SERIAL MONOGAMY AND RELATIONAL INFLUENCES ON PATTERNS OF CONDOM USE FOR YOUNG ADULTS IN DATING RELATIONSHIPS

by

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A thesis submitted in conformity with the requirements
for the degree of Master of Arts
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Your file Votre référence
ISBN: 978-0-494-59637-1
Our file Notre référence
ISBN: 978-0-494-59637-1

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Abstract

Within Canada, young adults have been identified as being at high risk for sexually transmitted infections (STI). One major contributing factor is inconsistent condom use, particularly within monogamous relationships (Civic, 2000; Critelli & Suire, 1998; Misovich, Fisher & Fisher, 1997; Winfield & Whaley, 2005). This research used qualitative methods to investigate the process by which young women rationalize inconsistent condom use and the relational influences that aid in this transition. A sample of fifteen women (between 18-24 years of age) were surveyed and interviewed. Using grounded theory analysis, the results indicated that the process of discontinuing condoms is multifaceted. Within relationships, unprotected sex comes to signify developmental milestones for the couple. It is associated with desirable relationship characteristics of commitment, trust, intimacy and fidelity. The results suggest that health promotion interventions should emphasize the high risk for STI posed by using condoms inconsistently within the monogamous relationships of young adults.

Acknowledgements

I would like to express my deep gratitude and appreciation to my supervisor, Dr. Margaret Schneider, whose instrumental guidance and support has enriched the quality of this research and my development as a sexuality researcher. Also, a special thanks to my committee member Dr. Alex McKay, whose expertise on this issue brought valuable insight into this study.

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CHAPTER 1

Introduction

Young adults have been identified as being at high risk for contracting sexually transmitted infections (STI) (East, Jackson, O'Brien & Peters, 2007). In Canada, the incidence of common bacterial (e.g. Chlamydia) and viral (e.g. HPV) STI are highest among this population (Public Health Agency of Canada, 2006). The majority of individuals who contract these infections are under the age of twenty-five (Dehne & Riedner, 2005; East et al., 2007).

It is widely acknowledged that consistent condom use significantly reduces the risk of STI (Civic, 2000). As such, public health campaigns are typically geared towards the promotion of male condom use (East et al., 2007). Regardless of these efforts, young adults fail to use condoms consistently (Civic, 2000; Corbin & Fromme, 2002; East et al., 2007; Winfield & Whaley, 2005). Despite being at high risk, young adults often act as if they are not at risk for STI (East et al., 2007; Redston-Iselin, 2001).

Studies have suggested that inconsistency in condom use is largely dependent upon the type of sexual encounter (whether casual or within a relationship). The types of contraceptives used are often correlated by relationship type. Research has illustrated that young adults are more likely to use condoms with casual encounters, such as 'one night stands' (Catania, Stone, Binson & Dolcini, 1995; Harrison et al., 1991; Misovich et al., 1997). Within dating relationships condoms are often replaced by other measures, namely, oral contraceptives (Civic, 2000; Critelli & Suire, 1998; Manlove, Ryan & Franzetta, 2007; Misovich et al., 1997). Although condoms have the dual purpose of preventing STI and pregnancy, oral contraceptives do not.

The perception of monogamy contributes to the decision to discontinue condoms (Critelli & Suire, 1998; East et al., 2007; Misovich et al., 1997). There are high rates of unprotected sex for young adults within relationships (Michael, Gagon, Laumann & Kolata, 1994). During this age, it is unlikely that one's present monogamous relationship is their first or will be their last (A. McKay, personal communication, July 23rd, 2009) and they are likely to engage in several relationships throughout their young adulthood (Conley & Rabinowitz, 2004). Having multiple sexual partners, paired with inconsistent condom use within these relationships, leads to the high prevalence rates of STI (East et al., 2007; Lee et al., 2005).

Serial Monogamy

Transitioning from one monogamous relationship to the next has been identified in the literature as 'serial monogamy' (Britton, Levine, Jackson, Hobfoll & Shepherd, 1998; Choi, Catania & Dolcini, 1994; Critelli & Suire, 1998; Misovich et al., 1997; Overby & Kegeles, 1994). Within sexual health research, there is another type of monogamy defined as "realistic monogamy" which involves serial monogamy, but with casual relationships in between (Pinkerton & Abramson, 1993). For purposes of this research, both patterns of dating are considered to be serially monogamous.

Throughout the years, engaging in serial monogamy can lead to an accumulation of sexual partners. It is important to note that the accumulation alone does not increase ones risk of becoming infected with an STI. However, those who practice serial monogamy are more apt to engage in unprotected sexual intercourse with their partner (Catania et al., 1995; Misovich et al., 1997). The accumulation of partners without

consistent condom use is, in effect, multiple partners with unprotected sex which constitutes a high risk for STI (A. McKay, Personal communication, July 23rd, 2009).

In relationships, condom use is typically abandoned and replaced by oral contraceptives. Studies have suggested that it only takes twenty one days from a dating relationship to develop from the beginning stages to being considered by the couple a fully established relationship (East et al., 2007; Fortenberry, Tu, Harezlak, Katz & Orr, 2002). Although researchers differ on the exact timeline, this transition to oral contraceptives occurs rapidly. Many researchers propose that this occurs one month into the relationship (Civic, 2000); while others suggest the four month mark (Misovich et al., 1997). Nevertheless, studies have found that shortly after beginning a relationship, condoms are replaced with oral contraceptives (Civic, 2000; Critelli & Suire, 1998). This invariably places these individuals at a higher risk for STI.

As awareness of HIV/AIDS grew, advertising and public health campaigns efforts encouraged individuals to engage in monogamous relationships (as a self-protective measure against HIV) (Koop, 1987; Misovich et al., 1997). As a result, it has been suggested that being within a 'monogamous' relationship was perceived as a 'substitute' for different safer sex practices (Hobfoll, Jackson, Lavin, Britton & Shepherd, 1993; Misovich et al., 1997). The belief that monogamy alone can be used as a self-protective measure against STI by young adults is problematic (Misovich et al., 1997). The establishment of a relationship as monogamous provides young adults with a veil of perceived safety.

Safer Sex Practices

To date, the definition of what constitutes effective safer sex practices is disputed. Misovich, Fisher & Fisher (1997) argue that within intimate relationships, when partners

are tested (time-appropriate STI testing) and commit to monogamy, there is a decreased level of risk in having unprotected sexual intercourse. Theoretically, this would be indicative of safer sex practices. However, when discussing safer sex practices for young adults this ideal may be problematic. Research indicates that despite declarations of monogamy, many individuals lie about their fidelity (Cochran & Mays, 1989; Conley & Rabinowitz, 2004). Furthermore, many individuals are simply unaware of their sexual health status (contracting STI's prior to the relationship) and may unknowingly carry an STI (Cochran & Mays, 1989; Conley & Rabinowitz, 2004). Misovich et al. (1997) recognize that although there are certain measures that lead to safer sex practices without condom use, only a fraction of relationships may be realistically able to practice these standards. For those who cannot, monogamy may be providing a false sense of security (Misovich et al., 1997).

In addition, the reliance on STI testing to rationalize condom use discontinuation is problematic in-of-itself. The standard battery of STI tests offered at clinics and general practice physician's offices typically includes tests for HIV, Chlamydia, and a PAP test for women to detect cervical abnormalities related to HPV infection. However, in most cases, this does not include general testing for HPV or HSV-2 (genital herpes), the two most common STI in Canada (A. McKay, personal communication, July 23rd, 2009). Therefore, for individuals who receive testing without explicitly requesting that these tests also be included, they may still be at risk. Conversely, consistent condom use has been shown to significantly reduce the risk of STI (McKay, 2007) and is often used as a measurable indication of safer sex practices (Winfield & Whaley, 2005). For purposes of

this study, consistent condom use will be assessed to gain insight into the safer sex practices of young women within dating relationships.

Perception of STI risk

Research has illustrated that one's level of perceived STI risk will influence the choice of contraceptives used. Those who engage in casual sex with different partners rate their level of sexual risk to be significantly higher than those within relationships (Britton et al., 1998; Misovich et al., 1997). Individuals typically perceive engaging in casual sex as risky behavior (Corbin & Fromme, 2002; Manlove et al., 2007). As such, the fear of STI acts as a motivating factor to use condoms with casual partners (Britton et al., 1998). Whereas in monogamous dating relationships, young adults feel less risk and will therefore use condoms less often, inconsistently, or not at all (Cooper & Orcutt, 2000; Corbin & Fromme, 2002; Manlove et al., 2007; Misovich et al., 1997). There is a perception of low probability of contracting a STI within a monogamous relationship (Ishii-Kunzt, Whitbeck & Simons, 1990; Misovich et al., 1997).

Young adults often believe themselves to be impervious to STI. They recognize that while others may be affected by STI, they maintain the belief that it won't happen to them (East et al., 2007; Misovich et al., 1997; Redston-Iselin, 2001). Many are driven to maintain the perception that their sexual partner is safe, to avoid feelings of instability or that the partner poses a threat (Misovich et al., 1997).

Within dating relationships, young adults typically base their opinions of sexual safety subjectively. They consider their partner's appearance, trust, personality characteristics and they make assumptions (ie. 'just knowing') (Civic, 2000; East et al., 2007; Skidmore & Hayter, 2000). For many, there is the implicit assumption that

someone they have an emotional connection with and trust would not have a risky sexual history, or be a risk to their health (East et al., 2007; Misovich et al., 1997; Skidmore & Hayter, 2000). During this stage many individuals become protective of their relationship. Due to the often negative connotations associated with safer sex practices, many young adults will forgo engaging in these actions to protect their relationship (Misovich et al., 1997). Feeling a sense of security and protection within a monogamous relationship contributes to the decision to discontinue condom use (Corbin & Fromme, 2002).

At the beginning stages of a relationship there are often concerns with impression management. In the presence of one's partner, individuals will be conscientious or alter their behavior to ensure presenting themselves in a positive light (Misovich et al., 1997). For many young adults, impression management factors into engaging in higher risk sexual behaviors (Misovich et al., 1997). Notably, as couples engage in personal conversations and gain familiarity, feelings of intimacy increase (Misovich et al., 1997). However, the subject of sexual health and sexual histories may not arise so readily. These topics of conversation are often perceived as negative, disruptive and pose as a potential threat to the relationship (Baxter & Wilmot, 1985; Misovich et al., 1997). There is a fear that one's partner may become 'suspicious' about their past (Hammer, Fisher, Fitzgerald & Fisher, 1996; Misovich et al., 1997). Whereas, the relationship may be developing and becoming more intimate through conversation, sexual health discussions are often avoided. The desire to present oneself favorably to their partner, often lends into forgoing sexual health discussions.

Although many young adults are making assumptions, there is another group of individual's who extend beyond 'just knowing' and are discussing sexual histories with their partner (Civic, 2000). Having this discussion often poses as a means of negotiating safer sex practices (Manlove et al., 2007). These conversations are often 'vague' rather than detailed discussions about sexual health (Misovich et al., 1997). For many, the idea of sharing sexual history with a partner can be uncomfortable. There is the chance that 'impression formation' and the desire to be regarded in high esteem by a loved one, could deter an individual from engaging in these discussions in great length (Masaro, Dahinten, Johnson, Ogilvie & Patrick, 2008).

Few young adults candidly discuss sexual health testing or ask about sexually transmitted infections (Masaro et al., 2008). Within established relationships, partners often are reluctant to inquire about or request STI testing because to do so might imply that one has engaged in higher risk behaviors previously or has been unfaithful during the course of the relationship (Misovich et al., 1997). Research has illustrated that the majority of young adults do not get tested for sexually transmitted infections such as HIV (Hardy & Dawson, 1990; Kalichman & Hunter, 1993; Misovich et al., 1997). This is especially true of those within longstanding relationships (Phillips, 1993). Notably, sexual health testing has negative connotations within relationships. Again, this is perceived as a possible 'threat' to their relationship, fearing their partner's reaction (Misovich et al., 1997).

Research indicates that subjective means of appraising risk are rarely accurate. Young adults often make faulty assumptions about their partner's sexual health, including their sexual past and relationship status (East et al., 2007; Seal & Palmer-Seal, 1996).

Additionally, they may also be unaware of their own status themselves (Civic, 2000; Cochran & Mays, 1989; Misovich et al., 1997). There is no empirical evidence to support the notion that simply inquiring about a potential partner's prior sexual behavior history (e.g., number of sexual partners) results in a significantly lower risk of STI (A. McKay, personal communication, July 23, 2009). Finally, the process of undergoing STI testing is not a concrete measure of safety. As previously mentioned, STI testing in Canada fails to test for the two most common types of sexually transmitted infections. Research has revealed that those who have contracted an STI reported underestimating their level of risk prior to being infected (East et al., 2007; Stoner et al., 2003).

It is clear that for many young adults, the process of getting to know one's partner 'well' results in a perception of low risk which, in-turn, results in non-condom use (Civic, 2000). Regardless of the level of 'objectivity' involved in building this perception of risk, it is not sufficient for the purposes of reducing STI risk. The process by which one assumes this perceived lower risk (whether subjective or objective) is arguably irrelevant as neither partner can be guaranteed to be free of infection.

