INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®
A PHENOMENOLOGICAL EXPLORATION OF WOMEN'S
SAFE SEX EXPERIENCES IN COMMITTED RELATIONSHIPS

by

Meghan Raymond

A Dissertation Submitted to the Faculty of the
DIVISION OF FAMILY STUDIES AND HUMAN DEVELOPMENT
In Partial Fulfillment of the Requirements
For the Degree of
DOCTOR OF PHILOSOPHY
In the Graduate College
THE UNIVERSITY OF ARIZONA

2000
UMI Microform 9983907
Copyright 2000 by Bell & Howell Information and Learning Company.
All rights reserved. This microform edition is protected against unauthorized copying under Title 17, United States Code.

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346
As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Meghan Raymond entitled _A Phenomenological Exploration of Women's Safe Sex Experiences in Committed Relationships_ and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

---

Dr. Susan Silverberg Koerner  
Dr. Mari Wilhelm  
Dr. Donna Hendrickson Christensen

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director  
Dr. Susan Silverberg Koerner
STATEMENT BY AUTHOR

This dissertation has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this dissertation are allowable without special permission, provided that accurate acknowledgment of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [Signature]
ACKNOWLEDGEMENTS

First and foremost, I want to thank my advisor, Dr. Susan Silverberg Koerner, who has been an unwavering source of encouragement, and a wonderful role model and mentor throughout this process. I thank her for her faith in my ability to conduct a project that was a true culmination of my developing interests through our years of working together.

I also wish to thank the other members of my dissertation committee: Dr. Donna Hendrickson Christensen and Dr. Mari Wilhelm from Family Studies and Human Development, and Dr. Myra Dinnerstein from Women's Studies. They each brought an expertise to this project that provided me guidance and vision.

Others I wish to recognize include Lucinda Richmond, for her timely assistance with qualitative data analysis, but mostly for her support, advice and friendship as we simultaneously dealt with the excitement and exhaustion of writing a dissertation. My gratitude goes to James Ronan for loaning me his stellar digital recording equipment. The quality of the tapes afforded me access to intonations and nuances of the participants' words that made their stories come alive. Finally, I wish to extend my deepest regards to the 12 young women who shared with me their challenges and skills in their negotiations of safe sex. Their stories kept me laughing and occasionally saddened me, but mostly opened my eyes.
DEDICATION

I dedicate this dissertation to my family: my mother, Lynn Jewett, and father, Joseph Raymond, who offered their love and support during each stage of this process; to my grandmother and late grandfather, Doad and Charles Jewett, my number one fans who have been so proud to have the first Ph.D. in the family; and my twin sister and soulmate, Courtney.

I include in this dedication two others who I consider my immediate family: my dear friend Stephanie Jacobs, who understood in a way that no one else did the joys and challenges of pursuing a doctorate; and Charley Raker, whose love, patience, humor, and daily encouragement carried me through this dissertation from the moment I began.
TABLE OF CONTENTS

I. LIST OF TABLES................................................................. 9

II. ABSTRACT............................................................................. 10

III. CHAPTER 1: INTRODUCTION........................................... 12
    Phenomenon of Interest .................................................. 12
    Purpose........................................................................... 14
    Explanation of Significance............................................ 16
    Overview of Qualitative Approach................................. 17

IV. CHAPTER 2: EVOLUTION OF THE STUDY......................... 23
    Historical Context.......................................................... 23
    Experiential Context........................................................ 27
    Scientific Context........................................................... 29
    Sexual intercourse....................................................... 30
    Unintended pregnancies.................................................. 31
    Sexually transmitted diseases....................................... 32
    Condom use...................................................................... 34
    STD and HIV testing...................................................... 37
    Casual versus committed relationships......................... 39
    Young women’s sexuality in heterosexual relationships.... 41
    Experience of safer sexual activity................................. 43

V. CHAPTER 3: RESEARCH DESIGN....................................... 47
    Overview.......................................................................... 47
    Philosophical Foundations............................................. 47
    The Phenomenological Method......................................... 52
    Phenomenological reduction........................................... 53
    Phenomenological description....................................... 56
    Search for essences....................................................... 57
    Giorgi’s Phenomenological Procedure............................ 58
    1. Sense of the whole.................................................... 63
    2. Identify meaning units................................................ 64
    3. Describe central themes............................................. 66
    4. Consolidate themes and transform into redescribed
       statements................................................................. 71
    5. Situated structural description................................... 78
    6. Expressing essences.................................................. 80
    7. General structural description.................................. 84
### TABLE OF CONTENTS – Continued

<table>
<thead>
<tr>
<th>VI. CHAPTER 4: RESEARCH METHOD</th>
<th>85</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexibility in Phenomenological Methods</td>
<td>85</td>
</tr>
<tr>
<td>Sample</td>
<td>86</td>
</tr>
<tr>
<td>Criteria for inclusion</td>
<td>86</td>
</tr>
<tr>
<td>Recruitment</td>
<td>87</td>
</tr>
<tr>
<td>Sample size</td>
<td>88</td>
</tr>
<tr>
<td>Sample characteristics</td>
<td>89</td>
</tr>
<tr>
<td>Data Collection</td>
<td>90</td>
</tr>
<tr>
<td>Human Subjects</td>
<td>93</td>
</tr>
<tr>
<td>The Phenomenological Interview</td>
<td>95</td>
</tr>
<tr>
<td>Data Management</td>
<td>100</td>
</tr>
<tr>
<td>Trustworthiness of Data</td>
<td>101</td>
</tr>
<tr>
<td>“Truth value” or credibility</td>
<td>101</td>
</tr>
<tr>
<td>Applicability of fittingness</td>
<td>105</td>
</tr>
<tr>
<td>Consistency or auditability</td>
<td>106</td>
</tr>
<tr>
<td>Neutrality or confirmability</td>
<td>107</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VII. CHAPTER 5: FINDINGS</th>
<th>108</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Structural Description</td>
<td>109</td>
</tr>
<tr>
<td>Essence 1: Self-Protection</td>
<td>111</td>
</tr>
<tr>
<td>Concern with pregnancy</td>
<td>112</td>
</tr>
<tr>
<td>Concern with STDs</td>
<td>115</td>
</tr>
<tr>
<td>Fear</td>
<td>119</td>
</tr>
<tr>
<td>Essence 2: Unwavering Internal Standard</td>
<td>121</td>
</tr>
<tr>
<td>Not optional</td>
<td>122</td>
</tr>
<tr>
<td>Integral aspect of sex</td>
<td>125</td>
</tr>
<tr>
<td>Essence 3: Personal Responsibility</td>
<td>127</td>
</tr>
<tr>
<td>Dual method use</td>
<td>128</td>
</tr>
<tr>
<td>Control</td>
<td>130</td>
</tr>
<tr>
<td>Benefits of responsibility</td>
<td>134</td>
</tr>
<tr>
<td>Essence 4: Relational Support</td>
<td>135</td>
</tr>
<tr>
<td>Characteristics of partner</td>
<td>136</td>
</tr>
<tr>
<td>Characteristics of committed relationships</td>
<td>139</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. CHAPTER 6: DISCUSSION</th>
<th>145</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature Review</td>
<td>146</td>
</tr>
<tr>
<td>Characteristics of the Sample</td>
<td>146</td>
</tr>
<tr>
<td>Dual Method Use</td>
<td>150</td>
</tr>
</tbody>
</table>
**TABLE OF CONTENTS — Continued**

Intrapersonal Influences on Condom Use.............................. 153  
The Health Belief Model: Susceptibility, severity, barriers and benefits to condom use .............. 154  
Past negative experience........................................... 161  
Fear................................................................. 163  
Coping responses................................................... 163  
Unwavering internal standard..................................... 164  
Interpersonal Influences on Condom Use......................... 165  
Power and inequity in heterosexual relationships.............. 168  
Partner’s attitudes towards condom use......................... 177  
Communication about safe sex.................................... 178  
Trust and assessments of personal safety....................... 182  
Feminist Perspectives on Women’s Sexuality.................... 187  
Commentary and Feminist Critique of Methodology .......... 195  
Limitations of the Study.......................................... 203  
Significance and Future Directions.............................. 207

IX. APPENDIX A: Outline for Phenomenological Research Reports...... 212
X. APPENDIX B: Redescribed Statements and Situated Structural Descriptions for all participants................................. 214
XI. APPENDIX C: Recruitment Flyer / Posted Advertisement........ 240
XII. APPENDIX D: Sociodemographic Survey.......................... 242
XIV. APPENDIX E: Human Subjects Committee Approval Letter...... 246
XV. APPENDIX F: Participant Consent Form............................ 248
XVI. APPENDIX G: General Interview Guide.......................... 252
XVII. REFERENCES.................................................. 254
LIST OF TABLES

TABLE 1. Steps of Giorgio's Phenomenological Method.......................... 63
TABLE 2. Excerpt from Interview 7, Abby........................................... 67
TABLE 3. Meaning Unit Discriminations from Table 2 Excerpt.................. 68
TABLE 4. Excerpt from Interview 3, Kate............................................ 69
TABLE 5. Meaning Unit Discriminations from Table 4 Excerpt.................. 70
TABLE 6. Meaning Units and Central Themes for Interview 4, Janice......... 73
TABLE 7. Meaning Units and Central Themes for Interview 1, Leah.......... 74
TABLE 8. Meaning Units and Central Themes Expressing the Category of "Responsibility," Interview 9, Kristan................................. 77
TABLE 9. Redescribed Statements from Interview 9, Kristan................... 79
TABLE 10. Situated Structural Description, Interview 9, Kristan.............. 81
TABLE 11. Ethnicity, Religious Affiliation, and Age at First Intercourse for Participants and Partners............................................. 91
TABLE 12. Essences and Themes Describing the Phenomenon of Safe Sex for Women in Committed Relationships........................................ 109
ABSTRACT

The purpose of this qualitative dissertation was to describe the experience of safe sex via consistent condom use for unmarried, young women involved in committed, long-term relationships. A phenomenological research approach was utilized throughout the study. The intent of phenomenological research is to describe and understand human experience. Phenomenology accomplishes this goal through a process of revealing the fundamental, defining structures of experience, called “essences.” Essences are the invariant, shared elements of phenomena that are similar or common to anyone with that experience.

Twelve women (M age = 20.6 years; M length of relationship = 19.3 months) recruited from a large, Southwestern university participated in semi-structured, individual, one-hour interviews. Interviews were audio-recorded and transcribed word for word. Transcripts were submitted to an adaptation of Giorgi's (1985, 1997) phenomenological data analysis procedure.

Analysis revealed four essences that defined the experience of consistent condom use within the context of long-term, committed relationships: self-protection, an unwavering internal standard, personal responsibility, and relational support. (1) Participants maintained a conscious awareness of the need to protect themselves against the perceived, realistic threats of both pregnancy and sexually transmitted diseases. (2) Participants' internal standard to practice safe sex was formed independently and prior to meeting their current partners. Practicing consistent condom use was a resolute and
integral facet of being sexually active, such that the decision to practice safe sex within their relationships was not regarded as optional. (3) In addition, participants believed that they alone were ultimately responsible for their own health, and the majority expressed this responsibility through dual method contraceptive use (i.e., condoms and the birth control pill). (4) Characteristics of partners (e.g., supporting participants' decision to use condoms, absence of complaints about condom use) and of the relationship itself (e.g., open communication) made the practice of safe sex easier for participants. Finally, neither participants nor their partners interpreted condom use in the relationship as a sign of infidelity. Results were discussed in the context of existing research on the intrapersonal and interpersonal influences on safe sex behavior, as well as with respect to feminist literature on female sexuality.
Chapter 1: Introduction

Phenomenon of Interest

In currently popular television shows and movies aimed at a teenage or young adult audience, rarely are love scenes between close, dating partners marked by a frank discussion regarding condom use. In sexual education programs, emphasis on the physical, emotional, and interpersonal dangers of unprotected sex often overshadow any positive messages regarding the benefits of safe sex. In public health commercials for condoms, the typical scenario depicted to promote the use of condoms is a casual, spontaneous sexual encounter. These examples illustrate that in current American society, we rarely talk about the experience of condom use within loving, committed relationships. This is despite the fact that the need for condom use within committed relationships—particularly for women—is well documented. The following dissertation project explored the experiences of women who practice safe sex via consistent condom use in committed relationships.

In this research project, I define safe sex as consistent condom use with every act of sexual intercourse. Unintended pregnancy and sexually transmitted diseases present serious risks to individuals who engage in unprotected sexual behaviors. Abstinence is the only completely effective method of protection. Although hormonal contraception—such as the birth control pill and implant or injection methods—provides protection against unintended pregnancy, it does not offer any protection from STDs. Condoms are the only form of safe sex that significantly help reduce the likelihood of STDs. In addition.
condoms, although not as effective as hormonal contraception, nonetheless provide a reliable form of protection against pregnancy (Eng & Butler, 1997; USDHHS, 2000). Because the use of the female condom by women is less than 1%, condom use in this report refers to the use of the male condom (AGI, 1998).

The effectiveness of condoms in protecting against pregnancy and STDs depends, however, on the correctness and consistency of usage (Bankole, Darroch, & Singh, 1999; Fu, Darroch, Haas, & Ranjit, 1999). To provide best possible protection, condoms must be used correctly with each and every act of intercourse. Condom use among never married women aged 15-44 who report using contraception has increased over the past few decades, such that in 1995 30% of women reported condom use. This percentage is even higher for adolescents (37%) (AGI, 1998; Piccinino & Mosher, 1998).

Existing rates of unintended pregnancies and STDs, especially among sexually active individuals under the age of 25, suggest that condom use is not consistent. National data regarding condom use among late adolescent and young adult women indicate that a majority of sexually active women in these age groups do not consistently use condoms during intercourse (CDC, 1997, 1998). More than 50% of unintended pregnancies among women reporting contraceptive use result from inconsistent or incorrect use (AGI, 1998). Recent data suggests that although perfect use failure rates for condoms is about 3% (Hatcher et al., 1998), typical use failure rates more closely approximates a 15% failure rate (Fu et al., 1999). Inconsistent use renders women who choose to use this method of safe sex still at risk for pregnancy or disease infection. Thus, condom use remains a public health priority. Indeed, the US Department of Health and Human Services, in the recently
issued Healthy People 2010 report, cite “Responsible Sexual Behavior” as one of 10 leading health indicators for the next decade. A primary objective of this indicator is to increase the rate of condom use among sexually active individuals (USDHHS, 2000).

Most research regarding condom use has focused on the population of individuals who encounter significant barriers to the effective practice of safe sex. What do we know, however, about those individuals who are able to use condoms consistently? What can be learned from sexually active individuals – especially women, who must negotiate a male controlled method of safe sex – who protect themselves from unintended pregnancy and STDs via consistent condom use? This group of women was the focus of the current research project.

Purpose

The two main purposes of this research were: (a) to describe the experience of safe sex for women involved in committed, long-term relationships; and (b) to discover the essential characteristics of safe sex experiences for young women in committed relationships. My primary research question was: What is the nature and defining element(s) of safe sex experiences for women in committed relationships? Secondary research questions included: What does it mean to consistently practice safe sex? How have these young women been able to negotiate and implement safe sexual behaviors in their day-to-day lives? I wanted to describe and understand the meaning of “safe sex” by eliciting the perspectives of young women who have personally experienced it.
I arrived at this purpose after recognizing a notable lacuna in the existing literature on safer sexual activities among adolescents and youth. Much research has been devoted to the investigation of barriers or impediments to safer sex -- and particularly to condom use -- among young adults (e.g., Bryan, Aiken, & West, 1997; Critelli & Suire, 1998; Hynie, Lydon, Cote, & Wiener, 1998; Wendt & Solomon, 1995). A portion of this research recognizes that safe sex behavior typically is a relational activity, and relatedly, that risky sexual behavior -- that is, sexual intercourse without the use of condoms -- occurs more often within committed rather than casual relationships (Catania, Stone, Binson, & Dolcini, 1995; Reisen & Poppen, 1995). Some literature in this manner has conceptually discussed or empirically examined barriers to condom use, specifically within the interpersonal context of a committed relationship (e.g., Amaro, 1995; Hammer, Fisher, Fitzgerald, & Fisher, 1996; Kelly & Kalichman, 1995; Lear, 1995).

Scholarship such as this has been conducted with a view toward illustrating the experiences of individuals who engage in risky sexual practices. Empirical research studies, such as Hammer et al.'s (1996), attempt to identify the cause of such risky behavior by asking young people to discuss a number of potential reasons that may inhibit their practice of safe sex during sexual encounters. Notably, however, there has been scant attention directed to those individuals who do practice safe sex within a committed relationship. That is, the existing literature on safer sexual behavior has yet to explore in a meaningful or purposeful manner the experiences of young women who, unlike the majority of their peers, are indeed able to consistently negotiate and engage in safe sexual behavior.
Explanation of Significance

For researchers like myself who are motivated by an applied goal of fostering the sexual health and well-being of late adolescent and young adult women, understanding the shared phenomena of women who do engage in safe sex is not only interesting and informative, it is critical to the achievement of this goal. Knowledge such as this will help to facilitate and promote women's sexual health, by drawing upon and learning from the experiences of women who have been able to make day-to-day decisions that function to promote their own health.

Some phenomenological nursing researchers would suggest that phenomenological investigation should be conducted with a view toward pragmatic purposes that directly contribute and give direction to health-related prevention and intervention efforts, as well as nursing and medical practice (e.g., Munhall, 1994). In concert with this pursuit, research that reveals the essential facets of safe sex in young women's lives embodies a potential for inquiry that is "practice-oriented." In other words, the current research will not only contribute to an empirical literature base regarding young adult safer sexual practices: perhaps more importantly, it could actively inform the development of HIV/STD prevention or intervention programs. Indeed, one of my practical aims for embarking on this inquiry was the desire to inform the sexuality education programs for college undergraduates at this university. Additionally, knowledge regarding the safe sex experiences of young women in relationships will be useful for those health professionals — such as health educators, nurse practitioners, or physicians — who have the unique and
valuable opportunity to promote young women's sexual health in a direct, face-to-face manner.

Overview of Qualitative Approach

To explore young women's experience of safe sex within committed relationships, I chose to utilize a specific form of qualitative inquiry, phenomenology. In general, qualitative approaches to research are known for their attention to rich description and desire to tap the meaning or nature of experience via data gathering techniques (e.g., focus groups, open-ended written questions, in-depth interviews) that value and privilege the voices of a specific population of interest (Rosenblatt & Fischer, 1993). Qualitative approaches are especially appropriate when investigating relatively new unexamined research areas. Typically, the goal of qualitative research is not generalization to a larger sample, but rather to explore meanings and discover new directions of thinking about a substantive area (Ambert, Adler, Adler, & Detzner, 1995). However, a variety of qualitative approaches to research exist (e.g., grounded theory, ethnography), and they each espouse unique purposes and methods. Phenomenology, in particular, is one type of qualitative inquiry that ultimately tries to understand the essence of shared experience (Anderson, 1991).

Phenomenology has been described as both a philosophy and a methodological approach (Oiler Boyd, 1993). As a philosophy, phenomenology is associated most explicitly with the writings of Edmund Husserl (1913/1952, 1971/1980) and later, Martin Heidegger (1927/1962). The method of phenomenology emerged from these original
philosophical works as a way to scientifically study phenomena. A number of scholars have articulated varying processes that capture the phenomenological method (e.g., Colaizzi, 1978; van Kaam, 1959; van Manen, 1990). Nursing is the discipline that currently most actively embraces phenomenology as a valid and revealing approach to science, and indeed many phenomenological nursing studies exist in the literature (e.g., Beck, 1998; Carter, 1989; Costello-Nickitas, 1994; Hartrick, 1997; Haase, 1987; Haase & Rostad, 1994). As well, several distinguished nurse researchers have explained the manner in which nursing has appropriated phenomenology for its specific field (e.g., Munhall, 1994; Oiler Boyd, 1993; Parse, 1990; Streubert & Carpenter, 1995).

Recently, skepticism has emerged as to whether nursing phenomenology can be considered analogous to the phenomenology that Husserl and Heidegger originally developed. Michael Crotty, a qualitative researcher in public health at the Flinders University of South Australia, maintains in his provocative book, Phenomenology and Nursing Research (1996) that the goals, purpose, and methods of nursing phenomenology are quite distinct from those of mainstream, or "authentic" phenomenology (i.e., the phenomenology that Husserl and Heidegger intended). Several of the differences that Crotty accentuates will be described in Chapter 3; for now, I will provide an abbreviated overview of phenomenology.

Phenomenology is more than a qualitative research approach; it is a philosophical perspective that attempts to grasp what it means to be human. The pursuit of what it means to be human is conducted via an exploration of the "reality" of humans precisely as they describe it. Reality is comprised of the meanings in human experience (Omery &
Mack, 1995). Underlying these beliefs is the basic tenet that all experience is constituted by fundamental, or essential, structures. In other words, all human experience contains essential elements that explicitly define a given phenomenon. These essential structures are invariant; that is, they are a primary and unchanging part of that phenomenon. This means that the essence of phenomena, or "the basic units of common understanding of any phenomena" (Streubert & Carpenter, 1995, p. 32), should be present regardless of individual differences in an experience. This is a critical feature of phenomenology. The essences of a phenomenon are the shared commonalities that emerge from differing individual experiences of that phenomenon. It is these shared commonalities of phenomena that make us human.

An important clarification is needed at this point. Within phenomenology, "phenomenon" and "experience" are not synonymous concepts. Experience refers to individuals' daily behaviors, feelings, beliefs, attitudes, or events. It is historically, culturally, and contextually bound. It is that which is unique or particular to each of us. Phenomenon, on the other hand, is that which is seen as universal. It is the essential, defining structure of experience. Phenomenon is that which is common or shared within experience (Crotty, 1996).

As a method, the way in which phenomenology reveals invariant essences of phenomena is through detailed and exacting attention to the meanings of experience as expressed by the individuals who undergo them in everyday life (Cohen & Omery, 1994). Phenomena can only be exposed through analysis of individuals' experiences. Thus, as a phenomenological researcher, one elicits detailed descriptions of experience -- also
referred to as personal narratives or personal stories -- from participants. The process of analyzing these descriptions requires that the researcher set aside any preconceived beliefs or suspend personal biases so as to look upon the participants’ descriptions of their experience with “naiveté” (Giorgi, 1985). By removing expectations, such “bracketing” enables the researcher to view phenomena with a sense of newness and openness. The researcher then immerses herself or himself in the data, and works with the described experiences until shared essences can be identified and accurately described.

Phenomenology, therefore, is foremost a discovery-oriented approach to inquiry. It is descriptive. “intuitively sensitive,” and emphasizes the richness and depth of experience (Giorgi, 1997). As such, it was an appropriate qualitative approach to investigate my phenomenon of interest -- young women’s experience of safe sex behavior -- given the lack of empirical knowledge regarding this experience. Adopting a phenomenological stance, for example. I assumed that there were essential structures that were fundamental to women’s experience of safe sex within the context of a committed relationship. These structures would emerge through meticulous attention to participants’ descriptions of their experiences of safe sex in their relationships.

The following dissertation addressed, via phenomenological inquiry, my primary research question: What is the nature and defining elements of the experience of safe sex for young women involved in committed relationships? The organization of this dissertation is somewhat different than the format of typical empirical studies. I followed the format for phenomenological research reports as described by nursing researchers Oiler Boyd and Munhall (1993) and Munhall (1994) (see Appendix A). In the next
chapter. "Evolution of the Study." I described the various historical, personal, and scientific contexts that led me to select this particular phenomenon of inquiry. This is not analogous to a traditional literature review, but rather a contextualization of the purpose of the study within broader relevant contexts.

Because the aim of phenomenology is to discover the essential meaning of human experience, it would be inappropriate to impose a theoretical or conceptual framework a priori (Oiler Boyd & Munhall, 1993). Consequently, the literature review does not "prepare" the study to investigate a narrowly defined set of theory-driven hypotheses. Instead, the phenomenological literature review creates an argument for the significance of the study, and highlights the inadequate or limited nature of existing knowledge regarding the phenomenon of interest. Thus, it should be "instrumental in opening up the inquiry rather than narrowing it down to a selected conceptual framework" (Oiler Boyd & Munhall, 1993, p. 438). In a phenomenological project, a description and critical analysis of existing literature -- akin to a traditional literature review in empirical other empirical studies -- is introduced in the discussion of the particular study's findings, so that results can be placed within and evaluated against related research.

The paramount aim of the third chapter, "Research Design," is to educate the reader by offering a much more detailed explanation of the philosophy and method of phenomenology. In this chapter I provided a more thorough discussion of phenomenology, as well as a very detailed description of the particular phenomenological procedure that I used for analysis. For illustration, I supplemented the analytic description with actual findings derived from the steps of my own analysis. In the fourth chapter,
"Research Method." I described how I actually conducted my study. Included is an explanation of my sampling procedures and sample characteristics, data collection process and interview process. I also discussed issues related to the ethics of the project, as well as strategies for enhancing the trustworthiness of the data. The fifth chapter, "Findings," presents the major findings of the study. Finally, in the sixth chapter, "Discussion," I contextualized the findings within a current literature review of related research, highlighted the significance and implications of the study, described the limitations of the project, and discussed future directions.
Chapter 2: Evolution of the Study

Historical Context

The historical context for this research was grounded within the recent national attention that adolescent sexuality has received specifically from medical and public health professionals. In 1990, the United States Department of Health and Human Services (USDHHS) released the pivotal *Healthy People 2000*, an influential report containing 300 health promotion and disease prevention objectives for the United States (USDHHS, 1990). These objectives targeted 15 priority physical health and safety areas, with a vision toward increasing quality of life and reducing morbidity and mortality for Americans by the advent of the next millennium. In 1992, the USDHHS released a compendium report, *Healthy Children 2000*, based on these national health objectives (USDHHS, 1992).

*Healthy Children 2000* focused specifically on the 170 health-related objectives in the 1990 report that concerned mothers, infants, children, adolescents and youth. Notably, three of the 15 priority areas in the *Healthy Children 2000* initiative target health improvements related to sexual health: Family Planning, HIV Infection, and Sexually Transmitted Diseases. Although significant progress has been made in a number of the health and safety priority areas (e.g., immunization, unintentional injury prevention), achieving the desired objectives in these three sexuality-related areas, in particular, has presented a more challenging task.

Adolescents (i.e., aged 15-19) and young adults (i.e., aged 20-24) face health opportunities and challenges; that is, during these years, many negative or positive health
behaviors become established lifestyle choices (Elliot, 1993). Thus, the adolescent and young adult years may be especially critical times for promoting safe and reducing risky health practices. Achieving healthier practices among individuals within these age groups, however, has proved to be a difficult goal. Accordingly, adolescents and young adults are identified within several of the *Healthy Children 2000* sexual health objectives as "special population targets" in need of particularly focused attention. Special population targets, according to the *Healthy People 2000* Midcourse Review report are "groups that are of highest risk of premature death, disease, or disability...or [are] more vulnerable to the subject disease or condition than the population as a whole" (USDHHS, 1995, p. 273-274). For example, adolescents aged 15-19 have been identified as a special population target for reducing the incidence of gonorrhea and hospitalizations for pelvic inflammatory disease, and for increasing the use of condoms. Clearly, one of the most powerful conclusions drawn from the collection of *Healthy People 2000* reports is the continuing and urgent need for research and prevention efforts aimed at improving the sexual health of today's teenagers and youth. Indeed, the USDHHS concludes the Sexually Transmitted Diseases chapter in *Healthy Children 2000* by highlighting two important directions for future research:

1. Definition of the determinants of adolescent and youth sexual risk-taking behavior and development of appropriate behavioral interventions. Little is known about why people change (or fail to change) risk-taking behaviors. Without such basic knowledge, it is virtually impossible to design programs that are effective in helping people choose healthy behaviors.
2. Understanding of the factors affecting use of preventive measures (condoms, chemical prophylaxis), so that such precautions will be more widely taken. (1992, p. 201)
The most recent reports concerning progress on the Healthy People 2000 initiatives suggests that advancement is being made in the achievement of sexual health objectives. However, a discrepancy still exists between actual practice and desired goals. For example, the 2000 target regarding condom use at last intercourse by sexually active unmarried females ages 15-44 was 50%; in 1995 (the most recent year for which data is currently available). actual condom use by this group was 25% (National Center for Health Statistics. 1999). Increased use of condoms remains a primary health objective for Healthy People 2010 (USDHHS, 2000).

In addition to the Healthy People 2000 initiative, several other national campaigns have drawn increasing attention to the sexual health needs of adolescents and young adults. For instance, in 1997 the Institute of Medicine (IOM) released The Hidden Epidemic, an extensive report on the enormous health and financial consequences incurred by sexually transmitted diseases in the United States (Eng & Butler, 1997). One of the primary conclusions reached by the IOM was that adolescents and young adults are at the greatest risk for STDs, and thus both research regarding STD-related health practices and national strategies to prevent STDs must prioritize efforts aimed at these two age groups. At a more general health level, the National Adolescent Health Information Center in 1997 released the summary report, Improving Adolescent Health, a description of policy recommendations for improving the lives and health status of adolescents and young adults (Brindis et al., 1997). Notably, one of the primary themes raised in this comprehensive report is the need to promote healthy sexual decision-making and increase
images of healthy sexuality for adolescents. Finally, internationally recognized experts in
the field of sexual health have issued resounding calls for attention to the promotion of
healthy sexuality for all adolescents (e.g., Haffner. 1998; Yarber. 1995).

Such notable attention to adolescent sexuality has perhaps originated in part from
an explosion of large-scale, nationally representative, multi-wave surveys investigating
American adolescent and young adult sexual health practices and behaviors (e.g., Youth
Risk Behavior Survey, National Survey of Adolescent Males, National Survey of Family
Growth). These enormous epidemiological and surveillance studies, with sample sizes
well into the thousands, have generated an unprecedented wealth of critical information
regarding adolescent and young adult sexual practices. These surveys reveal that a
significant percentage of youth are engaging in unsafe or risky sexual practices -- such as
unprotected intercourse -- and thus have elicited concern for the well-being of adolescents
and young adults.

As significant as these surveys have been in terms of mapping the terrain of sexual
behaviors among today’s adolescents and youth, they leave numerous questions
unanswered. To interpret the vast amounts of quantitative, epidemiological data that have
been accumulated in the past decade, sexual health experts have recognized that research
efforts must address more adequately the social and cultural aspects of adolescent
sexuality (CAPS, 1999; Haffner. 1998). For instance, very little is known about the
interpersonal context in which sexual activity takes place, or about how cultural norms or
gender relations influence the negotiation of safer sexual behaviors between partners.

Further, to understand adolescent and young adult sexual behaviors in context, researchers
must incorporate methodological designs that allow for the meanings and perspectives that these individuals themselves hold regarding sexuality and sexual behaviors to emerge (Goodson, Evans, & Edmundson, 1997; Kelly & Kalichman, 1995). Indeed, in the 1997 Gallagher Lecture to the Society for Adolescent Medicine, Debra Haffner -- CEO of SIECUS (Sexuality Information and Education Council of the United States) -- encouraged researchers and practitioners to:

...conduct research on the broader topic of adolescent sexuality, not just young people's involvement in intercourse. There is a tremendous need for research on noncoital behaviors as well as understanding how young people view love, intimacy, and relationships...There is a need for qualitative studies to understand better how young people learn about their sexuality...and the meaning of sexuality and sexual relationships in their lives. (Haffner, 1998, p. 457)

Importantly, it was within these powerful calls for attention to (1) adolescent and young adult safer sexual behaviors, (2) the contexts of adolescent sexuality, and (3) qualitative research that I decided to pursue the current project. It seemed to me likely that one reason for the limited success in the Healthy People 2000 sexual health objectives could be that researchers and practitioners alike possess a narrow understanding of what sexuality and specific sexual practices mean to adolescents and youth, and of the influences that facilitate young people's ability to make healthy sexual choices, and how to incorporate this knowledge into effective sexual health education.

Experiential Context

The purpose of my phenomenological study was situated not only within a historical context that speaks to a need for this type of inquiry, most saliently represented
by the *Healthy People 2000* and *Healthy People 2010* sexual health objectives. I also brought to this project a personal context that clearly motivated my research. During my academic career, I have become increasingly tied to the goal of conducting research that will directly help young people. One of my most memorable experiences that contributed to this goal occurred in 1992 as an undergraduate, when I conducted a small honors project regarding inner-city adolescent girls’ knowledge of AIDS. The first interview I conducted as part of this project was with a 14-year old young woman. During the course of the interview, she revealed to me that she had just found out that she was HIV positive. She was not sure how she contracted the virus (even though she often traded sex for drugs); and although she was scared, she clearly did not understand that she would likely die from the virus. I remember struggling with the decision to either continue the interview in an “impartial” manner, so as to properly adhere to the methods of science that the honors project demanded, or to disregard the attempt to “collect data,” and instead talk with this young woman about her questions.

This experience contributed to my decision to attend graduate school, and to study adolescent sexuality in particular, because I viewed graduate education as holding a potential for me to help teenagers, especially young women, negotiate their sexual lives safely. As a graduate student in Family Studies, my previous research, a project that included both quantitative and qualitative components, spoke to this potential by using feminist developmental theories to explore how adolescent women formed their beliefs regarding sexuality (Raymond, 1997). Indeed, the value I place on feminist theories of women’s relationships, and the importance I attribute to the findings that emerged from
interviews with adolescent girls, are two personal assumptions that I will need to “set aside” within the current phenomenological project. Although I do not question the merit of my existing work, I feel increasingly compelled to conduct research that will facilitate the sexual health of young women in a more direct fashion. I hope that the results of my current project can be utilized to inform the development or refinement of sexual education and safe sex promotion programs for college students at this university. Additionally, I anticipate that I will be able to use the knowledge generated by this project to help educate medical professionals to communicate more empathically and effectively with young women around issues of safer sexual practices.

Therefore, the experiential context I brought to this project was explicitly located within an expectation and desire to actively apply what I discovered about the nature of this experience to promote, in a variety of ways, the sexual well-being of young women and to further prevent the sexual choices young women make that give rise to compromised health.

Scientific Context

Finally, this current research project is situated within a scientific context of existing literature on young women and sexual behaviors. This literature speaks to the importance of conducting research that would contribute to the reduction of sexual infections and unintended pregnancies among young women that are so costly in terms of the health and financial impact incurred by these infections and pregnancies. To understand the relevance and significance for a study focused on young women’s safe sex
experiences. I described three literatures: (1) the rates of sexual intercourse among adolescents and young adults, (2) the implications of unsafe sexual activity in terms of unintended pregnancies and sexually transmitted diseases, and (3) the experience of risky sexual activity.

