Anecdotal information suggests that, for Hispanic women who are involved with abusive partners, condom use request as an HIV/AIDS sexual risk-reduction behavior may expose the women to risk of both abuse and HIV/AIDS. A qualitative study explored barriers to condom negotiation for HIV/AIDS prevention among Mexican and Mexican American women in abusive relationships. A convenience sample of 14 Mexican and Mexican American women was recruited from a battered women’s shelter. A demographic form, a domestic violence assessment form, and audiotaped responses to a semistructured interview guide were used to collect data. Descriptive statistics were used to describe the sample. Audiotaped interviews were transcribed verbatim and submitted to content analysis, which revealed past and present themes of physical, psychological, and sexual abuse of Mexican and Mexican American women who requested condom use by their male sexual partners. Also identified by content analysis was the influence of men’s power on women’s public, private, and sexual interactions.

Autoimmune deficiency syndrome (AIDS) is a serious and rapidly growing threat to Hispanic women’s health. Hispanic women account for less than 8% of the total adult U.S. population, yet they represent 19% of all Centers for Disease Control (CDC)-reported AIDS cases.
Among adult women (CDC, 1997). AIDS is now the second leading cause of death among Hispanics between the ages of 25 to 44 and the eighth leading cause of death among all Hispanics. Forty-six percent of all CDC-reported AIDS cases among Hispanic women have been acquired through heterosexual intercourse (CDC, 1997). The public health message to women is to prevent AIDS through condom use. However, women are often not in a position to negotiate condom use with their male sexual partners. The fear of abuse or the experience of abuse plays a role in the reality of requesting condom use. In this article, we describe a pilot study that looked at woman abuse as a barrier to condom negotiation for HIV/AIDS prevention among specific Hispanic ethnic subgroups of women.

The need for this study was identified in a psychiatric mental health nursing clinical practice in a battered women’s shelter located in an urban city in south central Texas. The focus of the clinical practice was individual psychotherapy for women in abusive relationships. Within the clinical practice, it became apparent that for some women in abusive situations, abuse and AIDS risk were common and sometimes interdependent realities. Numerous women described incidents of physical, psychological, and sexual abuse. The majority of the identified perpetrators of the abuse were spouses or significant others. Recurrent themes within the psychotherapy sessions of abuse and risky sexual behaviors led to development of this pilot study.

REVIEW OF THE LITERATURE

The term Hispanic, as an ethnic identifier, is an umbrella term developed in the 1980s by the U.S. Bureau of the Census (del Pinal, 1993). As used by the bureau, Hispanic includes U.S. citizens as well as people from the U.S. territory of Puerto Rico. The term Hispanic also includes citizens and residents who identify themselves to be from Mexico, Central and South America, and Spain (Rochin & de la Torres, 1996). The development of the concept of Hispanic as an ethnic category is based on common cultural heritage and values such as ancestry, Spanish language, Catholic religion, and social scripts such as simpatia, the preference for pleasant interpersonal interactions (Garcia, 1996; Sabogal, Faigeles, & Catania, 1993). Although cultural commonality is shared, the different groups of Hispanic women have distinct historical, racial, economic, and political differences. In the United States, the Hispanic women’s ethnic subgroups differ in birthplace and are composed of individuals from Mexico (64.3%), Puerto Rico (10.6%), Cuba (4.7%), Central and South
Mexican and Mexican American Women

America (13.4%) and Other (7%; U.S. Bureau of the Census, 1993). Hispanic women’s ethnic subgroups also differ in region of residence, age, education, socioeconomic status, drug use, sexual behavior, and AIDS risk (Amaro, 1988; Fernandez, 1995; Gomez and Van Oss Marin, 1996; Hargraves, 1996; Marin & Van Oss Marin, 1991). These different socioeconomic and sociodemographic characteristics directly affect the health and lifestyles of Hispanic women’s ethnic subgroups. At present, most health care data, including AIDS cases, use the term Hispanic and do not distinguish among the ethnic subgroups. This failure to distinguish among ethnic subgroups has prevented accurate identification of AIDS risk factors and hindered development of culturally appropriate and effective AIDS prevention strategies among Hispanic women’s ethnic subgroups (Amaro, 1988; Diaz, Buehler, Castro, & Ward, 1993; Wyatt, 1991).

