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A qualitative analysis of safer sexual decision-making among college women

Jennifer Gregson
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**A QUALITATIVE ANALYSIS OF SAFER SEXUAL DECISION-
MAKING AMONG COLLEGE WOMEN**

A Thesis

Presented to

The Faculty of the Department of Health Science

San Jose State University

in Partial Fulfillment

of the requirements for the Degree

Master of Public Health

by

Jennifer Gregson

December 1994

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ABSTRACT

A Qualitative Analysis of Safer Sexual Decision-Making Among College Women

by Jennifer Gregson

This qualitative study explored safer sexual decision-making among single, undergraduate women. Twelve participants were recruited and interviewed. Interviews were audio taped and transcribed verbatim when possible. The study found that safer-sexual decisions were strongly influenced by women's perceptions of trust and commitment to their partners. Participants embraced sexual history exchange as a tool to assess a partner's trustworthiness and the degree of risk he represented, making this behavior a crucial step in sexual decision-making. Participants identified seven decision-making patterns, and their accounts yielded a data-based model of learning self-protective behavior. These findings suggest that women need to practice sexual decision-making and communication skills before they are required to use those skills, and that health educators should emphasize a definition of trust which does not exclude condom use.

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CHAPTER 1: INTRODUCTION

Purpose

The purpose of this study was to explore factors which inhibited or facilitated safer sexual behavior among single, undergraduate women enrolled at San Jose State University. Specifically, this qualitative study was designed to explore women's safer sexual choices and the circumstances under which the choices were made.

Statement of the Problem

Morbidity and Mortality Weekly Report had counted over 400,000 cases of Acquired Immune Deficiency Syndrome, Gonorrhea, and Syphilis (primary and secondary) in the United States from January to November, 1994 (Centers for Disease Control, November, 1994). Some estimates of STD prevalence are as high as 12 million reported cases in the United States each year (Fisher, 1992). Of cases among women, 86% are diagnosed between the ages of 15 and 29 (CDC, 1991). Women report being treated for an STD three times more often than men (Cochran & Peplau, 1991). These statistics indicate that women under 30 face a real and significant health threat from sexually transmitted diseases.

Over the past decade, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have emerged as the most serious sexually transmitted diseases. Twenty percent of all diagnosed AIDS cases are reported among people between the ages of 20 and 29 (CDC, 1992). Human Immunodeficiency Virus (HIV), which causes AIDS, is reported to have a seroprevalence rate in college women of 0.02% (Gayle et al., 1990). This rate was derived from a sample population taken from 19 universities in the United States. When men and women were grouped together in the analysis, the seroprevalence rate was 0.2%, or one positive

test result per 500 students. At San Jose State University, with a student population of 30,000, a seroprevalence rate of 0.2% would yield 60 HIV positive students.

Factors which increase the risk of contracting HIV infection include: concurrent involvement with more than one sexual partner, having received a blood transfusion between 1978 and 1985, intra-venous needle sharing, unprotected sexual intercourse, and any other activities which permit the exchange of blood, semen, or vaginal fluids. Another risk factor is sexual involvement with a partner who engages in the "risky" behaviors (Catania et al., 1992; Dolcini et al., 1993; Roper, Peterson, & Curran, 1993). Guidelines for the prevention of sexual transmission of HIV recommend abstinence, condom use during sexual intercourse, and monogamous involvement with one seronegative sexual partner. Of these recommended "safer sexual behaviors," the use of a latex condom is considered the most effective method of protecting oneself from HIV and other sexually transmitted diseases when one is sexually active.

Surveys of college students' knowledge of HIV transmission show that most college students (92-100%) are well informed of transmission routes and know that condoms can significantly reduce the risk of infection (Dilorio, Parsons, Lehr, Adame, & Carlone, 1993; Keller, 1993; O'Leary, Goodhart, Sweet Jemmott, & Boccer-Lattimore, 1992). However, knowledge has not been shown to predict use of condoms. Valdiserri, Arena, Proctor, and Bonati (1989) found that 82% of the college women sampled had used a condom, but the use was not consistent. In a different study, college women who were knowledgeable about AIDS were no more likely to use condoms than women who knew less about AIDS (Carroll, 1991). These findings suggest that

women do not take active measures to prevent sexually transmitted diseases, even when they understand the reasons for doing so.

Although condoms are effective in preventing both unwanted pregnancies and STDs, including HIV, they are not widely used for either of these purposes. In one sample of college women, 72% reported using a method of contraception with each act of sexual intercourse, but only 26% reported using a condom with each act of intercourse for STD prevention (Grimley, Riley, Bellis, & Prochaska, 1993). Despite widespread STD infection rates among women in the college age group, low usage rates of condoms are reported. It is apparent that at least this safer sexual behavior is not consistently practiced.

Gold, Karmiloff-Smith, Skinner, and Morton (1992) found that the primary reason male and female college students reported unsafe sex was because they were confident they were not at risk for AIDS. Mickler (1993) writes that college students underestimate their own risk of contracting HIV, even when compared with hypothetically similar people. Among another sample of college students, Manning, Balson, Barenberg, and Moore (1989) found that social images and stereotypes of college students, such as being young, heterosexual, and of high economic status, reinforced the misconception that they are not susceptible to HIV. These studies, indicating that college students may not take the threat of AIDS personally, suggest one reason why condoms are not widely used.

The potential for the spread of HIV and other STDs through heterosexual contact is suggested by results of the National AIDS Behavior Survey (NABS). This study noted that in cities which had high incidence of AIDS, including San Francisco, Oakland, and San Jose, 21.7% of women aged 18-30 reported having two or more sexual partners in the previous year.

Among women reporting two or more partners, only 22% used condoms consistently with their primary partner and 32% used condoms consistently with other partners (Dolcini et al., 1993).

Monogamous involvement with one seronegative partner is considered a safer sexual behavior (Catania et al., 1992; Dolcini et al., 1993; Roper et al., 1993). In these studies, terms used to define this type of relationship included "long-term," "boyfriend/girlfriend," and "having strong emotional commitment." Research often indicates that large percentages of college students report current involvement with only one partner. Other research shows that 56-68% of male and female respondents report an exclusive relationship (Gold et al., 1992; Keller, 1993).

While involvement with only one partner is defined as monogamous in many studies, Dolcini et al. (1993) found that reported rates of monogamy for one year (88%) for women aged 18-75 in the general population were significantly higher than rates of monogamy for five years. Women aged 18-29 had a much higher odds ratio (.80) for reporting multiple partners over one year, compared with an odds ratio of .39 for women aged 30 and over. Kost and Darroch-Forrest (1993) found that over 70% of 20-24 year olds reported two or more partners, and 38% reported four or more partners up to that point in their lives. Carroll (1991) cites other studies which found that college students average more than two sexual partners per year, projecting that many will have six or more partners before marriage.

Exclusive relationships may exist within the community of college students and are reported by many students. However, considering the pattern of multiple partners over a period of years described in previous studies, labeling the relationships as "serial monogamy" may be more accurate. Expecting serial monogamy to provide protection from STDs or HIV

is a faulty risk-reduction strategy, particularly at a time in one's life when sexual experiences with many different partners are most likely to occur.

One behavior which is becoming prevalent in response to the threat of AIDS is screening potential partners. Carroll (1991) found that among college students, the most common behavioral change in response to AIDS was becoming more selective about potential partners. Selectivity was often an evaluation of the HIV risk, indicated by a potential partner's disclosure of past behavior. This is sometimes referred to as "interviewing a partner." However, O'Leary et al. (1992) comment that it is unlikely that a new partner would actually disclose all relevant information about his or her past, thereby decreasing the effectiveness of this risk reduction strategy. Cochran and Mays (1990) found this to be true, as 47% of men and 42% of women indicated they would understate the number of previous partners.

Despite the obvious flaws in using partner interviews to screen prospective partners, refusing intercourse is sometimes the result of this strategy. Lottes' (1993) study addressed men's and women's reasons for refusing intercourse. This study found that the primary reason men refused intercourse was fear of contracting an STD, which may indicate that partner screening is somewhat effective. However, for women, the most common reasons for refusing intercourse were not knowing a partner well enough, or not having enough commitment in the relationship. Fear of contracting an STD was most infrequently reported, indicating that factors pertaining to the interpersonal relationship are more salient to women than health threats.

Anecdotal data, collected from personal contacts prior to this study, support these research findings regarding women's safer sexual behavior. In informal settings before the study began, women have frequently recounted instances of their own unsafe sexual behavior, and described intimate

situations in which they experienced power inequalities. The context in which unsafe behaviors occurred, as informally reported by the women, tended to relate to “courtship dynamics,” such as which partner initiated the date, gender-role expectations, discomfort acknowledging sexual involvement, and initiating condom use. Paradoxically, the women indicated awareness of the prevalence and risks of HIV, expressed knowledge about prevention, and experienced anxiety over the possible consequences of their own unsafe behavior. Despite their concerns, the behavior patterns were repeated with new partners. These anecdotal accounts, combined with the growing literature on safer sexual behavior, suggest that there may be an important gap between the recommended safer sexual behaviors women intend to follow and their actual behaviors.

A limited body of research has anticipated such a gap. When studying the meanings and experiences of female sexuality as a whole, Daniluk (1993) states that little is actually known about the development of female sexuality. She concludes by calling for individual interviews to refine and validate themes suggested in her study, such as the significant influence of health and medical-related activities on a woman’s construction of female sexuality. Additionally, quantitative studies on safer sex behaviors have identified the need for further research using qualitative methods to deepen the level of analysis and understanding. For example, in studying demographic characteristics of heterosexuals with multiple partners (Dolcini et al., 1993), the authors identified a need for research about developmental influences on HIV and STD risk behaviors. Manning et al. (1989) specifically suggest that “...in order to understand why these intelligent young people say they are unlikely to practice safer sex even when they know the facts indicate they should,” researchers need to ask the students directly (p. 67).

Health professionals have long acknowledged the threat of STDs and HIV and have recommended specific preventive behaviors, but these behaviors have not been incorporated into the lifestyles of college students. Quantitative studies have helped to define the scope of the problem. However, it is imperative that college health educators understand why college students, and women in particular, abandon safer sexual behaviors, even when they are aware of disease transmission routes and recommended safer sexual guidelines. This knowledge is essential to stopping the spread of AIDS and other STDs, and to designing effective reproductive health and STD prevention programs for the college-age population.

Objectives

This qualitative study was designed to explore college women's safer sexual choices and the factors which inhibit or facilitate those choices. The following broad objectives were used to guide this research:

- 1) to explore the women's perceptions of which sexual behaviors are "safe" and which are "unsafe,"
- 2) to document women's accounts of specific incidents of decision-making about safer sexual behaviors, and
- 3) to synthesize the accounts in order to identify factors which contribute to the practice of safe and unsafe behaviors.

These objectives enabled the researcher to facilitate a process in which women could explain their experiences and reconstruct the meanings in their own words.

Study Design

This exploratory, phenomenological study used qualitative data from face-to-face interviews. The interviews were conducted using a semi-structured interview guide (see Appendix A) containing open-ended questions

and potential clarifying probes. The main objective of the interview was for the participants to recount decision-making associated with their sexual behaviors and to describe the context in which the decisions occurred. Special emphasis during the interview was placed on 1) identifying which safer sexual behaviors a participant practiced, 2) a participant's description of situations in which safer sexual behaviors were inhibited or facilitated, and 3) a participant's exploration of reasons why certain behaviors were practiced or abandoned.

The interviews were conducted by the researcher, and tape recorded for later transcription. Each interview lasted between 40 and 60 minutes. The transcribed interviews were analyzed for patterns, emergent themes, and key issues.

Participants

A purposeful sample was selected of female, sexually active, heterosexual, unmarried undergraduates from San Jose State University. Participants were recruited from class announcements, referrals from other participants, and referrals from community residents. Twelve women between ages 19 and 34 participated in the study.

Significance and Limitations

There were several limitations inherent in this study and qualitative research in general. Limitations due to methodology were anticipated from the outset. First, the research was dependent upon the participants' willingness to disclose personal information. It is important to acknowledge that the data reflects only those perceptions and experiences that participants chose to share; the responses may not have reflected the full complexity of actual lifestyle behaviors. Secondly, this study may have a self-selection bias. The women who consented to participate may have been more

comfortable discussing sexual behaviors than women who chose not to participate. Finally, because this exploratory study was based on a purposeful sample, the specific experiences cannot be generalized to broader populations.

Despite these limitations, this initial qualitative inquiry has addressed a major gap in the literature relating to women's sexuality during this phase of life. This research explored the context in which safer sexual behaviors have occurred or been abandoned and why this happens. The findings outline specific behavior patterns and decision-making processes central to safer sexual behavior adoption. The results of this study will be useful in developing reproductive health workshops and educational materials appropriate for women, particularly in the college environment. These findings may also enable women to better understand their own behavior. By exploring women's thoughts about safer sexual behaviors, the findings will assist health professionals to understand specific aspects of women's decision-making processes and the resulting choices. This knowledge will enable health educators to design safer sexual promotion programs which incorporate these basic psychosocial processes.

In addition to guiding interventions, this study has identified directions that can be taken in future research. The themes and patterns established here can be explored in greater depth in qualitative research focused on specific findings of this study. The purposeful sample should be expanded to include a more complete range of ages and missing or poorly represented groups, such as single parents, Asian women, and African American women. Adding diversity to the purposeful sample would yield a more complete range of experiences and provide internal validity of the study findings. And finally,

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CHAPTER 2: REVIEW OF LITERATURE

Threat of Sexually Transmitted Diseases

Sexually Transmitted Diseases

Morbidity and Mortality Weekly Report had counted over 400,000 cases of Acquired Immune Deficiency Syndrome, Gonorrhea, and Syphilis (primary and secondary) in the United States from January to November, 1994 (Centers for Disease Control, November, 1994). Some sources cite more than 12 million cases of sexually transmitted diseases (STDs) in the United States every year (Fisher, 1992). Fisher (1992) also reports that STDs are now second only to colds and flu as the most common infectious diseases in the United States. Cochran and Peplau (1991) found that women are three times more likely to report being treated for an STD than men. Of cases among women, 86% of STDs are diagnosed between the ages of 15 and 29 (CDC, 1991).

Statistics on STDs include infection rates for genital herpes, chlamydia, gonorrhea, and syphilis. The American Social Health Association (ASHA) estimates that 30 million people in the United States have genital herpes (as cited in Fisher, 1992). Some experts suspect that exposure to the genital herpes virus may be related to later development of cervical cancer (Fisher, 1992).

According to Perl (cited in Fisher, 1992), three to four million women a year become infected with chlamydia, making it the most common STD in the United States. Left untreated, chlamydia can spread throughout the reproductive tract. This infection is responsible for an estimated 40% of the country's cases of Pelvic Inflammatory Disease (PID) and infections of the uterus and fallopian tubes. Chlamydia can also scar the tubes, causing ectopic pregnancies and sterility (Fisher, 1992).

Gonorrhea affects about 1.4 million Americans each year (Perl, 1990, as cited in Fisher, 1992). In women, gonorrhea can also cause PID and possible sterility if the infection travels into the fallopian tubes. Syphilis outbreaks are dramatically increasing, and an estimated 134,255 cases occurred in 1990, almost double the number occurring in 1985 (Fisher, 1992). Treatment for this infection is particularly essential, because an untreated infection may reactivate years later, causing paralysis, senility, insanity, convulsions, or heart failure (Fisher, 1992).

Human Immunodeficiency Virus (HIV)

Another more recently identified sexually transmitted disease (STD) is the Human Immunodeficiency Virus (HIV), which leads to the development of Acquired Immune Deficiency Syndrome (AIDS). Women are the fastest growing group of people becoming infected with HIV (Reiss, 1991), and 20% of all diagnosed cases of AIDS are reported in men and women between the ages of 20 and 29 (CDC, 1992). These findings indicate that HIV is a rising threat to college age women, a population whose health is already seriously impacted by other STDs. In an attempt to quantify this threat, a study was conducted among college students. Based on HIV blood tests among student volunteers, the HIV seroprevalence rate in college women was estimated at 0.02% (Gayle et al., 1990). When men and women were grouped together in this study, the seroprevalence rate was 0.2%, or one positive test result per 500 students.

Generally, sexually transmitted diseases (STDs) can be prevented by following safer sex guidelines, particularly those which promote condom use and protected sexual activity. With more than 12 million new cases of STDs reported each year in the general population (Rosenberg & Gollub, 1992), it is

apparent that safer sexual behaviors are not being practiced despite the significant health threats of unprotected sexual activity.

Available Forms of Prevention

The most effective protection from STDs and HIV is the correct and consistent use of a latex condom (Wilson, Jaccard, Endias, & Minkoff, 1993). Oral contraceptives, IUDs, and sterilization offer no protection against lower reproductive tract infections, such as chlamydia or gonorrhea (Rosenberg & Gollub, 1992). Barrier contraceptives, such as the diaphragm and the cervical cap, have been found to offer some degree of protection from sexually transmitted diseases. Observational studies of these methods report STD reductions varying from 50-100% among users. Spermicides, such as the sponge, foam, and jellies, also show reductions (10-69%) for some STDs. However, these methods leave large portions of the vagina unprotected and open to possible infection. There has been little or no evaluation of the effectiveness of these methods in HIV prevention (Rosenberg & Gollub, 1992).

Initial studies of the female condom have found it to be as effective as a male condom for HIV and STD prevention. This is a significant development because the female condom gives women control over a highly effective barrier method of contraception and STD prevention (Gollub & Stein, 1993).

Knowledge of HIV and STD Transmission and Prevention

HIV and STD Transmission

Studies of college populations show that knowledge of HIV transmission is very high. Keller (1993) reported that 100% of her college-based sample knew that unprotected vaginal intercourse with a seropositive person is one means of HIV transmission, and over 92% knew that contact

with the semen or vaginal fluids of an infected person could lead to HIV transmission. O'Leary et al. (1992) similarly reported high levels of knowledge. Ninety-six percent of college students in their study agreed that anyone who has unsafe sex or shares needles with an infected person can get AIDS. Dilorio et al. (1993) reported 100% of the respondents agreeing with similar statements about transmission routes.

Knowledge of HIV prevention was also very high. In a study by Dilorio et al. (1993), 99.4% of college students agreed that using a condom during sexual intercourse would reduce one's risk of becoming infected. A study by Radius, Joffe, and Gall (1991), with a sample of women using oral and barrier contraceptives, found that 97% of the oral contraceptive users and 99% of the barrier users agreed that using a condom decreases the risk of HIV transmission.

