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The Influence of Trauma History and Relationship Power on Latinas' Sexual Risk for HIV/STIs

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Abstract

A community sample of Latinas completed surveys that included measures of sexual abuse and intimate partner violence history, relationship power, negotiating power regarding condom use, perceived HIV/STI risk of sexual partner, and sexual behavior. Over half of the women reported a history of intimate partner violence in the past year and/or sexual abuse in their lifetime. Intimate partner violence was correlated with lower overall sexual relationship power scores, while sexual abuse was correlated with lower condom use negotiating power. More extensive intimate partner violence had the strongest association with higher HIV/STI risk, controlling for relationship status, sexual abuse, and relationship power.

Keywords

trauma history; HIV/STI prevention; risky sexual behavior; relationship power; Latina health

An estimated 7,484 Latinos were diagnosed with HIV/AIDS in the U.S. in 2007, accounting for 18% of all new diagnoses. For Latinas, the estimated rate of HIV/AIDS was16.0 per 100,000, more than 5 times that for white women (CDC, 2009). This high risk for the development of sexually transmitted infections has been attributed, in part, to demographic factors that disproportionately affect Latinas as well as to relationship and cultural factors. Factors associated with HIV risk for Latinas addressed by previous studies include education, income, drug use, relationship power, intimate partner violence, and sexual abuse (e.g., Pulerwitz, Gortmaker, & DeJong, 2000). Relationship power appears to particularly affect Latinas' risk for STIs/HIV, while trauma history, such as history of intimate partner violence and sexual abuse, has been related to sexual risk behavior for women in general, including Latinas.

Relationship Power and Trauma History

Women's decision-making power and control in sexual relationships are important factors in whether they are able to protect themselves from the risk of STIs, including HIV, as condom use requires male cooperation. High relationship power is related to having more education

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and greater personal income (Pulerwitz et al., 2000; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002). As Latinas report lower incomes and having more dependents than women of other ethnicities (Wyatt et al., 2002), this economic dependence may limit control over sexual relationships. More sexual power, or condom negotiating power, is correlated with condom use (Gómez & Marín, 1996), thus, women with a high level of relationship power are more likely to report consistent condom use than women with lower levels of relationship power (Pulerwitz, et al., 2000; Pulerwitz et al., 2002).

A relationship history of physical violence or forced sex has been found to be inversely related to relationship power (Pulerwitz et al., 2000) and Latinos who perpetrate interpersonal violence report higher HIV risk behavior (El-Bassel et al., 2004) and are reported by Latina partners to engage in higher HIV risk behavior (Raj, Silverman, & Amaro, 2004). Correspondingly, Latinas who have experienced intimate partner violence in primary relationships are more likely to report perceiving themselves at risk for STIs/HIV and greater partner control over sexual activity than Latinas who do not report intimate partner violence (Raj et al., 2004). Latina and African-American women in violent relationships indicate greater willingness to use female-controlled STI/HIV prevention methods, such as vaginal spermicide (Saul et al., 2004). They also report less likelihood of using male condoms than women in nonviolent relationships (Saul et al., 2004), likely due to their fear of their partners' response (Raj et al., 2004).

In both general and HIV-positive samples, intimate partner violence has been found to be more common among Latinos and African-Americans than other ethnicities (Caetano, Cunradi, Clark, & Schafer, 2000; Galvan et al., 2004; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003). Rates in studies of male-perpetrated intimate partner violence toward Latinas range from 17% in a probability sample from the US household population (Caetano et al., 2000) to 49% in a sample of women at some risk for heterosexual transmission of HIV/STDs (Saul, Moore, Murphy, & Miller, 2004). Conversely, a history of sexual trauma is more likely to be reported by White and African-American women than by Latinas (Paxton, Myers, Hall, & Javanbakht, 2004; Wyatt et al., 2002).