**Sexual intercourse.** Data on the extent of adolescent sexual intercourse reported by the Alan Guttmacher Institute suggest that sexual intercourse is hardly an uncommon occurrence among middle adolescents, and a normative experience among late adolescents. The average percentage of adolescents who have engaged in sexual intercourse steadily increases with age, such that: 25% of 15 year olds, 42% of 16 year olds, 55% of 17 year olds, 67% of 18 year olds, and 80% of 19 year olds have engaged in sexual intercourse (AGI, 1999). The most recent statistics available from the 1997 Youth Risk Behavior Survey indicate that the average percent of high school students (9th-12th grade) who have ever had sexual intercourse decreased from 54% in 1991 to 48% in 1997 (CDC, 1998). Although this decrease is encouraging to some health practitioners, it is critical to note that this decrease was accounted for solely by a decrease in sexual intercourse for males. The percent of high school females with sexual intercourse experience did not significantly decline during this time span.

Among college students, the most current surveillance data come from the National College Health Risk Behavior Survey (NCHRBS). This survey was the first of its kind to nationally monitor six health-risk priority areas among young adults attending college (CDC, 1997). The data are representative of undergraduate college students aged 18 and older in both two-year and four-year colleges and universities in the United States.
The college population for this study was divided into one group of 18-24 year olds representing the more "typical" college student, and one group of 25-older representing the more "nontraditional" -- yet growing -- college population. The NCHRBS revealed that 79.5% of the college students aged 18-24 reported experience with sexual intercourse. Slightly more women (81%) than men (78%) had engaged in sexual intercourse.

To provide a sense of the existing sexual "climate" among adolescents and young adults, I present the most recent statistics available on the results of risky sexual practices. First, I describe current rates of unintended pregnancies. Secondly, I discuss sexually transmitted diseases. I also describe rates of condom use, the only method of safe sex currently available to prevent both pregnancy and STDs.

Unintended pregnancies. Presently in the United States, half of all pregnancies are unintended (Henshaw, 1998). That is, 49% of pregnancies occurring to fecund women are unplanned. Although this percent represents a decline in unintended pregnancies since the late 1980s, availability of contraceptive technology and rates of unintended pregnancy in other industrialized countries suggest that this rate should be significantly lower (USDHHS, 2000). A leading family planning objective for Healthy People 2010 is for 70% of all pregnancies to be intentionally planned by the end of the decade (USDHSS, 2000). The Institute of Medicine suggests an even more ambitious goal -- that the United States adopt a social norm for all pregnancies to be consciously planned and wanted (Brown & Eisenberg, 1995).
Although unintended pregnancies are a problem for all women in their reproductive years, they disproportionately affect younger women. In 1995, among women aged 20-24, only 42% of pregnancies were intended. Not surprisingly, this percent is even lower for adolescent women. Among women aged 15-19, only 22% of pregnancies were planned (USDHHS, 2000). Other notable disparities exist, such that the highest rates of unintended pregnancies also occur among African-American women, women who are poor, and never-married women (USHDDS, 2000).

Sexually transmitted diseases. Sexually transmitted diseases present an often neglected, but very substantial threat to the sexual health of young women, in particular. Notably, females are biologically more susceptible to sexually transmitted pathogens than are males. Male-to-female transmission of gonorrhea and herpes, for example, is significantly higher than female-to-male transmission (Eng & Butler, 1997). Male-to-female transmission of HIV is estimated to be eight times more likely than female-to-male transmission (CAPS, 1999). Additionally, once infected with a STD, women suffer from both more severe and a greater number of negative health consequences and complications (e.g., reproductive cancers) than do men (Eng & Butler, 1997). For example, cervical cancer, which is linked to certain strains of human papillomavirus (i.e., the virus that causes genital warts), is responsible for the death of at least 5,000 women each year. The HPV virus is incurable. Chlamydia and gonorrhea, which are curable, can lead to pelvic inflammatory disease (PID) if untreated, an upper genital tract condition that affects at least 1 million women each year. PID can cause infertility, chronic pelvic pain, and life-threatening ectopic pregnancies. Genital herpes, if actively present within a woman's
reproductive system during childbirth, can be transmitted to the child causing either stillbirth or severe physical and mental health complications for the child. Additionally, infection with any STD significantly increases a woman's susceptibility to HIV infection (CAPS, 1999; CDC, 1996).

The United States experiences an estimated 12-15 million new cases of reported STDs each year, and has the highest rates of STDs of any industrialized nation (Eng & Butler, 1997). Indeed, the Institute of Medicine recently concluded that STDs have reached "epidemic" proportions in the U.S. The rates of STDs among young people and among young women, in particular, are alarming. Each year, 3 million adolescents between the ages of 13 and 19 become infected with a sexually transmitted disease (Eng & Butler, 1997; USDHHS, 2000). By age 21, 25% of all sexually active adolescents have acquired an STD (USDHHS, 1992). Chlamydia is the most common bacterial STD (4 million new cases each year), and is more likely to occur in teenagers than in adults; the highest rates of chlamydia are among adolescents aged 15-19. Teenagers also account for the highest rates of gonorrhea. Each year, it is estimated that there are as many as 1 million new cases of human papillomavirus (HPV), and up to 500,000 new cases of herpes (CDC, 1996). Women are one of the fastest growing populations infected with the HIV virus, and in 1996 young women under age 30 accounted for 22% of all AIDS cases among women (CAPS, 1999). Although progress has been made towards achievement of the Healthy People 2000 sexually transmitted disease objectives, the percentage of young people affected annually by STDs is nevertheless drastically high.
Condom use. The health benefits of condom use for sexually active young women cannot be overstated. Condom use is typically the most frequently practitioner-recommended contraceptive practice for young people because of the barrier protection it offers against both pregnancy and sexually transmitted infections, including HIV (American Academy of Pediatrics, 1995; Francis & Chin, 1987). Although several alternative forms of contraception are available to prevent pregnancy (e.g., birth control pill), condoms provide the only form of contraception that protects against HIV and other sexually transmitted infections, and therefore have been recommended for nearly all sexual exposures (Padian & Francis, 1988).

The consistency of condom use is somewhat difficult to assess, as condom use is measured in several different ways, depending on the study. The Youth Risk Behavior Survey reported increases in condom use among high school students “at last intercourse,” from 46% in 1991 to 57% in 1997. Although condom use at last intercourse increased among both male and female students, males in 1997 reported higher rates of condom use (62.5%) than females (51%). Importantly, measuring condom use “at last intercourse” does not speak to the regularity of condom use among high school students.

The NCHRBS reported that among 18-24 year old college students who had been sexually active within the past three months, 38% had used a condom “at last intercourse” (CDC, 1997). Among those students who were sexually active within the past 30 days, only 37% used a condom “always or most of the time.” It is critical to note that condoms only provide protection against HIV and other STDs if they are used during each and every act of sexual intercourse. For example, a woman’s chance of contracting gonorrhea
from one act of unprotected sexual intercourse with an infected partner is as high as 90% (SIECUS, 1999). Thus, the above statistics may overestimate the actual number of adolescents and young adults who are effectively protected from disease by regular and consistent use of condoms. Accordingly, in MacDonald et al.’s (1990) survey of Canadian college students, only 20% of students reported “always” using condoms during every act of sexual intercourse. Importantly, these various statistics would suggest that among late adolescent and young adult women, those engaging in various risky sexual practices likely outnumber those women who consistently engage in safe sexual behavior.

Data from the most recent wave of the National Survey of Family Growth provide estimates of condom and other contraceptive use among all sexually active women. Among sexually active women aged 15-44 at risk for unintended pregnancy, 93% reported using some contraception in 1995. This percent was somewhat lower among younger age groups, such that 91% of women aged 20-24, and 81% of women aged 15-19 reported some contraceptive use. However, these percentages do not reflect the number of women who use contraception consistently and correctly for every sexual encounter. Notably, 53% of unintended pregnancies occur among women who reported some contraceptive use. That is, over one-half of all unintended pregnancies are the result of contraceptive failure and improper use (Fu et al., 1999). Fu and colleagues highlight that efficacy of a particular contraceptive method depends upon the ability of the female and her partner to use contraception correctly and consistently. For example, the “perfect use” failure rate for condoms is approximately 3% (Hatcher et al., 1998), but the typical use failure rate annually is much higher, about 15% (Fu et al., 1999).
The most popular form of reversible contraception (i.e., not including sterilization) among women aged 15-44 who reported practicing contraception in 1995 is the birth control pill, used by 27% of women. The second most popular form was the male condom, used by 20% of women. Although the percent of pill users changed very little since the early 1980s, condom use has continually increased over the past two decades (Piccinino & Mosher, 1998). However, age strongly correlates with method choice among contraceptive users. Therefore, I also present corresponding percentages for the two age groups represented in the current study. Among white contraceptive users aged 15-19, 49% used the pill, and 36% used condoms. Among 20-24 year olds, 57% used the pill, and 24% used condoms. For both age groups, African-American contraceptive users were more likely than whites to use condoms, and less likely to use the pill (Piccinino & Mosher, 1998). For black adolescents only, condom use (38%) exceeded use of the pill (32%). Over time, condom use increased in every age group among all women, but most significant increases occurred among women in their 20s.

Another way to examine this data is by marital status. Over time, changes in contraceptive use patterns were much more significant for never-married women than among married women. Among never-married white women, use of condoms increased from 14% in 1982 to 30% in 1995. Corresponding figures for black women are 8% condom use in 1982 and 28% condom use in 1995. Bankole and colleagues (1999) suggest that these increased trends in condom use among never-married women are understandable because these women are more likely to perceive themselves at risk for
STDs, including HIV, than are married women, and further may regard condom use as more convenient.

However, again it is critical to remember that these reported percentages of condom use do not necessarily reflect the correct and consistent use of condoms among sexually active women. The high rates of STDs and unintended pregnancies reflect, in part, the fact that a majority of young people do not use condoms regularly or consistently during sexual encounters, and many young women -- even though they may use other forms of contraception -- do not use condoms at all (CDC, 1997; Joffe et al., 1992; MacDonald et al., 1990; Prince & Bernard, 1998). For example, in MacDonald's study of Canadian college students, only 16% of women reported "always" using condoms during sexual intercourse. Data from the NCHBRS revealed discouraging percentages for college women in the United States as well: only 34% of sexually active female college students aged 18-24 reported using a condom "at last intercourse" (CDC, 1997).

**STD and HIV testing.** I want to mention the practice of testing for STDs as a form of safe sex behavior. Although the health benefits of testing for and detecting STDs are unarguable in terms of appropriate treatment for the infected individual and any sexual partners, relying on the knowledge of test results alone as a practice of safe sex should be viewed with caution. Assessing the rates of HIV testing or testing for other STDs is extremely difficult. There are no national data available with respect to STD testing. Many college and community health clinics routinely screen for some STDs, such as chlamydia or gonorrhea, during a gynecological exam (e.g., Cleavenger, Juckett, & Hobbs, 1996), and at both the college and community level routine STD screenings have
been recommended (CDC, 1996; Grace, 1997; Rothenberger & Buck, 1998). However, the patient does not have to be informed of the results of these screenings. The issue is complicated by the fact that most young people who are tested likely do so when clinical symptoms of an STD are present, rather than prophylactically (i.e., being tested without any symptoms present). Many STDs will not manifest in the form of clinical symptoms, and this is especially true of infections in women (Eng & Butler, 1997). That is, the presence of certain STDs will remain asymptomatic for long periods of time (e.g., chlamydia). Other STDs, such as HPV and herpes --- are viruses that are never cured, even though symptoms of an outbreak can be treated. Thus, individuals with HPV and herpes are always potentially able to infect another partner during unprotected sexual encounters.

In contrast, HIV testing is typically conducted prophylactically, rather than when symptoms of infection emerge. That is, many people who are tested for HIV do so even though they do not have any HIV illness-related conditions. Surprisingly, national rates of HIV testing are also difficult to locate. In the national college health survey discussed earlier (CDC, 1997), students were asked if they had ever had their blood tested for the presence of HIV infection. Among the students in the age range most relevant for the current study, the 18-24 year old sample, 32% had indicated that they had their blood tested for HIV infection at some point in their past (35% of women, 29% of men). It should be noted, however, that this percent does not indicate the number of students who were both HIV tested and informed of their results. Previous research has indicated that it
is not uncommon for tested individuals to choose not to receive their test results (Zenilman, Erickson, Fox, Reichart, & Hook, 1992).

For both HIV and other STDs, testing may be a necessary but not sufficient condition of increasing efforts at safe sex. Tests will only detect the presence of STDs in the body under certain conditions. In addition, rates of infidelity among sexually committed couples and the incidence of lying about sexual histories suggest that reliance on test results at one point in time to determine safety of a sexual encounter may be unwise (Cochran & Mays, 1990; Prince & Bernard, 1998). The recommendation for consistent condom use is arguably the strategy most effective for ensuring safer sexual encounters among young adults.

In summary, in light of the disproportionate negative health outcomes of unprotected sexual intercourse, the advantages for women of using a condom during intercourse are arguably greater than for their male partners. Clearly, there is a pressing need for researchers concerned with promoting women's sexual health to address the extremely low rates of consistent condom use among late adolescent women.

**Casual versus committed relationships.** One of the most interesting findings to emerge repeatedly from the surveillance data on condom use speaks to relationship status as a significant influence on condom use. Importantly, sexual partners are more likely to use condoms in casual sexual episodes than in committed relationships (Catania et al., 1995; Forste & Morgan, 1998; Ku, Sonenstein, & Pleck, 1994; Reisen & Poppen, 1995). Condom use declines, and is typically replaced by the birth control pill as the preferred
form of contraception, as a relationship progresses (Hammer, et al., 1996; Ku et al., 1994).

Ku and colleagues conducted one of the most thorough investigations of the pattern of condom use in relationships (1994). Using 1988 and 1990-1991 cross-sectional data from the National Survey of Adolescent Males, the authors found that condom use is most likely to be frequent at the beginning of a relationship, and then declines over time as the relationship progresses. The longer the relationship, the less likely young men in their study were to use condoms at last intercourse. This trend was accounted for, in part, by changes in contraceptive method. Partners of respondents were more likely to transition to female controlled contraceptive methods, such as the birth control pill, at most recent intercourse. The discontinuation of condom use in this sample reinforces the notion that couples use condoms primarily for pregnancy prevention; indeed, 83% of respondents indicated that they used condoms to prevent pregnancy, while only 12% of young men said to prevent disease.

Thus, it is probable that young women who are in committed relationships use condoms even less often than women engaged in casual, short-term sexual encounters. Young women in committed relationships, therefore, may be a population at high risk for exposure to STDs, because of the unprotected sexual intercourse that occurs within the context of the committed relationship. Importantly, this proposition -- that women in relationships are at risk for STDs -- is inconsistent with most health promotion and AIDS-related media campaigns that have targeted safer sex messages primarily to the "one-night-stand," risky, anonymous or casual sexual encounter (Kelly & Kalichman, 1995; Ku et al.,
As I noted earlier, the risk of unprotected sexual intercourse, assuredly, is lowered if both partners have been medically tested and/or treated for STDs (although herpes, HPV, and HIV are incurable, and thus always present a risk for infection). Ku and colleagues suggest that the most significant implication of their study, however, is that many men are likely using some informal criteria, rather than clinical testing, to decide that their partners are uninfected.

*Young women's sexuality in heterosexual relationships.* The examination of condom use in committed as compared to casual sexual relationships highlights the relational characteristics of heterosexual intercourse. Safer sexual practices between heterosexual partners, by definition, occur within an interpersonal, relational context. Until recently, however, the literature on safer sexual behaviors seemed to disregard entirely the basic tenet that sexual interaction is a relational activity (Amaro, 1995; Kelly & Kalichman, 1995). Indeed, empirical research has rarely explored how the interpersonal context of sexual episodes influences sexual risk-taking.

One of the most salient examples of the lack of attention to the relationship context of sexuality was the early "Just Say No" abstinence campaigns aimed at preventing sexual activity among early and middle adolescents. These campaigns promoted the teaching of morals against premarital intercourse, and emphasized that a teenager merely needed to assertively "say no" when confronted with a choice regarding intercourse (Kirby, 1984). This well-publicized strategy for preventing adolescent intercourse has been demonstrated to be ineffective, in part because of the inherent discounting of cultural, social, and interpersonal influences on adolescent sexual activity (Christopher &
Roosa, 1990; Kirby, 1984). For this reason, more recent adolescent sex education curricula have attempted to account for the interpersonal nature of sexual activity by incorporating components including partner communication and skills-based resistance strategies, as well as practice of these skills via role playing (Kirby, Barth, Leland, & Fetro, 1991).

Psychosocial models of risky sexual activity, such as health-belief conceptual models (e.g., the Health Belief Model; Becker, 1974), generally have also focused more on individual, psychological factors (e.g., perceived susceptibility to AIDS) than on interpersonal ones in predicting the enactment of safer sexual behaviors (Bryan et al., 1997; Catania, Kegeles, & Coates, 1992). These behavior change models typically fail to account adequately for relational variables in predicting risk reduction behaviors. Consequently, for scholars who want to understand young women’s sexual behavior within relationships, these models provide limited usefulness (Raffaelli et al., 1998).

Within research on safer sexual practices, college women involved in committed partnerships are a frequently overlooked group. It is certainly likely that researchers who sample from college populations unknowingly include individuals in committed relationships in their studies. However, in studies of sexual risk behavior it is rare that young women are asked about their relationship status (other than married/never-married); also rare are investigations that incorporate relationship status as a primary informative variable. This gap is somewhat surprising, especially because college has been recognized as an important time and environment for exploring and establishing intimate and sexual relationships (Shaver, Furman, & Burhmester, 1985).
One related body of literature that speaks to the importance of relationship status on the sexuality of young women is research that examines college students' decisions to engage in sexual intercourse, both for the first time and within a specific relationship. Findings from these investigations suggest small yet significant and enduring gender differences with respect to levels of sexual intercourse. In general, these studies have revealed that, compared to young men, young college women are more uncomfortable with sexual intercourse occurring within a casual relationship (Hendrick, Hendrick, Slapion-Foote, & Foote, 1985; Oliver & Hyde, 1993); require a relationship to be more serious before engaging in intercourse (Cohen & Shotland, 1996); are more likely to be dating or consider themselves “in love” at first intercourse (Sawyer & Smith, 1996); and are more likely to cite the lack of a loving relationship as a reason to remain a virgin (Christopher & Cate, 1985; Sprecher & Regan, 1996). Christopher and Roosa clarify that emotional commitment and love is important to men and does influence their sexual decision-making; nevertheless, men tend to feel more comfortable engaging in casual intercourse and are less concerned with the "emotional climate" of a relationship than are women (1990, p. 120). Despite the fact that emotional commitment in a relationship appears to occupy a crucial role in young women's decisions about sexual intercourse, researchers have only begun to examine women's relationship status and safe sex behaviors.

Experience of safer sexual activity. Within very recent years, some research has emerged that explicitly investigates young people's safer sexual behaviors in the context of relationships (e.g., Hammer et al., 1996; Lear, 1995; Lock, Ferguson, & Wise, 1998;
Pilkinton, Kern, & Indest, 1994; Williams et al., 1992). This new body of literature clearly represents an improvement in the available research on safer sexual behavior, because it goes beyond examining individual-level influences only, and attends to the fact that typically sexual decisions and choices are negotiated between partners. Further, this literature advances the extant research because many of the designs in these emerging studies are qualitative, and thus allow for a richer portrayal of various interpersonal experiences within a sexual relationship. For example, Lock et al. (1998) used a grounded theory approach to study sexual communication about risk behaviors between college students in committed relationships. Lear (1995) used questionnaires and in-depth interviews to explore as well the concept of sexuality communication. Hammer et al. (1994) adopted a focus group methodology to explore the various barriers that being involved in a committed relationship places on the successful negotiation of condom use. Although Hammer et al.'s study in particular, because it explicitly examines sexual experiences in committed relationships, possesses a potential to understand young women's experience of safe sex, the project is flawed in several important respects.

First, the students in Hammer et al.'s focus groups were asked to answer every semi-structured question posed during the focus group, as long as they were comfortable answering it. In this procedural respect, the focus groups resembled individual interviews that happened to take place within a group. The focus group questions did not tap attitudes or feelings about sexual risk or contraception in general, but rather in terms of the sexual decisions, contraceptive use, sexual risk, and partner communication that occurred within each individual's own relationship. Thus, students were asked to provide
-- in a group setting -- information of an extremely private nature. Focus group methodology has, in fact, been discouraged as the best choice of qualitative method when the purpose of the research is to explore a topic that is of an especially personal or sensitive nature (Vaughn, Schumm, & Sinagub, 1996).

Secondly, the researchers came to the focus group process with particular relationship-oriented influences in mind. The focus group questions were then designed to elicit student comment on these preconceived notions about what might serve as barriers to condom use in relationships. This strategy may have prevented novel or unexpected findings to be fully pursued during the interview process itself; or, unique findings may not have been developed thoroughly within the presentation of results. In other words, the process of “testing” presuppositions about what might be occurring in relationships could have lessened the possibility for the meanings of these sexual experiences from the participants’ own perspectives to emerge.

More generally, the result of Hammer et al.’s (1996) qualitative project is a description and greater understanding of the experience of risky sexual activity between college couples. Description and understanding of risky sexual activity is a focus shared by the other recent studies on sexual activity within relationships (e.g., Lear, 1995; Lock et al., 1998; Williams et al., 1992). That is, what has emerged from these studies is a portrait of risky sexual experience. These research projects focused on risky sexual experience have not produced an equally thorough description of the experience of safe sex. Thus, as researchers interested in young adults’ sexual experiences, we still do not know much at all about the experience of safe sex; nor do we understand the experiences
of the individuals who are able to consistently practice safe sex within the context of a committed relationship. Obviously, we cannot assume that safe sex is the "opposite" of the experience of risky sex, or that safe sex occurs, by default, in the absence of the barriers that lead to risky sex. In other words, we cannot know about or understand the experience of safe sex merely because we are informed about the experience of risky sex.

What, therefore, is the nature of the experience of safe sex for young women involved in committed relationships? How are they able to negotiate and implement safe sex in their everyday lives? What makes them so unique from the majority of their peers who are hindered by a variety of barriers to safe sexual practices? These are the questions that were the focus of the current phenomenological project. Before I describe specifically how I attempted to answer these questions, I provide in Chapter 3 an explanation of phenomenology and of the phenomenological approach to research. In particular, Chapter 3 offers not an entire history of the phenomenological movement, but rather a more focused description of phenomenology as it pertains to the current study.
Chapter 3: Research Design

Overview

Phenomenological inquiry is a qualitative research approach that explicitly focuses on the meaning of experience. Its origins trace back to the philosophical works of Edmund Husserl (1913, 1954), and later Martin Heidegger (1927); and it is their ideas that serve as the primary foundation for current applications of phenomenology as a method of scientific inquiry (e.g., Oiler Boyd, 1993; van Manen, 1990). In this chapter, I first discuss phenomenology as a philosophy, by highlighting some of Husserl’s and Heidegger’s defining concepts. I also discuss Crotty’s (1996) distinction between nursing phenomenology and mainstream phenomenology. Of particular import will be how phenomenology is actually played out in current research. Secondly, I describe the phenomenological method, which represents a general way for generating knowledge within a phenomenological framework. Finally, I explain the specific phenomenological procedure that I used in the current study, and describe each step involved in data analysis, illustrating the steps with excerpts from my data. By the conclusion of this chapter, the reader should be adequately informed about phenomenological inquiry in general so as to understand how this perspective was implemented in my specific research investigation.

Philosophical Foundations

The ultimate goal of any phenomenological inquiry is to describe and understand human experience (Streubert & Carpenter, 1995). Phenomenology focuses on human
phenomena, and strives to describe experience as authentically as possible. Within phenomenology, "reality" cannot be separated from these human experiences. Indeed, what is regarded as "reality" is what is perceived to be "real" by those experiencing any given phenomenon. In other words, "reality consists of the meanings in a person's lived experience [and] humans know the world only as they experience it" (Omery & Mack, 1995, p. 141). Thus, reality is dependent upon the meanings that each person assigns to his/her experience.

Husserl, who is generally regarded as the founder of phenomenology, believed that philosophy could function as a rigorous science (1913). He maintained that the philosophy of phenomenology could generate knowledge through meticulous attention to human experience (Cohen & Omery, 1994). The core component of Husserl's position was that human experience contained basic, meaningful structures that, if revealed, would allow for an understanding of the universal nature of that experience. Knowledge was derived from these fundamental concepts of experience (Omery & Mack, 1995). Husserl referred to these basic, meaningful structures of an experience as essences. Others have defined essence as "a constant identity that holds together and limits the variations that a phenomenon can undergo" (Giorgi, 1997, p. 242). The essences of an experience are fundamental to that experience: they are invariant and inherently a part of that experience. Essences are the principle structures that define phenomena.

In addition, essences -- because they are the fundamental, defining structures of an experience -- should be the shared component of an experience. Unlike experience itself, which is unique and individual, the essence is that which is similar or common to anyone
with that experience. For example, in a phenomenological study of 40 women’s experiences of their partners at the birth of a child, one of the fundamental essences to emerge from the women’s accounts was that the partners’ presence signified communion for the women (Bondas-Salonen, 1998). In that study, the nature of the experience of having a partner present at childbirth was defined by the feature of communion, a feature that was invariant in all of the women’s experiences.

Husserl believed that essences were universal; that is, not linked to time or context. Further, the essence of a phenomenon was considered to be “pure” and pre-existent, the most basic element that exists before any interpretation or preconception regarding the phenomenon is introduced (Crotty, 1996). Phenomena can be accessed only through attention to individual experiences, which are unique and contextually linked. Husserl maintained that in focusing on human phenomena as a source of knowledge, one should attend to the lived experiences of individuals (1913). By lived experience, Husserl was referring to humans’ conscious experiences in the everyday world (Cohen & Omery, 1994). Individuals are not passive in their experiences; rather, through day-to-day experiences, individuals consciously, actively, and intentionally give meaning to the world around them. The meanings of these experiences, though, are not readily apparent. Although Husserl was not primarily interested in everyday experiences, he recognized that it was only by attending to descriptions of these lived experiences that phenomena would be exposed. Thus, Husserl maintained that what can be known from phenomenological inquiry arises from discovering the essences of phenomena that are constituted from the everyday experiences of human beings.
Heidegger’s phenomenology differs from Husserl’s in several important respects. Heidegger, like Husserl, believed that experience contained essential structures that were invariant and shared between individuals experiencing a phenomenon. In accessing phenomena, Heidegger, too, posited that one needed to turn to lived experience (Cohen & Omery, 1994; Omery & Mack, 1995). Husserl believed that phenomena could be described just as they present themselves in experience; hence, Husserlian phenomenology is often called “descriptive” or “eidetic.” Heidegger, on the other hand, believed that phenomena could never be comprehended apart from context. He suggested that parameters of our everyday world — time, culture, and history — always defined and limited the way in which we can understand phenomena (Crotty, 1996). Thus, for Heidegger, the aim of phenomenology was to elucidate an understanding — but not necessarily the understanding — of being-in-the-world; that is, the world as it is bound by context (Ray, 1994).

Because phenomena from the Heideggerian perspective are inherently contextually linked, analysis of phenomena necessarily involves interpretation of meaning. Hence, Heideggerian phenomenology is often referred to as “interpretive” or “hermeneutic.” In hermeneutic phenomenology, what the researcher seeks to make explicit are participants’ own interpretations of their experiences, and how these interpretations are constituted by language and culture (Ray, 1994). Ultimately, meaning cannot be separated from the context in which the meanings are formed.

I should assert here that phenomenology as it is actually practiced is “messier” than the descriptions of “pure” Husserlian or Heideggerian phenomenology. For instance,
although some researchers will explicitly refer to either Husserl's eidetic phenomenology or Heidegger's hermeneutic phenomenology as the philosophy grounding the study (e.g., Beck, 1998; Lauterbach, 1992), others either utilize a blend of these frameworks or do not specify from which tradition their work draws (e.g., Carter, 1989; Pascucci & Loving, 1997). In addition, researchers often use an appropriated form of Husserl's or Heidegger's phenomenology. It is this appropriation that has received marked attention by Michael Crotty (1996). Crotty suggests that "pure," European, or mainstream (terms he uses synonymously) phenomenology -- as Husserl or Heidegger intended -- is rarely practiced by "new," North American, or nursing phenomenology. Further, he notes that this trend is largely unrecognized by the new phenomenologists. Using a sample of 30 recent nursing phenomenological studies, Crotty highlights the goals of the new phenomenology. Specifically, he posits that nursing phenomenology is primarily concerned with explicating the subjective lived experiences of individuals, a practice that yields "everyday understandings of everyday experiences" (1996, p. 12). The emphasis in this goal, according to Crotty, appears to be on the uniqueness of experience. Thus, what the new phenomenologists attempt to achieve is understanding of experience "from the participants' own perspectives." The result of such practice is often a mere summary of thoughts, feelings, or attitudes of participants. The aim of mainstream, authentic phenomenology, in contrast, is to elucidate the shared essence of phenomena that derive from individual experience, but that is universal and not particular to any specific experience (Crotty, 1996).
It is likely that many studies that fit into Crotty's "new" phenomenology, although claiming to discover "universal essences," are actually articulating summed subjective experiences (e.g., Hartrick, 1997). A study resulting in summed subjective experiences certainly presents information that is valuable in its own right. The most important recommendation, perhaps, is for researchers who practice phenomenology to be explicit about their intent and their conclusions -- especially if these differ -- and to highlight the tension within their work between looking for universals and describing individual subjectivism.

The Phenomenological Method

The primary aim of phenomenology is to understand the essence of experience (Giorgi, 1994). Husserl suggested that to achieve this goal required meticulous and systematic attention to individual experience, which could yield an authentic description of phenomena. This rigorous attention took the form of a particular phenomenological method that captured the best way to discover the essences of phenomena. The phenomenological method has been articulated by a number of recent phenomenologists (e.g., Giorgi, 1985, 1997; Kvale, 1996; Oiler Boyd, 1993; Streubert & Carpenter, 1995), and it is to their scholarship that I turn to describe this method.

The phenomenological method as it is applied within scientific inquiry consists of three interrelated steps: reduction, description, and a search for essences. Most current phenomenological investigations contain some version of each of these processes, with varying degrees of adherence to "pure" standards as articulated by Husserl and Heidegger.
**Phenomenological reduction.** The first process of the phenomenological method emphasizes the point that what is important in phenomenological description is the participants’, not the researcher’s, perspective of an experience. Reduction refers to the criterion that description of phenomena must be free from the researcher’s preconceived beliefs and biases. It is a form of “rigorous reflection” (Oiler Boyd, 1993), that demands that the researcher set aside any knowledge, theory, conceptual ideas, assumptions, or prejudices about the experience under investigation. This setting aside or disengaging from personal biases is called **bracketing**. Importantly, it is neither possible nor necessary to bracket all past knowledge, merely the knowledge or preconceived ideas that relate specifically to the research question of interest (Giorgi, 1994).

As researchers, we bring to our research taken-for-granted assumptions and personal biases about how phenomena in the world operate. In other words, “we are always selective in our perception of situations, focusing on certain aspects and ignoring others” (Crotty, 1996, p. 160). If we are not aware of our biases, and if we do not “suspend” or disengage from these ideas, they will continue to influence our understandings of phenomena. In short, we will see within phenomena what we want or expect to see. Therefore, because phenomenology is discovery-oriented, the goal behind reduction is to approach experience with a fresh, open mind so that it becomes possible to see, or discover, all potential variations and nuances within phenomena (Oiler Boyd, 1993; Streubert & Carpenter, 1995).

Ideally, bracketing is not a one-time activity, but rather involves a continuous process of taking a critical view toward personal biases, presuppositions, or theoretical
commitments in a phenomenological project. These personal beliefs should be articulated. Some researchers (e.g., Bondas-Salonen, 1998) have done so by keeping a journal or collection of notes throughout the research process of personal bracketed experiences and expectations. For the current project I kept a collection of notes that described my biases regarding the phenomenon that I chose to investigate. I revealed within the experiential context of the study one expectation that I needed to set aside, and that was the expectation that what I learned from this project would be useful within applied programming and practice-oriented settings.

A second personal bias that required bracketing was my theoretical commitment. In my past academic education I chose to study and emphasize various feminist developmental theories -- such as those of Gilligan (Brown & Gilligan, 1992; Gilligan, 1982) and Jordan (1997; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) -- that speak to the importance of relationships for women. These theories guide an interpretation of women's experiences as being relationally oriented and enacted in such a way as to maintain and facilitate connection with others and avoid disengagement (Jordan, 1997). Clearly, my belief in the value of this framework could have influenced what I expected to occur within the experience of safe sex for women in committed relationships.

A third personal assumption that demanded articulation and suspension is grounded within some of my past qualitative research with middle adolescent girls regarding their beliefs about sexuality. One theme to emerge from interviews with these young women was their view that sexuality was more "dangerous" for girls than for boys, in terms of the physical risks presented by STDs and pregnancy, and the social risks such
as acquiring a “bad reputation” (Raymond, 1997). Because of these perceived risks, girls viewed it to be a female responsibility to make “smart” sexual decisions and choices. Thus, these girls indicated that decisions regarding safe sex within a relationship should be enforced by women themselves. Again, without recognizing and laying aside this knowledge in phenomenological inquiry, the experience of conducting these prior interviews could have colored my perspective within the current project regarding how safe sex decisions are made and by whom in an older population.

A final assumption that I wanted to recognize was my expectation that women’s condom use primarily would be due to a concern with sexually transmitted infections. Based on previous knowledge of contraceptive practices among young women, I would have been surprised if women who chose to use condoms did so due to an exclusive concern with pregnancy, because of the availability of hormonal contraception that is more effective than barrier protection in preventing pregnancy.

Crotty (1996) highlights that the process of placing personal expectations in abeyance allows for an “opening up” to phenomena, so that we can view experience as it presents itself, rather than as we have been taught to see it. This is a key feature of phenomenology that makes it quite distinct from quantitative or other qualitative approaches to science. Rather than viewing a phenomenon within a lens of active, operating expectations or assumptions -- as is typical in theoretically derived research -- in phenomenology the researcher is “passive before the phenomena” and open to any meaning that may present itself (Crotty, 1996, p. 160). We become receptive to a phenomenon presenting itself in any variety of ways, rather than as we might expect or a
priori hypothesize that it would present itself. For the researcher, throwing off expectations and assumptions allows for a seeing of experience unencumbered and unrestrained.