Primary Use of Condoms within Dating Relationships

Within dating relationships, condoms are primarily used as a method of pregnancy prevention (East et al., 2007; Flood, 2003; Garside, Ayres, Owen, Pearson & Roizen, 2001; Ott, Adler, Millstein, Tschann & Ellen, 2002). Researchers have suggested that the perception of condoms as pregnancy prevention means that when oral contraceptives (or the equivalent) are introduced into the relationship, condom use decreases (Civic, 2000; East et al., 2007; Wulff & Lalos, 2004). This association is held

by both females and males in this age group. Research has illustrated that the primary use of condoms for young men is pregnancy prevention. For males, the assurance that their partner is using oral contraceptives permits the discontinuation of condom use within relationships (Flood, 2003). Pregnancy poses as a risk to their youthful way of living, carrying serious financial and emotional ramifications (Flood, 2003). These considerations appear to carry a greater weight than concerns about STI.

Decreased Condom Use within Dating Relationships

In an attempt to understand what influences the decision to discontinue condom use, previous research has attempted to piece apart and isolate specific factors that contribute to this transition. These situational variables include trust, intimacy and level of commitment.

Trust In Partner

Trust in one's partner plays an instrumental role in the decision to discontinue condom use (Civic, 2000; Masaro et al., 2008; Misovich et al., 1997; Winfield & Whaley, 2005). Research has found that when couples begin to identify their relationship as exclusive and monogamous, a greater sense of trust develops (Winfield & Whaley, 2005). Upon establishing monogamy and expressing feelings of trust, young adults are then more likely to engage in unprotected sex (Civic, 2000; Winfield & Whaley, 2005). For many, it is inconceivable to imagine contracting a sexually transmitted infection from a loving partner (East et al., 2007; Goldmeier & Richardson, 2005; Misovich et al., 1997; Pilkington, Kern & Indest, 1994).

Commitment Level and Discontinuation of Condom use

Within dating relationships, transitioning from condom use to oral contraceptives is a symbolic event. It results in greater feelings of commitment to the relationship (Conley & Rabinowitz, 2004; East et al., 2007). It is often perceived as a progressive step in a favorable direction, signifying stability. For many it creates a new 'identity' for their relationship, graduating to the quintessential monogamous couple. Additionally, it signifies ones commitment to fidelity within the partnership. For many, the transition to oral contraceptives is a means of 'ensuring' their partners faithfulness (Conley & Rabinowitz, 2004). Discontinuing condoms is therefore framed as a positive process (Conley & Rabinowitz, 2004).

This romanticist view of unprotected sex is not gender discrepant. Young males' also associate the transition from condoms to oral contraception with developmental milestones within relationships. Similar to young women, males also associate unprotected sex with monogamy, trust and intimacy (Flood, 2003). Condoms are perceived as a barrier against these milestones, as the physical barrier becomes representative of emotional roadblocks, preventing the relationship from escalating to the next level (East et al., 2007; Flood, 2003). For example, consistent condom use throughout the relationship begins to become affiliated with infidelity (Flood, 2003). The meaning of condoms changes from practicality to a hindrance within the first couple weeks of becoming sexually involved with their partner (Flood, 2003).

As previously mentioned, many young adults will refrain from condom use due to the potential negative ramifications that may have on their relationship (Misovich et al., 1997). When engaging in a romantic relationship, one carries feelings of familiarity,

trust, and emotional ties to their partner. For many, condom use may threaten their relationship. Young adults typically perceive condom use as a precaution to be taken within casual sexual relationships rather than loving relationships (Baylies, 2001; East et al., 2007). Many young adults associate condoms with adverse meaning to the relationship. Condoms are symbolic of disease, infidelity, lack of trust, and less commitment (East et al., 2007; Kirkman, Rosenthal & Smith, 1998).

For many young adults, there is the belief that using condoms within the relationship sends their partner the message that they are worried about contracting an STI. Albeit that may be the reality, many are apprehensive to perceive their relationship as a threat to their health. This would contradict their perceptions of their partner and relationship as being healthy and loving (Conley & Rabinowitz, 2004). Furthermore, condom use carries the implication of infidelity (East et al., 2007; Kirkman et al., 1998). Many young adults believe that using condoms within a relationship implies that the relationship is not a highly committed one. There is also the message to one's partner that they do not trust their partner to remain faithful to them (Conley & Rabinowitz, 2004). Within relationships, once that transition occurs to oral contraceptives alone, it is likely more difficult to transition back to condom use as it would carry all of these negative connotations (Conley & Rabinowitz, 2004; Pilkington et al., 1994). To transition back to using condoms is often believed to be representative of problems within the relationship (Conley & Rabinowitz, 2004).

It appears that the discontinuation of condoms is representative of relational milestones. Whereas, continued condom use or re-establishment of condom use within relationships appears indicative of instability (Conley & Rabinowitz, 2004). Due to the

perceived threat that condom use carries within relationships, young women often forgo their own self protection (condoms) in favor of protecting the relationship (East et al., 2007; Rosenthal, Gifford & Moore, 1998). Whereas unprotected sex is affiliated with these positive developmental milestones, condoms come to symbolize an external object that will contaminate the intimacy within a loving partnership (East et al., 2007).

Social Influences on Condom use

For purposes of this research, the primary focus is on the situational influences within relationships that contribute to the discontinuation of condom use. However, this is not to discard the larger societal influences that impact this transition. This includes variables such as peer influence, level of sexual health education, gendered power dynamics and systemic issues of intimate partner abuse.

Peer comparisons

Young adults often defer to group norms (as classified by age category) when weighing the risk of sexual behaviors. Sexual norms are influenced by peer groups (Lewis, Lee, Patrick & Fossos, 2007). While individuals often acknowledge that peers are vulnerable to STI, they typically underplay their own level of risk (East et al., 2007; Redston-Iselin, 2001).

Sexual health education

Research has illustrated that many young adults falsely believe that oral contraceptives protect against sexually transmitted infections (Critelli & Suire, 1998). Conceivably, one's lack of proper knowledge of STI transmission results in increased STI risk behavior.

However, many propose that regardless of one's knowledge about sexually transmitted infections, information alone is insufficient in instigating safer sex decisions (Andersson-Ellstrom & Milsom, 2002; Conley & Rabinowitz, 2004; East et al., 2007; Helweg-Larsen & Collins, 1997). For young adults, sexual health knowledge alone fails to change one's risky behaviors (Andersson-Ellstrom & Milsom, 2002; East et al., 2007). During this age individuals feel immune to contracting STI's. Although being aware of the constituents of these infections, they perceive the risk to be external to themselves (East et al., 2007).

Power dynamics and safer sex practices

When examining the negotiation of condom use, one must incorporate gender dynamics. Since condoms are typically worn by males (with the exception of the female condom) if a woman wishes to engage in safer sex practices, this often has to be directly communicated to her partner. For young women, this negotiation may be intimidating. At this age and maturity level, it may be difficult for young women to communicate the need for safer sex practices with their partner, especially if one hasn't much experience in doing so (Dehne & Riedner, 2005; East et al., 2007). For many, there is a fear that requesting condom use from a partner may evoke a negative response or threaten the relationship. Depending on how one appraises the stability of their relationship, condom use may not be negotiated (Umphrey & Sherblom, 2007). As such, young women may weigh the perceived risk in negotiating safer sex practices with their partner against the potential implications for their relationship.

Recent studies suggest that young adults within low commitment relationships (casual sexual relationships) are less likely to perceive any threat to their relationship by

requesting condom use and are therefore more likely to do so (Umphrey & Sherblom, 2007). Due to the noncommittal nature of the relationship, these individuals had less to lose by requesting condom use. However, for those within monogamous relationships, individuals will often feel apprehensive in negotiating condom use as it acts to threaten the relationship (Umphrey & Sherblom, 2007). As a result, young women within committed relationships are less likely to negotiate safer sex practices with their partner (Umphrey & Sherblom, 2007). As previously mentioned, when the commitment level to one's partner begins to strengthen, then condom use decreases.

Researchers have suggested that the transition to oral contraceptives may be influenced by gendered power dynamics and the unease in negotiating condom use (Swan, 1999). Whereas condom use has to be negotiated, women have full control over use of oral contraceptives. Many researchers have acknowledged the gendered power differentials in society award men a higher level of power within relationships (Swan, 1999). Deep-seated gender expectations of male dominance regarding sexuality often inhibit women from communicating their own desires for safer sex and negotiating condom use in relationships (East et al., 2007; Rademakers, Mouthaan & De Neef, 2005; Swan, 1999). Whereas women are more receptive to their partner's requests for safer sex, they believe that their male partner may not be as open to their own request for safer sex (Misovich et al., 1997).

When men make the decisions regarding the use of condoms, they requested condoms to a significantly lesser degree than if the female was the one making the contraceptive decisions (Swan, 1999). Research has suggested that generally males dislike using condoms (Dehne & Riedner, 2005; East et al., 2007; Flood, 2003).

Therefore, even in situations where the female does attempt to negotiate safer sex practices, they may be disregarded. Research suggests that males may provide an ultimatum, whereby they outwardly refuse condom use. This creates an unnerving situation for the woman who must now make the decision between her own level of safety and the preservation of the relationship (East et al., 2007; Rosenthal et al., 1998).

Intimate partner abuse

When discussing environmental influences, the issue of partner abuse must also be included. For those young women who are in abusive relationships discussing safer sex practices may evoke abusive behavior from the partner (Misovich et al., 1997). Requesting condom use can be dangerous which inhibits the implementation of safer sex practices (East et al., 2007; Ehrhardt et al., 2002).

Purpose of the study

The discontinuation of condom use within dating relationships reflects developmental milestones of trust, intimacy, and commitment. Within relationships, condoms become associated with unattractive messages of infidelity and mistrust. The use of condoms comes to represent an emotional barrier that tarnishes the ideal of a monogamous relationship. For young adults, the transition towards a sole reliance on oral contraceptives is perceived as a desirable option. There are a multitude of identified relational influences that contribute to the transition to discontinue condom use. This research seeks to illuminate the process of how young women rationalize away the risk of engaging in unprotected sexual intercourse within their relationship. Based upon previous research, this study will inquire into the main identified variables (assumptive

appraisals of risk, sexual health knowledge, familiarity, impression management, commitment levels, and relationship milestones).

CHAPTER 2

Methodology

Research Participants

Participants were heterosexual young women (between the ages of 18-24) who are currently within a dating relationship. To meet the selection criteria individuals had to be in steady relationships (identified as being 'exclusive' or 'monogamous').

The final sample size was comprised of 15 females who ranged in age from 18-24 (M= 21). Upon the preliminary analysis of the interviews data saturation occurred. Any participant over the age of 24 was excluded due to possible confounds (as the definition and meaning of a dating relationship may change as the person ages). The majority of participants (n=13; which translates to 86% of the total sample) were students (at the undergraduate or masters level). All participants were fluent in English.

Dating and Sexual History

The majority of participants interviewed were sexually active (n=14; which translates to 93% of the total sample). The age at which individuals first engaged in sexual intercourse ranged between 15-21 years old (M=18). Approximately half of the participants are currently within their first sexual relationship. However, the majority of participants have been in multiple relationships to date (n=13; which translates to 86%). Within this sample, one's total number of sexual partners ranged between 0-6 (M = 2). In terms of casual relationships, 13% of participants reported having engaged in casual sex (n=2; see Appendix A).

Relationship Lengths and Types

Every participant classified their present relationship as exclusive/steady, with 13% cohabitating with their partner (n=2). The length of time within the relationship varied from two months to five years. One third of respondents (n=5) have been within their relationship for less than three months; and 60% (n= 9) for less than one year (see Appendix A, Figure A1). Although the length of time participants knew their partner prior to dating varied, 27% (n=4) noted having no prior knowledge of their partner prior to entering the relationship (see Appendix A, Figure A2). The majority of participants (73%) classified their relationship as exclusive and monogamous from the first day of dating their partner (n= 11; see Appendix A, Figure A3).

Within their present relationship, participants varied in the length of time before first having sex with their partner: 20% stated that they had engaged in sexual intercourse within the first week of dating (n=3); 33% within two weeks of dating (n=5); 67% within one month of dating (n=10); and 80% before three months of dating (n=12; see Appendix A, Figure A4). This was based upon cumulative percentages. The frequency of sexual intercourse ranged between 8-56 times per month (M=17).

Procedure

Initiatives to recruit participants for this study began in August 2008. Interviews were conducted starting at the end of September 2008 and continued into January 2009.

Participants were recruited by flyers that were distributed throughout the downtown core of Toronto (see Appendix B). Upon administrative consent from various medical centers, residence coordinators, and registrar's office at the University of Toronto, flyers were also distributed across the University of Toronto campus.

Recruitment flyers were posted on notice boards throughout the University of Toronto and the wider Toronto community.

The information on the recruitment flyers indicated the nature of the study (advertised as a dating relationship and sexual health study). It included the selection criteria, stating the eligibility requirements to participate. Participants were also informed that upon completion of the interviews they would be monetarily compensated for their time ($20). The researcher's contact information (telephone number and email address) was provided on accessible pull tabs for participants to take.

When the researcher was contacted by potential participants via telephone, she followed a phone script to ensure impartiality (see Appendix C). A similar protocol with the identical information was also used for individuals who communicated interest by email. All participants were offered the information page prior to booking an interview. Upon contact, the participant was provided with the information page, which specified all of the pertinent information regarding the nature, duration and expectancies as the result of participating in the study (see Appendix D). The information provided indicated that the participant would be asked to participate in both a survey and semi-structured interviews inquiring about their current dating relationship, sexual risk, contraceptive use, sexual health and dating history. Upon reading the aforementioned information form, individual appoints were then made with the researcher.