In an attempt to correct this failure to distinguish among specific Hispanic ethnic subgroups, we focused on the identification of HIV/AIDS risk factors specifically among Mexican and Mexican American women. For the purpose of this study, Mexican ethnicity is the term we earn to identify individuals born in Mexico who live in the United States and self-identify as being of Mexican descent. Mexican American ethnicity is the term used to identify individuals born in the United States who self-identify as being of Mexican descent. The term ethnicity is defined as “the culture of a people that is thus critical for values, attitudes, perceptions, needs, modes of expression, behavior and identity” (Jalali, 1988, p. 10).

Often associated with Hispanic ethnicity is the experience of poverty because of limited educational and economic resources. As members of an ethnic minority, numerous Hispanic women experience inadequate education, unemployment or underemployment, low employment wages, and limited personal resources (del Pinal, 1993). Previous research has identified an association between the experience of poverty with its associated life stressors, and the experience of intrafamilial abuse (Bayne-Smith, 1996; Rodriguez, 1995; Straus, Gelles, & Steinmetz, 1980). Table 1 summarizes relevant research on women’s socioeconomic status and its influence on women’s experiences of abuse and AIDS risk.

Woman abuse, a type of intrafamilial abuse, can be defined as any act of coercion, physical or verbal force, humiliation, denial of access to resources, deprivation of liberty, or life-threatening situation that results in psychological or physical harm. The ultimate result of these acts is a woman’s subordination (Browne, 1993; Heise, Germaine, & Pitanguy, 1994). Although woman abuse occurs in families of all educational,
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Study/theory</th>
<th>Purpose</th>
<th>Sample</th>
<th>Results/position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amaro (1988)</td>
<td>Theory</td>
<td>Analyses of factors that place HW at risk for HIV.</td>
<td>Demographics and psychological characteristics of HW must be addressed in HIV prevention strategies.</td>
<td></td>
</tr>
<tr>
<td>Amaro (1995)</td>
<td>Theory</td>
<td>Exploration of societal factors that influence women’s sexual behaviors.</td>
<td>Gender and social status have an adverse impact on women’s sexual behaviors.</td>
<td></td>
</tr>
<tr>
<td>Babcock et al. (1993)</td>
<td>Study</td>
<td>Determination of marital power discrepancies as risk factors for spouse abuse.</td>
<td>Husbands’ violence may be a method to gain control of power over wives.</td>
<td></td>
</tr>
<tr>
<td>Gomez and Van Oss</td>
<td>Study</td>
<td>Obtainment of knowledge on factors that act as barriers to women’s condom use.</td>
<td>Ethnic and sexual gender norms have an adverse impact on women’s condom use.</td>
<td></td>
</tr>
<tr>
<td>Marin (1996)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holland et al. (1990)</td>
<td>Theory</td>
<td>Description of risks women encounter during safer sex negotiation.</td>
<td>Imbalance of power between the sexes prevents women from practicing safer sex.</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 1. Relevant Research on Women’s Social Status and Power
<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>Description</th>
<th>Sample</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kline et al. (1992)</td>
<td>Qualitative study</td>
<td>Exploration of sexual decision making among Black women and HW.</td>
<td>Sixteen focus groups from drug treatment agencies (N = 134).</td>
<td>Women did not adhere to traditional sex roles or exhibit economic independence on their male partners.</td>
</tr>
<tr>
<td>Pizzi (1992)</td>
<td>Theory</td>
<td>Description of psychosocial and sociocultural aspect of women’s lives in relation to HIV/AIDS.</td>
<td></td>
<td>Women’s empowerment is a prerequisite for HIV prevention among women.</td>
</tr>
<tr>
<td>Taylor (1995)</td>
<td>Theory</td>
<td>Examination of gender–power relations and implications for women’s safer sex negotiations.</td>
<td></td>
<td>Social class, culture, and power influence women’s safer sex negotiations.</td>
</tr>
</tbody>
</table>