**Phenomenological description.** At the most elementary level, this second process states that phenomena must be described just as they present themselves (Giorgi, 1994). The researcher should describe experience as precisely, completely, and directly as possible. Importantly, the goal action of this process is to describe, not to interpret, which would introduce some external influence on the experience (Giorgi, 1997). Bracketing and being open to the phenomenon allows for this process to occur.

Description, however, is more complicated than simply holding preconceptions in abeyance so as to describe phenomena as they present themselves. This process is quite challenging, and it forefronts one of the key differences between Husserlian and Heideggerian phenomenology (Oiler Boyd, 1993; Ray, 1994). Husserl believed that it was possible not only to describe phenomena in the absence of preconceptions, but also to describe phenomena as they are pre-reflectively, primordially, or immediately, without any filters or lenses (Crotty, 1996). The result would be a “pure” description of “pure” phenomena. Heidegger disagreed, and suggested that because our language is inherently informed by culture and history — and to describe phenomena we must use language — that our descriptions are necessarily interpretations. Crotty concurs, stating that “we can understand it [phenomenon] and describe it only in and through thought patterns deriving from our culture and embedded therefore in our language...our phenomenological descriptions cannot but be interpretations and constructions” (1996, p. 166).
Scholars have adopted a number of variations in achieving this phenomenological description and in recognizing the extent to which the description is context specific. Indeed, researchers who claim to follow Husserl's phenomenology nonetheless produce descriptions of phenomena that are certainly linked to culture (e.g., Costello-Nickitas, 1994). Again, the best that researchers can do is to explicitly articulate the goal of the project and the actual findings, and make an attempt to be aware of what is necessarily interpretive.

**Search for essences.** The final process of the phenomenological method is described as a search for the essences of a phenomenon, or a search for "that which makes the phenomenon the phenomenon that it is" (Crotty, 1996, p. 168). After a description of experience has been generated within the perspective of phenomenological reduction, a search for the invariant, fundamental structures of that experience is undertaken. The critical process necessary to achieve this step is free imaginative variation. Within a specific phenomenological research project, free imaginative variation involves meticulous attention to the range of concrete examples of an experience as described by the participants, and the systematic varying of these examples to determine what is spurious about the phenomenon and what is fundamental (Streubert & Carpenter, 1995).

According to Giorgi, free imaginative variation means "that one freely changes aspects or parts of a phenomenon or object, and one sees if the phenomenon remains identifiable with the part changed or not" (1997, pp. 242-243). In other words, the researcher reflects upon and freely varies a phenomenon in all its possible forms, and that aspect(s) of the
phenomenon that stays constant or unchanged throughout the variations is the essence of the experience.

As Crotty (1996) and others (e.g., Giorgi, 1997; Colaizzi, 1978) recognize, this process is much more than just summarizing participants' feelings or attitudes. It involves explicitly articulating that about phenomena which is implicit. It is a way of "phenomenological seeing" that requires intuition and involves "a-ha" moments (Crotty, 1996). There are not measurable criteria to definitively determine when the essence of a phenomenon has been elucidated. Rather, there are moments when the researcher feels that the description generated exquisitely captures the very nature of a phenomenon, the core element that distinguishes it from a similar phenomenon. It is a way of knowing and feeling.

Giorgi's Phenomenological Procedure

Phenomenological researchers have developed various interpretations regarding how to implement the three general processes of the phenomenological method (e.g., Colaizzi, 1978; Giorgi, 1985; Parse, 1990; van Kaam, 1959; van Manen, 1990). Others have suggested that no one procedure is the "correct" or "legitimate" methodological interpretation: rather, each procedure has a slightly different focus and method of analysis, and choice of a specific interpretation should be informed by the researcher's phenomenon of interest, philosophical beliefs, and practical considerations (Oiler Boyd, 1993; Streubert & Carpenter, 1995). For the current project, I chose to follow Giorgi's phenomenological procedure (1975, 1985, 1997).
Giorgi articulates his procedure as a method of “pure,” descriptive phenomenology (as distinct from interpretive phenomenology in the Heideggerian sense), that yields a description of phenomena precisely as they are experienced by individuals (Giorgi, 1997). He explains that “interpretation would be the clarification of the meaning as experienced objects in terms of a plausible but contingently adopted theoretical perspective, assumption, hypothesis, and so on” (1992, p. 122). Importantly, two points regarding Giorgi’s view of interpretation require acknowledgment. First, Giorgi’s view of interpretation is as a purposeful mental process in which theory or assumptions are deliberately put upon the data. This is one type of interpretation that followers of Husserlian phenomenology attempt to avoid. However, interpretation as described by Heidegger, and later by van Manen (1990) and Crotty (1996), also includes placing upon the data a viewpoint that cannot be helped, that is not deliberate, but occurs nonetheless. As described earlier, this second type of interpretation occurs because our language and even the phenomena chosen for study are necessarily linked to history and culture (Heidegger, 1927). Therefore, it is not possible to describe phenomena in “pure” fashion, as Husserl and Giorgi suggested. In my study, I made every attempt to refrain from the first type of interpretation through the phenomenological reduction. Regarding the second type of interpretation, in the final chapter I tried to explicitly articulate how contextual influences necessarily guide the description and understanding of the phenomenon that is generated.

The second point regarding Giorgi’s view of interpretation that requires recognition concerns the fact that Giorgi does allow for and actually promotes the
expression of findings back into the disciplinary discourse of the researcher. I would argue -- although Giorgi would likely disagree with me -- that this is yet another type of interpretation. Specifically, Giorgi suggests that analysis should take place "with a special sensitivity to the perspective of his or her discipline," for example, psychology, sociology or nursing (1997, p. 244). Thus, even Giorgi cannot generate a pure description that is completely free from any external direction; further, he recognizes that the identification of essences is, indeed, dependent upon -- at the very least -- a disciplinary perspective.

I want to articulate my reasons for choosing Giorgi’s procedure versus one of the other procedures. Primarily, my decision is based upon practical considerations. Of the various researchers who have described different phenomenological procedures, Giorgi’s seemed the most clear and direct, offering explicit steps for engaging in data analysis. For illustration purposes, he provides examples of each of these steps in his 1985 book chapter. I have also been able to read several current nursing phenomenological studies that follow Giorgi’s procedure; this has been invaluable in understanding and explaining phenomenological analysis within this proposal. Because this is my first attempt at phenomenology, Giorgi’s explicitness and directness, as well as the access to a variety of research studies that use his procedure, played a quite significant role in determining my choice of procedural interpretation. Of course, when I actually sat down with my data to begin analysis, I found that Giorgi’s seemingly clear and precise description of his method was vague and uninformative in places. I highlight these limitations shortly, in my description of how I analyzed my data.
Giorgi's procedure is an example of "descriptive" phenomenology, following a Husserlian philosophical foundation. As I have articulated in the proposal, I disagree with Giorgi's belief that what can be described as phenomena are free from any contextual influences. In this respect, my own beliefs are probably more in line with Heidegger's thought. However, I do believe that as long as these contextual influences are recognized by the researcher, then a description of phenomena that is close to "truth" for those participants' at that point in time can be generated. This recognition would be required by the researcher, but no attempt to have the participants themselves interpret their own experience would be made during the interview process. The practice of facilitating participants' deconstruction of their own experiences as linked to language, history, and culture would occur, however, during an interview that was grounded in Heideggerian phenomenology (personal communication. Dr. M. Koitham and Dr. J. Haase. Department of Nursing. University of Arizona. 3/25/99).

Giorgi's analytic interpretation of the phenomenological method has changed somewhat over the three decades that he published his phenomenological work (1975, 1985, 1997). His earlier work describes analytic steps that are more structured and discrete, whereas in his later publications, the analytic steps become more flexible and integrated. One limitation that I discovered in following his analysis was that although Giorgi recommends the collection of descriptions from more than one participant, in his own published examples of analysis he only uses one description. This made it difficult to determine exactly how Giorgi would have conducted analysis with a greater number of participants. A second limitation that I faced was that the examples Giorgi provides of his
interviews are very "clean." In other words, the presented excerpts of dialogue are practically formal -- his participants never provide one word responses, and do not use filler words as people do in everyday speaking, such as "um," "you know," or "whatever." In addition, his excerpts are very short, and therefore he does not display data that are repetitive. For these reasons, during my analysis I occasionally had to infer what the analysis might dictate and adapt his analysis for use with my sample. Other empirical research using Giorgi's procedure became helpful at this point (e.g., Ashworth & Hagan, 1993; Costello-Nickitas, 1994; Wertz, 1985), and demonstrated that other phenomenological researchers describe their analysis as an adaptation of Giorgi rather than a completely faithful replication of his method. Giorgi himself remarks of his analysis that "the concrete steps are rather straightforward, although infinite procedural variations are possible" (1989, p. 72). What is presented below is a combined description of Giorgi's concrete analytic steps from his 1975, 1985, and 1997 publications. I noted where my analysis needed to become an adaptation of his work, and why I felt it was essential to do so. Table 1 presents a summary of the steps in Giorgi's analysis.
Table 1


1. Sense of the Whole
2. Identify Meaning Units
3. Describe Central Themes
4. Consolidate Themes and Transform into Redescribed Statements
5. Situated Structural Description
6. Expressing Essences
7. General Structural Description

1. Sense of the whole. Giorgi's analytic procedure begins after detailed descriptions of participants' experiences have been obtained. The first step of analysis is characterized by reading the entire description of an experience (i.e., the interview transcript) to reach a general idea about the whole experience (1975, 1985, 1997). This step involves being highly familiar with the global, holistic nature of the experience as presented in the narrative. The researcher does not attend to specifics at this point, but rather achieves a holistic understanding.

To arrive at this global sense of the experience, for each interview I listened to the complete audiotape of the interview two full times -- once without interruption, and once during transcription. After I transcribed each interview, I read the transcripts from beginning to end at least two times before proceeding to the next step of analysis. The use of high quality recording equipment significantly contributed to my ability to gain a global
understanding of each woman’s experience. Because the recording was so exquisitely audible, I was able to hear every pause, laugh, hint of sarcasm, or tentativeness — expressions that are sometimes difficult to accurately reflect on a written transcript — that my participants expressed during their interviews. Throughout the entire analytic process, I would “hear” a participant’s voice in my head as I read and worked with the transcript.

2. Identify meaning units. Giorgi recognized that it is impossible to analyze a description all at once, and so for analysis to proceed the text must be divided into manageable sections. These manageable sections are not determined arbitrarily, but rather are based on meaning units within a text (1975, 1985, 1997). Meaning units are loosely defined as a collection of thoughts that express a similar idea of meaning. Any change in this idea or change in meaning is considered a transitional unit of an experience. Importantly, meaning unit discriminations are made with the researcher’s specific scientific disciplinary perspective in mind. The idea is that, reading the same text, a historian, anthropologist, and psychologist, for example, would all identify different meaning units. However, these discriminations are also conducted within a relatively open and spontaneous mindset, to allow unexpected meanings to emerge. The importance of the phenomenological reduction and bracketing becomes clear at this point, because a researcher should not discriminate meaning units based on what he/she expects to find, but rather on how a meaning changes for the participant (Giorgi, 1985).

Giorgi instructs to note directly on the transcript every time the researcher becomes aware of a change in meaning for the participant (1985). For each interview, I marked on the transcript each time I noted a change of meaning for my participant. I did
not submit to this process sections of the narrative that clearly were not relevant to the study. For example, I began each interview by asking participants to describe how they and their partner met. Their responses did not address the topic of the research in any way, and so I did not include these responses in the discrimination of meaning units. In addition, recorded interruptions of an interview because of a phone call, for example, were not included in this step. Participant responses that were only one-word or one-phrase also were not included in the meaning units, unless that response clarified or further described a previous statement. In those cases, that word or phrase was placed between brackets within the relevant unit. I read through each transcript once, demarcating meaning units. I then read through the transcript a second time to re-examine my demarcations and make any changes. In very few cases did I end up changing a meaning unit discrimination.

Following Giorgi (1975), all meaning units from an interview were transferred to a table format. In the table, the meaning units — expressed exactly in the participant’s own words — are presented in the left hand column, and are preceded by my stem question, which is underlined. Meaning units that were not preceded by a stem question are continued participant responses to the previously underlined stem question. Meaning units are consecutively numbered. By the conclusion of this step, the entire narrative has been divided into meaning units and transferred to a table, retaining the exact words of the participant.

To illustrate this process, below I provide excerpts from transcribed narratives of two of my participants. Following each excerpt is the table of meaning units that was
discriminated from that excerpt. In Table 2, Abby discusses the first time that safe sex was an issue in her relationship with her boyfriend. Table 3 demonstrates how Abby’s excerpt was transformed into meaning units. In Table 4, Kate describes why safe sex for her was “just a given.” Table 5 illustrates the meaning unit discriminations that were derived from this excerpt.

3. Describe central themes. The next step represents a change in Giorgi’s analytic procedure between his earlier work and later work. In Giorgi’s 1975 chapter, he suggests that the next step after a transcript has been divided into meaning units is to state as simply as possible the natural theme that dominates each meaning unit. Themes should be expressed as simply as possible, without losing any relevant data. The purpose of this step, then, is to elicit one theme from each meaning unit that captures the primary idea of that unit. Most of the time it should be possible to express this theme in a few sentences; these sentences maintain for the most part the original language of the participant. In writing the themes, Wertz, a colleague of Giorgi’s, suggests that the researcher should focus on the question, “What does each statement [meaning unit] express that is different from the others?” (1985, p. 176).
Table 2

Excerpt from Interview 7, Abby

M: Why don’t you think back over the course of your relationship, and tell me a little about the first time that safe sex became an issue for you in your relationship.

A: I don’t know. We talked a lot about it...fairly soon into the relationship. Because, I think we both wanted boundaries. And, like, I had decided no sex during high school, just because it was too much trouble, and my mom would have killed me. Or, his mom would have killed him and me or something. And, it just was not worth it. But, you know, we had a lot of conversations, and somehow that just came up, among other things. And, that it’s something that we both wanted, and, I mean, it seems like a bad idea not to.

M: A bad idea not to...

A: Practice safe sex.

M: And so when you first started having conversations about safe sex, was that before you were practicing sexual intercourse?


M: And how did those initial conversations go?

A: We spent a lot of time on the phone, and we ended up talking about all kinds of stuff. But, I don’t know, one of my big things is...I come from, my mom comes from a very traditional family. And, therefore, my grandfather expects me to grow up and have children. And having kids is not on my agenda at all.

M: Now or ever?

A: Ever. I’m just not interested in it. And, so, you know, I think that’s probably how safe sex was brought up. Just, you know, the pregnancy issue. And I don’t want that to happen. So.
Table 3

<table>
<thead>
<tr>
<th>Meaning Unit Discriminations From Table 2 Excerpt</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First time safe sex became an issue</strong></td>
</tr>
<tr>
<td>I don't know. We talked a lot about it...fairly</td>
</tr>
<tr>
<td>soon into the relationship. Because, I think we</td>
</tr>
<tr>
<td>both wanted boundaries. And, like, I decided no</td>
</tr>
<tr>
<td>sex during high school, just because it was too</td>
</tr>
<tr>
<td>much trouble, and my mom would have killed me.</td>
</tr>
<tr>
<td>Or, his mom would have killed him and me or</td>
</tr>
<tr>
<td>something. And it just was not worth it. But.</td>
</tr>
<tr>
<td>you know, we had a lot of conversations, and</td>
</tr>
<tr>
<td>somehow that just came up, among other things.</td>
</tr>
<tr>
<td>And, that it's something that we both wanted,</td>
</tr>
<tr>
<td>and, I mean, it seems like a bad idea not to</td>
</tr>
<tr>
<td>practice safe sex.</td>
</tr>
</tbody>
</table>

| **First conversations before practicing sexual intercourse** |
| Right. Yea. Way before. We spent a lot of time on the |
| phone, and we ended up talking about all kinds of stuff.|
| But. I don't know. one of my big things is...I come from, |
| my mom comes from a very traditional family. And,        |
| therefore, my grandfather expects me to have children.   |
| And having children is not on my agenda at all. Ever.    |
| I'm just not interested in it. And, so, you know I think |
| that's probably how safe sex was brought up. Just, you    |
| know, the pregnancy issue. And I don't want that to      |
| happen. So.                                             | 2 |

| **Table 3** |

Meaning Unit Discriminations From Table 2 Excerpt

**First time safe sex became an issue**
I don't know. We talked a lot about it...fairly soon into the relationship. Because, I think we both wanted boundaries. And, like, I decided no sex during high school, just because it was too much trouble, and my mom would have killed me. Or, his mom would have killed him and me or something. And it just was not worth it. But. you know, we had a lot of conversations, and somehow that just came up, among other things. And, that it's something that we both wanted, and. I mean, it seems like a bad idea not to practice safe sex.

**First conversations before practicing sexual intercourse**
Right. Yea. Way before. We spent a lot of time on the phone, and we ended up talking about all kinds of stuff.
But. I don't know. one of my big things is...I come from, my mom comes from a very traditional family. And, therefore, my grandfather expects me to have children. And having children is not on my agenda at all. Ever. I'm just not interested in it. And, so, you know I think that's probably how safe sex was brought up. Just, you know, the pregnancy issue. And I don't want that to happen. So.
Excerpt from Interview 3, Kate

M: Why would you say it's just a given? Because, for a lot of people it's not just a given.

K: I guess we were both conscientious about it. Because it was, god, I'm trying to remember. Because I know I have without, which is bad. I know I have with other people without using them. So I'm not sure why...I think maybe it was more him. Because I know he had them. Oh...I do remember! It was him! It was kind of his insistence to use them. Which is pretty cool! Yea, it was him.

M: Do you have a sense of why he had them, or why he was insisting?

K: No. And I remember almost being insulted! I mean, I knew that was great that he was like that. But I thought, "Well, what am I exuding here that it seems like that!" (laughter) But, I know that he had an ex-girlfriend who had cheated on him and gave him something, like chlamydia or something like this. And they had a really tumultuous relationship. But, I know that happened to him in the past. So, I think that might be why he has a thing with them.

M: O.k.

K: Seems kind of tacky. But it happened.

M: Have you ever talked with him about that incident, or about why he had condoms ready, right there?

K: Nope. I think it was just real like, that's just how it is. You've got them right there beside the bed and you use them and that's it. It was never uncomfortable. We were never shy about it or whatever. It's just what we did.
Table 5

Meaning Unit Discriminations from Table 4 Excerpt

<table>
<thead>
<tr>
<th>Why was it “just a given”?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I guess we were both conscientious about it. Because it was, god. I’m trying to remember. Because I know I have without, which is bad. I know I have with other people without using them. So I’m not sure why...I think maybe it was more him. Because I know he had them. Oh...I do remember! It was him! It was kind of his insistence to use them. Which is pretty cool! Yea, it was him.</td>
</tr>
<tr>
<td>And I remember almost being insulted! I mean, I knew that was great that he was like that. But I thought, “Well, what am I exuding here that it seems like that!” (laughter)</td>
</tr>
<tr>
<td>But I know that he had an ex-girlfriend who had cheated on him and gave him something, like chlamydia or something like this. And, they had a really tumultuous relationship. But, I know that happened to him in the past. So, I think that might be why he has a thing with them. Seems kind of tacky. But, it happened.</td>
</tr>
<tr>
<td>Did you talk about why he had condoms ready</td>
</tr>
<tr>
<td>Nope. I think it was just real like, that’s just how it is. You’ve got them right there beside the bed and you use them and that’s it. It was never uncomfortable. We were never shy about it or whatever. It’s just what we did.</td>
</tr>
</tbody>
</table>

In Giorgi’s later work, he combines this step with the following analytic step, such that for each meaning unit he generates themes, but these themes go beyond merely describing in participant language the main idea of each meaning unit (1985). Instead, Giorgi suggests that the researcher should move directly from meaning units to a transformation and abstraction of participant language that takes place through the process of reflection and free imaginative variation. Because of the number of meaning
units generated for each of my interviews (range, 43-84 units; $M = 60$), and because a number of meaning units throughout an interview might express a similar theme, I chose to follow Giorgi's 1975 guidelines to better manage the volume of data with which I worked.

Therefore, for each meaning unit in a transcript, I wrote a short summary statement, or central theme, that described the meaning unit. Importantly, these themes retained much of the participant's own language. I worked with each transcript in its entirety at one sitting. Then, after putting the transcript away for a short time, I returned to it. reexamined the generated themes, and made any changes or refinements to the themes. At this point, the themes for a particular interview were transferred to the right hand column of the corresponding table of meaning units.

To illustrate this step, I have included below the Meaning Unit / Central Theme statements from two additional interviews. Table 6 presents an excerpt where Janice describes her reaction when a condom broke during a sexual encounter that happened before she began dating her current boyfriend. The second example, presented in Table 7, describes a different negative experience that Leah encountered, when she discovered that she might have been exposed to a sexually transmitted disease.

4. Consolidate themes and transform into redescribed statements. As I mentioned in the previous step, the purpose of this current step is to transform the participants' language into the researcher's disciplinary language. In other words, until now consolidation of data from raw data to central themes has remained at the level of the participant's own description of her experience. At this point, data needs to become more
abstract and is expressed in the language of the researcher’s scientific field. It is a process of narrowing and transforming the experience as expressed by the participants by extracting the key elements of the entire experience that are relevant to the researcher’s discipline (Giorgi, 1997). Giorgi explains that to achieve this “the researcher begins to reflect on possibilities”—that is, uses free imaginative variation—“and discards those [possibilities] that do not withstand criticism” (1985, p. 18). Notably, this is not an easy or quick process, and it is here that the researcher begins to “dwell” intensely with the data. The transformation occurs via rigorous re-readings of the data, finding and articulating increasingly deeper levels of meaning.

During my analysis, at this point I discovered that I needed to use an adaptation of Giorgi’s method, rather than exactly follow his analytic procedure. In his 1985 chapter, because he does not write central themes, Giorgi writes a transformed statement directly for each meaning unit. In his 1975 chapter, he writes a transformed statement for each central theme. However, the examples of narratives that he provided in both the 1975 and 1985 chapters are short and non-repetitive. Because I worked with an average of 60 central themes per narrative, and because many themes per narrative were redundant, I needed to consolidate and combine similar themes to a more manageable number. To do this, I took a copy of an entire, tabled narrative and cut each meaning unit/central theme statement into sections, so that for a narrative with 60 central themes I had 60 pieces of paper, each piece containing one central theme.
Table 6

Meaning Units and Central Themes for Interview

4. Janice

<table>
<thead>
<tr>
<th>Talk about when condom broke</th>
<th>J describes when a condom broke with a previous partner, and how much it scared her.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oh yea, freaked the hell out of me! Cause that had never happened before. And the condom completely broke, I mean, we’re talking HUGE hole, and it was very frightening.</td>
<td></td>
</tr>
<tr>
<td>How long did you wait to have sex after that</td>
<td>After that experience of a condom breaking, J was very paranoid and didn’t have sex for five months. She had a lot going for herself, and getting pregnant would have been a bad thing.</td>
</tr>
<tr>
<td>Five months. Yea, I was pretty paranoid. Just because I was getting ready to come down here. You know, and it was the end of my senior year. And I have a lot going for myself, and it would not have been a good thing or a right thing. So, that’s why.</td>
<td></td>
</tr>
<tr>
<td>Were you as adamant about using condoms before that, and if so, why</td>
<td>J has always adamantly used condoms to avoid any STDs. but to still have and enjoy sex. She waited to go on the pill until college so her parent’s wouldn’t know.</td>
</tr>
<tr>
<td>Always. Just not wanting to get HIV, any STDs, trying to avoid all that as much as possible, but being able to enjoy having sex, too. And I didn’t get on the birth control pill until I got down here, because I wanted to be away from home and do it on my own without my parents having to know and having to deal with it, or having to pay for it or anything.</td>
<td></td>
</tr>
<tr>
<td>Why using both forms and not just condoms</td>
<td>J uses two forms of safe sex because the pill doesn’t protect against STDs, and condoms break. Plus, the pill isn’t 100% reliable against pregnancy.</td>
</tr>
<tr>
<td>Just because of that experience of the condom breaking, it sort of hit reality, like. Oh, it really can break like they say it can! That’s why I said, I’m getting on birth control. And if I decide to have sex he’s still going to wear a condom. Because birth control is only 99.9% and there’s still that little chance that it couldn’t be safe, and plus the fact of STDs and stuff.</td>
<td></td>
</tr>
</tbody>
</table>
Table 7

Meaning Units and Central Themes for Interview

1. Leah

<table>
<thead>
<tr>
<th>Have you and your partner talked about just using the birth control pill</th>
<th>They would not just use the pill, because it doesn't protect against STDs, and because using two methods keeps the chance of pregnancy lower.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. because the whole point of getting another form of birth control is, a, to keep the chances of getting pregnant, you know, low. And, and the condom will keep the chances of getting any STDs low so, no that would defeat the purpose.</td>
<td></td>
</tr>
<tr>
<td>Um, also, it was like maybe...three weeks after we had started intercourse. he got a, his father is a doctor in Iowa. And he had gotten a phone call from his dad saying that. I guess an, an ex-girlfriend that he had back home, um, went to the hospital and she had HPV, which is Human Papilloma Virus. And she didn't know when she had gotten it. If she'd gotten it before or after. Because it wasn't, ah, she didn't have any symptoms. It was late, and, and so...She, she just happened to go into the hospital for something else and they discovered that her cells were low. So, ah, she called her dad 'cause she didn't, his dad 'cause she didn't know how else to contact him. So that started a big old thing. We both got tested, and...but you can't really test for HPV, but you know, we, I got a pap and, and he went and got tested and so that's another reason why we use precautions of that sort.</td>
<td>L describes an incident where an ex-girlfriend of her boyfriend had HPV, and didn't know whether she had given it to L's boyfriend. L and her boyfriend both got tested for HPV after finding out. They also use condoms because they aren't positive that he isn't infected.</td>
</tr>
<tr>
<td>What was that experience like for you</td>
<td>L says that incident could have broken them up, because she could have decided that she didn't want to deal with it. L recognizes that HPV presents more of a health danger to her (because of the link with cervical cancer) than to him.</td>
</tr>
<tr>
<td>Yeah, well, um. That could have been a really, breaking point for our relationship. 'cause I just could have said, &quot;You know, I don't want to deal with this. This is way too much. And it can, you know, harm me more than it could harm you.&quot; So, you know, the cervical cancer and stuff.</td>
<td></td>
</tr>
</tbody>
</table>
As I read each theme individually, I wrote a word or phrase on each paper that captured what the theme expressed. For example, "concern with pregnancy," "family influence," or "partner's characteristics" were all phrases that expressed themes in various interviews. I then divided the themes into categories or clusters based on these short phrases. Some categories contained many central theme statements; other central themes were a category unto themselves. I occasionally re-read the original meaning units for greater detail or to clarify an emergent category. Thus, the process of reducing the data to more manageable units is not unidirectional, but rather flexible and "flowing."

Let me illustrate this process using one of the interview narratives. One category to emerge from Kristan's interview concerned responsibility. Three separate central themes throughout the narrative, expressed in Table 8 below, all described Kristan's feelings about the role of responsibility in a sexual relationship. These themes were placed into one category, labeled "Responsibility."

To continue with the present example, the 44 meaning units in Kristan's interview were clustered into seven categories. Six central themes did not fit into any category and were considered a category unto themselves. For example, only one central theme in Kristan's interview addressed possible gender differences in practicing safe sex. Thus, Kristan's interview contained a total of 13 categories that each expressed a separate idea about her experience of safe sex.

Once I had categorized the central themes of a transcript, I followed Giorgi's process to transform categories into more abstract, disciplinary language; in other words, to move from a concrete, specific experience to a more general psychological statement.
(Giorgi, 1985). Working within categories or clusters of central themes, I used imaginative variation to determine the essential nature of that category to the participant's experience. I queried of each category, (a) "What in this category is essential to this participant's experience of safe sex?" and (b) "Could this category be absent without altering the participant's experience of safe sex?" Following Giorgi's procedure, if the category did not reveal anything essential to the participant's experience of safe sex, I eliminated it. I retained all categories that were essential, defining elements of that participant's experience. Returning to Kristan's interview, through this process I discarded seven categories and retained six: responsibility, not optional, why condoms, concern with pregnancy, partner's characteristics, and love/contraceptive use.

In most cases the categories with the greatest number of central themes were retained, versus those categories that were comprised of only one theme. Participants tended to spend a greater amount of time during the interviews talking about the elements of their experiences that were defining features of that experience for them. However, there were exceptional cases. For example, only once did one of the participants, Tanya, say during her interview that she would not have unprotected sex. Only one meaning unit/central theme represented the category of "not optional" for her. But, it nonetheless was an essential part of her experience of safe sex, because her experience of safe sex would not be the same without the notion that safe sex is not optional for her.
Table 8

Meaning Units and Central Themes Expressing the
Category of “Responsibility,” Interview 9, Kristan

That’s like the big thing for me. Is that, I would not want an unintended pregnancy. Like, I wouldn’t be able to handle it. And, I think the only way to take responsibility for something like that is making sure it doesn’t happen to me. Which, if I really wanted to make sure, then I wouldn’t be sexually active. But, I think I’m doing the next best thing. (Laughing) I don’t know, that’s the only way I can rationalize it! So, yea, I can’t think of any specific experience when somebody was messed up and it set a clear example for me. But, just along the way I’ve known people that in general have me be, um...like...proud that I can like, I can’t spit it out! (Laughing)

K doesn’t think she could handle an unplanned pregnancy. So, she wants to take responsibility for pregnancy and make sure it does not happen to her. Although she realizes abstinence is safest, she’s doing the next best thing. K is proud of her decision and ability to use condoms.

I think it’s just about responsibility. I mean, if you’re going to be sexually active, then I think you should be prepared for, like, be prepared. Period. And be able to, to deal with the consequences. So, like, if it’s really inconvenient to buy a box of condoms and bring it into your house, then, those people are going to have a big problem with inconvenience when they’re pregnant! It seems so easy to go out, and I don’t know what the problem is. Like, maybe it’s that people are embarrassed. But, now at this age, I don’t think that’s really one of the big issues. But...yea...for me it just all comes down to responsibility. Cause there are consequences. And I think most people are aware of those consequences.

K states that if you’re going to have sex you should act responsibly & be prepared to deal with consequences if you aren’t prepared. She compares the inconvenience of buying condoms to the inconvenience of being pregnant, and doesn’t understand why people wouldn’t use condoms. She believes most people understand the consequences, so the underlying issue is responsibility.

Just in general I think it’s the best way to take responsibility for your actions. Um, it’s safe. It’s, like, easy to get information about. Well, like I said before, I’m not going to judge anybody based on whether they practice safe sex. But, just in general, I think it’s the best way to take responsibility for your actions.

K says in general, safe sex is the best way to take responsibility for your actions.
Following Giorgi’s procedure (1975), for each retained category I wrote a redescribed statement describing the elements captured within the category. I wrote one redescribed statement for each invariant category that emerged from each particular interview. Basically, this step allows the researcher to discover the essences of the experience of safe sex for one participant at a time. Redescribed statements are expressed less directly at the concrete level of participants’ experience, and more within the researcher’s disciplinary language. For example, redescribed statements would not reference specific events, interactions, or conversations experienced by the participant. However, it is still a comprehensive description of the essential elements of their experiences. Table 9 contains all redescribed statements from Kristan’s interview. Appendix B includes all redescribed statements for all participants.

5. Situated structural description. The second to last step of Giorgi’s analytic procedure is to “synthesize and integrate the insights...into a consistent description of the psychological structure of the event” (1985, p. 19). In narrative, paragraph form the redescribed statements for an interview are fused together to form a consistent description about the participant’s experience (Costello-Nickitas, 1994). The importance of this step is that it allows for the demonstration of the interrelationships between and among the redescribed essential statements, and for the demonstration of the importance of each category. The situated structural description for each participant remains faithful to the specific context of that participant’s experience of safe sex.
Table 9

Redescribed Statements from Interview 9, Kristsn

1. Responsibility
For Kristin, safe sex is about responsibility. She believes that people who decide to be sexually active should be prepared by using contraception, or be prepared to deal with the consequences if contraception is not used. Kristin knows that she is ultimately responsible for protecting herself against pregnancy and STDs, and thus would rather be proactive about safe sex than deal with negative consequences that are the result of her own irresponsibility.

2. Not Optional
Kristin has used condoms consistently during her six year relationship with her partner. She says that since the beginning of their sexual relationship, they both assumed that condoms would be used. It has never been a question to not use condoms, because using condoms is not optional for either of them. Kristen describes condom use as automatic, something she does not even think about, and the easiest part of the relationship.

3. Why Condoms
Kristin uses condoms because they are inexpensive, convenient, and easy to use. The only reason she does not use the birth control pill is because they have had a long distance relationship for three years, and it does not seem necessary when she sees him so infrequently. If they did live together and she started the pill, they might try sex without a condom to see what it was like, but then would use dual protection to be extremely safe.

4. Concern with Pregnancy
Kristin’s main concern is pregnancy; she knows that she cannot handle a pregnancy at this time in her life. Kristin explains that she values the relative freedom she has to pursue her goals and figure herself out, and does not want anything to interrupt that. Because both she and her partner are monogamous and trust each other, STDs are not a concern.

5. Characteristics of Partner
Kristin’s boyfriend shares her feelings about safe sex, and about being responsible. Because he feels the same as her, she has never had a problem getting him to use condoms, and he does not complain about condom use like most other men. Kristin believes his responsibility comes from: (1) watching his older brother, who modeled what not to do by being promiscuous and not using contraception; and (2) being goal-oriented and successful, and wanting to do the right thing. Kristin feels lucky to have him as a boyfriend, because his attitudes make condom use easy.

6. Love & Contraceptive Use
Condom use is also easy for Kristin because she and her boyfriend are in love and committed to each other. Kristin believes that safe sex is easier when partners love and care for each other, because physical gratification is less important than respecting a partner’s values and being concerned for his/her well being. In addition, condom use is easier in committed relationships because any negative consequence resulting from unsafe sex is shared and becomes both partners’ problems.
To illustrate, Table 10 provides the situated structural description for Kristan. I wrote the situated structural descriptions several days after writing the redescribed statements for the corresponding interview. By this point in analysis I was so familiar with each interview that I wanted the situated description to accurately reflect the meaningful relationships between redescribed statements. To do this, I needed to step back from the data for a short period of time, to allow myself to view the participant’s experience more holistically. Appendix B contains all situated structural descriptions for all participants.