Prevention Knowledge

Knowledge of prevention of STDs other than HIV is less accurate among sample populations. The findings of Radius et al. (1991) showed that 9% of the oral contraceptive users, and 12% of the barrier method users, thought withdrawal could reduce transmission of STDs. Nineteen percent of the oral users and 27% of the barrier users thought foam would decrease transmission; 16% of both groups also thought the sponge would reduce risk. Dilorio et al. (1993) also found confused and incorrect knowledge about transmission and prevention of STDs. In their sample of college freshmen, 53% thought that taking oral contraceptives would reduce STD risk, 42% thought that urinating after sex was a safer sexual behavior, and 59% thought a diaphragm would protect one from STDs. However, as stated previously, 99% of this sample correctly reported that using condoms would decrease one's risk of becoming infected with HIV.

In summary, these studies report very high rates of HIV transmission knowledge and awareness of condom use as an effective preventive measure against HIV. However, there are important gaps and inconsistencies in this knowledge, particularly concerning STDs other than HIV. Assessments of knowledge rarely focus on prevention of STDs other than HIV. Additionally, the knowledge assessments frequently omit evaluating perceived effectiveness of methods other than condoms, such as spermicides and diaphragms. Finally, when studies have addressed these questions, the findings include confused and incorrect knowledge reported by the sample. However, the knowledge gap is not large enough to account for the very low rates reported for condom use, which would indicate that factors other than knowledge, or lack of knowledge, are influential in their use.

Condom Use

Condom Effectiveness and Usage Rates

Correct and consistent condom use is the most significant way to reduce exposure to HIV and other STDs during sexual intercourse (Wilson et al., 1993). Condom use is advocated as a safer sexual behavior and is the only preventive behavior offering protection from STDs while actually engaging in sexual intercourse.

Rosenberg and Gollub (1992) cite observational studies which show that condom use decreases STD infection rates by an average of 50%. Other studies by Laurian, Peynet, and Verroust (1989, as cited in Roper et al., 1993) and Musicco (1990, as cited in Roper et al., 1993), have found that consistent condom use provides a 70% to 100% reduction in the risk of contracting HIV. The different effectiveness rates are largely due to the use of different research methodologies. For example, those researchers who group consistent condom users with sporadic users report lower effectiveness rates.

For condoms to be most effective in STD prevention, they must be used correctly and consistently with each act of intercourse. Another example of the difference between sporadic and consistent condom use is cited in Roper et al. (1993) in which the average pregnancy rate for couples using condoms is reported at 10%. However, the rate may be as low as 2% for couples who use condoms consistently and correctly. The higher effectiveness rate for condoms used consistently for pregnancy prevention applies to STD protection as well.

Valdiserri et al. (1989) reported that although 82% of the women in their survey reported having used condoms at some point in time, the use was not consistent. Inconsistent use is not an effective prevention for STDs. Demographic data from the National AIDS Behavioral Survey (NABS) indicated that many heterosexuals, both men and women, were not protecting themselves from STDs by using a condom with each act of intercourse (Dolcini et al., 1993). This study found that among women having two or more partners over the past year, 48% never used condoms with their primary partner and 45% never used condoms with secondary partners. Additionally, only 22% of the women with multiple partners used condoms 100% of the time. Hingson, Strunin, Berlin, and Heeren (1990) report a particularly ominous finding: people with 10 or more partners were much less likely to report always using condoms (17%) than people with fewer partners (26-36%). In the same study, men were much more likely to report always using a condom (34%) than women (26%). However, the NABS data reveal lower rates of condom use among men; in that data base, men reported 3-4% lower condom use rates than women (Dolcini et al., 1993). Regardless of whether heterosexual men or women are using condoms more, the usage rates

reported in these studies are very low and demonstrate the potential for HIV and other STDs to be spread through heterosexual contact.

Factors Inhibiting Condom Use

Research on condom use reports that factors which inhibit use do not include mechanical aspects, such as one's ability to put on a condom quickly or gracefully (Brien, Thombs, Mahoney, & Wallnau, 1994). Instead, the factors which inhibit condom use are not directed at the condom itself, but at larger issues. For example, 21% of women said that they do not use a condom because of embarrassment (Butcher, Manning, & O'Neal, 1991). In other studies, the most common reasons given by college students for not using condoms arose from involvement in an exclusive relationship and their related perception of minimal risk of STD transmission (Keller, 1993; Gold et al., 1992).

Not using condoms because of the protection offered by an exclusive relationship was reported by 57% - 68% of respondents in these studies. The terms researchers used to define this type of relationship included "long-term," "boyfriend/girlfriend," and "having strong emotional commitment" (Keller, 1993; Gold et al., 1992). Monogamous involvement with one seronegative partner is considered to be a safer sexual behavior by both the general population and health professionals. Research often indicates that large percentages of college students report current involvement with only one partner, and are in this way practicing safer sexual behavior. However, over time, college students and people in the 18-29 age group are very likely to report multiple past partners.

While involvement with only one partner is defined as monogamous in some studies, Dolcini et al. (1993) found that reported rates of monogamy for one year (88%) are much higher than rates of monogamy for five years (69%).

as reported by women under 50 in the general population. Women aged 18-29 had a much higher odds ratio (.80) for reporting multiple partners over one year, compared with an odds ratio of .39 for women aged 30 and over. Kost and Darroch-Forrest (1993) found that over 70% of 20-24 year olds reported two or more partners and 38% of their sample reported four or more partners up to that point in their lives. Carroll (1991) cites other studies which found that college students average more than two partners per year, projecting that many will have six or more partners before marriage. Exclusive relationships may exist within the community of college students and are reported by many students. However, considering the pattern of multiple partners over a period of years described in Dolcini et al. (1993) and Carroll (1991), identifying these relationships as serial monogamy may be more accurate. Expecting monogamy to provide protection from STDs or HIV is a faulty risk-reduction strategy, particularly at a time in one's life when sexual experiences with many different partners are most likely to occur.

Studies of college populations frequently find that while contraception is widely practiced, condoms are not frequently used. Grimley et al. (1993) found that almost 72% of the college women sampled were using a method of birth control with every act of sexual intercourse, but over 63% were not using condoms every time for STD prevention. Most of the 63% were in a decision-making phase which Grimley called "pre-contemplation," the stage before a need for behavior change is recognized. This indicates that the women did not perceive a need for their behavior to change, and they perceived that using only non-condom contraception was adequately self-protective. Furthermore, a 1990 study by Perlman, Kelaghan, Wolf, Baldwin, Coulson, and Novello (cited in Rosenberg & Gollub 1992) reported that only 12% of heterosexual women rely on their partners' use of condoms for birth control,

and only 18% reported that their male partners used condoms for any reason at all. Again, these data indicate that condoms are rarely used for birth control or STD prevention, although other methods of contraception are practiced more frequently. Consistent use of condoms specifically to reduce exposure to STDs is even more uncommon.

Talking About Condoms

Stein (cited in Wilson et al., 1993) states that women have traditionally been responsible for birth control, but using a condom is more difficult because it requires the compliance of both partners. Wilson et al. (1993) also describes condom use as being potentially confounded for women by the need for the partner's compliance. Assuming these statements are accurate, communication between partners about condom use is an important step for women in facilitating their actual use.

Talking about condoms requires several interpersonal skills. Using verbal exchanges to regulate condom use requires sophisticated interaction skills. A pause in sexual activity to focus on self-protection may be perceived as threatening to the continuation of sexual involvement. Verbal interaction can be an especially difficult barrier for sexually inexperienced people and for those interacting with new partners (Wilson et al., 1993). Brien et al. (1994) found that people who ritualistically used condoms were more confident in their ability to be assertive about their use and more confident in their ability to cope with a partner's negative reaction to them. Non-users and sporadic users tended to lack confidence in their own ability to communicate about condom use and had greater fears of partner rejection than routine users (Brien et al.). According to this finding, people who have more experience talking about condoms are more comfortable and successful in their implementation.

Chan and Fishbein (1993) studied college women and their intentions of telling their partner to use a condom. This study found that women saw this behavior as under their control but difficult to perform. The Chan and Fishbein study further found that women who did not intend to tell their partners to use condoms cited concerns about making partners angry, reducing intimacy, and decreasing pleasure. Women's responses in the study by Valdiserri et al. (1989) supported the finding that telling a partner to use condoms is difficult, and that 37% of the surveyed women were unsure of their own ability to initiate use. Women who did report intending to tell their partners to use condoms also reported perceiving more pressure from peer reference groups to do so than women who reported not intending to tell partners to use condoms (Chan & Fishbein).

Fisher (1988) suggests that group norms, such as those developed by reference groups, are influential in facilitating discussions about condom use and other AIDS preventive behaviors. Specifically, he suggests that if sexual relations typically occur without a preceding discussion of STD prevention, people will fear having such a discussion because it will seem abnormal. Having such a discussion and breaking a perceived norm is feared because it may result in rejection (or other sanctions) by the partner. This hypothesis is supported by data from interviews conducted with male and female heterosexual college students who reported that having unprotected sex was perceived as being "easier" than having a discussion about STD prevention (Fisher, 1988).

Lacking the social skills to communicate with a partner about STD prevention and condom use has been shown to inhibit safer sexual behaviors (Gold et al., 1992). On the other hand, social norms established by reference groups, reinforcing the appropriateness of a discussion of safer sexual

behaviors, can promote women's intentions to initiate such discussions. However, not all men and women have reference groups which share these values, and a discussion about condom use is perceived by many as likely to be met with surprise or disapproval.

Partner Interviews and Exchanging Sexual Histories

Although discussions between partners regarding condom use are perceived as difficult to initiate and apt to be met with disapproval, other verbal behaviors perceived to promote safe involvements are reported to be much more preferable. One means of eliminating potentially infected partners is to ask the potential partner about past sexual and HIV risk-related behaviors, such as number of sexual partners and whether or not the person has been tested for HIV. Keller (1993) reported that students were most comfortable with the self-protective behavior of having only one partner, and least comfortable with self protective behaviors that require abstaining from sex or asking potential partners if they had been tested for AIDS. As a result of concern about HIV, Butcher et al. (1991) and Carroll (1991) found that the most common behavioral change among college students was to decrease the number of partners. In Butcher et al., this was reported by 50% of the men, and 60% of the women.

Discussing past sexual histories with new partners is reported to be a widely practiced risk reduction strategy. Butcher et al. (1991) found this to be reported by 76% of students who acknowledged engagement in risky behavior. Those students who expressed confidence in their ability to interview partners and discuss sexual histories also reported exposing themselves to more unsafe, unprotected sexual experiences. Keller (1993) reported similar findings, in which 53% of students reported not using condoms because they felt that they knew their partner's sexual history.

Other studies (Butcher et al., 1991; Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1992; O'Leary et al., 1992) report that history taking is widely used by college students and by women in particular. However, these researchers warn that this strategy may be highly ineffective because it is unlikely that a young person would actually disclose all relevant information to a new or potential sexual partner.

Women have been found to have higher self-efficacy for history taking than men (O'Leary et al., 1992). Holland et al. (1992) state that women use talking with partners and exchanging sexual histories before sex as an elaborate means to establish trust in a relationship, as well as an attempt to allay anxiety about AIDS. However, talking may obscure real risks that actually exist and may actually lead the woman to expose herself to greater risk-taking, such as abandoning safer sexual behaviors, than if the exchange of histories had never occurred (Holland et al., 1992). O'Leary et al. (1992) hypothesized that students believe that knowing a partner's self-reported history of sexual behavior is adequate protection against the possibility of HIV infection.

Cochran and Mays (1990) agree that partners do not disclose all relevant events during an exchange of sexual histories. Their findings showed that 68% of men and 59% of women had lied to their partner about being sexually involved with more than one person when the other partner did not know. Forty seven percent of men said that they would understate the number of previous partners, compared with 42% of women; 34% of men would tell a lie in order to have sex compared with 10% of women. The largest gender difference showed 20% of men affirming they would lie about having a negative HIV antibody test, compared to only 4% of the women. While both men and women frequently report fabrications or intentions to tell

them, men in this study were significantly more willing to deceive a partner than were women.

The lies and deceptions reported by men and women show that using an interview to screen potential partners, and thereby reduce of STD infection, is based on naive and dangerous assumptions. Many men reduce the effectiveness of this strategy by claiming untruths and promoting deceptions significantly more often than do women, and possibly more often than women might anticipate. Interviewing partners has become a tool college students use to make decisions about safer sexual behavior. However, these studies strongly suggest that interviewing partners may merely serve to make unsafe behavior appear safe, and to minimize perceptions of their own risk of being exposed to HIV and other sexually transmitted diseases.

Perceptions of Personal Risk for Contracting HIV

Assessing how college students personalize their own risk of contracting HIV is one way researchers have attempted to explain why students do not habitually practice safer sexual behaviors. Studying personal susceptibility beliefs also helps to explain how partner interviews are used to support these beliefs. Several studies have focused specifically on describing how college students assess and personalize the threat of HIV contraction (Kaplan & Shayne, 1993; Manning et al., 1989; Mickler, 1993).

Mickler (1993) found that even those college students who had a high level of knowledge about AIDS and HIV transmission had no greater tendency to practice safer sexual behaviors. These students estimated their own risk of HIV contraction to be lower than hypothetical characters suggested in the study, regardless of similarities between the student and the hypothetical scenarios. Keller (1993) noted that participants knew there may be no

apparent signs of HIV infection and yet they believed they could identify a new partner who might be infected. In this sample, 49% reported having unsafe sex because they “just knew it was safe” or “assumed the partner did not have AIDS.” Gold et al. (1992) asked students to recall an unsafe sexual encounter. Eighty one percent of the sample recalled thinking they might contract AIDS at the time they made the decision to have unprotected intercourse. These studies demonstrate a denial of the actual threat of AIDS and an illusion of invulnerability operating among college students.

Like the sample of female college students in Mickler’s study (1993), Carroll (1991) found that college women who knew more about AIDS were no more likely to use condoms than women who were not as informed. Additionally, one woman in three in this study believed that women have a greater natural immunity to the virus. Carroll concludes by hypothesizing that women may see themselves as less at risk than men, and therefore may be less motivated to apply knowledge about AIDS to their own lives.

In Cochran and Peplau’s research (1991), a woman’s perception of her own personal susceptibility to contracting an STD positively predicted a woman’s worry about contracting one. A higher level of worry about contracting AIDS or herpes was significantly related to one’s reduction of risky sexual practices. Worry was predicted by unsafe past behavior. This research noted that the predication of worry from behavioral pasts was only true for women. For men, non-rational factors, such as homophobia, were more significant to risk reduction than rational factors, such as number of partners (Cochran & Peplau, 1991).

Specific assumptions used by college students to depersonalize their own HIV susceptibility were researched by Gold et al. (1992) and Manning et al. (1989). Over 47% of the sample studied by Gold et al. (1992) used

assumptions to cognitively confirm that a partner was unlikely to be infected with HIV. The assumptions were based on the partner's characteristics, actions, speech, or appearance. In this study, the primary reason participants reported having unprotected sex was that they were confident they were not at risk for AIDS, especially if the partner was a significant other rather than a casual acquaintance.

Manning et al. (1989) used focus groups to explore what college students believe about AIDS susceptibility. The ideas reported in the focus groups showed that the self and social images of college students work against the notion that college students are susceptible to AIDS. Specifically, comments reflected beliefs that being of high socio-economic status, being young, knowing their partners well, and not being homosexual, would adequately protect them, and college students like them, from AIDS.

Kaplan and Shayne (1993) discuss heuristic associations used to understand the contraction of the HIV virus. Heuristics are self-educating techniques people use when trying to understand complex blocks of information. A complex concept, such as the threat of HIV, is reduced to smaller blocks of information, such as high risk groups, so it can be more readily understood. The identification of these groups allows people to categorize their own risk. By assuming that they are not in one of the groups, they assume they are not at risk, or that they have already been exposed and have no hope of avoiding HIV, and therefore safer sexual behavior would be of no use. Kaplan and Shayne suggest that many media and news stories, which have often focused on people of high risk groups, reinforce categorizations and heuristics, allowing people to ignore data which indicate that HIV can be contracted by anyone who has not been fully abstinent. Use

of these heuristics by college students reinforces the idea that, because they are not in a high risk group, their own risk of contracting HIV is minimal.

Heuristics, stereotypes, and self-images have been used to explain how college students assess their own risk of contracting HIV. These cognitive devices promote the mistaken belief that college students are not susceptible to the HIV virus, and further decrease the perceived need to incorporate safer sexual behaviors into their lifestyles. Unfortunately, research has not focused on how college students perceive the risk of other STDs, regardless of the widespread infections in college aged groups, or how perceptions of personal risk for these diseases influence the adoption of safer sexual behaviors to prevent other sexually transmitted diseases.

Alcohol Consumption and Safer Sexual Behaviors Among College Students

Alcohol consumption is a common behavior of college students, and it is important to note that student patterns of alcohol consumption are quite different from consumption patterns of non-student populations. Brien et al. (1994) quantified the drinking activity of college students and found that over one year, 96% of students in the sample had at least one drink; almost half reported drinking once a week; and on a typical drinking occasion, 60% reported consuming five drinks or more. Of the sample, 40% said they “often” or “always” drank to the point of intoxication. The effect of alcohol consumption on decisions about sexual involvement and safer sexual behaviors is a topic of much speculation, especially regarding the college population where heavy drinking frequently occurs.

Meilman (1993) reported that alcohol use is related to sexual involvement. His research found that 47% of the men and 57% of the women reported engaging in sexual intercourse one to five times because they were intoxicated. Meilman further found that significantly more women (38.8%)

than men (22.5%) had participated in sexual activity which was alcohol-related, and significantly more women (29.9%) than men (16.3%) reported this happening more than once. Another estimate found 70% of college students, and 57% of college women, were involved in sexual activity as a result of alcohol consumption (Butcher et al., 1991; Manning et al., 1989). However, the investigators grouped all sexual encounters in their findings, and did not specify whether safer sexual behaviors were used or not.

Other studies concerning alcohol consumption and unsafe sexual encounters have reported a lower, yet still high, occurrence of this relationship. Gold et al. (1992) reported that when college students recalled an unsafe sexual encounter, almost one quarter of the sample reported being extremely or moderately intoxicated at the time it occurred. Meilman (1993) noted that college women abandoned safer sexual behaviors at rates twice those of college men when consuming alcohol. Keller (1993) found that among college students, being under the influence of alcohol or drugs had occurred for 25% of the respondents reporting unexpected sexual involvement. Brien et al. (1994) found that respondents who reported the heaviest drinking were also sporadic condom users. This group expressed lack of confidence in their ability to use condoms when intoxicated.

Temple, Leigh, and Schafer (1993) attempted to link event-specific alcohol consumption with abandonment of safer sexual behaviors. Their results indicated no significant association between alcohol consumption and whether birth control or STD protection was used, suggesting that drinking did not predict condom use. However, alcohol use was found to be more common in encounters with new partners, casual partners, or unexpected partners. In this study, factors which did predict condom use for men were: younger age, sexual attitudes, fewer number of previous partners, less

frequent drinking habits, less sensation seeking, less risk taking, and less impulsiveness. For women, only younger age and higher education predicted condom use; alcohol consumption did not. The findings in this study show a relationship of sexual risk taking and general drinking patterns for men, but not for women. These findings show the importance of considering variables that influence both drinking and safer sexual behaviors. It is possible that other variables, rather than alcohol consumption, are more associated with lack of condom use.

