

## **Relational influences on condom use discontinuation: A qualitative study of young adult women in dating relationships**

Melissa Bolton<sup>1</sup>, Alexander McKay<sup>2</sup>, and Margaret Schneider<sup>1</sup>

<sup>1</sup> Graduate Department of Adult Education and Counselling Psychology, Ontario Institute for Studies in Education, University of Toronto, Toronto, ON

<sup>2</sup> The Sex Information and Education Council of Canada, Toronto, ON

**Abstract:** A large proportion of young people move from one sexually active dating relationship to another over the course of their teen and young adult years. A common behavioural pattern is for dating couples to use condoms the first time they have sex but to discontinue condom use as the relationship progresses and contraceptive pill use increases. A repeated pattern of condom use discontinuation in a series of dating relationships over time places individuals at an increased risk of sexually transmitted infection (STI). This study used qualitative methods to examine and illuminate the psycho-social dynamics of condom use discontinuation within dating relationships. Thirteen young women aged 18-24 currently in dating relationships were surveyed and interviewed concerning factors influencing condom use decision-making. All of the participants used condoms the first time they had intercourse in the current relationship but over half did not use condoms at most recent intercourse. A number of themes and factors were evident in influencing patterns of condom use including general but unconfirmed assumptions about the monogamous status of the relationship and the partner's sexual history. For many of these young women condom use discontinuation was associated with an enhanced sense of trust, intimacy, and pleasure with the partner and signified a transition to a more formal relationship status. Less than half of the participants had received STI testing but those who had were confident that negative results indicated that they were at low risk for infection. The results suggest specific issues that need to be addressed in sexual health education for teens and young adults.

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### **Introduction**

Lack of consistent condom use places many young adults at high risk for sexually transmitted infections (STI) (East, Jackson, O'Brien & Peters, 2007). The incidence of common bacterial (e.g., Chlamydia) and viral (e.g., HPV) STI are highest among this population (Public Health Agency of Canada, 2006). Although consistent condom use significantly reduces the risk of STI within this age cohort, condoms are often only used for casual relationships or "one night stands" (Catania, Stone, Binson, & Dolcini, 1995; Civic, 2000; Misovich, Fisher, & Fisher, 1997). In addition, a common behavioural pattern is for dating couples to use condoms at the beginning of their relationship but discontinue condom soon after in favour of oral contraception (Civic, 2000; Critelli & Suire, 1998; Manlove, Ryan, & Franzetta,

2007; Misovich et al., 1997). It is therefore evident that for such couples contraception rather than STI prevention is the over-riding rationale for condom use in new relationships (East et al., 2007). In sum, the decision to discontinue condom use is often influenced by one's perception of being in a monogamous relationship (Critelli & Suire, 1998; East et al., 2007; Misovich et al., 1997).

### ***Serial monogamy and STI risk***

Typically, young adulthood is characterized by a pattern of serial monogamy (Britton, Levine, Jackson, Hobfoll, & Shepherd, 1998; Choi, Catania, & Dolcini, 1994; Critelli & Suire, 1998; Misovich et al., 1997; Overby & Kegeles, 1994). That is, the individual has one sexual partner at a time and has a series of monogamous relationships over time.

It has often been suggested that sexually active people should use condoms until they are in a mutually monogamous relationship with an uninfected partner. For example, according to recommendations from the U.S. Centers for Disease Control (Workowski & Levine, 2002), "The most reliable way to avoid transmission of STDs is to abstain from sexual intercourse (i.e., oral, vaginal, or anal sex) or to be in a long-term, mutually monogamous relationship with an uninfected partner" (online). In the absence of these conditions, condom use is recommended. Hypothetically, individuals who restricted their sexual activity to what takes place within a monogamous relationship between partners who do not have an STI would preclude the risk of STI transmission. However, in practical "real life" terms this standard may be less than ideal for the purposes of reducing or eliminating STI risk.

First, beyond an assumption of monogamy the relationship must, in reality, be monogamous. An individual who assumes she or he is in a monogamous relationship and thus does not use condoms, but whose partner actually has concurrent sexual partners is, in fact, at higher risk for STI. Research suggests that despite declarations of monogamy, some individuals deceive their partners regarding their sexual fidelity (Cochran & Mays, 1990; Lenoir, Adler, Borzekowski, Tschann, & Ellen, 2004). In situations where the non-monogamous partner has an STI, the monogamous partner who does not use condoms will be at risk for STI.

