5-year longitudinal, randomized control trial study of 701 African American adolescent women aged 14-20 that aims to reduce both the risk of STIs/HIV in young African American females through a culturally and gender appropriate intervention (group sessions) coupled with an individualized HIV Telephone Maintenance Intervention. Initial eligibility requirements for this study included being female, African American, age 14-20, receiving care at participating clinics, reporting having had unprotected vaginal sex in last 6 months and ability to give written informed consent. Participants were excluded from AFIYA if they were pregnant or trying to get pregnant, married or had any developmental condition that would preclude attending group-based intervention sessions. The primary outcome measure for this study was the proportion of condom protected sexual acts over the last 90 days measured at 6, 12, and 18 months post-randomization, with a secondary outcome measure of incident infection of chlamydia, gonorrhea or trichomoniasis as confirmed by laboratory PCR testing measured at 6, 12, and 18 months post-randomization.

Eligibility requirements for the qualitative piece of this study include having participated in AFIYA at baseline, being assigned to the control condition of the study, and answering “Yes” to the question: “During your relationship with your boyfriend, has he had vaginal sex with another woman?”

Quantitative Measures

Background information. The first section of the quantitative questionnaire included questions about age, highest educational level completed and two items designed to asses socioeconomic status (does your primary care giver currently have a job and do you currently have a job).

Sexual Happiness. This scale was developed specifically for the AFIYA study by Diclemente and Milhausen (2007). It consists of 6 items designed to examined individual differences in sexual happiness by evaluating the varying levels of importance individuals assigned to three specific dimensions of sex: their own sexual pleasure, their partner's sexual pleasure and emotional connection with their partners. This scale included items such as, “How important is it to your sexual happiness that you have an orgasm when engaged in sexual activity?” "How important is it to your sexual happiness that your partner is sexually satisfied?" and "How important is it to your sexual happiness that you feel emotionally close to your partner as a result of your sexual activity?" Participants indicated levels of importance assigned to each item on a 5-point scale ranging from *Not At All Important* (1) to *Extremely Important* (5). Potential scores ranged from 6 to 30, with high scores indicating people who felt that their own sexual pleasure, their partner's

sexual pleasure and emotional connection with their partner were all very important to their sexual happiness. This scale had a Cronbach's alpha of .822.

Self-Esteem. Self-esteem was assessed using the Self-Esteem Scale developed by Rosenberg (1965). This scale consisted of 10 items designed to examine individuals' perceived self-esteem. This scale included items such as, “I feel that I'm a person of worth,” and "I feel I do not have much to be proud of." Participants were asked to indicate how frequently they typically experienced feeling each of the items in their day-to-day life, using a 4-point scale ranging from *Never* (1) to *Always* (4). Potential scores ranged from 10 to 40, with high scores indicating greater perceived self-esteem. This scale had a Cronbach's alpha of .858.

Fear of Condom Negotiation. Fear of condom negotiating was assessed using the Fear of Condom Negotiating Scale developed by Wingood & DiClemente (1998). This scale consisted of 7 items designed to assess women's level of worry about potential negative outcomes that may result from talking about condom use with a male partner. This scale included items such as, “I have been worried that if I talked about using condoms with my boyfriend or sex partner he would threaten to hit me,” and "I have been worried that if I talked about using condoms with my boyfriend or sex partner he would leave me." Participants were asked to indicate how frequently they typically worry about negative outcomes resulting from talking to their partners about condom use, using a 5-point scale ranging from *Never* (1) to *Always* (5). Potential scores ranged from 8 to 40, with high scores indicating greater fear of communicating about condoms with a partner. This scale had a Cronbach's alpha of .871.

Refusal Self-Efficacy. Self-efficacy around refusing sex was assessed using the Refusal Self Efficacy Scale developed by Zimmerman (1996). This scale consisted of 7 items designed to assess women's confidence in their ability to say no to sex with a male partner. This scale captures unbalanced, male dominant power dynamics by measuring women's fear associated with potential outcomes from speaking to their partner about using condoms, such as being ignored, threatened or abandoned. This scale included items such as, “How sure are you that you would be able to say NO to having sex with someone you have known for a few days or less?” and " How sure are you that you would be able to say NO to having sex with someone who is pressuring you to have sex?" Participants were asked to indicate how confident they were in their ability to refuse sex in varying situations, using a 4-point scale ranging from *I definitely can't say no* (1) to *I definitely can say no* (4). Potential scores ranged from 7 to 32, with high scores indicating greater refusal self-efficacy. This scale had a Cronbach's alpha of .815.

Power in Relationship. Power within romantic relationships was assessed using a modified version of the Power in Relationship Scale developed by Pulerwitz, Gortmaker and DeJong (2000). This scale consisted of 17 items designed to assess power dynamics within women's romantic relationships. This scale included items such as, “My partner won't let me wear certain clothes” and "No other man could love me the way my partner does" Participants were asked to indicate their level of agreement with the items, using a 4-point scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (4). Potential scores ranged from 17 to 69, with high scores indicating lower levels of power within romantic relationships. This scale had a

Cronbach's alpha of .720.

Partner Communication. Communication between partners was assessed using the Partner Communication History Scale for Boyfriends developed by DiClemente & Wingood (1998). This scale consisted of 11 items designed to assess how difficult it is for women to ask their male partner's about sexual history and behavior. This scale included two main types of items. The first type included items such as, “How hard is it for you to ask if he has an STD?" and "How hard is it for you to ask if he is having sex with you and other women." Participants were asked to indicate their level of difficulty associated with talking to their partner about the items, using a 4-point scale ranging from *Very Hard* (1) to *Very Easy* (4). The second type asked women to report how many times within the last 90 days they actually had a conversation with their partner about various sexual behaviors, i.e. " During the past 90 days, how many times have you and your boyfriend or sex partner(s) talked about how to use condoms?" Here participants indicated the number of conversations that occurred, using a 4-point scale ranging from *Never* (1) to *7 or more times* (4). For both types of items, potential scores ranged from 0 to 32, with low scores indicating difficulty communicating with partners about sex. This scale had a Cronbach's alpha of .832.