Condom Carrying Behavior

The research reviewed previously introduces the possibilities of alcohol consumption, screening partners, embarrassment, uncertainty, and denying susceptibility to STDs as explanations for why women do not incorporate condom use into their sexual practices. Possessing condoms, however, has been identified as a factor which facilitates condom use. According to Hingson et al. (1990), 16-19 year olds who carry condoms are 2.7 times more likely to use them than those who don't. Wilson et al. (1993) state that the availability of a condom is one way to ensure effective, consistent condom use, and that having one reduces the likelihood of unprotected sex.

However, Wilson et al. (1993) also assert that carrying of condoms by women is confounded by negative social stigmas, such as premeditation of a sexual act. Wilson et al. (1993) tried to specify women's beliefs about condom carrying. They found perceptions that the carrying of condoms would make a woman appear "easy" (p. 1097) or unclean, or that bringing one for use would accuse the partner of being unclean. Sacco, Rickman, Thompson, Levine, and Reed (1993) found that college undergraduate females had more negative attitudes about carrying, keeping, and buying condoms than did

male undergraduates. Additionally, college women were found to rarely possess condoms.

Unfortunately, other studies have also found that women view condom carrying less favorably than men. Valdiserri et al. (1989) found that 22% of the females in their study would feel “too embarrassed” to purchase condoms at a drugstore. Sacco et al. (1993) reported that women were much less likely than men to carry or keep condoms because they were sensitive to negative social images, particularly the assumption that sexual intercourse was premeditated. Holland et al. (1992) found that buying condoms, as well as carrying them, was reported by female respondents to be embarrassing. Their study further found that carrying a condom was perceived as unfeminine, because a woman would appear to be seeking sex. This would also be indicative of her lack of sexual innocence.

Sacco et al. (1993) comment that these findings suggest not only that both genders expect men to provide condoms, but also that male provision predicts their use. If the woman were to provide condoms, she must either be able to convince the male partner to use them, or avoid sexual contact with men who will not. In these situations, Sacco et al. (1993) state that “females may enter the sexual situation with less control than men” (p. 323). The authors further suggest that these findings reflect different cultural expectations between men and women, and these expectations may influence the decisions which are essential for self-protection from STDs and HIV. These attitudes may influence male sexual behavior more than female sexual behavior.

Gender

Gender roles are a product of culture, and are central to understanding women's sexual behavior. Gender roles of women have changed significantly

over the past 30 years. These changes have influenced public and private perceptions of contraception, femininity, and what is considered appropriate sexual behavior for women. Recently, Daniluk (1993) found that medical procedures “employed in the name of health” (p. 58), and the medical profession itself, were perceived as primary influences in women’s experience of their sexuality, from menarche on.

In much earlier periods of American history, women were largely evaluated by their sexual actions, and their sexual identity stemmed from this. In the eighteenth century, Mary Wollstonecraft (1792/1992) wrote that, “Respect for the opinion of the world, has, however, been termed the principal duty of women” (p. 26). During this time in history, a woman’s reputation for chastity was central to her sexual identity. Despite the profound changes in women’s roles since that time, current research finds parallels in the importance of peer opinions. A woman’s tendency to carry condoms (Wilson et al., 1993) and her intention to discuss condom use with a partner (Chan & Fishbein, 1993) are largely influenced, positively or negatively, by her peers and her perceptions of the opinions of others.

In the early 1900’s, Margaret Sanger (1922/1992) wrote about a woman’s responsibility for the practice of contraception, another issue central to women’s sexuality. She writes, “In ideal society, no doubt, birth control would become the concern of the man as well as the women. The hard inescapable fact which we encounter today is that the man has...refused any such responsibility” (p. 56). Researchers today make a similar justification for the need for a female condom. Heterosexual condom use has been shown to be significantly influenced by male attitudes. The female condom will not require male compliance for use and it will give women more control in STD prevention.

Safer sexual behaviors in today's society are strongly influenced by gender roles. Understanding gender roles, and how they influence sexual involvement and decisions about safer sexual behaviors, is an important element in understanding the social context in which safer sexual behavior decisions are reached. Lottes specifically researched the gender role experiences of college students (1993). Because women have gained considerable power and independence over the last 100 years, she expected to find convergence of some aspects of sexual behavior between men and women. Lottes (1993) writes that, according to sex-role stereotypes, men are cautious about becoming emotionally involved and making commitments. Women, on the other hand, are taught to value love, affection, romance, and commitment. For women, sexual involvement is often contingent upon these elements. Carroll (1991) asserts that among unmarried college students, men and women have different values and attitudes about pre-marital sex. He classifies women as being less permissive, more responsible, and having more emotional meanings attached to sexual intercourse. If these stereotypes are accurate, the significance each partner in a heterosexual relationship attributes to sexual involvement can be very different.

The survey data collected by Lottes (1993) reflected what the stereotypes have suggested. Fully 92% of women indicated that emotional involvement was a "necessary" component of sexual involvement, compared to 65% of men. However, the data also reflected some behavior convergence: 44% of the women reported having experienced sex without an emotional involvement; this was reported by 65% of the men. Further convergence of sex-roles was indicated when similar percentages of men (76%) and women (78%) reported that men and women should be equal

initiators of a sexual involvement, even though initiation is traditionally viewed as a behavior more appropriate for men.

Several studies have examined female initiation of sexual contact as an example of “non-traditional” gender role behavior. In all of the studies, men reported female initiation more frequently than women themselves reported doing it (Anderson & Aymami, 1993; Lottes, 1993; O’Sullivan & Byers, 1993). Anderson and Aymami (1993) further explored the motivation women have for initiating sexual contact. This study compared the difference between women’s self-reported motives for initiating sexual involvement and men’s perceptions of these motives. Men reported that women had more external motives for initiating sexual involvement, such as making another partner jealous or ending another relationship. Overall, women reported fewer external motives for initiation, and the study inferred that women tended to view their actions as “giving the man what he already wants” (p. 341). The women therefore did not see themselves as the initiator of a contact. This may explain the large discrepancy between male and female reporting of female initiation.

Some studies have used Gender Role Theory to explain discussions about condoms (Sacco et al., 1993; Wilson et al., 1993). Applications of this theory suggest that females will focus on the feelings and concerns of their partners. As a result, male attitudes about condom use during a discussion are more important than women’s feelings in predicting actual use (Sacco et al., 1993). As relationships develop over time, behavior determinants focus less on stereotypes and more on interpersonal skills; later in a relationship greater influence on condom use may come from the females, who tend to be more proficient at socially complex tasks, such as discussing condoms (Sacco et al., 1993). Holland (cited in Abraham & Sheeran, 1993) asserts

that social skills in these types of sexual situations must empower women to challenge gender role constraints, in order for them to be more proficient at protecting themselves from STDs.

Lottes' study also addressed the concept of refusing sexual intercourse. The most common reasons given for not having sexual intercourse differed by gender. Women most commonly reported not knowing the partner well enough (39%), whereas men reported fear of contracting an STD (34%). More specifically, women chose responses of "not knowing partner well enough," "not enough commitment," and "wanting to be faithful to current partner" more frequently than "fear of contracting an STD." The men's reason for refusing sexual intercourse was much more self-protective, reflecting a different perceived outcome of sexual involvement, and a potentially safer response to possibilities for casual sex. Again, only 12 % of the women indicated fear of contracting an STD as a primary reason for refusing sex. The fact that nearly half of the women in the study had experienced casual sex suggests that while women may have adopted some aspects of male sexual behavior, women have not adopted the accompanying self-protective behavior of men. Eighty-four percent of the women reported reasons for refusing intercourse which supported the stereotype of a woman's greater desire for commitment and emotion within sexual relationships, rather than a comprehensive convergence of behavior patterns.

Literature Summary

Considering that statistical estimates of STD infection indicate that a third of all people between ages 15 and 40 will get or have had an STD, and that many college students have four or more sexual partners, the chances that a college student will contract a sexually transmitted disease are very high. Previous research clearly shows that knowledge of HIV transmission

has not been influential in promoting the use of condoms. Factors which inhibit the use of condoms by women, such as fear of rejection by a partner or not perceiving risk of STDs if contraception is used, are socially constructed and reinforced by attitudes within this age group. The research also shows that the ineffective prevention behaviors which college women use to protect themselves, such as interviewing partners, are condoned by peers and widely practiced.

Previous research has begun to describe how men and women perceive sexual involvement, and have identified some of the motivations for sexual involvement and specific behaviors. The studies further imply that women continue to value love and commitment and view sex as something that men desire. These ideas are important elements in understanding sexual involvement, but the studies do not allow the women to describe how they personally view their own behavior or what motivates it. This omission allows many assumptions to be made without providing evidence to substantiate those assumptions.

These gaps are particularly important when considering the unique vulnerability of sexually active college women. Although women are traditionally responsible for birth control, their assumption of responsibility for STD protection is not adequately documented, even with the huge impact STDs have on the immediate health and future fertility of their cohort. A study of how college age women describe their own behavior would confirm or disprove many of the assumptions in the existing literature, and could help to explain how a woman's perception of gender roles influences her choices about safer sexual behaviors.

CHAPTER 3: RESEARCH FRAMEWORK AND METHODOLOGY

The purpose of this research was to explore women's experiences of safer sexual decision-making. Qualitative methodology was selected to maximize the potential for participants to provide data in their own words and from their own perspectives. The principles of naturalistic inquiry were the basis of the theoretical framework within which women's perceptions, decisions, and behaviors were explored.

Theoretical Framework

Naturalistic inquiry and qualitative methodology are rooted in the broad approach often called holistic inquiry. An important commonality of all holistic inquiry is understanding that multiple realities can occur within the natural setting of the human experience and behavior. Therefore, the research designs which are used to investigate human phenomena need to occur in the natural environment in order to discover their complexity and meaning (DePoy & Gitlin, 1994).

The WRAP Study

The Women, Risk and AIDS Project (WRAP) (Holland et al., 1992) is a valuable example of research using a holistic approach to study young women and their experiences with safer sexual behaviors. The intention of these investigators was to identify factors which were likely to constrain or encourage safer sexual behaviors. They accomplished this by investigating the "sexual beliefs, practices, and understandings of young women in order to identify the processes and mechanisms whereby they construct, experience and define their sexuality" (p. 274). The data collection involved intensive interviews and permitted the participants to use their own ideas to define issues of sexuality. In presenting the results, the authors explained their findings using the women's words.

This particular methodology permitted the researchers to test hypotheses generated by the research team and allowed the emergence of unexpected hypotheses, constructed using the words and experiences of participants. The qualitative nature of the analysis allowed the data to be explored through several levels of meaning and was not restricted to analyzing one-dimensional data which would have been collected in a quantitative study. The WRAP study approach, grounded in naturalistic inquiry and using qualitative methods, provided important guidance for this research.

Naturalistic Inquiry

Naturalistic inquiry implies a holistic philosophy. Two of the assumptions of this type of inquiry are that the human experience cannot be understood by examining only part of it; and that meaning in the human experience comes from understanding individuals within their social environments. This approach assumes that many versions of reality exist, and a particular interpretation of reality is determined by how events are viewed through individual biases. A final tenet of this approach is that the people who have had an experience are the most knowledgeable about it.

Life History is a branch of naturalistic inquiry which focuses on individual lives within the context of the social environment. The goal of this type of research is to reveal life processes over time. The informants produce the data and provide analysis of the meaning. Some investigators look for the human experience as discovered through the examination of many individual lives. Another branch of holistic inquiry is phenomenology, in which the underlying principle is that human meaning can be understood only through experience. Within this framework, the researcher's understanding is limited to knowing an experience without interpreting that experience. Therefore,

there is no interpretive framework imposed on the data, but interpretation emerges from the information that a researcher obtains from a participant. In this approach, the informant creates the primary interpretation and the analysis of experience within the interview (DePoy & Gitlin, 1994).

Emic perspective

An emic perspective refers to the insider's or informant's way of understanding and interpreting an experience. This perspective is phenomenologic because the experience is understood as that which is perceived and expressed by informants in the field. The methods of data gathering are designed to enable the investigator to bring forth and report the voices of individuals as they speak and interpret their perceptions of reality (DePoy & Gitlin, 1994).

Approach to the Study of Women's Sexual Decision-Making

The phenomena of how and why college women practice safer sexual behaviors presented itself to the researcher both anecdotally and empirically. The literature review further defined this area as needing exploration, primarily because the empirical findings rarely explain women's decisions about safer sexual behaviors from the women's perspective. For these reasons, a theoretical framework based on naturalistic inquiry was considered most appropriate for further exploration of this phenomenon. Methodologies commonly used in naturalistic research, including interviewing in depth and analytic techniques borrowed from phenomenology and life history approaches, allowed exploration of this topic within the context in which it occurs, and explanation in the words of those who experience it.

Methodology

The purpose of this study was to explore factors which inhibited or facilitated safer sexual behavior among single, undergraduate women

enrolled at San Jose State University. Specifically, this qualitative study was designed to explore women's safer sexual choices and the circumstances under which the choices were made.

Objectives

The broad objectives used to guide this research were:

- 1) to explore the women's perceptions concerning which sexual behaviors are "safe" and which are "unsafe,"
- 2) to document women's accounts of specific incidents of decision-making about safer sexual behaviors, and
- 3) to synthesize the accounts in order to identify factors which contribute to the practice of safe and unsafe behaviors.

These objectives enabled the researcher to facilitate a process in which women could explain their experiences and reconstruct the meanings in their own words.

Research Questions

Broad, open-ended research questions were developed to allow individual responses in this exploratory study. The questions that guided this research were:

1. What types of sexual behaviors do women report practicing?
2. Why are the reported behaviors chosen and practiced?
3. Under what conditions are the reported behaviors chosen?

Broad Definitions

The following definitions were derived from the existing body of literature on safer sexual behaviors and related topics. The definitions were useful in defining the scope of this research and clarifying the study's objectives. However, in this exploratory study the way a participant operationalized a definition was considered to be part of the study findings.

Specific definitions of many terms were deliberately left undefined for this reason. The ways in which participants operationalized these terms will be presented as study findings in Chapter 4.

Sexually Active

The term sexually active can refer to many degrees of sexual involvement, and is often used by health practitioners to describe behavior regarding sexual intercourse. The term may refer to current activity (personal communication, Planned Parenthood, San Jose, 2/27/94), or to past involvement (personal communication, SJSU Student Health Center, 3/16/94). For the purposes of this research, sexual activity was defined as a woman's experiences of ever having had sexual intercourse with a male partner, and was used as a sampling variable for inclusion in the study.

Intimate Situations

An intimate situation was defined as an encounter between a woman and her partner that was sexual in nature. In these situations, sexual matters may have been discussed. Intimate situations may lead to sexual intercourse, but for the purposes of this study, the exact parameters were defined by the participants.

Safer Sexual Behaviors

Safer sexual behaviors are recommended practices which will reduce one's risk of contracting a sexually transmitted disease. Actions which reduce risk include condom use, HIV testing, condom negotiation, abstinence, interviewing partners, and not allowing alcohol or drug use to influence condom use (Butcher, Manning, & O'Neal, 1991; Carroll, 1991; Catania et al., 1992; Dolcini et al., 1993; Grimley et al., 1993; Meilman, 1993; Roper et al., 1993; Walker, 1992). The term "safer" is increasingly preferred by health

professionals, but the terms “safer” and “safe” sexual behaviors were used interchangeably in this research.

Safer Sexual Choices

Safer sexual choices are those behaviors which are adopted to reduce one's risk of contracting an STD. While a woman may be aware of what safer sexual behaviors may be, the behaviors which she actually practices define a behavioral choice. Safer sexual behaviors may reflect recommended behaviors, but they are not necessarily those chosen. Choices may consist of a combination of recommended behaviors or other behaviors which a woman also expects to offer protection from STDs.

Condom Use

Literature about safer sexual practices includes condom use as a preventive behavior. Correct and consistent condom use is an effective means of preventing sexually transmitted diseases and unwanted pregnancies (Roper et al., 1993). Using a condom actually requires several preliminary behaviors, including acquisition of condoms, having the condom available at the appropriate moment, as well as using it during intercourse. In this study, the definition of condom use was defined by each participant and could include any combination of the above behaviors.

Use of Contraception

Technically, contraception refers only to birth control. Contraceptive devices available to women in the United States include condoms, spermicides, sponges, diaphragms, cervical caps, intrauterine devices, oral contraceptive pills, injection of contraceptive hormones, and a hormonal contraceptive implant. With the exception of condoms, these methods are not intended to provide protection from sexually transmitted diseases (Rosenberg & Gollub, 1992). Some contraceptive users choose methods, such as the

condom, which offer additional protection from STDs. In this study, participants defined their own contraceptive practices and explained their own motivating factors for use.

Condom Negotiation

Negotiation between partners about condom use can be both an active and an internalized process. It can consist of verbal and non-verbal elements. Condom negotiation leads to a decision to use, or not use, condoms. Self-justifications which rationalize a decision not to use a condom, or mentally balancing potential losses and gains expected with using condoms, are examples of this process (Gold et al., 1992; Gollub & Stein, 1993; Grimley et al., 1993).

Operational Definitions for Study Design

The following discussion describes how the researcher operationalized key concepts in the interview guide. These definitions were used to focus and structure the research. The construction and elaboration of these terms by participants was encouraged during each interview. This was accomplished by extending probes as encouragement for a participant to further discuss an operationalized concept. These probes were integrated into the interview guide and are described below.

Partner

During the interview, a partner was acknowledged as anyone the participant referred to when answering questions about current or past relationships. Specific opportunities for a participant to identify a partner were included in sections 1 and 3 of the interview guide (see Appendix A). Specific and individual definitions of “partner” emerged through the interviews, as defined by each participant.

Gender Roles

In designing the interview questions, sections 4 and 5 (see Appendix A) were intended to elicit responses reflecting attitudes and beliefs about gender roles and appropriate behavior. This discussion was encouraged by asking questions about thoughts, feelings, and expectations a participant experienced when interacting with a partner.

Safer Sexual Behaviors

Sections 2, 3, and 4 of the interview guide (see Appendix A) were designed to generate discussion about practices, attitudes, and beliefs concerning safer sexual behaviors.

Condom Use

For the purposes of interview questions in this study, condom use was intended to be included in a discussion of safer sexual behaviors. It was specifically addressed in areas 3 and 4 of the interview guide (see Appendix A).

Condom Negotiation

During the interview, condom negotiation was explored through questions about situations in which participants had used condoms, or any other behavior which demonstrated a discussion about using or not using condoms. These questions were intended to encourage a discussion of condom negotiation. Section 4 of the interview guide addressed this specifically (see Appendix A).