6. Expressing essences. To reiterate, the purpose of phenomenology as described by Husserl is to uncover the invariant, fundamental structures of human experience. And, unlike experience itself which is unique and individual, the essence of a phenomenon is that which is similar or common to anyone with that experience. Essences are accessed through systematic attention to individual’s everyday experiences. Up until this point in data analysis, analysis has focused on one narrative at a time, working intensely with each interview as a case study. The rigorous attention to individual participant’s experiences within the previous steps of Giorgi’s analysis — moving from raw data to the situated structural description -- has prepared the data for the final step of analysis.

During this last step, the researcher compares across cases to look for the essences of a general phenomenon, rather than the essences of an individual’s experience (1975, 1985, 1997). In other words, the researcher compares across individual participant experiences, and gradually discards those meanings that are unique or particular to a certain individual (Giorgi, 1985). The researcher looks for places of convergence between all cases.
Table 10

Situated Structural Description. Interview 9, Kristan

The most important element of safe sex for Kristin is responsibility. She believes that to be sexually active means she must be prepared to use protection, or else be prepared to deal with the consequences. Safe sex is not an option for her; it is a requirement. She has consistently used condoms during the entire course of her six year relationship. Kristin uses condoms primarily to prevent pregnancy. Because she feels so strongly about practicing safe sex, she says condom use is just automatic, not at all difficult, and the easiest part of the relationship. Currently, Kristin does not use the birth control pill, because she and her partner -- who lives in a different state -- do not see each other frequently enough to warrant its use. However, if they did not have a long distance relationship and had sex regularly, she would use the pill and condoms, because she is not willing to risk one method failing.

Condom use is easy for Kristin because her boyfriend feels the same way that she does about responsibility and safe sex. He has never objected to or complained about condom use. Kristin feels lucky that he acts this way, since most men do complain about condoms. Kristin believes his responsibility comes from both watching a promiscuous older brother be extremely irresponsible about contraception, and from being successful, goal-oriented, and wanting to do the right thing. Kristin, as well, does not want an unplanned pregnancy to interrupt the current freedom she has to pursue her goals.

Finally, Kristin says that condom use is easy because she and her boyfriend are in a committed relationship and love each other. Being in love means that respecting a partner’s values and concerns for his/her well being are more important than physical gratification or being momentarily irresponsible. Being committed also makes condom use easier because both partners know that any negative consequence would be a shared problem.

What is common or shared among participants -- those elements of experiences that are collective -- is retained. Thus, in this step, the researcher finally moves from individual experiences to the general, collective experience; diverse individual cases are viewed as examples of a more general phenomenon (Wertz, 1985). The goal of this step is to eliminate the variations in experience, and to access and make explicit the underlying
general structure of the phenomenon. To do this, the researcher again uses imaginative variation, this time to determine what elements from all the individual experiences are essential to the general phenomenon, without which the phenomenon would cease to exist, and what elements could be eliminated without altering the structure of the phenomenon (Giorgi, 1997). In other words, the underlying general structure should take account of the redescribed statements that are common to all or most participants, and that are essential to the phenomenon (Wertz, 1985). Giorgi states that the greater the number of subjects, the greater the possible variations, and thus the easier to see what is constant across cases (1985).

For my research, to reveal the underlying general structure of the phenomenon of women's safe sex in committed relationships, I first consolidated similar redescribed statements. I divided the redescribed statements for each participant into separate pieces of paper, such that if an interview yielded seven redescribed statements I had seven pieces of paper. I then clustered, across interviews, all similar redescribed statements, and noted the redescribed statements that were truly idiosyncratic. For example, "making condom use fun" was a redescribed statement that emerged for only one participant.

I examined each cluster of redescribed statements one at a time, and described each cluster with a collective theme. For example, several redescribed statements across participants described the notion that practicing safe sex was a way to protect participants from sexually transmitted diseases. Therefore, I labeled this cluster of redescribed statements with the collective theme, "Concern with STDs." I repeated this process for each cluster of redescribed statements. Some collective themes captured most or all
participants' experiences (e.g., "Concern with Pregnancy") and others captured a smaller number of participants' experiences (e.g., "Concern with STDs"). Redescribed statements that were idiosyncratic were eliminated.

Essences of the phenomenon of safe sex for women in committed relationships were derived from examining the relationships and patterns between the collective themes. For instance, three themes may relate to each other because they all express or illustrate a more abstract construct, which is the essence of the phenomenon. The essences represent the most universal and general level of understanding the phenomenon. Although the essences characterize the defining features of an experience for each participant, they do not contain any specifics or concreteness of individual experience (Wertz, 1985).

The process of deriving the essences is rigorous, and involves being able to step back from the attitude of concrete experiences within which the researcher has been working in until this point. Deriving, or filtering out essences from the collective themes calls upon the researcher to now see the previous analytic steps as holistically as possible; in other words, trying to "see the forest through the trees." Analysis at this stage is recursive, cyclical, and requires readings, re-readings, and reflection on not only the collective themes, but perhaps also the original transcripts to look for what may be implicit within the interviews (Wertz, 1985).

To illustrate this process, in the current research three collective themes interrelated and shared similar concepts: Concern with Pregnancy, Concern with STDs, and Fear. I determined that these themes expressed the essence of "Self-Protection."
Most participants described a concern with pregnancy, three-fourths described fear, and about half described a concern with STDs in their narratives. These themes are understood as variations of a larger concept. Examined collectively and holistically, these three themes all illustrated the more abstract and universal construct of self-protection. In other words, self-protection is one fundamental, invariant structure that defines the phenomenon of safe sex for women in committed relationships.

7. General structural description. The general structural description is a fairly brief narrative, written in paragraph form, that describes the relationships and patterns between the invariant essences of the phenomenon. The general structural description captures these interrelationships in a concise, consistent statement of the phenomenon. Because they are the defining, core elements of a given phenomenon, essences described within the general description should overlap and interrelate, rather than exist as discrete entities.

The analytic process can be summarized as follows:

<table>
<thead>
<tr>
<th>Raw Data</th>
<th>Sense of the Whole</th>
<th>Identify Meaning Units</th>
<th>Describe Central Themes</th>
<th>Consolidate Themes and Transform into Redescribed Statements</th>
<th>Situated Structural Description</th>
<th>Expressing Essences</th>
<th>General Structural Description</th>
</tr>
</thead>
</table>
Chapter 4: Research Method

To reiterate, the purpose of the current research was to describe and discover the essential nature of the experience of safe sex for young women in committed relationships. This chapter presents the method that I used to address this goal. Specifically, I discuss six focal areas: (1) the sample, including criteria for inclusion, recruitment procedures, and sample characteristics; (2) the data collection process; (3) ethics, or human subjects issues; (4) phenomenological interviewing, including general aims and guidelines, as well as specific interview questions; (5) data management; and (6) strategies that enhanced the trustworthiness of the data.

Flexibility in Phenomenological Methods

In contrast to many quantitative designs in which methodological decisions are typically fixed, standardized, and therefore unchangeable after the initiation of data collection, a defining characteristic of qualitative research is the potential for flexibility in method throughout the data collection process (Kvale, 1996; May, 1991; Seidman, 1991). Because the aim of phenomenology is in-depth understanding of the meaning of experience, allowances are made in the methodological process for changing the method in such a way so as to more closely pursue this goal. Phenomenological methodology is not a linear, unidirectional procedure, but rather a dialectical process that incorporates provisions for adapting to emergent insights (May, 1991). For example, in many phenomenological projects, data gathering and data analysis occur concurrently. Another
example of this flexibility is that the exact number of participants often cannot be
predetermined, because the sample size is typically dependent on the nature of the data
generated (Morse, 1991; Sandelowski, 1986). In addition, the content or structure of the
interview may require alteration in response to an emergent need for a different type or
quality of data (Seidman, 1991). This characteristic of flexibility or openness of method
has been recognized as a strength of qualitative approaches in general (Hendrickson-
Christensen & Dahl, 1993; Maxwell, 1996); and Popay and colleagues even state that
evidence of methodological responsiveness and redesign should be a standard for the
assessment of good qualitative research (Popay, Rogers, & Williams, 1998). It is also
important to note, however, that affording flexibility is not the same as a lack of
preparedness on the part of the researcher; nor does it mean that methodological decisions
are made without systematic attention and thoughtfulness to the “fit” between the purpose
of the research project and the resulting method choices. In the following chapter, I
highlight the decisions that were open to adjustment during the research process.

Sample

Criteria for inclusion. For the current study, I used Morse’s (1991)
recommendations for sample selection as a guide. Morse suggests that in qualitative
research, one of the most commonly used samples is the purposeful sample, in which the
researcher selects “informants best able to meet the informational needs of the study”
(1991, p. 127). Because I wanted to understand a specific experience – the safe sex
experiences of young women in committed relationships – I established four criteria for
inclusion as a participant in the project: (1) unmarried women between ages 18-23; (2) involved in a committed, heterosexual relationship for at least 3 months; (3) sexually active (i.e., engaging in intercourse) within that relationship; and (4) consistently practices condom use within that relationship.

In addition to participants having knowledge via direct experience of the topic of interest, Morse highlights two additional criteria necessary for a purposeful sample. These additional characteristics satisfy what Morse (1991) terms "qualities of a 'good' informant": (5) an ability to reflect upon and provide detailed and thoughtful information regarding the experience of interest; and (6) a willingness to share this information in an in-depth fashion with the researcher. During recruitment, I made an effort to obtain participants for my study who met these additional two criteria (see Data Collection).

Recruitment. Recruitment of participants followed several avenues. First, I made announcements in undergraduate classes at one large southwestern university. During the announcement I described the purpose of the study, the first two criteria (i.e., age and involvement in a committed relationship), and distributed a flyer to all students in the class that listed the four primary criteria listed and a phone number. I attempted to recruit from a variety of disciplines and from classes with a high number of female students, including family studies, psychology, women's studies, and sociology. Secondly, I posted advertisements at various campus locations including the Family Studies and Women's Studies buildings, the Health Promotion Office, and the Student Health Gynecology office. These posted advertisements contained the same information as on the flyer described above. Finally, I placed an advertisement in the university student newspaper, with a brief
project description and number to call for further information. Appendix C contains a copy of the recruitment flyer used for classroom handouts and for the posted advertisement.

Sample size. As previously noted, the sample size in phenomenological studies is typically not predetermined. Several phenomenological scholars suggest that data collection from participants should continue until “saturation” is reached (Morse, 1991; Streubert & Carpenter, 1995; Oiler Boyd & Munhall, 1993; Sandelowski, 1986). Saturation refers to the point in data collection in which no new information is being revealed or repetitiveness in the data becomes apparent (Morse, 1991). Others, however, posit that although saturation may be a useful guide, practical considerations of time and money are also important factors to consider (Kvale, 1996; Seidman, 1991). In the current project, these practical factors -- of necessity -- were weighted quite heavily.

Existing phenomenological investigations can provide an estimate of the average sample size in phenomenological studies. Streubert and Carpenter (1995) offer a description of 19 selected phenomenological research studies. The sample size among these 19 studies ranged from 2-108 participants; however, eight of the studies consisted of sample sizes of 10 or fewer informants; five studies reported sample sizes between 10-20 participants; and six studies reported over 20 informants. In my own file of 10 published phenomenological nursing studies, four of them had sample sizes of less than 10 participants; two studies consisted of between 10-20 participants; and four studies contained over 20 informants. The final sample for my study consisted of 12 participants. Two participants were recruited from the classroom announcements, four were recruited
from the posted flyer, and six participants responded to the newspaper advertisement. Based on the above considerations, I stopped scheduling interviews when I reached 12 participants.

**Sample characteristics.** Table 11 displays selected characteristics of the sample. Participants were asked to provide information about themselves and their partners on a short survey that was completed after the interview (see Appendix D for this survey). Participants ranged in age from 18-23 years, with an average age of 21 (M = 20.6). All participants were undergraduate women attending a large university in the southwestern United States. The male partners of the participants ranged in age from 18-31 years, with an average age of 23 (M = 23.1). Regarding partner educational status, seven partners were currently enrolled in or had completed a four-year college/university degree; one was enrolled in a two-year college; and two had not attended any postsecondary education. Table 11 provides participant and partner ethnicity and religious affiliation. Most participants and partners were Caucasian, and the majority did not formally identify with any religion. Participants were asked to rate both their own and their partner's degree of religious adherence. Among participants, two rated themselves as "not at all religious;" eight as "a little religious;" and one as "pretty religious." The corresponding ratings for partners were as follows: six partners were rated as "not at all religious;" four as "a little religious;" and one as "pretty religious." One participant did not respond to these two questions.

Table 11 also presents age at first intercourse for participants and partners. Participants' age at first intercourse ranged between 15-21 years, and the average age of
first intercourse for participants was 17 ½ (M = 17.6). Partners’ age at first intercourse ranged between 15-28, and the average age of first intercourse for partners was 18 (M = 18.2). The length of the participants’ current relationships varied. Participants were asked to provide the length of time during which their relationship was committed and monogamous. Some participants had casually dated their boyfriends for a period of time before the relationship was understood by both partners to be committed and monogamous. The following figures reflect only that length of time that relationships were considered under the more committed category. Relationships ranged in length from 4 months to 6 years. The average length of relationship among the sample was about 1 1/2 years (M = 19.3 months). Median length of relationship was 14.5 months.

Although no questions on the demographic survey inquired about sexual history, during the course of interviews I discovered that seven participants had been virgins before becoming sexually active with their current partners. The remaining five had at least one previous sexual partner before their current partner. I do not have definite virginity status data on the partners. Interestingly, although the criteria for participation in the current study only specified consistent condom use, 10 participants practiced dual method use by also taking the birth control pill. The significance of virginity status and dual method use will be discussed later in this report.

Data Collection

Data collection involved two screening processes. All potential participants contacted me by phone for further information. During this initial phone contact, I re-explained the project in greater detail, and assessed their eligibility for
Table 11

Ethnicity, Religious Affiliation, and Age at First Intercourse for Participants and Partners

<table>
<thead>
<tr>
<th></th>
<th>Participants</th>
<th>Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian*</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Asian-American</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>African-American</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Protestant</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Non-denominational</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Does not identify with any religion</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Age at First Intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-16</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>17-18</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19-20</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>21+</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note: 2 participants and 1 partner were Native East German.

participation by explaining the six criteria. At that time, participants had the opportunity to refuse participation. Although none of the participants decided against participation at
that time, one recruited participant failed to show up for her interview, and did not return my phone call attempting to reschedule.

Once participants agreed to engage in an interview, we arranged for an appropriate time and location. Although I allowed participants to suggest an alternative location that was convenient and comfortable to them, all participants chose to conduct the interview at my office. I conducted all of the interviews, and they were conducted privately.

When participants arrived at my office we introduced ourselves, and I further explained the purpose of the study. Before interviews formally began, informed consent was obtained (see Human Subjects). The second screening process occurred after the interviews began. Morse (1991) suggests that "secondary selection" is used to ensure quality of data. Secondary selection involves the decision to delete participants from the study if, during the interview, the participant turns out to be a "poor" informant; in other words, if the participant is not able to discuss or reflect upon her experiences in a revealing way. In this situation, Morse (1991) suggests that the interview be terminated prematurely, and the participant is dropped from the study. None of the participants were dropped from the study.

Following the interview, all participants completed a short questionnaire consisting of socio-demographic questions (see Appendix D). I emphasized that they may be contacted during the research process for a second interview, for clarification of any unclear points, or for validation of study findings (see Trustworthiness of Data). In
addition, the participants were invited to contact me should they have further information to share at a later point in time. Finally, a referral list with university and community sexual health resources was distributed.

Human Subjects

Because of the often intimate and personal nature of data generated during in-depth interviews, some qualitative researchers posit that ethics and human subject issues should be an explicit part of any qualitative report (Oiler Boyd & Munhall, 1993; Seidman, 1991). Following these suggestions, I discuss five elements of informed consent as they related to the current study: confidentiality, attempts to protect anonymity, uses of data, right of withdrawal, and risks and remuneration.

Before each interview began, confidentiality was described to informants. I explained to each participant that she was assigned a code number. Access to the link between code numbers and names was restricted to myself and my advisor, and only code numbers would appear on any audiotapes or transcriptions.

Related to this issue of confidentiality is the notion of anonymity. I explained that every attempt would be made to protect the identity of each participant. Steps taken to protect the participants' identities included: (1) the use of pseudonyms in the transcripts of the interviews for all persons mentioned during the interviews; (2) the use of pseudonyms in any research publications or presentations for any persons, schools, or cities mentioned during the interviews; (3) the disguising of any other identifying information in publications and presentations based on the data; and (4) the storage of
audiotapes and consent forms in a locked file accessible only by the researcher and her advisor (Seidman, 1991).

Each participant was also told that the data generated from the interview and any future contact may -- but not necessarily will -- be used in a variety of ways. The potential uses of data included: dissertation, published research articles, conference presentations, and for teaching purposes. Again, I reiterated that every attempt would be made to protect participants' identities within each of these forms of publication.

I emphasized that, because participation was completely voluntary, the participant had the following rights: (1) to withdraw from the study at any time without causing bad feelings; (2) to turn off the tape recorder at any time during the interview; (3) to refrain from answering any question; and (4) to request that a particular portion of data be excluded from the study.

Finally, the minor risks (e.g., in terms of emotional upset) were described. and the participant was reminded of the token payment of $20 that she would receive at the close of the interview. Following this verbal review of informed consent, the participant read the written consent form containing the same information and ask any questions. After written consent was obtained, the tape recorder was turned on and the interview began. Appendix E contains the Human Subjects Approval letter. Appendix F contains the consent form used in this study.
The Phenomenological Interview

In general, the goal of phenomenological interviewing is to understand an informant’s perspective about an experience, and the meaning he or she attaches to that experience (May, 1991; Seidman, 1991). In other words, the purpose is to reveal participants’ experiences from their perspective, not from the researcher’s perspective. Bracketing of the researcher’s presuppositions, prior knowledge, and assumptions, therefore, becomes crucial at this phase of the research process.

In an ideal phenomenological interview, the researcher does not influence or lead the participant to any specific response; rather, the participant’s story guides the interview. The process of asking leading questions is often referred to as “topic control” (May, 1991). Topic control is the subtle manipulation of the informant to produce information that is consistent with the researcher’s expectations through the language of the research question. May (1991) suggests several strategies for avoiding topic control during a phenomenological interview. First, she suggests using open-ended questions and non-specific (i.e., non-scientific or non-discipline) language until the informant’s own vocabulary can be identified and used during the interview procedure. Thus, the language used throughout most of the interview should reflect the informants’ language. Secondly, May (1991) recommends clarifying any vague participant responses until meaning is understood from the participant’s own perspective. In this way, the researcher will not be tempted to interpret an ambiguous statement from his or her own preconceived expectations. Finally, the researcher can analyze early interviews for the presence of leading questions, and eliminate this type of questioning in later interviews (May, 1991).
During my interviews, but particularly during the early interviews, I made an effort to be aware of the issue of topic control and to avoid asking leading questions. I also took notes on words or phrases used by the participant during early parts of the interview, and tried to use this language throughout the remainder of the interview.

In preparation for my interviews and during the interview process, I followed a general guideline for phenomenological interviewing. Because the purpose of phenomenological interviewing is to understand experience as expressed by the participants, interviews typically begin with a general question that is focused on the topic of the research project (Seidman, 1991). The rest of the interview can be viewed as a follow-up and expansion to the participant’s response to that general, introductory question (Kvale, 1996). In other words, once the researcher has set the “groundwork” for what the interview will focus on, the interview is structured so that the participant can take the interview in any direction and can emphasize whatever it is that he or she views as important regarding that topic. Some nursing phenomenologists recommend giving the participant the general question a day before the interview to think about (M. Koitham and J. Haase, personal communication 3/25/99, University of Arizona). Importantly, the participant is to think about the topic and the meaning of the experience under study without analyzing the experience. The goal is for the participant to be prepared to offer a meaningful and insightful description of his or her experience, not an analysis of the experience. The general, introductory question that establishes the focus of the interview is open-ended, and should elicit a lengthy description from the participant. Examples of what this question should look like include: “What is it like to.....?”, “Can you tell me
about...?". "Could you tell me what the experience of ‘X’ is like for you?", or "Could you 
describe in as much detail as possible...?" (Kvale, 1996; Seidman, 1991).

Although I had originally planned to ask of my participants, "Talk about what the 
experience of safe sex in your current relationship is like for you," input from colleagues 
suggested that this question may be too vague, and not grounded enough in their daily 
experiences to enable participants to easily respond. To provide more guidance an open-
ended question that was a bit more specific was posed to the participants. I called each 
participant the night before the interview to confirm the interview. At this time, I told the 
participant that the next day during her interview I would ask her to, "Think back over the 
course of your current relationship and talk about both how and why safe sex became an 
issue for you." At her request, rather than calling I emailed one participant this question 
the night before her interview. I was not able to talk to and provide this question to only 
one participant before our scheduled interview.

My first participant agreed to serve as a pilot interviewee, by offering me feedback 
about the interview questions and format at the close of her interview. Although she was 
comfortable with most of the interview, this participant thought that the opening question 
-- the one I had given to her the night before, and started the actual interview with -- was 
too direct, especially given the sensitive nature of the topic. She recommended keeping 
this question the same for the night-before phone call, but starting the face-to-face 
interview with a more comfortable question. With this input, I changed the beginning of 
the interview so that my initial question was designed to be an ice-breaker to help the 
participant feel comfortable talking during the interview situation. Therefore, for the
remainder of the interviews. I began with the query: "Why don't you describe for me how you and your current partner met." I asked a few follow up questions to clarify the length of time they had been dating exclusively. After those initial questions, I posed the following primary interview question: "Think back over the course of your current relationship, and tell me about the first time that safe sex became an issue for you."

According to the standards of phenomenological interviewing (Kvale, 1996; Seidman, 1991), once the informant has provided a response to the introductory question, the rest of the interview should be elaborations and clarification on this initial response. "Tell me more" is often a commonly used statement to encourage the participant to continue talking about his or her experience. Kvale (1996) suggests that other questions designed to elicit participant elaboration or concrete details include: "Could you say something more about that?", "Can you give a more detailed description of that?", or "Do you have further examples of this?" The researcher should also clarify any vague statements and reflect back to the participant brief summary restatements, to ensure that the researcher's understanding of the experience is consistent with how the participant experienced it (May, 1991; Seidman, 1991).

After the participants responded to the primary interview question, I followed up on all issues or points raised during the response. However, I also had several other questions that I asked of participants, if these questions were not addressed during response and follow up to the initial question. These additional queries included: "Describe how and why you decided to use condoms as a safe sex practice;" "In general, what are your attitudes about safe sex?" and "What makes you able to consistently
practice condom use?” During the first few interviews I had also asked, “What are the
primary challenges to practicing safe sex?” I eventually dropped this question, as every
single participant I asked responded simply that there were no challenges. Appendix G
provides the general interview guide used in this study.

Because the researcher is engaged in multiple tasks during the interview -- such as
listening, being aware of time and participant comfort, and keeping the participant focused
-- it is often difficult to remember during an interview all the important points brought up
by the participant that require elaboration or clarification. Seidman (1991) suggests that
the researcher take notes of important words or phrases during the interview. Taking
notes not only helps the researcher concentrate on and remember the points to revisit and
explore with the informant, but it also helps the researcher to refrain from interrupting the
participant. Listening is the most important skill in phenomenological interviewing, and
interviewers should make an explicit attempt to listen as much as possible and avoid overly
talking or interrupting the participant (Seidman, 1991). Relatedly, the interviewer should
be comfortable with the natural silences and pauses during an interview, and allow the
informant ample time to comprehend a question, think about it, and formulate a response.
Before interviews began, I told the participants that I would be taking some notes during
the interview to ensure that I followed up on all important points that they raised. During
the interviews, I took notes of key words or phrases to follow up later in the interview. I
also attempted to be aware of interrupting the participant or filling silent spaces with
needless talk, and analyzed the first few interview audiotapes for the presence of these
occurrences.
Although some phenomenological researchers suggest that interviews should last a specific amount of time (e.g., Seidman, 1991), others suggest that time is often not an accurate measure of the quality of an interview, and that complete and revealing interviews can be conducted in a fairly short amount of time (e.g., less than 20 minutes) (M. Koitham & R. Dumas, personal communication 3/11/99, University of Arizona). Perhaps more important than setting a minimum amount of time for an interview is setting a maximum amount of time. An interview that exceeds 1 & 1/2 hours is likely too long, as both the participant may become tired and the researcher may no longer be alert to the nuances of the experience being described. The length of my interviews ranged from 45 - 75 minutes, with the vast majority lasting about one hour.

Data Management

All interviews were audiotaped. I transcribed all audiotapes to Microsoft Word computer files typically within 1-2 weeks after completing the interview. During transcription, I transcribed the interview word-for-word and also included non-verbal data, such as laughter, pauses (short and long), sighs, interruptions (e.g., phone ringing), or sarcasm. The goal was to achieve on paper a transcription of each interview that was an accurate reflection of the actual face-to-face interview as it occurred. The transcriptions were used during data analysis.
Trustworthiness of Data

Issues of reliability and validity are discussed within most quantitative and qualitative traditions. Qualitative research has often been criticized for a perceived failure to maintain methodological rigor during the research process (Lincoln & Guba, 1985). Qualitative scholars suggest, however, that the specific issues concerning scientific rigor are different for qualitative research than for quantitative research, and thus should not be described nor evaluated by the same vocabulary used in quantitative research (Lincoln & Guba, 1985; Sandelowski, 1986). Although some researchers who primarily use qualitative methods employ the terms "reliability" and "validity" (e.g., Maxwell, 1992) to discuss methodological rigor, others suggest that a more accurate description would center around issues of the "trustworthiness" of data (e.g., Lincoln & Guba, 1985; Sandelowski, 1986). Lincoln and Guba articulate the central question concerning trustworthiness of data in qualitative research as follows: "How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (1985, p. 290). They posit four criteria that contribute to the trustworthiness of data: "truth value," applicability, consistency, and neutrality. Sandelowski (1986) re-expressed these four criteria for nursing research. For the remainder of the chapter I describe how trustworthiness of data was enhanced in the current study by utilizing the contributions of these authors.

"Truth value" or credibility. The truth value, or credibility, of data refers to the notion that experience as lived and described by participants is accurately portrayed in the research findings, and that the researcher has generated faithful representations of these
experiences (Lincoln & Guba, 1985). Sandelowski suggests that findings are credible when the participants can recognize the described experiences in the study results as their own (1986). Lincoln and Guba propose several strategies to enhance the credibility of findings. The most important of these is "member-checking." Member checking refers to the process of confirming themes, descriptions, interpretations, or conclusions with the participants from whom the data were collected. The purpose of such verification or validation is multi-faceted, and includes: correcting errors or incorrect interpretations of experience, giving the participants an opportunity to volunteer more information, and providing participants with the chance to assess the overall accuracy of the research (Lincoln & Guba, 1985). In addition, credibility is enhanced when other "experts," typically peer scholars, review the findings.

In this research project, I enhanced the credibility of my findings in several ways. First, I conducted member checks with informants' who indicated an interest in doing so. I contacted four participants after I had completed data analysis and written the results, and asked if they would be willing to read a summary of the results. All four women agreed, and I emailed them the general structural description and asked them to return comments via email within one week. Sandelowski (1993) warns of the complexities of member checking, and highlights issues for the researcher to keep in mind when engaging in this process. She suggests that participants can be shown a situated or general description that is written in lay language, rather than the discipline-oriented language of the researcher. I chose to have the four participants read the general structural description exactly how it is presented in the Findings. Sandelowski (1993) also reminds the
researcher that participants may engage in member checking because they are reluctant to disagree with the researcher or want to be a "compliant" subject of science. To protect this from occurring, I emphasized to the participants that their engagement in this phase of the research was completely voluntary. Further, I encouraged these women to be forthright in their assessment of the study results. Specifically, I asked participants to read the summary and talk about both if the summary accurately reflected their experiences (and if so which pieces resonated with them the most), and if the summary or pieces of the summary did not reflect their experiences. I encouraged participants to be as honest as possible, and emphasized that I would welcome constructive criticism.

All four participants replied that they believed the summary to very accurately represent their experience of safe sex in a committed relationship. Some of the participants' comments were:

I believe my first reaction when reading the findings was something along the lines of, "Thank god, I'm not the only one!" Nice to know that I'm not the only woman out there who needs to feel in control of her future and feel safe before the thought of sex even comes up... Your summary more or less fits me to a "T!"

Your summary sounds right on the ball to me. All of the factors that you mention were important in my decision to use condoms. To me, the most important factors that you discuss are those of protecting oneself and of remaining in control of one's body.

None of the four participants who read the general structural description indicated changes that would need to be made in the summary to more accurately reflect their experience.
I also enhanced the credibility of my research findings by asking a “disinterested peer” to participate in a small segment of analysis. A fellow graduate student with experience in qualitative methods engaged in an abridged version of analysis with two interview transcripts. She read one interview transcript from beginning to end, writing down major themes or issues as they arose in the narrative. We then discussed the themes she identified, and compared them to the Redescribed Essential Statements that I developed for that interview. For the first interview transcript, she identified five of the seven themes that were represented in the redescribed statements. We discussed the remaining two themes, and realized that these themes were more implied within the data, and would not necessarily emerge from one reading. The graduate student only noted one theme that I had not included within the redescribed statements. We discussed this topic, and came to consensus that, although it was a theme in the interview, it did not seem to be an essential, defining part of the participant’s experience.

Because of our high level of agreement, we agreed to review only one further interview. I selected the interview that gave me the most difficulty in analysis. The participant for this interview was East German, and the interview was confusing in places because of some language barriers. The graduate student read through this interview twice, noting and then re-checking themes that emerged in her reading of the narrative. When we compared her themes with the redescribed essential statements that I had developed for this participant, we again arrived at a high degree of overlap. She noted only one theme that was not specifically represented in the redescribed statements. We discussed this theme and arrived at consensus that I had alluded to the concept under a
similar category; however, I did reword the redescribed statement to make this theme more blatant.

Finally, the graduate student read the general structural description that I had developed, which represented the shared elements of the phenomenon across participants. The purpose of this step was to see if that description “fit” each of the two narratives she had read. She agreed that the description accurately captured the experiences of those two participant’s interviews.

The process of “checking” my findings with another individual was extremely helpful in the final analytic process. Although she identified many of the same themes after reading the narratives once or twice that I had developed after a lengthy analytic process, her themes were akin to topics or brief statements (e.g., trust, communication) without any of the depth that the analytic process afforded. Further, she was not able to identify relationships between the themes after a quick reading of the narrative, a finding that I was able to accomplish through the detailed analysis.

Applicability or fittingness. Sandelowski (1986) refers to the applicability of findings as an assessment of the typicality or atypicality of the described results in the lives of the participants. In other words, do the findings that were generated “fit” the data from which they were derived, or do they make sense? In addition, fittingness refers to the issue of whether the results “fit” contexts and individuals outside of those studied in the research process (Lincoln & Guba, 1985). This may be an especially salient issue in phenomenological research, because informants are usually the most well-spoken, eloquent, and accessible members of a group (Sandelowski, 1986). Lincoln and Guba
(1985) suggest that the determination of fittingness is more the responsibility of the reader or audience, and that the responsibility of the researcher is to provide a detailed enough description so that the reader can indeed make this assessment.

To enhance the applicability or fittingness of findings, I engaged in member checks so a subsample of participants could assess if my generated description was representative of their experiences of safe sex. In addition, I attempted to be extremely detailed in my descriptions of the phenomenon, and attended to the nuances and depth of the phenomenon, so that others could evaluate if the phenomenon is consistent with other individuals or contexts. I strived to be forthright about how my descriptions of participants’ experiences, and how the experiences themselves, reflected certain cultural, societal, or historical influences.

**Consistency or auditability.** The concept of consistency or auditability refers to the notion of repeatability. Auditability exists when another researcher can clearly follow the research process from beginning to end, and repeat the decision trail or progression of events in the original study (Sandelowski, 1986). Lincoln and Guba (1985) highlight that auditability applies to every stage of the research: sampling decisions, data collection procedures, analytic decisions, descriptions of findings, interpretations, and conclusions. Sandelowski (1986) suggested that the decision trail to be explicated by the researcher should also include how the researcher became interested in the study and the researcher’s perspective on the experience of interest.

In the current study, I attempted to enhance the auditability of this research by being very explicit about each aspect of the research process, with special attention given
to the analytic process. In addition, I asked a peer scholar (another graduate student) who had experience with qualitative methods, but was fairly unfamiliar with the specific phenomenological method that I used, to review my description of the analytic process for places of ambiguity, or points at which my decision or reasons for my decisions become unclear or vague. She read Chapter 3 of this dissertation, and raised only minor suggestions for increasing the readability of the paper. These suggestions were incorporated into the text.

**Neutrality or confirmability.** The final criteria for enhancing the trustworthiness of a research project is referred to as neutrality or confirmability. Essentially, confirmability is achieved when evidence for the other three criteria are established (Sandelowski, 1986). Thus, in evaluating a research study, one would look to see if, for example, findings were validated with the informants, detailed descriptions were given of the phenomenon of interest, and procedural and analytical decisions were made explicit and auditable. This aspect of trustworthiness was assessed by reviewers of my project, such as my advisor.
Chapter 5: Findings

To reiterate from Chapter 3, the findings of the current research are the products that resulted from completing all seven steps of Giorgi's analysis. The findings should be a faithful representation of the participants' experiences under study, and should reflect the purpose of the research. The dual purposes of the current research were to: (a) describe the experience of safe sex for women involved in committed, monogamous, relationships; and to (b) discover the essential characteristics of safe sex experiences for women in these committed relationships.

To address these aims, I have organized the findings in the following way. First, I present the General Structural Description, which is the consistent, integrated statement that demonstrates the interrelationships between the four essential characteristics, or essences, of the phenomenon of safe sex for women in committed relationships. Second, I present a descriptive narrative for each essence separately. This narrative is followed by a description of the collective themes that contributed to the meaning of that particular essence. I used excerpts from the original transcripts to illustrate each essence and theme. I also indicated, when appropriate, how many participants endorsed a particular theme, to provide a sense of whether a theme was commonly shared by all participants, or whether it was a more distinct variation shared by a smaller group of participants (Giorgi, 1997).

