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Young Women's Experiences with Coercive and Non-Coercive Condom Use Resistance: Examination of an Understudied Sexual Risk Behavior

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Abstract

Objectives.—To investigate young women's engagement in and receipt of condom use resistance (attempts to avoid condom use with a partner who wants to use one; CUR), including nonconsensual condom removal ("stealthing"), with male partners.

Methods.—Participants were 503 women aged 21–30 with elevated sexual risk characteristics recruited from 2013 to 2017. Participants completed measures assessing sexual victimization history and CUR experiences.

Results.—Findings indicated that 87% of women experienced non-coercive CUR from a partner, while 49% experienced coercive CUR. 58% and 19% of women reported having engaged in non-coercive and coercive CUR, respectively. 12% of women had a partner engage in stealthing; none of the women engaged in stealthing. Severity of sexual victimization history was positively associated with both use and receipt of coercive and non-coercive CUR. STI diagnoses were positively associated with receipt of, but not engagement in, CUR.

Conclusions.—Findings demonstrate that sexual victimization and both the use and receipt of CUR are positively related for young women, suggesting that prevention efforts focusing on women's sexual health would benefit from joint consideration of sexual violence and risk behaviors and that such efforts should target victims of sexual violence.

Keywords

condom use resistance; sexual victimization; sexual risk behavior; sexually transmitted infection

Although correct, consistent condom use can greatly reduce STI transmission and unwanted pregnancies, research demonstrates that active resistance of condom use (i.e., attempting to avoid using a condom with a partner who wants to use one) is common among young adults, primarily due to concerns about reductions in physical pleasure for both men and women (Higgins & Smith, 2016; Measor, 2006). One study of undergraduates revealed that almost

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half of the sample reported forgoing condom use at least once due to a partner's influence (Smith, 2003). In a study of young men who have sex with women, 80% of participants reported having engaged in condom use resistance with a female partner who wanted to use a condom (Davis, Stappenbeck, et al., 2014). Participants described various ways of resisting condom use, including seduction (used by 73%) and assuring their partner that they are low risk (74%). A study of 235 young heterosexual women reported that nearly half (48.5%) had resisted condom use with a male partner, and women who reported having an STI diagnosis were significantly more likely to have resisted condom use than were women without an STI history (Wegner, Lewis, Davis, Neilson, & Norris, 2017). The above studies demonstrate that women experience condom use resistance from their partners as well as engage in condom use resistance themselves. However, to date no study has examined the factors associated with women's experiences of receiving and initiating resistance of condom use or how these experiences might relate to one another.

One individual factor likely associated with women's experiences with condom use resistance is their sexual victimization history. Estimates of sexual victimization rates of women in the general population vary across Western countries, with 36.3% of American women and 20.3% of women in England and Wales reporting lifetime sexual victimization and 13.4% of young Canadian women reporting sexual victimization over a 12 month period (Conroy & Carter, 2017; Office for National Statistics, 2018; Smith et al., 2017). Although women differ in their post-assault sexual behaviors (Campbel, Sefl, & Ahrens, 2004), research indicates that some women may engage in greater sexual risk behavior (e.g., condomless sex) following sexual victimization (Orchowski, Gobin, & Zlotnick, 2018). This may in part be due to mediators of the sexual victimization-sexual risk link that occur during condom negotiation processes. For example, relative to their non-victimized counterparts, women who have experienced sexual victimization are less sexually assertive and more likely to anticipate that their male sex partners will react negatively to condom use insistence, potentially increasing their likelihood of acquiescing to a partner who resists condom use (Stoner et al., 2008; Masters et al., 2014). Although studies have reported that men with a history of sexual aggression perpetration are more likely than non-perpetrators to engage in condom use resistance (Davis & Logan-Greene, 2012; Davis et al., 2016; Purdie, Abbey, & Jacques-Tiura, 2010; Raj et al., 2006), no studies have examined how a history of sexual victimization might relate to women's experiences of condom use resistance from their male partners or their own engagement in condom use resistance. Because women with a sexual victimization history may be especially vulnerable to condom use resistance strategies that involve pressure, manipulation, or coercion (George et al., 2016), research in this area is warranted.