Trauma History and Sexual Risk Behavior

Despite the significant rates of STIs in Latinas, Latina women generally report less sexual risk behavior than African-American and White women. According to data from the CDC, the majority of HIV-positive Latinas are infected heterosexually and within stable relationships (CDC, 2003). Paxton and colleagues (2004) reported similar findings. Additionally, Latinas tend to be older at first intercourse and to have fewer sexual partners (Paxton et al., 2004). In contrast, Ickovics et al. (2002) found no differences in HIV risk behaviors by race/ethnicity after controlling for income and education, while Marín, Tschann, Gómez, and Kegeles (1993) found that Spanish-speaking Latinas had the lowest rates of condom use compared to Latinos, white men and women, and English-speaking Latinos (men and women).

In terms of a history of trauma, for women, intimate partner violence is associated with unprotected sex, multiple sexual partners, past or current STI, and having partners with a

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known HIV risk factor (Fuentes, 2008; Raj et al., 2004; Wu et al., 2003). The association of intimate partner violence and sexual risk appears to persist after a safe-sex intervention, as at least one intervention study found that women with a history of intimate partner violence were less likely to report consistent use of condoms after the intervention than women without a history of abuse (Hamburger et al., 2004). Child sexual abuse has also been associated with sexual risk behavior in a number of studies (Wyatt et al., 2002). History of trauma (including child and adult sexual abuse and intimate partner violence) predicts sexual risk behavior as well as HIV status, regardless of race/ethnicity (Paxton et al., 2004; Wyatt et al., 2002). With regard to Latinas, Wilson, Lavori, Brown, and Kao (2003) estimated the risk of HIV acquisition in Latino couples using a mathematical model of HIV transmission and found that sexual abuse was independently associated with Latinas' background sexual risk (based on risk behavior prior to the current partner). Adult sexual abuse in particular has been associated with being HIV-positive in Latina samples (Newcomb & Carmona, 2004).

The purpose of this research was to clarify the role of trauma history and relationship power in HIV/STI risk for Latinas. Specifically, we wanted to examine the relationship between trauma history and sexual risk behavior; to clarify the associations between trauma history and relationship power; and to determine in what way trauma history and relationship power are associated with sexual risk behavior, independently and in interaction. To this end, we proposed the following hypotheses: 1) more extensive trauma history will be associated with greater sexual risk behavior (i.e., unprotected sex with a casual partner, having a steady partner suspected of cheating or a steady partner suspected of injecting drugs, having more than 1 sexual partner, having too much to drink before sex, and using drugs before sex); 2) trauma history will be associated with less relationship power; and 3) relationship power will mediate the effects of trauma history on sexual risk behavior.

Method

Participants

Participants consisted of 135 Latinas whose ages ranged from 18 to 68 with a mean of 34.05 (*SD* = 11.42; 7 participants did not provide age information). Just over half of participants (56%) were single, separated, or divorced, though 76.9 % had a steady partner. Most had completed high school (40.5%) or at least some post-high school education (19.9%), though 60.9% were currently unemployed. Family income was generally low, with 44.2% of women reporting incomes less than 20,000 a year (30.5% reported incomes of less than 10,000). However, 39.7% of the women indicated that they did not know their family income level and 4 women did not respond to this question. The majority of participants were of Mexican (42.4%) or Puerto Rican (40.2%) origin and 72.3% were born outside the United States.

Procedure

Participants were recruited at United Migrant Opportunity Services, Inc., which is a nonprofit service organization serving the Latino community. The study was explained to potential participants by bilingual research associates and those who volunteered to participate gave their informed consent and chose to complete the survey in either English or

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Spanish. Questionnaires that had not previously been translated into Spanish were translated by one bilingual individual and back-translated into English by another bilingual individual. A resource guide created for this study containing referrals to appropriate sources for assistance in dealing with trauma or other psychological issues was offered in the informed consent form to all participants after completing the questionnaire. An on-call psychiatrist was available as well. Potential participants were eligible for the study if they were (1) Latina; (2) 18 or older; and (3) sexually active in the past year. Upon completion, participants were given $15 in cash, a $10 Walgreens giftcard, and $5 childcare offset if they had a child that required care for them to participate in the study.