Table 12 contains the essences and themes that emerged from the analysis.
Table 12

**Essences and Themes Describing the Phenomenon of Safe Sex for Women in Committed Relationships**

<table>
<thead>
<tr>
<th>Essence 1. Self Protection</th>
<th>Essence 3, Personal Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern with Pregnancy</td>
<td>Dual Method Use</td>
</tr>
<tr>
<td>Concern with STDs</td>
<td>Control</td>
</tr>
<tr>
<td>Fear</td>
<td>Benefits of Responsibility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Essence 2. Unwavering Internal Standard</th>
<th>Essence 4, Relational Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Optional</td>
<td>Characteristics of partners</td>
</tr>
<tr>
<td>Integral Aspect of Sex</td>
<td>Characteristics of relationships</td>
</tr>
</tbody>
</table>

**General Structural Description**

The phenomenon of safe sex for young women in committed, long-term relationships is defined by an absolute resolution by women to protect themselves. Women who consistently practice condom use possess an unwavering, internal standard that characterizes their beliefs and determines parameters for their behavior. This standard centers upon a sense of personal responsibility for their own health and well being. In other words, women believed the ultimate responsibility to protect themselves fell upon their own shoulders. This standard also incorporates a belief in the need to control facets of a sexual relationship – such as contraceptive use – that reduce the occurrence of negative consequences. Women who consistently use condoms view acting responsibly as
a mandatory part of being sexually active, because they do not want to experience pregnancy or STDs. Rather than seeing pregnancy or STDs as events that would never happen, or simply avoiding thinking about them, women perceived these negative health consequences as realistic, concrete threats to their health and lives. These women would not allow themselves to engage in unprotected sex, not only because of possible negative health consequences, but also because they were unwilling to sacrifice enjoyable or valued aspects of their current lives or their future goals. Maintaining vigilance about practicing safe sex inhibited women’s anxiety and worry about these unintended consequences, and therefore increased their enjoyment of sex.

For women who practice consistent condom use in the context of a committed relationship, safe sex is not an optional decision. These women’s convictions are not negotiable, and existed prior to and irrespective of their current partner. Women entered their current relationships with a securely established knowledge of their feelings regarding safe sex, and a belief that practicing safe sex is part of how they define themselves as sexual active women. Strong emotions of love and care existed for partners, but partners were not ceded influence to change the women’s beliefs. Importantly, even though the women viewed their unwavering convictions as derived from within themselves, relational support enabled them to maintain their standards in the context of a long-term relationship. That is, women recognized that they would not be able to uphold their personal standards regarding the practice of safe sex without the cooperation and support of their partners. Women felt able to communicate to their partners their intent to practice safe sex and use condoms before becoming sexually active within the relationship, and
subsequently negotiate contraceptive use in a given situation. Partners exhibited respect for their girlfriends’ wishes, even if inconsistent with their own preferences. Partners’ attitudes and behaviors enabled condom use to become an easy, natural, and integral aspect of sex.

**Essence 1: Self-Protection**

The phenomenon of safe sex for women in committed relationships was defined, in part, by a marked priority placed on women’s self-protection. In response to feelings of fear, anxiety, or perceived vulnerability to some negative consequence of unprotected sex, women acted in such a way to consistently protect themselves. For these women, what required protecting were valued aspects of their lives, including their health and their future goals. Women maintained a conscious awareness of the need to protect those facets of themselves, and vigilantly monitored sexual encounters and often their sexual partner so as to ensure their own safety.

The following excerpts illustrate the essence of self-protection:

_No. I don’t want to get pregnant. And, no. I don’t want any STDs. I mean, it’s that simple._ (Kristan)

_Probably for me it’s about myself. I don’t want to get pregnant!...If you really think about it, yea, I wouldn’t want that for him and he wouldn’t want that for me either. But I think it’s pretty personal, like, for ourselves...looking out for yourself._ (Kate)

_How much can you really trust somebody? Because they could cheat on you. Or they could have been. I don’t know, they could have done something. And I don’t care what it is, but I don’t want it! You know? That’s what it boils down to. I don’t want what they have._ (Colleen)
Three interrelated collective themes reflected the essence of self-protection: Concern with Pregnancy, Concern with STDs, and Fear.

**Concern with pregnancy.** All participants mentioned being concerned about experiencing an unintended pregnancy, and for 10 participants, this was a primary reason why they practiced safe sex. Pregnancy was viewed as a realistic risk, and these women perceived themselves as susceptible and vulnerable to that risk. That is, rather than thinking, “this will never happen to me” or simply not thinking about pregnancy at all, participants believed pregnancy was something that could realistically happen. Indeed, several participants likely overestimated this risk and called themselves “paranoid” about experiencing an unintended pregnancy. Therefore, they acted in ways to prevent this risk from occurring.

Women’s reasons for wanting to prevent pregnancy varied. For three participants who were raised in very traditional, religious households, premarital sex, premarital pregnancy, and out-of-wedlock childbearing was viewed extremely negatively, and was regarded by the participants and by their families as socially unacceptable. These families did communicate about sex and pregnancy, although typically in the context of others’ behaviors that were regarded as inappropriate. These participants grew up with a clear idea of their parent’s values about sexuality. Although they all expressed that, obviously, they disagreed with their family’s stance regarding premarital intercourse, they felt similarly as their parents did that pregnancy and childbearing should only happen after marriage. Accordingly, these women attributed their motivation to practice safe sex at
least in part to these family influences, and talked about a specific order being appropriate for the establishment of a family.

*I just wouldn't be able to have a baby before marriage. It's just, it's just not right. In my view, or, the way I've been brought up I suppose, it's just not the way things work...I come from a really traditional family. You know, you go to school, you get married, you have kids. You have a family. It just wouldn't fit into the model if that were ever to occur.* (Leah)

*Nobody in my family gets pregnant without being married. My grandparents are really strict Roman Catholics, and they're like, "This is NOT how it goes! You get married! You have seven kids!"...I mean, it's like writing an outline: "This is how it goes! And you don't deviate from the plan."* (Colleen)

These three participants were not the only women in the study whose families did not approve of premarital sex. Both Asian-American participants expressed that the mere discussion of sex was considered taboo in their house growing up, and they knew their parents felt strongly against premarital sex and pregnancy. However, neither of these participants attributed their reasoning to practice safe sex to their family’s values about pregnancy.

The majority of women who wanted to protect themselves against pregnancy — including those who also identified family influence as playing a role — did so because becoming pregnant would compromise their own current lives and their goals for the future. Participants spoke about a variety of personal future plans (e.g., finishing an undergraduate degree, attending graduate school, beginning a career), and about enjoyable and cherished aspects of their lives (e.g., a relative lack of responsibility, a spontaneous relationship with a partner) that they were not willing to forego because of an unintended pregnancy. Women placed these goals and enjoyable parts of their lives as priorities and
recognized that the achievement of these would not occur if they had a child. Pregnancy and children were seen as obstacles that would prevent the fulfillment of the women’s current happiness. Because of this belief, participants said they were not emotionally mature or responsible enough to have a child, because they were not ready to make the kind of sacrifices that being a mother demands.

_I don’t want a baby right now, and if I got pregnant I don’t think I could have an abortion. So, I would have to have it. And that would totally skew every plan that I have...I want to go to grad school after I graduate. And if I had a baby I just don’t think that that would happen._ (Tanya)

_I don’t want anything to get in the way of letting me pursue my life. Like, I know I’m young. I know that I’m going to look back on this time and be like, “Oh, I was young and happy and had no responsibilities!” I would really hate to mess it up in any way possible._ (Kristan)

_Had I gotten pregnant, that would have been a responsibility for the rest of my life! You know? And I’m not even old enough to. I don’t know, pay my own insurance yet! How am I supposed to have a child?_ (Colleen)

Only about half of the women directly mentioned their feelings on abortion. Half of these women said they would not have an abortion, and the others were unsure as to whether they could actually endure the physical and emotional process of having an abortion were they to become pregnant. For these women, becoming pregnant meant that they would have to sacrifice their goals to have the child. However, even the women who did not explicitly express their feelings about abortion talked about sacrificing current or future aspects of their lives if they had an unintended pregnancy in a way that implied they could not rule out the possibility of having the child.
Interestingly, very few participants discussed how an unintended pregnancy or having a child would affect their partner. In fact, boyfriends having any role in a pregnancy — for example, by providing emotional or financial support — was rarely brought up during their conversations about pregnancy. These women were primarily focused, instead, on how their own lives would be impacted and severely limited by pregnancy or motherhood.

Concern with STDs. Ten of the participants also expressed some degree of concern about contracting a sexually transmitted disease. Condom use was viewed as the best way to protect their sexual health from any infections. Participants varied in the accuracy of their knowledge regarding avenues of transmission or symptoms of different STDs. For example, two participants — who both had been raised in East Germany and had not received much if any sex education in school — mentioned being able to contract diseases from toilet seats or from partners’ not washing their hands. Three other participants who were Health Education or Nursing majors had extensive knowledge of the symptoms and severity of different STDs. All women, however, knew that they could help protect themselves by consistently using condoms. Having the physical barrier protection that condoms provide during sex was reassuring to some participants.

*I still did not know what women he had before. And, so, I mean, I just felt kind of safer...it might sound silly, but I don’t get all the stuff from him, you know? Like, all the fluid stuff from him!...So, I’m thinking that I don’t have the chance of getting any other illnesses or whatever. (Serena)*

For others, the link between using condoms and being protected against STDs was second nature.
When I was in junior high, we had to go through sex ed. And, they showed us these slides...I've never seen anything like that with the blisters!...They said, "Some people actually have this. This is what could happen if you don't use a condom." Like, the two are inextricably linked in my mind. (Abby)

For the women in this study, protecting themselves from disease first involved being certain that they did not have any diseases from prior sexual experiences. At least seven participants had been tested for HIV and often other STDs, and described during the interviews their own motivations and feelings about being tested. Most often, the decision to get tested was not expressed as a desire to protect any potential partner, but rather to relieve anxiety and ensure their own safety. For example, Janice explains her decision to get tested for HIV and other STDs during her first visit to the Women's Health Office after coming to college:

Just to. I guess, basically check myself out after having sexual experiences in high school and not having anything checked out and just assuming everything was okay.

Two women who were virgins before their current partners also got tested for STDs at the beginning of their current relationships. Each of these women decided to get tested not because of previous sexual experiences, but rather "just to be sure" for other reasons (e.g., having surgery). Participants who had been tested – all of whom chose to receive their test results -- were greatly reassured by the knowledge that they did not currently have any STDs from their previous or current sexual experiences.

A concern with STDs was reflected more powerfully in women's request for their partners to receive testing for HIV and other STDs. Nine of the participants revealed that they had either asked their current partner to get medically tested or had arrived at a
mutual agreement with their partner to both get tested. Participants talked about wanting to make sure that they would not incur any disease that their partner may have contracted from his prior sexual experiences (i.e., before his current relationship with the participant). Participants “asking” their partners, however, was often more akin to an “order,” because the expectation existed that the partner did not have the choice to say no to this request. Samantha illustrates this concern with a partner’s previous sexual encounters. Samantha was a virgin before becoming sexually active with her current boyfriend.

_I knew I was clean. But, the girl he dated prior was bisexual, and so I’m like. “O.k., you’re going to get tested, right?!”_

Importantly, just because a partner was tested did not necessarily mean that the participant was assured of his safety as a sexual partner. Several participants expressed a distrust of the accuracy of medical tests to detect STDs in their partners. These women who expressed distrust were well informed about the ability of various STD tests to detect different STDs in the body. At least five of the participants whose boyfriends were tested for STDs stated that a primary reason they continued to use condoms even after their boyfriend was tested and received negative test results was to protect against STDs. For example, Tanya, whose friend died of AIDS, explained her knowledge of the HIV test:

_I know that tests can fail, and there’s a window period for certain things and all that. I don’t want to have to worry about it, so I’d rather just have him do it [use condoms] and be safe._

Colleen, whose friend was diagnosed with herpes, knew that herpes is incurable and the virus remains in the body even if a person does not exhibit symptoms:
We got tested for HIV, and for, just the STDs. And we both came out okay, but how do you know it won’t develop? How do you know it’s not just dormant? I mean, the tests aren’t 100%. They only give you something like 87% accuracy, so where’s my 13% I don’t know about? That’s what I want to know.

Not surprisingly, all five women who still used condoms to protect against STDs even after their partner received a STD test had encountered some negative experience with STDs in their own lives. This direct experience with STDs is discussed shortly. Because these women did not feel as though they could rely exclusively on the medical system to keep them safe from disease, they ultimately trusted only their own personal actions. These actions demanded that they consistently use condoms with a partner.

Interestingly, only one participant whose partner had previous sexual experiences reporting relying exclusively on her boyfriend’s own words to assess her safety from disease. This participant’s boyfriend told her he was “clean,” and she trusted him because he had discussed with her his past sexual partners. Most other participants whose boyfriends had previous sexual partners discussed his sexual history. However, these women did not use these conversations to solely determine risk. The knowledge that a boyfriend had prior partners certainly contributed to the women’s request for him to get tested. But, even participants whose boyfriends had said they used condoms with these previous partners, or “knew” they did not have any disease, testing was still considered necessary. That is, even if the boyfriend believed himself to be free from disease, the participants nevertheless requested for him to be tested. Just because she knew his history, did not lead automatically to feelings of safety.
Fear. For nine of the participants, a concern with pregnancy and/or a concern with STDs was expressed primarily as fear. For three women, this fear originated from variable sources, such as "disgusting" STD slides in sex education classes, or a general "paranoia" about pregnancy from being raised to believe that "sex is bad." However, for fully half of the sample, feelings of fear, anxiety, or worry originated from a direct experience with a negative health outcome from unprotected sexual intercourse. This negative experience significantly influenced these participants' practice of safe sex. After the experience, which in most cases happened before meeting their current partner, women increased their use of self-protective measures (e.g., initiating dual method use rather than using only one form of safe sex, refusing to have sex until a partner was tested for STDs). Women attempted to attenuate their fear and concern by actively responding with preventative behaviors that they believed would increase their safety. All six women attributed their commitment to consistently practice safe sex in large part, if not completely, to this negative experience. Importantly, these negative consequences of unprotected sex did not necessarily occur only to themselves. Two participants described traumatic experiences that happened to their best friends. In addition, some participants encountered multiple negative experiences. The specific experiences that elicited fear and anxiety among the participants in this study included: participant who became pregnant at age 16, friend who died of AIDS, friend with unplanned pregnancy who dropped out of high school to have the child, friend with herpes from an unfaithful partner, two participants who contracted sexually transmitted infections, partner with a history of STDs, pregnancy scares for two participants after a condom broke, and an STD scare for a participant and her partner.
Participants reacted to these various experiences with an increased, pervasive fear of another negative experience if they did not take measures to protect themselves. For all of these women, the experience left them feeling personally vulnerable, and with a heightened perceived susceptibility to the negative consequences of unsafe sex.

Participants were haunted by the experience, as it was often consciously present in their minds. The following examples illustrate some of the participants’ responses to a traumatic experience. Kate became pregnant at age 16:

> I’ve been pregnant before. When I was young, I didn’t have sex for four years after that because it was like, sex equaled pregnancy to me... To me, it was an abomination. It was the worst, horrible, god-awful thing.

Leah’s partner was contacted by an ex-girlfriend during Leah’s relationship with him. The ex-girlfriend informed him that she had been diagnosed with HPV (genital warts). Leah discussed her feelings of alarm at having to suddenly worry about having been exposed to an incurable STD:

> It wasn’t so abstract. It brought, you know, concrete examples that could actually happen. “She has HPV. I could have contracted HPV and I could have given it to you”...it was concrete. It was something that was an actual issue.

Colleen’s best friend contracted herpes when a long-term partner cheated on her:

> I was just thanking God it wasn’t me. I was like, “Thank You! It was not me!”...I think I was more scared because I went through it with one of my friends. I took her to her doctor appointments to get treated. I went and picked up all the medication for her.

Tanya’s close friend died of AIDS:

> I had a friend who just recently died of AIDS. And I knew she was sick. She’s been sick for a couple years. So, that made me really firm [to use condoms]. To know, to see it and to know that it can affect anyone... Actually knowing someone
Thus, for the women in the current sample, consistent condom use as a method of safe sex represented a way to reduce concern, anxiety, or even fear about the negative consequences of unprotected sex – pregnancy and STDs.

Essence 2: Unwavering Internal Standard

Another essential characteristic of the phenomenon of safe sex for women in committed relationships was an unwavering, internal standard that dictated women's beliefs and behaviors. For the women in this study, practicing safe sex was a resolute and integral part of being sexually active. The personal commitment to practice safe sex was formed independently from their partners. How they wanted to act in sexual situations with respect to safe sex was something these women consciously thought about even before meeting their current partners. Women were not only comfortable with their own decision about safe sex, they were dogmatic in their adherence to their beliefs, and assertive in their communication to their partners about these beliefs. Because of the strength of their convictions, women entered their current relationships absolutely knowing that they would not have sex if it were unprotected. The importance women placed on this personal value guided their behavior, and they acted in such a way within the relationship to consistently uphold this value. This personal standard was independent of any characteristic about the women’s partners, who exercised no influence for these women on their ultimate decision to practice safe sex.
The essential characteristic of safe sex that was characterized by an inflexible internal standard was represented by two collective themes: safe sex as not optional for the participants, and safe sex as an integral aspect of sex.

**Not optional.** All participants expressed during their interviews that practicing safe sex was not an optional facet of being sexually active. The decision of whether or not to practice safe sex was never a question that these women seriously entertained. When asked why practicing safe sex was not optional, most women referred to their feelings about pregnancy and/or STDs. All participants had consciously thought about what they wanted to do in terms of practicing safe sex **before** becoming sexually active with their partners. Thus, they entered their relationships with a conviction that was not considered negotiable. This belief was such an integral part of the way in which these women not only viewed sex, but also defined themselves as sexual beings, that in their descriptions it was analogous to a statement of fact, rather than a belief. The following excerpts illustrate this idea.

*Safe sex to me is not an option. It's just something that has to be done.* (Leah)

*By the time I hit high school I knew that if sex was going to happen it was going to be safe sex. Unconditionally.* (Abby)

*There was never any question about that [condoms]. We've never not used them over the past six years...It was never an option to not use them.* (Kristan)

*It really wasn't an option of whether or not we were going to be protected or not. It was just, "Well, this is the safest way to go if we're going to do it."* (Tricia)

*We didn't really talk about it. I was just like, "This is how it's going to be."* (Colleen)
As the last quote illustrated, for these women the belief in the importance of practicing safe sex was so strong and so entrenched that it existed regardless of, or even in spite of, a potential partner. Partners of these women were not ceded any power or authority to challenge this resolute standard. For many women, their partners were not even provided with an opportunity to question the decision. Women did not allocate much priority to partners’ desires or preferences regarding safe sex. Women entered their relationships with their decisions to practice safe sex established, and they have not compromised those standards to accommodate their partner. Instead, their partner was expected to accommodate the women’s decision, or else the relationship would not have continued. Participants explained that as the relationship progressed and they became closer with their partners, they may have tried to explain to their partners why — in terms of pregnancy or STDs — they felt so strongly about practicing safe sex. But, typically when conversations first arose about sex, these women let their partners know that either they would use condoms or they would not have sex. The following selection of quotes illustrates the similarity of participants’ beliefs:

*I just couldn’t ever see a guy telling me, “No, I don’t want to use a condom.” Well, just cause it’s like, “Well guess what? It’s not your choice. You’re either going to use a condom, or you’re going to sleep over there.”* (Abby)

*It was never an issue of whether we were going to [practice safe sex] or not. It was either we’re going to, or we’re not going to have sex. Or the relationship would. I think, really would have ended.* (Leah)

*I always do that. I say, “Well, either we use a condom or nothing’s going to happen.”* (Gretchen)
Just the issue that he can't feel as much wouldn't be an issue for me, or a reason for me to not use it [condoms]. I mean, I think he still has enough fun! (Serena)

I didn't really care what he thought. Because as far as I was concerned, it wasn't going to happen unless [he used condoms]. (Tanya)

An important distinction emerged with respect to exactly what was not optional in the experience of safe sex among participants in this sample. All 12 women practiced consistent condom use. For seven participants, it was specifically the condom use that was an inflexible aspect of being sexually active. These women would not have sex without using a condom, regardless of whether any other contraception was used. In fact, all seven of these women were also using the birth control pill, because they were very concerned about preventing unintended pregnancies. Even though they used hormonal contraception, these seven women nevertheless insisted upon condom use to feel comfortable and protected during sex.

Of those seven women, five either had contracted an STD, experienced an STD scare, or had a friend become infected with an STD. These five women made sure their partners were tested for STDs, but still expressed lingering doubts about the accuracy of tests to detect the presence of an STD. The remaining two women expressed great concern about STDs, even though they had personally never been affected by one. These seven women who insisted upon condom use expressed a sense of heightened awareness and vulnerability to disease. Because of this perceived susceptibility, they used condoms to protect themselves against STDs.
The remaining five women in the study also practiced consistent condom use. However, for this group practicing some form of contraception was the facet of safe sex that was not optional, rather than specifically using condoms. These women would not have sex without contraception, and yet used condoms as their preferred form of contraceptive practice. For two of these women, condoms were the only form of contraception being used. One of these participants used condoms because they were easily disposable, and she needed to use a safe sex method that she could easily hide from her parents. The other participant used condoms because they were inexpensive, convenient, and easy to use. In addition, they were appropriate for her relationship, because the long distance nature of it meant that she and her partner did not have sex on a regular basis. The other three participants who viewed contraception, rather than condoms per se, as necessary used condoms in addition to the birth control pill. All five of these participants were primarily concerned with pregnancy, rather than sexually transmitted diseases. Not surprisingly, none of these women had any past history with an STD. The partners of three of the women had been tested for STDs, and the women were confident that the negative test results meant their partners did not have any diseases. Condom use was viewed as necessary for pregnancy prevention, rather than disease prevention.

Integral aspect of sex. The fact that practicing safe sex was an internal standard that guides these women's beliefs and behaviors was also reflected in the way they talked about their current condom use in their relationships. In their descriptions of their safe sex practices with their partners, all women directly stated or implied that condom use had
become a genuinely integral aspect of safe sex. These women used various terms to describe this pattern of condom use, such as “natural,” “a habit,” and “a given.” Because they had set an expectation within the relationship about condom use and had not permitted any deviations from this expectation, the practice of condom use had become an established part of the act of having sex. These women did not have to think much about using condoms anymore, because they felt confident that it would automatically happen.

Importantly, these women recognized that the actual act of using a condom is relational; that is, their partner has to physically put on the condom. Accordingly, when these women spoke of condom use being an integral aspect of sex, it was with the knowledge that they could achieve this assumption of use because of their partner’s willingness to use condoms consistently. Thus, condom use as an integral aspect of the relationship was intimately connected to characteristics of the women’s partners that afforded the women the ability to reach this regular and expected pattern of use.

*It’s [using condoms] kind of natural now. Just, okay, if we are going to have sex, then, yea, he can take that 10 seconds or whatever it takes so that he can put it on.* (Tricia)

*I don’t even have to tell him anymore. Like, that I want to use the condoms. It’s just, it’s so normal.* (Gretchen)

*The longer you date somebody, the easier it gets, I think. And it’s just like, it no longer becomes a cycle, like, “Okay, we HAVE to do this.”...It becomes an everyday thing. We’ll just do this. And it’s natural, and we don’t question each other anymore.* (Colleen)

*I can’t imagine not practicing it [safe sex]. I mean, absolutely. It’s just, that’s what comes before sex. That’s just what you do.* (Kate)
The condom thing is such a little thing to do. It's just such a little thing to do. That's the easiest part. Where, some people would be like, "Oh, that's the hardest part!"...It's not something we even think about! (Kristan)

Several women discussed during their interview the pattern of condom use at the beginning of their relationship versus at the present point in their relationship. Although a few women said condom use had always been an integral part of sex, others described a progression of comfort. This progression was explained as being consciously aware of needing to use a condom and needing to ensure that their boyfriend did indeed use one at the beginning of the sexual relationship, to eventually feeling secure that their partner would automatically use a condom. Participants described ways to facilitate this progression, such as keeping condoms right next to the bed so they were always available. Only one participant described this progression as encountering significant resistance by her partner. She referred to the process of her boyfriend's eventual acceptance of condom use and understanding of her reasoning to use condoms as "the transition." For this participant, the transition was facilitated by having her girlfriend, who was infected with an STD, explain to him why condom use was so important in terms of STD protection. At the time of the interview, this participant said that she never had to tell her partner to use a condom anymore because he automatically reached for one whenever they had sex.

**Essence 3: Personal Responsibility**

Safe sex for women in committed relationships was also defined by a third essence of personal responsibility. These women believed that they alone were ultimately responsible for their own health and well being. That is, these women saw their health as
actively and directly within their own control, rather than under the control of other sources (e.g., a partner, fate). These women recognized that they could choose to act in a variety of (irresponsible) ways regarding safe sex. Instead, they made a conscious choice to be responsible for their own health by practicing safe sex. Being responsible included: awareness of the negative consequences that result from unprotected sex, preparedness to practice safe sex by having condoms and often other contraception readily available, and control over both the use of condoms, as well as over their own and their partner’s emotions during sexual encounters. Knowing that they were being responsible, and knowing that they controlled the likelihood of any negative consequences afforded these women increased enjoyment and comfort during sex. The following quote exemplifies the essence of personal responsibility:

When it really comes down to it, you’re the person — you, yourself — you’re the person who decides if that condom is going to be used, if you’re going to be on birth control, did you take that pill, do you want to have children, do you want to risk doing this? (Janice)

The essence of personal responsibility was reflected in three different themes: dual method use, control, and benefits of responsibility.

**Dual method use.** Ten of the twelve participants practiced safe sex not only by consistently using condoms, but also by using the birth control pill. For half of these ten women, using hormonal contraception began before they were even sexually active with any partner for other medical reasons, such as controlling acne, regulating the menstrual cycle, or lessening negative symptoms during a menstrual period. These women continued using the pill once they became sexually active, at which point they added condom use.
The other five participants began by using condoms once they became sexually active, and then adding the pill at a later point. Three of these women who added hormonal contraception did so as a direct response to either becoming pregnant or experiencing a pregnancy scare when a condom broke during sex. Two women had tried a different form of hormonal contraception – the Depo-provera injection – but both women experienced significant negative side effects in terms of depression and moodiness and switched to the pill.

Because all women in this study expressed a concern with becoming pregnant, it is not surprising that so many of them used hormonal contraception, which was recognized as a more effective means of contraception than a barrier method alone. However, the dual method users in this study were not willing to take any chances with using only one method of contraception. For the purpose of pregnancy prevention, the pill and condom were viewed as working in concert, so that participants always had a “back-up” method in case one method failed. For example, women who had experienced a condom breaking or slipping used the pill in case this happened again. Similarly, some women expressed concern about the efficacy of the pill. These women used condoms in case the pill did not “work.” Several participants specifically referred to the failure rates of the pill and condoms, and stated that unless a method is developed that is 100% effective at preventing pregnancy, they plan on using two methods. These women were extremely motivated to protect themselves from getting pregnant, and did not want to take any chances -- no matter how small -- that the pill alone might not be effective.
I decided to put myself on some hormonal birth control, because they are more reliable than just a barrier method. But, as I said, we continue using condoms because it's still not 100%. (Samantha)

There's no sense in tempting fate, or whatever. Cause I know they're (birth control pills) not effective absolutely all of the time. But, I know neither are condoms, so hopefully between the two of them. (Abby)

If I decide to have sex, he's still going to wear a condom. Because birth control is only 99.9% and there's still that little chance that it couldn't be safe, and plus the fact of STDs. (Janice)

As illustrated by the last quote, the participants who were also concerned with STDs recognized that the pill does not provide any barrier protection against disease. Condom use, therefore, was necessary so that they could protect themselves in what was perceived as the most responsible and thorough way possible.

The whole point of getting another form of birth control is to keep the chances of pregnancy, you know, low. And, the condoms will keep the chances of getting any STDs low. (Leah)

Thus, for some, dual method use was perceived as necessary to be confident about the prevention of unintended pregnancy. For others, dual method use allowed them to feel secure in being protected from pregnancy and STDs. For all participants, dual method use represented a proactive decision to take personal responsibility for the prevention of any negative consequences. Especially since potential failure of a safe sex method was often viewed as a result of participants' own actions. For example, some participants admitted to occasionally forgetting to take a pill. Others mentioned incorrect condom use in certain situations, such as after drinking.

Control. Closely related to the notion of responsibility for the women in this study was the need to be able to control different facets of being sexually active. Control was
more than simply acting in a responsible way so as to prevent pregnancy and/or STDs.

Control described how these women were able to act responsibly. Most women described at some point needing to exercise self-restraint, or needing to control a partner, during “the heat of the moment” in a sexual encounter. These women were prepared to regulate and mindfully monitor themselves and their partner to make sure condoms were used at the most challenging point during a sexual episode. The women did not describe these situations as easily negotiated, but they nevertheless were aware that they had to insist on condom use, no matter what. The challenge of using condoms at the heat of the moment was even more significant because most of the women were also on the birth control pill. In other words, if they did not use condoms during a sexual episode, they would still be protected from pregnancy by the pill. However, they were not willing to risk using only one form of protection. For example, all of the women in the upcoming examples used the birth control pill in addition to condoms.

At the heat of the moment you’re just like, sometimes it’s, “Why?!” [exasperated]. But then you remember, it’s just smarter. (Tricia)

I wouldn’t want to end up with a disease, just because in the heat of passion we couldn’t [use condoms]. (Tanya)

When it comes down to it and it’s the heat of the moment...you have to keep level-headed. And you kind of learn how to do that. [M: How do you learn?] Control yourself? Like, I personally, it’s just like, “Whoa. Wait a second. Hey. Whoa. What are you doing? STOP. And put something on.” (Janice)

Several of the women described in more detail specific sexual encounters in which they had to make a decision about using condoms – such as discovering that the condoms had run out immediately before planning to have sex – and how they were able to regulate
their partner’s and their own feelings so as to maintain self-protection. The following excerpt is an exemplary quote of these types of descriptions:

*He’s asked me once if I would without, and I said no. I was like, “NO.” And he said, “Okay.” I thought for that split second, I was like, “Oh it won't matter this one time.” And I almost did, but then I thought, you know what? That’s really dumb, because you’ve been doing it this long. And if you start now, every once in a while you’re going to not. And that could end up being all the time. So I thought, if you just keep it consistent, then you won’t have to deal with, you know, letting it lapse.* (Tanya)

As illustrated by Tanya, both responsibility and control involved the notion of consistency. Women in this sample did not talk about using condoms “most of the time” or skipping condom use once in a while. Given the criteria for participation, their consistency would be expected. The discussion about condom use “in the heat of the moment” indicated that the participants may have thought about using condoms less than always, but the need for consistency prevailed. Participants did not necessarily believe that not using condoms once would lead to pregnancy or disease. Rather, like Tanya expressed, any lapse of condom use was viewed as a potential doorway to continual non-use. Several women explained of either themselves or of a partner that they liked not knowing what sex felt like without a condom, because they (or their partner) cannot compare the feelings and decide that sex without a condom is “better.” Janice explains:

*Once we do do it without a condom, is he going to constantly want to do it without a condom because now he knows? I almost like him always using a condom, because there’s never that question of, “Come on. We’ve done it this way and it feels better.”*
A smaller group within the sample (three of the participants) talked about the broader implications of control. That is, being in control was not merely an action regarding the negotiation of a specific sexual episode. Rather, control represented to the women the ability to protect and keep to themselves those valued aspects of self that could be rendered vulnerable by sexual activity. For example, Tanya explains that condom use is “just a way to control what’s going on...I feel like I have more control over whether or not I would get pregnant, or get an STD.” She elaborates that this control extends beyond the prevention of negative consequences to “everything -- my health, my life, what I’m going to do in the future.” Gretchen suggests that using condoms is a way to “keep your body to yourself.” For her, using condoms enables her to control access to her body, and a true sharing of her body only occurs if she has sex without a condom. Colleen most eloquently captures this idea of controlling valued aspects of self by using condoms:

I'm very possessive of the things I can control. You know, like, I don't want somebody to take advantage of what's mine...My sexuality is something that I want, that is mine. And if I want to share it with somebody, that's fine. But I have not given it to anybody yet.

For Colleen, her sexuality -- a valued aspect of her self -- is protected until she chooses to have sex without a condom. She was rewarded in her control because, even though she had been in several sexual relationships, her sexuality had not been “harmed.”

I feel like it's kind of a pure substance right now, and I know it hasn't been, it hasn't been altered in any way. I don't have any STDs. I don't have any medical problems that would hinder me from having children...it hasn't been tainted yet.

Importantly, Tanya, Gretchen, and Colleen had all been affected in the past by either themselves or a friend contracting an STD.
Benefits of responsibility. Eleven women in the study talked specifically about what they gained by using condoms or dual protection. Women felt comforted by the ability to take responsibility for their actions and to control sexual encounters. The knowledge that they were protected because of their own responsible actions, rather than relying on some other source (e.g., a partner) who may not be as responsible as they are, allowed these women to enjoy sex. Enjoyment of sex was directly related to feelings of safety for most of these women. Women knew that they had taken the necessary precautions against pregnancy and/or STDs, and thus could relax during sexual encounters with their partners. Safety provided women with a sense of security and relief, so that they could choose to not think about the risks during sexual episodes. Thus, taking responsibility and doing “everything possible” to protect themselves and be safe reduced feelings of worry and anxiety, and thus increased women’s ability to relax and enjoy being sexual. Most women were able to articulate experiencing sexual desire for their partner, as in their conversations of needing to control their own emotions. Similarly, enjoyment of sex was something participants strived for and communicated to their partners. Practicing safe sex enabled participants to experience desire and sexual pleasure, because they were not distracted by feelings of anxiety. It afforded them an overall peace of mind.

I remember previous sexual experiences where I didn’t get to enjoy it. I was constantly worrying about, oh my god, what if it breaks? Now it’s like, I can enjoy having sex. (Janice)

I guess I’m kind of looking at sex as it’s not just there for the guys. You know? And so, in order for me to be able to enjoy it and not have to worry, a condom needs to be there. (Abby)
If I didn’t feel like I was practicing good enough safe sex... I wouldn’t enjoy sex. Because I’d just think of pregnancy. But since I’m so in control of it, I feel like I can not think about it and I can just enjoy being sexual. (Kate)

The women in this sample rarely discussed any significant barriers to condom use. Several women who had previous sexual experiences without condoms said that they did not really like using condoms, because it reduced sensitivity or the spontaneity of a sexual episode. Other joked that running out of condoms was a minor, occasional irritation. However, none of the participants discussed with any emphasis serious barriers that were enough to prevent them from using condoms.