Prior to data collection, administrative consent was obtained to permit interview room bookings within OISE's Psycho-educational clinic. Upon reading the information letter and communicating interest, participants were scheduled for individual interviews. All participants received an information sheet and signed two copies of a consent form

(see Appendix D). One copy was kept by the participant and the other copy was kept by the researcher. Upon completion of the interview, participants were awarded $20 compensation for their time.

To ensure anonymity and confidentiality, the consent forms (containing identifying information, i.e. signatures) were stored securely and separately from transcripts. Interviews were transcribed by the primary researcher. Each transcript was assigned a numerical code, and did not contain any identifiers (i.e. name, age). Additionally, the audiotapes were held separate from the other files. These tapes did not contain any identifiers (i.e. name). All files were encrypted and stored in a secure, locked location. Only the primary researcher had access to these files. Due to technical difficulties, three interviews were rendered irrecoverable (the original sample was n=18). The partial information obtained through these participants was not included in this study.

Interview

The interviews were approximately 30-60 minutes in length. Due to the sensitive nature of sexuality, participants were explicitly aware that they were free to pass or decline answering any question that made them feel uncomfortable. Prior to asking open-ended questions, participants were asked to answer a brief questionnaire (conducted verbally). Questionnaire tools were based upon empirical evidence pertaining to sexual health and contraceptive decision making for young women, and encompassed pertinent areas of interest including: participant's perceived level of sexual risk, contraceptive use, relational influences on contraceptive choices (relational milestones), sexual history, and exclusivity of current relationship. Next, semi-structured interviews echoing the same

topics were conducted (see Appendix E). These interviews were semi-structured and were developed based on a review of the currently existing literature in the research area. Upon completion, the participant was provided with debriefing and contact information regarding local sexual health clinics, websites, and hotlines. The audio files were then stored and secured by the primary researcher, and were later transcribed.

Data Analysis

The qualitative data was analyzed using the constant comparison method (grounded theory methodology). The entire set of transcripts (containing numerical codes only) was pooled. In accordance with constant comparison methodology, each line of data was analyzed for common and divergent themes. This process was conducted in thorough detail several times, to refine and assure the validity of the themes. For purposes of this research, responses by three or more participants constituted a theme. Analysis was ongoing throughout the completion of the interviews. To ensure inter-rater reliability, several of the transcripts were randomly assigned and analyzed by a third-party researcher. Identical results were revealed through this process, ensuring the validity of the findings.

CHAPTER 3

Results

The results section will present the study's findings. The analyses are classified by major themes.

Within the interviews, two prevailing positions on the process of sexual health decision- making within relationships arose. This differentiation is best described as those who based their knowledge of partner and sexual risk on assumptions (assumption-based) and those who based their opinion on information collected through discussions (information-based) in measuring their degree of STI risk (see Appendix G). Notably, the majority of interviewees fell into the former category (n=9; which translates to 64% of those who are sexually active). For this group, assumptions were often made about the establishment of monogamy, perceptions of sexual risk and sexual health of both themselves and their partner. The latter group appeared to approach these same developments with a higher degree of objectivity, inclusivity and pro-activity with their partner (n=4; which translates to 29% of those who are sexually active). Due to this dichotomy, the results will be divided when discussing the perceived level of risk and the associated factors (perception of monogamy and sexual health knowledge of self and partner). The results will then discuss the process of sexual health decision-making and contraceptive choices as it applies to both groups. As represented by the majority, those who based relationship and sexual health perceptions on primarily assumptive measures will be discussed first.

Subjective Acquisition of Relational and Sexual Health Knowledge

Perception of monogamy

For many young women, assumptions were made from the beginning of their dating relationships. Often, monogamy was assumed and based upon subjective measures. The results indicate that there are common themes for how young women initially appraised the exclusivity of their dating relationship. These included: general assumption of monogamy, romantic gestures and personality characteristics.

monogamy was assumed.

Participants in the assumption group stated that despite not having explicit conversations regarding monogamy, they assumed that their relationship was indeed exclusive. When discussing monogamy and their own perception of monogamy, participants often answered these questions from both her and her partner's perspective.

> We have never ever had the conversation of being exclusive because it's never crossed- and I can say this with confidence- it has never crossed either of our minds that we wouldn't be- if we were in a serious relationship.

> I think it's just like an assumption that both of us had from the beginning. I don't think we ever- well I guess we sort of talked about it- we never had the sort of like, are we exclusive relationship?

For many young women, there is an implicit assumption that the relationship is monogamous from the beginning stages. Seventy three percent of participants noted that they were monogamous from the beginning (from their first date). Many believe that it isn't necessary to make this statement of monogamy explicit with their partner. For other women, having their partner engage in romantic gestures indicates to them that they are officially in a monogamous relationship. Romantic gestures such as: receiving presents,

accepting favors, using terms of endearment, were all identified as implications of an exclusive relationship.

> Before we hooked up or wait, it was around my birthday, he started doing all these little things for me and I thought that was really sweet. So I could tell that he was completely into me. So I didn't really feel too worried or anything like that. And I also felt stronger I guess.

Although this participant did eventually have a conversation with her partner regarding monogamy, initially it was based upon subjective measures, such as romantic gestures. Another participant expressed, "We were still seeing- we just didn't have the title of 'girlfriend' 'boyfriend'. But we were exclusive." When this participant was asked what let her know they were exclusive she responded, "Um he gave me a card, and a teddy bear." One participant noted that she assumed they were monogamous by the way her partner behaved around her stating, "Um, because when you are around them you just kind of always want to be next to them. Your gaze is always falling back to them. There are more intimate gestures or touches."

partner's 'character'.

Other participants simply made a leap of faith concerning their partner's character, assuming that their partner would be unlikely to date multiple women at the same time. This was a major factor in their ability to confidently state that their relationship was exclusive.

> He was a virgin. So that was a big thing. He is really sensitive. And I have never been in a non-monogamous relationship. So it wasn't something that we even had to talk about. It was obvious that it was going to be 'just us'… He has never had a girlfriend before. He had never had sex before. He is really sensitive. He had been raised with really good Christian morals and all that kind of thing. And with me it's like, the opposite with me. I have had multiple boyfriends. I wasn't a virgin. And I wasn't raised with good Christian morals. I have my own personal morals and sex is just too personal a thing to be doing with someone else at the same time.

Participants were more apt to use the term ‘we’, generalizing their own standards and expectations to that of their partner’s. This was especially evident in how young women appraised themselves as not being the type to date multiple partners. One woman explained, “We never really had that conversation but it was just kind of assumed that really early on. And I am not the kind of person who dates many people at the same time.”

Other young women expressed this by stating,

> Both of us are not the type of person who are interested in having casual sex or a casual relationship. I think that both of us just want to be exclusive because we think that, we can only enjoy the exclusive relationships.

> I don’t think we immediately used the terms ‘boyfriend’ and ‘girlfriend’ but it was an exclusive relationship because I think we just liked each other enough and weren’t interested in other people. Neither of us are the type, well I don’t know about him too much but, we had never had the opportunity where we suddenly started sleeping with two people at the same time, so I think that wasn’t what we really wanted to do.

For many young women, this assumption of ‘type’ influenced their decision to forego any conversation about monogamy with their partner.

> With him there was never a question of that. It was never like we had to have that conversation. It was kind of- he was always dating someone- but he is never dating lots of people. He is just- into the whole relationship thing. I just kind of knew from the beginning that I didn’t have to ask him. He started talking- it was just us.

The majority of participants based their perception of monogamy on subjective assessments. Many based their assumptions of monogamy on their partners’ character or romantic behaviors (‘not the type to date multiple people’, being sensitive, romantic gestures). Notably, engaging in the ‘monogamy conversation’ can be quite awkward for many (which will be discussed subsequently). This awkwardness may partially explain

why many young women forgo this conversation and instead make the assumption that the relationship is monogamous.

Perception of Sexual Risk

Monogamy was not the only area of the relationship where assumptions were made. This group of young women tended to also make assumptions regarding their risk of contracting a STI from their partner. Participants were asked: a.) Whether they had sufficient knowledge of their partners sexual past; b.) Whether they had discussed sexual histories with their partner; c.) Whether they (and their partner) have ever been tested for STI. For this group of interviewees, assumptions were made about their partner and his sexual health.

knowledge of partner's sexual history.

All of the participants noted that they felt confident that they had accurate information about their partner's sexual history. All of the respondents noted that they had engaged in a conversation with their partner regarding dating and sexual histories. However, the level of detail of these conversations varied in degree. Within this group, interviewees often relied on a vague discussions pertaining to dating histories rather than previous sexual partners. However, whereas all of the participants stated that they had engaged in a discussion, it was later revealed (in the interview section) that 13% of the respondents had not. For these participants, the knowledge of sexual history was derived from their knowledge of that person prior to dating (as friends or acquaintances). For the individuals who did not engage in this discussion with their partner, familiarity (through previously established friendship) or fear (of an emotional reaction) arguably posed as barriers to engaging in this conversation.

fear of emotional response.

It is apparent that the degree and depth of discussion regarding sexual histories is varied. Many participants noted a level of awkwardness and embarrassment in having this discussion with one's partner. This feeling of discomfort may explain why there is such varied degree of detail in these discussions (as will be discussed subsequently). Many participants noted that they feared evoking negative emotions from discussing sexual histories.

> It's a really touchy subject for me to find out that you have had HOW many sexual partners. So that is why I won't ask but I will ask the health related questions. I don't have a problem asking those… Yeah, like the 'Do I have to be worried about this, about sexually transmitted diseases? I don't have a problem saying that, or if he has a bump here, what is it? Like that, I wouldn't have a problem saying that. I would have a problem if I had to ask about other partners. That would make me feel really awkward… I don't want to because I am aware of how it would make me feel. That's why I sort of don't want to know...

> I was okay just saying that but getting into details I am kind of out of, I don't know how much I want to know *laughs*. And if it's going to make me feel more, if it is going to make me feel more paranoid and worry more about performance things and stuff like that if 'Oh my Gosh you have had sex with HOW many people?'

> Um well, he did eventually tell me that he never really had an official girlfriend before. So, I guess, this was something that I suspected but never really asked about because I didn't want to embarrass him um. I did ask him before we had sex. I said, 'Look do I need to be worried about things like sexually transmitted diseases cause if so put that back in your pants'. And he was like, 'No no no'. So I was like, 'Okay you don't need to worry about that with me either.' So this is okay. So we have had that discussion without going into detail.

For others, there was fear that engaging in a discussion regarding sexual history would evoke a negative reaction such as jealousy. One young woman stated, "Yeah. Sometimes I worry that he gets jealous but yeah it's fine."

When engaging in conversations regarding sexual history, many participants noted that it can often feel awkward or uncomfortable. This may be playing into the variability in detail of the conversations held about sexual pasts.

For those who did have these discussions with their partner, they often engaged in the conversation in vague terms, asking surface level information such as number of dating partners rather than whether condoms were used.

> I know he had had many girlfriends before- I just kind of clarified that because I had known all of this from just being friends with him for a couple of years- This sort of stuff just comes out. And I think I had probably mentioned previous boyfriends that I had had. I don't remember us discussing it in any particularly deep detail.

level of knowledge regarding STI testing.

Participants were also directly asked about whether they had discussed STI testing with their partner. They were asked whether their partner had ever been tested for a STI, and whether that ever came up in discussion. It was believed that this would provide further insight into the establishment of sexual risk from one's partner.

physical symptoms.

Interestingly, some participants (n=3) noted that in order to feel concerned about STI , some form of imminent danger such as physical symptoms must be present.

> I don't know, I am not afraid of them because I know that I have nothing that would trigger my brain and say, 'whoa. I should be careful about this, or watching out for this or there is a sign that something could be wrong. There is nothing like that…Yeah, I feel like if I saw something that should not look like that or that should not be there or something doesn't feel right. That would worry me.

Another participant noted that since she had been having sex without a condom within her present relationship for several years, the lack of physical symptoms implies that she is free from risk.

> So I feel at this point it's like, if nothing has shown up in that amount of time of us sleeping together then I probably don't. But there is still that possibility there. But that's just with him. Because we have been in that relationship for so long and only with each other. But not with other people.

For many participants, physical symptoms become warning signs that they may have a sexually transmitted infection. The lack of visible symptoms provides perceived certainty that concern is not warranted at the present time. This is incorrect reasoning, as most cases of STI are asymptomatic and therefore would be present but not visible. Regardless, for many young women there is a perceived level of safety from STI unless physical symptoms are present.

intention for future testing.

Many of the respondents engaged in discussions about STI testing with their partner (to varying degree of detail). Despite engaging in a conversation regarding STI testing, some participants had never been previously tested. Many of these individuals intended on getting tested for STI in the near future.

> We were talking and he asked me how many sexual partners I had had before. And I think because I had had more than him it was a bit daunting for him. *laughs* So he suggested getting tested and I agreed that it would be a good idea. And I actually brought it up again more recently and we said 'yeah we really need to get on that' And so we are going to do it. I think. Eventually.

> Yeah, we talked about all of that. About whom we had had sex with and he offered to get tested for HIV and I was like 'Okay we will'. But I am very scared of needles and so I haven't done that yet. And he hasn't done that yet either. We are going to go together. But I think we will in the future because even if we have already started having sex together it is very important to do- getting tested for HIV because it is pertinent in our society no matter what.

