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What Girls Won't Do for Love: Human Immunodeficiency Virus/ Sexually Transmitted Infections Risk Among Young African- American Women Driven by a Relationship Imperative

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Abstract

Purpose—Rates of Human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) continue to increase among African-American youth. Adolescents who have a stronger identity in relation to others (relational identity) rather than to themselves (self-identity) may view intimate relationships as imperative to a positive self-concept, which may lead to risky sexual behavior and abuse. Therefore, the present study assessed the associations among a relationship imperative and HIV/STI-related risk factors and behaviors.

Methods—Participants were 715 African-American adolescent females, aged 15 to 21 years. They completed measures that assessed how important a relationship was to them and HIV-related risk factors and behaviors. Participants also provided vaginal swab specimens for STI testing.

Results—Multivariate logistic regression analyses, controlling for covariates, were conducted. Females who endorsed a relationship imperative (29%), compared to those who did not, were more likely to report: unprotected sex, less power in their relationships, perceived inability to refuse sex, anal sex, sex while their partner was high on alcohol/drugs, and partner abuse. Furthermore, participants with less power, recent partner abuse, and a perceived ability to refuse sex were more likely to test STI positive.

Conclusion—These results indicate that if African-American adolescent females believe a relationship is imperative, they are more likely to engage in riskier sexual behaviors. Additionally, less perceived power and partner abuse increases their risk for STIs. HIV/STI prevention programs should target males and females and address healthy relationships, sense of self-worth, self-esteem and the gender power imbalance that may persist in the community along with HIV/STI risk.

Keywords

Relationships; Sexual behavior; STIs; African-American; Adolescents

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“I haven’t had a boyfriend or gotten asked out. I feel so unwanted. For heaven’s sake I am 13!”

excerpt from 1990s *Teen Magazine*’s advice column [1]

Human immunodeficiency virus (HIV), other sexually transmitted infections (STIs), and teenage pregnancy contribute to morbidity and mortality rates among adolescent girls and young women in the U.S. [2,3]. While the effects of various prevention programs have shown promise in reducing sexual risk behaviors among youth [4], understanding social factors that have been largely ignored among this group and their relationship to sexual risk can serve to strengthen these efforts. Adolescent romantic relationships and sexuality, once considered transitory and/or the byproducts of social dysfunction [5], have garnered increased attention in the literature. Although the study of the nature and development of romantic relationships in adolescence has increased in the last decade, its course has been largely descriptive and qualitative or lacking a focus on quantifiable adverse sexual outcomes [6]. This study quantifies the heightened risk for HIV/STIs during adolescence by examining the association between the relative importance adolescent girls place on being in a relationship and their engagement in risky sexual practices and other adverse relationship dynamics.

Although young people aged 15–24 years represent only 25% of the sexually experienced population, they acquire approximately half of all new STIs, [3] and approximately half of all new HIV infections occur in those less than 25 years of age [7]. It is estimated that 24.1% of adolescent girls aged 14–19 years have one of the five commonly reported STIs: herpes simplex virus (HSV), trichomoniasis, chlamydia, gonorrhea, and human papillomavirus (HPV) [8]. African-American adolescents are particularly at risk for STIs and account for 65% of HIV diagnoses among individuals who are 13–24 years old [7]. A national study found that among African-American female adolescents, aged 14–19 years, 44% had at least one STI [8]. Additionally, adolescents living in the southern part of the U.S. are more likely to be at risk for HIV infection [9].

Therefore, it is important to turn attention to more expansive research questions that consider factors occurring within romantic relationships that help and hinder normative development from adolescence to adulthood [6]. Findings in the past 10 years suggest the development of romantic relationships during adolescence may facilitate the development of a positive self-concept, general self-competence, and a sense of self-worth [10–13]. Conversely, given the literature [2,14], it is also likely that the initiation and maintenance of such relationships may function to increase the likelihood that youth, particularly young women, may compromise psychosocial and sexual health to meet the demands of present-day social expectations for romantic relationships. This study extends previous research by attempting to better understand how the intensity and drive for a relationship in adolescence may affect sexual decision-making and risk.