*Note.* HW = Hispanic women.
economic, and ethnic classes, most research has focused on the European American population. Only recently has the cultural context of woman abuse studies been acknowledged as a vital but missing component in family violence research (Perilla, Bakerman, & Norris, 1994; Sorenson & Telles, 1991; Torres, 1991). Abuse research on Hispanic women varies in topic, ranging from the effects of abuse on a woman’s self-concept (Dimmitt, 1995) to the prevalence and incidence of abuse during pregnancy (McFarlane, Parker, & Soeken, 1996). Table 2 summarizes relevant research on woman abuse among Hispanic samples.

Recent research suggests that for some Hispanic women condom negotiation for HIV/AIDS prevention can increase their risk for both HIV/AIDS and abuse (Davila & Brackley, 1997, 1998; Gomez & Van Oss Marin, 1996). Condom negotiation is a woman’s attempt to persuade a male partner to use a condom during sexual intercourse for prevention of either pregnancy or sexually transmitted disease (Amaro, 1995). For some Hispanic women, condom negotiation can create additional psychosocial stress because it violates sociocultural values and gender norms. Core Hispanic sociocultural values include allocentrism, the emphasis on group conformity rather than personal independence; simpatia, the preference for pleasant interpersonal interactions; and familialism, the promotion of strong attachment to and identification with one’s nuclear and extended family. Power distance—the perception that certain individuals are to be given deference and respect because of inherited or acquired characteristics—is another significant Hispanic cultural value (Marin & Van Oss Marin, 1991). Within Hispanic gender roles, males are expected and encouraged to have numerous sexual conquests as demonstration of their virility. Hispanic women, however, are expected to be virginal and to obtain sexual knowledge and experiences within a marital relationship (Forrest, Austin, Valdez, Fuentes, & Wilson, 1993; Goldstein, 1994). Additionally, Hispanic gender roles stress that “men are men if they father children” and “women are women if they bear children” (Pivnick, 1993, p. 435). Condom negotiation may violate these sociocultural values and gender norms. Within Hispanic culture, which emphasizes children as a sign of virility, condom negotiation by a Hispanic woman may be viewed by a male partner as an affront to his masculinity (Heise & Elias, 1995). Condom negotiation is also in direct conflict with cultural norms that a “good” and “virtuous” woman be pure and naive about sexual topics. A Hispanic woman who negotiates condom use may be viewed as a “bad” or “loose” woman who is overly knowledgeable and experienced in sexual matters (Weeks, Schensul, Williams, Singer, & Grier, 1995).
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Purpose</th>
<th>Sample</th>
<th>Results</th>
<th>Strengths and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell (1989)</td>
<td>Examination of sexual abuse in battering relations.</td>
<td>97 battered and 96 nonbattered women. 5% of battered group was Hispanic.</td>
<td>44.3% of battered women sexually abused; 51% raped at least once in battering relationship.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Davila and Brackley (1997)</td>
<td>Examination of abuse as a barrier to condom use.</td>
<td>MA and Mexican women from a battered women’s shelter (N = 14).</td>
<td>Themes of accusations of infidelity and associated abuse.</td>
<td>Limited generalization to other populations.</td>
</tr>
</tbody>
</table>