It was later revealed that this respondent had already made the transition to a sole reliance on oral contraceptives.

It is suspected that for many young women, merely having the conversation regarding future testing may aid in lowering perceived risk of contracting a STI. The intention to get tested may be factoring into the decision to discontinue condom use within the relationship.

Summary

The majority of young women interviewed used primarily assumptive means of establishing their relationship and identifying sexual risk. Within this group, assumptions were often made from the onset of the relationship. Monogamy was often first assumed based upon romantic gestures and judgment of character. As young women begin to weigh the level of sexual risk in their relationship, assumptions are also made during this process. Some participants decided to forgo sexual health discussions with their partner due to familiarity or fear of emotional repercussions. Others engaged in discussions about dating histories rather than sexual health or histories. Furthermore, many of these young women were presently unaware of their own sexual health status having never engaged in STI testing. For many, there was no cause for concern unless/until there are physical markers of a problem.

Information-based Acquisition of Relational and Sexual health knowledge

In contrast to the previous group, the results indicate that there was a subpopulation of participants who appeared to use a greater degree of pragmatism in the establishment of monogamy and assessing sexual risk and health in one's relationship. Albeit the minority, these young women displayed a communicative, investigative and often directive approach with their partner regarding matters of sexual health.

Basis & Perception of Monogamy

Within this group of young women, relationship status and monogamy were typically discussed with one's partner in a communicative and explicit manner. The establishment of the relationship was based upon this communication. There appeared to be a level of directivity and understanding that this was required to fully establish their relationship. One young woman expressed, "It was exclusive and discussed as a serious relationship." Another participant stated, "We would talk about it. But, overall that's the way that I see relationships and the way that he sees relationships. So if we were together it had to be exclusive."

Interestingly, for the majority of participants who had the 'monogamy' discussion with their partner, it was females who initiated the conversation.

> We both liked each other; I think we kissed a few times. And I was like, well pretty much I was just like, 'yeah you can either date me or we can be friends and you can do whatever you do. Cause I…yeah…one or the other- I think it's kind of gross to be with other people. I don't know… I just like to establish like that.

> I was actually like 'it's one or the other. You can either get to know me and see how it goes and then date other people or do whatever you are doing- which I don't know about which is fine- and we'll be friends. But it's not both ways.

Despite initiating this conversation, many participants acknowledged that this conversation is often awkward and uncomfortable. Many noted the discomfort in approaching their new partner to discuss the nature of the relationship. Some feared that this kind of communication might frighten or put-off their partner. They were hesitant that their partner may perceive them as being presumptuous or pushy.

> You know how when you start dating someone it's generally like those terms are really scary at the beginning. There is so much awkwardness. You can't be like, 'Oh I like you so much!' Because then they will be like 'WHOA' and get all scared off. Communication is usually really hard at the beginning. That stage (with current boyfriend) was brief to non-existent. We could talk about those

> things right away. It was probably within a week. At the first day that we hooked up at the party, we were like, 'Let's call this official.' Within maybe four or five days we decided it was official…
>
> I was pretty sure just because he seemed to think a bit like me that that was how we was thinking as well. But still I felt like I needed to ask and say like, 'Is this exclusive? Do you want this to be? Cause I haven't actually been calling him my boyfriend because I didn't want to be out of line.

For many young women, the monogamy conversation can appear to be awkward, uncomfortable and slightly distressing. However, this barrier did not stop these participants from engaging in this level of communication with their partner.

Perception of Sexual Risk

initiation of sexual history conversation by females.

As with the 'monogamy conversation', females were more likely to initiate the conversation regarding sexual history with their partner.

> I think that I would be the one that was more bringing it up. He would not take the initiative. But now, he would be more comfortable to talk about it but he wouldn't bring it up. But that's probably because he already knew a lot about my sexual history because it is not as big as his.

Within this group, participants often asked about sexual histories in great length, inquiring about specifics.

> And so I asked, 'how many people have you slept with? What's your sexual history? That's how that conversation came about… I know like how many of those people have been long term relationships cause his number was kind of high. It was very high. Um and so how many were like one night stands? Or actual relationships?.. I asked him- did you use protection? If he gets tested often?

For both groups of young women there was the shared experience of feeling awkward or discomfort in initially discussing sexual histories with one's partner. Despite this, many still engaged in considerably in-depth and inquisitive discussions regarding their partner's sexual history.

Summary

The results indicate that there are two different processes by which young women develop their perception of sexual risk within their dating relationships. There are those who take a primarily assumptive stance on the establishment of monogamy and in acquiring knowledge regarding their partner's sexual history. Whereas, there is a second grouping of young women who base their sexual risk on information gathered through detailed conversations with their partner. Interestingly, regardless of how one establishes that level of perceived sexual risk, both processes lead to feelings of safety with their partner. During the initial survey, participants were asked to rate their level of risk in contracting a STI from their partner on a scale from one to five (1 being no risk and 5 being extremely risky). Regardless of whether assumptive measures were taken to judge the risk, the majority of the overall sample (87%) rated themselves as being at low risk of contracting a sexually transmitted infection rated at either a 1 or 2 (n=13). The next sections will discuss the shared experience of the overall population of participants (regardless of classification type). Both groups of young women have similar opinions of what constitutes sexual risk for others.

Perception of Risk for Others

As previously mentioned, young adults often compare their own sexual behaviors to that of their peer group (Lewis et al., 2007). This basis of comparison often permits individuals to feel as though they are engaging in safer choices (East et al., 2007; Redston-Iselin, 2001). Within the interviews, this theme of comparison emerged. Regardless of whether one used assumptions or gathered information, both groups of

young women commonly noted the sexual behaviors of others, namely, friends and/or peer groups.

When referencing the sexual behaviors of others, it was often done in one of two ways. Participants were either judging the behavior of others, contrasting their own safer choices in comparison. Or they would refer to how others influenced their own sexual health decision making within their relationship.

> It's not a rush and when I see people my age having sex, and they are not even in relationships and don't even really like the person. Like I remember one of my friends, she was drunk one night and was like, 'Ah I just have to have sex tonight with someone'. And someone else was like, 'yeah but with who?' We were at a party and she was like, 'oh I don't even care.' And it's just like, to have that mentality, it's like, I don't know, it's just, I feel like it's kind of like you have already done everything so then what's the excitement? What's left?

For others, peer groups played an influence over their own sexual health decisions.

> I was going to be very safe about it. Be on the pill as well as use condoms. Um I think that was partly influenced, probably greatly influenced by my friends who most of them who had had sex were on the pill.

The results reveal that peer groups play an influential role as either instigators for similar sexual health decisions, or as a comparative measure. Regardless, peer groups do play a role in how young women make and justify sexual health decisions within relationships.

Perception of Sexual Risk for Young Women as a Collective

Previous research illustrates that young adults often comparatively perceive their own behaviors as safer to other young women their age as a collective (East et al., 2007; Redston-Iselin, 2001). As such, researchers inquired as to what participants perceived to be sexually risky for young women in general. Participants were asked, 'What do you consider to be sexually risky behaviors for other young women?" Within the interviews

one prevailing theme emerged. The majority of participants believed that it was risky to have sex with individuals whom they did not know 'well enough' (n=9; which translates to 60% of total sample). This was usually defined in terms of having insufficient information regarding one's sexual history. Many participants noted that there is a high level of perceived risk for young women who engage in sexual intercourse without the use of condoms. Interestingly, this risk was narrowly focused to casual relationships rather than to relationships. The rationale appears to be that when engaging in casual sex, one runs the risk of not having significant knowledge about that person and their sexual history. As such, they pose a greater threat of having a STI.

> I think having casual sexual relationship like one night stands, just having sex with someone you don't know, you just met for the first time, this is so risky because um I think that the virus now a days is like so, a lot of people are just virus carriers and you can never tell. And even they don't know.
>
> Or else just having sex with people that you don't really know. Um I think its kind of good to know their partners- if they have a lot or if they have none- your kind of connected to that so.

Other participants believed that even when condoms are used, there is higher risk when having sex without knowing their partner well.

> I think that all sex is risky. Even if you are having sex, assuming that it's with a complete stranger or something, even if you are having sex with a condom I think that it's extremely extremely risky. Condoms are not 100% effective, and if you do get an STI or a pregnancy it will completely change your lifestyle depending on the STI, obviously pregnancy and your choice and whether you are pro or against abortion. I think all sex is extremely risky.
>
> They were two one night stands. I realized that they were completely risky. I was drunk for both of them. Um I used condoms for both of them. I regret them. But there is nothing that I can do about them now. Um, I doubt that I will ever again have a one night stand.

Consistent with previous research, the participants expressed a higher level of concern for contracting sexually transmitted infections through casual sex or when having insufficient understanding of their partner's sexual history.

Primary Use of Condoms

Due to the dual role of condoms as both a barrier against STI and contraception against becoming pregnant, participants were asked to identify what was their primary reason for using condoms. The responses typically fell into one of three categories: pregnancy, sexually transmitted infection or both (indication of a hierarchy).

The majority of the sample indicated (in an often automatic form) that their primary reason for using condoms is to prevent pregnancy (n=9; which translates to 60% of the total sample). Many noted that in conjunction with oral contraceptives, they perceived condoms to be a 'back-up' in case the other method failed. This was a consistent trend throughout the interviews. One participant noted, "Pregnancy. That's the first thing that comes into my mind." This was echoed by another participant who stated, "Definitely pregnancy. I mean- I wasn't really thinking about STI's- yes if I was like perfectly rational that would have been a consideration but I wasn't." One young woman went on to explain, "Yeah it was more as kind of a backup risk. For- in case of getting pregnant."

For those individuals that did identify condoms as a barrier against sexually transmitted infections, it was almost always paired with it also being a pregnancy preventative. Interestingly, many young women believe that condoms serve as a 'back up preventative' rather than contraception in and of its own right. So although young

women can commonly conceptualize condom use for pregnancy prevention solely, it is rarely perceived as a measure of preventing STI alone.

For individuals who do acknowledge condoms as a method of STI prevention, many rate its pertinence as a hierarchy. When participants were asked to rate their use of condoms as primarily a barrier against pregnancy or against transmission of STI, twenty-seven percent of participants conceptualized a hierarchical system based upon the degree of severity, visibility and fatality. One participant stated that, "I would say, if I was creating a hierarchy, it would go at the bottom: STI's like Herpes. Then in the middle, pregnancy. And then at the top, something like HIV."

Many participants noted that the potential lethalness of an STI would weigh into their perception.

> I never really thought it they were equal in weight or anything but I feel like there are some really dangerous sexually transmitted diseases especially; I think the worse that I can think of would be AIDS and our school had a lot of awareness around that; a lot of fund raising for it; a lot of campaigning for it and so we have heard a lot about it and that would be really scary. And I think that would be worse than getting pregnant, because you would die.

For others, the visibility of pregnancy was of greater concern.

> …Because, depending on the STI it could be manageable. It could be cure-able. It's something that just you know about not the whole world. And you can deal with it internally. But being pregnant is just like 'are you going to keep it' 'are you not?' 'Are you going to give it away?' Like everything that comes with that. Financial. Everything- responsibility. Too big.

> I guess that it's just a bias in terms of what I would find more traumatic. I am sure it would depend on what the STI was, and certainly some things would probably be more devastating um.. and I guess a lot of it would be depending on what the STI was. You could potentially deal with that yourself and with your partner, it's not necessarily something that you would have to be sharing with other people. Especially your family or your parents. Whereas, pregnancy you may have to, depending on how you choose to cope with it. It's a lot more visible.

For many young women, the threat of STI is based upon levels of permanency, and whether or not it can be hidden from others. Pregnancy appears to carry the potential threat of being exposed, having others aware of your status. Additionally, life-threatening diseases also pose a larger risk, as they carry a level of permanency as well. However, participants were less concerned with contracting STI that are treatable, with less threat of having others become aware of their condition.

The results indicate that the meaning of condoms is dependent upon the degree of perceived risk. The majority of participants indicated fear of becoming pregnant. As such, condoms are primarily used in conjunction with the pill as a backup method of contraceptive. There is unequal distribution of concern. Unless severe or permanent (for example HIV) individuals expressed greater concern with becoming pregnant over contracting a STI. It is important to understand the associated meaning of condoms within relationships. Notably, if condoms are perceived as primarily a pregnancy preventative, this will lend into the decision to transition to an alternate form of birth control during the course of the relationship (to be discussed).

The Transition to Oral Contraceptives within Dating Relationships

The preliminary survey revealed that 100% of participants reported using condoms the first time they had sex with their partner (n=13). Moreover, 46% of participants paired condom use with oral contraceptives, using both as a means of protection for the first time engaging in sexual intercourse with their partner (n=6). No participant used oral contraceptives alone the first time. Analyses reveal that indeed condom use was higher at the beginning of a dating relationship (to be discussed).

Initiation of Condom Use

Within this study, the researchers were interested in who takes the lead in initiating condom use within dating relationships. Although condoms are used as a barrier worn by men, there appears to be an interesting dynamic within relationships when negotiating contraceptive use. The results of this study indicate that initiation of condom use can be best phased into three categories: initiation of condom use by the female; decision was mutual; or the condom-use was initiated by male partner.

initiation of condom use by the female.