Destructive Arguing Inventory. Communication, in terms of ability to resolve arguments within romantic relationships, was also assessed using the Destructive Arguing Inventory developed by Brody (2000). This scale consisted of 8 items designed to assess how destructive arguments are between individuals in romantic relationships. This scale included items such as, “You and your partner's arguments

are left hanging and unsettled" and "When you and your partner argue, nobody really seems to win." Participants were asked to indicate their level of agreement with the items, using a 5-point scale ranging from *Disagree Strongly* (0) to *Agree Strongly* (4). Potential scores ranged from 0 to 32, with high scores indicating an inability to effectively resolve arguments within a relationship. This scale had a Cronbach's alpha of .711.

Pleasure. Sexual pleasure was measured using three items from the Sexual Dysfunction Scale developed by Milhausen (2007) for the AFIYA study. This modified scale consisted of questions designed to assess how much pleasure women experienced from engaging in sexual intercourse with their main partner. This scale included the items, “How much physical pleasure or satisfaction do you get from sexual intercourse with your main partner or boyfriend?" "How much emotional pleasure or satisfaction do you get from sexual intercourse with your main partner or boyfriend?" and " How much relational pleasure or satisfaction (satisfaction or pleasure related to your relationship) do you get from sexual intercourse with your main partner or boyfriend?" Participants were asked to indicate their level of pleasure associated with each of the items, using a 4-point scale ranging from *None* (1) to *A Great Deal* (4). Potential scores ranged from 3 to 12, with high scores indicating high levels of pleasure received from intercourse with a main partner. This scale had a Cronbach's alpha of .868.

Intimacy. Intimacy was assessed using a scale developed specifically for the purpose of this study. This scale consisted of questions designed to assess how much intimacy existed between women and their main sexual partner or boyfriend.

This scale was comprised of 9 items, including, “I see myself marrying my current boyfriend" and "If I think that I am being used sexually it completely turns me off." Participants were asked to indicate their level of agreement associated with each of the items, using a 4-point scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (4). Potential scores ranged from 4 to 36, with high scores indicating high levels of intimacy with a main partner. This scale had a Cronbach’s Alpha of .711.

Infidelity. Experiences with infidelity were measured using the item, "During your relationship with your boyfriend, has he had vaginal sex with another woman?" Here, participants were asked to respond *Yes* (1) or *No* (0) to whether or not they had experienced infidelity.

Condom Use. Condom use at last sex was measured using the item, "The very last time you had sex, did you use a condom to prevent STDs or pregnancy?" Here, participants were asked to respond *Yes* (1) or *No* (0) to whether or not they had used a condom.

STI Status. STI status was measured using the item, "Have you ever had a positive STD test result?" Here, participants were asked to respond *Yes* (1) or *No* (0) to whether or not they had ever tested positive for a STI.

Qualitative Measures

A semi-structured interview guide directed the qualitative interviews. Interview questions were informed by the constructs Sexual Division of Power and Social Norms within the Theory of Gender and Power. Additionally, quantitative AFIYA questions asked at baseline were used as a framework to determine areas that may benefit from deeper understanding, and were also be included in the

interview guide. For example, the baseline questionnaire includes items such as "How much physical pleasure or satisfaction do you get from sexual intercourse with your main partner or boyfriend?" and "How much emotional pleasure or satisfaction do you get from sexual intercourse with your main partner or boyfriend?" asking participants to respond on a 5 point Likert scale ranging from "None" to "A great deal." The qualitative interviews went beyond quantifying amount of pleasure, to better understand how the physical and emotional pleasure derived through sexual intercourse are understood, valued and how they may overlap or differ within the context of a sexual relationship.

Generally, the domains covered by the guide included previous and current friendship and romantic relationship experiences, sexual pleasure, intimacy and experiences with infidelity. Given the personal nature of some questions regarding sexual behavior, interviews began broadly with general questions about the important relationships in the individual's life to build rapport, and then gradually moved towards more concrete questions surrounding sexual activity. Please see interview guide attached (Appendix 2). A combination of note taking and audio recording was used to collect interview data. Interviews were transcribed verbatim by the principal investigator and audio-checked for accuracy.

Procedure

Individuals who met the inclusion criteria for the qualitative component of this study (N=30) were identified within the existing AFIYA data set and contacted via telephone asking them to participate in a 60-minute one-on-one interview about friendships, romantic relationships and sexual behavior (Appendix 1). From this

larger population, researchers sought to interview a target sample size of 10-15, however, the exact number was dependent on recruitment response rate, the content of completed interviews and when the researcher believed theoretical saturation had been reached. Interviews took place in a private room on Emory's campus and participants were compensated $25 for their time. Written informed consent was obtained from all participants prior to their participation in qualitative interviews.

Quantitative Analysis

Data were analyzed using SPSS, version 18.0, statistical software package. Descriptive statistics were calculated for each of the independent variables, as well as demographic variables (i.e. age, highest grade completed in school, and two items designed to capture socioeconomic status: "Does your primary caregiver have a job?" and "Do you have a job?"). Frequencies were calculated for categorical data and means (sds) were calculated for all continuous data.

Specific aim #1 involved analyzing individual and interpersonal factors to determine how they were related to experiencing male partner infidelity. Means and standard deviations were calculated for individual scales included in analyses. T-tests and chi-squared tests were performed to analyze these relationships. Variables significant at the $p<.2$ level were included the logistic regression model.

Specific aim #2 involved analyzing individual and interpersonal factors to determine how they were related to self -reported condom use at last sex. Means and standard deviations were calculated for individual scales included in analyses.

T-tests and chi-squared tests were performed to analyze these relationships. Variables significant at the p<.2 level were included the logistic regression model.

Specific aim #3 involved analyzing individual and interpersonal factors to determine how they were related to self-reported STI status. Means and standard deviations were calculated for individual scales included in analyses. T-tests and chi-squared tests were performed to analyze these relationships. Variables significant at the p<.2 level were included the logistic regression model.

All variables significant at the p<.2 level were included in the logistic regression models. A separate model was designed for each outcome variable: infidelity, condom use at last sex and self-reported STI status. Variables that were significant at the p<.05 were considered to be significant predictors.

Results

Characteristics of the quantitative sample

The sample consisted of 701 participants between the ages of 14 and 21. The mean age of participants was 17.6 years, (standard deviation (sd)=1.67). All participants were female and African American. The majority of participants were in 9-12th grade (n=368, 52.5%), with 18.5% indicating they graduated high school or had obtained a GED (n=130). In our sample, 58.2.3% (n=408) reported that their primary caregiver was employed, while the majority reported not having a job for which they themselves were paid 63.6% (n=446)(Table 1).