Second, verifying that a partner is uninfected can be quite difficult depending on the STI in question. The standard battery of STI tests offered at clinics and general practice physician's offices typically includes tests for HIV, Chlamydia, and a PAP test for women to detect cervical abnormalities related to HPV infection. However, in most cases, this does not include general testing for HPV or HSV-2 (genital herpes), the two most common STI in Canada. As noted in the Public Health Agency of Canada (2006) *Canadian Guidelines on Sexually Transmitted Infections*, "It is important to tell patients that we do not and cannot routinely test for all STIs (e.g., human papillomavirus [HPV], herpes simplex virus [HSV]), so even if they or their partner's tests are all negative they may still have an asymptomatic STI" (p. 17).

### ***Young adults' perceptions of STI risk***

Many young adults believe that the risk of STI is greater when involved in a casual sexual relationship than when involved in a presumably exclusive sexual relationship. Within dating relationships, perceptions of sexual risk are largely based upon subjective assessments: partner's appearance, trust and personality characteristics (Civic, 2000; East et al., 2007; Skidmore & Hayter, 2000). There is often the implicit assumption that the object of their affection would not be a risk to their health, or have a sexual history that confers high STI risk (East et al., 2007; Misovich et al., 1997; Skidmore & Hayter, 2000). Based on this assumption, many young adults in dating relationships rationalize engaging in unprotected sex (Misovich et al., 1997). While it might be assumed that an open discussion of sexual history could be a legitimate basis for forgoing condom use, research indicates that only a small proportion of young adults do discuss sexual health with their partner (Civic, 2000). In addition, these conversations are often vague in nature (for example: inquiry about dating histories) (Manlove et al., 2007; Misovich et al., 1997). Few ask about STI directly, or request STI testing (Masaro et al., 2008) because to do so might imply that one has engaged in higher risk behaviours previously or has been unfaithful during the course of the relationship (Misovich et al., 1997). Subjective assessments of partner risk are often inaccurate, especially with respect to a partner's sexual history (East et al., 2007; Seal & Palmer-Seal, 1996). Furthermore, there is no empirical evidence to support the notion that simply inquiring about a partner's prior sexual behaviour history (e.g., number of sexual partners) results in a significantly lower risk of STI. Finally, because STI testing typically does not include tests for common, often asymptomatic STI (e.g., HPV, HSV-2), restricting sexual activity to uninfected partners as part of a STI risk reduction strategy is difficult to verify.

### ***Relationship formation and patterns of condom use***

Trust plays an instrumental role in the decision to discontinue condom use (Civic, 2000; Misovich et al., 1997; Masaro et al., 2008; Winfield & Whaley, 2005). It can be psychologically difficult for one partner within a dating relationship to conceive of their otherwise desirable partner as a source of STI

(East et al., 2007; Goldmeier & Richardson, 2005; Misovich et al., 1997; Pilkington, Kern, & Indest, 1994). In addition, transitioning from condom use to sex that is unprotected against STI can be a symbolic event representing commitment (Conley & Rabinowitz, 2004; East et al., 2007). This transition may signify a new “identity” for the relationship beyond casual dating to a more solidified couple status. Abandoning condom use may also represent fidelity, as unprotected sex is often perceived as a means of affirming partner faithfulness (Conley & Rabinowitz, 2004). In this respect, discontinuing condom use is framed as a positive process (Conley & Rabinowitz, 2004).

As dating relationships progress and develop, condom use tends to be viewed by the couple as a method of pregnancy prevention rather than STI prevention (East et al., 2007; Flood, 2003; Garside, Ayres, Owen, Pearson, & Roizen, 2001; Ott, Adler, Millstein, Tschann, & Ellen, 2002). When oral contraceptives are introduced into the relationship, condom use decreases (Civic, 2000; East et al., 2007; Wulff & Lalos, 2004).

### ***Purpose of the current study***

Our review of the literature identified a number of key factors associated with condom use discontinuation among young adults in dating relationships. In the current study, we sought to examine the contraceptive/safer sex practices of young women in dating relationships with a focus on the process of condom use discontinuation. In particular, we sought to identify and illuminate the factors and dynamics underlying condom use discontinuation in relationships that were perceived by participants as monogamous. These issues have been examined previously in the literature. Our purpose with this research was to more fully elucidate how young women living in a large Canadian urban centre articulate their own decisions to discontinue condom use within dating relationships. Hearing young women’s voices on these issues can help inform effective educational strategies to promote sexual health among young Canadian adults.