The majority of young women noted that they were the ones in the relationship to initiate the condom use with their partner (compared to male initiative). Many participants requested that their partner use a condom (n=7; which translates to 54% of the sample who are currently sexually active with their partner). There appeared to be an ease of discussing contraceptives, where women felt comfortable stating their preference for condom use at the beginning of the relationship. For many young women, their partner reacted favorably to this request. Often participants would note that they believe their partner would have initiated condom use, if they hadn't already done so. One participant noted, "I probably initiated it but he was very much in agreement. I am sure that if I hadn't initiated it he would have."

mutual decision to use condoms.

For other participants, the decision to use condoms was a mutual decision (n=5; which translates to 38% of the sample who are currently sexually active with their partner). One young woman noted, "I think it was mutual. Neither one of us wanted to have sex without a condom." Another echoed this by stating, "I think both of us. Yeah

Because in the beginning I didn't really know him that well so obviously I thought it was important. And he, he was asking about that so yeah." There was often overlap between this category and the former, as many women who had originally initiated condom use stated that it was also a mutual decision with their partner.

initiation of condom use by the male.

Notably, some of the participants identified that their partner took the lead on condom use at the beginning of their relationship (n=2; which translates to 15% of the sample who are currently sexually active with their partner). Interestingly, this was more common for young women who were currently within their first sexual relationship. The results identify that for these women, the males took the lead on contraceptive decisions because they felt a lack of sexual experience.

> I knew that he had used condoms with his previous girlfriend even though… cause I had never had sex before this; I think the general sort of advice of what to do came from him... not came from him but sort of 'well I have done this before and it has worked for me' for him. So I knew he had condoms because he just had some. I think it's a guy thing they just; probably born with them in their back pockets.

When talking about one of her first sexual partners, one participant stated that due to her inexperience, her partner initiated the contraceptive use.

> I think he made the choice because I didn't know anything at that time. And he bought condoms, and he used them every time and he said he didn't want me to get pregnant. So I didn't worry about that. I didn't think too much of that.

Unlike other forms of initiation (such as initial discussions of monogamy and sexual histories) females are not the only ones in the relationship initiating condom use. Although many young women did initiated condom use within their relationships, males played a role in this decision. Often if the female partner was the first to bring it up, the male reacted favorably. Furthermore, if the relationship was the first sexual relationship

for the female partner, the male often took the lead on the contraceptive choices. Interestingly, there were many different patterns in who initiated condom use at the beginning of the relationship.

Condom Use at the Beginning of the Relationship

There are different factors at the beginning of the relationship that contribute to the decision to use condoms. Approximately one-third of the participants noted that it is simply common knowledge to use condoms when having sex. A typical response was, "Condoms are what people generally use." Or, " You hear so much about use condoms, use this and that…Yes it was natural for us to use it at the beginning-at the beginning yeah."

It was revealed that for many participants there was a discrepancy in risk dependent upon the timeline in the relationship. Consistent with previous research, many young women implicitly perceived higher levels of risk at the beginning of their relationship. Forty percent of the participants (who are currently sexually active with their partner) noted that at the beginning of their relationship they used condoms because they felt as though they didn't know their partner well enough to engage in unprotected sex. As such, higher rates of condom use were reported during this period of time.

Young women explicitly communicated their safety concerns the first time having sex with their partner. She stated, "I was already on the pill. And the first time, you don't know the sexual history of your partner. You don't know how well he protected himself so we used a condom." When discussing the beginning of her relationship another participant stated, "I am very absolute that condoms must be used." She later described transitioning to a sole reliance on oral contraceptives later on within her relationship.

When asked what the difference had been since the beginning of the relationship she replied, "Well there is…although you won't get pregnant, you will have a very high risk of transmitting or contracting a STI."

Participants frequently noted the higher levels of risk in contracting a sexually transmitted infection from their partner at the beginning of the relationship. Many young women stated that at this early stage in the relationship, they required more information about sexual histories, feeling unsure about their partner's dating/sexual history. The results indicate that for many young women there is a perception of increased risk at the beginning of a dating relationship.

One-third of the participant's who discontinued condom use within their relationships, noted that getting to know their partner better was an instigating factor in their decision to transition to oral contraceptives alone. One young woman stated, "I guess it was just getting more comfortable with each other and getting to know each other better and they kept breaking anyways…"

Another participant expressed,

> Like in the beginning I didn't trust him completely I was still like had my doubts, even though we were using condoms I was like, I don't know I guess a part of me is always still a bit scared. Um yeah. Because there is still even a small risk with condoms. Of pregnancy. But not in terms of STD well? I think its okay in terms of sexually transmitted diseases but in terms of pregnancy and stuff I was worried. And then after I don't know- I guess I just got used to being with him more. And then I felt more comfortable. I would like- It was okay to me.

Notably, as the familiarity with one's partner develops, the perception that one may be at risk for contracting a STI within the relationship decreases.

Inconsistent Condom Use

Within this study, researchers were interested in the process of discontinuing condoms in favor of oral contraceptives. During the preliminary survey, participants

were asked to rate their level of condom use during the first month of dating ('every time' 'frequently' 'sometimes' or 'never'). For comparative measures, individuals were also asked to rate their level of condom use within the previous month. The majority of participants used condoms every time during the first month of dating (n=11; which translates to 85% of the sample who are currently sexually active with their partner). However, since the first month of dating, the majority of the sample has since engaged in inconsistent condom use (n=9; which translates to 69% of the sample who are sexually active with their partner). Furthermore, 38% of participants transitioned from using condoms every time during the first month of dating to fully discontinuing condoms within their relationship (n=5; see Appendix F).

The process of how one appraised their STI risk (whether assumptive or informative) held little influence on whether they would discontinue consistent condom use within their relationship. For example, "participant A" was categorized within the information based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved feelings of greater commitment and trust towards her partner. Whereas, "participant B" was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons also involved feeling greater trust and commitment (see Appendix G). Whether one used assumptive or informative means appeared to have little bearing on consistent condom use as young women from both categories discontinued condom use.

decreasing condom use and relying on oral contraceptives.

When assessing which factors contributed to decreased condom use, notably using oral contraceptives played a significant role. For participants who transitioned from using condoms at the beginning to never using condoms, all cited that they were now on oral contraceptives (i.e. 'the pill'). Upon using oral contraceptives, the majority noted then making the transition to decreasing condom use within their relationship. One participant expressed, "I don't remember if it was the third or fourth time. But then it was kind of like, 'well I am on the pill'. We had this conversation, and then we decided to have sex without them." Another echoed this by stating that she used condoms, "Oh, all the time. We've never had sex without a condom until I went on the pill. Then we didn't use condoms at all."

The results revealed an interesting pattern of decreased condom use. For the majority of young women who switch to a reliance on oral contraceptives, the switch is often progressive. First, there is an event where condoms are disregarded. From then on, instances of barrier-free sex become more frequent. Upon using condoms infrequently, the onset of discontinuing condom use entirely becomes swift. It appears that once a couple has had sex without a condom, it becomes more difficult to re-establish condom use as the normative within that relationship.

One participant was asked whether there was ever a time within her relationship where condoms were not used.

> Yeah…Um it's kind of I guess, I mean- we know that I am on the pill right? Which is 99% effective-so sometimes when you are like in the 'heat of the moment' it just kind of doesn't happen. *laughs*. And it happens less and less- I mean we- I think we use condoms less than we used to… I would say probably fifty percent.

Another participant explained, “After the first time we did that we kind of made a ‘half assed’ attempt to keep using condoms but it’s not really so much.”

When discussing patterns of decreased condom use, the themes that emerged from the interviews signify that oral contraceptives contributed to the transition. It is suspected that infrequent condom use then re-defines the norms within the relationship, and it becomes more difficult to re-establish condom use.

STI testing prior to transitioning to oral contraceptives.

Nearly half of the sample noted having been tested for STI’s at some point in their life (n=7; which translates to 47% of the total sample). However, upon further disclosure, it was revealed that participants conceptualized this test by differing definitions. For many, the inclusion of one’s annual papanicolanou’s smear (also known as a pap test) was considered to be a sufficient STI test. Whereas, others had engaged in blood testing or requested particular STI tests (for example: genital herpes). Regardless of the level of testing, it was apparent that the experience of being tested lowered participants perceived risk level of contracting a STI from their partner.

> Now I feel confident…Just because I feel like I understand him more, because as of now I know he doesn’t have, because I have been checked. And I trust that- I really do trust that he wouldn’t do any, go with anyone else at the moment. So that’s why I am not worried right now.

Another participant stated, “Yeah we have discussed it, we know each other’s sexual history very well and we saw each other’s reports so I think I am quite confident.” For many, STI testing acted as a catalyst in their decision to discontinue condom use with their partner. One third of those who transitioned to oral contraceptives explicitly stated that the testing provided the safety needed to engage in unprotected sex within their relationship without concern.

> Well, it was a common decision. We knew more about each other, so we decided to take a test to make sure that neither of us had a sexually transmissible disease. From then on, since we knew that the relationship was exclusive, it was clear between us, there was no reason to use condoms anymore.

The results indicate that the process of undergoing STI testing (to varying degrees) creates a sense of security within the relationship. This act often allows individuals to justify discontinuing condoms within the relationship.

Psychological/Emotional Influences in the Transition to Oral Contraceptives

Transitioning to oral contraceptives within one's relationship is often a significant event. There are several psychological & emotional factors that influence the decision to discontinue condom use. The majority of participants linked unprotected sex with emotional variables such as trust, commitment and intimacy. This was true for both groups of women, regardless of the level of sexual health proclivity. By not using condoms within their relationship, most of these young women believed it was symbolic of being in a solid relationship.

Switch to Oral Contraceptives as Indicative of Stronger feelings and Higher Commitment within the Relationship.

When transitioning to oral contraceptives alone, participants would often note the change in their relationship. The act of not using a condom signified that their feelings for one another had deepened and intensified. Of those who discontinued condom use within their relationship, 85% stated that it was reflective of the higher commitment level they felt towards their partner and their relationship (n=11).

Often young women noted the direct correlation between their contraceptive use and the intensity of emotion for their partner,

> I think the relationship was going really well and uh we just ah started feeling our emotions and feelings going deeper, so that's why we are very confident to avoid

> using condoms…I think so. Cause for my second boyfriend we used condoms all the time. For my first boyfriend it is because he doesn't want me to get pregnant that's why he wants to protect me so every time he use condoms. With my second boyfriend our emotions were not as strong as my present one (boyfriend), so I asked him to use a condom every time to make sure.

For another participant, not using condoms was a direct indication that the relationship had become serious.

> I guess it did mean that we were in the kind of relationship where you don't use condoms. Which notches up the level to 'okay now we are serious'. Because now somebody else is also going to be effecting me because you know what I mean? Because we are not using that level of contraception anymore… I guess it would make the relationship more serious.

The link between not using condoms and higher commitment levels was prevalent throughout the interviews. For many young women there is the perception that condoms are associated with the beginning of a relationship. Therefore, to no longer use this barrier method of protection signifies that the relationship has been taken to a higher level.

Unprotected sex was also used to re-establish commitment. Upon times of turmoil within the relationship, some participants noted that having unprotected sex was a way of expressing their commitment to their partner.

> And then I guess the handful of other times it happened (stopped using condoms), it was more of a… I don't know, I guess an emotional time when I felt like we were going through, we had just come through a difficult time, or something had just happened where I think we felt strongly about sort of reaffirming the bond, and making a statement about how serious the relationship was and how much trust there was.. I guess when there was just times when we had had, you know, a fight, or it had seemed like we had gone through a time where we weren't sure how we felt about staying in the relationship, and we were then sort of reconciled, it seemed like a way of reaffirming the fact that 'you know I do want to be with you and I want to be with you so much that I trust you and I guess I am willing to engage in behavior that may be a little more risky cause I do feel like we have that kind of intimacy where it is okay to do so.

One of the major themes that arose from the interviews is the association of unprotect sex with a greater level of commitment. The discontinuation of condoms begins to represent developmental milestones within the relationship.

Level of Trust in Decreasing Condom Use

Concurrent with higher feelings of commitment for ones partner, trust also played into the decision to use oral contraceptives. For those young women who only rely on oral contraceptives, all alluded that trust factored into their decision. Moreover, 46% of participants who transitioned stated a direct link between discontinuing condoms and the trust that entailed in one's partner (n=6).

> Actually both with him and my other relationship where I didn't use a condom, I think I just trusted both of those people a lot. Whereas the other relationships where I have always used a condom, I didn't have as much trust.

> I guess we had just been together for awhile… I guess we were just comfortable, and I knew him and we had been sleeping together for awhile. I never really put too much thought into it. I guess it just happens. It must be associated with the level of trust, and comfortability that I guess it just happens.

Furthermore, participants believed that by engaging in unprotected sex they were endorsing a high degree of trust in their partner. Many participants indicated that they needed to trust that their partner was being faithful to them in order for them to stop using condoms. Participants often noted that there is a higher level of sexual risk associated with engaging in barrier-free sex. Therefore, they must maintain a high degree of trust that their partner is being faithful to their relationship otherwise they risk a higher chance of contracting a sexually transmitted infection.

> Cause if he then is also sleeping with someone else then it would almost make me feel like I am sleeping with that person as well. Cause, you know what I mean? He would be exposing me, I would just find it a cruel thing to do if you were sleeping with…If he was sleeping with me without a condom and then going off and sleeping with other people with or without a condom. Even with a condom I

> would just feel violated…Yes. I would not be at that stage if I did not actually think that we were both monogamous.