For gender and power variables, participants reported mean levels of power within their relationships of 35.7, (sd=6.3), mean fear of condom negotiation scores of 8.3, (sd=3.2), mean refusal self efficacy scores of 24.6, (sd=3.4), mean partner communication scores of 32.5, (sd=6.4) and mean productive argument score of 14.1, (sd=5.2)(Table 2). For individual level variables, the mean level of intimacy within relationships was 29.9, (sd=4.8), mean level of pleasure from sex was 10.1, (sd=2.3), the mean self-esteem score was 26.9, (sd=2.8) and the mean sexual happiness score was 21.6, (sd=5.1)(Table 3). Nearly 57% of the sample (n=399) reported not using a condom the last time they had sex, and correspondingly, 56.6% of women (n=397) reported receiving a positive STI test result at some point in their lives**.** Moreover, a nearly 20% of women in this study reported experiencing infidelity (n=139)(Table 4).

Bivariate Analyses

Covariates. Relationships between sociodemographic variables (i.e. age, SES, education level) and the outcome variables (i.e. experienced infidelity, condom use at last sex and self reported STI status) that were significant at the $p \leq 0.2$ were controlled for in multivariate analyses. None of the sociodemographic variables were significantly related to condom use at last sex or self reported positive STI status. Reporting having a job was associated with infidelity, such that participants who had not experienced infidelity (n=139, 37.4%) were more likely to report having a job than those who had experienced primary partner infidelity (n=43, 30.9%) (Chi-square=1.825, df=1, p=.177).

Specific Aim #1:

Bivariate statistics and a logistic regression model were created to evaluate factors associated with women's experiences of primary male partner infidelity. Chi-square tests were used for dichotomous variables and independent sample t-tests were used for continuous variables. Sexual happiness, self esteem, condom negotiation abilities, power in relationship, partner communication, ability to resolve arguments with partner, pleasure and intimacy variables, as well as condom use and self reported sti status, were evaluated to determine the relationship they had with experiences of infidelity. Factors that were significant at the $p \leq 0.2$ were controlled for in subsequent multivariate analyses.

No significant differences were observed between sexual happiness ratings or levels of self esteem between women who had experienced male partner infidelity and those who did not (t=.272 df=509, p=.785) and (t=-.713 df=509, p=.476) respectively. Women who reported experiencing partner infidelity did, however, have significantly higher levels of fear in regards to negotiating condom use (mean=9.04, sd=4.26) than individuals who did not report partner infidelity (mean=8.01, sd=3.09) (t=-2.986, df=509, p=.003). Similarly, women who experienced infidelity reported having significantly less power in their romantic relationships (mean=38.2 sd=6.06) than individuals who did not report partner infidelity (mean=35.90, sd=5.65)(t=-4.09 df=509, p<.001).

Correspondingly, women who experienced infidelity also reported having less ability to communicate with their partners (mean=32.04 sd=6.19), compared to individuals who did not report partner infidelity (mean=33.68, sd=6.85)(t=2.59,

df=509, p=.010). Women who experienced infidelity also reported greater difficulty resolving arguments with their partners productively (mean=15.91 sd=4.62) compared to women who did not experience infidelity (mean=12.91, sd=5.12)(t=-6.07, df=509, p<.001). In terms of intimacy, results showed that women who reported experiencing partner infidelity reported significantly lower levels of intimacy (mean=29.49, sd=4.66) than individuals who did not report partner infidelity (mean=30.43, sd=4.65) (t=2.042, df=509, p=.042).

Finally, there was no significant difference for condom use at last sex between individuals who reported infidelity and those who did not (Chi-squared=1.12, df=1, p=.289); however, self reported STI status was associated with infidelity, such that participants who had experienced infidelity were more likely to report having a positive STI result (n=100, 79.7%) than those who had not experienced primary partner infidelity (n=39, 59.1%) (Chi-square=16.65, df=1, p<.001). Refusal self efficacy and pleasure also reached a significance level of p<.02 and thus, were considered as covariates in the model.

Controlling for participant having a job, fear of condom negotiation, refusal self efficacy, partner communication, ability to resolve arguments with partner, pleasure, intimacy and self reported sti status: individuals who have unbalanced, male dominant, power dynamics in their relationships are 1.043 times more likely to have reported partner infidelity than those who have more balanced power structures (AOR=1.043; 95% CI: 1.004, 1.083, p=.03). In other words, for each unit increase in perceived male power within a relationship, the odds of experiencing infidelity increase by 4.3%. Additionally, for each unit increase in inability to resolve

partner disagreements, the odds of experiencing infidelity increases by 11% (AOR=1.11; 95% CI: 1.061, 1.165, p<.001). Finally, individuals who reported having received a positive STI test result were 2.54 times more likely to report experiencing infidelity than individuals who have never received a positive STI test result (AOR=2.54, 95% CI: 1.62, 3.99, p<.001). Having a job (AOR=.776, p=.272), fear of condom negotiation (AOR=1.03, p=.352), refusal self efficacy (AOR=1.01, p=.746), partner communication (AOR=.992, p=.641) and intimacy (AOR=.981, p=.520) were not found to be significant predictors of infidelity (Table 5).

Specific Aim #2:

Bivariate statistics and a logistic regression model were also created to evaluate factors associated with self-reported condom use at last sex. Sexual happiness, self esteem, condom negotiation abilities, power in relationship, partner communication, ability to resolve arguments with partner, pleasure and intimacy variables, as well as partner infidelity and self reported sti status, were evaluated to determine the relationship they had with condom use at last sex. Factors that were significant at $p \leq 0.2$ in bivariate analyses were included as predictor variables in the logistic regression model.

Women who reported using a condom at last sex assigned significantly lower levels of importance to individual and partner pleasure for their sexual happiness (mean=21.09, sd=5.27) than women who did not report using a condom at last sex (mean=22.01, sd=5.00) (t=2.37, df=699, p=.018). In terms of power, women who used a condom at last sex reported having significantly more power in their romantic relationships (mean=34.75, sd=6.47) than women who did not use a

condom at last sex (mean=36.49, sd=6.09) (t=3.67, df=699, p<.001). Similarly, women who used a condom reported greater ease communicating with their partner (mean=33.4, sd=5.94) compared to women who did not report using a condom (mean=31.79, sd=6.69) (t=-3.3, df=699, p=.001).