Coercive condom use resistance strategies are not uncommon. For example, a U.S. survey of heterosexual men found that just over one-third reported having successfully used verbal coercion and/or physical force to obtain unprotected sex with a partner who wanted to use a condom; 31% of the sample reported having successfully used these tactics on more than one occasion (Davis & Logan-Greene, 2012). Almost one-third of men reported having used emotional manipulation (e.g., threatening to become angry) and approximately 25% reported having used deception (e.g., lying about not having an STI; Davis et al., 2014), while a smaller minority of women reported engaging in emotional manipulation (15.3%) and

deception (5.5%) to avoid condom use (Wegner et al., 2017). Of particular interest is a condom use resistance behavior that some have termed “stealthing”, in which one agrees to use a condom during intercourse, but then removes the condom before or during intercourse without the partner’s knowledge or consent. Stealthing behavior has received a great deal of coverage in the popular press in Western countries since 2017 (Colino, 2017; Glasser, 2017; Hosie, 2017; Mullin, 2017; Nedelman, 2017). Because this behavior involves the nonconsensual removal of a condom, legislators in several U.S. states are seeking to categorize stealthing as a form of sexual assault through legislative efforts (Assembly Democrats, 2018; Persio, 2017). Although previous studies have investigated “condom sabotage” which includes nonconsensual condom removal as well as intentional condom breakage (Davis, Stappenbeck et al., 2014; Wegner et al., 2017), no published studies have examined experiences of nonconsensual condom removal (stealthing) in isolation.

The purpose of this study was to (1) investigate the association of young women’s engagement in and receipt of condom use resistance with male partners; (2) identify the relationship between women’s sexual victimization history and condom use resistance; and (3) present novel information on women’s experiences with nonconsensual condom removal (stealthing). We hypothesized that women’s receipt of and engagement in condom use resistance would be positively associated, and that women with a more severe history of sexual victimization would be more likely to have received condom use resistance from their partners. We also predicted that women who had experienced condom use resistance would report higher rates of lifetime STI diagnoses than women who had not experienced condom use resistance.

Method

Participants

We recruited women ages 21–30 who were non-problem drinkers and met the following inclusion criteria: 1) condomless consensual sexual intercourse with a man at least once in the past year; 2) at least one indicator of sexual risk (e.g., lifetime STI diagnosis; within the past year having two or more male sex partners, having a new male sex partner, or knowing/suspecting that a male sex partner was having a concurrent sexual relationship, had a current STI, had been incarcerated in the past 12 months, or had ever used IV drugs or had same-sex sexual experiences); 3) had sex at least twice in the past month; and 4) consumed alcohol at least twice in the past month. The larger study included an alcohol administration component and therefore exclusion criteria were consistent with the NIAAA guidelines for the administration of alcohol (NIAAA, 2005): 1) history of problem drinking based on the Brief Michigan Screening Test (Pokorny, Miller, & Kaplan, 1972) or negative reactions to drinking (e.g., fainting or having a seizure after drinking); and 2) medication usage or a medical condition (e.g., pregnancy) that contraindicated alcohol consumption.

Procedure

All procedures were approved by the university’s Institutional Review Board. Participants were recruited via online and print advertisements from the local community. Interested women were screened over the telephone for inclusion and exclusion criteria. The larger

study was conducted in 3 phases. First, women completed an online background survey. Next, they participated in a 32-day daily monitoring period. Finally, they attended an in-lab session that consisted of an online survey and an alcohol administration protocol. The current study included data from the online background survey and the in-lab survey only. We split the administration of background measures across two surveys (one administered online in the location of the participant's choosing and one administered in-lab) to reduce participant burden, and opted to administer measures with greater sensitivity in-lab to mitigate the effects of any distractions and manage any potential participant concerns. Six hundred women were recruited and completed the online survey; and 503 (83.8%) participated in the in-lab session. Therefore, our final sample consists of 503 women. Both surveys were administered online using secure software (i.e., Qualtrics).

Eligible participants were sent an email with a link to a survey and were given one week to complete an information statement describing the study and the online background survey. Participants received reminder calls, texts, and emails to increase participation and compliance. Participants were asked to complete the online survey in a private place all in one sitting. Upon completing the online survey, participants were scheduled for a 32-day daily monitoring period not described here. Following that, 83.8% ($n=503$) presented for an in-lab session conducted by a trained female research assistant (RA). The RA checked the participants' identification to verify age and identity, obtained informed consent for this portion of the study, and then participants completed the in-lab survey on a computer in a private room. Participants were paid \$20 for the online survey and \$15/hr for the in-lab session.