Situational Factors

In structuring the interview questions, sections 1, 3, 4, and 6 of the interview guide were intended to facilitate descriptions of situational factors which influenced practicing safer sexual behaviors (see Appendix A). Examples included how a participant described the relationship with her

partner and whether sexual involvement was described as planned or spontaneous.

Inhibiting Factors

Sections 3, 4, and 5 of the interview guide were intended to encourage participants to discuss and identify things which inhibited the practice of safer sexual behaviors (see Appendix A).

Use of contraception. Sections 3 and 4 of the interview guide were intended to encourage participants to discuss contraceptive methods and behaviors (see Appendix A).

Non-verbal Communication

Sections 4 and 5 of the interview guide asked specifically about the participant's impression of non-verbal communication with partners (see Appendix A).

Assumptions

The following assumptions were held by the researcher when designing this research, and were influential in guiding the scope and emphasis of the study.

Knowledge

The participants were assumed to have had some awareness of HIV and STD transmission at the time of the interview. This was assumed because of the educational opportunities and resources available to them as students at San Jose State University and because of their geographic residence near an AIDS epicenter. It was also assumed that this population of college students was similar to college student samples used in other research, which demonstrated that greater HIV knowledge was not indicative of practicing safer sexual behaviors.

Cognitive Grouping

It was assumed by the researcher that the participants would mentally group perceived threats, such as unwanted pregnancies, STD infection, and HIV infection, as negative outcomes of sexual involvement. It was further assumed that because of this grouping, sexual behavior decisions would be made to collectively protect a participant from whichever perceived threats were included in a person's cognitive grouping.

Desirability of Safer Sexual Behavior

This assumption was related to the nature of HIV and the AIDS epidemic. It was assumed that participants had thought about safer sexual behaviors. It was further assumed that they would find HIV prevention to be desirable because AIDS is a fatal disease and has caused reactions of fear and behavior change in many populations (Carroll, 1991; DiClemente, Zorn, & Temoshok, 1986).

Past Experiences

The participants were assumed to have experienced an intimate situation that would be relevant in a discussion of choices about safer sexual behaviors. This was assumed because condom use by college students, as well as other segments of the population, is reported as very sporadic in many studies (Catania et al., 1992; Dolcini et al., 1993; O'Leary et al., 1992). This was also assumed because the age of first sexual intercourse is often younger than 18 years. Since the participants in this study had to be 18 or over, and were aware of the nature of the study upon participation consent, they were assumed to have experienced sexual decision-making.

Sensitizing Concepts

In addition to the definitions and assumptions used to frame this study, seven sensitizing concepts, derived from anecdotal data and the literature

review, were influential on this study. While these dynamics were not assumed to be present, the researcher's acknowledgment of their potential existence was essential to understanding women's experiences. The researcher expected that these dynamics might have a subtle but important influence on a participant's decisions about adoption of safer sexual behaviors. It was expected that specific probing might be required to fully explore the behavioral influence of these concepts. It was further assumed that some of the sensitizing concepts would influence a participant's disclosure choices during the interview. Questions designed to explore these influences were included in the interview guide. Participants' responses were considered in relationship to the seven sensitizing concepts when conducting the interviews and when analyzing data.

Discomfort

During an interview, a participant may have recalled or expressed discomfort. Emotional or social discomfort could reflect preconceived attitudes or values which conflict with a participant's behavior. For example, a woman may feel uncomfortable purchasing condoms because she feels it is improper. In this case, she may be less likely to purchase condoms in the future. In general, safer sexual behaviors which make women feel uncomfortable may be less likely to be adopted. In this study, discomfort was explored to examine how this experience influenced a participant's experiences.

Comfort

A participant's recall of comfort regarding safer sexual behaviors was anticipated to be perceived as significant during the interviews. Comfort may identify an area in which a participant's values and behaviors support each other. This may result as a participant's absence of regret, or demonstration

of actions which she feels were wise. For example, a woman may feel comfortable refusing sexual intercourse because she feels the relationship does not involve enough commitment. In this case, she perhaps may feel comfortable refusing because she believes commitment is a prerequisite for sexual involvement and refusing intercourse supports this belief. Comfort during specifically intimate situations also may have been recalled by a participant. Sexual behaviors which support preconceived values and beliefs which feel comfortable or natural may be more likely to be practiced. In this study, the experience of a participant's expression of comfort on safer sexual decisions was explored.

Relationship to Partner

Participants were asked to define their relationship to a partner in order to provide a context in which to examine past behaviors or decisions. Factors such as monogamy, trust, commitment, or lack thereof, were thought to influence a participant's definition of her relationship(s). How one defines a relationship can change the perceived need for safer sexual behaviors. A participant's definition of her relationship to her partner was considered to be influential on the perception of need for safer sexual behaviors, and the ensuing actions.

Sexual Desirability

It was assumed that a woman wishes to be sexually desirable to a partner and wishes to remain so during a discussion of safer sexual behaviors. Aspirations to remain desirable may have influenced a participant's behavioral choices. Behaviors which a woman perceives as reducing her desirability, such as requiring a partner to use a condom, may be less likely to be performed, even if those behaviors are self-protective. Conversely, those behaviors a woman perceives as enhancing desirability

may be more likely to be performed. It was important to recognize the underlying, personal need to maintain sexual desirability in order to more completely explore the context of sexual interactions during the interviews and data analysis.

Female Sexuality

The interviews for this research probed the experience of female sexuality. The significance and meaning a participant attributed to her sexuality was expected to influence her sexual behavior and her perceptions of it. Because of this, disclosure choices may have been influenced during the interview. Recognizing the existence and importance of this construct was essential to reliable data collection, identifying possible reporting biases, and valid analysis.

Gender Roles

The Encyclopedic Dictionary of Sociology (Frank et al., 1986), describes gender roles as that which is “proper or natural for women and men to look like, talk about, or be interested in” (p. 259). Perceptions of expected gender roles may have influenced a participant’s behavioral choices. For example, a woman may have chosen not to bring condoms on a date because she felt it was a man’s responsibility. Gender role attitudes may also influence her recall of an event, or how it was reported in an interview. Accounts of behaviors which a woman perceives as incongruent with appropriate gender roles may have been withheld during the interview or recounted to fit gender role expectations. Additionally, the influence of gender roles or pre-existing concepts of appropriate behavior was explored as a behavior motivator.

Non-verbal Communication

Non-verbal communication between partners may be an influential means of communication in situations where safer sexual behaviors are being decided, and verbal communication is perceived as awkward. Kinesics, the science of body movement, studies meanings attached to posture and gestures. Within this branch of science, these types of non-verbal communications are considered building blocks for behavior sequences (Borgatta & Borgatta, 1992; Sills, 1968). Non-verbal indications of displeasure, such as a negative gesture preceding condom use, may be as influential on sexual behavior choices as verbalizations. However, a participant's awareness of non-verbal communication with her partner does not indicate that she would discuss this process during an interview. The modes of communication are very different and the process of reporting a non-verbal action with a verbal response requires sophisticated expression skills. To understand the influence non-verbal communication may have on sexual behavior choices, and to ensure that the influence not be overlooked, the researcher acknowledged the potential presence and the possible need to facilitate a discussion on this topic during the interview.

Study Design

This exploratory, phenomenological study collected qualitative data from face to face interviews with the participants. The purpose of the interview was for the participants to recount their experiences with safer sexual behaviors. The resulting data were analyzed for themes and factors related to those safer sexual behaviors women chose to practice, and why a behavior was chosen.

Human Subjects Approval

A Human Subjects protocol, which explained study methods, participants, participant consent, and confidentiality of data, was submitted in mid-October 1993, to the Committee for the Protection of Human Subjects-Institutional Review Board at San Jose State University. The research was approved November 10, 1993 (see Appendix B).

Informed participation letters were required for all participants. Participants were presented with the letter at the interview. They were given the opportunity to read the informed participation statement and to ask any questions regarding the research or proceedings before the interview began. Participants were told of their right to withdraw participation at any time during the course of the interview, both in the letter and verbally by the researcher. The informed participation letter was signed and retained by the participant in the event any questions arose after the interview was completed. At the end of the interview, the participants were given the opportunity to leave a mailing address with the researcher so that findings from the study could be mailed to them.

Participants

The accessibility of San Jose State University undergraduates was an important factor in establishing a sampling frame (Kuzel, 1992). This limited possible participants and focused the study on the experiences of undergraduate women currently enrolled at San Jose State University. To be considered for participation, a woman had to define herself as sexually active, heterosexual, and unmarried. Participation was limited to undergraduates from San Jose State University between the ages of 18 and 35.

Recruitment Strategy

Within the sample parameters, attempts were made to achieve maximum variation of experience and perspective. Attempting to develop an ethnically diverse sample was one means of achieving this. Recruiting participants from a variety of undergraduate classes and asking for referrals from ethnically diverse community members were other methods. It was essential to include women who had experiences which would add relevance to a discussion of safer sexual behaviors. It was assumed that by consenting to participate, the women would have had these types of experiences.

Active recruitment of participants began in November 1993, after Human Subjects approval was granted. It was anticipated that recruitment would end in March 1994. It was assumed that, by that point, the sampling goal would have been met and new sources of potential participants would be exhausted. The sampling goal was 15 participant interviews.

The Interview

To meet the objectives of this study it was important for each participant to have a forum in which to discuss her own experiences with safer sexual behaviors. The arrangement needed to be respectful of personal differences in the time required to reconstruct events and flexible in the progression of subject matter, in order to create a level of comfort acceptable to each participant. Data collection was designed to allow the introspection and self-expression process to be meaningful and astute, instead of rushed. For these reasons, a flexible interview format was developed. This allowed the participants the time and freedom necessary for expressing themselves to their own satisfaction.

To encourage individual expression, but still focus the interview to address the research questions, data were collected through a semi-

structured, face to face interview. An interview guide consisting of open-ended questions about relationships, safer sexual behaviors, and behavior choices was prepared in advance (see Appendix A). This guide was used during the interviews to ensure that the same topics were addressed with each respondent. Each interview was intended to resemble a conversation more than a structured interview, and the guide was used only to ensure that the topics were covered, rather than to control the progression of the interview.

Because each respondent's experiences were unique, some interviews placed more emphasis on particular topics. Each topic area was explored to a depth determined by the participant. Questions were asked in relationship to past and current partners. The researcher encouraged responses which described how a woman chose to abandon or practice safer sexual behaviors and contraception, descriptions of situations in which safer sexual behaviors were inhibited or facilitated, and attitudes about use of condoms or other safer sexual behaviors. Questions in addition to those on the interview guide were asked if further clarification of the subject was desired. Questions referring to sensitizing concepts were asked if the topic had not yet been explored during the course of the interview. Additional relevant topics not included on the interview guide were introduced at the discretion of the participants.

The interviews were conducted by the researcher and lasted approximately 40-60 minutes. The interviews were audio taped with the participants' consent. Audio taping was chosen for the recording method because it seemed to be the most accurate, yet least intrusive, to the interpersonal dynamics of the interview. At times when questions might have been intrusive to the current thought process of the participant, notes were taken by the researcher as reminders to later probe specific areas.

The interviews were conducted between December 1993 and March 1994 at a site and time chosen by the participant. Locations included the homes and workplaces of participants as well as on-campus locations.

Method of Analysis

The interview recordings were transcribed by the researcher. Initially, the interviews were transcribed verbatim and in their entirety. After the eighth interview, conversational sections about topics not noted on the interview guide and unrelated to the focus of this research were not transcribed. Comments made by the interviewer were indicated by bold print in order to avoid confusion during later analysis.

The interview transcriptions were coded for content shortly after transcription. This initial content analysis was done by writing in the margin next to important lines or paragraphs. For example, "fear of pregnancy" was marked next to a paragraph in which a participant discussed reasons for her contraceptive choice. As more interviews were coded, more categories were added and some were merged.

After the initial grouping, the researcher conferred with the thesis advisor about content validity and discussed the preliminary findings. This phase of analysis emulated a method described by Stewart (1992), in which commentary on data interpretations were invited by other researchers to validate her own preliminary analysis. Similarly, the advisor meeting was used as a validity check on initial groupings marked on the transcriptions, and as a validity check on the actual interview proceedings. The interview validity was evaluated based on the transcripts, and sought to ensure that the interviewer had not used leading questions or other behaviors directly influencing the response of a participant.

The next phase of analysis was to physically group data categories together from all interviews. Technically called “fracturing” the data, this process was very similar to a cut and paste organizational procedure. Each interview transcription was photocopied onto a different color of paper. A reference list was constructed listing the participant number, demographic information, and the paper color. Important sections were cut out of the transcription, and placed in a folder marked with the appropriate label, such as “condom negotiation.” These files were then used when developing the findings of this research. Interviews completed after the analysis had begun were incorporated into this process.

Conclusion of Research

After the analysis was completed, a brief, two page description of the results was composed for the participants (see Appendix C). This paper thanked the participants for their assistance and cooperation and was mailed to each participant in a sealed envelope.

CHAPTER 4: RESULTS

Description of Sample

Interviews were conducted with twelve participants. The ages of the participants ranged from 19 to 34 years (see Figure 1). Three additional women consented to interviews, but did not appear at the appointed time.

Figure 1. Age distribution of participants.

Five participants were recruited through community referrals, five through class announcements at San Jose Stte University, and two through participant referrals. Seven of the participants identified themselves as White or European American, three as Hispanic or Mexican American, one as Middle Eastern, and one as Filipino. The interviews were conducted at places of employment, participants' homes, and on the San Jose State University campus.

Eight participants reported current involvement in a monogamous relationship at the time of the interview. Two participants were actively practicing abstinence, one of whom was involved in an "exclusive" relationship but, "not sexually involved." One participant was not currently involved with a sexual partner and unintentionally practicing abstinence. One participant reported multiple, "not committed" involvements. One participant's current relationship status was not disclosed because she stated only that she

was not in a monogamous relationship. Within the sample, the number of reported lifetime partners ranged from 1 to 50 or more. Although many of the reported current relationships were monagamous, most had been monagamous for less than one year. Despite the short duration, participants often chose a method of contraception, such as the pill, which does not provide STD protection. The specifics of each respondent's relationship status, lifetime contraceptive use, and current contraceptive methods are outlined in Table 1.

Table 1

Reported Relationship Status, Contraception, and STD Prevention

No.	Current Relationship	Methods	Methods
	Status	Ever Used	Currently In Use
101	monogamous, 10 mo	pill, condom	pill
102	monogamous, 3 mo	condom, injection	condom,
			injection
103	monogamous, 1 mo	pill, condom	abstinence
104	non-monogamous	condom	condom
105	monogamous, 3 yr	pill, condom, foam	pill
106	monogamous, 3 mo	pill, condom,	pill, sponge
107	not currently involved	pill, condom, nothing	--
108	monogamous, 11 mo	pill, condom	pill
109	not currently involved	condom, pill, diaphragm and contraceptive jelly, rhythm	abstinence
110	monogamous ^a	condom	condom
111	monogamous, 5 mo	condom	condom
112	monogamous, 2 yr	pill, condom	pill

^alength not indicated by participant

Participant Definitions of Conceptual and Operational Terms

One of the first results of the qualitative analysis of the interview was the emergence and definition of key terms as they were explained by the participants. These definitions reflect how the participants perceived the terms and how they have incorporated those definitions in their own lives. A participant's definition describes her interpretation of each concept and often suggests related behavior. These definitions define the parameters within which sexual choices are made.

Partner

When identifying their own partners, participants limited this term to someone with whom they had shared sexual intercourse. Partners described as "boyfriends" were referred to within a context of "relationships," "monogamy" or "committed involvement." However, "boyfriends" were not termed "partners" unless the relationship was sexual. "Partners" were also identified as "friends who I sleep with" or "flings." These partners were referred to in a specifically non-committal involvement, described by one participant as "mutual consent, where there are no strings attached."

Use of contraception

Participants indicated that they had used a variety of contraceptive methods (see Table 1). Each of the 12 women indicated that both past and current contraceptive methods were chosen to prevent pregnancy. Condoms had been used as either a primary or secondary contraceptive method by all participants.

Condom use

Condoms were the most frequently chosen contraceptive method for women not wishing to use the birth control pill, and the most common back-up

birth control method for women who were using other contraceptive options. In addition to birth control, condom use was viewed both as an event-specific behavior and a behavior pattern. Event-specific condom use was described by participants who used condoms during some sexual involvements, but not others. For these women, condoms were most frequently used when no alternate form of birth control was employed. Condom use as a behavior pattern was described by participants who felt that condoms were an integral, necessary part of sexual intercourse. For these women, condoms were used specifically to prevent transmission of HIV or STDs.

Safer Sexual Behaviors

The behaviors participants defined as safer sexual behaviors were: getting tested for HIV or other STDs, having a partner get tested for HIV and STDs, using condoms, using a diaphragm, being aware of a partner's sexual history, and involvement in a monogamous relationship. Although participants identified these as safer sexual behaviors, they were not necessarily chosen or practiced.

Sources of Knowledge about HIV, STDs and Contraception

Each of the twelve respondents indicated high levels of awareness of the possibility of unwanted pregnancies, and accurate knowledge of how to prevent them. Knowledge about HIV transmission and prevention was less comprehensive, but still accurate. Awareness of other STDs was less salient, as only two participants referred specifically to an STD other than HIV. In these cases, the reference was within the context of recalling a personal experience. STDs were collectively referred to as "a disease" or "other diseases," if they were mentioned by participants at all.

The most commonly reported source of information about HIV and STDs was a health class at either the secondary or collegiate level.

Participants who attended both public and Catholic high schools reported receiving some “sex education.” References to high school health education were very brief, acknowledging the presence but not indicating content. Health classes at the post-secondary level had been taken at community colleges and San Jose State University. The perceived value of college level classes was mixed, “...(I took) the human sexuality class here [at SJSU]. I don’t remember much of it.” A more positive reaction, referring to a participant and her boyfriend, was “... we took a human sexuality course together. It was very educational for both of us.” A different participant recalled that seminars available through her job as a health care worker had been a valuable source of information and training.

Several non-academic educational sources were listed as primary sources of knowledge. Television was commonly recalled as an information source, including both “seeing some stuff about it on talk shows on TV” and “what you hear on the news.” Magazines and other reading material were also mass media sources which participants reported using for information about HIV, STDs and contraception.

Doctors’ offices were recalled as a good source for brochures, and Planned Parenthood was referred to as a good source for information in general. However, acquiring information from these places required the participant to be motivated enough to seek it out. Participants who used these sources indicated their self-education. “I’ve gone and got information for myself so that I know what it’s about.” Another participant said, “most of the stuff I learned on my own through books.”

A final source of education for participants came was friends and family members. Friends helped participants learn by providing examples. For instance, one participant recalled that the need for condom use was learned

“from my gay uncle, and I learned it from friends that have gone through pregnancy because they weren’t using condoms.” Another participant said a valuable source of information was her boyfriend. “He teaches me a lot about the use of condoms. He really opened my eyes.”