Measures

Participants completed written surveys that included measures of trauma history, relationship power, power regarding condom use, perceived STI/HIV risk of sexual partner, and sexual behavior.

Trauma history—Trauma history included separate measures for sexual abuse history and history of physical abuse by an intimate partner in order to examine relations between unwanted sexual experiences and sexual risk behavior and relationship power, as well as relations between physical abuse and sexual risk behavior and relationship power. History of childhood and adult sexual abuse were assessed using a sexual abuse questionnaire containing five questions about incidents of sexual abuse, such as unwanted touch, unwanted oral sex, and unwanted vaginal/anal sex (Carlin & Ward, 1992). The questionnaire was adjusted to change the response options from yes or no to a 5-point rating scale that addresses how often each type of incident occurred ranging from “never” to “five or more times.” A question inquiring about other unwanted sexual experiences was added with an open answer response choice, along with the 5-point rating scale. Scores were summed, with questions addressing forced oral sex and forced sexual intercourse weighted by 2 (Meston, Heiman, & Trapnell, 1999). Scores of zero thus reflect no sexual abuse experience and higher scores reflect greater extent or severity of sexual abuse history. Internal consistency of this measure was adequate (alpha = .85). Intimate personal violence was measured using the physical abuse subscale of the Abusive Behavior Inventory (Shepard & Campbell, 1992). This subscale consists of 10 items asking about the frequency of abusive behavior from a current or past primary partner on a scale from “never” to “very frequently ” (alpha = .92). Three items include sexual abuse or sexually dominating behavior by an intimate partner, such as being forced to have sex, being pressured to engage in unwanted sexual behaviors, and having sexual parts of the body physically attacked. The timeline was modified for this subscale to query respondents about abuse in the past year.

Sexual Relationship Power Scale (SRPS; Pulerwitz et al., 2000)—The SRPS measures power in intimate relationships. It has two subscales, a relationship control factor subscale and a decision-making dominance factor subscale. Items address how much control the partner has over the participant in the relationship, who primarily makes the decisions about activities, and on safer sex negotiation. For the present study, the modified scale (SRPS-M) which excludes items regarding condom use was used, as recommended when assessing the association of the SRPS with condom use. As with the full scale, this scale has

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good internal reliability (alpha = .92), as does the modified relationship control subscale (alpha = .93) and the decision-making dominance subscale (alpha = .85).

Sexual risk behavior—Questions taken from the Hispanic Condom Use Study (Gómez & Marín, 1996) were used to assess sexual behavior. These questions ask about the number of sexual partners in the past 12 months (a question was added to ask about number of sexual partners in the past 3 months), condom use with steady and casual partners in the past 3 months, and alcohol and drug use before sex. Condom use was coded as “always/more than half the time” and “less than half the time/never.” Alcohol and drug use items were recorded using a five-point response scale from 1 “always” to 5 “never.”

Perceived partner risk—Women who reported having a steady partner were asked two questions from the Hispanic Condom Use Study (Gómez & Marín, 1996) to assess their perceptions of their steady partners' risk of acquiring HIV or another STI. Specifically, these participants were asked if they knew or suspected that their steady partner has sex with other partners and if they knew or suspected that he injects drugs. These items were combined and recoded into a dichotomous variable indicating whether steady partners were perceived to engage in one or both of these risk behaviors (1) or not (0).

Negotiating power for condom use—The negotiating power for condom use scale (termed “sexual power” in Gómez & Marín, 1996) consisted of three items regarding the anticipation of negative responses by steady sexual partners to a request for condom use (i.e., “If you asked your steady partner to use a condom/rubber, do you think he would refuse to have sex with you?”; “…do you think he would get violent?:; “…would he think you had sex with someone else?” alpha = .68). Negotiating power for condom use was measured using a four- point yes/no response scale with higher scores meaning higher negotiating power. Negotiating power scores are conventionally calculated as the mean scores of the respective items; however, to adjust for skewed scores, items were recoded as 1 “yes” or “probably yes” and 2 “probably no” or “no” and the items were summed.