Measures

Condom use resistance.—The Condom Use Resistance (CUR) survey was administered in the online survey (Davis, Stappenbeck, et al., 2014). Participants were asked to indicate the number of times (capped at '*20 or more times*') since the age of 14 in which a male sexual partner successfully used each of the 35 tactics to obtain condomless sex when she wanted to use a condom. Items were summed within each of the 12 subscales and within the two overarching categories of non-coercive and coercive tactics. The following are the 7 non-coercive subscales: Risk-Level Reassurance (4 items; e.g., "Reassuring you that he was 'clean' so that you would have sex without a condom"), Seduction (3 items; e.g., "Getting you so sexually excited that you agreed to have sex without a condom"), Loss of Arousal (3 items; e.g., "Telling you that he could lose his erection during sex if you had to use a condom"), Reduced Sensitivity (3 items; e.g., "Telling you that he didn't want to use a condom because sex doesn't feel as good with one on"), Direct Request (3 items; e.g., "Asking you to not use a condom during sex"), Withholding Sex (3 items; e.g., "Telling you that he would not have sex with you if you had to use a condom"), and Relationship and Trust (3 items; e.g., "Telling you that you trusted each other so that you would have sex without a condom"), and 5 coercive subscales: Emotional Manipulation (3 items; e.g., "Telling you how angry he would be if you insisted on using a condom"), Deception (4 items; e.g., "Pretending that he had been tested and did not have any STD's"), Stealthing (1 item; e.g., "Agreeing to use a condom, but removing it before or during sex without telling you"), Intentional Condom Breakage (2 items; e.g., "Agreeing to use a condom but

intentionally breaking the condom when putting it on”), and Force (3 items; e.g., “Preventing you from getting a condom by staying on top of you”). Participants also completed a similar set of 38 items regarding their own use of these tactics with male partners who wanted to use a condom.

Adolescent and adult sexual assault victimization.—The revised Sexual Experiences Survey was administered as part of the in-lab survey to assess nonconsensual sexual experiences since age 14 to the present (Koss et al., 2007). The sex of the perpetrator was not assessed. Types of unwanted sexual behavior assessed included sexual contact (e.g., fondling) and attempted or completed oral, vaginal, or anal penetration. Perpetrator tactics included verbal coercion, intoxication, and force. Participants indicated the number of times each sexual act occurred by each tactic used on 3-point response scales (0 = *never*; 3 = *3 or more times*). Sexual assault severity was calculated by multiplying a severity rank that represented a cross between the tactic and outcome (0 = *none*, 1 = *sexual contact by verbal coercion*, 2 = *sexual contact by intoxication*, 3 = *sexual contact by force*, 4 = *attempted or completed rape by verbal coercion*, 5 = *attempted or completed rape by intoxication*, 6 = *attempted or completed rape by physical force*) by the frequency with which each combination occurred, resulting in a possible range of 0–63 (Davis, Gilmore, Stappenbeck, Balsan, George, & Norris, 2014).

Sexual history.—The Sexual History and Experiences questionnaire was administered in the online survey and used to assess sexual behavior including the number of lifetime male consensual sexual partners and STI diagnosis history (George et al., 2011).

Analytic Plan

First, we used chi-square analyses to examine differences in STI diagnosis and sexual assault history by CUR experiences. Because coercive and non-coercive CUR are not mutually exclusive, we conducted separate chi-squares for receipt of non-coercive CUR, use of non-coercive CUR, receipt of coercive CUR, and use of coercive CUR. Next, we examined whether a more severe sexual assault history was associated with receipt of and engagement in coercive and non-coercive CUR. Because the CUR variables were significantly positively skewed and were count variables, we used Generalized Linear Models (GzLMs) with negative binomial distributions and log link functions. These models provide incidence rate ratios (IRRs) which serve as standardized effect sizes. Additionally, in all models we controlled for age and the number of lifetime sexual partners which could be associated with CUR due to increased opportunity for sexual experiences. Victims of sexual assault tend to have more sexual partners than their non-victimized counterparts (Senn, Carey, & Venable, 2008) and we wanted to determine if sexual assault severity was associated with CUR above and beyond the influence of the number of sexual partners (which may also increase the likelihood of having been exposed to CUR).