Individuals who used a condom reported deriving less physical, emotional and relational pleasure from sexual experiences with their partner (mean=9.86 sd=2.4) than women who did not use a condom (mean=10.25, sd=2.22)(t=2.26, df=699, p=.024). Additionally, women who used a condom reported marginally significant lower levels of intimacy (mean=29.48, sd=4.89) than women who did not use a condom (mean=30.19, sd=4.7) (t=1.73, df=555, p=.084). Self-esteem, fear of condom negotiation, refusal self efficacy and ability to resolve arguments also reached a significance level of p<.02 and thus, were considered as covariates in the model. Finally, there were no significant differences in experiences with partner infidelity (Chi-squared=1.12, df=1, p=.289) or self reported STI status (Chi-squared=.209, df=1, p=.648) among individuals who used a condom at last sex and those who did not. Chi-square and t-tests that found significant relationships were included in the model.

Controlling for sexual happiness, self esteem, fear of condom negotiation, refusal self efficacy, ability to resolve arguments with partner, pleasure and intimacy: individuals who have unbalanced, male dominant, power dynamics in their relationships are 3.3% less likely to have reported using a condom at last sex than those who have more balanced power structures (AOR=.967; 95% CI: .937, .999, p=.041). In other words, for each unit increase in male dominant power within

a relationship, the odds of using a condom decreases by 3.3%. Additionally, for each unit increase in partner communication, the odds of using a condom increases by 6.1% (AOR=1.061; 95% CI: 1.029, 1.093, p<.001). Sexual happiness (AOR=.977, p=.425), self esteem (AOR=.985, p=.662), fear of condom negotiation (AOR=.995, p=.868), refusal self efficacy (OR=.986 p=.619), ability to argue productively (AOR=.994, p=.769), pleasure (AOR=.915, p=.095) and intimacy (AOR=1.001, p=.988) were not found to be significant predictors of condom use (Table 6).

Specific Aim #3:

Bivariate statistics and a logistic regression model were also created to evaluate factors associated with self-reported STI status. Sexual happiness, self esteem, condom negotiation abilities, power in relationship, partner communication, ability to resolve arguments with partner, pleasure and intimacy variables, as well as partner infidelity and condom use at last sex, were evaluated to determine the relationship they had with STI status. Factors that were significant at $p \leq 0.2$ in bivariate analyses were included as predictor variables in the logistic regression model.

No significant differences were observed in sexual happiness ratings (t=-.677, df=699, p=.499), refusal self efficacy (t=-.099 df=699, p=.921), power within relationships (t=-1.07 df=699, p=.286) ability to resolve arguments (t=-.44 df=699, p=.663) or intimacy (t=.363 df=555, p=.717) between women who reported a positive STI result and those who did not. Women who reported receiving a positive STI test result reported marginally higher levels of fear in negotiating condom use with their partners (mean=8.43, sd=3.32) than women who did not report a positive

test result (mean=8.02, sd=3.07)(t=-1.69, df=699, p=.092). They also reported deriving marginally more physical, emotional and relational pleasure from sexual experiences with their partner (mean=10.21 sd=2.2) than women who did not receive a positive test result (mean=9.92, sd=2.43)(t=-1.66, df=699, p=.097).

Finally, self-reported STI status was associated with infidelity, such that participants who reported a positive test result were more likely to have experienced infidelity (n=100, 71.9%) than women who had not received a positive test result (n=193, 51.9%) (Chi-square=16.65, df=1, p<.001). Self-esteem and partner communication also reached a significance level of p<.02 and thus, were considered as covariates in the model. There were no significant difference, however, in condom use at last sex (Chi-squared=.209, df=1, p=.648) among individuals who used had a positive STI test result and those who did not. Chi-square and t-tests that found significant relationships were included in the model.

Controlling for self esteem, fear of condom negotiation, partner communication and pleasure: individuals who experienced infidelity were 2.32 times more likely to have reported a positive STI test result than those who did not experience infidelity (AOR=2.32; 95% CI: 1.509, 3.563, p<.001). Self esteem (AOR=1.05, p=.177), fear of condom negotiation (OR=1.02, p=.445), partner communication (OR=.982 p=.225 and pleasure (OR=1.07, p=.131) were not found to be significant predictors of positive STI status (Table 7).

Qualitative

Themes that emerged from one-on-one, in depth, qualitative interviews provided a rich context to better understand the quantitative findings. With respect

to specific aim #1, data analysis provided critical knowledge as to some of the factors associated with women's experiences of infidelity, and demonstrated a significant relationship between infidelity and positive STI test results. However, these quantitative data alone failed to capture what factors motivated women to remain in relationships where infidelity was taking place, and thus continue to place themselves at higher risk of disease. Qualitative interviews among women who experienced infidelity allowed for a deeper exploration of what contributed to acceptance or tolerance of male partner infidelity.

Demographics

A total of 7 African American women who resided in the metro Atlanta area, participated in AFIYA at baseline and answered "Yes" to the question "During your relationship with your boyfriend, has he had vaginal sex with another woman?" participated in one on one, in depth interviews. Participants were recruited via telephone over the course of three months, December, January and February.

Research questions guiding the acceptance of partner infidelity theme include:

1. What were some of the reasons you decided to stay with/leave your partner after you found out he cheated?
2. How did your partner's infidelity change your sex life?
3. How is male infidelity viewed by your community?

Thematic Analysis

Qualitative analyses revealed that women respond in many different ways to experiences with infidelity. Although some women chose to end their relationships

upon learning their partner had been unfaithful, other women chose to remain in relationships with their partners. Several themes surrounding tolerance of male infidelity emerged across transcripts.

A major theme that materialized was that women wished they learned about infidelity from their partner, rather than from other sources such as friends, Facebook or other women. One woman shared:

"I got locked up. And when I got out, he wasn't going to tell me, so I had to find out from the female that they had intercourse,"

While another woman said:

" I was upset because he didn't tell me. I've always been the type of person like, just let me know what's going on and give me the chance to decide, don't leave me out of the loop, so that was really the thing that hurt me the most... he didn't tell me I had to find out on Facebook."