Essence 4: Relational Support

The final essence that defined the phenomenon of safe sex for women in committed relationships was relational support. Although belief in the importance of safe sex, and the motivation and commitment to enact this practice were seen as internally driven -- that is, as deriving from within the women themselves -- all women described characteristics of their partners that made the practice of safe sex easier. Part of the reason these relationships reached a long-term status was because the women’s partners supported the participants’ decisions regarding safe sex. Partners’ support was demonstrated through both attitudes and behaviors. These included a willingness to use condoms without complaining or otherwise making the women feel guilty or defensive about their decision. Characteristics of the relationship as well facilitated safe sex, including open communication, a sense of comfort, and mutual respect. These women recognized that many potential sexual partners would not support their decisions
regarding safe sex in this way, and so current partners were regarded as special and unique. The “uniqueness” derived from a sense that partners were willing to place the needs of the women and the relationship over and above their own physical gratification. Women did not feel that many men were willing to act in such a manner.

Relational support was reflected in two collective themes: Characteristics of Partner, and Characteristics of Committed Relationships.

Characteristics of partner. All participants described characteristics of their partner that made the actual practice of safe sex easier in the day-to-day experiences within the relationship. Because these women possessed such strong convictions about practicing safe sex, they indicated that they would not be involved in a relationship in which a partner refused to wear a condom. That is, participants viewed the commitment to use condoms as originating from within themselves. However, the fact that the relationships of the couples in the study averaged 1.5 years indicated that all partners supported the participants’ decisions regarding safe sex in some way. In other words, the relationships would not have reached a “long-term” status unless partners agreed to use condoms. Two clear patterns emerged with respect to the nature of partner support.

The first pattern that characterized seven of the couples involved a partner being described as feeling the same way as the participant about condom use. That is, within this group, partners felt as equally strong as their girlfriends about the importance of using condoms. These men were viewed as sharing with their girlfriends the internal commitment to use condoms as a form of safe sex. Participants believed that these partners feelings about condoms and practice of condom use would remain consistent
even if they no longer were involved with the participant. Women felt fortunate to be involved with a partner who did not question decisions about condom use, and never presented any challenge to using condoms. These partners also shared in the worry about pregnancy. Kristan explains this characteristic regarding her partner of six years:

*I think he just feels the same way I do about being responsible. Like, it’s not anything to get him to put it [a condom] on. It’s nothing. Like I said before, it’s just assumed. There’s never been any trouble. There’s never been any pressure to, like. “Oh let’s just see once what it’s like!”*

The second pattern, which characterized the partners of the other five participants, demonstrated a support and respect for the participant’s decision, even though the partners did not share similar feelings about condom use. This group of men did not perceive a need to use condoms to the same degree as their partners. The women knew that if the decision regarding safe sex were left up the these boyfriends, they likely would not elect to use condoms. However, boyfriends did use condoms out of respect for their girlfriend’s wishes. Four of these men also agreed to get tested for STDs at their girlfriend’s request, even though they also would not have chosen to do this on their own. Participants described that their partners acted this way because they recognized and were sensitive to the fact that their girlfriends were concerned, anxious, or even fearful about pregnancy and/or STDs. These women believed that comfort and happiness were priorities for their boyfriends.

*I didn’t think that he’d object [to using condoms]. I would think that he would want to do everything possible to make me happy and comfortable.* (Tanya)

*That says a lot to me, I guess, is that he always approached it as a “I am concerned about you, and I want what’s going to be best for you” kind of a scenario. Not, “Oh...man...I don’t want to...”* (Samantha)
For all the women in the sample, regardless of why their partners used condoms, the fact that they did use condoms was viewed as a unique and special characteristic. These women believed that the majority of men complain about condom use, and will pressure a woman not to use one. Current partners were consistently compared to “most other men” who complain about condom use. Women who had past sexual partners in which condom use was more difficult were surprised and delighted at their partner’s willingness to use condoms.

_I never had anyone do that to me before [want to use condoms]! And in a way, it’s what attracted me to him even more, because here are all these other guys, and they didn’t care, and here, he cared. And I thought that was kind of cool, actually. For a 22 year old guy to be that way._ (Kate)

Janice was so surprised at her boyfriend’s own insistence to use condoms that she assumed he had an STD that he was not telling her about:

_Most guys I’ve ever talked to, or the ones that I have been with sexually, always are trying to persuade you NOT to use the condom. “Oh, it feels better! Come on!”...It actually kind of scared me, because I was like, “What’s wrong with you?” Cause he was dead set in, “I will always use a condom until I get married to someone.”_

Some women interpreted their boyfriend’s actions as an indication of his concern or love for her, as well as a “sign” about the integrity of their partner more generally. Most women joked that sex without condoms probably does feel better for men. But, these women viewed the act of sacrificing physical gratification – that is, the better feeling of sex without a condom – for the health of the relationship as an important quality about their partner that makes the relationship itself work.
It seems like, the kind of guys who don’t want to get their dogs neutered are the kind of guys who don’t want to use condoms. You know? Like, they have all these really weird issues about their manliness...and James is not like that at all...It just seems like he respects me as a human being, and not just something that’s giving him sex. (Abby)

The way I interpreted his actions was that he really cared that I felt safe. That, um, I felt protected. And that...he would rather sacrifice the “better feel” or whatever you want to call it, and make me happy, than his just getting a better feel...Really, to me, that is one of his little physical actions of saying, I really care about you. I really want you to be safe. I really want us both to be happy. (Samantha)

These women were relieved at never having to “nag” or remind their partners to use condoms. Their boyfriends’ actions, as well as their attitudes and acceptance of the women’s beliefs, made the practice of safe sex easy for the participants. These men’s willingness to support their partners was absolutely integral to the experience of safe sex within the context of a committed, long-term relationship. Negotiation of safe sex behaviors was, for the most part, rarely a struggle.

Characteristics of committed relationships. Relational support was not only characterized by personal features of the women’s boyfriends, but also by open communication within the relationship itself. All but one of the participants were able to talk with their partners about their feelings regarding safe sex and intent to use condoms. For these women, ease of condom use was attributed, in some degree, to this ability to communicate. Relational talk about condom use was not viewed as much different from open communication in the relationship more generally, and women described a dynamic in the relationship in which communication was encouraged and expected. Women described being extremely comfortable with their partner, and being able to talk about
anything. This general characteristic of the relationship extended to the realm of sexuality. Many participants described conversations with their partner about sex in general, or about safe sex in particular. They did not report being nervous or reticent to engage their partner in these conversations, and typically engaged in these conversations before having sex for the first time. Only one participant described being extremely uncomfortable talking with her boyfriend about safe sex. She was able, however, to use condoms consistently, a practice that started without any discussion surrounding it. Open communication allowed these couples to know exactly where the other person stood in terms of feelings about safe sex. For the women in this sample, it was critical that their partners understand their feelings about condom use. Women expressed that partners’ knowledge about their feelings enabled these boyfriends to be sensitive to the participants’ preferences and concerns.

Another characteristic of the relationship that women described was trust. Within this sample, trust was a fairly complex issue. In terms of pregnancy, women believed that trusting a partner had no bearing on an accidental, unintended pregnancy. One participant explained this reasoning:

*Even though I would trust you with my life, that still doesn’t mean you’re not going to get me pregnant if we don’t use a condom.* (Abby)

Participants tended to view trust and risk of pregnancy as unrelated, other than trusting that their partner would use condoms. The issue of STDs made the role of trust much more complicated. Most participants stated that they trusted their partner to be monogamous. Several participants specifically explained that the reason for using
condoms had nothing to do with thinking a partner was unfaithful. That is, participants implicitly recognized the existence of a relationship between condom use and infidelity.

*I'm not afraid of him cheating on me and then me catching something. That's not why we do it [use condoms].* (Samantha)

*The primary use isn't health related things [i.e., for disease] for us. It would be if all this time that we're doing long distance, he's sleeping with somebody else. And so he comes back and he wants to use a condom to make sure that I don't get anything from the girl that he was with. It's not like that at all.* (Kristan)

Some compared the reasons for condom use in short versus long-term relationships by explaining that in short-term relationships there is an understanding between couples that each could have other sexual partners, making the use of condoms necessary. This issue was viewed as not relevant in long-term relationships, because couples were expected to be monogamous. In addition, the women also described that their boyfriends did not interpret the request to use condoms as a sign that they (their girlfriends) had been unfaithful, but rather as a mechanism to be extra cautious in terms of preventing pregnancy.

*It was more just for a safety precaution, in terms of pregnancy, rather than. “Oh, she wants me to use condoms, so she must not be having just a monogamous relationship with just me.”* (Tricia)

To reiterate, in most couples within this study, both partners trusted each other to be faithful. The rationale for condom use, therefore, was not to protect from any new diseases a partner might have contracted from being unfaithful during the course of the current relationship.
A few participants explained how the issue of condoms and trust could be a barrier for couples in committed relationships, because of the stereotyped link between condoms and a lack of monogamy. Abby explains:

*Somebody could feel offended because their partner doesn't trust them... with long-term [relationships] there's commitment and trust involved. And so I could see a really big problem with someone going, "What, you don't trust me enough to have unprotected sex with me?"

Two participants in the study did not quite trust their partners to be monogamous. One of these women described herself as influenced by her friend's experience of contracting an STD from an unfaithful partner. Colleen explains how this episode impacted her feelings regarding her own relationship:

*I just feel like I can't. I just feel that guys aren't honest now. And so I was like, how could you trust somebody who would do something like this to you? And then I was like. "Well, how do I trust this guy?"

Both participants who were not completely assured of the monogamy of their partners sought others ways to increase this assurance. Colleen described moving in with her boyfriend as reassuring because she now had "permanent tabs on where he goes and what he does." Colleen also asked her boyfriend not to drink when she was not with him, because she felt especially insecure about his actions when he drank. Gretchen, the other participant who was not entirely sure of her partner's monogamy, gained reassurance from having her friends monitor her boyfriend's actions. Gretchen and her boyfriend live in two different states, and therefore she could not monitor him on her own. Both of these women attributed their reason for using condoms in part to this concern about their partner's fidelity.
Although the majority of women in the sample trusted their partners to be monogamous and thus did not have any new STDs, they did not put the same degree of faith in their partner's past sexual history. Women did not want to potentially compromise their health in any way by assuming that their partner was completely disease-free at the time that they entered the current romantic relationship. The mindset of these women could be described in the following hypothetical scenario: "I trust you now to be monogamous, but how can I be sure that you didn't contract something from your past sexual relationships? I love you, but just telling me you're clean isn't good enough."

These women did not view their boyfriends negatively in any way, but they also did not think that just because they were in love meant that they were automatically safe from disease. The following excerpts illustrate this issue:

*I was like, "Um, you've had a couple partners, and, so, go get tested. Love you babes, BUT..."* You know, "I trust you, as adamant as you are with using the condoms in our relationship, I can't imagine you not being the same way in others. BUT." (Samantha)

*If you're committed, that trust is already there. So, the reasoning [to use condoms] has to be really spelled out. Like, for me, I don't want to get pregnant and any STDs. So, and I think it's harder to explain that in a committed because you are committed and you want to trust them completely. But, it's not really trusting them, it's kind of like their history.* (Tanya)

To clarify, although these women trusted their partner to be currently monogamous, they did not trust that their partner knew for certain whether he had already contracted any STDs. It was for this reason that many participants asked their partner to get tested for STDs, and used condoms. Importantly, women felt able to talk to their partners about this concern with past STDs, and believed that partners would understand and not take
offense. Open communication about sexual histories did occur in many of these
relationships, but women did not necessarily trust a partner's own feelings about his
safety. Serena explains her partner's reaction when she told him that she wanted him to
use condoms and get HIV tested:

First he was a little, well, not shocked, but, "Why do you want to do that?" kind
of like that. "I know what women I had," kind of that direction. But he said, "If
you want it, then it's okay with me."

Therefore, for women involved in committed, long-term relationships, not viewing
condom use as a statement about monogamy was an integral aspect of being able to
consistently use condoms within a committed relationship. That is, because participants
expected fidelity, neither these women nor their partners interpreted condom use as a sign
about the infidelity of the partner. In addition, trust of partners did not extend to past
sexual experiences. Women were able to talk with their partners about these concerns,
and partner's reacted in an understanding, non-defensive manner.
Chapter 6: Discussion

My purpose in conducting the current qualitative research project was to discover and describe the essential characteristics of the phenomenon of safe sex for young women involved in long-term, committed relationships. I chose the topical and methodological relevancy of this pursuit in light of the striking lack of research on young women who are able to consistently practice safe sex via condom use within the context of a monogamous, heterosexual relationship. Recent literature that does address women's safe sex behaviors within intimate relationships has focused primarily on barriers to condom use. The current study was an important step towards illuminating the picture of safe sex for women who are not impeded in their efforts to practice safe sex by a variety of barriers.

In this Discussion, I first contextualize the findings from the present investigation within existing literature on safe sex behaviors and particularly condom use among young people. Important to this literature is the division of empirical research that has explored either intrapersonal or interpersonal influences on safe sex behavior. I then incorporate feminist literature and theory on female sexuality, and suggest the importance of developing understandings of women's protective sexual behavior that adopt a more inclusive perspective. This inclusive perspective would recognize and value the multiple, dynamic, shifting influences on women's sexual behavior that differ among women as well as for individuals over time.

Following this application of feminist literature, I turn to a commentary on the chosen methodology of the current study. I readdress Crotty's comparison of mainstream
phenomenology and nursing phenomenology, as well as reflect on the compatibility, convergences, and divergences of the phenomenological method with feminist methods of empirical investigation. After this discussion on methodology, I highlight the relevance and significance of the present study with respect to both findings and method. I conclude with recognition of study limitations, and suggestions for future directions.

**Literature Review**

**Characteristics of the Sample**

The purposeful sample in this study was selected based on criteria that included involvement in a committed relationship for at least three months and consistent condom use within that relationship. My goal was to recruit women who I felt represented one of the most responsible populations of women engaging in safe sex practices. This sample was of particular interest to me given numerous studies indicating that condom use is more common in casual than committed relationships (Catania et al., 1995; Critelli & Suire, 1998; Forste & Morgan, 1998; Jadack, Hyde, & Keller, 1995; Ku et al., 1994; Reisen & Poppen, 1995). Although the length of relationships among the current sample varied widely from four months to six years, relationship length averaged about 1 1/2 years. These relationships were not relatively new committed relationships, but rather fairly long-term partnerships in which patterns of sexual behavior likely had been established and become stable. Existing literature has not specifically addressed at what point in a relationship condom use is typically terminated (e.g., after how many weeks/months of sexual involvement), other than to suggest that prophylactic use is
commonly replaced by hormonal contraception as a relationship progresses in length (Civic, 1999; Grimley, Riley, Bellis, & Prochaska, 1993; Hammer et al., 1996; Ku et al., 1994). Thus, it is likely that the women in the current study are especially unique given their continued, consistent condom use over a year into the relationship.

The women who volunteered to participate in this project turned out to be even more exceptional than I had expected, because of their high rate of dual method use. At the time of the project interviews, ten women used condoms in combination with the birth control pill. Only two women used condoms exclusively. This characteristic of the sample was quite surprising, particularly because no mention of other contraceptive use was included during any participant recruitment efforts. The fact that most participants were dual method users added strength to the likelihood that this sample represents women on the high end of a continuum of responsible sexual behavior. Dual method use, in which the condom is one method of safe sex and the second is any other form of systematic contraception (i.e., not withdrawal), is quite rare among young women in the United States (Bankole et al., 1998; Cushman, Romero, Kalmuss, Davidson, Heartwell, & Rulin, 1998). Using national data from the most recently available wave of the National Survey of Family Growth, Bankole and colleagues examined condom use with another systematic method (e.g., birth control pill, implant, injection) among women aged 15-44. They found that in 1995, only 3% of sexually active women used the condom in combination with some other systematic method. Although this percentage is extremely low, it nonetheless represents a significant increase from dual method use in 1988, which was practiced by only 1% of sexually active women in this age group. In 1995, dual
method use was more likely to be practiced among women in relationships for less than six months, among younger women, among unmarried women, and among women not cohabitating (Bankole et al., 1999). Similarly low rates of dual method use were found by Cushman and colleagues, in a sample of urban, low-income participants who used either the implant or injectable hormonal contraception (Cushman et al., 1998). Among the women in Cushman et al.'s sample, only 11% reported consistent condom use concurrent with other hormonal methods. Women with more than one sexual partner were more likely to always use condoms with other contraceptive use compared to women with only one partner (Cushman et al., 1998).

Health professionals have recommended combined method use for sexual encounters (i.e., condoms and effective hormonal contraception) because only condoms provide adequate protection against sexually transmitted diseases, but hormonal contraception is typically more effective than condoms against pregnancy (American Academy of Pediatrics, 1995; USDHHS, 1992, 2000). Thus, contrary to the vast majority of sexually active women, participants in the present sample are practicing safe sex in ways consistent with “best practice” recommendations. Participants’ reasons for dual method use will be discussed shortly.

Another sample characteristic that I will briefly discuss within the context of existing literature is age at first intercourse. Among the current sample, women’s average age at first intercourse (17.5 years) was slightly higher than the national average (17 years). However, partners in this sample were about two years older at first intercourse (18 years) than the average age for men nationally (16 years) (AAP, 1995; Haffner, 1998).
Because age at first intercourse in my sample was not retrieved from partners directly, but rather through the female participants reporting about their boyfriends, there is the possibility that the data may not reflect partners' true age at first intercourse. However, only one participant during the interviews indicated that she was not completely sure about when her boyfriend became sexually active, and therefore recorded her best guess. I will discuss possible effects of partners' older age at first intercourse later in the Discussion, within the context of gender and power in relationships.

One last sample characteristics concerns the number of lifetime partners of the participants. For over half of the women in this sample (n=7), their current sexual partner was also their only sexual partner. That is, they were virgins before their current relationship. Research indicates that college students often have several lifetime sexual partners (MacDonald et al., 1990; Reinisch, Sanders, Hill, & Ziemba-Davis, 1992; Wendt & Solomon, 1995). Indeed, recent national data suggest that approximately 25% of college women in the U.S. report six or more lifetime partners (CDC, 1997). Seven of the college women in my study demonstrate somewhat safer sexual behaviors by only having one lifetime partner. Among the other five participants: for one her current sexual partner was her second lifetime partner; for another participant, her current partner was her seventh lifetime partner; the remaining three did not disclose their exact number of lifetime partners, but talked generally about at least several previous partners. Finally, consistent with characteristics of the current sample, extant literature also suggests that women who use condoms at first intercourse are more likely to report consistent condom use at later intercourse (Reisen & Poppen, 1995; St. Lawrence & Scott, 1996).
Overall, demographic indicators of the current sample portray the majority of these women as slightly more conservative than national estimates with respect to sexual debut and number of partners, and highly responsible with respect to dual method prophylactic and contraceptive use. Indeed, behaving responsibly with respect to contraceptive and condom use was consistently expressed by the women in this sample as a defining, essential feature of their sexual relationships.

**Dual Method Use**

Because dual method use is rare among sexually active women nationally, yet pervasive in my sample, I would like to comment further on this sample characteristic. A limitation of existing large-scale surveys that estimate the number of dual method users nationally is that these reports do not speak to the reasons why women engage in dual method use. I do not know of any study that targets dual method use specifically to reveal women's motivations and rationale behind consistent combined method use. One might speculate that since hormonal contraception best protects against pregnancy, and condoms protect against STDs, that dual method users would be motivated by a concern to self-protect against both unintended pregnancy and disease. This explanation would be consistent with trends suggesting that dual method use is more likely to occur earlier in a relationship, perhaps before women have determined whether their partner has any STDs. That is, this speculation might explain why dual method users eventually discontinue condom use as a relationship progresses, because the perceived need for disease protection declines (Bankole et al., 1999; Critelli & Suire, 1998). Research noting a
different pattern of safe sex behavior -- the pattern of exclusive condom use at the onset of a relationship gradually replaced by exclusive use of hormonal contraception -- supports a similar point. Women may choose to use condoms at the onset of a new relationship for both disease and pregnancy protection, and then switch to hormonal contraception to protect against pregnancy only after developing feelings of trust that a partner does not have diseases (Overby & Kegeles, 1994; Williams et al., 1992). Thus, this speculation behind dual method use suggests that the condom component of dual method use is exclusively for disease protection.

Existing empirical literature has not come to consensus on whether sexually active college students use condoms primarily for pregnancy prevention or disease prevention. Some evidence exists to suggest that college students may find disease prevention at least equally as important as pregnancy prevention, especially at the beginning of a sexual relationship (Hammer et al., 1996), but most research indicates that college students view condom use primarily for pregnancy prevention (Lewis, Malow, & Ireland, 1997; Pilkington et al., 1994; Williams et al., 1992; Wulfert & Wan, 1993). In other words, the reason for condom use among people who only use condoms may be different than the reasons for condom use among people who use condoms in combination with another method.

One study regarding the question of condom use motivations was conducted by Cooper and her colleagues (Cooper, Agocha, & Powers, 1999), who examined pregnancy versus disease protection catalysts for condom use. Although not focused on college students in particular, Cooper et al. found that, regardless of gender, race, or age, sexually
active individuals were motivated to a greater extent by concerns about pregnancy than concerns about STDs. However, condom use motivations interacted with relationship status. Young adults who used condoms to prevent pregnancy only were more likely to be in an exclusive relationship, and those motivated by disease prevention only were less likely than this pregnancy prevention group to be in an exclusive relationship. Further, individuals who said they used condoms for both pregnancy and disease prevention were least likely to be involved in an exclusive relationship. Cooper and colleagues discuss that to interpret patterns of condom use, one must first understand the diverse motivations (e.g., pregnancy, disease, both) for condom use among different populations of users (e.g., people in committed relationships versus casual relationships), and target interventions to these specific subgroups. This research also suggests that health promotion messages encouraging condom use that are based on protection against STDs only, especially AIDS, likely do not capture or reflect the reasons why a significant number of people use condoms, especially women in close relationships.

Studies such as Cooper et al.'s, however, do not address the full picture regarding motivations for condom use and its relationship to dual method use. For example, in the current sample, all women reported being concerned with pregnancy. For some, dual method use was considered necessary because women did not trust the birth control pill only or condoms only to protect against pregnancy. Women knew that either because of contraceptive failure, or more likely user failure, that both the pill and condoms are not 100% effective against unintended pregnancy. Even though when citing failure rates women tended to refer to the "perfect use" failure rate of the pill (less than 1%) or
condoms (3%) rather than the “typical use” failure rate (9% pill; 15% condoms) (Fu et al., 1999), this more conservative estimate still presented too great of a pregnancy risk for these women. Dual method use was employed as a strategy to provide a back-up protection in case one method failed. Only dual method use afforded these women the feelings of comfort and safety against pregnancy necessary for them to engage in a sexual relationship. Thus, not all women in the current sample used condoms — when already using another form of contraception -- for the purpose of disease prevention. This double protection against pregnancy has rarely been discussed in survey research regarding women’s dual method use: nor has it been utilized in public health campaigns to increase condom use. I was very surprised at this finding regarding a motivation for dual method use as well. Indeed, my expectation that using condoms would be for the primary purpose of disease prevention was one bias I recognized and bracketed before data collection began. Notably, other dual method participants did describe condom use as providing disease protection and the birth control pill as providing pregnancy prevention, a pattern of motivations more congruent with existing literature. Unlike extant research, however, women in the current sample had not stopped condom use after several months into the relationship. The consistent pattern of condom use for disease prevention is discussed shortly.

Intrapersonal Influences on Condom Use

Personal motivations to use condoms -- such as concerns about becoming pregnant or contracting a sexually transmitted disease -- frequently have been studied under the
rubric of intrapersonal influences on condom use; that is, variables that reside within an individual that affect his or her contraceptive behavior. Most of the research that has examined intrapersonal influences is situated within health psychology conceptual frameworks of individual decision-making regarding a variety of health related behaviors. In the current context, I focus on applications of these conceptual frameworks to AIDS preventive behavior.

The Health Belief Model: Susceptibility, severity, barriers, and benefits to condom use. Probably the most well known of the health preventive behavior conceptual frameworks is the Health Belief Model (Rosenstock, 1974). The HBM posits that individual preventive health behaviors can be predicted based on an individual's beliefs and knowledge about a particular health threat. The model consists of four variables: perceived susceptibility to the health threat, perceived severity of the health threat, perceived benefits of protective behavior, and perceived barriers to protective behaviors. The HBM or individual components of the HBM have been used in a number of studies to predict protective behaviors, such as condom use (e.g., Abraham, Sheeran, Spears, & Abrams, 1992; Catania et al., 1990). For example, perceived susceptibility or vulnerability — that is, perceived risk to AIDS — is often examined as an indicator of the intent to use condoms (e.g., Goldman & Harlow, 1993; Kusseling, Shapiro, Breenberg, & Wenger, 1996; Wulfert & Wan, 1993). Perceived barriers to condom use (e.g., reduces sexual pleasure) and perceived benefits to use (e.g., feelings of safety) are also frequently examined predictors that derive from the HBM (Helweg-Larsen & Collins, 1994; Thompson, Anderson, Freedman, & Swan, 1996).
Although research using the HBM to predict other health preventive behaviors has found that perceived **susceptibility** and perceived **barriers** are the components most often related to changes in health behavior (Janz & Becker, 1984), all variables within the model exhibit consistent, yet relatively small, associations with diverse health behaviors (Rosenstock, Strecher, & Becker, 1988) as well as intentions to use condoms (Sheeran & Taylor, 1999). However, the utility of the HBM has been criticized for use with AIDS preventive behavior because of its inability to account for social, contextual, or interpersonal influences (Brown, DiClemente, & Reynolds, 1991). In other words, by examining only individual-level influences, the HBM fails to recognize that AIDS preventive behaviors, such as condom use, are necessarily dyadic activities. Particularly for women, condom use must involve cooperation and agreement to use a condom by a sexual partner. Thus, recently AIDS researchers have issued a call for more interpersonal frameworks with which to understand protective behavior, that account for the dynamic, dyadic nature of practicing condom use (Amaro, 1995; Kelly & Kalichman, 1995; Soet, Dilorio, & Dudley, 1998).

In spite of this criticism, in the current study intrapersonal factors based on the HBM did appear to play a large role in women's experiences of safe sex. Indeed, self-protection emerged as one of the essential characteristics of safe sex for the women in this study, and they described that the need to protect themselves was paramount in their experiences of sexual activity within a heterosexual relationship. Participants frequently expressed feelings of vulnerability to and fear of negative health outcomes. However, and quite importantly, the negative outcomes most often mentioned that elicited feelings of
susceptibility among participants were pregnancy and other STDs, rather than AIDS. Several participants said that they did not feel at all vulnerable to AIDS, because they never knew anyone who had AIDS. One participant explained that AIDS is just "too far away," that is, it is too removed from the college population to be perceived as a real threat. A few participants expressed fear with respect to AIDS, but in these cases they also always expressed fear about other STDs as well.

Thus, consistent with extant research (Thompson et al., 1996; Wulfert & Wan, 1993), the women in this sample did not perceive themselves at great risk for contracting AIDS in particular. This perception may not be entirely inaccurate. Although the percent of women with AIDS is growing, it is nonetheless mainly concentrated among specific populations of typically low-income, high poverty, urban minority women, rather than college populations (Collins, 1997). Therefore, a lack of association between condom use and perceived risk of AIDS among college students is somewhat understandable.

The women in this sample felt much more at risk for unintended pregnancy than for AIDS, consistent with research suggesting that college women are more likely to cite pregnancy prevention as a primary motivation for condom use (Cooper et al., 1999). However, the majority of women in the current sample also felt, at least in the beginning of their relationships, at risk for other sexually transmitted infections, and this concern continued well into the relationship for half of the participants. That is, even the participants who did not feel particularly vulnerable to HIV did feel susceptible to other STDs that, as one participant described, "may not be deadly but can still mess you up pretty bad." Some participants recognized that the health threat of STDs is rarely
discussed by college students in comparison to the health threat of AIDS. Indeed, most empirical research on condom use with college students cites AIDS as the primary rationale for the research effort, to the exclusion of other STDs. This is surprising in light of the high rates of STDs such as chlamydia, herpes, or genital warts among college populations (Joffe et al., 1992; Wenger, Greenberg, Hilborne, Kusseling, Mangotich, & Shapiro, 1992). For instance, of the 12 current participants, half had either experienced directly or knew someone close to them who experienced a STD, including chlamydia, herpes, HPV, bladder infections, and bacterial vaginal infections. Those six participants cited their experience with STDs during the interviews as strongly influencing their own condom use, because it made them feel vulnerable to disease. In other words, participants consistently used condoms because of their perceived ability to reduce salient health threats. Thus, public health efforts to increase condom use among college women may be more effective if, in addition to AIDS related messages, health messages emphasized the protective benefits of condoms against risks that present more salient and realistic threats to this population, including unintended pregnancy, infection with other STDs (e.g., chlamydia, herpes), or other vaginal infections (e.g., yeast infections, bladder infections) that are linked to unprotected intercourse (Bury, 1994).

In addition to perceived vulnerability, the three other intrapersonal components of the HBM also were raised by the participants in the current study. Perceived barriers to condom use -- a variable that has received much attention in extant literature (Geringer, Marks, Allen, & Armstrong, 1993; Helweg-Larsen & Collins, 1994) -- were additionally mentioned by the participants in this investigation. Barriers to condom use described by
the women in the current sample included a loss of sexual pleasure, a loss of the spontaneity of a sexual encounter, awareness that condoms must be used carefully and correctly to avoid slippage or breakage, condoms feeling “unnatural,” and needing to make sure condoms were available and conveniently located during sexual encounters. Thus, it would be inaccurate to assume that people who consistently use condoms do so because they do not perceive any barriers to use. Clearly, not all participants who used condoms consistently expressed favorable attitudes towards condoms.

For the women in this sample, however, the benefits of condom use outweighed these recognized barriers. Although in some research low barriers are more strongly associated with preventive health behavior than high benefits (e.g., Grimley et al., 1993), this did not seem to capture the experiences of the participants. Within existing studies, benefits of condom use are often measured by a belief that condoms provide effective protection against AIDS (e.g., Wulfert & Wan, 1993). In the current study, benefits included this belief, as well as feelings of safety, a variable only occasionally described in existing research on condom use (e.g., Grimley et al., 1993).

Further, benefits of condom use for the women in this study also included increased enjoyment of sex. Women’s increased enjoyment of sexual activity has not been adequately considered as a motivation for condom use by women. Feminists might argue that this is because women’s sexual desire is rarely recognized as a valid experience (Fine, 1988; Tolman, 1994). For example, the relation between condom use and sexual pleasure is typically constructed in terms of reducing male sexual pleasure, rather than increasing sexual pleasure vis-à-vis a psychological feeling of safety. In the present investigation,
women described that condom use and especially dual method use enabled them to “not think” about STD and pregnancy risks, and thus increased their ability to concentrate instead on enjoying their sexual experience. This relationship between condom use eliciting a psychological feeling of safety, which in turn affords greater sexual pleasure, has yet to be represented in correlational models that associate barriers and benefits of condom use to actual behavior. Surprisingly, extant qualitative research on condom use has not discussed this benefit in any significant way either. The results from the present qualitative investigation suggest that a better understanding of women’s condom use may be achieved if condom use in quantitative research was studied as a predictor variable, rather than exclusively as an outcome variable. That is, research could explore the prediction of increased sexual pleasure from condom use, via a possible mediator of worry. Further qualitative research is also needed to develop the concept of sexual pleasure for women who consistently use condoms by articulating a more sophisticated construct of “sexual pleasure” than merely the physical sensation of intercourse without a condom.

The final component of the HBM, perceived severity, was also discussed by participants in the current study. Because women in this sample felt susceptible to pregnancy and STDs other than AIDS, severity for them was conceptualized as the severity of personally experiencing an unplanned pregnancy or contracting an STD. In studies examining AIDS preventive behaviors, perceived severity may not exert an influence on condom use intentions because of a statistical ceiling effect; that is, all study participants recognize the objective severity of AIDS as a disease that currently leads to
death, and thus the variable as measured does not contain enough variability to correlate with other variables (Milne, Sheeran, & Orbell, 2000; Thompson et al., 1996). In the present study, severity of STDs and particularly pregnancy was not conceptualized in an objective manner but rather in a highly subjective manner of how severe pregnancy would be for women given their current life situation or future goals. That is, unlike AIDS that would likely be considered always severe regardless of other situational factors, severity of pregnancy was dynamic and variable. The women discussed situational variables -- being in college, wanting to attend graduate school, not living with or being married to a partner -- that exacerbated the perceived severity of pregnancy at this particular point in their lives, and thus motivated their consistent condom use.

Women discussed the perceived severity of STDs as less dynamic than pregnancy, but still variable depending on whether a health threat was a disease -- such as chlamydia -- that is curable with antibiotics, or whether it was a disease such as herpes that is permanent. Thus, perceived severity of STDs was informed by a distinct level of knowledge about the various diseases. For the women in the current study, perceived severity of STDs was also related to an incompatibility between future goals and STD infection. All participants talked about something desired that either would be altered or could not be achieved at all if pregnancy or STDs were to occur. These findings are corroborated by Woodsong and Koo's (1999) qualitative investigation of condom use. In that study, participants articulated personal goals that were incompatible with pregnancy or STD infection, and it was a desire to achieve these personal goals that motivated condom use.
In summary, the HBM provides a useful heuristic to interpret several key findings from my research investigation that reflect intrapersonal influences on women's condom use. The model's utility, nevertheless, is constrained because by only accounting for discrete effects of individual components on a health behavior, the HBM cannot completely capture the complex interrelatedness between components that function synergistically and dynamically within an individual over time to elicit health behavior (Cooper et al., 1999). HBM variables are not the only intraindividual constructs to be represented in this study's findings. I would like to briefly mention several additional factors that emerged from participant's accounts as influences on consistent condom use.