Adolescence is typically defined as 11 to 25 years old [5] and is marked by the developmental task of establishing a positive sense of self (self-identity) and self in relation to others (relational identity), including parents and same-sex and opposite-sex peers [15]. Adolescents may be most concerned with their identity within a romantic relationship, which differs from peer relationships, in that romantic relationships embody a “distinctive intensity, commonly marked by expressions of affection and current or anticipated sexual behavior” (p. 632) [5]. Furthermore, youth with a stronger relational identity than self-identity may view intimate romantic relationships as imperative to a positive self-concept [10,16–18]. In a qualitative textual analysis of 875 letters written to the advice column of *Teen Magazine* by adolescent girls in the 1990s, Van Roosmalen [1] uncovered a formidable sense of despair and anxiety plaguing young women regarding the urgency to be “coupled.”

Teens expressed conflict between wanting to remain true to themselves and avoid sexual situations, while also desiring the social benefits of being in a romantic relationship, namely, social inclusion and popularity, often by engaging in or experiencing pressure to engage in sexual activity. This conflict characterizes the struggle between developing a self-identity and relational identity inherent in adolescence.

During adolescence, teens are learning how to interact with the other sex, methods for initiating and engaging in sexual activity, and in which sexual activities to participate [19]. Research suggests that how girls engage and communicate with same sex peers compared to cross-sex peers often looks different. A qualitative study found that while most girls were outspoken with their female friends, parents, and others, they were not able to “speak their minds” in their cross-sex relationships [20]. Overwhelming societal and same-sex peer pressure to be in a romantic relationship, [2,14] as well as pressure by potential male partners to engage in sex in order to maintain relationships, [21] may heighten sexual risk behaviors among young women. Another study [14] found that social status and fear of relationship termination was related to girls placing their boyfriends’ sexual needs above their own needs and placing condom negotiation and other safer sex practices at risk.

For many, dating in adolescence teaches young women how to bargain for the perceived social and emotional benefits of being in a relationship by exchanging sex in order to attain or maintain the coveted “girlfriend status” [1]. In addition to increased rates of HIV/STI infection, relationship factors such as partner abuse disproportionately affect this group and increase their risk for HIV/STIs [22]. Other related relationship dynamics and psychosocial factors are perceived power in the relationship and self-efficacy to refuse a partner’s or potential partner’s request to have sex [23]. The principle of least interest [24] suggests that young women who endorse the need to always be in a relationship will have less relational power and will be more likely to risk their sexual health by engaging in risky sex practices. In an ethnographic study exploring health-related issues within romantic relationships among female adolescents [14], girls reported abuse in response to attempts at condom negotiation. The study found that young women’s attitudes towards dating and their desire to be coupled outweighed their desire to limit or avoid substance abuse and partner abuse present in their relationship. Furthermore, they described their use of sex as a viable means to negotiate control in their dating relationships—going as far as to state that sex is “part of what you do” in order to hold onto the relationship [14].

Placing significant importance on being in a relationship at all times may lead to psychological traits that can significantly impact the developmental trajectory from adolescence to adulthood. Whereas previous work has focused on the qualitative and descriptive aspects of the importance of romantic relationships in adolescence, this study sought to identify the independent associations between a relationship imperative and sexual risk behaviors (e.g., unprotected vaginal sex, anal sex) and psychosocial factors (e.g., sex refusal self-efficacy, relationship power, and partner abuse) among African-American adolescent girls in the southeastern part of the U.S. In addition, this study assessed the associations between these factors and biological testing for STIs. Due to their associations with sexual risk behavior and relationship dynamics, age [7,8], receipt of public assistance [25], perceived social support [26], and typical or current age of partner [22,27] served as covariates in this study.

Methods

Participants and procedures

Participants were part of a larger study evaluating a sexual risk reduction intervention tailored for African-American adolescents [28]. The current analyses are from baseline data.