Demographic characteristics—Participants were asked their age, ethnicity (e.g. Mexican-American), country of origin, education level, employment status, and relationship status.

Results

Of the 134 women completing the Abusive Behavior Inventory, 75 (56%) reported some type of intimate partner violence by a steady partner or former partner in the past year. Lifetime sexual abuse was reported by 71 (53.8%) women. Scores on the intimate partner violence scale correlated with sexual abuse scale scores, $r = .36$, $p < .001$. Frequency of intimate partner violence was also associated with relationship status, Spearman $r = -.23$, $p = .007$, indicating that women who were married or living with their partner had a lower incidence and frequency of intimate partner violence.

Despite study criteria requiring that participants had been sexually active in the past 12 months, 19 women (14.1%) reported not having had sex with a male partner in the past 12

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months (put zero for number of partners) and 9 (6.7%) did not respond to this question. Thus, all subsequent analyses include only the 106 (78.5%) women who reported having sex with at least one male partner in the past 12 months. Women who reported having sex with at least one male partner in the past 12 months were younger than women not reporting at least one male sexual partner, t (126) = -2.76, p = .007, more likely to have ever used condoms, χ^2 (1,134) = 4.55, p = .03, and to have a steady partner, χ^2 (1,134) = 9.16, p = .002, though they were not more likely to be married or living with a partner, χ^2 (1,134) = 0.05, *ns*. Of the 106 sexually active women, 57 (53.8%) reported intimate partner violence and of the 103 completing the sexual abuse scale, 54 (52.4 %) reported sexual abuse.

Univariate Relationships

Table 1 shows the descriptive statistics for the main variables analyzed in this study. Frequency or severity of intimate partner violence was related to sexual abuse severity, r = .21, p = .03. As predicted, intimate partner violence was correlated with lower overall scores on the sexual relationship power scale (r = -.25, p = .01). Relationship power was correlated with condom use negotiating power with steady partner, as measured by perceptions of partner response to requests for condom use (e.g., “If you asked a steady partner to use a condom/rubber, do you think he would get violent? …would he think you had sex with someone else?” Spearman r = .23, p = .03). Sexual abuse was not associated with relationship power, but was correlated with condom use negotiating power (Spearman r = -.25, p = .02), indicating that the experience or greater extent/severity of sexual abuse was related to lower negotiating power in asking a steady partner to use a condom. However, negotiating power for condom use was not associated with reported condom use with steady partners.

More extensive intimate partner violence was related to more often drinking before sex in the past 3 months, r = -.30, p = .002 and to more often using drugs before sex in the past 3 months, r = -.40, p < .001. More extensive or severe sexual abuse was correlated with more frequent use of drugs before having sex, r = .21, p = .03. Perceived partner risk, characterized by having a partner suspected or known to ever inject drugs or to have had sex with another person during the relationship, was not related to intimate partner violence but was associated with extent of sexual abuse (Spearman r = .22, p < .05).

Sexual Risk Factors

A sexual risk index was created by summing the number of risks that participants reported. Sexual risks included having unprotected sex with a casual partner in the past 12 months, having a steady partner suspected of cheating, a steady partner suspected of injecting drugs, having more than 1 sexual partner in the past 3 months, and having too much to drink or using drugs before sex in the past 3 months. The most frequent risk factors were sex after having too much to drink and having a steady partner suspected of cheating (see Table 2). At least one risk factor was reported by 41 (38.7%) participants. Table 3 shows the correlations between the sexual risk index, sexual abuse frequency/severity, intimate partner violence frequency/severity and relationship power.

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Sexual risk index scores were correlated with condom use. The more sexual risk factors participants reported, the more likely they were to "always" use condoms with steady partners in the past 3 months, Spearman $r = .29$, $p = .007$. As no other variables were correlated with condom use, including demographic variables, condom use was not further assessed.