**Past negative experience.** First, it seems highly noteworthy that half of the current sample discussed some negative outcome related to unprotected intercourse that either they directly experienced or that occurred to a close friend. Although these women attributed their consistent condom use in part, or exclusively, to this negative experience, there is surprisingly little research that examines the impact of a personal event such as pregnancy or sexually transmitted infection on condom use. Further, the literature that does address this issue remains inconclusive regarding the relationship between past experience and current condom use. For example, in Sheeran and Taylor's (1999) meta-analysis investigating a wide variety of influences on behavioral intentions to use condoms, previous experience of an STD exerted no influence on intent to use condoms. In a qualitative project, Lear (1995) found mixed evidence regarding the impact of a past STD on condom use. Accordingly, among her sample of homosexual and heterosexual college students, for some a past experience with an STD did not lead to increased condom use or
even increased worry about contracting an STD again in the future. Others, however, responded to past STD experience with consistent condom use in all subsequent sexual encounters. Within a very different sample from Lear’s, past experience of an STD was not related to current condom use. Specifically, for inner-city, drug-using women, condom use with primary partners was extremely low, even among those women who were HIV positive, or whose partner was HIV positive (Pivnick, 1993).

Clearly, negative past experience is a variable deserving of further empirical attention. Although it seems rational that someone who has experienced an unplanned pregnancy or STD in the past would be strongly motivated to protect themselves in the future -- as was strongly evident by the emotional testimonies in the current sample -- this reason does not represent the experiences of those individuals who do not protect themselves after a negative experience. The question raised by this study is, why were safe sex behaviors positively influenced by a negative past event in the current sample? Obviously, it may be that the strength of past negative experiences on current condom use is greater for some populations of women than for others, especially in consideration of the realities of women’s relational contexts.

In addition, research could also pursue the intriguing finding of condom use motivation based on a best friend’s experience with negative consequences. In the previously cited study of drug-using women, a large percent of these women had watched husbands, ex-husbands, children, siblings, and members of their community die of AIDS. These women had high levels of knowledge regarding HIV, and personal, tragic experiences of loved ones becoming infected. Yet, condom use remained extremely low
among this sample. Because of the daily struggles with survival for the women in this sample, I do not think accurate comparisons could be drawn to a college population with respect to the impact of a friend's traumatic experience. For example, in communities where the devastation of AIDS is apparent on a daily basis, women's safe sex behaviors may be affected by friends' or relatives' death from AIDS quite differently than for a college student who likely has little direct exposure to the impact of AIDS. Indeed, among the twelve women in the current sample, only one had known someone close to her who was infected with the HIV virus. The differences among varying subgroups of women speak to the need for multiple frameworks with which to understand women's safe sex behaviors.

Fear. Secondly, participants expressed their concerns with pregnancy and STDs in a highly emotional manner, and often as fear. For them, pregnancy and/or STDs were not merely outcomes to which they felt vulnerable. Participants emotionally described their feelings of fear regarding these consequences of unprotected intercourse. As one participant emphasized, "I was just scared." Again, it is surprising that affective motivations are not included more often in empirical investigations of condom use, even though Sheeran and Taylor (1999) emphasize that affective responses to perceived risks are conceptually distinct from judgments about the severity of, or susceptibility to, that personal risk.

Coping responses. Third, the women in the current investigation responded to feelings of vulnerability and fear of a health threat (i.e., pregnancy or STDs) with actions that prevented the threat from happening. This type of response has been investigated
within the vast literature on personal coping responses to a stressor. The participants in this project demonstrated what Lazarus and Folkman (1984) have termed "problem-focused coping." That is, participants attempted to eliminate the health stressor by adopting some instrumental action -- consistent condom use -- that prevented the stressor from occurring. Indeed, participants’ descriptions of their safe sex experiences could be fully interpreted using a coping strategy framework. For instance, adopting a coping strategy framework, one could say that the participants perceived realistic threats to unprotected intercourse, demonstrated a belief in the ability to exert control over a health threat and the self-efficacy to enact protective behaviors, and responded to the threat with a problem-focused approach strategy to reduce or eliminate the threat. Although I wanted to recognize the potential applicability of stress and coping literature to the current study, I chose to contextualize these women’s coping responses instead within another relevant literature, feminist views of women’s sexuality. This perspective is discussed shortly.

Unwavering, internal standard. Finally, I was surprised to discover that one essence that emerged to define the experience of safe sex for the women in the current sample was rarely discussed within extant literature. This was the essence of an unwavering, internal standard that characterized participants’ beliefs that unsafe sex was not an option in their lives. Because emphatic statements from nearly all women describing their individual, absolute decision to only engage in protected sex were such an inherent and integral part of the interviews, I expected to find this concept represented in published research. Similar concepts, such as non-negotiated condom use, arose in qualitative studies only (Kline, Kline, & Oken, 1992; Lear, 1995; Woodsong & Koo.)
Further, even in these qualitative studies, the idea of a personal standard was not discussed by the researchers, but rather expressed directly in quotes from participants provided in the publications.

Undoubtedly, this unwavering, internal standard that guided women’s behavior in the present study emerged so strongly precisely because of the nature of the sample. The current study was the only investigation uncovered in the literature that focused specifically and exclusively on women who always use condoms in their relationships. Thus, it is somewhat understandable that this concept has not yet emerged in empirical research, because the majority of extant literature focuses on a population of individuals who are inconsistent condom users. Further research is needed to determine if this standard surfaces among other samples of consistent condom users, such as adolescents, older women, low-income women, or women of varying ethnicities.

**Interpersonal Influences on Condom Use**

As the preceding literature review has illustrated, how individuals assess their own vulnerability to negative sexual health outcomes (e.g., most often AIDS), their knowledge about these outcomes, their opinions about the benefits and limitations of condom use, and how they cope with a potential health threat contribute to decision-making and behavioral action regarding safe sex. Theoretical models of health behaviors that test the influence of intrapersonal variables on safe sex behavior typically reveal consistent yet weak associations. Researchers have expressed frustration and confusion that, in a decade when most sexually active individuals know about AIDS, and know that condoms can
significantly reduce the likelihood of infection, people continue to practice unsafe sex in astounding numbers (Kelly & Kalichman, 1995). Clearly, condom use is a much more complex behavior than what has been reflected in models of individual preventive health decision-making alone.

In 1995, several influential articles were released that critiqued and challenged the usefulness of the intraindividual approach to predicting safe sex behavior. Probably the most eloquent and widely cited of these was an American Psychologist publication by Hortensia Amaro (1995). Amaro argued that the limited ability of intraindividual frameworks to predict safe sex behavior resulted from a lack of attention to the interpersonal and social nature of sexuality. Amaro focused her comments specifically on women, gender, and power, and the realities of the context in which safe sex behavior takes place for women. For example, Amaro drew needed attention to an obvious, yet regularly overlooked difference between the safe sex behaviors of women and men. That is, because condoms are worn by men, they are a male controlled method of safe sex. Thus, “using a condom” for women is necessarily a different behavior than it is for men, and involves communicating, negotiating, and convincing a partner to wear a condom.

Women’s ability to negotiate condom use may be facilitated or impeded by the distribution of power in a relationship, as well as by proscriptions for gender-appropriate behaviors within a sexual context (Amaro, 1995). In addition, Amaro suggested that frameworks of intraindividual influences on condom use fail to account for affective dimensions of sexual relationships. Feelings of love, romance, and trust may exist within a relationship that determine parameters for safe sex behaviors. For example, condom use is often associated
with the concept of both disease and infidelity (Polacsek et al., 1999; Williams et al., 1992). Thus, asking a partner to wear a condom may be regarded as analogous to an accusation of unfaithfulness. For women, who some feminist developmental theorists suggest are motivated by a relational need to maintain connection (Brown & Gilligan, 1992; Surrey, 1991), asking a partner to wear a condom and possibly offending or angering that partner may be judged as more risky than the physical risk of engaging in unprotected intercourse (Amaro, 1995).

Amaro's request to focus on the importance of relational influences on safe sex was echoed by other researchers. Kelly and Kalichman (1995), for example, argued that the effect of interpersonal variables on safe sex behavior is not only important for women in heterosexual relationships, but rather for all sexual relationships, including same sex unions. They suggested that the complexity of sexual behavior necessitated efforts to understand condom use that would account for the meanings of safe sex within varying types of sexual encounters. Interpersonal processes that motivate or hinder condom use in casual encounters, for instance, are likely quite discrepant from those in long-term, committed partnerships. Amaro, Kelly, and Kalichman not only called for the content of safe sex research to change, but also for methodologies to become more inclusive. Empirical inquiries examining intraindividual variables typically relied upon quantitative approaches that aggregate survey data from large samples. Because quantitative data rarely allow for an in-depth understanding of behavior, qualitative work was regarded as necessary to reveal these complex, interpersonal processes of meaning making within the context of sexual relationships (Collins, 1997).
These powerful solicitations for new types of research on safe sex behavior significantly changed the course of empirical research conducted on this topic. Although currently intrapersonal variables have not been excluded from investigation, the number of studies -- quantitative and qualitative -- that pursued interpersonal influences blossomed. Within this literature, quantitative designs have typically looked for associations between interpersonal variables (e.g., communication) and either intention to use condoms or actual condom use. Importantly, the explication of which variables to study often derives from revealing qualitative efforts that asked individuals to describe and explain their personal reasons for the sexual decisions -- safe or unsafe -- that they make.

In the following discussion, I place the findings of the current study within the existing literature regarding interpersonal influences on safe sex behavior. Specifically, I summarize and discuss four areas of research: power and inequity in heterosexual relationships, partner’s attitudes towards condoms, communication about safe sex, and trust and assessments of risk.

**Power and inequity in heterosexual relationships.** In the study of interpersonal influences on women’s safe sex behavior, particularly condom use, feminist researchers have explored the nature of power and inequality that exist within heterosexual relationships. As Amaro (1995), and others (Campbell, 1999; Gómez & Marin, 1996) have highlighted, women’s safe sex behavior necessarily involves an ability to negotiate condom use with a male partner. The success of this negotiation depends upon, among other things, the distribution of power and the configuration of traditional gender roles in the relational context. For example, especially in the realm of sexuality, women have been
socialized to behave in a demure, submissive, and passive fashion. Asserting personal wishes for condom use directly conflicts with traditional gender appropriate expectations for female behavior (Amaro, 1995; Campbell, 1999). Further, within relationships characterized by extreme discrepancies in power, insisting upon condom use may not be possible without instigating a threat of male violence. Thus, women in these situations experience less control over their sexual health, including whether they are placed at risk for AIDS, other STDs, or unplanned pregnancy, than men experience. Researchers sensitive to power issues are interested in exactly how women negotiate or fail to negotiate condom use – what happens during those negotiations, are requests for condom use raised with a partner, if so are the requests direct or indirect, and what is the range of partner reaction to these requests. Because detailed descriptions are sought of these sexual encounters, qualitative research has been most revealing in this area. Feminists who examine these influences on women’s safe sex behavior have concentrated most heavily on two groups of women who may be regarded as less powerful given their positions in society: inner-city, low income women, and adolescents.

Pivnick interviewed a sample of 126 drug-using African-American and Latino women who reported extremely high levels of unprotected sex, especially with long-term partners (1993). A small percent of these women or their long-term partners were HIV positive. Pivnick described various characteristics of these women’s urban lives that illustrate the lack of control to protect their own sexual health. For example, the most often cited reason in her study for unprotected sex in the women’s long-term relationships was because long-term partners did not like condoms. Women in this sample suggested
that insistence on condom use, in many cases, would anger their partner because of the association between condoms and infidelity. Condom use with a long-term partner may engender suspicions, and therefore was not worth the risk of possible physical harm. Pivnick also described a pattern of "conjugal authority" in her sample in which long-term partners attempted to control and direct women's behaviors much like a father would. These paternal like relationships attenuate women's decision-making ability with respect to safe sex choices. However, for these high-risk women, the economic support provided by long-term partners, often needed to support children, was worth the trade off of reduced power in the relationship.

Sobo (1993) explored the meanings of unprotected sex among impoverished, urban, African-American women. Although the women in Sobo's sample suggested that the decision to practice unsafe sex with a long-term partner was mutual, Sobo speculates that, "a woman's calling the decision to forego condoms 'mutual' can reduce feelings of powerlessness. It can also camouflage emotional and social (and in some cases economic) dependence on men" (1993, p. 473). In other words, Sobo suggests that constructing a decision to not use condoms as mutual rather than as imposed by a partner enables the women to ignore their own lack of control over their health in relationships.

In one of the few quantitative studies in the area, Gómez and Marin (1996) conducted a survey investigation of condom use among Latino and non-Latino white women. These researchers found that Latino women expressed greater fear than did white women that asking a partner to use a condom would elicit partner anger or even violence, highlighting cultural expectations of appropriate female gender roles in sexual scenarios.
Gómez and Marin further indicated that among all women in the study, women's lesser sexual power to request condom use in a relationship was related to a decreased likelihood that women actually used condoms with a steady partner.

However, not all studies on power relationships between women and men and the effect on condom use have portrayed women at a disadvantage with respect to relationship equality. Kline et al. (1992) uncovered spaces for women's control and personal authority among an unlikely sample. Former intravenous (IV) drug-using African-American and Hispanic women were interviewed within a focus group setting. Kline et al. (1992) revealed that rarely in these focus groups did the women present themselves as submissive to or dependent upon their male partners. Since most partners were current IV drug-users and could not provide financially for the family, women's economic dependence was not a significant issue. Many women reported inconsistent condom use due to various barriers, such as the disruption of spontaneous sex or inaccurate assessments of risk. However, a perceived lack of power in their relationships was not one of the expressed barriers. Further, many other women in the sample reported considerable control over condom use, and negotiated its use successfully via strategies such as withholding sex and redefining sex with condoms in a pleasurable way for their partners (Kline et al., 1992). Kline and colleagues concluded that lack of control in their sample was less of a barrier to safe sex than faulty assessments of personal risk.

Power and inequity in heterosexual relationships have, of course, also been raised in discussions of adolescent girls' sexuality (Holland, Ramazanoglu, Sharpe, & Thomson, 1996; Moore & Rosenthal, 1998). Briefly, this literature speaks to the ways in which
adolescent women and men are socialized to become sexual beings. Holland and her colleagues (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1991; Holland, Ramazanoglu, Scott, & Thomson, 1994; Holland et al., 1996) conducted interviews with adolescent women and men in the U.K. between the ages 16-21 regarding their developing experiences of sexuality, and relationships with sexual partners. The researchers discovered powerful scripts of sexual behaviors based upon gendered expectations of female sexual innocence and the pursuit of love versus male sexual prowess and the pursuit of sexual conquests. Women's desire for condom use was viewed in a variety of ways that were incompatible with these gendered scripts. For example, carrying condoms blatantly conflicts with the construction of young women as sexually innocent, and thus women who do so run the risk of developing a reputation as "easy." In addition, insisting upon condoms could be interpreted as a subversive attempt to gain power in the relationship, and usurp power from the male partner (Holland et al., 1991; Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1996).

Further, age differences between young women and their partners cannot be ignored. The finding that a majority of teenage pregnancies occur to women whose partners are adults (Collins, 1997) speaks to an obvious power difference that renders young women vulnerable to male preferences within a relationship. As Campbell suggests, "girls perceive [older] men as having power because of their maturity, life experiences, and financial resources" (1999, p. 87). In these types of relationships, young women may continually subordinate their own needs for those of the older partner.
Indeed, this scenario depicts the experience of one of the women in the current sample. Twenty-year old Cara had been romantically involved with 31-year old Zachary for about two years. When they met, Zach was still involved in a 10-year marriage, in which he had a grade school aged son. When Zach and Cara began seeing each other, he sought a separation from his wife. At the time of Cara’s interview, Zach was not legally divorced, but his wife did know of his relationship with Cara. Cara is Asian-American, and was raised in an unstable home, being shifted around from mother to father to aunt. She described her aunt and uncle, who have permanent custody of her, as extremely conservative, religious, and disapproving of Cara’s relationship with Zach. During her interview, Cara talked about Zach as someone who takes care of her, and whom she trusts completely. She characterized their relationship as highly romantic and spontaneous. Zach and Cara agreed about the need for contraception, and they used condom as a contraceptive method. Cara was a virgin before Zach; her level of sexual experience prior to her relationship with him did not exceed kissing. Cara asked Zach about his sexual history before they began having intercourse. He told her he was “clean,” which Cara trusted completely. Because she trusted his word about his sexual history, she had never asked him about past STD testing, and had not asked him to get tested in their relationship. Cara expressed during her interview that they were planning to switch contraceptive methods in the near future, because Zach did not like condoms due to the reduced sexual pleasure he received. Cara did not want to go on the birth control pill for a variety of reasons, and so their intentions were to use spermicide only as a contraceptive
method. The typical use failure rates of spermicide only as a form of contraception exceeds 25% in the first year of use.

This case study represents a notable outlier among the sample of women in the current study. Although Cara used condoms consistently to prevent pregnancy, and was adamant about her wish to avoid pregnancy at this point in her life, her recent decision to switch contraceptive methods illustrates her deference to the sexual preferences of her much older partner. In addition, her implicit trust in her partner’s disease status, without any objective knowledge of this status, differed considerably from the majority of the sample who insisted upon a number of mechanisms to protect themselves from the consequences of their partner’s past sexual experiences. Cara engaged in safe sex behavior as a result of her choice to use condoms, but she did not conform to the self-protective, uncompromising standards that characterized the rest of the women in the study. Cara’s decision to potentially compromise her sexual health by stopping condom use may also reflect what Chin (1999) describes as a culturally-based desire to accommodate others. In Chin’s interviews with Asian/Pacific Islander women about their experiences of risky sexual encounters, women’s accommodations to a partner’s sexual desires – which was attributed by the women directly to Asian cultural expectations of women’s role – were continually raised as a prominent barrier to safe sex. Thus, Cara’s story argues for further attention not only to power relations between couples of notably discordant ages, but also to the interaction with cultural or ethnic proscriptions for women’s behavior.
For the rest of the women in the present study, power and inequity were not discussed as barriers to condom use. In fact, women addressed the equality within their committed relationships as facilitators of safe sex behavior. Participants described and also praised the men who respected their desires and preferences regarding condom use, even if those preferences contrasted with the men’s preferences. These women were not afraid of men’s reactions to a request to use condoms; indeed, many women expressed that they would have simply ended the relationship if their partner had not agreed to use them. However, participants also said they had a very good idea of how their partner would react to the request to use condoms before even asking. Typically, the participants described an ability to negotiate condom use, even in immediate situational contexts where sex seemed imminent but condoms were not available. In no cases did a participant describe “giving in” to a partner’s wish or pressure to not use condoms during a particular sexual encounter. Importantly, participants recognized that they needed a partner’s support to use condoms. As Amaro (1995) emphasized, the participants realized that no matter how strong their own personal resolution to use a condom, they still had to rely on their male partner to actually wear the condom. In this sense, women were aware of the fact that to be protected they relied upon a method under their partner’s control. It is also important to remember that seven of the partners in this sample would have used condoms during their sexual encounters, regardless of their girlfriend’s wishes (at least as described by their girlfriends). Thus, in these cases, condom use was not set up as a diametrically opposed behavior between partners, but rather as an individually agreed upon activity.
within the sexual arena. Therefore, women felt comfortable using this male-controlled method because they knew their partners would use condoms without an argument.

Men’s age at first intercourse also could have contributed to the greater equality between partners. Boyfriends of the participants tended to be about two years older at first intercourse than the national average. Although speculative, it could be that the lesser amount of sexual experience among these men decreased their sexual power within the relationship. In some instances, women in the sample admitted to having more sexual experience in terms of the number of past sexual partners than their current boyfriend. In other cases, women described their partners as having only one or two prior sexual relationships, and at least a few of the men had been virgins as well before entering their current relationship with the participant. Holland and colleagues (Holland, Ramazanoglu, Sharpe, & Thomson, 1994) suggests that in gender-stereotypic sexual scenarios, masculinity and power are associated with increased levels of sexual “performance” and “conquests.” The women in this sample certainly did not paint a collective picture of the men as sexual conquerors. In fact, they often contrasted that image of the man who “just wants another black mark over his bed” or “is into exerting his power over women” with their boyfriends. Thus, ease of condom use for the women in the current study may be directly related to characteristics of the chosen partner. Several recognized that they may have more difficulty negotiating condom use if they were with a different sexual partner who did not feel so positively about condoms. Extant research, as well as the participants in this study, characterizes “most men” as resisting condom use in any way possible. However, as described in this study, there are men for whom this safe sex behavior is just
as important and integral to sexual activity as it is for women. Men who support condom use are certainly a population deserving of further attention, especially because the primary method of STD protection will remain under male control, at least in the near future.

**Partner's attitudes towards condom use.** Closely related to the previous discussion of partner dominance, control, and reactions to requests for condom use is the influence of partner's attitudes towards condom use on women's adoption of this safer sexual activity. Soet, Dilorio, and Dudley (1998) examined the role of perceived partner's attitudes on condom use among sexually active women college students. These researchers found that among sexual predictor variables, including anticipated partner reaction to a request for condom use and self-efficacy to use condoms, partner attitudes toward condoms was by far the most powerful predictor in the explanation of variance in women's condom use. Thus, women who perceived their male partners to hold negative attitudes toward condom use were least likely to engage in consistent condom use. Of course, Soet et al's study (1998) would be conceptually stronger if they had male partner's direct reports of their own attitudes towards condoms, rather than women's perceptions. But, this study nevertheless speaks to the finding in the present qualitative effort that women and men who share attitudes regarding the importance of condom use are less likely to encounter significant difficulty engaging in safe sex. Again, a majority of women mentioned the benefits of feeling the same way about condom use as their partners, such as mutually agreeing to forego sex when a condom is not readily available. Sharing similar attitudes as
their partners for the women in this study also facilitated communication about safe sex, a third interpersonal variable that emerged in women’s interviews.

**Communication about safe sex.** The vast majority of women in this investigation were able to talk to their partners about a variety of issues related to sexual health behavior, including their feelings about safe sex and intent to use condoms. Despite the fact that communication itself did not emerge as an essence that defined the nature of the phenomenon of safe sex in a committed relationship, open communication did contribute to the essence of Relational Support. Open communication was described as a characteristic of the relationship that facilitated women’s ability to enact condom use by making their partners aware of the participant’s expectations. Importantly, in most cases this open communication occurred before partners engaged in sexual intercourse for the first time. Thus, partners were not surprised at the initiation of a sexual episode by their girlfriend’s intent to use condoms. Communication occurring prior to sexual activity enabled couples to be prepared with condoms when sex finally happened.

Communication occurring before the onset of sexual intercourse in a relationship in the present sample appears somewhat unique when compared to existing research regarding communication about contraception in a relationship. Hammer et al. (1996), in their focus groups with male and female college students, discussed that couples’ choice of contraceptive method/condoms occurred with very little discussion prior to sexual activity. When method choice was talked about by couples, it was the women who typically initiated this communication. Couples tended to increase their level of sexual communication after becoming sexually active, because of higher levels of comfort further
into the relationship. In other words, comfort with a partner is perceived as a necessary condition for sexual communication to occur. The process of engaging in a sexual relationship actually increases this comfort and intimacy. Sexual communication occurs after this intimacy has been established; unfortunately, this is also after sexual activity has been initiated (Hammer et al., 1996).

This pattern is echoed by Lock et al. (1998). The college students these researchers talked to also expressed difficulty engaging in sexual communication before becoming sexually active with partners. Women in Lock et al.'s study tended to initiate sex talk when such communication did occur. The content of sexual communication had less to do with the negotiation of method choice, and was more oriented to discovering the "safety" or "riskiness" of the partner, by talking, for example, about prior sexual partners. Discussions about sexual risk were more likely to occur after trust had developed in the relationship, which occurred subsequently to the couple establishing a sexual relationship (Lock et al., 1998). It is unclear from Lock et al.'s study how patterns of condom use fluctuated with the presence or absence of discussions regarding sexual risk. The authors do conclude, however, that many couples did put themselves at risk for disease without comprehensive knowledge of their partner's risk factors.

The discomfort associated with sexual communication did not emerge among the vast majority of participants in the current study. Nearly all women talked with their partners about their feelings regarding condom use early in the relationship. Women described this discussion around method choice as fairly uncomplicated and comfortable. In many cases the discussion was more akin to a simple declaration of what was
acceptable, rather than engaging in a true dialogue with their partner. For some participants, this was the extent of sex talk that occurred until after they had become sexually active. That is, some participants seemed to follow the pattern identified by Hammer et al. (1996) and Lock et al. (1998) in that further discussion of sexual risk factors was reserved until later in the relationship. Consistent condom use enabled these women to feel protected, even while lacking knowledge about their partner’s sexual history. For instance, one of the participants, Leah, said she was never uncomfortable telling her partner that he had to wear a condom in order for her to have intercourse with him. Communication about their respective past sexual histories, however, did not occur for Leah and her partner until they experienced an STD scare. Only at that point did “the flood gates open” and both Leah and her partner questioned each other extensively about past sexual relationships. However, other participants talked with their partners prior to intercourse about both method choice and sexual histories. These conversations were described as somewhat more awkward and uncomfortable than conversations only involving method choice.

Pliskin (1997) sheds light on why these conversations about sexual histories elicit greater discomfort. She interviewed adults infected with herpes about their sexual discourse with partners. Pliskin suggests that verbal intimacy is a more risky and difficult level of comfort to achieve than is physical intimacy:

For these subjects, the act of sex became a way of communicating with a new partner, a way of overcoming the discomfort of talking about sexual experiences and the self...Being naked in bed with a new partner whom one does not know very well is not regarded as an act of intimacy. Rather, intimacy refers to verbal openness. (1997, p. 96)
Therefore, talking about past sexual experiences symbolizes an intimacy most couples have not developed until the relationship has become established. In the current study, conversations about method choice and sexual history are actually very different conversations. Although participants described talk about method choice as “open communication,” this talk involved very few intimate revelations. The talk was fairly unidirectional – from the participants to the partners – and did not require any further conversation about private aspects of their former sexual lives. It was a statement of beliefs and attitudes. Communication about sexual histories, on the other hand, was truly bidirectional, and required that both partners reveal personal and intimate details of their past sexual practices, such as whether condoms were used with former partners. This level of intimate communication, for most individuals, requires a comfort and trust in a partner that he/she will react in ways that do not damage the relationship (Lear, 1995; Pliskin, 1997). Thus, for women to engage their partners in this type of sexual discourse before securing knowledge in the partners’ likely responses to such communication potentially places the relationship in jeopardy. Importantly, the act of asking a partner about past sexual history is not a meaning-free act. Rather, it is heavily imbued with implications about that person, as well as about the asker of the question. For example, a woman who asks her boyfriend about his sexual history may imply to him that she does not trust him, or believes him to have an STD. Indeed, by far the majority of literature regarding interpersonal influences on safe sex behavior concerns the topic of trust in relationships.
Trust and assessments of personal safety. A variety of research efforts, utilizing both qualitative and quantitative designs, converge on the finding that individuals in sexual unions base their assessments of personal risk from a specific partner on subjective criteria rather than on objective knowledge of partner's disease status (Chin, 1999; Jadack et al., 1995; Kusseling et al., 1996; Overby & Kegeles, 1994; Reisen & Poppen, 1995; Thompson et al., 1996; Williams et al., 1992). Frequently, the subjective criteria involve feelings of trust that a partner does not carry an STD. This finding has been replicated across discrepant samples, including drug-using minority women (Pivnick, 1993); inner-city urban women (Sobo, 1993); male and female college students from 2-year and 4-year colleges (Lear, 1995; Thompson et al., 1996; Williams et al., 1992); young adults attending an STD clinic (Kusseling et al., 1996); and Asian/Pacific Islander adult women (Chin, 1999). Indeed, the subjective assessment of disease risk was one of the most pervasive findings in all of the literature I reviewed.

I have already discussed several interpersonal influences on safe sex behavior that relate to the subjective assessment of risk, including discomfort with sexual communication about risk factors and gender stereotypes about appropriate sexual behaviors. These processes contribute to the likelihood that women will forego the pursuit of an objective criterion for the safety of a sexual partner. For instance, among impoverished, urban women, condoms may be used with casual sexual partners, but are rarely used within primary sexual relationships with a husband or long-time partner (Pivnick, 1993; Sobo, 1993). In these communities, condoms are instilled with meanings of infidelity and disease, whereas unprotected sex signifies intimacy and emotional
closeness. For the urban women in these samples, to request use of condoms with primary partners would elicit several possible interpretations from their partners. A long-term partner could view condom use as a sign that the woman regards her partnership as casual, does not trust him, is accusing him of unfaithfulness, believes him to be HIV positive, or is unfaithful. Any construction may elicit anger from the male partners. For women concerned about the threat of physical violence and/or the needed financial support of partners, the possibility of eliciting these responses poses a greater personal threat than does unprotected intercourse (Pivnick, 1993). Alternatively, inner-city women may also engage in unprotected sex to maintain a belief that they can judge the “cleanliness” and faithfulness of their chosen partners (Sobo, 1993).

Chin (1999) as well uncovered indirect assessments of risk among her sample of adult Asian women. These participants rarely asked their sexual partners whether they had received HIV tests, because this would violate a sense of trust in a partner. Rather, these women relied on an “overall intuitive sense” to assess whether they were at risk. Thompson et al. (1996) found similar rationales in their survey of male and female college students. In this study, college students judged themselves to be at low risk for disease due to a belief that their sexual partner was safe. Safety was assessed based on status in a monogamous relationship, and “knowing” their partner did not have HIV even if this “knowing” was not based on objective knowledge of HIV status (Thompson et al., 1996). Jadack et al. (1995) also corroborated these findings in a survey of heterosexual college students. Within this sample, several of the most commonly endorsed reasons for not using a condom at last unprotected intercourse were that respondents “knew their
partner’s sexual history,” that sex “occurred in a long-term relationship,” and they “just knew it was safe / assumed partner was not infected with HIV” (Jadack et al., 1995), illustrating that assumptions of safety likely occur without actual knowledge of HIV status, especially in committed relationships.

Importantly, Thompson et al.’s (1996) and Jadack et al.’s (1995) findings that college students felt safe because unprotected sex occurred in a long-term relationship or monogamous relationship elicits cause for concern. Several studies of college students cast doubt on the honesty of this population with respect to relational fidelity. Cochran and Mays (1990) argued that the safe sex strategy of relying on a partner’s self-reported monogamy may place significant numbers of women, in particular, at risk. Among a sample of over 400 students, the authors found that 34% of men (compared to 10% of women) reported telling a lie to a partner in order to have sex. Even more disturbing, results indicated that: 20% of men would lie about having a negative HIV test; 47% would underestimate the number of previous partners; and 43% would never disclose a single episode of infidelity (Cochran & Mays, 1990). These findings were replicated in another survey of college students. Stebleton and Rothenberger (1993) revealed that 36% of men had been sexually unfaithful in a monogamous relationship, and 33% admitted telling a lie to have sex. These statistics clearly highlight that questions about a partner’s sexual history, in many cases, should not be used as a criteria for assessing the safety of the sexual relationship.

The belief that monogamy or long-term relationship status provides protection from risky sexual experiences is related to the idea of “knowing” a partner. Williams et al.
(1992) found that students perceive riskiness based on whether they “know and like” a potential partner. In a series of focus groups, students revealed that the decision to use or not use condoms was often based on how well they felt they knew their partner, even though this knowing was not based on HIV knowledge. Instead, knowing was related to how much they cared for a partner and how much they trusted that partner in ways completely irrespective of disease status. Risky partners were viewed as those who “dress provocatively, whom one met in bars, who were older than most college students, who are from large cities, or who are very anxious for sex” (1992, p. 926). Thus, these students used flawed criteria to ascertain the safety of sexual encounters. Further, perceptions of safety abounded in committed relationships, because partners who are liked and trusted are not viewed as potential disease threats (Hammer et al., 1996). Lear (1995) explains that because of the association between commitment, monogamy, love, and trust, suggesting condom use implies a lack of those desired characteristics, and damages the process of creating increasing intimacy with a desired partner.

The combination of this literature suggests a compelling motivation behind the failure to use condoms consistently in long-term, committed relationships. So what are the implications of this literature for the current study? Does this suggest that, because the women in the current study used condom consistently in their long-term relationships, that love and trust did not exist in these unions? Clearly this was not the case. Participants reported being very much in love with their partners. Further, most trusted their partners to be monogamous in their current relationship. What differed for the women in this sample, and for their partners, was an ability to detach themselves from the
stereotypical meanings associated with condoms. Participants spent much time during the interviews explaining that condom use, for them, did not mean they lacked trust in their partner, and that their partners did not interpret a request to use condom as a symbol of infidelity. This understanding did not always come easily, and several women discussed this process of explaining to partners their feelings about precisely this issue. However, women did not put that same faith in a partner's sexual history, and admitted that doubt remained about the disease status of their partners even after partners had been tested for HIV and/or other STDs. Importantly, partners did not view this lack of confidence in their sexual history as an insult or an offense. In addition, some of the participants in the study used condoms for primary or secondary pregnancy prevention, and for these women trust could be completely divorced from the stigma of condoms.

Therefore, in the current sample, women described an interesting schism between current trust of a partner to be monogamous and trust of his sexual history. The fact that partners did not react with anger or accusations of a lack of care again underscores the needed research attention to personal characteristics of these male partners. In addition, these findings suggest a level of knowledge among women and the partners that some STDs are relatively undetectable, depending on the stage of infection. Because some STDs are undetectable, assessment of accurate safety may not be possible. Woodsong and Koo (1999) found similar beliefs among their sample, who noted that:

Someone may have an STI and not know it, therefore making her/him less culpable for exposing others. Even though a person may love and trust someone, participants acknowledged that almost everyone has a past sexual history and with or without a visit to the clinic, no one can be certain of her/his risk to exposure. (1999, p. 578.).
Heath promotion efforts would benefit from forefronting this type of message; that is, that given the course of certain STDs, absolute knowledge of disease status cannot be determined in all cases. Successful implementation of this message would remove the stigma associated with condoms, and reduce the blame and stereotyping that accompanies a request for condom use within committed relationships.

Feminist Perspectives on Women's Sexuality

For the past four decades, feminists have adopted a critical perspective toward constructions of sexuality, by bringing into question dominant discourses of women's behaviors, feelings, and desires. Feminism calls attention to the notion that women's sexuality must be interpreted through an accurate, unencumbered picture of women's lived realities, rather than through the distorted lens of patriarchal meanings. Arguably, the reality in women's lives that feminists considered most often are the power relations that are inherently structured in gendered expectations of appropriate male and female sexuality. Historically, as well as in present day, men as a collective group have access to power that women are not afforded. This power oftentimes has been wielded as power over women. Feminists in the past few decades have struggled to change this reality in political, social, and interpersonal arenas through fighting for women's rights with respect to: women's reproductive freedom and access to contraception (Nathanson, 1991); pornography, rape, and sexual violence against women (Koss, Gidycz, & Wisniewski,
1987; MacKinnon, 1982); women's work and unequal wages (Baber & Allen, 1992); and women's family work and constructions of motherhood (Rich, 1986; Ruddick, 1989).