Participants were recruited from three local community health agencies that provided sexual health services to predominantly inner-city adolescents in Atlanta, Georgia from March 2002 to August 2004. Eligibility criteria included: African-American female, age 15–21 years, and vaginal intercourse during the past 60 days. Adolescents who were married, currently pregnant, or attempting to become pregnant were excluded. Informed consent was obtained from all adolescents, with parental consent waived for those younger than 18 due to the confidential nature of clinic services. Of the 847 eligible adolescents, 84.4% ($n = 715$) completed baseline assessments. Adolescents also provided self-collected vaginal swabs to assess for STIs. Participants who tested STI-positive received directly observable single-dose antimicrobial treatment, risk-reduction counseling per CDC recommendations, and were encouraged to refer sex partners for treatment. The county health department was notified of reportable STDs, which included chlamydia and gonorrhea. The Emory University Institutional Review Board approved all study protocols.

Measures

Data were collected through an audio computer-assisted self-interview (ACASI) *Relationship imperative*, was assessed by asking participants to rate the degree to which they agreed with the statement “Having a partner at all times is important to me.” Responses were collapsed into two categories, 1 =relationship imperative (agree or strongly agree) and 0 =no relationship imperative (disagree or strongly disagree).

Covariates—*Public assistance* was assessed by asking participants if, in the past 12 months, they or someone they lived with received any money or services from Welfare, including TANF (Temporary Assistance to Needy Families) or SSI (Supplemental Security Income), or any money or services from food stamps, WIC (Women, Infants and Children), or Section 8 housing (housing subsidies). An 11-item, Likert-type scale [29] ($\alpha = .90$) was used to measure each participant’s *perceived social support* (e.g., “There is a special person who is around when I am in need”). Low and high perceived social support categories were derived using a median split of the scale scores (Median = 35).

To assess the typical age difference between participants and their male sex partners, participants were asked, “In general, how old are the people you have sex with?” and participants responded to a 5-point Likert-type scale ranging from 1 (much younger than you—5 or more years) to 5 (much older than you—5 or more years). Typical age difference was categorized as 0 (participant being between 0 and 2 years younger) and 1 (participant being three or more years younger). Participants were also asked the age of their current boyfriend (if applicable). The age difference was dichotomized as 0 (boyfriend is two years older or less) and 1 (boyfriend is three years older or more).

Psychosocial factors—*Relationship power* was assessed using an 11-item, Likert-type scale [30] ($\alpha = .70$). Items included “Most of the time we do what my partner wants to do,” and “I am more committed to our relationship than my partner.” A median split of scores was used to create high and low perceived relationship power categories (Median = 22). To assess participants’ *perceived self-efficacy to refuse sex* in various situations, participants responded to a 7-item, Likert-type scale [31] ($\alpha = .87$) that asked participants whether they could or could not say no in various situations, such as “How sure are you that you would be able to say NO to having sex with someone you (a) want to date again? or (b) who refuses to wear a condom?” Response options ranged from (1) I definitely can’t say no to (4) I definitely can say no. Low and high refusal self-efficacy categories were derived using a median split of the scale scores (Median = 25). To assess *fear of abuse and other negative consequences due to condom negotiation* [32] an 8-item scale ($\alpha = .89$) was used to ask participants about the degree to which they were worried about discussing condom use with

their boyfriend/sex partner because he would respond in negative ways including threatening to hit, push, or kick them; leave them; swear at them; or call them names. Participants responded on a 5-item Likert-type scale ranging from 1 (never worried) to 5 (always worried). All scores were summed and fear (indicating some degree of fear for one or more items) and no fear categories were created.

Lifetime partner abuse was assessed by asking participants if they had ever been emotionally abused and if anyone had ever made them have vaginal or anal sex when they did not want to. To assess *recent main partner abuse*, participants 18 years and older were asked if they had been emotionally, physically (hit, punched, kicked, slapped, etc.), or sexually abused (forced vaginal or anal sex) by their boyfriend or main partner in the past 60 days. Due to mandatory reporting of suspected child abuse, participants under the age of 18 ($n = 325$) were not asked to report recent partner abuse experiences.