Supportive Influence of Friendship on Behaviors

In addition to being an important source of education, women and their friends assisted and supported each other when attempting to make safer sexual choices. Support was received by participants from friends, and by friends from participants. Verbally promoting safer choices, providing companionship for HIV testing, and acquiring condoms for friends were mentioned as specific forms of assistance.

The participants frequently recalled directing a concern for safety toward close friends. “I’m like a mother to one of my friends. She tells me I’m worse than her mother.” The most common form of support was acknowledging to a close friend concern for her safety. “I hope that my lectures are getting through to her. She gets a stern warning from me every time she gets involved with someone else.” These verbal concerns are often reinforced by gestures supporting safer choices, such as an offer of condoms.

In some cases, support was offered to the participants because of concerns about pregnancy and HIV. “I have a lot of friends that have gotten pregnant. They see us, single or whatever, and they want to make sure we protect ourselves.” Specifically relating to HIV, one participant recalled, “I’ve been told, ‘Maybe you should go get checked out.’ ” Anxiety regarding HIV testing illustrates the supportive network of friends: “If I decided to go down and get tested, she would do it with me. We’d both do it together.”

Acquiring condoms (see Table 2) was also an area in which participants recalled friends receiving and giving assistance. “I bought her

some condoms and I just gave them to her. I said, 'Please, just use these, because I worry about you.' ” “The first time she had to go buy condoms, she was too embarrassed. So, she made me do it.” In the following story, a participant recalls how a friend assisted her in overcoming the obstacle of acquiring condoms.

I was at the grocery store with my roommate and she was picking up some condoms. She just threw a pack into my cart.

When I got to the checkout line, I was like, where did these come from? She said “Oh, I just threw them in just in case.”

What do you do? You're standing holding a box of condoms at the grocery counter... go ahead, put them on (the bill). That was good; she did it. I didn't actually have to grab them off the shelf.

In these descriptions, friends and participants assisted each other in overcoming perceived embarrassment from acquiring condoms.

Table 2

Where Do Women Get the Condoms They Use?

Source	Example
Male Partner ^a	<p>"He had it in his drawer. I guess he was prepared."</p> <p>"He bought this huge box of Trojans."</p>
Drug Store, Grocery Store	"I went to the drug store. My boyfriend was too embarrassed to buy them."
Planned Parenthood	"I got them when I went to Planned Parenthood"
SJSU Peer Education	"At orientation, Peer Education was giving out free condoms. I was there six days of the week, so I took a condom here, a condom there. Especially the colored ones."
Female Friends	"I bought them and gave them to her."

^aFive of the twelve participants relied on their current partners to supply condoms.

Influence of Substance Use on Decision Making

Responses regarding the influence of alcohol and drug use were mixed. For some participants, substance use was not perceived as influential on sexual behavior. Participants who offered responses about marijuana and alcohol perceived little relationship: "I've smoked pot before, but I think that's different from being drunk." Responses referring to alcohol described several types of perceived influence. Several participants reported that, "I don't drink" and therefore reported no influence on their behaviors. For participants who did consume alcohol, the reported perceived influence ranged from alcohol having no effect on their behavior "at all" to alcohol causing them to make a sexual choice they would have not made if sober.

Some respondents acknowledged a relationship between alcohol consumption and sexual involvement, but denied any influence on decision-making. This was particularly true if the woman was in a pre-existing relationship with the sexual partner. "I don't think it's [alcohol] changed anything I've done at all. There have been times I've had a lot to drink and things have happened... but I've been in relationships." Some respondents acknowledged a potential relationship between alcohol use and sexual behavior, but downplayed its influence because it did not result in forced or involuntary actions. For example: "When you're drunk you are more easily convinced to sleep with someone, but I've never had anyone take advantage of that... So, it hasn't really influenced me." In cases such as this, the effects of alcohol were recognized but not perceived as influencing safer sexual behavior.

Other participants felt that alcohol has a powerful, almost inherent, effect on safer sex. Participants who reported this perception of alcohol felt that it had caused poor decisions. "It affects. Whoever says it doesn't, it's

BS.” Another participant defined this more specifically. She stated, “I’d have to say alcohol is the thing which caused me to choose partners that I normally wouldn’t choose.”

More frequently, influence from alcohol reported by other participants was described as much milder and less causative. In these cases, alcohol use had an effect, but the actual decision-making had occurred earlier. “The first time I had sex with [a partner] I had gotten drunk. I had already decided [to have sex], I guess it was just to give me courage.” These respondents felt that the decision-making was under their own control and that alcohol “helped” them in what they had decided to do. “The time I lost my virginity I was drinking. But I don’t think it had much to do with the fact that I was drinking, it was just a little bit easier. I knew what I was doing.” These participants specifically stated that alcohol had not influenced the actual decision-making process or outcome.

Alcohol consumption was also an area in which friends were relied upon to provide support and negate possible negative outcomes due to alcohol-impaired judgment. Some participants reported staying close to friends while consuming alcohol to ensure that they wouldn’t do anything unsafe. “I make sure that if I do decide to go overboard and get drunk that someone is there to watch me, just so I don’t do anything stupid,” or, “I stick with my friends if I’m a little bit happy.” In these cases, the positive influence of friends is used to diminish potential negative outcomes from alcohol consumption.

Finally, alcohol use was addressed in relationship to the use of condoms. Participants did not report alcohol to decrease or inhibit condom use. “I’ve never been so drunk that I didn’t know what I was doing, or that I wouldn’t remember something. I always knew I would use condoms if it

would happen.” In this case, the woman perceived herself as having control of her drinking, and reported her intentions to use condoms as unaffected. Another participant recalled drinking, and actually using condoms. “We have used a condom even though we were drinking. I guess it’s subconscious in that I automatically say ‘condom’.”

In summary, participants reported the influence of alcohol to manifest itself in different ways. The responses ranged from no influence from alcohol and marijuana to strong influence. It is important to acknowledge the many forms of influence alcohol can have. This range was reflected in participants’ comments. Some reported no influence because alcohol did not cause a situation in which they were “taken advantage of.” Others reported no influence because of infrequent or no alcohol consumption. When influence was reported, responses ranged from severe, leading to regretted actions, to mild, offering courage for a pre-determined action. Actual condom use was not reported to be influenced by alcohol consumption.

Reported Contraceptive Behavior

At the time of the interviews, all participants were currently practicing contraception, or had done so in the past. This was true for women in monogamous relationships and those in uncommitted relationships, both past and present. Only two participants reported ever regularly engaging in intercourse without any type of contraception. This behavior had occurred at a younger age, and had since been changed to incorporate regular contraceptive use. Both respondents said that this behavior change had occurred a significant length of time before the interviews were conducted. Several participants also recalled a time when they thought they might have been pregnant. Despite the inconsistencies in contraceptive use, all

participants perceived contraception as necessary. This motivated them to maintain their contraceptive practice and to practice it in the future.

Contraceptive practices were performed with self-assurance and persistence by all participants. Women using female-controlled methods (pill, diaphragm, injection) reported great self-confidence and a sense of empowerment in their use. This is illustrated in statements such as, “I would prepare myself ahead of time on a date,” and, “I’ve never thought of not being on the pill.” The women reported that these methods were consistently practiced. Female-controlled methods were also used to reduce potential condom failure. “I am going to be using condoms, but condoms are not always reliable.” Women chose the pill because they perceived it to be the most effective of all contraceptive methods. Methods other than oral contraceptives were chosen when the woman did not like birth control pills, was not taking them at the time of sexual involvement, or did not feel comfortable using them.

Women using condoms for contraceptive reasons also felt very empowered. Younger participants tended to choose condoms as their primary method of contraception. When condoms were required for birth control, participants reported compliance from their partners, “he knows he has to wear one.” Compliance was promoted when participants took responsibility for reminding partners to wear a condom. Condoms were the chosen method of birth control when the woman was not on the pill or using any other form of contraception. Condoms were also preferred because they were easy, available, and were not perceived as requiring evidence of contraception, “You have to carry that little thing [pill box] with you all the time. That’s why we use the condom.”

Men, as reported by women, had more mixed contraceptive actions. Women indicated that some men were specifically concerned about unintended pregnancies and used condoms to prevent them. "He knows that if something happens, it's because of both of us, and we both have the responsibility." However, women most often reported that male partners take less responsibility for contraception. In a specific case, a participant indicated her partner did not ask about contraceptive measures before sexual intercourse, "...I said, 'you never said anything about birth control or condoms, and we just (had sex).' He said, '..I trust you.' I said, 'by the way, I am on the pill.' " When generalizing about men's behavior, another participant also found men to be passive about contraception. "Men are stupid. If I were a guy, I would ...use a condom anyway. If I would have never said something about using a condom, the majority [of past partners] would have had sex...without any birth control."

Safer Sexual Behavior

During the interviews, participants identified the following as safer sexual behaviors: being aware of a partner's sexual history, involvement in a monogamous relationship, getting tested for HIV or other STDs, having a partner get tested for HIV and STDs, using condoms, and using a diaphragm. The process of determining the need for safer sexual behavior and performing the actual behavior consisted of several elements, each of which was influential on the behavior outcome. These elements, as identified by participants, were: perceiving risk of HIV and other STDs, assessing trust and commitment in a relationship, discovering a partner's past sexual history, and negotiating condom use. The process of practicing safer sexual behaviors was the result of the interaction of these elements.

Perception of Personal Risk

A crucial part of enacting safer sexual behaviors for STD prevention was the process of deciding whether the safer behaviors were needed. How a participant identified her own exposure potential and susceptibility to STDs was an important element of this decision. All participants reported being aware that sexual activity involved a risk of contracting an STD. Some attitudes were based on a gradual acquisition of knowledge.

When I was growing up, AIDS wasn't a big deal. But I think now, with the person that I'm dating, there's a chance. It's something I thought I would never have to think about or deal with, and now I do.

For a few participants, decisions about risk were very simple because perception of her own risk was very high. For other women, the process of assessing risk was much more complicated because this assessment was made based on several variables.

When participants perceived potential exposure, personal risk perception increased. "It scares me that I could get some kind of disease. Health is number one. I feel protection's always needed. I want to be healthy. I don't want to end up dying early or being infertile." "I think about it and it scares me sometimes. I know I haven't been as safe as I should have been." Other risk perception was based on personal experience. "The guy I got my STD from, he didn't seem like anything was wrong, and so it's very scary." Another participant recalled:

As time went on, and I've had more partners, [AIDS] became more known to me, that it's out there. The thought is always in your head, that, "no it would never happen to me," but that's not realistic. It's become more of a big thing.

These women all acknowledged that AIDS and STDs were issues which posed threats to themselves.

For women who perceived high risk of STDs, the decision to use safer sexual behaviors was based on a realization of personal susceptibility, regardless of whether she had actually been exposed. "I was very sick, and the first thing the doctors did was give me an HIV test. That was a point when it hit me in the face." Although this woman's experience was not caused by STDs, other women's perceptions of risk were based on an acknowledged risky life-style. One participant, anticipating repercussions from a sexually active past, acknowledged her risk awareness by saying, "Now I look at everyone as a potential AIDS carrier." This was a conclusion she had reached after assessing her knowledge gained from past involvements, and comparing it to safer sexual guidelines. Another participant based her high risk perception on her current behavior, which included non-monogamous relationships. "I can see that there is a great risk that I'm taking with two or three different partners, but I really try to be as safe as possible." In this case, the participant has acknowledged the potential risk of her non-monogamous behavior, and consistently used condoms in response to her awareness of risk.

Part of the decision about which safer sexual behaviors to adopt was based upon a woman's beliefs about personal susceptibility to STDs. While all participants acknowledged some risk, not all participants experienced this the same way. Risk of STDs, HIV, and infertility were acknowledged as potential negative outcomes, but some participants personalized this risk more than others.

Trust and Commitment

In addition to risk awareness, trust and commitment were influential on a participant's perceptions of personal risk, and ultimately influential on safer sexual behavior decisions. Perception of susceptibility was increased when women indicated a lack of trust. Concerns about trust were directed tactfully at current partners, and more bluntly at men in general.

If I take the HIV test and he takes the HIV test we might slip away from condoms. But right now, I've only seen him for five months. I know I can trust him, but you can't trust anybody totally."

In this case, a participant admitted trust, but did not depend on it to protect her from contracting an STD or reduce her perceived risk. Another example describes distrustful attitudes directed at all men, and also indicated high risk perception.

After being in a relationship where I was partly naive and partly in love, I have a really hard time trusting them [men]. I don't believe anything they say. He's going to say he's not with anyone else, he doesn't have a girlfriend, whatever. That doesn't mean anything to me. I'm going to protect myself.

This perspective does not include trust at all. Because of a past experience, this woman learned to depend only upon herself for protection, and she re-affirms the need for self-protection in future relationships.

Although lacking trust increases a woman's perception of susceptibility, trusting a partner reduced one's perception of risk, especially for women in committed relationships. The decisions about safer sexual behavior were sometimes dependent on the relationship to one's partner. This was true for women anticipating future safer sexual decisions, and for women recalling

past decisions. One woman described her criteria for using condoms with a new partner, “I guess it would depend on whether he had been tested before. It would really depend on him, how open he was, and if I believed him and felt comfortable with him.” This participant indicated that her perception of risk would decrease if she felt comfortable with a partner, and if his responses inspired her trust. When describing a past incident of unprotected intercourse, a different participant explained how trust was demonstrated. “We both trusted each other because, basically by having unprotected sex that night, we could have [infected each other]. Neither one of us knew [if we had anything].” In this experience, trust was based on the assumption that both partners were free from disease and proven by the act of unprotected intercourse. A third participant explained her reasons for unprotected sex, “I guess because he had been tested before... I felt different, really comfortable with him. I knew it was going to be a really long [relationship]. I just really trusted him.” In her case, trust was inspired by both comfort and knowledge of a partner’s previous testing experience.

Trust and commitment were influential on safer sexual behaviors in addition to risk perception. Trust was used to classify an established relationship and to assist in assessment of the need for safer sexual behaviors. In some cases, trust was demonstrated by unprotected intercourse. One reported method of facilitating the establishment of trust in a relationship was to exchange sexual histories with a partner.

Exchange of Sexual Histories

The exchange of sexual histories was an important element of becoming acquainted with a new partner, of assessing the partner’s trustworthiness, and of determining the need for safer sexual behaviors. To accomplish this, the process of discovering a partner’s sexual history often

involved an elaborate interchange of information. "I think a lot of things would be discussed in terms of whether or not my boyfriend has been tested or has had partners and stuff like that." Despite the intricate communication, this process was viewed by participants as less threatening than other types of safer sexual behaviors. "We talked about his past relationships, my past relationships. That's one thing I'm not shy about." Some women discovered more about their partners than others. Women who reported non-committal involvements sometimes skipped this step, but if they were previously acquainted, they felt they already knew enough about each other.

Knowing a potential partner's sexual history was an important element of feeling acquainted with that person. Feeling acquainted, or "knowing," a partner was a preceding step to sexual involvement. "I feel I've got to really know the person, and really trust the person." One participant described her experience with this process, and how it facilitated the acquaintance process.

We talked about his family, and my family. We talked about past relationships: he's only been with (a few) girls, and how many guys I had been with, how long our relationships had been, problems we'd had. I didn't have to be embarrassed to tell him I got an STD because he didn't make me feel bad. He took an interest and wanted to know. He was so honest, and he was asking questions.

If a partner was perceived as being open about his past, he was also believed to be honest. During the actual exchange, how the male partner behaved was as important as the responses he gave. Also, the more interest a partner showed during the exchange, the more positive the attitude formed by the participant. He was more favorably viewed if he was supportive during the woman's revelations, and if he offered his own. If a participant knew the

specifics of her partner's sexual history, it helped her feel more comfortable when sexual involvement occurred: "I felt like I knew enough about him, and he felt the same." Knowing someone's history also helped participants reduce fears of contracting STDs. "The people I've been with I've known reasonably well, so there's not so much concern."

Exchanging sexual histories was an important step towards establishing trust in a new relationship. A male partner was expected to be honest about his past, and his revelations were treated as truth by the participants. If a participant perceived high personal susceptibility to STDs, knowing a sexual history was less influential on safer sexual behaviors. However, believing a partner had been safe in the past, based on his disclosure, frequently led to a decreased perception of a need for safer sexual behaviors in the ensuing relationship.

Finally, when a partner revealed he had been tested for HIV, participants found this to be reassuring of his overall disease-free status. In these cases, the women assumed that their partners were truthful in their disclosures. Awareness of a past test sometimes increased the comfort level to the point that women who habitually used condoms found them to be unnecessary. "I knew he had been tested twice, and he was really honest." Assuming a partner had been tested, based on his admission, decreased participants' perceived need for safer sexual behaviors because they assumed he would not transmit a disease to them.

Exchanging sexual histories was used by the participants to facilitate acquaintanceship with their partners. How the male partner conducted himself could inspire trust in the participant. This trust enabled the participant to believe his disclosures, and assess risk potential based on his revelations.

HIV Testing

While inquiries about HIV testing were sometimes included in a sexual history exchange, HIV testing was sometimes important during later stages of a relationship or after a relationship had ended. Participants felt protected by knowing a partner's HIV test results. Many participants indicated they had considered getting tested themselves to calm their fears of being infected from a past partner. Learning through the sexual history exchange that a partner had been tested for HIV allayed participants' fears of contracting AIDS. Of the twelve respondents, five of the participants had actually been tested; two specifically for the purpose of future sexual involvement without condoms.

Participants sometimes indicated that a partner would need an HIV test prior to sexual involvement or before abandoning condom use. "It's just too scary out there right now. It would have to be something I was really sure of, not just in my mind, but medically." However, the reality of possible test results caused participants not to embrace this behavior.

When the time comes for us to decide whether or not we'll sleep together, that's something I'll have to address. I'm not looking forward to it, I really don't want to discuss it. It's very scary. If you're in love with that person, you don't really want to know if there's a chance you could lose them.

When HIV tests were intended to protect a participant or her partner from infection and condoms were not used, participants reported a past HIV test as an indication of being disease-free. Two participants reported being tested specifically for their current sexual involvement (see Figure 2), and felt this was an essential step for unprotected sex. One participant described her technique for dealing with this emotional issue.

I blamed it on myself. I didn't want to make him feel bad. So, I said, "I was with this horrible guy, and I don't know what he did. I want to protect you. And, since we're there, why don't you get it done too?"

Despite some participants reporting recent testing, more participants reported that several years or several partners often fell in between the testing occurrence and the current relationship. A partner's disclosure about the time, the result, and ensuing behavior was taken as truth by the participant.

Figure 2. Occurrence of HIV Testing Among Participants and Current Partners

^aIf a participant did not specify if her partner had been tested, he was counted as no. ^bEach partner was tested for HIV prior to having unprotected intercourse.