It goes without saying that infidelity is damaging to a relationship. Even when women decide to continue such relationships, the women reported that the nature of the relationship changed. When asked how her partner's infidelity changed the relationship, one woman indicated she lost emotional closeness with her partner, saying:

"I look at him like I look at any other male...I look at him like he's not even a fiancé or a baby's daddy to me."

Similarly, another woman voiced:

" I just decided to let it go because the emotional connection wasn't there anymore...I didn't feel the love for him any more, I couldn't trust him, it was just like a friendship or a roommate situation."

Additionally, women reported that infidelity put a strain on their ability to interact with their partners. One woman summed this up saying:

"from there, like the relationship just escalated in terms of us not trusting each other… we would argue."

Women's desire to seek out male attention outside the relationship or exact revenge on their partner was also a theme that emerged in response to experiences with infidelity. One woman described:

" I didn't trust him anymore so...that's when I started dealing with the other guys."

While another woman shared more directly:

"We was workin it out and I was like, since you went out and cheated I'm going to go out and cheat, since you had sex with someone else, I was going to go have sex with someone else."

Infidelity also had implications for intercourse within relationships. One woman reported that she and her partner had a healthy sex life before she found out he had slept with another woman; however now:

"Basically he don't sleep by me and I don't sleep by him."

Similarly, another woman voiced that she would not have sex with her partner when she suspected he was with other women:

"I found out about the girls so… um… I didn't… like he would still come spend the night with me and stuff but I didn't really have sex with him because he was dealin with other women… um… during a point when I felt like ok he's not dealin with her anymore then I we would have sex."

Despite this apparent loss of intimacy and emotional connection, many women decided to remain in their relationships. Different reasons were given for maintaining relationships with partners who had been unfaithful. One main theme reiterated across interviews was a sense of not wanting to have wasted time, especially with long-term relationships. One woman best exemplified this saying:

"I been with him for too long. Like this is the longest I've been in a relationship with anybody. And I'm not going to let three years go to waste for nothing."

Women also cited desire to keep the family together as a reason for accepting partner infidelity, one woman shared:

"It wasn't worth leaving him and not letting him see his kids because that it'll be on my part not on his part."

In this case, since her partner still wanted to be part of the family, she didn't want to be in the position of making the choice for him, despite his actions. Another woman also reported trying to stay together for their child, saying:

"I was trying to make it work so she could be a happy baby but she still happy without him, she still got both of us."

In this case, however, desire to remain together for the child was not enough to make the relationship last.

Women not wanting to be in the position to restrict their partner's options was also a sentiment echoed across interviews. One women who had experienced physical abuse shared:

> *"Um… I ended up dropping the charges cause I wanted him to like, I didn't want me to feel like I was the person that had anything to do with him like, not being in school or hindering anything."*

Even in cases where women were mistreated, they still reported not wanting to inconvenience their partner. This finding specifically highlights the gendered power dynamics that can exist between men and women.

Additionally, vulnerability was cited as a main reason for remaining in these relationships. When asked why she remained with her partner after his infidelity, one woman responded:

> *"I guess out of vulnerability and stupidity...I guess I stayed with him cause I kinda felt like I didn't really have much of a choice."*

Self-esteem also contributed to this individual's vulnerability. She shared:

> *"I had self esteem issues like really bad cause I'm so dark, so like I will always get picked on or whatever… um… so I guess it was like a lot of emotional reasons."*

By sharing this she suggests that low self-esteem about her appearance contributed to her tolerance of her partner's infidelity, and perhaps a skewed view of her sexual options. This idea was reinforced by another woman who shared:

> *"like I think if a boy is telling a girl with low self esteem all this I don't use condoms and stuff and she might really like him and might not have*

opportunities with a lot of boys she may be like I'm willing to try anything to keep him."

Environmental factors, such as social support, also seem to play into an individual's acceptance of infidelity. One woman described the transition to college as a particularly difficult time:

"you get to school you don't really know anybody so it's like oh my gosh like I don't really like it here… um… I had to make new friends type of thing, so I spent so much time with him, so I didn't even really have any friends...had I spent less time with him like I prolly woulda made friends like quicker."

This individual admits that she was using her relationship as a coping mechanism to help her through a difficult time:

"It [her relationship] was more of a comfort thing once I got past my self esteem issues...I was like, ok well, it's just easier you know to deal with the bull crap cause I don't have any friends I don't really know anyone. "

Doing so, however, served to limit her social support system.

Women who remained in unfaithful relationships also seemed to find ways to minimize the damage associated with their partner's infidelity. For example, one woman explained:

"*If a female say that it's your child and the male wants a DNA test but you decides that you don't want one, you obviously hiding something. Either it's his or not his. And the little girl, I seen her a couple of time but she don't like none of his family or him. She don't like for nobody to touch her."*

Another woman shared:

"We were like on again and off again but… um… so it was kinda cheating kinda not cheating type thing but I accepted a lot… um… in those three years that we were dating or in a relationship… um… and there were like yeah lotta women so..."

Here women use unstable relationship status and doubts about whether their partner is the father of outside children to soften the consequences of their partner's behavior.

Across interviews, women who decided to remain in these relationships were not blind to the possibility of future infidelity. When asked if she was worried about the idea of her partner cheating on one woman replied:

"Not really cause if he do, once a cheater, always a cheater. So I don't be studdin it... just wouldn't pay it no mind because I know who he be home with and who he comes home to so."

Here it becomes clear that for some women, so long as they are the primary partner or "one he comes home to," what happens sexually outside the relationship does not carry as much weight. A woman in a relationship with another woman also expressed similar feelings:

"when we really just start falling for each other it's like here go this female here go this female okay, but at the end of the day I wasn't too much worried about it because we was going to be together either way it goes, me for my own words, I wasn't going to let nothing like that just come between us."

Another woman also shared:

"I was like, I wouldn't care if you messing around, just have a baby on me... ima still be here regardless."

These interviews also revealed many cultural factors that contributed to women's tolerance of partner infidelity. One woman shared:

"I can't say anything for other cultures but I know African American women...like in the past decades ago the mindset of a woman was you take care of the home if your husband cheats I mean it's okay like you just accept it type thing. You usually you have to do what you have to do for your relationship. And I'm guessing a lot of it has to do back then because you know women couldn't do for themselves… um …past a certain point in history."