In linear regression analysis, controlling for relationship status (married or living with a partner versus single, $\beta = .12$, $p > .05$), greater intimate partner violence was associated with higher scores on the sexual risk index, $\beta = .32$, $p < .01$, $F(4, 98) = 5.09$, $p < .001$, adjusted $R^2 = .14$.. Relationship power was not significantly correlated with sexual risk index scores, $\beta = .03$, *ns*, and thus did not mediate the association of sexual abuse or intimate partner violence with sexual risk factors. Severity of sexual abuse history was no longer associated with sexual risk index scores, $\beta = .14$, *ns*, after controlling for relationship status and intimate partner violence.

Discussion

Over half of the women in our sample reported a history of intimate partner violence in the past year and/or sexual abuse in their lifetime. Women who reported a history of intimate partner violence were also more likely to report sexual abuse. As hypothesized, in accord with previous research in both Latina and other samples of women, intimate partner violence was negatively associated with sexual relationship power. In turn, greater relationship power was correlated with greater condom use negotiating power with a steady partner, which was also related to a less extensive or no sexual abuse history. However, neither relationship power nor condom use negotiating power was associated with actual condom use, in contrast to studies by Pulerwitz and colleagues (2000; 2002) and by Saul et al. (2000).

Both intimate partner violence and sexual abuse frequency/severity were correlated with the sexual risk index, consistent with previous research. In the regression analysis, only intimate partner violence continued to be associated with higher sexual risk index scores. Women who reported more sexual risks did show a greater tendency for protective sexual behavior as they more likely to "always" use condoms with steady partners in the past 3 months.

In acknowledgement of evidence that the vast majority of Latinas who are infected with HIV have acquired the virus within presumably stable relationships and to increase generalizability, we used a community sample from a large nonprofit service organization rather than a high-risk sample of Latinas. As a result, the rates of sexual risk behavior in the study were not high. However, for this type of community sample, the rates of intimate partner violence and sexual abuse were quite high. However, because the sexual abuse history items did not ask about the timeline for the abuse or about the perpetrator, it is unclear how much of the sexual abuse scores were also a reflection of intimate partner violence. In light of the high rates and the fact that intimate partner violence and sexual abuse can be experienced with a wide range of severity, we felt that it was very important to use continuous scales of frequency/severity of abuse rather than simply classify participants as abused or not. Trauma can have contradictory associations with sexual risk and the wide ranges in severity seem to play some role in this relationship. Women with more extensive/

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severe sexual abuse histories have been found to engage in higher rates of risk behavior, such as greater number of sexual partners and alcohol or drug use before sexual activity, especially when these trauma histories are accompanied by other risk factors such as younger age at first intercourse, permissive sexual attitudes, and revictimization (Randolph & Mosack, 2006). In the present study, more extensive sexual abuse history was associated with higher sexual risk as reflected by sexual risk index scores, but was no longer significantly related when intimate partner violence was in the model, indicating that intimate partner violence was the variable more strongly associated with sexual risk. To our knowledge, these variables have not been previously addressed in the same analysis. This finding suggests that abuse from an intimate partner, perhaps in part because it is more recent and especially because it is perpetrated by someone the victim is attached to in a close relationship, has a stronger association with sexual risk behavior than less recent abuse or physical or sexual abuse from someone who is not an intimate partner. Because intimate partner violence was measured as violence from a current partner or any partner in the past year, the association with sexual risk behavior could be concurrent or resulting from a history of intimate partner violence.

As mentioned previously, results from this study differed from previous studies in that neither relationship power nor condom use negotiating power was associated with actual condom use. Several explanations may exist for these findings. For example, psychopathology (e.g., depression) or levels of assertiveness in females might account for this difference. It is also possible that regardless of a woman's relationship or condom use negotiating power, she prefers not to use condoms, and this would not have been reflected in the data collected in this study. Future research should assess for personality/psychological variables to determine associations between these and condom use, as well as an assessment of women's attitudes toward condom use.