## **Methods**

### ***Research Participants***

Participants were 13 women aged 18-24 (Mean = 21). To meet the selection criteria, individuals had to be presently in an “exclusive” or “monogamous” heterosexual relationship. Eleven participants (85%) were students at either the high school level (n=5), or at undergraduate (n=3), masters (n=2), or PhD (n=1) university levels. All participants were fluent in English.

### ***Sexual health survey/ demographics***

Participants were presented with a demographic and sexual health information questionnaire. With respect to sexual health, the questionnaire included items on relationship status (e.g., “Are you two monogamous and exclusive?”) contraception (method used for first intercourse in current relationship, method used for most recent intercourse in relationship), perception of sexual risk (e.g., “Do you feel you are at risk for a sexually transmitted infection?”), perception of partner’s sexual history (e.g., “Do you feel confident you know your partner’s sexual history?”) and STI testing (e.g., “Have you ever been tested for sexually transmitted infections?”).

### ***Semi-structured interview***

Semi-structured interviews were developed based on a review of the existing research literature. The interviews addressed the following major topics: the development of the current relationship, contraceptive use at the varying stages of the relationship, contraceptive choices, relational influences, sexual behaviours, and sexual history. Sample questions addressing these topics included:

- (1) “How did you know that you two had become monogamous? What were the signs? How did the relationship change?”;
- (2) “Did you use condoms when you first started dating? If so, would you say that you used them consistently?”;
- (3) “Did you switch to using oral contraceptives as a replacement for condoms? Or would you say that you have used the same kind of contraceptives since the beginning of the relationship (condoms, the pill...)?”;
- (4) “(If there was a switch) How long were you dating when you decided to switch to \_\_\_\_?”

- (5) Can you tell me what was happening in the relationship during that time?";
- (6) "What did it mean to you to use oral contraceptives instead of condoms? Did it change the way you felt about the relationship? How so?";
- (7) "Do you feel that you are at risk for contracting a sexually transmitted infection?";
- (8) "What do you consider to be sexually risky behaviours for other young women?" If applicable, these questions were additionally used to query previous sexual relationships.

### **Procedure**

The study was advertised throughout the Greater Toronto Area, including the University of Toronto campus, Toronto community settings and health agencies. All participants were volunteers who received \$20 compensation for their time. The first 15 individuals who responded were recruited. Two respondents were subsequently excluded because they were not currently sexually active in their relationships. Informed consent was consistent with the procedures described in the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans* (Canadian Institute for Health Research, 2005). Participants read and signed two copies of a consent form, retaining one copy for themselves. The study was approved by the University of Toronto's Office of Research Ethics. Interviews lasted approximately 45 minutes and took place within a counselling clinic at the University of Toronto which was equipped with private offices for confidentiality. Interviews were audio-taped and later transcribed by the first author. At the end of the interview participants were encouraged to ask questions or voice any concerns about the nature of the study. They were also provided with a pamphlet for sexual health information and services. No risks, harms or concerns were observed in any of the participants during the course of the study.

### **Data Analysis**

The results of the quantitative sexual health survey were analyzed using frequency distributions and descriptive statistics using SPSS 17.0. The qualitative data (semi-structured interviews) were analyzed using the constant comparison method (Glaser & Strauss, 1967). The entire set of transcripts (containing numerical codes only) was pooled. In accordance

with constant comparison methodology, each line of data was analyzed for common and divergent themes. This process was conducted several times in thorough detail to refine and assure the validity of the themes. For the purposes of this research, responses by three or more participants constituted a theme. The semi-structured interviews were based on the literature summarized above and designed to elicit responses that would illuminate the process of condom use discontinuation in dating relationships and identify factors that might contribute to it. In this respect, some of the themes generated and presented below were pre-determined to some extent by the questions asked. Those questions focused specifically on factors influencing condom use within dating relationships.

### **Results**

The length of participants' current dating relationship ranged from two months to five years (mean = 16 months, median = 4 months). All participants described their current relationship as exclusive, with nine of thirteen respondents stating that they believed the relationship had been monogamous since the first date. Three participants noted first engaging in sexual intercourse with their partner within one week of dating; two within two weeks of dating; and four within one month of dating. Of the 13 participants, 7 had been in a previous sexual relationship prior to the current one (Table 1). Twelve of the 13 participants rated themselves, in response to a questionnaire item, as being at low risk of contracting an STI from their current dating partner.