Sexual risk behaviors—The outcome variable, *risky sexual behavior*, was assessed five ways: whether participants (1) used a condom during the last sexual intercourse with a main partner; (2) used a condom during the last sexual intercourse with casual partner; (3) engaged in unprotected sex while experiencing STI symptoms prior to treatment; (4) engaged in unprotected sex while their partner was high on alcohol or drugs; and (5) ever engaged in anal sex.

Sexually transmitted infections—Participants provided two self-collected vaginal swab specimens to test for Chlamydia, gonorrhea, and trichomonas. Specimens were delivered and tested at the Emory University Pathology Laboratory. *Any STI* was defined as testing positive for one or more of the three STIs.

Data analyses

Separate hierarchical logistic regression analyses assessed the association between endorsing a relationship imperative and multiple risky sexual behaviors and psychosocial factors while controlling for previously mentioned covariates. Additionally, a backward stepwise logistic regression analysis examined the association between multiple risky sexual behaviors and psychosocial factors and STIs, while controlling for age and public assistance. An alpha of .05 was used to retain factors in each model.

Results

Participant characteristics

Among this sample of 715 young African-American women, the mean age was 17.8 ($SD = 1.7$). Approximately half (47.8%) reported living in a household that received public financial assistance. Additionally, half (50.6%) reported that their sexual partners usually were two to four years older than they and 13.7% ($n = 98$) reported having partners who usually were 5 or more years older. The majority (83.6%) reported having a boyfriend at baseline and 29% ($n = 206$) endorsed a relationship imperative.

Separate hierarchical logistic regression analyses indicated that young women who endorsed a relationship imperative, compared to those who did not, were more likely to report perceiving themselves to have less power in their relationship ($AOR = 2.3$), perceiving themselves to be unable to refuse sex in multiple high-risk situations ($AOR = 2.0$), fear of negotiating condom use with a partner ($AOR = 1.5$), lifetime ($AOR = 1.5$), recent ($AOR = 1.6$) partner abuse, unprotected sex prior to being treated for STI symptoms ($AOR = 3.9$), unprotected sex at last sex with a casual ($AOR = 2.1$) and main ($AOR = 1.6$) partner, anal sex ($AOR = 1.8$), and sex while their partner was high on alcohol/drugs ($AOR = 1.5$) (see

Table 1). Based on these findings, post-hoc analyses were conducted among participants reporting a relationship imperative ($n = 206$). Relationship between boyfriend status (yes vs. no) and perceived sex refusal self-efficacy was examined among this subgroup. Findings indicated that the odds of perceiving oneself as able to refuse sex in multiple situations (e.g., someone who you want to fall in love with you, date again, you've known for a few days, refuses to wear a condom, is pressuring you to have sex, or have had sex with before) was 2.8 times as great for girls with boyfriends as for girls without boyfriends.

Correlates of sexually transmitted infections

When examining laboratory-confirmed STIs, a three-factor model was significant ($\chi^2(6) = 20.59, p = .002$), and the H-L goodness-of-fit statistic ($\chi^2(8) = 7.65, p = .47$) indicated that model fit was satisfactory. This model was able to correctly classify 70.4% of young women according to whether they had an STI. The odds of testing STI-positive were 3.9 times as great for those who perceived themselves as having less power in their relationship than for those who perceived themselves as having more relationship power. Also, the odds of testing STI-positive were 3.4 times as great for participants reporting recent partner abuse as for those reporting no recent partner abuse (see Table 2). The odds for testing STI-positive were 3.8 times as great for youth who perceived themselves as more able to refuse sex under various circumstances as for youth with a lower perceived ability to refuse sex. Endorsing a relationship imperative, reporting fear of condom negotiation, lifetime partner abuse, any unprotected sex, anal sex, or sex while partner was high on alcohol/drugs was not retained in the model examining correlates of STIs.