(Continued on the next page)
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Purpose</th>
<th>Sample</th>
<th>Results</th>
<th>Strengths and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eby et al. (1995)</td>
<td>Assessment of incidence in violence and risk factors for STD/HIV infection.</td>
<td>$N = 110$ women: 49% White, 42% Black, 5% Latina, and 4% Native American.</td>
<td>1/4 experienced sexual violence, and 2/3 experienced physical violence.</td>
<td>Study was a portion of a larger longitudinal study.</td>
</tr>
<tr>
<td>Kaufman Kantor, Jasinski, and Aldarondo (1994)</td>
<td>Examination of marital violence among Hispanic American and Anglo American families.</td>
<td>1,025 Anglos, 236 Cubans, 175 MA, 327 Mexican, and 105 Puerto Ricans.</td>
<td>Increase in wife assaults by MA and Puerto Rican husbands born in the United States.</td>
<td>Study was a part of a larger, national study.</td>
</tr>
<tr>
<td>McFarlane et al. (1996)</td>
<td>Examination of abuse during pregnancy.</td>
<td>African American, Hispanic, and White women. Approximately 1/3 Hispanic ($N = 1,203$).</td>
<td>16% of all women reported physical or sexual abuse. 13% of all Hispanic women reported abuse.</td>
<td>Stratified prospective cohort analysis.</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Participants</td>
<td>Findings</td>
<td>Generalization</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Parker et al. (1993)</td>
<td>Comparison of abuse among teen and adult women.</td>
<td>African American, Hispanic, and White pregnant women. 34% Hispanic (predominantly MA) (N = 691).</td>
<td>Prior to pregnancy, 32% of teens and 24% of adults were abused; during pregnancy, 22% of teens and 16% of adults were abused.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Perilla et al. (1994)</td>
<td>Examination of domestic violence predictors.</td>
<td>Immigrant Latinas (N = 60).</td>
<td>Depression, stress, and male intoxication associated with abuse.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Pivnick (1993)</td>
<td>Description of the meaning of condoms.</td>
<td>African American and Latino women (N = 126).</td>
<td>Theme that condom negotiation may result in physical abuse.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Rodriguez (1995)</td>
<td>Description of abuse among farm worker women.</td>
<td>Mexican and MA women (N = 112).</td>
<td>35% reported physical abuse, 21% forced sex, and 28% fear of partner.</td>
<td>Limited generalization to other populations.</td>
</tr>
</tbody>
</table>

(Continued on the next page)
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Purpose</th>
<th>Sample</th>
<th>Results</th>
<th>Strengths and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rodriguez (1993)</td>
<td>Description of meaning of health for migrant farm worker women.</td>
<td>Mexican and MA women (N = 32).</td>
<td>Health defined as a peaceful life and lifestyle.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Salgado de Snyder et al. (1996)</td>
<td>Identification of information and high-risk behaviors of rural women in Mexico.</td>
<td>Mexican women married to migrant workers in the United States (N = 100).</td>
<td>Theme of owing husbands sex regardless of fear of consequences.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Smikle et al. (1995)</td>
<td>Evaluation of abuse in middle-class women with access to health care.</td>
<td>54 HW, 14% with no history of abuse and 37% with abuse history (N = 531).</td>
<td>75% physically abused women, 35% physically and sexually abused women, and 16% sexually abused women identified their intimate partner as their abuser.</td>
<td>Limited generalization to other populations.</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Sample Description</td>
<td>Findings</td>
<td>Limitations</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**Note:** MA = Mexican American; STD = Sexually transmitted disease.
METHOD

We used an exploratory qualitative research design to acknowledge and incorporate the contextual framework of women’s life experiences. We recruited a convenience sample of 14 Mexican and Mexican American women from a battered women’s shelter. Inclusion criteria were female gender, Mexican or Mexican American ethnicity, self-identification as an abuse survivor, and a minimum age of 18 years. Exclusion criteria were pregnancy, severe injury, severe pain, and mental incompetence as determined by Yolanda R. Davila, who is a clinical specialist in psychiatric mental health nursing.