Results

Participant characteristics are presented in Table 1. Eighty seven percent of the sample reported receipt of non-coercive CUR and 48.9% reported receipt of coercive CUR from

their male sex partners. A smaller percentage of women engaged in CUR tactics with their partners: 57.9% reported engaging in non-coercive CUR and 19.4% coercive CUR. Of note, 12.2% of women reported that their partner had engaged in stealthing with them; however, none of the women reported engaging in stealthing. Table 2 provides the frequencies of receipt and engagement in the specific coercive and non-coercive tactic types.

Compared to women who reported not receiving each form of CUR, women who reported receipt of coercive or non-coercive CUR were more likely to have ever been diagnosed with an STI ($\chi^2 = 19.54, p < .001$, Cramer's $V = .20, p < .001$; $\chi^2 = 5.14, p < .05$, Cramer's $V = .10, p < .05$, respectively), and were more likely to have a history sexual assault ($\chi^2 = 18.25, p < .001$, Cramer's $V = .19, p < .001$; $\chi^2 = 8.42, p < .01$, Cramer's $V = .13, p < .01$, respectively). There were no differences in STI diagnoses for women who used coercive and non-coercive CUR and those who did not use those forms of CUR, respectively (p 's $> .33$). However, women who used non-coercive CUR were more likely to have a history of sexual assault ($\chi^2 = 6.47, p < .05$, Cramer's $V = .11, p < .05$) compared to women who had not used non-coercive CUR.

Results of the GzLMs are provided in Table 3. After controlling for age and number of lifetime sexual partners, a more severe history of sexual assault was associated with both receiving and engaging in a greater number of non-coercive and coercive CUR events. To contextualize the findings, an increase in sexual assault severity from 0 (i.e., no history of sexual assault) to the mean ($M = 9.1677$) would be associated with receipt of 6.4 additional instances of non-coercive CUR, and an increase from the mean to +1 standard deviation above the mean would result in the receipt of 12.4 additional instances of non-coercive CUR. Similarly an increase from no history of sexual assault to the mean of sexual assault severity would be associated with an increase in 0.6 additional instances in receipt of coercive CUR, and an increase from the mean to +1 standard deviation above the mean would be associated with an additional 1.4 instances of receipt of coercive CUR. In regards to the association of sexual assault severity with engagement in CUR, an increase from no history to the mean would be associated with 2.0 and 0.2 more instances of non-coercive and coercive CUR, respectively, and an increase from the mean to +1 standard deviation above the mean would be associated with 3.6 and 0.4 more instances of non-coercive and coercive CUR, respectively.

Discussion

This study presents novel information about women's use and receipt of coercive and non-coercive CUR with male sexual partners, the associations of these experiences with lifetime STI diagnoses and sexual assault history, and the occurrence of stealthing within this sample. Our investigation demonstrates that many of the young women in our sample who have sex with men experience condom use resistance. A large majority of our sample reported receiving non-coercive condom use resistance from their male partners; almost half of the sample had a male partner resist condom use coercively. Moreover, non-coercive condom use resistance was experienced an average of 40 times, demonstrating that these experiences were both widespread and common. Future research could investigate not only

the number of times such coercive condom use resistance events occur, but also what proportion of sexual experiences these events represent.

Our innovative examination of women's use and receipt of CUR revealed that although women were more likely to experience condom use resistance from their partners, over half of the sample also engaged in condom use resistance themselves, with almost 20% reporting that they had used coercive tactics such as emotional manipulation to resist condom use. Because the receipt of and engagement in condom use resistance were positively correlated, prevention programs targeting young women's condom use and negotiation skills could be enhanced by not only teaching women how to respond to men's condom use resistance tactics but also motivating them to desist from engaging in the practice themselves. Notably though, resistance to condom use by male partners was positively associated with women's STI diagnosis rates while women's own engagement in condom use resistance was not, suggesting that male partners who resist condom use may present increased STI risk to their female sex partners. This, coupled with the higher rates of men's condom use resistance, indicates that targeting men's condom use resistance, and women's responses to it, may deserve prioritization in sexual risk reduction programs. Finally, we know little about the ways in which women's condom use resistance may affect their male partners' sexual health; future research should investigate this knowledge gap.