Even though times have changed, women still indicated that their friends would likely remain in relationships where infidelity was taking place, one woman shared:

"her and I have had these conversations and she's like well if I'm in a relationship with my husband like I don't think I would leave him just because he's cheating. So I'm not sure exactly what would get her to the point where she would leave him..."

Another motivating cultural factor driving acceptance of partner infidelity was the perceived lack of "good men" in the community. This notion was best exemplified by one woman who said:

"Now I think it's there's not that many men because...so many men are in jail so many men are homosexual… um… so now I think it's well I need to stay with him because if he leaves me like what if I don't find anyone else or …um… I need

to accept him cheating because if not then he's gonna leave me for someone else who will accept this type of thing."

Another shared:

"Umm…I would say most of them are locked up, most of them are selling dope and who wants a boyfriend who does that you can't get not good living out of that but there is some good men whose out there in school but you really gotta find them, you really gotta look hard."

This idea was also reiterated in a story one woman shared about a close friend:

"I know she hadn't dated in a while so when they got together it was kinda "i finally have somebody" kinda feeling with her so I think when that happened she was kinda afraid of being alone again...so they just got back together."

Across interviews, women also reported the belief that men in the community were conscious of the unbalanced ratio between men and women, and even took advantage of it. One woman said:

"they [men] done got away with it so much that they just like oh yea I can get away with it this time or they might see somebody else they are attracted to and be like I just gotta have her"

Religion also emerged as a cultural factor that may indirectly contribute to acceptance of male partner infidelity. One participant shared:

"Some people really love to quote the bible....in the bible the men have multiple wives… um… tribes in Africa in other countries they or they… um… have multiple wives it's okay for the man to do that and then now also because there's been such an emphasis on the ratio of men to women especially in black

America they talk about it all the time… um… I think it's becoming more acceptable."

Finally themes emerged around infidelity and receiving positive STI test results. Two women interviewed reported contracting STIs as a result of their partner's infidelity. One woman shared:

"We started using a condom and then we weren't using one and when we weren't using one he cheated on me and I ended up with chlamydia."

While another woman said:

"When I first got pregnant, he cheated well he didn't cheat he left me to go to a younger girl that he used to be in love with and the girl she was out there so she had ghonnorhea and crabs and he came back to me and gave it to me and that just ended our whole relationship."

However, receiving a positive STI test did not necessarily result in women leaving their partners. In speaking about a friend, one woman shared:

"I forget what she got but it was something serious and...they did end up getting back together after all of it, I guess cuz he admitted that he did cheat and he apologized."

Discussion

This baseline sample of African American adolescent women from Metro Atlanta reported low levels of condom use and high prevalence of STIs, similar to national averages (CDC, 2008). Moreover, a significant number of women in this study reported experiencing infidelity, indicating that this life event, and the

relationship factors that are associated with it, may be particularly relevant to poor sexual health outcomes.

The sociodemographic variables included in this study: age, education level and two items designed to assess socioeconomic status (Does your primary care giver have a job? and Do you have a job?) were not significantly related to the outcome variables condom-use or self reported STI status. It is possible that since all of the women screened into this study were African American, between the ages of 14-18 and recruited from clinics in Atlanta, there was not much differentiation between participants on these variables. Moreover, there was not an item that measured household monthly income directly, thus it is difficult to tell whether the items selected to indicate SES were truly valid. For example, answering "Yes" to the question "Do you have a job" may indicate low SES if an individual is required to work to help provide for their family, or may simply be a reflection of a teenager wanting to work part time earn more spending money. That being said, individuals who reported having a job were significantly less likely to have reported experiencing infidelity. The interpretation of this finding is two-fold, first women without boyfriends were significantly more likely to have jobs than women with boyfriends, and thus less likely to experience infidelity. Secondly, women with boyfriends were significantly more likely to report receiving financial assistance from their partner, and thus may not require a job of their own.

A key finding, in line with the hypotheses, was that experiencing infidelity was significantly predictive of receiving a positive STI test result. This finding is consistent with the previous literature, and highlights the reality that partner

infidelity places women at increased risk for sexually transmitted infections. As a result, it is particularly important that women have the power to negotiate condom use or end relationships with unfaithful partners to protect themselves from disease. Additionally, it is crucial that women are able to communicate with their partners effectively in order to achieve these goals.

Decreased power within romantic relationships and inability resolving arguments effectively, however, were found to be significant predictors of infidelity. These finding suggests that women who experience infidelity may be in unbalanced relationships where they feel unable to negotiate condom use, vocalize their sexual needs or have the power leave a relationship where infidelity is taking place. Similarly, women who reported difficulty resolving arguments with their partners indicated that many times arguments were left unsettled, or that individuals stayed mad at each other for days, This may be particularly relevant, in that it may contribute to women's inability negotiating condom use, or discomfort voicing sexual concerns for fear they may incite a difficult, seemingly irresolvable conflict by doing so. Taken together, these findings are very much in line with the Sexual Division of Power construct within the TGP, which asserts that reduced sexual power within a relationship may serve as a physical risk factor for disease.

These same findings hold true in regards to condom use at last sex. Women's power within a relationship and ability to communicate with her partner around issues of sexuality were predictive of condom use at last sex. Women reported reduced power in their romantic relationships were less likely to use a condom than women had higher levels of power. Moreover, women who had difficulty

communicating with their partner about sex were less likely to report using a condom. These finding suggests that women with reduced relational power and who experienced difficulty communicating with their partners, were less able to negotiate condom use. Again these findings are in line with Sexual Division of Power and Social Norms constructs within the TGP. In terms of Sexual Division of Power, women's reduced relational power resulted in decreased condom use, placing women at higher risk of poor sexual health outcomes. As far as Social Norms, it is possible that pervasive social norms, such as the perception that women should be passive or not think/talk about sex, may be interfering with women's abilities to communicate with their partners. Here this social mechanism has implications for condom use, and ultimately manifests as a behavioral risk factor for disease.