Instruments

The instruments used in the study were a demographic form and a semistructured interview guide that we developed. The demographic form and semistructured interview guide were translated and then back-translated into both English and Spanish formats. The original English demographic form and interview guide were translated by a bilingual individual into Spanish. Another bilingual individual then independently translated the Spanish demographic form and interview guides back into English. Then the two English versions were compared and any inconsistencies between both versions were noted and corrected (Marin & Van Oss Marin, 1991). The demographic form assessed ethnic cultural identity and socioeconomic characteristics such as age, years of education, employment, marital status, number of dependent children, and contraceptive use. McFarlane’s abuse screening tool, the Domestic Violence Assessment Form (as cited in Migrant Clinicians Network [MCN], 1993) also was administered as part of the demographic form.

To compensate for any variation among participants’ educational and reading levels, we completed the demographic forms for all participants. We chose a semistructured interview guide format because it allowed for the systematic collection of information and provided an opportunity for participants to provide details that might otherwise remain unacknowledged (Burns & Grove, 1993). Development of the semistructured interview guide was based on a review of the current literature related to woman abuse, condom beliefs and practices, and AIDS awareness (Mays et al., 1993; Norris & Ford, 1992; Nyamathi, Bennett, Leake, Lewis, & Flaskerud, 1993; B. Van Oss Marin, personal communication, 1997; see Figure 1). The sequence of the interview questions began with safe topics; sensitive topics were reserved until late in the interview process (Burns & Grove, 1993).
English Version

1. Tell me what you know about HIV/AIDS.
   A. How do women and men get it?
   B. What does it do to the body?
   C. Is there a vaccine or cure for HIV/AIDS?
2. What can a person do to keep from getting HIV/AIDS?
   A. What do you do to keep from getting HIV/AIDS?
3. In the past three months, what would you say your chance of being infected with HIV/AIDS has been?
4. In the past three months, how have you protected yourself against HIV/AIDS?
   A. For what reasons have you protected yourself?
   B. For what reasons have you not protected yourself?
5. What do you know about condoms?
6. Tell me what you think or know that is good about condoms?
7. Tell me what you think or know that is bad about condoms?
8. Tell me about your first experience with a condom.
9. Tell me about your last experience with a condom.
10. Tell me about your best experience with a condom.
11. Tell me about your worst experience with a condom.
12. Have you ever asked a male partner to use a condom?
    A. When?
    B. Under what circumstances?
    C. How did you ask him?
13. How does your partner respond when you ask him to use a condom?
14. What additional information would you like to discuss or share related to condom use?

Spanish Version

1. Digame lo que sabe usted de VIH/SIDA.
   A. Como las mujeres y los hombres lo cogen?
   B. Que le hace al cuerpo?
   C. Hay una vacuna o cura por el?
2. Que puede hacer una persona para evitar infeccion de VIH/SIDA.
   A. Que hace Ud. para evitar infeccion de VIH/SIDA?
3. En los ultimos tres meses, que piensa ira su peligro de ser infectada con VIH/SIDA?
4. En los ultimos tres meses, como se ha protejido en contra del VIH/SIDA?
   A. Cual son las razones porque se ha protejido?
   B. Cual son las razones porque no se ha protejido?
5. Digame lo que sabe Ud. de condones.
6. Digame que piensa o sabe Ud. de porque condones son buenos.
7. Digame que piensa o sabe Ud. de porque condones son malos.
8. Digame de su primera experiencia con condones.
9.Digame de su ultima experiencia con condones.
10. Digame de su mejor experiencia con condones.
11. Digame de su peor experiencia con condones.
12. Ud. ha preguntado a su companero que use condones?
    A. Cuando?
    B. En que circunstancias?
    C. Como le pregunto?
13. Como responde su companero cuando Ud. le pregunta que use condones?
14. Que otra informacion gustara Ud. discutir con relacio al uso de condones?