Our findings also demonstrate that targeting sexual risk reduction interventions towards women with more severe sexual assault victimization histories may also strengthen the impact of these programs on women's sexual health. After controlling for age and number of lifetime sexual partners, the severity of women's sexual victimization history was positively associated with receiving and using both coercive and non-coercive condom use resistance. Although other studies have demonstrated that men's history of perpetrating sexual assault is associated with resistance to condom use and use of force to obtain condomless sex (see Davis, Neilson, Wegner, & Danube, 2018 for a review), this is the first investigation documenting the association of sexual assault history and condom use resistance in women. Previous studies have documented that sexually victimized women are more likely than non-victims to engage in a variety of sexually risky behaviors, such as inconsistent condom use and having a higher numbers of sexual partners (Senn et al., 2008). Our results suggest that at least part of women's inconsistent condom use rates may be due to active resistance of condom use by themselves and their partners. Although women with a sexual assault history may be more likely to acquiesce to men's resistance of condom use due to lower sexual assertiveness and/or fear regarding their partners' reactions to condom use insistence (George et al., 2016; Masters et al., 2014; Stoner et al., 2008), reasons for the association between women's sexual victimization history and their own engagement in condom use resistance are unclear. Additional study is needed to clarify the possible mechanisms underlying these associations, as well as the event-level associations between sexual assault and condom use resistance. For example, research indicates that the majority of sexual assaults do not involve condom use (Davis, et al., 2012; Davis, Danube, Stappenbeck, Norris, & George, 2015); however, little research has examined how the processes regarding consent and condom use negotiation may unfold. Perhaps some sexual situations begin consensually but then become nonconsensual due to disagreement about condom use. Future research should examine these event-level dynamics. Additionally, although women are less

likely to perpetrate sexual aggression than men (Breiding et al., 2014), future studies should investigate how women's sexual assault perpetration may relate to their condom use resistance experiences.

This study also presents novel information about "stealthing" (nonconsensual condom removal). Approximately 12% of participants reported having a sexual partner surreptitiously remove a condom before or during intercourse; none of the women reported engaging in this behavior themselves. Importantly, because stealthing occurs without the partner's knowledge, many women may never realize that a condom was not used in a particular instance. Currently there is no research evidence demonstrating the extent to which women ultimately discover whether or not they have been a victim of stealthing; as such, it is possible that the rate of stealthing reported in this study is an underestimate. While there is some debate about whether such events should be considered a form of sexual assault in that the partner is engaging in a sexual act without explicit consent from the woman (Brodsky, 2017; Colino, 2017; Mullin, 2017; Nedelman, 2017), the potential consequences to women's health are clear. Condomless sex increases one's risk for STI transmission and unintended pregnancy. Moreover and significantly, because the partner did not know that a condom was not used, early prevention strategies such as Plan B (pregnancy) or PEP (post-exposure prophylaxis for HIV) may not be used. Further, most STI's do not have preventative measures other than condoms; thus, coercive condom use resistance tactics like stealthing that undermine women's ability to protect their sexual health are particularly egregious.

Limitations

Our findings should be considered within the context of the study's limitations. First, generalizability of study findings is somewhat limited. Our use of a volunteer community sample of elevated sexual risk does not allow us to generalize our results to all young women. That noted, investigation of higher risk individuals strengthens the public health impact of the findings. Second, women were asked to report on their sexual assault victimization and condom use resistance experiences that had occurred since age 14; because of the retrospective nature of the data, some participants may not have accurately recalled every event experienced. Condom use resistance items did not specify the type of sexual act or sexual partner with which the resistance occurred; future research could assess whether condom use resistance events and tactics vary by the type of sexual act or sexual partner involved (Sparling & Cramer, 2015). Finally, the cross-sectional nature of our data does not enable us to make causal inferences about our study results.

Implications for Policy and/or Practice

Findings from the current study demonstrate the importance of addressing the sexual risk behavior of condom use resistance in interventions targeting the sexual health of young women and men. In particular, because of the prevalence of coercive CUR tactics, such interventions should include discussion of healthy communication and consent in sexual situations for men and women, both generally and within the specific context of condom negotiation. These interventions may be especially important for women with a history of sexual victimization given their higher rates of CUR experiences.