Women who used a condom at last sex also reported significantly lower sexual happiness scores than women who did not report using a condom at last sex. This sexual happiness scale asks women to indicate how important items such as having an orgasm, feeling emotionally close to their partner or whether of not their partner has an orgasm are to their own sexual happiness. Thus, this finding suggests that for women who use condoms there may be factors beyond individual or partner sexual pleasure that contribute to their overall sexual enjoyment. Similarly, individuals who used a condom reported deriving less physical, emotional and relational pleasure from sexual experiences with their partner than women who did not use a condom. Again this finding is somewhat ambiguous, it is possible that condoms may decrease pleasure (not feeling as good physically, creating a barrier emotionally, leading to tension between women and their partners relationally).

However, these women are still using condoms, so this finding may also point to the notion that there is something beyond these dimensions of pleasure that women desire from intercourse. Sexual happiness and pleasure were not predictive of condom use in the logistic regression model; however, these significant findings highlight the need for future research around women's motivations for intercourse in order to increase condom use.

Qualitative interviews give greater clarity to understanding the power dynamics and factors that motivate women to remain in relationships where infidelity is taking place. Qualitative findings suggest that there are several interpersonal and cultural factors that influence tolerance of male partner infidelity. A main theme that emerged was women's desire not to feel like they "wasted time" by ending long-term relationships, even after learning about infidelity. It is possible that this response may serve as a means of reclaiming power in the face of their partner's actions. For example, they did not have any direct power over their partner's infidelity, however the decision to maintain the relationship is something often in women's control. Given the quantitative finding that reduced relationship power is predictive of infidelity, this qualitative theme may highlight tolerating infidelity as a mechanism to increase women's perceived power.

Another theme that emerged was women's desire not to be the one to restrict her partner's access to anything, especially children. This finding suggests a power structure where even when women have been victims of infidelity, they are still making choices that place their partners needs foremost. Moreover, this finding suggests an overarching sense of duty felt by women to their partners and their

families. Similar to the finding above, it is possible that the strength necessary to keep relationships and families together may empower women and provide a sense of purpose and control they may not receive within their romantic relationships.

Qualitative findings also suggested that male dominant power structures and social norms might also influence women's acceptance of partner infidelity more directly. A theme expressed across interviews was that women remained with their partners because they felt vulnerable, or that their sexual choices were limited. In accordance with the TGP it is possible that these feelings of vulnerability are rooted in socially constructed and sustained male power structures. For example, qualitative findings suggest that these feelings may be reinforced by cultural realities, such as low ratios of men to women in African American communities as a result of the disproportionate number of men behind bars, giving the limited number of available men even higher levels of relational power.

This reality also has the power to shape social norms around "appropriate" ways for men and women to behave. Women across interviews indicated that culturally, infidelity was more acceptable for men, and institutions, such as the Church and media, served to reinforce these norms. These norms were also reinforced on an interpersonal level. It seems that the increased ratio of women and existence of women who tolerated infidelity, work together to create a permissive environment where men feel they could find a woman that would tolerate infidelity, even if that is not their current partner. Cyclically, this may reinforce women's own acceptance of partner infidelity, as they may feel cultural pressures to make compromises to keep their romantic relationships afloat. Here, when infidelity

becomes normative, it seems women are forced to prioritize being the primary partner or the "one he comes home to" above being the only partner. This may be even further reinforced by residual power dynamics from past decades where women's employment options were extremely limited.

Limitations

The mixed methods research design was of particular value to the proposed research questions. The in-depth qualitative interviews allowed for a deep understanding of the context in which these women make their sexual choices that quantitative data could not provide alone. Conversely, the quantitative markers collected in this data set such provided concrete information about condom use outcomes and STI status that could not be gained from just from qualitative interviews. Given the complexity of the proposed research questions, combining these two approaches allowed for the best information possible, analyzing data in a way that did not lose sight of the context in which it was created.

This method, however, was not without its limitations. First, given that the AFIYA study is longitudinal and nearing the end of its 5 years the age range of women recruited to participate in qualitative interviews had shifted. As a result, all women who took part in these interviews were between 18-24 rather than 14-20. Thus, the quantitative data collected at the initial time point is likely not reflective of how these women might answer today. Further, this reality does not lend support to stratifying qualitative interviews by age. There are likely important developmental differences surrounding intimacy, pleasure and relationship dynamics that exist

between women age 14-16 and 17-20, however this age distinction does not seem as relevant when the age range is shifted to 18-24.

Moreover, the choice to recruit individuals who reported experiencing infidelity in a relationship may also be both strength and a limitation. Limiting the sample to these individuals ensured that the women interviewed had experienced infidelity in the past and thus, were better able to speak to the context of their relationship in which it existed, and the factors that motivated them to either continue or end their relationships. On the other hand, however, limiting the sample to women who had previously experienced infidelity greatly reduced the sample of women to be recruited, resulting in a low number of qualitative interviews completed. Although a great deal of information was gained through these seven qualitative interviews, these findings are not generalizable and future research should seek to interview more women and create scales to better capture information about the tolerance of male infidelity quantitatively. Finally, only the primary investigator for this study transcribed, coded and analyzed the qualitative data. Although every effort was taken to ensure objectivity, without multiple coders and inter-rater reliability assessments, it is impossible to know whether or not the data were interpreted universally.

Implications

Much work has been done to identify the risk factors that lead to STIs/HIV among African American adolescent women; however, little research has expanded beyond merely establishing these relationships to better understand the specific contexts in which they occur. As a result, the present study filled existing gaps in the

literature by exploring the relevant and previously under-researched area, acceptance of partner infidelity, to gain better insight into specific cultural and gendered power structures in this population with their serious implications for condom use and STI/HIV acquisition.

Although this study was not without limitations, results showed that there was a high prevalence of positive STI test results, low prevalence of condom use at last sex and a clear relationship between experiences with infidelity and having contracted an STI, in this sample of African American adolescent women. Male dominant power dynamics within romantic relationships were found to be predictive of experiencing infidelity and failure to use a condom at last sex. Additionally, the Sexual Division of Power and Social Norms constructs within the TGP were found to be factors both directly and indirectly influencing women's decisions to tolerate infidelity and remain in relationships with unfaithful partners.