Discussion

The present study examined the association between the relative importance African-American female adolescents place on being in a relationship and their engagement in risky sexual practices and other adverse relationship dynamics as well as whether these risk factors and behaviors increase risk for STIs. The results indicated that if young girls believe a relationship is imperative, they may engage in higher sexual risk behaviors or be in relationships characterized by a power imbalance or abuse. Furthermore, young women in relationships characterized by a power imbalance or abuse are at increased risk for STIs.

Interestingly, among young women who endorsed a relationship imperative, those without boyfriends perceived themselves to be less likely to refuse sex under various circumstances than those with boyfriends. It is possible that young girls who view relationships as imperative but do not have boyfriends are more likely to engage in sex because they believe it may help them get a boyfriend. One surprising finding was that young women who perceived themselves as more able to refuse sex under various circumstances were more likely to test STI-positive than those with a lower perceived ability. However, it is important to note that perceived ability to refuse sex was assessed and not actual refusal. Future research is needed to determine whether young women with higher self-efficacy actually utilize these skills with their partners or if the importance of being in a relationship takes precedence [22].

Peer norms often emphasize the importance of being in a relationship and male adolescent partners may compound the issue by pressuring their female partners to engage in sex [2,14]. As a result, relationships may be perceived as imperative in order to conform to peer pressures and to maintain self-esteem, and young women may be more likely to engage in risky behaviors to maintain their romantic relationships. Risks may be further exacerbated if they are in relationships where a power imbalance exists or where they experience partner abuse. In this study, partner abuse was associated with testing STI-positive.

Theories, such as the Theory of Gender and Power [33] should be considered when developing culturally appropriate and gender-specific HIV prevention interventions that promote self-worth and identity among youth. The Theory of Gender and Power [33] is a social structural theory that examines how three overlapping but distinct societal structures characterize the roles between men and women: (1) the division of labor; (2) the division of power; and (3) the structure of cathexis. In particular, the structure of cathexis is often illustrated by the emotional attachments that young women have with their male partners, who are often older, which is associated with STI-related risk factors [34] as seen in the current study. However, it is worthwhile noting that in this study, despite controlling for typical age of partner, relationship imperative was still associated with several adverse psychosexual outcomes and sexual risk behaviors. Girls who reported that being in a relationship at all times is important to them were also more likely than those not endorsing a relationship imperative to fear negotiating condom use with a male partner because it might lead to abuse, relationship termination, or other adverse relationship consequences.

Potential limitations of this study include cross-sectional data analyses that prevent causal interpretations, the use of a crude 1-item measure for assessing relationship imperative, data on risky sexual behaviors relying on retrospective self-report data and data not being available to support attachment theory [35] as a potential explanation for the findings. Given the limited research on relationship imperative, future research should focus on developing a scale to better examine it. Finally, the sample was homogeneous, all African-American female adolescents from the southeastern part of the U.S. who were seeking community-based sexual health services. Therefore, findings may have limited generalizability and replication with diverse populations would be needed.

Many HIV/STI intervention programs for young women focus on increasing skills regarding communication and negotiation of condom use [36]. Although it is important for young women to learn and utilize these skills within their relationships, it also is important to consider the context in which these skills will be most beneficial. If young women perceive that utilizing these skills may place their relationship at risk or if they may experience abuse, then they will be less likely to request or use condoms [22,37]. Therefore, it is important to focus on improving sense of self-worth and self-esteem among young women and to increase their understanding of healthy relationships. Given that previous research has indicated that adult African-American women are also more likely to engage in risky behaviors in order to maintain their relationships [38], it is pertinent to intervene with African-American female adolescents so that they do not continue to engage in these behaviors into adulthood.

Interventions that target both males and females and are couples-based or peer-led may be beneficial so that peer norms regarding relationships also can be targeted. This would provide an opportunity for peers to have an open discussion regarding relationships and potentially change cultural norms. It is important for adolescents to be targeted early so that they have a better understanding of what it means to be in a relationship. By increasing self-worth and self-esteem of African-American female adolescents along with addressing peer norms that may place them at risk, healthy relationships and the reduction of risky behaviors and STI infection can be facilitated.