Conclusions

Our results demonstrate that resistance of condom use is a widespread and frequent occurrence among both male and female young adults and may, at least in part, account for the high rates of some STI's in this population. Because sexual assault victims report greater receipt of and engagement in condom use resistance, targeting prevention efforts towards women with a sexual victimization history may increase their public health impact. Study findings also demonstrate that stealthing, which is coercive and diminishes women's sexual agency, poses a significant risk to women's sexual health and merits further research.

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Table 1.Participant characteristics ($N = 503$).

Characteristic	M (SD)
Age	25.0 (2.7)
	%
Race/ethnicity	
White	71.7
Asian/Asian American	8.3
Black	4.9
Native American/Alaskan Native	2.2
Multi-racial or other	12.9
Education	
At least some high school	4.0
Trade or vocational/technical school	1.8
At least some college	84.3
Graduate school	9.9
Employment	
Not employed	25.0
Employed part-time	50.4
Employed full-time	24.6
Marital status	
Single	89.9
Married or cohabitating	5.4
Separated or divorced	4.4
	Mode
Annual income	\$11,000 – 20,999

Note. The observed age range was 21–30.

Table 2.

Descriptive information for CUR subscales.

	Experienced CUR			Used CUR		
	N (%)	Range	M (SD)	N (%)	Range	M (SD)
Frequency of non-coercive CUR	434 (86.6)	0–352	40.7 (56.6)	290 (57.9)	0–290	17.4 (37.7)
Frequency of coercive CUR	245 (48.9)	0–91	3.9 (9.4)	97 (19.4)	0–43	1.1 (3.8)
Frequency of non-coercive CUR by tactic type						
Risk-level reassurance	373 (74.6)	0–76	9.3 (12.9)	251 (50.2)	0–80	6.4 (12.2)
Seduction	385 (76.8)	0–60	11.2 (14.8)	186 (37.2)	0–60	4.2 (10.4)
Loss of arousal	125 (25.1)	0–60	2.9 (9.0)	44 (8.7)	0–76	0.8 (5.0)
Reduced sensitivity	294 (58.7)	0–60	8.7 (14.4)	120 (24.0)	0–60	2.3 (7.3)
Direct request	225 (45.0)	0–60	6.1 (13.1)	132 (26.4)	0–60	2.8 (9.1)
Withholding sex	42 (8.4)	0–45	0.6 (3.6)	4 (0.01)	0–40	0.1 (1.9)
Relationship and trust	162 (32.3)	0–60	2.1 (5.4)	78 (25.6)	0–26	0.8 (2.7)
Frequency of coercive CUR by tactic type						
Emotional manipulation	142 (28.4)	0–60	2.1 (5.7)	72 (14.4)	0–28	0.7 (2.7)
Deception	136 (27.2)	0–28	1.2 (3.5)	33 (6.6)	0–21	0.3 (1.6)
Stealthiness	61 (12.2)	0–17	0.26 (1.2)	0	0	0
Intentional condom breakage	13 (2.6)	0–12	0.7 (0.64)	3 (0.01)	0–8	0.2 (0.4)
Force	59 (11.8)	0–21	0.4 (2.0)	12 (2.4)	0–20	0.1 (1.0)

Note. CUR = condom use resistance

Results of Generalized Linear Models (GzLMs) examining the influence of sexual assault severity as a predictor of the experience and use of non-coercive and coercive CUR.

Table 3.

	Experienced CUR			Used CUR		
	B	IRR	95% CI	B	IRR	95% CI
Non-coercive CUR						
Age	.020	1.02	0.99, 1.05	-.020	0.98	0.95, 1.02
Number of lifetime sexual partners	.014	1.01	1.01, 1.02	.019	1.02	1.01, 1.03
Sexual assault severity	.020	1.02	1.01, 1.03	.014	1.01	1.01, 1.02
Coercive CUR						
Age	.023	1.02	0.99, 1.06	-.003	0.997	0.95, 1.05
Number of lifetime sexual partners	.002	1.00	0.99, 1.01	.023	1.02	1.01, 1.04
Sexual assault severity	.042	1.04	1.03, 1.05	.027	1.03	1.02, 1.04

Note. CUR = condom use resistance; IRR = Incidence rate ratio; CI = confidence interval