One young woman recounted her experience with an ex-boyfriend (where he had been unfaithful to her).

> I remember afterwards that I insisted we use a condom because I didn't trust him as much…He probably knew that I had doubts about him but he still did…He probably realized that I thought he might be a risk for me or something.

For many participants, there was recognition that having sex without a condom may be dangerous if their partner were to be unfaithful. As previously mentioned, for those who suspect that their partner may not be faithful, contraceptive patterns change and individuals are more apt to request condoms. Notably, trust plays a large role in the decision to transition to oral contraceptives alone.

Decrease in Condom Use and Feelings of Intimacy

As previously noted, a lack of condom use is symbolic of higher levels of trust and commitment. This is also true for intimacy. One major theme that emerged from the interviews was that the majority of participants noted that unprotected sex with their partner felt more intimate (n=8; which translates to 62% of those who used condoms inconsistently). One young woman expressed, "It's like obviously physically but emotionally…because of the physical closeness you feel emotionally closer. It's really a feeling. I don't know…" Another participant stated that, "It feels better. And because of that I feel like we have shared a more unique experience together. And that bonding brings us closer together."

This was echoed by another participant who expressed,

> Well I used the word intimate already and I think that really describes the difference in contraceptives. I think that without using a condom it is much more

> intimate. You can, you feel closer to each other and um it's much more pleasurable.

For the majority of participants, switching to oral contraceptives increased feelings of intimacy with their partner. The physical act of using a 'barrier free' contraceptive translated to feelings of greater intimacy with their partner. Interestingly, this association with intimacy was also expressed by many of the partners. A few of the participants noted that their partner wished to discard condom use, for purposes of being more intimate with one another.

> He just wanted it to be more intimate. I mean, like I said, I knew that we were going to be monogamous from day one and he is really sensitive. Like he really wanted the intimacy of skin to skin, nothing between us type thing.

Another young women described her partner's reaction to condoms stating, "He was like, 'oh, the condom is such a barrier, I want it to be more intimate." Although these recounts are third party from the female partner, it appears that many males also associate intimacy with decreased condom use. Interestingly, for many participants intimacy and commitment level tend to overlap, and these variables are interconnected.

There is an evident association between commitment, trust, and intimacy with having unprotected sex within a relationship. The discontinuation of condom use signifies developmental milestones within the relationship. The implicit association of unprotected sex being more intimate and signifying solidification of the relationship often poses as a desirable option. The meaning of condoms within relationships carries a negative stigma, and is often associated with lessened levels of trust or is indicative of lower levels of commitment. As a result, the choice to stop using condoms within dating relationships may pose as a desirable option.

Approximately one-third of participants indicated using condoms consistently within their dating relationship to date (n=4). As such, many were asked whether or not they could foresee themselves making the switch to oral contraceptives alone (hypothetically). Interestingly, the majority of these individuals explained that they had considered this option. Many of these young women stated that if they felt secure that they would not get pregnant, they would be more apt to transition to oral contraceptives alone.

> I mean we may someday when I go back to the UK or when he comes here to visit me, we may stop using condoms, and because, I use the pill regularly and I don't take antibiotics, fairly sure it's a fail-safe method.

> Probably, the fact that we are in an exclusive relationship and I am not seeing anyone else and I trust that he is not seeing anyone else. Probably just so far we haven't had any problems. We haven't had any pregnancy scares, or missed periods or anything odd about my body that has made me think something is not as it should be. So I don't see the harm in trying. And we are also in a secure enough relationship that should something happen and I got pregnant that we would be able to sit down and talk about what to do about it… So that would probably be why if we decided to stop using condoms, or if I ever decided to go off the pill. Whichever one we stop doing first we will keep doing with the other one.

Hypothetically, the primary factor that would lend into the decision was the level of risk of becoming pregnant. This consideration for future contraceptive changes also raises the question of whether the prevalence rates for those who discontinue condom use is higher than is portrayed in this research. Since this study provides a snapshot of relationships at varying stages and lengths, it is suspected that these prevalence rates may actually be higher than what is being presented.

Meaning of Condoms once Discontinued

As previously mentioned, once condom use becomes inconsistent it becomes more difficult to re-establish consistent condom use within the relationship. Many

participants noted that it becomes increasingly difficult to re-establish regular condom use. Once the norms within the relationship are changed to include unprotected sex, condom use takes on a new meaning between partners. For those who indicated the discontinuation of condom use, condoms became associated as a measure of fidelity. One participant was asked whether or not she would feel comfortable asking her partner to use a condom if she wanted to (having discontinued condom use for the past couple of years). She replied,

> I wouldn't ask him to use a condom at this point in our relationship because I have complete faith that we're both monogamous and you know what I mean, we are not screwing around on each other. So if I got it I already got it. So if at this point in the relationship if I asked him to wear a condom then I think he would be really insulted or I think that he would think that I was screwing around. Like when I have asked him before, 'we should go get STD checks'. He would be like, 'why? Who have you been sleeping with?' He just gets very defensive about it.

When she was asked what she believed the message would be she replied, "I think the message would be that we were taking our relationship back. You know what I mean? Like a step back, and like 'sleeping with other people'."

Once discontinued, the meaning of condoms becomes associated with infidelity, or instability within the relationship. Thus, for many young women they may be apprehensive to try to re-establish condom use if desired. It is suspected that these messages of instability and infidelity associated with condom use may make the re-establishment of condom use more difficult.

Physical & Practical factors Influencing the Transition to Oral contraceptives

Having discussed the emotional influences in transitioning to a sole reliance on oral contraceptives, it must also be noted that for many participants this decision was based upon physical factors. Within the interviews it was evident that for many young

women having unprotected sex was more pleasurable and convenient. In fact, 70% of the participants who discontinued condoms noted these as benefits of the transition. Many noted that using a 'barrier-free' method of contraceptive was attractive, because it felt physically pleasurable. One participant stated, "Well I think for both parties it was much more pleasurable to have sex without a condom. Um because there is no plastic in the middle, and you can feel each other better."

Others were drawn to having unprotected sex because it was more practical and convenient. This allowed them the freedom to have sex wherever and whenever they decided. One participant noted, "you can have sex whenever and wherever you want." Many expressed freedom in not needing to cease sexual activity to put on a condom.

> So I think it is, definitely, mostly a physical thing, but it is also less of 'we are having sex now we have to put everything on hold and figure out where the condom is'. It's more of a natural thing that we are doing together and it's not something that has to be regulated by a condom.

Many noted that by using oral contraceptives alone, they were free of many hassles. They no longer had to carry condoms with them, stop sexual behaviors till their partner placed a condom on; and overall it felt physically more pleasurable. All of these things factored into the decision for many participants to stop using condoms.

Male Influence: Partners expressed their preference for not using condoms

For those who discontinued condom use within their relationship, one third referenced their partners influence in this transition. Although this information is based upon third party reference from the participants rather than their partners directly, it appears that for some of the participants their partners factored into their contraceptive decisions. For many, their partner remarked in a subtle manner their preference for barrier-free sex. One participant stated, "He said that when I went on the pill he thought

it was just like so much better without a condom." When discussing this transition to oral contraceptives, it is important to consider that there may be influences or pressure from one's partner to switch to barrier-free sex.

No Difference in Relationship due to Switching to Oral contraceptives

The results indicate that albeit for most there were changes made in their relationship (higher perceived commitment, trust and intimacy) for others, discontinuing condoms did not make a difference within their relationship. For some of the participants, having sex without a condom was not significant.

> We had already discussed sort of long term plans and stuff so it was eventually. How awesome it's going to be when can finally have nothing when we have kids and stuff but that had already- I don't know if we had talked about that or we had talked about having kids in the abstract and staying together for the rest of our lives and stuff but we hadn't. I don't think we had talked specifics or like dirty terms… But I don't think it was symbolic of anything- everything had already been said.

It was apparent that for some young women, the transition carries little meaning or implication to their dating relationship. It is uncertain at this point in time, whether being in one's first sexual relationship would influence this perception.

CHAPTER 4

Discussion

Young women make powerful assumptions regarding what constitutes safer sex practices. Engaging in unprotected sex with one partner within a mutually exclusive relationship is often perceived to be safe. Monogamy creates a perception of immunity from STI and condom use is often discontinued in favor of 'barrier-free' oral contraceptives. This perception is questionable; given the varying effectiveness of STI testing and the high likelihood that this is neither one's first nor last relationship (A. McKay, personal communication, July 23rd, 2009).

While condoms are not infallible, research has proven that if used consistently and properly they significantly reduce the risk of infection (particularly: HIV, Chlamydia, gonorrhea, genital herpes and HPV) (McKay, 2007). Despite the assertions of experts that condoms are the best way to reduce risk of contracting an STI, young women are not using them consistently (McKay, 2007).

Process of Appraising STI Risk

Consistent with previous research, there are two main processes in how young women appraise their STI risk within relationships (Civic, 2000; Manlove et al., 2007). This study revealed that the majority based their risk by making assumptions regarding monogamy, sexual health and history (assumptive group). These individuals made leaps of faith regarding their partner's character, personality and sexual past. Arguably, this proved to be an easier route as it is perceived to be less emotionally charged or potentially threatening to the relationship. Conversely, there was a group of young women who based their STI risk on information gathered through discussions and fact

finding missions (information based group). These young women appeared to be proactive in their initiation of discussions and testing with their partner. They maintain the importance of being informed about their risk and taking a self protective stance over their sexual health. There was the perception that by taking these precautionary measures (detailed discussions and STI testing) that they were engaging in safer sex practices.

One might assume that individuals who engaged in fact finding initiatives with their partner would be at a lesser risk compared to those who assumed safety. This would be incorrect. This study revealed that there was no connection between being more informed and consistent condom use. Regardless of their initial process of appraising STI risk, young women from both groups discontinued condom use.

Consistent with previous research, the notion of getting to 'know a partner well enough' played a significant role in unprotected sex (Civic, 2000). There is a connection between romantic feelings towards a partner and the perception that said partner is not a threat to one's personal health. These two disjointed views equate sexual health with affection. Individuals are generally averse to believing that someone they love would be a risk to their personal health (East et al., 2007; Misovich et al., 1997; Pilkington et al., 1994; Skidmore & Hayter, 2000). Therefore these two separate entities appear to become confounded. As such, there is an increased risk of contracting STI within monogamous relationships. Regardless of which process of risk appraisal (whether assumptive or informative), both groups of young women sought to rationalize the discontinuation of condom use with their partner.

Young women perceived higher levels of STI risk from their partner within the beginning stages of the relationship. As such, it was considered 'common knowledge' to

use condoms at this vulnerable period of time. However, as the relationship evolved and emotions deepened, condoms were perceived as a burden (both physically and emotionally). As the relationship developed, that perceived risk became overruled by the desire to protect the relationship and portray oneself as a committed partner. The introduction of oral contraceptives provides a means for these young women to rationalize the discontinuation of condom use (Civic, 2000; Critelli & Suire, 1998; Misovich et al., 1997). Consistent with previous research, the majority of participants did transition to using condoms inconsistently or infrequently throughout the course of their relationship (Civic, 2000; East et al., 2007; Lee et al., 2005).

Relational Implications of Discontinuing Condoms

The present findings mirrored those of previous literature which state that there are positive relational ramifications in discontinuing the use of condoms (Conley & Rabinowitz, 2004). For those who transitioned away from using condoms, they believed to have benefitted from intimate shifts within the relationship. Participants noted that their relationship had graduated to a heightened level of commitment. Accompanying feelings of love, intimacy, trust and promise all developed as a result of this contraceptive switch. Consistent with previous findings, the physical act of discarding condoms was associated with emotional milestones within the relationship (Conley & Rabinowitz, 2004; East et al., 2007).

Contrary to the established literature, the present findings suggest that practicality and physical pleasure acted as important influences in the decision to discontinue condom use. While previous studies have emphasized these influences with reference primarily

to male pleasure (Flood, 2003), the present findings suggest that these physical benefits are also contributing factors for young women.

Once discontinued, the meaning of condoms becomes negatively juxtaposed as a threat to the relationship. Consistent with previous research, condoms became associated with notions of mistrust and infidelity (Flood, 2003; Pilkington et al., 1994), potentially compromising the continued success of their relationship. Again, as the relationship is established, this method of contraceptive is significantly associated as a barrier or roadblock to developing to the next level of commitment. Condoms carry powerful negative stigma within relationships.

Level of Actual STI Risk

The present findings suggest that young women misjudge their level of STI risk. Many believe that having multiple sexual partners is of greater risk than having sex within a relationship. Having protected, casual sex was deemed to be riskier than unprotected sex within a dating relationship. This is a dangerous misconception. It is less risky to engage in protected sex with multiple partners than multiple incidences of unprotected sex with one partner (McKay, 2007). Individuals who engage in unprotected sex within a relationship are at a very high risk for infection. Individuals who engage in consistent condom use with multiple partners are at a relatively lower risk by comparison (McKay, 2007). As the present findings illustrate, young women appear to rely on monogamy (having only one sexual partner) rather than consistent condom use as their principle method of maintaining a low risk for STI.