#### **Condom use discontinuation**

All of the young women in the sample reported that they had used condoms the first time they had intercourse with their current partner (Table 1). Eight used a condom and five used a condom and the pill. In contrast, at most recent intercourse over half of the participants did not use a condom: three used a condom, two used a condom and the pill, and eight used the pill only. For this sample of young adult women in exclusive dating relationships, the pattern of condom use at relationship onset followed by condom use discontinuation and the initiation or continuation of oral contraception was evident for over half of the participants.

**Table 1** Sexual behaviour profile of thirteen young women in exclusive dating relationships (n = 13)

Currently sexually active	Yes = 13	No = 0	
Age at first intercourse	Mean = 18	Range = 15-20	
No. of sex partners within dating relationships	Mean = 2	Range = 1-4	
Current dating partner is first sexual partner	Yes = 6	No = 7	
Ever engaged in casual sex (i.e., one-night stand)	Yes = 2	No = 11	
Contraceptive use at first intercourse in current dating relationship	Condom only = 8	Pill only = 0	Condom & Pill = 5
Contraceptive use at last intercourse in current dating relationship	Condom only = 3	Pill only = 8	Condom & Pill = 2

The primary purpose of this research was to qualitatively examine the process of condom use discontinuation among young adult women in monogamous dating relationships. The semi-structured interviews with the 13 women allowed for the identification and illustration of a number of factors that influence condom use decision-making for young women in exclusive dating relationships.

#### ***Appraisals of STI risk (Assumptive vs. Information-based)***

The interviews identified two distinct patterns of STI-risk appraisal and provided insights into the general process of sexual health decision-making. Some women made assumptions about monogamy, sexual histories, and sexual health in assessing their degree of STI risk (assumptive appraisals) and others based their opinion on information collected through discussions (information-based appraisals). Eight of the 13 participants fell into the assumptive category in relation to monogamy, sexual risk and sexual health of both themselves and their partners. The five in the information-based group appeared to attempt to gather sexual health related information from their partner in order to assess STI risk.

#### ***Themes***

The major themes arising from this research were: assessing monogamy; sexual history; perceptions of STI risk for young women; condom use as contraception; partner's sexual behaviour in previous relationships and perceived STI risk; the roles of trust, intimacy, commitment, and pleasure/convenience in

the transition from condom use to oral contraception; and STI status/testing.

#### ***Assessing monogamy***

Among the participants who used a primarily assumptive method to assess their STI risk, it appeared that they had made such assumptions from the onset of the relationship. This included assumptions about its monogamous status. As one participant stated,

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

Other participants made similar comments:

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

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

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

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

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

It is evident from several of the excerpts above that some participants made the assumption that their partner was not the "type" of person who engages in non-monogamous sexual activity. As these interview excerpts make clear, the monogamous status of the relationship is often assumed rather than explicitly discussed and agreed upon. However, several participants did adopt an information-based approach by addressing the topic of exclusivity with their partner.

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

Another participant asked her partner directly about exclusivity.

I was pretty sure just because he seemed to think a bit like me that that was how we were thinking as well. But still I felt like I needed to ask and say like, "Is this exclusive? Do you want this to be?" Cause I haven't actually been calling him my boyfriend because I didn't want to be out of line.

### **Sexual history**

Several participants indicated that making specific inquiries about their partner's sexual history would result in discomfort for both partner and participant. As a result, these participants adopted an assumption-based strategy instead.

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

Others recalled general discussions about previous dating partners to make assumptions about risk rather than inquiring for specific risk information.

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

The five women who used an information-based approach to STI risk assessment appeared to use a greater degree of pragmatism than did the assumption-based group. These young women

displayed a communicative, investigative and often direct approach with their partner regarding matters of sexual health. One participant recalled asking her partner,

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

Other information-based queries were more general.

I did ask him before we had sex. I said “Look, do I need to be worried about things like sexually transmitted diseases cause if so, put that back in your pants.” And he was like, “No, no, no.” So I was like, “Okay, you don’t need to worry about that with me either.” So this is okay. So we have had that discussion without going into detail.