This study has some limitations common to many studies of sexual risk behavior. It is hard to characterize risk in women who do not report a current partner or are not currently sexually active. A substantial proportion of the women in this sample were in a situation that is likely particularly relevant in U.S. Latina samples, in that 7 (5.2%) of the women reported that they were married or living with a partner, while also reporting 0 sexual partners in the past 12 months and an additional 5 (3.7%) partnered women did not respond to this question (2 women married or living with a partner, who also reported sex with a partner other than their steady partner in the past 12 months, either answered 0 to the number of partners query or left it blank). It is not clear if some of these women were not sexually active with their partners or if they were currently geographically separated. The study was also limited by the cross-sectional design and self-report nature of the measures as well as by the relatively small sample size. It is possible that participants who were currently with abusive partners were less likely to report intimate partner violence, though the high rate reported in this study is perhaps evidence against this possibility. Additionally, sexual behavior is complex and there are likely other variables that affect sexual risk in this population that were not measured, for example, perceptions of HIV/STI risk. It would be helpful as well, to measure actual partner risk behavior.

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Intimate partner violence and HIV/STI risk are significant problems in some segments of the Latino community. Besides the trauma of abuse by one's partner, intimate partner violence can affect women's ability to protect themselves by enforcing fidelity from their partner and negotiating consistent condom use. Interventions to encourage condom use and teach condom negotiating skills presume control over safe sex behavior that may not exist in women experiencing violence from their partners. Thus attempts to reduce sexual risk for HIV/STIs in this group are likely to have little benefit if intimate partner violence is not addressed. Proposed methods of HIV/STI prevention that address intimate partner violence include improving intimate partner violence risk assessment and intervention strategies for women in primary health care settings (Wu et al., 2003), focusing efforts on men with a history of perpetrating intimate partner violence (Raj et al., 2004), encouraging the use of alternative, female-controlled methods of HIV prevention (Saul et al., 2004), and including both members of couples in interventions (Gómez & Marín, 1996). Additionally, given that there is evidence that past physical abuse, including intimate partner violence, even if it is not occurring in a current relationship, is related to sexual risk behavior (Fuentes, 2008; Wilson et al., 2003), the effects of trauma history on sexual behavior should be addressed in any risk reduction intervention with Latinas, and all women at risk for HIV/STI infection.

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References

Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. Atlanta: Department of Health and Human Services, Centers for Disease Control and Prevention; 2009. p. 1-63.Also available at http://www.cdc.gov/hiv/topics/surveillance/basic.htm#hivaidsrace

Caetano R, Cunradi CB, Clark CL, Schafer J. Intimate partner violence and drinking patterns among white, black, and Hispanic couples in The U.S. Journal of Substance Abuse. 2000; 11:123–138. [PubMed: 10989773]

Carlin AS, Ward NG. Subtypes of psychiatric inpatient women who have been sexually abused. The Journal of Nervous and Mental Disease. 1992; 180:392–397. [PubMed: 1593274]

El-Bassel N, Gilbert L, Golder S, Wu E, Chang M, Fontdevila J, Sanders G. Deconstructing the relationship between intimate partner violence and sexual HIV risk among drug-involved men and their female partners. AIDS and Behavior. 2004; 8:429–439. [PubMed: 15690116]

Fuentes CMM. Pathways from interpersonal violence to sexually transmitted infections: A mixed-method study of diverse women. Journal of Women's Health. 2008; 17:1591–1603.

Galvan FH, Collins R, Kanouse DE, Burnam MA, Paddock SM, Beckman R, Mitchell SR. Abuse in the close relationships of people with HIV. AIDS and Behavior. 2004; 8:441–451. [PubMed: 15690117]

Gómez CA, Marín BV. Gender, culture, and power: Barriers to safe sex. Journal of Sex Research. 1996; 33:355–362.

Hamburger ME, Moore J, Koenig LJ, Vlahov D, Schoenbaum EE, Schuman P, Mayer K. Persistence of inconsistent condom use: Relation to abuse history and HIV serostatus. AIDS and Behavior. 2004; 8:333–344. [PubMed: 15475680]

Ickovics JR, Beren SE, Grigorenko EL, Morrill AC, Druley JA, Rodin J. Pathways of risk: Race, social class, stress, and coping as factors predicting heterosexual risk behaviors for HIV among women. AIDS & Behavior. 2002; 6:339–350.