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References

1. van Roosmalen E. Forces of patriarchy: Adolescent experiences of sexuality and conceptions of relationships. *Youth Society*. 2000; 32:202–27.
2. Teitelman AM, Bohinski JM, Boente A. The social context of sexual health and sexual risk for urban adolescent girls in the United States. *Issues Ment Health Nurs*. 2009; 30:460–9. [PubMed: 19544131]
3. Weinstock H, Berman S, Cates W Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health*. 2004; 36:6–10. [PubMed: 14982671]
4. DiClemente RJ, Salazar LF, Crosby RA. A review of STD/HIV preventive interventions for adolescents: Sustaining effects using an ecological approach. *J Pediatr Psychol*. 2007; 32:888–906. [PubMed: 17726032]
5. Collins WA, Welsh DP, Furman W. Adolescent romantic relationships. *Annu Rev Psychol*. 2009; 60:631–52. [PubMed: 19035830]
6. Collins WA. More than myth: the developmental significance of romantic relationships during adolescence. *J Res Adolesc*. 2003; 13:1–24.
7. Centers for Disease Control and Prevention. HIV among youth. 2011. Available at: <http://www.cdc.gov/hiv/youth/pdf/youth.pdf>
8. Forhan SE, Gottlieb SL, Sternberg MR, et al. Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. *Pediatrics*. 2009; 124:1505–12. [PubMed: 19933728]
9. Rangel MC, Gavin L, Reed C, et al. Epidemiology of HIV and AIDS among adolescents and young adults in the United States. *J Adolesc Health*. 2006; 39:156–63. [PubMed: 16857526]
10. Harter, S. *The construction of the self*. New York: Guilford; 1999.
11. Connolly JA, Konarski R. Peer self-concept in adolescence: analysis of factor structure and of associations with peer experience. *J Res Adolesc*. 1994; 4:385–403.
12. Kuttler AF, LaGreca AM, Prinstein MJ. Friendship qualities and social-emotional functioning of adolescents with close, cross-sex friendships. *J Res Adolesc*. 1999; 9:339–66.
13. Masten AS, Coatsworth JD, Neemann JI, et al. The structure and coherence of competence from childhood through adolescence. *Child Dev*. 1995; 66:1635–59. [PubMed: 8556890]
14. Banister EM, Jakubec SL, Stein JA. “Like what am I supposed to do?”: Adolescent girls’ health concerns in their dating relationships. *Can J Nurs Res*. 2003; 35:16–33. [PubMed: 12908195]
15. Erikson, EH. *Identity: youth and crisis*. New York: W. W. Norton; 1968.
16. Davila J, Steinberg S, Kachadourian L, et al. Romantic involvement and depressive symptoms in early and late adolescence: the role of a preoccupied relational style. *Personal Relationships*. 2004; 11:161–78.
17. Zimmer-Gembeck MJ, Siebenbruner J, Collins WA. Diverse aspects of dating: associations with psychosocial functioning from early to middle adolescence. *J Adolesc*. 2001; 24:313–36. [PubMed: 11476609]
18. Zimmer-Gembeck MJ, Siebenbruner J, Collins WA. A prospective study of intraindividual and peer influences on adolescents’ heterosexual romantic and sexual behavior. *Arch Sex Behav*. 2004; 33:381–94. [PubMed: 15162084]
19. Furman, W.; Wehner, EA. Adolescent romantic relationships: A developmental perspective. In: Collins, WA.; Shulman, S., editors. *Romantic relationships in adolescence: Developmental perspectives*. San Francisco: Jossey-Bass; 1997. p. 21–36.
20. Way N. Can’t you hear the strength and courage that I have?”: Listening to urban adolescent girls speak about their relationships with peers and parents. *Psychol Women Q*. 1995; 19:107–28.
21. Banister E, Schreiber R. Young women’s health concerns: revealing paradox. *Health Care Women Int*. 2001; 22:633–48. [PubMed: 12141841]
22. Seth P, Raiford JL, Robinson L, Wingood GM. Intimate partner violence and other partner-related factors: correlates of sexually transmissible infections and risky sexual behaviours among young adult African American women. *Sex Health*. 2010; 7:25–30. [PubMed: 20152092]