The results of this study indicate that future research should evaluate relational power structures as a particularly powerful determinant of behavior. New interventions are necessary to increase condom use and reduce STI prevalence, however, individual level research and interventions may not be the most effective way to reduce poor sexual health outcomes in this population. The relationships that emerged between Sexual Division of Power and Social Norms constructs of the TGP suggest that there are larger, societal-level factors influencing behavior. As a result, future research should focus on reducing the negative effects of these macrosocial influences. Future interventions should integrate female empowerment, work to change existing social norms around appropriate behavior

for men and women, and teach coping mechanisms for cultural realities, to improve condom use outcomes and reduce the prevalence and incidence of STIs/HIV in the African American community.

This study was the first to apply the Theory of Gender and Power to the issue of acceptance of partner infidelity. As a result, the exploratory nature of the qualitative portion of this mixed methods application should give birth to future research questions in this area. Moreover, these findings about the relationships between gender, power and infidelity should propel the field forward by encouraging the continued use of societal level theories to better understand the intricate context of individual-level behavior.

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Appendix 1

Greetings AFIYA Sista,

We thank you so much for your past involvement in the AFIYA program. We are currently recruiting women who participated in AFIYA to take part in an additional interview during the coming winter months.

What we need you to do is:

- Meet for one 60-minute one-on-one interview about friendships, romantic relationships and sexual behavior.

You will be compensated $25 for your time.

Thank you in advance for taking the time to share your experience in order to help improve the health and well-being for other young women.

We anticipate a big response, so please call Kelly at 313-737-9019 to schedule your interview time.

Appendix 2

Thesis Interview Guide

This interview guide is divided by main themes. These have been organized in a way so as to logically flow from one question to the next, however, the order may change depending on the flow of each individual interview. Potential probes are also listed for many questions. These may or may not need to be used, depending on the richness, depth and detail of participant responses.

Interviews will begin with a brief introduction explaining that I am a student from Emory and will be asking a few questions about relationships. I will inform participants that there are no right or wrong answers but rather, I am interested in their personal experiences. I will also remind them they may discontinue the interview at any time. Interviews will end on an empowering, positive note by asking participants to discuss a time when they successfully negotiated condom use with a partner.

Opening Questions

Tell me about some of the important relationships you have in your life…

> *Sample probes: Of your relatives or caregivers, who was important to you and why? Tell me about your closest friend(s), What are some of the things you like most about this person? When was your last romantic relationship and what can you tell me about this relationship?*

Female Pleasure/Intimacy

Women define intimacy in many different ways, how would you define intimacy?

> *Sample probes: How are some of the ways you experience intimacy in your romantic relationships? Describe an example of intimacy within your most recent relationship? How might your friends define intimacy or experience intimacy with their current sexual partners?*

Tell me about the last time you had sex without a condom....

> *Sample probes: What were you doing that day? What did your partner mean to you? What are some of the things you enjoyed, what are some of the things you didn't enjoy? How might this encounter have affected your relationship with this person in any way? How might this experience have been different if you had used a condom? What role did you play in this decision? How might this situation have been different if you were the man?*

Partner Infidelity

Tell me about any experience you have had with a boyfriend cheating on you...

Sample probes: How did his cheating change your relationship? What were some of the reasons you decided to stay with him/leave him? Describe your sex life with him like after found out he had cheated? How might your friends have acted if they had a boyfriend cheat on them? Why might they choose to stay with/leave her partner after he cheated on them?

Empowerment

Tell me about the last time you had sex with a condom...

Sample probes: What led up to having sex? What did your partner mean to you? Why did you decide to use a condom? Who's decision was it to use a condom? How sexually satisfied were you with this encounter? What might have made it better/worse? What role did you play in this decision? How might this situation have been different if you were a man?

Is there anything else you would like to add?

Tables

Table 1: Demographic Information

Variable	**N**	**%**
Grade 9th-12th Graduated/GED	 368 130	 52.5% 18.5%
Caregiver Employment Yes	 408	 58.23%
Participant Employment No	 446	 63.65%
	Mean	**Standard Deviation**
Age	17.6	1.67

Table 2: Descriptives TGP Independent Variables

TGP Variables	**Mean**	**(Min, Max)**	**Standard Deviation**
Power within Relationship	37.5	(17, 63)	6.3
Fear of Condom Negotiation	8.3	(7, 35)	3.2
Refusal Self Efficacy	24.6	(7, 28)	3.4
Partner Communication	32.5	(11, 44)	6.4
Inability to Resolve Arguments	14.1	(0, 32)	5.2

Table 3: Descriptives Individual Level Independent Variables

Variables	**Mean**	**Min, Max**	**Standard Deviation**
Intimacy	29.9	(14, 39)	4.8
Pleasure from sex	10.1	(3, 12)	2.3
Self-Esteem	26.9	(10, 37)	2.8
Sexual Happiness	21.6	(6, 30)	5.1

Table 4: Descriptives Outcome Variables

Variables	**N**	**%**
Experienced Infidelity	139	19.8%
Did not use a condom at last intercourse	399	56.7%
Received positive STI test result	397	56.6%

Table 5: Predictors of Infidelity

	Fidelity		Infidelity		p	AOR	CI
Predictor Variables							
TGP Related Risk Factors	**x**	**(sd)**	**x**	**(sd)**			
Diminished Power within Relationship	35.9	(5.7)	38.2	(6.1)	.03	1.043	(1.004, 1.083)
Inability to Resolve Arguments	12.9	(5.1)	15.9	(4.6)	<.001	1.11	(1.061, 1.165)
Have you received a positive STI test?	**n**	**%**	**n**	**%**			
Yes	39	59.1%	100	79.7%	<.001	2.54	(1.62, 3.99)

* Controlling for participant having a job, fear of condom negotiation, refusal self efficacy, partner communication, pleasure and intimacy

Table 6: Predictors of Condom Use

Predictor Variables	Used Condom		Did NOT Use Condom		p	AOR	CI
TGP Related Risk Factors	**x**	**(sd)**	**x**	**(sd)**			
Diminished Power within Relationship	34.8	(6.5)	36.5	(6.1)	.041	.967	(.937, .999)
Ability Communicating with Partner	33.4	(5.94)	31.8	(6.7)	<.001	1.06	(1.029, 1.093)

Table 7: Predictors of Positive STI Test Result

Predictor Variables	Has NOT received positive STI test		Has received positive STI test		p	AOR	CI
During your relationship has your boyfriend had vaginal sex with another woman?	**n**	**%**	**n**	**%**			
Yes	193	51.9%	100	79.7%	<.001	2.32	(1.509, 3.563)