Condom Negotiation

Condom negotiation is the process in which a couple decides whether or not to use condoms. In this study, the condom negotiation process emerged as an interactive and important component of safer sexual behavior. After the participants evaluated their own susceptibility to STDs, assessed their contraceptive needs, and determined their partner's sexual history, they were ready to make a decision about condom use. The motivations and procedures for determining this were varied. However, when behavioral outcomes were separated by whether condoms were used or not used, different negotiation processes emerged.

Factors Promoting Non-Use of Condoms. Specific motivations for not using condoms were related to negative images of condom use, negative images of asking a man to use a condom, insecurity of a woman needing to initiate the process, and involvement in an exclusive relationship. Utilization of an alternate form of birth control further decreased a condom's perceived necessity, especially within monogamous relationships.

Negative images of condom use were reportedly held by male partners, as reported by the participants, and by the participants themselves. Such attitudes were perceived by the female non-verbally, "I got the impression he didn't like them," and verbally, "He just plain told me he didn't like them." The women also reported not liking condoms, "Sometimes I just don't want all that crap in me, so I won't use a condom." Dislike of condoms was a key motivation for deciding against their use.

Women who felt uncomfortable about initiating condom use also had less motivation to use them. Sometimes attitudes reflected personal insecurity in initiating the negotiation process, such as "I'm shy" or "It's uncomfortable." Some women's attitudes were more complex and

personalized than simply not liking condoms. For example, insecurity arose from anticipated partner reactions, “I was afraid he would say ‘you’re being silly.’ ” “If they feel uncomfortable, I feel uncomfortable. If he makes me feel uncomfortable, I may not bring up the topic.” Women who expressed personal discomfort or negative symbolism concerning condoms had less motivation to initiate condom use with their partners. Some women reported that using a condom was symbolic of meaning, “I have something I could give somebody” or “it’s almost like saying you think they have a disease, or you think you do.”

Additionally, condoms were not always perceived as necessary by women in monogamous relationships, which further decreased motivation for their use. Frequently, monogamous relationships were reported as an alternate form of STD prevention. “I guess if I had sex with everyone I would use one, but since I’m always with a particular person (I don’t).” The additional requirement of HIV testing before abandoning condoms was sometimes made. “We don’t use condoms anymore. We did for a long time, and we agreed we’d just be with each other. We were both tested for HIV before we stopped using condoms.” A different approach was being tested for HIV prior to sexual involvement. “I told him we will not have any type of sexual involvement until we got tested, and that’s exactly what we did.” In these cases, the motivation to use condoms for HIV prevention was taken away by the proven absence of the virus and the establishment of a monogamous relationship.

Use of alternate forms of birth control was commonly reported as a reason why condoms were not used. In some cases, couples had been using condoms, but switched to birth control pills. These decisions were based mainly on a perceived need to contracept. “Our decision was more to keep

from having children than to prevent AIDS.” Having taken measures to prevent unwanted pregnancy, the additional protection of a condom was thought to be unnecessary. This was especially common among participants who were discussing a decision which occurred within the context of a monogamous relationship.

Deciding to Not Use Condoms. The process for deciding not to use condoms was sometimes passive and sometimes active. A mutually agreed upon decision not to use condoms was a one-time event for both committed and non-committed relationships. This could occur before the first sexual involvement with a new partner, or in the middle of a relationship.

Decisions at the beginning of a relationship were much more spontaneous and passive. “Neither of us had brought it [using a condom] up. I’m shy, I should have asked, and he said he had trusted me.” In some cases, a woman’s passivity was the result of a man’s activity, “I just went along with it. He convinced me.” “I knew he had them [condoms], I just never pushed it.” In other cases, passivity occurred on the part of both partners. “We never talked about using a condom.” The passive decision was often verbally acknowledged after intercourse. “We had already had sex before we talked about it (contraception).”

Decisions to not use condoms which occurred within a committed relationship were frequently premeditated, involved HIV testing and active agreement from both partners. An active process included verbal agreement between the partners to be monogamous, and occurred before unprotected sexual intercourse. In some cases, both partners agreed to be tested before abandoning condom use. “We agreed we’d both be with just each other.” Once the decision to be monogamous was made, condoms were perceived as unnecessary.

Factors Promoting Condom Use. The motivations reported for using condoms were: a fear of unwanted pregnancy, the decision to use the condom as a primary method of birth control, and a fear of STDs including AIDS. Sexual involvement in a non-monogamous relationship intensified these motivations.

Fear of pregnancy was the most salient motivation cited by participants. Male attitudes about unwanted pregnancy were specifically recalled by the women. "He said he didn't trust me, he wanted to use them [so I wouldn't get pregnant]." When the male partner did not trust the participant to use contraception effectively, he willingly and consistently used condoms. "He doesn't want children, and condoms are the only thing he can do to ensure I don't get pregnant." Female attitudes also reflected that a fear of pregnancy was the primary reason condoms were used. Accessibility and cost were factors which encouraged women to choose the condom over other contraceptive methods. "It was readily available, and it was there. I don't use birth control (pills)." "It's the easiest and cheapest, I don't really know much about any other types."

Some participants, including those using oral contraceptives, also used condoms to prevent contracting an STD. "You have to be safe. You don't know who each other's been with." "I had a couple of flings, and there was no way I wasn't going to use one. I was on the pill, but it didn't matter." For these women, condom use was often referred to as a necessity for sexual involvement. "It's just something that has to be done." "There was no question." "If you don't talk about protection, you're pretty much jumping off a cliff because you don't know anything about your partner. You're talking a risk. I don't feel like risks in this situation should be taken." The high

perception of need to protect oneself from contracting an STD was a strong motivational factor for these women.

Process of Deciding to Use Condoms. The simplest decision-making regarding condom use occurred when male partners wanted to use them and did so. When women were motivated to use condoms, they had to ensure that the male partner was equally motivated. Women described remaining alert for indications that their partners' motivation was decreasing and being ready to re-assert the necessity of use. "If he doesn't have one, we won't have sex." A woman's explanation of how men decided to use condoms was very simple, compared to the elaborate explanations of her own condom experiences.

When men were motivated on their own to use condoms, the procedure was simplified. "He just got the condom, and just used it. I never had to say anything." When the man was motivated to use condoms, he internalized the negotiation process. In these case, women reported minimal or no communication about condom use.

Conversely, women who were motivated to use condoms felt that they were required to verbalize their desire for use. The women were required to remain vigilant and ready to re-communicate this desire every time a condom was to be used. Women felt that if they became passive, the negotiation process would not be prompted, "If I had never said something, the majority would have had sex with me without any birth control." Women were concerned that passivity might lead to the non-use of condoms, and so maintained an active role in their use. "I'm always reminding him, but sometimes he'll do it himself." "He knows he has to wear one, and I make sure he wears one."

Mechanics of Condom Use . Mechanical and aesthetic aspects of using a condom were sometimes reported to be undesirable. More frequently, however, all inclusive statements such as, “we didn’t see it as interrupting,” indicated that mechanical aspects of condom use were less influential than other aspects of safer sexual decision-making.

The participants did acknowledge specific perceptions of the mechanics of condoms when they were unfavorable. However, only two participants reported this. For these women, the condom was seen as a foreign object. One participant described her empathy for men using condoms.

It’s not loving. It’s really distracting to him. I think about it from their point of view. You’ve got this muscle, and it’s very sensitive. Then you stick on this horrible thing to hold it, and it hurts. I don’t understand how they do that.

Although the condoms were viewed by some participants as unnatural and invasive, more participants viewed condoms as a natural part of sex. They did not experience condoms as interfering with sexual involvement.

In summary, condoms were most likely to be used when the male partner wanted to use them, when no other method of birth control was in use, and when the woman would not agreed to have sex without them. Condoms were least commonly reported to be used when the male partner did not like them, when one or both partners had been tested for HIV, and when the participant and her partner were in a committed relationship.

Underlying Influences on Behavior

Throughout the interviews, several concepts were frequently referred to during a participant’s discussion of her experiences. These concepts were

influential as behavioral motivators. They also shaped women's interpretations of their own behavior.

Family Values

Morals and values taught to the participants by their families were sometimes mentioned as influencing a participant's behavior. Based on religious and/or cultural norms held by the participants' families, these values specify behaviors viewed as appropriate or inappropriate for single women.

Family values were most commonly referred to in explanation of a participant's denial of sexual involvement to her family, or when expressing her fear that family members might discover her involvement. For example, sexual activity was sometimes reported to cast a negative light for a woman: "If a girl does it [has several partners] then she's a 'ho. I don't want people to think that's what I am." One participant described her experiences of conflicting values and behavior:

You're not supposed to sleep with anyone before you get married. I feel guilty for going back on what I believed in. I felt like I was betraying my family because they wanted someone who was pure and perfect and the white dress and all of that.

Contraception created an additional area of conflict between respondents' behaviors and their perceptions of family values. "I finally told [my mother] I got on the pill. She was like, 'what are you talking about? Catholics don't do that.' " In another case, "If my mom finds out that I'm on the pill [she'll say], 'What about everything we taught you, what about your morals?' I'm afraid to disappoint my parents in that way." Frequently, the values with which participants were raised were in conflict with their current sexual behavior. These conflicts often extended to their attempts to protect themselves from STDs.

Comfort

Comfort was another underlying influence on behavior. A participant's use of or reference to "comfort" occurred when she was describing her feelings during a discussion with a partner about abstinence, monogamy, and his past relationships. In these cases, participants would describe a situation as comfortable because "we were on the same wavelength" and "he agreed with me." Other related terms included "easy and natural," and "being able to talk about anything." Comfort was also recalled in reference to any behavior a woman felt her partner supported, and to any behavior in which a woman did not care what her partner felt.

Feeling Uncomfortable

Participants identified feeling uncomfortable as influential on behavioral decisions. The term "discomfort" was not specifically used by participants. "Uncomfortable" was frequently used, however. Indeed, almost every aspect of safer sexual behaviors, decision-making, and information gathering was described as "uncomfortable" by at least one participant. While not all participants found every aspect of safer sexual behaviors uncomfortable, feeling uncomfortable about some aspect of safer sex was commonly expressed.

"Feeling uncomfortable" also arose when participants were relating discussions with their partners concerning birth control, particularly when methods if partners were not in agreement over the chosen method. "I get uncomfortable when he talks about the pill, I guess he gets tired of wearing condoms." Additionally, participants expressed feeling uncomfortable in response to their partner's discomfort. As one woman said, "if they feel uncomfortable, I feel uncomfortable." Women who were more experienced with sexual communication skills reported experiencing discomfort less often.

Embarrassment

Participants recalled that experiencing or perceiving embarrassment was influential on their behavior. Participants used “embarrassing” to describe situations which were uncomfortable because other people would be witnesses, or because a participant felt she was breaking a social stigma. For example, buying condoms was embarrassing because “people are going to look at me.” Women became less embarrassed as they repeated a behavior. One experienced participant described buying condoms as “no more embarrassing than standing in the tampon aisle.”

Reported Patterns of Sexual Decision-Making

During the course of the interview, women recounted how they had decided to use a specific contraceptive method or safer sexual behavior. When possible, the decision-making process was reconstructed from current and past relationships. Seven distinct patterns of decision-making emerged. The patterns are grouped by the extent to which the behaviors offer protection from STDs and HIV: those regarded as safe by participants and health professionals (see Figure 3), those regarded as safe by participants but not by health professionals (see Figure 4), and those regarded as unsafe by participants and health professionals (see Figure 5). In all patterns except one contraception was either practiced or unnecessary. The differences in the behavior patterns therefore tend to relate to methods of preventing STDs and HIV, not pregnancy.

Patterns of Safe Behavior

Behaviors which the participants defined as safe and also fit safer sexual guidelines are illustrated in Patterns 1, 2, and 3 (see Figure 3). The three patterns are abstinence, using condoms, or not using condoms after

both partners tested HIV negative. Each occurred within an established relationship. In all of these situations, the protective method was discussed.

Figure 3. Patterns of Decision-Making Behavior Defined as Safe by Participants and Professionals

Behaviors Defined as Safe By Participants but not Health Professionals

Behaviors which participants defined as safe, but are not considered safe by health professionals are illustrated by Patterns 4 and 5 (see Figure 4). The differences in opinion arise because of different applications of safer sexual guidelines.

In Pattern 4, the couple is in an established relationship, and sexual intercourse is preceded by a discussion about condom use because the woman is not using contraception. Condoms are used during sexual intercourse. If a participant indicated she was thinking about going on the pill, it was included in this pattern even if this point had not been reached. Other participants described a pattern of protected intercourse which changed to using the pill and monogamy. This was done to avoid the need to use condoms for pregnancy prevention. Monogamy was expected to protect the woman from STDs. The participants indicated this was safe behavior, as it prevented pregnancy and a monogamous relationship prevented possible infections. Health professionals may or may not consider this safe, depending on how one defines monogamy for single women.

Pattern 5 described consistent condom use, but not in a monogamous relationship. In this pattern, condoms were used “to be safe,” and condom negotiation was initiated by the woman. The condom negotiation process offered the male partner the option of using a condom during sexual intercourse, or not having sexual intercourse. As one woman said, “there was no way I wasn’t going to use it.” Health professionals may not consider these encounters safe because the relationships are not exclusive, but relying on a condom to prevent STDs and HIV may be more effective than relying upon monogamy. While this pattern was not most the frequently reported by

participants, it was usually reported by a participant to have occurred with more than one partner.

Figure 4. Decision-Making Patterns for Behaviors Defined as Safe by Participants, Not By Health Professionals

Behaviors Identified as Unsafe

Behaviors which were identified as unsafe by the participants, and do not comply with safer sexual guidelines, are listed in Patterns 6 and 7 (see Figure 5). In this pattern, a monogamous relationship was established prior to sexual involvement. An extensive exchange of sexual histories also occurred before sexual involvement. The process of condom negotiation was extremely passive or absent between both partners. When sexual intercourse did occur, no condom was used. In this pattern, participants reported that they felt behaviors were unsafe at the time of their initial occurrence. The couple discussed not using a condom after intercourse had actually occurred. The participants acknowledged that, “we should have used it (a condom).” As the relationship continued, perception of safety increased, although the actual behavior remained unchanged. Partners in these relationships continued using only the birth control pill for protection from pregnancy, and relied upon monogamy for STD prevention.

Pattern 7 was reported by only one participant. In this case, no contraception was used initially. Condom use had been discussed and discarded as a desired behavior after the initial intercourse and before use of birth control pills. This respondent acknowledged in retrospect that not using birth control and not using a condom for STD prevention was an undesirable action, describing this behavior as, “stupid.” The participant eventually began using birth control pills and continued to do so until the end of the relationship.

Figure 5. Decision-Making for Patterns Behavior Identified as Unsafe by Participants

Model of Learning Self-Protective Behaviors and Condom Use

The data provided by the participants suggest lifetime patterns of learning safer sexual behaviors and developmental patterns of condom use. The data suggest that, over time, a woman's collective experiences are integrated to define the process of learning how to perform behaviors which will protect her from STDs and unwanted pregnancy. The collective experiences allow the construction of a preliminary model for learning self-protective behaviors (see Figure 6). The lifetime pattern is created by identifying commonly reported experiences about past relationships of the participants.

A common trend uniting all participants was that they have learned from past relationships and experiences. According to the data, women learn from their own experiences and vicariously from the experiences of others. Furthermore, the experiences of the participants describe different stages of learning safer sexual behaviors. Each behavioral phase is reflective of the safer sexual behavior skills a woman has learned. As a woman learns from her experiences, she becomes more adept at incorporating safer sexual behaviors into her own lifestyle. In doing this, she moves towards constructing a relationship more conducive to the use of safer sexual behaviors, and eventually to a safer definition of trust. The steps of this preliminary model are described below.

Naive Trust

Women in the stage of naive trust have few or no skills for self-protective behavior, and they perceive little need for such skills. This stage was often described by younger or less experienced participants or by more experienced participants recalling an early relationship. Not thinking about negative consequences of sexual involvement is how one participant recalls

her own naiveté. “I wasn’t using anything [for birth control], not at first.” Other examples

Figure 6. Model of Learning Self-Protective Behaviors and Condom Use

of behavior found at this stage are trusting a partner for little reason, or having multiple partners with insufficient STD protection. Participants who had passed through this stage describe their earlier behavior as naive, “I was just stupid” or “I was basically blind.”

Negative Experience

A participant recognized her own naiveté when a frightening or sobering event occurred which caused her to recognize a previously unidentified personal risk. This type of negative experience alerts the woman to possible consequences of her earlier actions. These experiences may include discovering that a boyfriend has been unfaithful, getting pregnant, or contracting an STD. One participant gave the example of a late period. “...Praying that you had your period, it was like, ‘Oh God, is it going to come this month?’ ” Another participant experienced this stage by increasing her perception of personal risk. “My boyfriend really opened my eyes about [the need for] condom use.” Whatever the specific experience, “Something happens to you, and it changes the way you look at the world.”

Self-Protective behaviors

At this stage, a participant is aware of possible negative consequences from her sexual involvements and chooses behaviors for their self-protective value. It is at this stage that women are learning to practice effective prevention. Safer sexual behaviors described by the participants included abstinence, condom use, HIV testing, and involvement in a monogamous relationship. Women in this stage often reported using condoms for non-contraceptive reasons. “I know I can trust him, but you can’t trust anybody totally,” and, “There was no way I wasn’t going to use it [a condom].” Monogamy was another reported self-protective behavior. “I said, ‘If our relationship is going to be sexual, then I need to know it’s monogamous.’ ”

While still important, trust was not as influential at this stage on safer sexual behaviors, because women relied upon other means to preserve their safety.

Positive Experience

This stage consists of a positive experience which restores a woman's trust in her partner. An event may occur which causes trust for her partner to develop. In some cases, this occurred when a participant felt her partner had proven himself to be trustworthy, "He was so honest." Other participants relied upon external measures to affirm trustworthiness, "We were both tested for HIV." The common experience of these women is that their trust was validated and resulted in a positive, not self-endangering experience.

Established trust

After a positive experience, participants felt that earned trust had been established. During this stage, a woman may again cite trust as a reason for not practicing condom use. Relationships at this stage were often described in terms of longevity, "We've been together for over two years," and intensity, "It's very serious." Women reported using oral contraceptives for contraception and depended on monogamy to protect them from STDs.

Progression through the Model

Participants reported numerous behaviors which place them at different stages in this model of lifetime safer sexual behavior adoption. Some women had already progressed through several stages, while others had not experienced the progression from naive trust, learning self-protective behaviors, and establishing trust. Women in this latter group were in the process of learning to incorporate safer sexual behaviors into their lives. This model demonstrates the progression of learning to adopt safer sexual behaviors, and learning to identify when they are required. As with any learning process, women may make mistakes or otherwise regress to a

previous stage of the model. When a woman learns from her past experiences, she progresses through the stages. This model also demonstrates how trust, an important element to relationships for most women, is exhibited in ways which can be either threatening or protective.