FIGURE 1. English and Spanish semistructured interview guide.
Procedure

Institutional review board approval was obtained from Yolanda R. Davila’s academic health science center. Informed consent forms were approved in both English and Spanish formats. Participants were provided confidentiality through the use of a coding system. Beginning with the letter A, each participant was assigned a letter code that was immediately placed on her demographic form and audiotape. No other identifying information was collected. Individuals who met the inclusion criteria were identified by a senior social worker at the shelter and referred to Yolanda R. Davila, who invited them to participate in the study. Individuals who accepted the invitation were escorted to a private office. All participants were interviewed in their language of choice, either English or Spanish. Data collection followed a four-step sequence that began with informed consent and permission to audiotape the interview. The second step consisted of oral administration of the demographic form. The third step included oral administration and audiotaping of the semistructured interview. During the final step, closure, the investigator offered to answer any questions and expressed appreciation to the participant for her participation in the study. Data collection continued until theme saturation occurred and no new categories were identified. All audiotaped interviews were transcribed verbatim by Yolanda R. Davila, verified by a content expert, and submitted to content analysis.

RESULTS

Data analysis was accomplished through a two-step process. The first step was the use of descriptive statistics to describe the sample. Women described themselves as being American of Mexican American descent (42.9%), Mexican American (35.7%), Mexican (14.3%), or Hispanic (7.1%). The mean age of the women was 30.7 years, with a range from 20 to 43. Years of education averaged 8.7, with a wide range from 3 years of grade school education to some semester hours of community college. Only 21% of the women were employed outside the home; the majority were in low-paying positions within the service industry. Approximately half of the women were single, the other half were married. Of the women who identified themselves as single, 21.4% were divorced, and another 21.4% were either temporarily separated or in the process of obtaining a divorce. All of the women had dependent children under the age of 18. The mean number of children per woman was 3.5, with a range of 1 to 8. A large proportion of the women (42.8%) reported no
contraceptive use. Of the women who reported contraceptive use, 28.6% had undergone a tubal ligation, 14.3% were on birth control pills, and 14.3% used condoms.

Analysis of responses to McFarlane’s Domestic Violence Assessment Form (cited in MCN, 1993) indicated that 78.6% of the women reported physical abuse, 21.4% reported verbal abuse, and 42.9% reported at least one incident of forced sexual activity within the past year. We noted that during admission the majority of the women cited the experience of either physical or verbal abuse as the reason for seeking shelter services. None of the women cited sexual abuse as the reason for seeking shelter services. The majority of the women reported the perpetrators of the abuse to be their husbands and boyfriends. Husbands accounted for 50% of the physical abuse and 66.7% of the sexual abuse. Boyfriends accounted for 21.4% of the physical abuse and 33.3% of the sexual abuse.

The second step of the data analysis involved content analysis of the audiotaped responses to the interview questions. The purpose of content analysis is the reduction of data from large amounts of text into a few, mutually exclusive categories. The content analysis of this study followed the guidelines suggested by Webber (1990). As Webber suggested, we developed and defined a coding scheme for the unit of text to be analyzed. We selected themes—the grouping of data around a central issue or occurrence—as the basic unit of analysis. We searched the data for patterns and placed them into mutually exclusive categories.

The predominant themes of the content analysis were the women’s past and present experiences of physical, psychological, and sexual abuse. In addition, an unexpected theme of women’s lack of power relative to men within social and sexual relationships was identified. Physical abuse was the women’s experience of bodily harm and injury. Injuries ranged from slaps and punches that left only bruises to lacerations that required medical treatment. For some women, physical abuse resulted from the women’s request for condom use for prevention of pregnancy or venereal disease. The male partners of these women perceived the request as a breach of trust in either the partners’ or women’s fidelity. Because of this perception, these male partners felt justified in using physical abuse as a response to the women’s request for condom use. In all the described situations, the physical abuse was viewed by the women as an attempt to control their behavior. The following are selected comments from the interviews that describe two of the women’s experiences and responses to the physical abuse.

My mother-in-law was like the mother I never had. But she turned against me. She knew what was happening, the abuse. And what did she do? She
said, “You need to be more careful. Next time, you might get hurt enough to go to the hospital. And how will we explain it to the doctor?”