#### **Perceptions of STI risk for young women**

Participants were asked, “What do you consider to be sexually risky behaviors for other young women?” Although several themes emerged, having sex with a partner you do not know “well enough” was cited most often, by 6 of the 13 participants. As one participant stated:

I think having casual sexual relationship like one-night stands, just having sex with someone you don’t know, you just met for the first time, this is so risky because, um, I think that the virus nowadays is like so, a lot of people are just virus carriers and you can never tell. And even they don’t know.

Other participants believed that even when condoms are used, there is higher risk when having sex without knowing their partner well. One young woman recounted her experience stating,

They were two one-night stands. I realized that they were completely risky. I was drunk

for both of them. Um, I used condoms for both of them. I regret them. But there is nothing that I can do about them now. Um, I doubt that I will ever again have a one-night stand.

#### **Condom use as contraception**

Participants were asked directly for the primary reasons they had used condoms. Ten of the 13 participants indicated that pregnancy prevention was their primary reason for using condoms. For example, one participant noted, “Pregnancy, That’s the first thing that comes into my mind”. Another participant stated, “Definitely pregnancy. I mean I wasn’t really thinking about STIs. Yes, if I was like perfectly rational that would have been a consideration but I wasn’t.” As indicated above, five of the participants used a condom and the pill at first intercourse within the relationship. At least one of the dual method users viewed condom use not as an STI risk reduction measure but rather as a backup method of contraception: “Yeah it was more as kind of a backup...for in case of getting pregnant.”

#### **Current partner’s sexual behaviour in previous relationships and perceived STI risk**

The importance that participants placed on monogamy as an effective means of preventing STI also extended to the belief, expressed by several participants, that the current partner had been monogamous in previous relationships and, as a result, was unlikely to have an STI. When asked if she was at risk for STI in her current relationship, one participants responded that, “No I don’t think so cause he dated two girls before, but they were both virgins when they dated him and their relationship had been exclusive.” Another participant was asked whether her partner had always used condoms with previous partners. She replied, “I haven’t asked him. No I just always assumed that ’cause I know that his previous relationship was a long-term relationship as well. It was like four years—so I was pretty comfortable.” Another participant, when asked if her partner had used condoms in a previous relationship, responded that,

So as far as I know he has but if he hasn’t, I am not particularly concerned because they were in the relationship for three years and assuming they were as close as he and I are now I don’t think either of them

would have seen or slept with anyone else.  
Um, and I know that she was on the pill....

***The transition from condom use to oral contraceptive use: The roles of trust/comfort, intimacy, commitment, and pleasure/convenience***

A number of the psycho-social variables identified in the literature as contributing to the discontinuation of condom use within couple relationships were evident in the responses of the participants in this study. With respect to issues of trust, one young woman stated,

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

Other participants also explicitly pointed to trust as an important factor in their decision-making.

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

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

Several participants stated that one contributing factor in not using condoms was the increased level of intimacy with their partner. One participant said, "Well, I used the word intimate already and I think that really describes the difference in contraceptives.

I think that without using a condom it is much more intimate." Another participant stated that, "It feels better. And because of that I feel like we have shared a more unique experience together. And that bonding brings us closer together." Another participant expressed a nearly identical sentiment.

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

Transitioning to oral contraceptives within one's relationship can be a signifier of an increased level of commitment within the relationship. This appeared to be the case for a number of the participants, six of whom expressed the idea that not using condoms reflected both partners level of commitment. As one participant stated,

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

One participant noted that having unprotected sex was a way of expressing commitment to their partner when the relationship was in turmoil.

And then I guess the handful of other times it happened (stopped using condoms) it was more of a...I don't know, I guess an emotional time when I felt like we were going through, we had just come through a difficult time, or something had just happened where I think we felt strongly about sort of reaffirming the bond, and making a statement about how serious the relationship was and how much trust there was.... I guess when there was just times when we had had, you know, a fight, or it had seemed like we had gone through a time where we weren't sure how we felt about staying in the relationship, and we were then

sort of reconciled, it seemed like a way of reaffirming the fact that “you know I do want to be with you and I want to be with you so much that I trust you and I guess I am willing to engage in behaviour that may be a little more risky cause I do feel like we have that kind of intimacy where it is okay to do so.”

Some of the participants indicated that having unprotected sex was more pleasurable and convenient. In fact, 5 of the 13 participants noted this. One participant stated, “Well, I think for both parties it was much more pleasurable to have sex without a condom. Um, because there is no plastic in the middle, and you can feel each other better.” Others noted the convenience: “You can have sex whenever and wherever you want.” Several participants noted the perceived freedom of not having to interrupt sexual activity to put on a condom. As another participant suggested,

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

### ***STI status/testing***

Three participants indicated that they would assume they did not have a STI if they did not have any physical symptoms of one. For example,

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

Another participant stated,

So I feel at this point it is like, if nothing has shown up in that amount of time of us sleeping together then I probably don’t.