Concluding Remarks

Given the questionability of testing, the unreliability of using discussions to decrease risk, and the common practice of multiple sexual relationships within this age cohort, unprotected sex places young adults at high risk of contracting STI (A. McKay, personal communication, July 23rd, 2009). During this age, there are many assumptions made regarding safer sex practices, one of which is the perceived safety of monogamy. Furthermore, there is a pervasive belief that as relationships develop, condoms act as physical and emotional barriers to intimacy, as they are often symbolic of casual sex, infidelity and mistrust. Therefore, the discontinuation of condoms often represents relational milestones. Unprotected sex paired with serial monogamy acts to increase one's level of risk of acquiring an STI. Although it is recognized that consistent and proper condom use is the most effective means for preventing STI among this population, the message is not reaching those in relationships. Further promotion needs to be addressed to debunk the negative stigma associated with condom use within monogamous relationships.

Limitations of the Study

This study was not without some limitations. As previously mentioned, the recruitment flyers advertised the research as a dating and sexual health study. There is a probability that the type of individuals drawn to this study may not be representative of the population as a whole. Additionally, since safer sex practices are widely campaigned, within this research there is the risk of promoting socially desirable responses from participants. Finally, the majority of participants were currently students (at the

undergraduate level or higher). As such, it is uncertain whether the sample can be generalized to the experience of young women as a collective.

In conducting research on sexuality and relationships, it is often difficult to control variables across the sample. With that being noted, it was difficult to differentiate whether or not the length of time within one's current relationship played a significant role in their decision-making process. It is difficult to ascertain whether the same results would be revealed at a different snapshot in time. As such, there was wide variability in the lengths of time spent within one's present dating relationship.

Due to the sampling criteria, there was also great variability in the level of sexual behaviors and number of sexual partners accumulated across participants. Again, it is difficult to ascertain whether one's level of sexual experience plays a significant role in the conceptualization of contraceptive use. This population may be biased, as approximately 50% of the sample identified currently being within their first sexual relationship. It is difficult to identify whether or not this may influence the results, making them less representative of young women in general.

Additionally, the research is based upon self-report data. It is difficult to ascertain whether the statements made are an accurate representation of the events. For many young women these events occurred within the previous years. Thus, one's accuracy of recalling these memories may be skewed by time.

This study only views contraceptive decision-making through the female lens. Any account or knowledge of male opinions, reactions and influence is third party information. This is a limitation of the study, as it is difficult to ascertain the validity of

these statements. Although it would prove interesting to include a male sample, it was outside of the scope of this research to do so.

Suggestions for Future Research

The results of this study indicate that young adults in dating relationships engage in sexually risky behaviors. Since young adults are a vulnerable population for contracting sexually transmitted infections, undoubtedly more research needs to be conducted in this field. Since condoms are often discontinued in favor of oral contraceptives, further research should evaluate the seemingly negative stigma of condoms within relationships. It would be valuable to assess whether the negative connotations are manufactured at the personal (partners influence and previous relationships), group (peers and immediate environment) or societal level. Additional research evaluating patterns of condom use within one's first sexual relationship would prove interesting. It would be valuable to assess whether the norms established within one's first sexual relationship influence patterns of condom use throughout young adulthood.

Implications for Helping Professionals

It is aspired that this study will improve understanding of sexual health decision making for young women within dating relationships. As previously mentioned, young women can often face great pressure in the negotiation of continued condom use within relationships (Dehne & Riedner, 2005; East et al., 2007). As such, helping professionals should be aware of the resources, communication tools and how to empower young women to advocate for self protective sexual behaviors. Furthermore, public health campaigns should be geared towards erasing the misconceptions that equate monogamous dating relationships with a sense of sexual safety. These campaigns should

work towards debunking the negative stigma that condom use carries within relationships.

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Appendix A

Descriptive statistics pertaining to sample's sexual history

Table A1.

Descriptive statistics of the sample's sexual history

	yes	No
Sexually active	93%	7%
First sexual relationship	50%	50%
		Range= 0-6 sexual partners
		Mean= 2 sexual partners
Ever engaged in casual sex	13%	87%

Figure A1. Length of Current Relationship

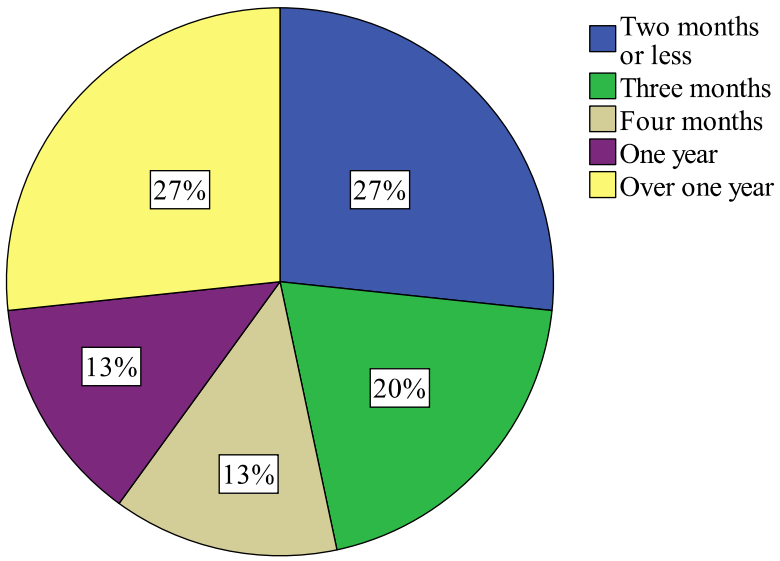


Figure A.2. Length of time individuals knew their partners prior to dating

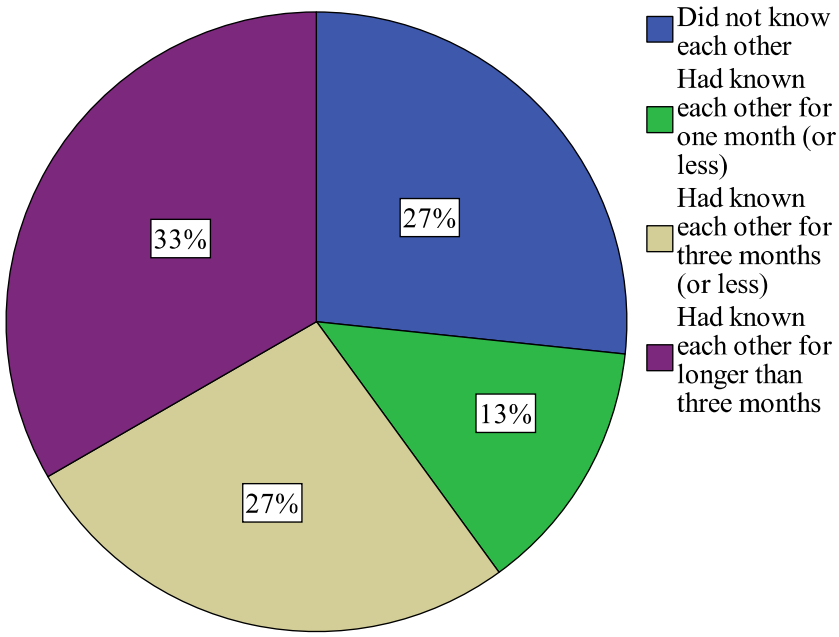


Figure A3. Length of time spent dating prior to the relationship becoming exclusive

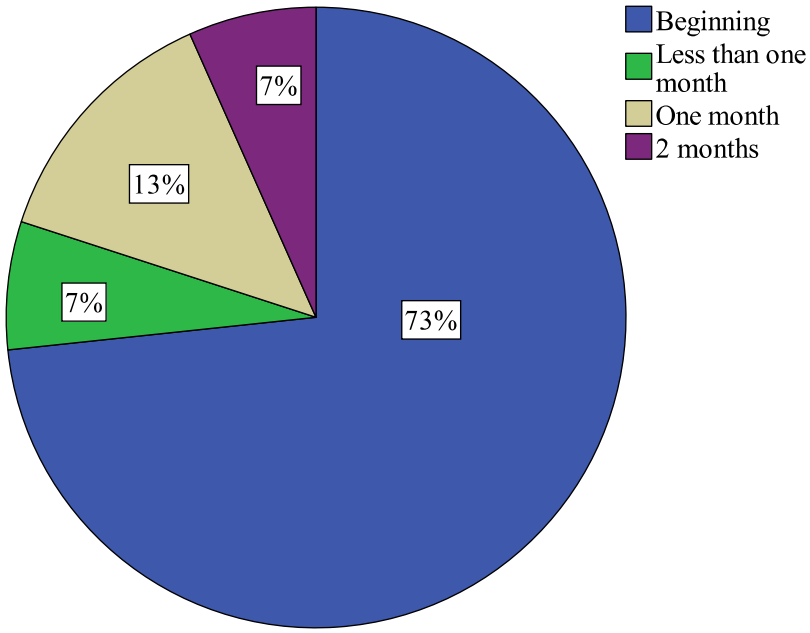
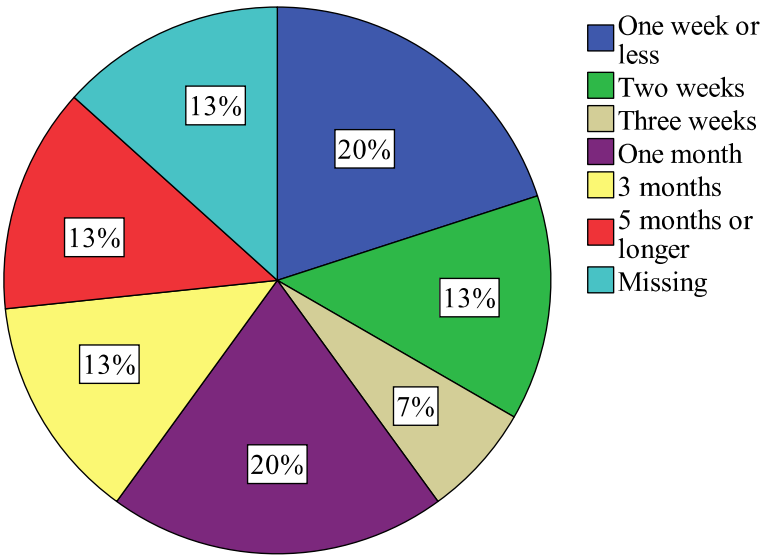


Figure A4. Length of time in relationship before having sex for the first time with partner



Appendix B

Recruitment flyer

Dating Relationships and Sexual Health

Seeking Research Participants
Are you female, heterosexual, age 18-24 and currently in a dating relationship?

Sexual health is an important concern, particularly if you are in a relationship. That's why this study was designed to look at how relationships influence sexual health decisions. You will be asked to answer a sexual health questionnaire and participate in an interview. This process takes approximately one hour. You will receive $20 for your participation in this study.

This study is being conducted under the supervision of Dr. Schneider at the University of Toronto.
If you are interested in participating, or have any further questions regarding this study, please call Melissa Bolton at ---------- or email me at: mbolton@oise.utoronto.ca

Dating and Sexual Health
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Appendix C

Phone Script

Phone Script: The participant either calls directly or emails and leaves a contact number.

*In the case that a potential participant emails and does not leave a phone number, they will be emailed the information letter.

If they leave a contact number:

"Hello **[potential participant's name]**, my name is Melissa Bolton and I am a graduate student at the counselling psychology department at the University of Toronto. You emailed expressing your interest in our study regarding sexual health decisions in relationships. Would you like to hear more about this study?"

(If No): "Thank you for your time, have a great day."

(If Yes): "This study involves filling out a sexual health questionnaire, as well as being interviewed. The interviews contain questions that ask about sexual health, sexual decision making and relationships (previous and current). For example, we may ask about the types of contraceptives that are used in your relationship."

"Participation in this study will take approximately 1 hour of your time. To show our appreciation you will receive $20 compensation."

"If you would like, I can sent you an information letter with more details about the study or I can provide more detailed information at the time of the interview. If you are unsure and would like some time to think about participating, you can contact me if you decide to participate and we can set up a time then. Or if you are interested in participating we could set up a time now."

[IF they want more time to think about it]: "Take some time to look over the information letter. Respond back if you wish to participate. Thank you for your time".

[IF YES; They want to participate]: "Thank you; we appreciate your interest in our research.

"I have a session open on **[day and date]** at **[time, a.m. or p.m.]**. Will you be available then? You will need to come in about 5 minutes early."

[IF NO]: Offer another day and time until one is found that is mutually convenient.

[IF YES]: "This is great. Let me give you some important details about the study. Have you got a pen so that you can write this down and keep it with you?"

"My name is Melissa Bolton, with the University of Toronto. You should go to the **[Xth]** floor of the **(place) [five minutes before the time scheduled]** on **[mention day and date again]**. If you discover that you will be unable to make it, please call me at ---------- and leave a message if I am not available or email me at mbolton@oise.utoronto.ca. Please try to provide at least 24 hours notice if possible. I look forward to meeting you on **(mention day, date, and time again)**. Thank you very much again for helping us with our research."

Appendix D

Information Page

You are invited to participate in a study about relationships and sexual health.

This research explores how young women in dating relationships make sexual health decisions. We are interested in looking at how being in a committed dating relationship influences choices on sexual health decisions. It is being conducted by Melissa Bolton, a Masters student at OISE/ University of Toronto.

First you will be asked to answer a brief sexual health/history questionnaire. This will include questions such as sexual history, length of current relationship, and contraceptive use. Then, you will be asked to participate in an interview. During the interview you will be asked questions about your relationship and sexual health. For example, you may be asked what types of contraceptives you are using in your relationship and how you and your partner made these decisions.