Summary of Results

Sources of Knowledge about HIV, STDs, and Contraception

All participants indicated high awareness of the possibility of unwanted pregnancies and HIV. Reported knowledge of other sexually transmitted diseases was the least comprehensive, often referring to STDs collectively and rarely to specific symptoms or consequences. The most common source of information about HIV and STDs was a health class at either the secondary or collegiate level. Other sources of knowledge included: television, magazines, doctor's offices, Planned Parenthood, friends, and family members.

Influence of Friendship on Behaviors

Participants reported that their friends supported each other's attempts to make safer sexual choices. Specific supportive behaviors included verbally promoting safer choices, providing companionship for HIV testing, and acquiring condoms for friends.

Influence of Substance Use on Decision Making

Marijuana was perceived as having no influence on safer sexual decision-making. Several participants reported themselves to be non-drinkers and therefore reported no influence from alcohol on their behavior. Some participants reported that they had consumed alcohol after a sexual decision had been made. Other participants reported that alcohol had a strong influence on decision-making and inhibited safer choices.

Contraceptive Behavior

All participants perceived contraception as necessary and performed this behavior with self-assuredness and persistence. Participants perceived their partners as supportive of condom use if it was the primary method of contraception. In some cases, partners were perceived as being very concerned about contraception. Other times, men were reported to have little or passively interest, and to assume that the woman had taken care of it.

Safer Sexual Behavior

Safer sexual behaviors identified by the participants were: knowing a partner's sexual history, monogamy, being tested for HIV and other STDs, using condoms, and using a diaphragm. Practicing any of these behaviors occurred after a participant assessed her perceived risk of contracting HIV, assessed the level of trust in her relationship, determined a partner's sexual history, and negotiated condom use.

Perception of Risk

All participants reported being aware that sexual activity involved a risk of contracting an STD. However, some participants personalized this more than others. Perception of risk was based on both a theoretical possibility of exposure and on personal experiences.

Trust and Commitment

Participants who reported not trusting or not being committed to a partner had a higher perception of risk. Being committed to a partner and trusting him decreased perception of risk. In some cases, trust was demonstrated by having unprotected intercourse.

Exchanging Sexual Histories

Exchanging sexual histories was an important element of becoming acquainted with a new partner, assessing the partner's trustworthiness, and

determining the need for safer sexual behaviors. Participants considered a partner's disclosures to be truthful. A partner was more favorably regarded by a participant if he was supportive during the exchange.

HIV Testing

Knowledge of a partner's HIV test results was sometimes determined during a sexual history exchange, and this allayed participants' fears of contracting STDs. Other participants reported requiring a current HIV test before unprotected sexual involvement. Five participants had actually been tested themselves.

Factors Influencing Condom Use

Factors which inhibited the use of condoms were negative images of condom use, negative images of asking a man to use a condom, insecurity of a woman needing to initiate the process, and monogamy. Factors which promoted condom use were a fear of unwanted pregnancy, condom use as a primary method of birth control, and fear of contracting an STD or HIV.

Underlying Influences on Behavior

Some participants identified several concepts as having a subtle influence on behavior. These were family values, comfort during sexual interactions, feeling uncomfortable during sexual interactions, and embarrassment in a sexual or related situation.

Patterns of Sexual Behavior Choices

Participants identified seven distinct patterns of sexual decision-making. Some resulted in safe behavior, some in behavior which could be considered safe or unsafe, and some patterns resulted in behavior identified as unsafe by participants.

Model of Learning Self-Protective Behavior and Condom Use

The collective experiences provided by the participants revealed lifetime patterns of learning safer sexual behaviors and condom use. Phases of this learning pattern were: naive trust, negative experiences, self-protective behaviors, positive experiences, and established trust. This model demonstrates the progression of learning to adopt safer sexual behaviors and learning to identify when they are required.

CHAPTER 5: DISCUSSION OF RESEARCH

This chapter will discuss the process and findings of this thesis research. The discussion will include validity of assumptions, findings, limitations and significance. In this chapter, implications for future practice and research will be identified.

Discussion of Assumptions

Assumptions about participant knowledge and past experiences, and a general assumption that safer sexual behaviors were desirable, were constructed during this research. The findings indicate that the assumptions about knowledge and past experiences were valid, but that the assumption about the desirability of safer sexual behaviors was only partially accurate.

Knowledge

During the design of this study, it had been assumed that the knowledge of the sample population in this study would be comparable to the knowledge of other college student samples. Because no quantification of knowledge was determined, a comparison is entirely subjective. The sample in this study was older than a typical college student population, but reflective of the age range at San Jose State University (SJSU). The older ages yielded many life experiences, so it is likely that this sample had better knowledge of HIV and STDs. Many of the participants acknowledged their own risk of contracting an STD and appeared to be less naive about disease transmission than the younger samples reported in previous literature (Butcher et al., 1991; Carroll, 1991; Dilorio et al., 1993; Holland et al., 1992; Manning et al., 1989).

Past Experiences

By consenting to be interviewed for this study, it was assumed that the participants would have experienced a situation relevant to the scope of the

research. This assumption was valid, and the interviews yielded a wide range of information and experiences. Both less experienced participants and more experienced participants were able to recount the sophisticated, and sometimes subtle interactions around contraceptive and STD prevention decision-making. More experienced women were able to offer several versions of this process, but each participant offered unique and valuable experiences during data collection.

Desirability of Safer Sexual Behavior

The participants indicated during the interviews that sexual experiences free from potential STD and HIV contraction were desirable, as was originally assumed. This construction of desirability was based on both theoretical knowledge and anecdotal data. However, participants also revealed that not all safer sexual behaviors were considered desirable, even though safer interactions were a desired outcome. Some participants indicated that condoms were not desirable, monogamy was not desirable, and HIV testing was not desirable. The assumption that women want risk-free sexual experiences which will not expose them to disease was accurate, but the assumption that the behaviors necessary to achieve this safety were also desirable was not accurate.

Limitations

The intent of this research was to facilitate a process in which women recounted in their own words their experiences and decisions regarding safer sexual behavior and to explore these experiences. For this reason, any experience offered was considered valuable and significant and contributed to the exploration. However, there were several limitations inherent in this methodology, all anticipated from the outset. First, the research was dependent upon the participants' willingness to disclose personal information.

It is important to acknowledge that the data reflect only those perceptions and experiences that participants chose to share; the responses may not have reflected the full complexity of actual lifestyle behaviors. Painful and embarrassing experiences may have been withheld.

This study may have had a self-selection bias. The women who consented to participate may have been more comfortable discussing sexual behaviors than women who chose not to participate. Participant comments may have been further influenced by their knowledge of recommended safer sexual behaviors, or by a sense of preferred response, rather than responses based on actual experiences.

Because this exploratory study was based on a purposeful sample, the experiences cannot be generalized to broader populations. Due to the small sample size, not all types of experiences may have been reported before interviewing was discontinued. Due to the use of participant referrals, similar experiences may have been reported by women who were friends or acquaintances. This could give the impression that an experience is more common than is actually true.

Limitations also arose during the course of the research. For example, the ethnic representation of the sample population was not reflective of the ethnic diversity of San Jose State University. In the study sample, African American, Asian, and South Pacific Islander ethnicities were not represented. Also, the ages of the women interviewed were older than a typical population of college students. This may be due to a selection bias, or because the student population at SJSU is older than a typical university. Although the age range of the sample does reflect the older SJSU population, the experiences of these women may not be comparable to those of a younger sample. While this limits generalization, the data offered a wide range of

experiences which may not have been detected in a homogenous college student population.

The data collection and analysis processes also revealed some limiting factors. Because the participants controlled the progression of the interview, some topics were addressed in more depth than others. This yielded an uneven amount of data from each participant for each topic. Furthermore, some participants offered no response on some topics, and the data pool for that topic was then smaller. These topics were not pursued because of a participant's discomfort or reluctance to disclose personal information. Finally, because the interviews were tape recorded, parts of a participant's response was sometimes lost if her voice lowered or another distracting noise interfered with the remainder of a comment. This was not noticed at the time of the interview, and occasionally a phrase was lost during transcription. All of these limitations, expected in qualitative research, must be acknowledged when considering the implications of the findings.

Discussion and Implications

General Knowledge

Other research has found that college students' knowledge of HIV transmission and prevention is very high (Dilorio et al., 1993; Keller, 1993; O'Leary et al., 1992; Radius et al., 1991), and a solid knowledge of HIV transmission and prevention was reflected in participants' comments in this thesis. Knowledge of prevention of other STDs was found to be less accurate in other studies (Dilorio et al., 1993; Radius et al., 1991). In the thesis sample, knowledge of other STDs was less accurate and less salient than knowledge of HIV. For example, one participant incorrectly indicated that a diaphragm could protect her from infections. Also, comments about other diseases were rarely offered. The lack of comments or concerns raised about

STDs may indicate that they are not perceived to be as significant a threat as HIV.

Sources of Knowledge

It is important to recognize that the knowledge referred to is abstract, theoretical information. The sources of knowledge which were reported by the participants (classes, television, doctors offices, and books) tended to be information-oriented rather than oriented toward behavior modification. Educational sources should include behavioral sources as well as informational knowledge sources.

If behavioral knowledge is not effectively taught in a formal curriculum, a person may still gain knowledge about behavior from other sources. Knowledge from other sources was reported by participants when recalling situations from their own experience or situations recounted by friends. Knowledge was sometimes learned at the very time that enacting the new behavior was required, such as the first time a woman needed to tell a male partner to use a condom.

The important distinction between abstract information and behavioral education should be determined in both research and practice when referring to HIV and STD prevention knowledge. As research has previously shown (Carroll, 1991), informational or factual knowledge about HIV does not predict preventive behaviors. This indicates that further research needs to be done to determine sources of behavioral knowledge and how it can be broadly and successfully incorporated into health education.

Influence of Friendship

Participants reported that friends were involved in many stages of safer sexual behavior, including promoting safer choices, providing companionship for HIV testing, and providing condoms. Female friendships were an

important factor in influencing choices about safer sexual behaviors and have been adapted to promote preventive behaviors.

According to participants in this study, women assist each other in learning to apply safer sexual behaviors to their own lives. This is accomplished by providing friends with information, warnings and tools, such as condoms, to maintain safer behavior. This is one forum where behavioral knowledge is both taught and learned. For example, a participant described how her friend assisted her in learning to buy condoms by putting them in her shopping cart. The participant reported that she now performs this behavior independently and with less embarrassment.

These friendships illustrate a natural incorporation of teacher and learner roles. This may be one reason that peer education programs are successful. Health educators could incorporate friendship into outreach and prevention programs by assuming that educated women will have better information to share with their friends and may be the most effective teachers.

Alcohol Influence

The anecdotes from participants in this study offer several hypotheses regarding the influence of alcohol on safer sexual decision-making. Commonly held conceptions suggest that drinking alcohol causes impaired judgment leading to unprotected sexual involvement. For example, Meilman (1993) noted that when women drank alcohol, they abandoned safer sexual behavior much more often than did men. Some participants reported that alcohol caused them to make poor decisions about safe sexual involvement. As one participant explained, "When you're drunk you're more easily convinced to sleep with someone."

The findings of this study offer additional insight into the influence of alcohol. Some participants adamantly stated that alcohol had not influenced

their past choices or past condom use. The lack of influence is supported by Temple et al. (1993), who found that alcohol consumption did not predict condom use by women. Other examples offered by study participants suggested that anticipated sexual involvement had encouraged them to consume alcohol. Alcohol was expected to give courage and make a sexual involvement seem less threatening. This explanation has not been noted in other research. In this sample, when decisions about sexual involvement preceded drinking, no protection was used.

Future research should attempt to generate additional and alternative explanations for the dynamics of alcohol and sexual behavior. The explanations developed in this thesis challenge traditional assumptions about why women drink in sexual situations and have important implications for safer sexual behavior. Further qualitative research is needed to understand why women may perceive a need to make a sexual involvement less threatening. The answers to this question, suggested by this study's respondents, may relate less to alcohol consumption, and more to a woman's experience of her own sexual activity.

Contraceptive Behavior

All participants perceived contraception as necessary. While many women used female-controlled methods such as the pill, some women were dependent on the condom for contraception. Although the condom is a male-controlled device, the women who relied upon it were very empowered, and used it much more successfully than women who reported using condoms for STD prevention.

According to participants, men appeared willing and capable of practicing contraception by using a condom with each act of intercourse. The interviews indicated that using condoms for contraceptive reasons was

perceived differently by both men and women than using condoms for preventive purposes. Using a condom for contraceptive reasons did not evoke the negative symbolism which the preventive reasons generated. Also, because pregnancy is a concern during heterosexual intercourse regardless of one's partner, contraception was practiced with greater vigilance. Participants were highly aware of this themselves and felt that their male partners were also.

This finding raises the question if men are able to practice contraception with a condom effectively, why is this behavior not transposed to STD prevention? It is true that almost all women can become pregnant, while only some women can transmit an STD. Do men perceive a greater threat from pregnancy than an STD? Further research should examine men's attitudes about contraception and STD prevention to answer these and other related questions.

Safer Sexual Behaviors and Misconstructions of Safety

An important finding of this research was that the actual practice of safer sexual behaviors is based on the combined result of many steps; perception of risk, assessing trust and commitment, exchanging sexual histories, and assessing the need for HIV testing. If it was determined in one of these steps that safer sexual behaviors were not needed, they usually were not practiced. These steps were also used to determine which type of safer behavior might be required.

Participants generally were accurate in their knowledge about safer sexual behaviors. However, participants believed that several behaviors provided more protection than they actually offered. These behaviors were monogamy, sexual history exchange, and HIV testing. The exploration of how these factors are incorporated into the safer sexual decisions of the

participants illustrate the potential for unsafe behaviors to be perceived as safe. Health education programs need to clarify confusion about these factors. One approach to this may be incorporating these findings into a comprehensive education and prevention program; another approach may be to focus an intervention to address monogamy, sexual history exchange and HIV testing individually.

Monogamy

Monogamous involvement with one uninfected partner is generally regarded as a safer sexual behavior. Participants were aware of this and expected their own monogamous behavior to provide protection from STDs and HIV. However, only two of the nine participants reported current monogamous involvement lasting for two years or longer, in which both partners had been tested for HIV. More frequently, participants reported a monogamous relationship of less than one year, and they also reported several preceding monogamous, or non-monogamous involvements.

A sexual history pattern consisting of short-term committed relationships and inconsistent condom use was reported by several participants. Although the participants defined their relationships as monogamous, and expected the protection implied by monogamy, their definition was very temporary. It did not include the long-term involvement which provides the safety suggested in the safer sexual assumption of monogamy. This mislabeling may in part be the result of negative images women have concerning noncommittal involvement. Women may feel the need to define their relationships as monogamous to both fit social norms and the recommended safer sexual guideline.

The experiences of monogamy reported in the thesis are similar to what is cited in Dolcini et al. (1993) in which younger women were more likely

to have more than one partner in one year than older women, and less likely to be monogamous for five years. Expecting a young, single woman to be monogamous for five years is contrary to typical behaviors of her cohort and to statistical estimates. Having multiple or successive partners is common to this demographic group. This understanding has important implications for health education and practice. Health professionals should not recommend monogamous involvement with an uninfected partner as a risk reduction strategy to young, single people, because it may well foster a false sense of safety.

Sexual Histories

All participants had experienced a sexual history exchange and considered it a valuable aspect of risk assessment and trust establishment. This questioning was viewed by participants as less threatening than other safer sexual behaviors. This is unfortunate, because it is also less protective. Several factors make this a dangerous behavior on which to rely for protection.

Participants relied on talking with a partner about his past sexual involvements to determine how sexually active he had been in the past and how much risk he represented. The conversation was conducted with the assumption that the partner would tell the truth, and his revelations were treated as such. Participants were often impressed with a partner's perceived honesty. Participants recalled that a partner appeared to be honest, which inspired trust and sometimes led to unprotected intercourse, perhaps a riskier behavior than if trust had not been perceived. A partner was also more favorably viewed if he was perceived as supportive during the female partner's revelations. This indicates an important parallel evaluation going on while the woman is evaluating the truthfulness of a potential partner's self-

revelations. Participants felt that, in addition to the information offered by the men, they could determine from his reaction to their own stories. From this dual diagnosis, women made decisions about whether or not safer sexual behaviors were required.

However, data from Cochran and Mays (1990) has shown that men lie about fidelity and the quantity of sexual involvements significantly more often than women, and intend to lie about these things significantly more than women. In Cochran and Mays (1990) women also reported lying, but in general a woman may expect a similar amount of dishonesty to occur from men as the woman would offer. As indicated from the participants in this study, women may not anticipate the increased frequency at which male dishonesty occurs and may make evaluations based on a perception of greater honesty than actually exists.

Disclosures about HIV testing are an example of how perceptions of honesty and safety influence behavior. If a partner disclosed that he had been tested for HIV, a participant frequently assumed that he was disease-free. Although several other partners or several years may have lapsed since his test, the assessment of safety was often still made. A partner's disclosure of an active sexual past was an indicator to a participant that he may not be disease-free. If he disclosed other things, such as having an HIV test, it is possible that this counter-balanced concerns, and that the woman would consent to unprotected intercourse. This was particularly true if she had assessed his character positively.

Asking partners about their past to determine risk is also unsafe because many men have asymptomatic STD infections; the man being "interviewed" possibly would not be aware of any infection and might not be able to acknowledge it. Symptom presence, such as odor, blisters or scabs

would not be present to alert a woman to a possible disease, should she know to look for such things.

The reality of the dangers inherent in relying upon sexual history exchanges do not exist in the minds of the women who use sexual history knowledge as a safer sexual behavior. This behavior is often used as a risk reduction strategy because a woman feels incompetent or uncomfortable with other safer sexual behaviors; she may practice sexual history exchange in an attempt to gain whatever protection it offers, regardless of how little. More frequently however, women regarded this behavior with a great deal of faith and efficacy. These women may place themselves at higher risk than women who practice other safer sexual behaviors such as condom use. Holland et al. (1992) wrote that women who practice the exchange of sexual histories expose themselves to more risk than if the exchange had never taken place. Data from this thesis supports this, since women who were not aware of, or didn't care about a partner's past were more adamant about condom use than women who "knew" their partner's past.

Some participants were aware of a partner's safe sexual history and still used condoms. For them, knowing a sexual history was merely part of being better acquainted with a partner. Other women abandoned safer sexual behavior when they learned of their partner's history. It is for those women who use sexual histories as a method of risk reduction that interviewing can lead to more risk exposure than she anticipates.