You get to the point where you get tired of wearing long sleeves, long pants. SA (the city) is not a cold place. You get tired. I’m like, she’s wearing a little sundress or shorts... I couldn’t even do that because I had to be hiding the bruises that were healing and the bruises I had just got.

Psychological abuse was experienced by the women in the forms of name calling, character defamation, and the humiliation and degradation of their self-respect and dignity. For many of the women, psychological abuse was a common occurrence in their everyday lives. For numerous women, the experience of psychological abuse resulted in a greater threat to their self-esteem than the physical abuse. The following interview comment expresses the long-term effect of psychological damage to one woman’s self-esteem. Although this woman had endured years of physical, sexual, and psychological abuse by her husband, it was the psychological abuse that had proven to be the biggest obstacle to her efforts to gain back her self-respect and dignity.

To me, I can’t handle the emotional because the emotional you can’t heal. Because you hear him in your head. You go out and get a job and try to fix yourself up and you hear him in there, “You don’t look good.” Broken bones you had would heal... but the emotional to me never did.

Another common form of psychological abuse was partner accusations of a woman’s infidelity. These accusations were often associated with a woman’s refusal to have sex with her partner or her request for condom use by her partner. Within the analysis, condom negotiation appeared to be an especially value laden topic associated more frequently with extramarital or casual sex than with safe sex. The following interview comments contain a combination of the most frequently reported partner accusations.

“Do you have a disease? You have a disease and you don’t want me to catch it.”

“You have a boyfriend? You have a boyfriend on the side, don’t you?”

“You’re the one messing around, not me. And you have something and you’re afraid to give it to me.”

The last predominant theme was the experience of sexual abuse. The women’s experiences of sexual abuse ranged from unwanted sexual fondling to forced involvement in unwanted sexual practices such as
oral and anal sex. For many of the married women, forced sexual activity by their husbands was another commonly reported experience. Although forced sexual activity was described, none of the women identified the experience as rape. Rather, the women spoke of the experience as “feeling like a rape.” The underlying assumption was that rape was not possible between a husband and wife. This assumption was evidenced by statements such as “But he’s my husband,” or “He tells me I’m his wife” when the women either submitted to or were physically coerced to engage in sexual activity with their husbands. The following selected interview comments describe some of the married women’s experiences of spousal sexual abuse. Through the women’s descriptions it becomes evident that women are not always in total control of their sexual encounters, practices, or behaviors.

He had been drinking and he had had a bad day...and [sex] was his release. He said, “Let’s go to bed now.” I said, “No, I’m not in the mood.” He said, “Yes, you are.” Before I knew it, he took off my clothes and he was on top of me. It felt like being raped.

He was just violent. I was his wife, you see. “You’re my wife.” And he would beat me up. If I didn’t want to, he would beat me up. And he would force me...and he said. “We’re gonna have sex right now. You’re my woman, nobody else’s woman.” And he put me on the bed and that was that.

A theme that emerged from the content analysis was that of abuse and HIV/AIDS risk due to the inequality of women’s power relative to the power of men. Within this theme, it became evident that for many women in abusive relationships, male partners commonly used coercion or abuse to maintain a position of power over the women. The male partners’ influence on the women’s public, private, and sexual interactions is best described in the following selected interview comments.

I wasn’t allowed to work. Because then I had money and that was my freedom. He wanted me to rely on him, ask him. That’s why he always made me quit. “You’re getting out of hand,” he’d say. All my jobs were little. But to me, they meant a lot. They were my freedom from him.