But there is still that possibility there. But that’s just with him, because we have been in that relationship for so long and only with each other. But not with other people.

Approximately half of the sample (7 of 13 participants) had ever been tested for an STI (including several participants who believed that a PAP test constituted an STI test). Although tests for the most common STI (HPV, HSV) are not typically available, three participants indicated that STI testing had increased their comfort level in making the transition from condoms to oral contraception without condoms. For example, “We know each other’s sexual history very well and we saw each other’s reports so I think I am quite confident.” Two other participants expressed a similar view:

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

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

Two participants had come to an agreement with their partners to access STI testing but had yet to do so.

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

Yeah, we talked about all of that. About who we had had sex with and he offered

to get tested for HIV and I was like, “OK, we will.” But I am very scared of needles and so I haven’t done that yet. And he hasn’t done that either. We are going to go together. But I think we will in the future because even if we have already started having sex together, it is very important to do—getting tested for HIV because it is pertinent in our society no matter what.

## Discussion

Young women in their late teens and early twenties are at relatively high risk for STI. Women in this age group who are currently sexually active within a dating relationship are very likely to, over time, be in a series of such relationships. If condom use is discontinued in favour of oral contraception in each of these relationships, these women will have unprotected sex with multiple partners thereby significantly increasing their risk of STI. This risk is also likely increased if the woman relies on assumptions and other unreliable methods of assessing their level of STI risk. A person in a dating relationship who misjudges their level of risk and discontinues condom use with a partner with an asymptomatic STI is at very high risk due to multiple unprotected exposures. As a result, educators and health professional need to help individuals objectively assess their level of STI risk and understand the psycho-social dynamics of condom use discontinuation within dating relationships. In this study we elicited the personal perspectives of young women living in a large Canadian city on patterns of condom use within their own dating relationships. The intent is to assist educators to better understand how young women in Canada currently articulate their perspectives on condom use in dating relationships.

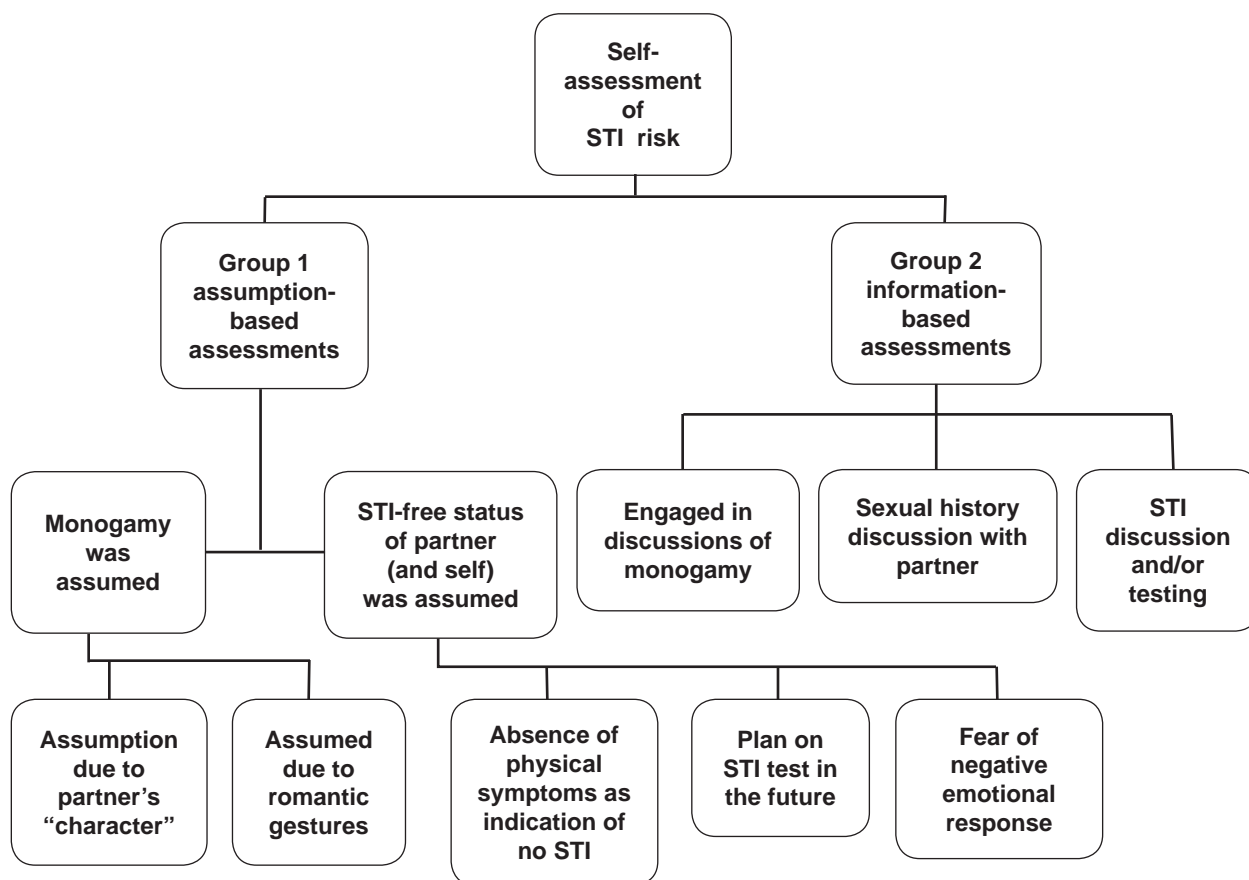
The findings of the present qualitative study of condom use discontinuation within dating relationships among young university student women are consistent with previous research (Civic, 2000; Critelli & Suire, 1998; Manlove, Ryan & Franzetta, 2007; Misovich et al., 1997). For example, over half of the participants in our study, all of whom were in self-reported monogamous relationships, discontinued condom use in favour of oral contraception at some point in the relationship.