Sometimes people become uncomfortable talking about sexual health. However, you are welcome to decline to answer or skip over any question that you do not feel comfortable answering. Additionally, if you wish to stop participating during the study, you are free to do so without any consequences. **If requested, a resource list on sexual health information will be provided.**

All information you supply during the research will be held in confidence. Your name will not be associated with any part of the study. Your data will be safely stored in a locked facility and only research staff will have access to this information.

The length of this study is approximately one hour. To thank you for your participation you will be compensated $20 for your time.

If you have any further questions at any time about the study please feel free to contact the researchers.

M. Bolton, Researcher, Department of Counselling psychology, Ontario Institute for Studies in Education at the University of Toronto mbolton@oise.utoronto.ca

Dr. M. Schneider, Faculty Member, Department of Counselling psychology, Ontario Institute for Studies in Education at the University of Toronto mschneider@oise.utoronto.ca

Dr. Alex McKay, Sex Information and Education Council of Canada, alex@sieccan.org

You can also contact the University of Toronto Office of Research Ethics at [416-946-3273] or email at ethics.review@utoronto.ca

I have read the attached information sheet and agree to participate in the study regarding relationships and sexual health as described.

Name and Date

If you would like a summary of the results of the study when it is complete, please provide and email or other mailing address below.

_____

Appendix E

Sexual health questionnaire and interview guide

This study is about relationships and sexual health. In order to get a picture of how young women make sexual health decisions we need to know what experiences you have had in your sexual relationships.

Participant Code: _____

Age: _____

How did you hear about this study?
_____

What is the highest level of education you have completed?
_____ Elementary school
_____ attended high school but no diploma
_____ High school diploma or equivalent
_____ 1 to 3 years of college/university (including study at a technical college)
_____ Undergraduate university degree
_____ Master's degree
_____ Doctoral degree
_____ Professional degree (e.g. medicine (M.D.)

Are you currently a student? No_____ Yes, full time_____
Yes, part time_____

Are you currently in a dating relationship?
Yes_____
No_____

What is your relationship status? (Please check the one that applies best to you)

_____ Single
_____ Casually dating someone
_____ In a steady relationship (exclusively dating someone)
_____ Cohabitating with partner
_____ Married

How long have you been in your current relationship? _____
If exclusive, how long were you dating your partner prior to becoming exclusive?
_____
How long did you know your partner prior to dating? _____

Sexual Health Behaviors

Are you sexually active? Yes_____ No_____

If yes, how old were you when you first engaged in vaginal intercourse? _____

Sometimes people who identify as heterosexual have some sexual experiences with the same sex. Has all your sexual activity been with a male? _____

If no: How many male sexual partners have you had? _____

Do you use contraception? Yes_____ No_____
If yes:
Birth control Pill_____
Condoms_____
Uterine Implants _____
Cervical barriers (i.e. diaphragm, the sponge) _____
Injections (i.e. Depo-Provera)_____

What age did you first go on this mode of contraceptive?
Birth control pill _____
Condoms _____
Uterine Implants _____
Cervical barriers _____
Injections _____

Have you experienced oral or anal sex with a male? _____ If yes- How old were you when you experienced oral or anal sex? _____

Previous Relationships

Have you ever engaged in casual sex with a male (i.e. one night stand)?
Yes_____ No_____
How many male sexual partners have been through casual sex? _____
If yes, did you use contraceptives? _____
Which type(s)_____

How consistently do you use condoms with casual partners?
Every time_____
Some of the time _____
Never _____

How many steady relationships have you been in? _____
How many male sexual partners were within steady relationships?
_____

How long have your past three relationships been?
_____ _____ _____

What was the method of "protection" used at first intercourse in the last three most recent committed relationships?
_____ _____ _____

At some point in the three most recent relationships, was condom use discontinued in favor of oral contraception?

No_____ Yes_____

If yes, how long after first intercourse in three most recent relationships was condom use discontinued? _____

Was the transition to oral contraception the suggestion of you, your partner, both of you?
_____

If it was your partner what reasons would did he give for why the transition to oral contraception was made? _____

Did the transition to oral contraception signify something larger about the relationship to the respondent?
No _____ Yes_____

If Yes, elaborate
_____
_____
_____
_____

Did the respondent and her partner receive HIV/STI testing as part of the transition to oral contraception process?

No_____ Yes_____

Present Relationship

How far along in your present relationship (in months) do you recall your first time engaging in vaginal intercourse (if sexually active)? _____

Have you ever experienced oral or anal sex with your partner? If yes, how far along into your present relationship (in months) do you recall your first time engaging in oral or anal sex? _____

How often do you engage in sexual intercourse with your partner a month (approximately)? _____

The first time you had sex with your partner, which type(s) of contraception did you use (if applicable)? _____

What was the frequency of condom use with your partner during the first month of dating?
Every time_____ Frequently_____ Sometimes_____
Never_____

If you stated never, were you on another method of contraceptive at the time?
No _____ Yes_____
If yes, which type(s)_____

The last time you had sex with your partner, which type(s) of contraception did you use (if applicable)? _____

What was the frequency of condom use with your partner last month ?
Every time_____ Frequently_____ Sometimes_____
Never_____

Do you feel confident that you know your partners sexual history?
No _____ Yes_____

If yes, did you engage in a discussion regarding sexual history? _____

How risky (in terms of contracting a sexually transmitted infection) would you rate your sexual behaviors with your partner? 1 being no risk- 5 being extremely risky.
1 2 3 4 5

How risky (in terms of concern of contracting a sexually transmitted infection) would you rate your sexual behaviors with previous partners (if applicable)?
1 being no risk- 5 being extremely risky.
1 2 3 4 5

Have you ever been tested for sexually transmitted infections?
No _____ Yes_____
If yes, how long ago were you tested? _____

Within your educational experience, were you taught sexual health education?
No_____ Yes_____

How confident would you rate your knowledge on sexual health, and how different sexually transmitted infections are transmitted?
(On a scale from 1-5: 1 being not confident at all, to 5 being highly confident that).
1 2 3 4 5

Interview Questions:

Present Relationship

- So tell me a little bit about your relationship, how long have you been dating?

- Did you know him before you started dating?

- Are you two monogamous and exclusive?

- How did you know that you two had become monogamous? What were the signs? How did the relationship change?

-Can you recall the first time you had sex with your partner, can you tell about what happened?

- How long into the relationship was it before you first started having sex?

- The first time you two had sex, did you anticipate (plan) it beforehand or did it just happen spontaneously?

- Did you use contraceptives the first time you and your partner had sex? Which kinds did you use (if applicable)? How did you decide on which ones to use?

-Whose choice was it on which contraceptives to use? You? Your partner? Both?

-Did you use condoms when you first started dating? If so, would you say that you used them consistently?

-Did you switch to using oral contraceptives as a replacement for condoms? Or would you say that you have used the same kind of contraceptives since the beginning of the relationship (condoms, the pill...)?

-(If there was a switch). How long were you dating when you decided to switch to _____? Can you tell me about what was happening in the relationship during that time?

-What did it mean to you to use oral contraceptives instead of condoms? Did it change the way you felt about your relationship? How so?

-Do you feel comfortable asking your partner to use a condom if you wanted to?

-Do you feel confident that you know your partners sexual health status (have you discussed sexual history, testing...?).

-Do you feel comfortable discussing sexual histories with your partner?

-Do you feel that you are at risk for contracting a sexually transmitted infection?

-For you, what would be sexually risky behavior?

Previous Relationships

-So now I am going to ask you some questions about your previous relationships. I want you to think back and choose your longest relationship previous to this one, and base your answers to the following questions with this particular relationship in mind. Do you have a previous boyfriend in mind?

-How long did you know your previous boyfriend before having sex? Did you know him well before you dated him?

-When you first started having sex with him did the two of you use contraceptives? If so, which kind(s)?

-Can you remember if you discussed contraceptives with him? Do you remember who made the choice of which contraceptives were used?

-Did the two of you talk about sexual histories? Dating histories?

-How long did you date him?

-At the end of the relationship, can you remember what types of contraceptives were you using?

-That's it for my questions, do you have any questions that you would like me to address at this time?

- If this has raised some issues for you I have some resources here for you (sexual health clinics; counselling).

-Thank you so much for taking the time to participate in this study

Appendix F

Frequency of condom use (first and last month)

Figure F 1. Frequency of condom use within the first month of dating (current relationship)

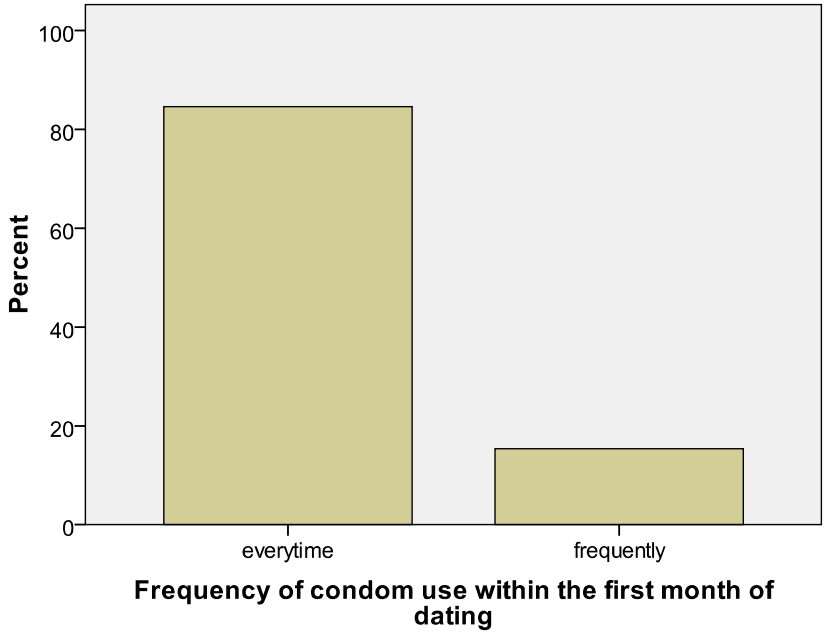
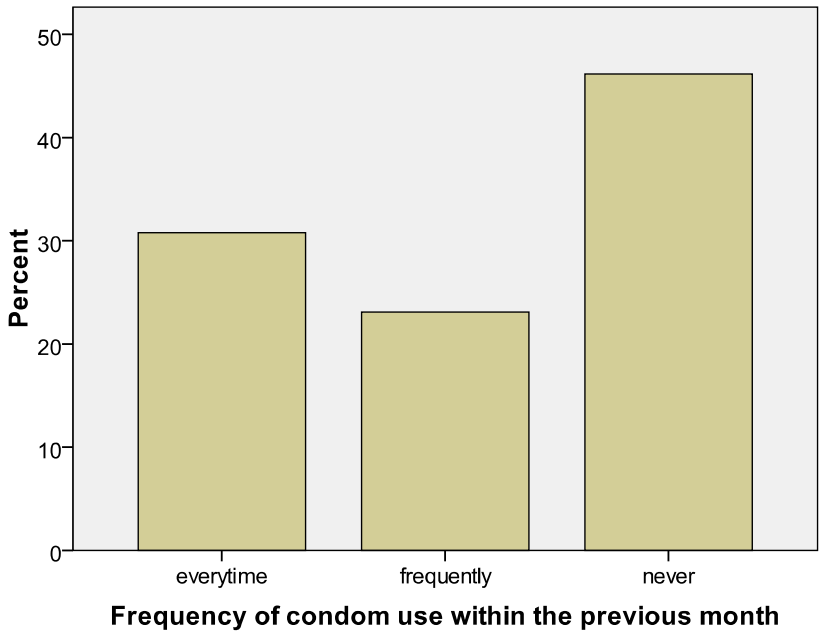


Figure F 2. Frequency of condom use the previous month of dating (current relationship)



Participants were asked to rate their level of condom use as either: every time, frequently, sometimes or never

Appendix G

Summary of singular processes in condom use within dating relationships

Participant A was categorized within the information based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved feelings of greater commitment and trust within the relationship.

Participant B was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved feeling greater trust and commitment within the relationship.

Participant C was categorized within the information based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved greater familiarity and commitment to her partner, as well as, practicality.

Participant D was categorized within the assumption based group; she is not currently on the pill and uses condoms consistently with her partner.

Participant E was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved physical pleasure, intimacy and greater commitment to the relationship.

Participant F is not sexually active.

Participant G was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved greater familiarity with her partner, commitment and trust.

Participant H was categorized within the information based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved physical pleasure, intimacy and commitment to the relationship.

Participant I was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved physical pleasure, practicality and convenience.

Participant J was categorized within the information based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved physical pleasure and greater commitment to the relationship.

Participant K was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved practicality and convenience.

Participant L was categorized within the assumption based group; she is not currently on the pill and uses condoms consistently with her partner. However, infrequently will begin to have sex without a condom (and then apply one).

Participant M was categorized within the assumption based group; she discontinued consistent condom use within her relationship (and relied on the pill alone). Her primary reasons involved physical pleasure and practicality.

Participant N was categorized within the assumption based group; she is not currently on the pill and uses condoms consistently with her partner.

Participant O was categorized within the information based group; although she is sexually active, she has not engaged in sexual intercourse with her present partner. With previous partners she has never engaged in unprotected sex (using condoms and the pill).