He had them (condoms) when we first started dating. Yeah, he had them. He didn’t want to get me pregnant. . . . (after getting married) he said, “No, we’re not. I don’t like it (condom). I can’t feel you”. We still had sex. But, that’s the chance he would take. And more or less he would do it like, we would have sex when I had my period because he would tell me I couldn’t get pregnant.
DISCUSSION AND IMPLICATIONS

This study was developed as a means to increase the knowledge base about barriers to condom negotiation as a HIV/AIDS sexual risk reduction behavior among Mexican and Mexican American women in abusive relationships. On the basis of the results of this study, current prevention programs that advocate sexual abstinence, condom negotiation, or both, by women must be viewed with skepticism. Women who experience male partner power and control over their daily life experiences and behaviors may not be in a position to successfully initiate condom negotiation for HIV/AIDS prevention. For some Mexican and Mexican American women, especially those involved in an abusive relationship, the initiation of condom negotiation may be in direct conflict with sociocultural and gender norms. Additional conflict may result from condom negotiation that is initiated by the women from a lesser power base.

Power is the process by which an individual gains or maintains the ability to impose his or her will on another. Power can withhold rewards as well as threaten punishment (Lipman-Blumen, 1984). Power can be divided into the three primary domains of power bases, processes, and outcomes. Power bases are culturally defined and consist of personal assets (e.g., male gender, socioeconomic status) on which an individual’s authority or control over another is based. Within the Hispanic culture, males are accorded respect and deference by females because of the male gender and, more often than not, greater financial resources (Marin & Van Oss Marin, 1991). Power processes are the interactional techniques (e.g., persuasion and influence, assertiveness, coercion, and violence) that are used by an individual to establish or maintain control within a specific situation. Power outcomes are related to which individual makes the final decision within a specific situation (Babcock, Waltz, Jacobson, & Gottman, 1993) Within the Hispanic culture, male authority figures, such as husbands, are perceived as heads of household whose decisions are to be accepted without question by their wives (Marin & Van Oss Marin, 1991).

The primary power bases the men used to maintain control over the women were resource and definitional power. Resource power, the ability of an individual to extract compliance even in the face of resistance, was wielded through the use of threatened or actual coercion or bribery. In most of the interviews it was apparent that the male partners possessed greater resource power than the women. This was due to the fact that Hispanic women have less education, fewer employment
skills and opportunities, and lower median earnings than Hispanic men (Weeks et al., 1995). Male partners also resorted to the use of resource power when they threatened or coerced the women into unwanted sexual activity.

**Definitional power**, an individual’s ability to impose norms and values, standards of judgment, and situational definitions on another, also is associated with resource power (Chafetz, 1991). Within the Hispanic culture, conformity, obedience, and support of male authoritarian attitudes are valued and promoted. In general, females fear expressing or engaging in disagreement with powerful male authority figures (Marin & Van Oss Marin, 1991). In this study it became apparent that for many women sexual encounters and practices were defined and determined by either their husbands or male partners. Definitional power was evidenced by male partners who imposed their norms and values on the women, such as a husband’s right to sex or, conversely, a woman’s duty to fulfill her husband’s sexual needs and desires.

The influence of male partners’ definitional power was most apparent in the women’s description of their ability to successfully negotiate condom use. Both single women in casual dating relationships and married women during their courtship days described a greater ability to negotiate condom use than women in current marital relationships. This finding suggests that women may have more power to negotiate safer sex during a one-night stand, a casual dating relationship, or a nonmarital relationship. In casual sexual encounters, it appears that men’s emphasis is on obtaining sex rather than being in a position of control. In marital relationships, men appear to place more emphasis on being in a position of control.

In summary, condom negotiation for Hispanic women may increase their risk for both abuse and HIV/AIDS. In order for women to be able to protect themselves from HIV/AIDS as well as the abuse that is sometimes associated with condom negotiation, women must have access to women-centered methods of protection. Future research with a focus on women-centered methods, such as the development and clinical testing of an HIV vaccine or an HIV preventative vaginal foam, is vital to the health and well-being of all women. This is especially important for minority women, who are at increased risk for HIV/AIDS through heterosexual intercourse (CDC, 1997). These women await protective methods that are effective, simple and convenient to use, nondetectable, inexpensive, easily accessible, and under the complete control of the women themselves.
REFERENCES


meeting of the 11th International AIDS Conference. Vancouver, British Columbia, Canada.