In investigating the psycho-social and relational factors underlying condom use discontinuation, the qualitative methodology of the current study allowed these young women to articulate their thinking on condom use and related issues in a more nuanced and contextualized way than would have been possible with a primarily quantitative study. In many respects, the views expressed by our study participants give a voice to, and are reflective of, the statistical findings of the existing quantitative research on condom use discontinuation in young adult couple relationships. As such the findings of this study may be of benefit to researchers seeking a fuller understanding of the factors involved in condom use discontinuation and to educators providing sexual health education to teens and young adults, many of whom will discontinue condom use repeatedly in a series of exclusive dating relationships.

Through analysis of the semi-structured interview transcripts it became evident that the respondents used a combination of assumption-based and information-based strategies to assess their STI risk. Respondents tended to rely more frequently on assumption-based strategies (Fig. 1). Although information-based assessments are less than fool-proof, particularly if they lead to condom use discontinuation, they likely yield more accurate conclusions about STI risk than do assumption-based assessments. Thus, it may be useful for educators to present to adolescents and young adults an organizational chart such as Figure 1 which can help students to understand the qualitative difference between assumption-based and information-based assessments of STI risk. The chart can form the basis of a discussion of how young people typically assess their STI risk and how they might make such assessment more accurate by adopting an information-based approach.

The assumption or assurance of monogamy clearly plays a critical role in the process of condom use discontinuation. Most of the participants in this study simply assumed that they were in a monogamous relationship without explicitly discussing sexual exclusivity with their partners. Previous research among teens and college students has found that subjects are often unaware of their partner’s extra-dyadic sexual activity (Lenoir, et al., 2006; Seal, 1997). We are unaware of research investigating

Figure 1 Organizational chart of two processes of STI risk appraisal



whether extradyadic sexual activity is more likely to occur in relationships where monogamy is assumed rather than explicitly agreed upon. If future research determines that periodic verbal confirmation of the monogamous status of the relationship contributes to actual relationship fidelity, educators can encourage young adults to use this strategy as one means of lowering STI risk. At present, sexual health educators need to caution young adults that assumed monogamy is, for a number of reasons, a poor indicator of low STI risk. Similarly, consistent with previous literature (e.g., Manlove, 2007; Misovich, et al., 1997), we found that the young women in the current study often relied on assumptions or vague inquiries to assess partner's sexual histories.