23. Pulerwitz J, Amaro H, De Jong W, et al. Relationship power, condom use and HIV risk among women in the USA. *AIDS Care*. 2002; 14:789–800. [PubMed: 12511212]
24. Guerrero, LK.; Andersen, PA. AfifiWA. *Close encounters: communication in relationships*. 2. Thousand Oaks, CA: Sage Publications, Inc; 2007.
25. Centers for Disease Control and Prevention. HIV among African Americans. 2011. Available at: <http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf>
26. DiClemente RJ, Crittenden CP, Rose E, et al. Psychosocial predictors of HIV-associated sexual behaviors and the efficacy of prevention interventions in adolescents at-risk for HIV infection: What works and what doesn't work? *Psychosomatic Medicine*. 2008; 70:598–605. [PubMed: 18541908]
27. Bauermeister JA, Zimmerman M, Xue YG, et al. Working, sex partner age differences, and sexual behavior among African American youth. *Arch Sex Behav*. 2009; 38:802–13. [PubMed: 18574686]
28. DiClemente RJ, Wingood GM, Rose ES, et al. Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services: A randomized controlled trial. *Arch Pediatr Adolesc Med*. 2009; 163:1112–21. [PubMed: 19996048]
29. Zimet GD, Dahlem NW, Zimet SG, Farley GK. Multidimensional Scale of Perceived Social Support. *J Pers Assess*. 1988; 52:30–41.
30. Pulerwitz J, Gortmaker SL, DeJong W. Measuring sexual relationship power in HIV/STD research. *Sex Roles*. 2000; 42:637–60.
31. Wingood GM, DiClemente R. Relationship characteristics and gender-related factors associated with noncondom use among young adult African American women. *Am J Community Psychol*. 1998; 26:29–51. [PubMed: 9574497]
32. Wingood GM, DiClemente RJ. Partner influences and gender-related factors associated with noncondom use among young adult African American women. *Am J Community Psychol*. 1998; 26:29–51. [PubMed: 9574497]
33. Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Educ Behav*. 2000; 27:539–65. [PubMed: 11009126]
34. Miller KS, Clark LF, Moore JS. Sexual initiation with older male partners and subsequent HIV risk behavior among female adolescents. *Fam Plann Perspect*. 1997; 29:212–4. [PubMed: 9323497]
35. Bowlby, J. *Separation: Anxiety and anger*. New York: Basic Books; 1973. Attachment and loss: Vol. 2.
36. Melendez RM, Hoffman S, Exner T, et al. Intimate partner violence and safer sex negotiation: effects of a gender-specific intervention. *Arch Sex Behav*. 2003; 32:499–511. [PubMed: 14574094]
37. Raiford JL, DiClemente RJ, Wingood GM. Effects of fear of abuse and possible STI acquisition on the sexual behavior of African American adolescent girls and young women. *Am J Public Health*. 2009; 99:1067–71. [PubMed: 19372531]
38. Adimora AA, Schoenbach VJ, Martinson FEA, et al. Social context of sexual relationships among rural African Americans. *Sexually Transmitted Diseases*. 2001; 28:69–76. [PubMed: 11234788]

IMPLICATIONS AND CONTRIBUTION

This study examined the association between the relative importance adolescent girls place on being in a relationship and their engagement in risky sexual practices and other adverse relationship dynamics. The findings demonstrate a heightened risk for HIV and other STIs during adolescence.