To better understand the importance of the sexual history exchange process, it is important for future research to further define what information women hope to obtain from such a conversation, and how women expect it to protect themselves. Practical implications relate to the need for health

educators to actively dispel the myth of protection perceived by many students. While being intimately acquainted with a partner may be important in establishing a close relationship, it is important for women to learn to assess protection based on criteria other than intimacy.

HIV and STD Testing

Asking a partner to take an HIV test was not a behavior the participants commonly performed. Explanations for this could be a participant's fear of causing discomfort, or fear of provoking negative images of HIV testing. One participant explained it as, "If you're in love with that person, you don't really want to know if there's a chance you could lose them." This explanation also is contingent upon fear and may discourage the use of testing.

A preferred way of acquiring knowledge of a negative test result was to ask the partner if he had ever been tested. This strategy had inherent problems, similar to those associated with discussing a sexual history. Participants who used this behavior assumed that their partner was truthful about his past testing experience. However, in the Cochran and Mays' (1990) study, 24% of the men indicated they would lie about having a positive HIV test result. This indicates that asking a partner about HIV results is an inadequate strategy for self protection.

An additional problem with asking a partner about testing experiences is that even a negative test result which was several years old was accepted by participants as adequately protective. This gap between testing and involvement allows the possibility that the partner could have been infected in the ensuing years, or that a negative result had not yet shown up at the first testing. Because HIV has a six-month incubation period before a positive test will be detected, even a partner who had been tested recently could be infected.

Finally, the testing conversations reported between participants and partners were exclusively directed at HIV. After determining that a partner was not infected with HIV, the participants reported few precautions for other STDs. Participants never reported asking a male partner to be tested for other STDs prior to sexual involvement, and a woman had no way of determining if her partner was carrying a disease or not. Participants may have assumed themselves to be safer from disease than they actually were. In several cases, this led to unprotected sexual intercourse. It is possible that an STD seems less threatening than HIV, and thoughts were focused on a more salient threat. The gap could also be indicative of a lack of awareness or a lack of concern about the severity of other sexually transmitted diseases.

Educational efforts should attempt to address and allay the high levels of fear associated with the HIV test, and to frame the test as a means of protecting oneself and one's partner. By reducing fears or making them more manageable, perhaps HIV testing will be a more commonly employed safer sexual behavior in the future. Educational efforts directed at STDs should also promote STD screening, particularly for men. Increasing STD screening will help decrease the spread of STDs in this population, and help prevent men and women from infecting each other.

Condom Use

An important finding which arose when participants were discussing condom use was that a decision not to use condoms was often a one-time decision in a relationship, but a decision to use them had to be made each time a condom was to be used. The constant need for discussion appears to be one reason that using condoms is more challenging than not using condoms. Also, to maintain use, a person must be deeply committed to the

importance of use. A casual attitude is not likely to promote the necessary vigilance for continual use.

Condom use was reported to be heavily dependent on a man's desire for their use. When men wanted to use condoms, they were very capable of exerting a positive influence on safer sexual behaviors within the relationship. In these cases, the decision-making process was largely internalized within the man and dependent upon his wishes. In contrast, when a woman wished to use condoms the decision-making process was very verbal, but still dependent on the man's wishes unless he was given no other options. When the male partner did not wish to use condoms, they were frequently not used, or required strong urging from a female partner for use.

Men were reported to be less enthusiastic about condom use than the participants reported themselves to be. This placed a much larger burden of the responsibility for condom use on the women. An additional challenge for women was presented when men were non-verbal about their intentions regarding condoms. In these situations, women felt they had to anticipate, or guess, about future intentions. Directly asking about a man's intention seemed to be an option women considered and often rejected either because of awkwardness or passivity. The exception to this was when a woman insisted on condom use. The experiences of the participants indicate that the male partner has a greater amount of control in situations involving condom use. The accounts also demonstrate the greater potential for increased safer sexual behavior when men offer their support.

Future research needs to explore men's experiences with condom use decision-making. Combining the experiences of men and women would provide greater understanding of the dynamics of condom use decision-making, and complement the missing perspectives in a single gender study.

Practical implications include a need to promote communication skills between couples and sexual partners. Women need to practice and feel comfortable discussing condoms with men. Men need to learn the importance of having such a discussion and how to contribute to a comfortable experience.

Patterns of Sexual Behavior Decision-Making

Seven patterns of sexual involvement were charted, based on participant disclosures. These patterns had common elements of trust and commitment, exchanging sexual histories, and discussing sexual involvement and birth control. The presence of these elements in six of seven patterns indicates the importance of these factors in establishing sexual involvement. A second important finding is the constant progression through the order of these steps reflected in the patterns. The identification of the progression is important because it provides a model of sexual involvement.

The plotting of the patterns also revealed a discrepancy between what is perceived as safe and unsafe by health professionals and those performing the behavior. In both cases, the discrepancies centered on monogamy. In one pattern, non-monogamous sexual intercourse with condoms is described. Participants defined this as safe, because they were taking the precautions which were possible and relied only upon the condom for protection. Health professionals may not consider this safe because the relationship was not monogamous, even though steps were taken to ensure safety. In the other pattern, monogamy was present but no condoms were used. Participants described themselves as safe and relied upon monogamy to protect them. Health professionals may have varying opinions on this matter because long-term monogamy is considered safe, but extended monogamy is uncommon in college populations.

The way in which monogamy has manifested itself as a safer sexual behavior in the college student population often exposes many women to more risk than they might anticipate. Health professionals working with college student populations need to recognize the interpretations of monogamy created by this age group. Implications for practice need to focus on clarifying the concept of monogamy. Future recommendations of monogamy as a safer sexual behavior for this population should be avoided.

Learning from Experiences

An important finding in this study was that the experiences or skills learned from one relationship may be carried over and practiced in the next relationship. This was illustrated in Chapter 4 by the Model of Learning Self-Protective Behaviors and Condom Use. Behavioral knowledge and safer sexual behaviors are frequently learned within the context of relationships or sexual interactions.

Participants in this study recalled events from a first relationship which were uncomfortable and often unsafe. This might indicate that safer sexual behavior skills are only practiced or learned when an opportunity to use them arises, such as when beginning a new relationship. If a woman's first experience with safer sexual behaviors is with a new partner, her inexperience will be greatly influential on the degree of safety practiced in the ensuing relationship. Women have very little opportunity to learn necessary self-protective skills before they are called upon to practice them. In contrast, older women who reported the safest behaviors identified their own learning process through relationships as an explanation for current behaviors.

Women need a forum in which to practice and become comfortable with safer sexual behaviors before they are actually needed. Developing educational interventions which allow for the behavioral learning process to

occur, or extending the reach of existing programs, would offer women an opportunity to learn these skills and to become more adept at practicing safer sexual behaviors.

Women's Behaviors

Women reported many aspects of safer sexual behaviors to be uncomfortable, such as talking about condom use and HIV testing. One explanation for this is that women do not have the skills to negotiate a situation with the grace they would prefer. However, responses of some women who indicated that sexual involvement was an inappropriate behavior for single women give rise to alternate explanations. Successfully practicing safer sexual behaviors requires women to use skills which are contrary to perceived images of femininity. These skills require women to exhibit behavior characteristics, such as assertiveness or adeptness at condom use, which are stereotypically not feminine. Safer sexual behaviors require acting out these behaviors during a sexual interaction, an environment in which a woman is attempting to maintain her desirability and femininity. These behavior traits may be perceived as contrary to some women's conceptions of desirable behavior, such as softness and modesty. The conflict of these ideals is likely to manifest itself in a compromise of safer behaviors until women learn to reconcile the images of safety and desirability.

Another interesting aspect of women's sexual behavior is the incorporation of trust into many aspects of decision-making. Trust has been reflected in almost every aspect of decision-making and establishing relationships. American culture embraces relationships, of which trust is an important element. Most women were reared to find a relationship and to experience love and trust as a part of it. Trust, in the context of safe sex, can be counter-productive for most self-protective behaviors. Frequently, when a

woman reported a naive trust, she was also practicing unsafe, unprotected sexual behaviors. Learning to trust a condom for protection rather than a partner requires women to break cultural beliefs about the construction of trust in a relationship. It challenges her to to reconstruct trust so that she need not relinquish protection as a sign of trust.

Significance

By exploring women's experiences with safer sexual decision-making, this study was able to identify crucial elements in this process, including the role of trust which was found throughout these experiences. This study has also helped identify and describe the different situations in which women feel uncomfortable and confident when practicing safer sexual behaviors. This research has described in detail participants' experiences of sexual decision-making, charted reported behavior steps, and drawn common experiences from all participants. The descriptions of patterns, stages, and steps has identified specific intervention targets for educating women. The experiences of the women have been assimilated to demonstrate the process of learning safer sexual behaviors.

Most importantly, this research gave women the opportunity to explain the choices they made, and to share their experiences. Presenting the data from the emic perspective was an important means of describing the perceived environment in which the choices were made. Risk taking behavior is sometimes regarded by outsiders as irresponsible or daring. However, by letting women explain their motivations, they have illustrated the complexity of their decisions and the various means they employ to protect themselves.

Summary: Implications For Practice

Several of the following implications have been identified in earlier sections of this chapter and all are based on the findings of this research.

This study defined specific steps within the larger process of safer sexual decision-making. By defining these steps, specific foci for educational interventions have been identified. Each step within the decision-making process has outcomes which influence the adoption of safe sexual behaviors. The data presented in this thesis makes it possible to focus educational interventions on very specific aspects of sexual decision-making. Following is a summary list of these implications for health education which emerged from the data:

1. Health educators should incorporate women's friendships into outreach and prevention programs. Educated women will have better information to share with their friends and be more effective teachers.
2. Health professionals should not recommend monogamy as a risk reduction strategy to young, single people. This population commonly has multiple or successive partners, and offering monogamy as a risk reduction strategy fosters a false sense of security.
3. Health educators need to actively dispel the myth of protection offered by sexual history exchanges, and instead, teach people to rely upon more effective safer sexual behaviors.
4. Health educators need to help people manage their fears about HIV testing, and focus attention on the protective benefits of the HIV test.
5. Health professionals should increase awareness and frequency of STD screening for men and women.
6. A need exists to promote communication skills between couples and sexual partners. Women need to increase skills for talking with partners and promoting comfort, and men need to increase their understanding of the importance of verbal communication and how to promote comfort. Currently, the responsibility for contraception and STD prevention rests primarily on

women. However, a few examples of pro-active men have demonstrated the positive influence they can have on these processes. Educating men to take responsibility for contraception and for STD prevention will relieve the uncertainty experienced by many women. Teaching communication skills to men, for use during sexual negotiations, will also help to distribute power and responsibility more equitably.

Summary: Implications for Research

This thesis has identified several directions for future research and has generated some specific questions to be addressed. Most implications have been previously discussed in this chapter and emerged from the findings of this study. These new directions are summarized below.

1. The distinction between informational knowledge and behavioral knowledge should be made in studies focusing on “knowledge rates.” Further research needs to determine where people are learning behavioral knowledge, and how it can be broadly and successfully incorporated into health education.

2. Further research is needed to generate additional and alternative explanations for the influence of alcohol on sexual behavior. The explanations offered in this thesis should be tested for prevalence. A final research need regarding alcohol use is an exploration of why women reported a need to drink prior to sexual involvement? Why was sexual involvement perceived as threatening?

3. The question of why men who effectively practice contraceptive condom use do not transpose this behavior to STD prevention should be addressed. Do men perceive a greater threat from pregnancy than an STD? What are men’s attitudes about contraception and STD prevention?

4. Research has demonstrated the ineffectiveness of sexual history exchanges. Despite this, sexual history exchange is embraced by women as a essential part of sexual decision-making. Future research needs to address what types of information women hope to actually attain from a sexual history exchange, and how women expect this knowledge to protect them.

5. The findings of this study suggest that men's sexual decision-making is a largely internalized process. Future qualitative research needs to further explore and describe men's experiences with safer sexual decision-making. This research should be expanded to address the decision-making experiences of couples, and to explore the dynamics of gender and power within the decision-making process.

6. A replication of this qualitative study with a larger sample size would provide more validity and generalizeability to the findings. Using a much larger sample of many ages, ethnicities, and educational levels would add depth to the findings presented here, and illuminate areas which were not represented in this sample. These results could be used to design a more specific interview instrument. A more specific focus could generate more comprehensive data from participants on any of several key topics. Conducting a similar study with a sample of men would be an interesting counterpart to this thesis. Additionally, a study population of couples could examine, from both gender perspectives, how couples decide on a sexual behavior. It would also add insight into the gender dynamics so important in this type of decision-making. Such research could then be adapted into a quantitative study design to determine the prevalence of the generated data.

Finally, additional research needs to examine how a woman's experience of her sexuality influences her sexual behavior. Understanding

the choices a woman makes is crucial to understanding her experiences as she navigates her sexual behaviors.

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Appendix A

1. Introduction

1.1. Describe your relationship with your partner.

2. Assessment of safer sex behaviors

2.1. How much did you know about your partner's past?

2.2. How much did your partner know about your past?

2.3. What have been your experiences with HIV testing?

2.4. What kinds of HIV education have you had?

3. Description of context of condom use and non-use

3.1. Describe your relationship with your partner.

3.2. Describe the context of the first time you were sexually involved with your partner.

3.3. Describe the use of contraception that was used, if any.

4. Experiences when negotiating condom use or during non-use

4.1. Describe any planning that occurred or why none occurred.

4.2. If condoms were ever discussed, how were they brought up?

4.3. How was the decision reached?

4.4. What was said that made you comfortable?

4.5. What was said that made you uncomfortable?

4.6. What was the environment like?

4.7. What kind of influence did alcohol or drugs have?

4.8. What wasn't discussed that you felt should have been?

4.9. What was your impression of non verbal communication (e.g. body posture, voice tone)?

4.10. How did that make you act?

5. Feelings of woman when negotiating condom use or non-use
 - 5.1. What were your feelings before condom use non-use?
 - 5.2. How did you think you were supposed to act?
 - 5.3. What were your thoughts or feelings during interaction with partner?
 - 5.4. What were your feelings after the experience, including long term feelings, hindsight.
6. Comparison of current behavior versus past behavior
 - 6.1. How is your behavior different or similar to your partner now versus when you first were together?
 - 6.2. How is your behavior different or similar with other partners (if any)
 - 6.3. What caused the change or what confirmed your current behavior?
 - 6.4. What do you think is your greatest influence for your current behavior?
 - 6.5. What do you think was your greatest influence on past behavior?
 - 6.6. How do you feel about your current behaviors?

Appendix C

Dear Participants,

I would like to thank you all for your willingness to be interviewed for my thesis. I appreciate your trust and candor, and was able to document a wide range of experiences due to your openness. Each participant's confidentiality was protected during the write up, but you might enjoy reading the thesis and looking for your own comments or experiences. If you would like to read the entire thesis, it will be located in the SJSU library after December, 1994 under my name (Jennifer Gregson). I have enclosed a brief summary of the thesis findings for those of you who are interested. Thank you all again for your valuable contributions.

Sincerely,
Jennifer Gregson

Summary of Results

Participants

Twelve participants consented to be interviewed. They were aged between the years of 19 and 34, and represented White or European American, Mexican American or Hispanic, Middle Eastern, and Filipino ethnicities. The participants had all experienced condom use, and the sample had used a variety of other contraceptive methods.

Sources of Knowledge about HIV, STDs, and Contraception

All participants indicated high awareness of the possibility of unwanted pregnancies and HIV. Reported knowledge of other STDs was the least comprehensive, often referring to STDs collectively and rarely to specific symptoms or consequences. The most common source of information about HIV and STDs was a Health class at either the secondary or collegiate level. Other sources of knowledge were: television, magazines, doctor's offices, Planned Parenthood, friends, and family members.

Influence of Friendship on Behaviors

Participants reported that their friends supported each other's attempts to make safer sexual choices. This included verbally promoting safer choices, providing companionship for HIV testing, and acquiring condoms for friends.

Influence of Substance Use on Decision Making

Participants offered responses about the influence alcohol and marijuana. Marijuana was reported to have no influence on safer sexual decision making. Several participants reported themselves to be non-drinkers, and therefore reported no influence from alcohol. Some participants reported that they had consumed alcohol after a decision had been made. Other participants reported that alcohol had strong influence on decision making, and inhibited safer choices.

Contraceptive Behavior

All participants perceived contraception as necessary, and performed this behavior with self-assuredness and persistence. Participants reported their male partners to be supportive of condom use if it was the primary method of contraception. Male partners were sometimes reported to be very concerned about contraception, and other times men were reported to passively assume the woman had taken care of it, or not care at all.

Safer Sexual Behavior

Safer sexual behaviors identified by the participants were: knowing a partner's sexual history, monogamy, being tested for HIV and other STDs, using condoms, and using a diaphragm. Practicing any of these behaviors occurred after a participant assessed her perceived risk of HIV contraction, assessed trust in a relationship, determined a partner's sexual history, and negotiated condom use.

Perception of Risk

While all participants reported being aware that sexual activity involved a risk of contracting an STD, some participants personalized this more than others. Perception of risk was sometimes based on a theoretical possibility for exposure, and sometimes based on a personal experience.

Trust and Commitment

Participants who reported not trusting or not being committed to a partner had a higher perception of risk. Being committed to a partner and trusting him decreased perception of risk. In some cases, trust was demonstrated by having unprotected intercourse.

Exchanging Sexual Histories

This process was an important element of becoming acquainted with a new partner, of assessing the partner's trustworthiness, and of determining the need for safer sexual behaviors. Participants considered a partner's disclosures to be truthful. A partner was more favorably regarded by a participant if he was supportive during the exchange.

HIV Testing

Knowledge of a partner's HIV test was sometimes determined during a sexual history exchange, and this allayed participants' fears of contracting STDs. Other participants reported that a current HIV test was required before unprotected sexual involvement. Five participants had actually been tested.

Factors Influencing Condom Use

Factors which inhibited the use of condoms were negative images of condom use, negative images of asking a man to use a condom, insecurity of a woman needing to initiate the process, and monogamy. Factors which promoted condom use were a fear of unwanted pregnancy, condom use as a primary method of birth control, and fear of contracting an STD and HIV.

Underlying Influences on Behavior

Some participants identified several concepts as having a subtle influence on behavior. These were: family morals and images of femininity, comfort during sexual interactions, feeling uncomfortable during sexual interactions, and embarrassment in a sexual or related situation.

Patterns of Sexual Behavior Choices

Participants identified seven distinct patterns of sexual decision making. Some resulted in safe behavior, some in behavior which could be considered safe or unsafe, and some patterns which resulted in behavior identified as unsafe by participants.

Model of Learning Self-Protective Behavior and Condom Use

The collective experiences provided by the participants revealed lifetime patterns of learning safer sexual behaviors and condom use. Phases of this learning pattern were: naive trust, negative experiences, self-protective behaviors, positive experiences, and establish trust. This model

demonstrates the progression of learning to adopt safer sexual behaviors, and learning to identify when they are required.