Previous studies have indicated that many couples in dating relationships use condoms first and foremost

as a form of birth control subsequently shifting to oral contraception as a matter of convenience (East et al., 2007; Flood, 2003). Several of the young women in the current study clearly expressed this view. This suggests that some young women perceive themselves to be at low risk for STI at the point of first sexual activity in a new dating relationship. This may indicate a general underestimation of STI risk among the young women in this sample. Sexual health education programs often address condom use primarily, if not exclusively, in the context of STI/HIV prevention. There may be an inherent assumption that existing condom use is motivated by the desire of individuals to prevent STI/HIV infection. Yet, there is growing evidence, including the results from this study, that this is not the case. Educators should not assume that heterosexual youth and young adults who are currently using

condoms are well educated about STI/HIV risk. Given relatively high rates of condom use among younger sexually active teens compared to older teens and young adults, it may well be that condom use discontinuation is largely a function of increased relationship stability as young people mature coupled with an increased comfort and ability to use other forms of reliable contraception. The apparent comfort and ease with which older teens and young adults transition from condom use to oral contraception in dating relationships suggests that many young people in Canada underestimate their STI risk. Educators should not be misled by the fact that most sexually active teens use condoms because they are likely often using them for contraception not STI/HIV prevention. In sum, this common behavioural pattern of condom use discontinuation is direct evidence that STI/HIV prevention education targeting Canadian youth and young adults requires enhancement.

In the interviews conducted for this study, it was clear that for some of the young women condom use discontinuation was facilitated by a sense of trust, intimacy, and commitment that had developed within the relationship. This observation is also consistent with the literature (Conley & Rabinowitz, 2004; East et al., 2007; Masaro et al., 2008). It is important for sexual health educators to clarify with young people that feelings of trust, intimacy, and commitment are psychological states that enhance relationship closeness and that such feeling and emotions do not in-of-themselves reduce the likelihood that one or both partners is infected with an asymptomatic STI. It is also relevant to note that in some instances, discontinuation of condom use appears to symbolize a transition in young women's dating relationships to a more formal relationship status. It is unclear, however, the extent to which the desire for a more formal relationship, as indicated by a willingness to discontinue condom use, is balanced by the need to objectively assess STI risk. More research is required to specifically unpack the symbolic role that discontinuing condom plays in the perceived progression of relationships.

Less than half of the sample had ever been tested for STI. Among those who had been tested, the tests appeared to function as an affirmation of the decision to discontinue condom use. Thus, it appears that these

young women may have been unaware that tests for common STI such as HPV and HSV-2 are not typically administered as a standard battery of STI tests. Research is required to assess people's awareness of the availability of tests for different STIs.

Several study participants suggested that their discontinuation of condom use was facilitated by a perception that condoms are a barrier to intimacy and pleasure. This barrier appears to be perceived as both physical ("It feels better" not to use a condom) and psychological ("the intimacy of skin to skin"). Overcoming the perception that condoms interfere with pleasure and intimacy is a challenge for sexual health educators. Several potential strategies are evident. One is that as people are made more aware of their actual STI risk, as opposed to their perceived STI risk, they may be more receptive to the message that because condom use reduces STI risk it reduces anxiety which in turn facilitates relaxation and pleasure. Educators can also emphasize the extent to which other aspects of the relationship in general (e.g., sharing of activities and interests) and other aspects of sexual activity enhance intimacy and pleasure in addition to the specific act of penetrative sex.

The perceived STI risk reduction benefits of assumed monogamy, combined with a lack of awareness that most cases of STI are asymptomatic and that the most common STI are not tested for in most clinics likely creates a constellation of factors that encourage condom use discontinuation among young women in dating relationships. Educators can relatively easily inform young people of the extent to which common STI are asymptomatic and that HPV and HSV-2 are not currently a part of routine STI testing as two teaching points in efforts to promote continuing condom use in dating relationships.

### ***Study limitations***

There are a number of limitations to this study including the small sample size and the demographic homogeneity of the participants. Of particular note is that this study focused exclusively on women. Within heterosexual relationships men represent half of the couple equation and for a number of reasons men may have a disproportionate influence on whether condoms use is discontinued within dating relationships. Sexual health behavioural research has

disproportionately focused on women and men who have sex with men. In the heterosexual context, the disproportionate focus on women may inadvertently imply that it is women who are largely responsible for contraception and safer sex practices. More research on male attitudes and behaviours related to condom use is clearly needed. Qualitative studies eliciting male perspectives on condom use within dating relationships are necessary in order to more fully understand the relational dynamics of condom use discontinuation and the increase in STI risk that comes along with it.

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