Table 1

The association between endorsing a relationship imperative and HIV/STI-related psychosexual outcomes and high-risk sexual behaviors

Psychosexual outcomes	Relationship imperative ^a		AOR ^b	95% CI
	Yes n (%)	No n (%)		
Perceived lack of power in relationship	127 (61.7%)	204 (40.1%)		
Age			1.0	.9–1.1
Public assistance			.6 ^f	.5–.9
Typical age difference of partner			1.2	.9–1.7
Endorsed a relationship imperative			2.3 ^h	1.7–3.2
Low self-efficacy to refuse sex ^c	133 (64.6%)	239 (47%)		
Age			1.1	1.0–1.2
Public assistance			1.2	0.8–1.6
Social support			1.9 ^h	1.4–2.5
Typical age difference of partner			1.0	1.4–.7
Endorsed a relationship imperative			2.0 ^h	1.5–2.9
Fear of condom negotiation	111 (53.9%)	219 (43%)		
Age			1.0	1.0–1.1
Public assistance			.8	.6–1.0
Typical age difference of partner			1.3	1.0–1.8
Endorsed a relationship imperative			1.5 ^e	1.1–2.1
Ever abused by a partner	113 (54.9%)	227 (44.6%)		
Age			1.1 ^f	1.0–1.2
Public assistance			.5 ^h	.4–.7
Typical age difference of partner			1.7 ^g	1.3–2.4
Endorsed a relationship imperative			1.5 ^e	1.1–2.1
Recent partner abuse ^d	41 (19.9%)	68 (13.4%)		
Age			1.0	.8–1.3
Public assistance			.6 ^e	.4–.9
Typical age difference of partner			1.7 ^e	1.1–2.9
Endorsed a relationship imperative			1.6 ^e	1.0–2.6
Sexual risk behaviors				
Unprotected sex prior to being treated for STI symptoms	32 (15.5%)	65 (12.8%)		
Age			.8	.6–1.1
Public assistance			1.4	.6–3.2
Typical age difference of partner			1.1	.4–2.8
Endorsed a relationship imperative			3.9 ^e	1.2–12.6
Unprotected sex at last sex w/boyfriend	111 (53.9%)	237 (46.6%)		
Age			.9	.8–1.0
Public assistance			1.2	.8–1.7

Psychosexual outcomes	Relationship imperative ^a		AOR ^b	95% CI
	Yes <i>n</i> (%)	No <i>n</i> (%)		
Age of current boyfriend			1.9 ^h	1.3–2.6
Endorsed a relationship imperative			1.6 ^e	1.1–2.4
Unprotected sex at last sex w/casual partner	35 (17%)	50 (9.8%)		
Age			1.0	.8–1.2
Public assistance			1.7	1.0–3.0
Typical age difference of partner			1.3	.7–2.5
Endorsed a relationship imperative			2.1 ^f	1.2–3.7
Ever had anal sex	68 (33%)	106 (20.8%)		
Age			1.2 ^h	1.1–1.3
Public assistance			.6 ^e	.5–.9
Typical age difference of partner			1.6 ^f	1.1–2.4
Endorsed a relationship imperative			1.8 ^g	1.3–2.7
Sex while partner was high on alcohol/drugs	108 (52.4%)	213 (41.8%)		
Age			1.2 ^g	1.1–1.3
Public assistance			.7 ^e	.5–.9
Typical age difference of partner			1.7 ^f	1.3–2.4
Endorsed a relationship imperative			1.5 ^e	1.1–2.1

^a Participants were coded 1 (yes, endorsed a relationship imperative) or 0 (no, did not endorse a relationship imperative).

^b Adjusted odds ratio (AOR); odds ratio adjusted by age, public assistance, and typical age difference of partner.

^c Odds ratio adjusted by perceived social support.

^d For participants 18 years and older (*n* = 388).

^e *p* .05.

^f *p* .01.

^g *p* .001.

^h *p* .0001.

Table 2

Psychosocial factors associated with testing positive for a sexually transmitted infection

Psychosocial factors	AOR ^a	95% CI	p
Perceived relationship power			
Low	3.9	1.0–14.9	.05
High	1.0		
Perceived self-efficacy to refuse sex			
High	3.8	1.2–12.2	.02
Low	1.0		
Recent partner abuse ^b (past 60 days)			
Yes	3.4	1.0–11.6	.05
No	1.0		

^aOdds ratio adjusted by age and public assistance.

^bFor participants 18 years and older ($n = 388$).