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Marín BV, Tschann JM, Gómez CA, Kegeles SM. Acculturation and gender differences in sexual attitudes and behaviors: Hispanic vs non-Hispanic white unmarried adults. American Journal of Public Health. 1993; 83:1759–61. [PubMed: 8259813]

Meston CM, Heiman JR, Trapnell PD. The relation between early abuse and adult sexuality. Journal of Sex Research. 1999; 36:385–395.

Newcomb MD, Carmona JV. Adult trauma and HIV status among Latinas: Effects upon psychological adjustment and substance use. AIDS and Behavior. 2004; 8:417–428. [PubMed: 15690115]

Paxton KC, Myers HF, Hall NM, Javanbakht M. Ethnicity, serostatus, and psychosocial differences in sexual risk behavior among HIV-seropositive and HIV-seronegative women. AIDS and Behavior. 2004; 8:405–415. [PubMed: 15690114]

Pulerwitz J, Amaro H, De Jong W, Gortmaker SL, Rudd R. Relationship power, condom use and HIV risk among women in the USA. AIDS Care. 2002; 14:789–800. [PubMed: 12511212]

Pulerwitz J, Gortmaker SL, DeJong W. Measuring sexual relationship power in HIV/STD research. Sex Roles. 2000; 42:637–660.

Raj A, Silverman JG, Amaro H. Abused women report greater male partner risk and gender-based risk for HIV: Findings from a community-based study with Hispanic women. AIDS Care. 2004; 16:519–529. [PubMed: 15203419]

Randolph ME, Mosack KE. Factors mediating the effects of childhood sexual abuse on risky sexual behavior among young college women. Journal of Psychology and Human Sexuality. 2006; 18:23–41.

Saul J, Moore J, Murphy ST, Miller LC. Relationship violence and women's reactions to male- and female-controlled HIV prevention methods. AIDS and Behavior. 2004; 8:207–214. [PubMed: 15187482]

Saul J, Norris FH, Bartholow KK, Dixon D, Peters M, Moore J. Heterosexual risk for HIV among Puerto Rican women: Does power influence self-protective behavior? AIDS and Behavior. 2000; 4:361–371. [PubMed: 20871803]

Shepard MF, Campbell JA. The abusive behavior inventory: A measure of psychological and physical abuse. Journal of Interpersonal Violence. 1992; 7:291–305.

Wilson SR, Lavori PW, Brown NL, Kao Y. Correlates of sexual risk for HIV infection in female members of heterosexual California Latino couples: An application of a Bernoulli process model. AIDS and Behavior. 2003; 7(3):273–290. [PubMed: 14586190]

Wu E, El-Bassel N, Witte SS, Gilbert L, Chang M. Intimate partner violence and HIV risk among urban minority women in primary health care settings. AIDS and Behavior. 2003; 7:291–301. [PubMed: 14586191]

Wyatt GE, Myers HF, Williams JK, Kitchen CR, Loeb T, Carmona JV, Wyatt LE, Chin D, Presley N. Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. Research and Practice. 2002; 92:660–665.

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Table 1

Descriptive statistics for participants who were sexually active in the past 12 months

	N	Minimum	Maximum	Mean	Std. Deviation
Physical Abuse	106	7	44	13.48	5.96
Sexual Abuse	103	.00	28	5.12	7.66
Relationship power	102	1	4	2.74	.69
Sexual Risk Index	106	.00	5	.67	1.07

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Table 2

Sexual risk index factors

	n (%)
Sex after too much drink	21 (19.8%)
Partner suspected of cheating	14 (16.1%)
More than 1 partner in past 3 mo	12 (11.5%)
Sex after using drugs	9 (8.5%)
Unprotected sex with casual partner	9 (8.5%)
Partner suspected of injecting drugs	6 (7.0%)

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Table 3

Correlations between relationship power, trauma, and sexual risk behaviors

	1	2	3	4
1. Relationship power		-.01	-.25**	-.08
2. Sexual Abuse			.21*	.24*
3. Physical Abuse				.37***
4. Sexual Risk Index				

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$