Most recently, feminists have examined the regulation of women's sexuality not simply vis-à-vis blatant forms of oppression (e.g., rape), but rather through more subtle and subversive attempts at control. For example, narratives about women's versus men's (or, girls' versus boys') sexuality within existing sex education have been deconstructed and challenged (Fine, 1988; Irvine, 1995; Ward & Taylor, 1994). Medical discourses about pregnancy, menstruation, and menopause that hide constructed meanings behind the authority of science have likewise been subject to feminist criticism (Lee & Sasser-Coen, 1996; Martin, 1987; Nathanson, 1991). As well, feminists explored how acceptable images of women's bodies are promoted through advertising and media, rendering some bodies ideal and others inadequate (Bordo, 1993). Feminist efforts bring to the forefront that which is typically invisible, those taken for granted assumptions about women's sexuality that work to maintain a status quo that affords men greater sexual freedom and privilege, while restricting the expressions and varieties of women's sexuality.

Feminist work on women's safe sex behavior in the age of AIDS, a body of literature that has exploded in the 1990's, drew attention to the power inequities within heterosexual relationships that limit women's ability to enact safe sex behaviors, specifically condom use (see Amaro, 1995, for a review). As I discussed previously, feminists argued that health promotion models for encouraging condom use necessarily must differ for women and men, because condom use -- the only currently available, widely used method of protection against HIV -- is a male controlled method of safe sex,
and therefore men's and women's behaviors involved in "using a condom" are inherently different. The success of women's condom use is contingent upon their partner's agreement to wear the condom. Through research efforts that drew upon intensive, revealing interviews with various disadvantaged and marginalized groups of women, feminists disclosed the reality of women's experiences; specifically, that many women do not occupy a space within their relationship that allows for this asking of a long-term partner to wear a condom. Economic dependence and possibilities of physical harm represent more pressing concerns for these women than negative outcomes presented by unprotected sexual intercourse.

Women's relational orientation and ideologies of love and romance present further areas that attracted feminist attention in the 1990's. Focusing mostly on adolescent women (e.g., Holland et al., 1994; Thompson, 1995), but also college aged women (Soet al., 1999) and adults (Chin, 1999; Giffin, 1999), feminists revealed relational scripts that guided women's expectations and behaviors in relationships. These scripts have been described in part in this paper because they set parameters on appropriate sexual communication at various points in a relationship. For example, women (and men as well) worry that asking a partner to use a condom as will be interpreted as a sign of mistrust, an action that opposes the intent to advance a level of relational intimacy. Judgments of safety are made, instead, based upon subjective criteria including how well someone likes a partner, lifestyle, physical appearance, or how much time they have spent together in the relationship. In addition, young women describe what can be called a romance ideology (Gavey & McPhillips, 1999; Holland et al., 1996; Lear, 1995; Moore & Rosenthal, 1998;
Tolman, 1999). Young women develop their sexuality in a cultural context that tells women how to look (attractive, but not too provocative), how to act (friendly, but not aggressive or brazen), and what to say (or, more accurately, what not to say). They must learn to negotiate sexual boundaries in a context that simultaneously tells them that to be valued as a potential partner they must be beautiful, and yet to be too sexy is to risk their reputation. The romance ideology captures and extends these messages, and submits that young women desire love and relationships, rather than sexual pleasure, and will act in such a way so as to achieve and maintain romantic relationships. Sex is construed as primarily for the male partner, whose role is to pursue sexual relations within the relationship. This places a young woman in the position of “gatekeeper” of sexual activity (Holland et al., 1996).

According to the romance ideology, when sex does happen it should be above all else romantic, passionate, and spontaneous. Young women should follow their knowing partner’s lead in the bedroom, trusting that he will protect her. Conversations about safe sex are embarrassing, and negotiating condom use at that point disrupts the passionate script of sexual activity (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1996). In addition, condoms introduce the threat of disease into the scenario, which challenges the romantic vision of the sexual encounter by implying distrust. Indeed, seeing a partner as a potential disease threat may be incompatible with seeing that person as desirable (Lear, 1995). Gavey and McPhillips (1999) demonstrate evidence of this romance ideology even among older women who entered a particular sexual encounter with full intent to use condoms, and yet failed to do so. These authors summarize the narratives they heard from
their participants as follows: "the man's role is to be in control of the situation in a chivalrous manner so that the woman can entrust herself to his protection. Moreover, a woman should rely on her lover's knowledge and skill and not be too explicit in expressing her desires and, presumably, her preference for safe sex" (p. 359).

Finally, feminist sexuality researchers have also tried to create a discourse for women's sexual needs, specifically their sexual desires and pleasure (Fine, 1988; Thompson, 1990; Tolman, 1994). Researchers in this area have focused primarily on adolescent women, who are socialized to believe that their sexual pleasure -- if it can be voiced at all -- must be secondary to that of a male partner. Young women's lack of access to their own sexual pleasure not only restricts the recognition and pursuit of personal desire. This exclusion of women's desire also prohibits a rightful voice to articulate and put first their individual needs and preferences, whether they be pleasure-oriented or protection-oriented, over those of a partner (Holland et al., 1996; Tolman, 1994).

Researcher understandings of the limits and barriers to women's safe sex behavior have increasingly resonated with women's actual lived experiences, and for this feminist researchers must be commended. However, part of the charge as a feminist researcher to attend to the lived experiences of women means revealing and valuing the multiplicity of women's experiences. In the area of women's safe sex behaviors, and more broadly women's sexuality in heterosexual relationships, feminists must be cautious to not replace one Truth (i.e., patriarchal constructions of women's sexuality) with another Truth (i.e., all women are oppressed by male power in sexual encounters). In essence, feminists -- via
an exclusive focus on inequity -- end up recreating that which they eschew -- one
dominant discourse that subsumes all women's realities. To do so would be to relegate
women's experience as similar; that is, all women experience male oppression and power
inequity in heterosexual encounters, even if the degree of oppression differs. Further, it
promotes an image of the sexual woman as perpetual victim (Baber & Allen, 1993).

Feminists ask questions about women's experiences that are previously unasked,
using methods that previously unused. This is how the realities of women who, indeed, do
experience extreme or subtle inequities that influence their ability to protect themselves
were revealed. Nevertheless, feminists have still to ask in a directed way the question that
will reveal experiences of women who are able to negotiate condom use consistently
within heterosexual relationships. In my review of the literature on women's safe sex
behaviors, I failed to come across even one study that focused expressly on this topic. The
volume of attention to women's lack of power in sexual relationships makes it difficult to
locate places of resistance to this discourse.

Places of resistance, however, do exist. For example, Kline et al. (1992) boldly
suggested that the inner-city, impoverished, minority women in their study did not
describe a state of inequity within their relationships; nor did they attribute their inability
to use condoms to a lack of interrelational power. Tolman (1994) and Thompson (1990)
found that at least a small percentage of the adolescent girls they interviewed recognized
and pursued their own sexual pleasures. In addition, the findings from the current study
could be interpreted as a place of resistance. Women in this study did not talk about
inequity in their relationships, the threat of violence, or "power over" from their partners.
Women in this study did not sacrifice their committed relationship for their own protection; nor did they sacrifice their self-protection to service their relationship. Women in this study managed to maintain, and even facilitate, connection with their partners while simultaneously protecting themselves and controlling their own sexual health.

Participants in this study recognized and privileged their own desire. This was evident in passages in which the women talked about needing to control their own emotions even during “the heat of the moment” in an intimate encounter with their boyfriends so that they would remember to use a condom. Unlike women in other studies (e.g., Jadack et al., 1995; Williams et al., 1992), participants were not blindly carried away by an idealized vision of romance characterized by spontaneity and passion that dissolved their ability to practice safe sex. Indeed, one participant joked that it was her boyfriend, not her, who began thinking about marriage after they initiated a sexual relationship:

*One of my friends, she’s weird, but I swear every relationship she’s in, “I’m going to marry the guy!” That’s like, that’s the way she justifies having sex...I never had that disillusion in my head. Even when we started having sex, he was the one talking about marriage. I was like, “Uh-huh, yea, well, you know, maybe” [extremely hesitantly]. I mean, he says I’m unromantic. I go, screw that! I’m realistic! (Samantha)*

These women recognized that ultimately their own increased sexual pleasure came from knowing they were protected from pregnancy and/or disease, and this knowledge afforded them the opportunity to truly and authentically enjoy their sexual experiences without worry or anxiety. Pleasure for them was not defined by a narrow definition of physical sensation, but as a more sophisticated construct involving psychological feelings of safety. Women expressed that their male partners, as well, gained happiness in the relationship
from knowing that their girlfriends felt safe and comfortable with the sexual relationship.

Further, the women in this study prepared for their sexual encounters, even the first experience of sex with their partner, by communicating about and planning for condom use. Women in this study expressed confidence in their beliefs about safe sex, and did not compromise these convictions for the needs of a partner. They did not fit with the stereotypical conventions of "femininity" that call for a sacrifice of personal needs to privilege the needs of the partner (Tolman, 1999). Instead, they expressed agency in their ability to regulate and implement their desired safe sex practices. For example, 18 year old Abby asserts her sexual boundaries defiantly and powerfully:

*I feel like I am in control of myself and what happens to me. And nobody's going to dictate what happens during sex as far as condom use. Because with me, it's not an option. And if a guy doesn't respect me enough to deal with that then he can go pee up a rope...I'm looking at sex as it's not just there for the guys. You know? And so in order for me to be able to enjoy it and not have to worry, a condom needs to be there.*

The women in this study, and their relationships, embodied a notion of sexual health that facilitated the promotion of both sexual pleasure and protection. Indeed, their relationships satisfied what Haffner has described as a standard for moral, ethical relationships: "consensual, nonexploitative, honest, mutually pleasurable, and protected against STDs and pregnancy" (1998, p. 457). The women were fearful of the negative consequences of unprotected sex to which they felt a sense of personally vulnerability, but coped with that fear in healthy ways. Women did not deny that risks from unprotected sex exist, as adolescents often admit to doing since the ideology of romance does not embrace worry over pregnancy (Thompson, 1995). Nor did the women in this study rigidly
withhold themselves from engaging in any sexual relationship. Rather, participants dealt
with their anxiety by taking the appropriate actions to protect themselves in as safe of a
manner as possible, which included not only consistent condom use often combined with a
method of contraception, but also selection of a romantic partner who would not
challenge their convictions and would contribute equally to a satisfying, mutually
rewarding relationship. Feminist perspectives on women’s sexuality would greatly benefit
from the addition of a literature that revealed women’s strengths in sexuality, including a
focus on women who successfully negotiate the dangers of sexual relationships.

Commentary and Feminist Critique of Methodology

Phenomenology is a philosophical and methodological approach to research that
focuses on the meaning of experience. It attempts to describe and produce accurate
understandings of what it means to be human. The phenomenological process as it has
descended from the philosopher Husserl strives to reveal the essences of a phenomenon --
the fundamental, universal, and invariant structures of that phenomenon that define it as
unique in comparison to similar phenomena (Omery & Mack, 1995). Essences are the
shared elements of experience that remain after all idiosyncratic features of individuals’
varying forms of an experience are discarded (Giorgi, 1997).

Crotty (1996, 1998) and others (Thorne, 1997) have critiqued the current wave of
phenomenological studies that primarily fall within nursing disciplines by suggesting that
this new wave of phenomenology is different in purpose and findings than “authentic”
phenomenology as intended by Husserl. The key departures made by nursing researchers
from pure phenomenology are the intent to uncover subjective lived experiences of participants, pursued through a participant-as-expert perspective, and a focus on uniqueness of experience. Authentic phenomenology pursues objective descriptions of experience; that is, what exists before any cultural interpretations are imposed (Crotty, 1998). Crotty advises that the aim of mainstream phenomenology, therefore, is to uncover "what we directly experience; that is, the objects of our experience before we start thinking about them, interpreting them, or attributing any meaning to them" (1998, p. 79). The idea is that, by bracketing our assumptions -- which include putting cultural meaning systems into abeyance -- the phenomenological researcher will see a phenomenon in a radically new, unencumbered way. Authentic phenomenology wants to elucidate the phenomenon to which people assign meaning, not reveal the meanings that people attribute to the phenomenon. In contrast, Crotty believes that what new phenomenology represents is "a single-minded effort to identify, understand, describe, and maintain the subjective experiences of the respondents" that does not challenge traditional ways of viewing that experience (1998, p. 83).

I should emphasize two further points with respect to the original proscriptions of mainstream phenomenology. First, phenomenology in its most pure form was intended as an objective, rigorous science. Giorgi, for example, suggests that phenomenologists seek Truths about a phenomenon (Giorgi, 1989). Authentic phenomenology retains elements of positivism in this way, by suggesting that if we do "good enough" science we can reveal what a phenomenon really is, not just what we or our participants think it is because of the cultural meanings attached to it. The researcher is viewed as an expert who breaks down
and makes sense of respondent data within a specific discipline. Phenomenology is not concerned with the point of view of the participants, and does not aim to see things from their perspectives (Crotty, 1998). To this end, Giorgi, for example, would recommend against validation of study findings with participants. He states:

Unless the subject is also a colleague from the same discipline whom I am deliberately using for a special purpose, I do not claim that the subject’s reflection on his or her experience is equivalent to the perspective that I bring to the research problem as a research psychologist (1989, p.78).

A very clear demarcation exists between researcher and “subjects” in authentic phenomenology.

Secondly, essences revealed through the analytic process should be universal; that is, should hold true for any participant with that experience, irrespective of age, race, culture, or historical period. This may be why phenomenological researchers who pursue mainstream phenomenology tend to explore abstract concepts of human existence, such as learning (Giorgi, 1975).

Although qualitative research has unarguably gained acceptance in the past decade, in the enthusiasm of acceptance it seems that in some cases an uncritical eye has been granted to qualitative research. Decisions or preferences regarding epistemological decisions, theoretical orientations, and methodological choices are often not rendered visible in qualitative research studies. Without the researcher making these decisions explicit, it is difficult for any reader to analyze whether there is consistency between these different levels of a research project. Thorne (1997) delivers a harsh criticism of the new wave of qualitative research, sarcastically making fun of the “sloppy scholarship” of new
qualitative researchers who view their "discovered constructs as if they were objective realities (essential structures) rather than (more or less) exhaustive, but definitely constructed descriptions" (1997, p. 289). Thorne further speculates whether the recent popularity of qualitative research -- as well as the egos of the researchers -- have "created the illusion that all thoughts deserve to be treated as significant contributions to fundamental knowledge" (1997, p. 290).

Thorne's criticisms border on excessive. However, I share her frustration that much qualitative work suffers from a lack of rigor to the theoretical foundations and methodological process in descriptions of such research. Indeed, one of my greatest challenges in conducting this project was trying to determine how other qualitative researchers actually carried out their "phenomenological research" -- a task made difficult when many publications devote no more than one paragraph to a description of their method and analysis. It was as if researchers magically moved from a sample of participants to an explication of findings.

It seems to me that the importance of a qualitative research project (as in any empirical effort) lies not in the irrefutable achievement of the intended goal that maintained the strictest of adherence to the suggested method, but rather in the willingness to be explicit about both decisions made throughout the project that contribute to the goal, and the theoretical perspective(s) that guided the pursuit. In other words, I could assert that I attempted to conduct a phenomenological research study that remained faithful to some key Husserlian principles. I made my decisions explicit during all phases of the research study, and spent considerable attention in particular to the precise method I used to
analyze the data. Because of this articulation, whether or not I actually achieved an authentic phenomenological project can be debated by those who become the audience for my study. And this -- the informed dialogue about qualitative research -- is what is important in the development of a qualitative literature in phenomenology, and on my topic of interest.

Of course, I have my own opinions regarding my degree of adherence to conducting an authentic phenomenological project. For example, although I believe that my method of data collection and analysis represented a fairly faithful delineation of phenomenology. I readily admit that my conclusions and interpretations of the findings significantly depart from the pure form of phenomenology. They depart because of the ways in which my conclusions are informed by a feminist theoretical perspective, a framework that in many ways is incompatible with authentic, Husserlian phenomenology (although, is much more similar to new, nursing phenomenology).

To elaborate, the analysis I performed was a rigorous process of discovering the essential elements of the phenomenon of safe sex for the women in my sample. What emerged from the analytic process as a final product -- the General Structural Description -- describes the defining features and the relationships between the features of consistent safe sex for women in committed relationships. This result of analysis I believe to be a description, not an interpretation or explanation, of a degree of reality that goes beyond summed subjective experiences. It reflects a shared reality, rather than idiosyncratic elements, for this sample of women. In this sense, the essences uncovered by analysis are objective in that they are a true reflection, or description, of the phenomenon as
experienced by the participants. Bracketing my assumptions contributed to the process of seeing elements of the phenomenon that I may not have been able to see if I were operating with an unrecognized set of biases that limited my view of the data.

However, I also believe my conclusions to depart from pure Husserlian phenomenology. I do not think that my findings can be completely divorced from culture. The very topic I chose to investigate is bound by cultural and historical understandings of what sex in recent decades means. Just over 20 years ago, “safe sex” was not imbued with the meaning that the advent of AIDS has introduced. Although I suppose I could attempt to describe the phenomenon of safe sex as if it were “culture-free” (e.g., what is safe sex apart from the meanings associated with it because of AIDS?), for both myself and my participants the language of “safe sex experience” was necessarily and inherently located in a wealth of meanings, determined by the cultural and historical features in which the investigation took place. For instance, the essence of self-protection may not make sense during an earlier time period when the HIV virus was not a threat, or in a different culture where women do not have choice to regulate their pregnancies.

Although it may be possible to remove oneself from specific culturally-based biases or assumptions -- such as my historically-derived expectation that safe sex only signified safe sex from disease, not pregnancy -- I view this as a different process than divorcing the study from culture completely. Not only do I think that this is rarely possible, I also am not sure when such an approach would be useful. And this is where my feminist commitment begins to problematize phenomenology. The value of qualitative work, for me, comes from its ability to reveal in-depth understandings of experience and challenge
taken for granted cultural assumptions of women's experience (e.g., "safe sex is the same for women and men"). To produce "culture-free" findings removes the ability to both usefully challenge the status quo for women, and to suggest new possibilities or opportunities for women not limited by reigning proscriptions that are rarely sensitive to women's reality. For example, how could I inform safe sex education programs for women in a practical, realistic way if the findings from my study are not related to the daily, culture-bound struggles to enact safe sex behaviors that women encounter?

This raises a second divergence between feminism and pure phenomenology — the expectation that findings are universal, and should be applicable to all people with a specific experience. Postmodern feminism would say that, as feminists, we need to attend to the differences between women's experiences (Baber & Allen, 1993). Postmodern feminism operates with an understanding that distinctive facets of women --- their age, ethnicity, economic status, sexual orientation, religion, or belief system --- make a difference in how they understand and are affected by certain experiences. Pure phenomenology, on the other hand, suggests that these individual variations, in a sense, are "noise" that should be disregarded. Thus, a true phenomenologist might say that a phenomenon of safe sex for all women -- regardless of these idiosyncrasies -- could be revealed (if the research process was "good enough").

I am uncomfortable with that assertion. I believe that my findings may be a relatively accurate description of the phenomenon of safe sex in heterosexual, committed relationships for middle-class, primarily Caucasian or ethnically acculturated, single, young, college educated women living in the U.S. However, I make no claim that my
findings would be equally descriptive for poor women, non-educated women, women of varying ethnicities or nationalities, or married women. For example, in pure phenomenology, Cara’s experience -- the Asian-American woman who intended to stop condom use as a compromise for her much older boyfriend -- would be considered extraneous material. A feminist postmodern researcher, on the other hand, would give meaning to Cara’s experience, even though it represented an outlier. This feminist researcher might use that information (as feminist AIDS researcher have) to investigate further whether specific populations of women in committed relationships, by nature of their cultural upbringing, are at greater risk for dangerous sexual health outcomes. Thus, feminists who adopt a postmodern perspective would suggest that no one group of women can claim a privileged standpoint with respect to a specific phenomenon; nor can a researcher claim any collective women’s experience (Baber & Allen, 1993). Instead, multiple realities exist that are linked to culture, and each deserves articulation.

Thus, there are multiple ways that women experience safe sex in committed relationships, and these are influenced by their culture, ethnicity, age, etc. I view this information as important. Because of this, there are decisions I made during the research process that are explicitly opposite to authentic phenomenology, and much more consistent with feminist methods. For example, I decided to share findings with a selection of participants, and request feedback. Pure phenomenology would tell me that the subjects’ opinions about my findings are irrelevant; that, further, subjects should not necessarily be able to recognize themselves in the description because they remain attached to their biased meanings of the phenomenon. The question I would pose,
however, is how can my findings be useful if my own participants cannot identify with the experience I described?

The consideration of the role of participants in authentic phenomenology raises yet another difference between pure phenomenology and feminist research (and new, nursing phenomenology). Feminist research and nursing phenomenology adopt a purpose that is applied. Findings should be useful and valuable to the improvement of women’s situation. Similarly, in nursing phenomenology, findings should have clinical relevance for better patient care (Munhall, 1994). Pure phenomenology, in contrast, is truly a basic research approach, that is relatively unconcerned with the relevance or significance of findings for applied purposes. Thus, in summary, I believe the current qualitative phenomenological effort to reflect elements of both pure phenomenology and feminist research / nursing phenomenology.

Limitations of the Study

Several limitations of the current study deserve mention. First, as I alluded to in the previous discussion, the sample was fairly homogeneous on several important characteristics. There was some variability with respect to participant ethnicity, and this variability did appear to be meaningful in terms of outlier characteristics in the sample. For example, one of the Asian-American participants who I have previously described talked about accommodation with respect to safe sex behavior for her partner. In addition, the participant who is Hispanic talked extensively about her culture and the expectations surrounding sexuality for women. The two participants who are Native East
German discussed, during their respective interviews, the relative lack of sex education that was in the schools when they attended high school. Both of these women had higher levels of inaccurate knowledge about the transmission of various STDs.

The sample also was variable in terms of religious affiliation and degree of religiosity, especially in the participants’ families of origin. Again, meaningful patterns emerged that seemed linked, in particular, to participant’s level of religious adherence growing up. All three participants (two Catholic, one non-denominational) who described their families as very religious attributed their attitudes regarding safe sex, in part, to these religious beliefs. For example, all three participants expressed the idea that premarital pregnancy was socially unacceptable, and would bring shame on their families or communities if this were to occur. The format of the method I used, however, did not afford much opportunity to describe or discuss these trends that emerged for just a few participants, or individual meanings related to dimensions of ethnicity or religion that played a role in a participant’s life. This in itself is somewhat of a limitation of the methodology, because in seeking to elucidate the shared essences of experience, the range of experiences and diversity of the sample is silenced.

The sample was fairly homogeneous, though, regarding education and economic status. I did not ask participants to provide information about their or their family’s financial state. However, the fact that all participants attended a 4-year university is some indication that their families are likely at least middle-class. As numerous studies reviewed in the Discussion illustrate, poverty exerts an impact on safe sex behavior due to the
association between poverty and a host of variables that restrict women's ability to enact safe sex.

A second limitation of the project concerned the interview process. Phenomenological interviewing guidelines suggest that interviews should be open-ended, beginning with a general introductory question and allowing the participant to lead the rest of the interview. Thus, each interview is mostly an emergent process of the researcher following up on issues raised by the respondents. During my interviews, there were several questions that I wanted to pose to each participant; for the most part, though, I allowed the participants to guide the content of the interview.

In retrospect, I wish I had been more forthright asking questions that I wanted the participant to discuss even if she did not raise the issue herself. For example, questions that I did not directly ask, but I wish I had included: partner's virginity status before becoming involved with the participant, participant views on abortion, further questions about why participants and/or partners received STD tests, questions regarding previous sexual relationships that may have informed current practices, and questions about monogamy. Several participants, for instance, spontaneously offered the belief that their partner was monogamous, and two women admitted to concern about a partner's fidelity. But, I never directly asked any participant whether they themselves, or a partner, had ever been unfaithful. Therefore, I felt somewhat constrained by the method in my ability to ask certain questions that likely would have more fully informed the findings.

This discussion leads to a third limitation. Because of the sensitive nature of the topic under investigation, there is always the possibility that participants may have
withheld or concealed important characteristics of the relationship that could have proved important to the study. For example, in relation to the previous limitations, consistency of condom use for the women in this sample could have been motivated by partner infidelity, which the participant chose not to disclose in her interview. Similarly, although at least half of the participants felt comfortable enough to reveal a negative past experience, such as a former pregnancy or STD, others could have withheld this potentially embarrassing and private information. I felt that I established good rapport with each participant, and I strongly emphasized the confidential nature of the study, but of course participants may not have felt comfortable enough to be completely honest about these types of sensitive, private aspects of the experience. Gathering further information through a less intrusive means of data collection, such as corroborating interview data with personal written narratives, may have been useful to the end of increased confidence that all potential influences on condom use for the women in this sample were revealed.

Finally, the intent of the current study was to describe the phenomenon of safe sex for women in committed, heterosexual relationships. The interview and analytic process were both geared to produce descriptive information about the phenomenon. Thus, I cannot address in any significant manner from the data how participants became so adamant about usage. Some participants began to provide explanations of this sort, such as messages from a “radical, liberal” mother about safe sex and healthy, respectful relationships for one participant, or growing up in San Francisco and being “bombarded” with information about safe sex for as long as she could remember by another participant. The purpose of the method was not to address the question of “How?,” but rather to
delineate a picture of what the phenomenon of safe sex for young women in committed relationships looked like.

**Significance and Future Directions**

One of the most simple yet important questions that could be posed to a research investigation is, "So what?" In other words, why is this study interesting, revealing, or important? Why should readers be intrigued, and how can findings be useful? Although, as Thorne (1997) bluntly suggested, every researcher believes his or her findings to be important, there are several key points that hold particular relevance for future research efforts in the current investigation.

First, I believe to be meaningful the mere fact that this sample of women was addressed in an empirical study. In the past decade, the overwhelming concern with unsafe sexual behaviors of women, in particular, has obscured the fact that young women do exist who consistently practice safe sex. Young women have been located in such a position of victimization with respect to sexual safety, that the voices of empowered women who act in ways to protect themselves have been effectively silenced. This study has contributed to a small body of literature (e.g., Kline et al., 1992; Thompson, 1994) that recognize the women's ability to put their needs first. The women in this study were confident, strong, and unwavering regarding their beliefs about safe sex, and could not imagine compromising their beliefs for the sake of a relationship. Safe sex had become an integral facet to how they viewed themselves as sexually active women. Further, they recognized their own pursuit of pleasurable sexual experiences, and viewed condom use as
inherent to the achievement of sexual pleasure because of the ability to “let go” of thoughts of worry and anxiety. This image of women presents clear relevance for sex education programs. Because peer influence appears to play an influential role in safe sex behaviors (Brown et al., 1991; Fisher, 1988; Sheeran & Taylor, 1999), it is important for female recipients of safe sex information -- especially young women -- to hear the experiences of women who do practice safe sex consistently in their committed relationships.

In support of a related issue, the women in this study who were committed to their practice of condom use for their own self-protection did so in a way that facilitated -- not undermined -- connection with a male partner. One criticism of many safe sex promotion messages has been the inattention to the relational nature of sexuality, and to women's orientation towards facilitation of relationships even at the expense of their health (Amaro, 1995). In the current study, women protected themselves, but did so in a way that maintained their relationships with their partners. Thus, for sex education programs, it provides a basis to suggest that -- at least for some women -- self-protection and relational connection are not incompatible. Participants maintained this connection by divorcing the stigma of condoms with the actual behavior of using condoms. Condoms were not interpreted as a symbol of infidelity, or lack of trust, but rather as a necessarily element to protect against a variety of negative health outcomes that result from unprotected sex. Women had knowledge that some STDs can manifest in the body without a partner even knowing about it. This helped remove any blame placed on a partner for potentially putting a participant's health in danger by engaging in unprotected sex. In this way,
women could feel connection, love, and trust in a partner currently, but still be concerned about their past sexual experiences.

The participants’ construction of condoms suggests important directions for sex education programs. By emphasizing the use of condoms in casual relationships (including relationships with secondary partners, that is, relationships where one partner is being unfaithful to a primary partner with an additional sexual partner), where partners do not know each other well and may expect that a partner could have a disease -- that is, with partners whom one does not love or trust -- public health messages have inadvertently created the message that “knowing a partner” relieves the need to use a condom. Further, these messages have constructed self-protection and love as incompatible. Sex education would benefit from the promotion, instead, of the message that self-protection from condom use is equally important in loving, trusting relationships, because the nature of many STDs makes it such that complete determination of disease status is difficult. In other words, committed, monogamous partners could have contracted an STD in a previous relationship, and yet be unaware, hence placing their current partner at risk.

Thirdly, the current study emphasized that the exclusive message of condoms as providing protection against the AIDS virus is limiting, and has an opposite effect on the intended message. Even in this sample of women who were relatively educated about STDs, women expressed greater susceptibility to pregnancy and other STDs than to AIDS. Among a college sample, AIDS is typically not viewed as a realistic, salient threat. Indeed, the majority of women in the sample practiced dual method use of condoms and
the birth control pill. About half of these women practiced dual method use only to provide additional protection against pregnancy. In light of the typical use failure rate of the birth control pill (9%) , which is much higher than the perfect use failure rate that even these knowledgeable participants referred to (less than 1%), having a back-up protection against pregnancy is a wise choice. In addition, given high rates of STDs other than AIDS in a college population -- not including the occurrence of other bacterial vaginal infections that are not considered an STD but are related to unprotected intercourse -- it would seem important to emphasize the use of condoms in preventing these types of infections that college women are more likely to acquire than the HIV virus. Thus, sex education needs to broaden the appeal of condoms for use against these other consequences of unprotected sex. Protection against pregnancy may be the most powerful message in terms of increasing use, because pregnancy does not carry the stigma of “uncleanliness” and “infidelity” that protection against disease carries.

Finally, the current study draws much needed attention to the role of male partners in women’s successful use of condoms. In most studies, males are configured as the primary barrier to women’s condom use, and charged with both subtle and not so subtle forms of pressure against condom use. The male partners in the current study supported participants’ safe sex behaviors, either because these men fully agreed in the use of condoms themselves, or because they wanted to do everything possible to make their partners comfortable with the sexual relationship. The men in this study were not willing to sacrifice their own or their girlfriend’s health for the sole purpose of physical pleasure. It is time that empirical research and public health efforts expected more of men with
respect to safe sex. By promoting messages that configure the male as only wanting
unsafe sex and the female as the "gatekeeper," there is little room for hearing the voices of
males who equally desire safe sex. Some researchers would suggest that these types of
public health messages also contribute to the maintenance of a discourse of "masculinity"
that, in fact, encourages men pursue unsafe sex (Holland, et al., 1994b).

The study of women's safe sex behavior will likely continue as long as women still
experience unplanned pregnancy and sexually transmitted infections in worrisome
numbers. Increasingly, empirical investigations have resonated more closely with
women's reality. by, for example, drawing attention to the inherent gender-based
differences in the practice of safe sex for women and men. The current study is yet
another contribution to a literature that reflects women's realities. However, unlike the
vast majority of literature, this investigation gave voice to women who have somehow
been ignored in the overwhelming concern with unsafe sexual behaviors. It is difficult to
achieve a behavior that seems insurmountable and unattainable. Hopefully, this
investigation begins to construct a message for young women with choices to make about
their practice of safe sex that emphasizes the feasibility of condom use, even in the context
of close, loving relationships.
APPENDIX A: Outline for Phenomenological Research Reports
Outline for Phenomenological Research Reports

I. Introduction
   1. Phenomenon of interest
   1. Purpose / research question
   3. Explanation of significance
   4. Identify qualitative approach / overview of design

II. Evolution of the Study
   1. Historical context
   2. Experiential context
   3. Scientific context

III. Research Design
   1. Introduction to the method
   2. Translation of concepts / terms
   3. Philosophical premises
   4. Method
   5. Specific procedural technique

IV. Research Method
   1. Sample (rationale for sample, selection process)
   2. Data collection procedure
   3. Ethics (human subjects)
   4. The interview process
   5. Data management
   6. Plan of analysis
   7. Trustworthiness

V. Findings
   1. Major findings / narrative form
   2. Support from raw data

VI. Discussion
   1. Relate to existing scientific literature
   2. Significance / relevance / implications
   3. Limitations
   4. Future Directions

APPENDIX B: Redescribed Statements and

Situated Structural Descriptions for all Participants
Redescribed Statements for Interview 1, Leah

1. Not Optional
Unsafe sex is not an option for Leah. She is extremely adamant that she would not have sex if there was not safe sex. This inflexible standard guides her behavior.

2. Responsibility
Practicing safe sex is a conscious decision for Leah. She has chosen to be responsible and proactive about preventing negative consequences, as has her partner. Being responsible includes dual method use -- using birth control pills and condoms.

3. Concern with Pregnancy
Leah strongly believes that premarital pregnancy is wrong, as does her partner. For herself, pregnancy is something she is not ready for and not willing to deal with at this point in her life.

4. Negative Experience / Fear
Negative personal experiences have scared Leah into using two forms of protection. She and her partner had a condom break, and they experienced a pregnancy scare. This is why she is on the birth control pill. They had an STD scare when a former partner of her boyfriend told him she had HPV. At that point, the fear of STDs became concrete for Leah.

5. Family Influence
Leah’s traditional, Catholic family had a significant influence on her beliefs and actions regarding safe sex. They taught her to be responsible about health in general, and Leah has applied that value to sexual health. More importantly, growing up she learned from listening to her family’s conversations about other people that premarital pregnancy and promiscuity are “tragedies” or “voodoo.”

6. Characteristics of Committed Relationships
For Leah, sex should only occur in a committed relationship. To be involved in a sexual relationship, certain relational characteristics must be present. These include: commitment, love, trust, responsibility to each other, and the possibility of marriage with the partner. The opposite of this is casual sex -- characterized by lust and physical gratification -- which Leah believes is wrong.

7. Communication
Leah credits much of the success of her relationship to open communication about sex with her partner. Leah can talk to her partner about anything, including worries and concerns. This has facilitated intimacy, and strengthened the relationship. Leah would not be comfortable having sex if open communication with her partner were not present.
Situated Structural Description for Interview 1, Leah

The experience of safe sex for Leah is not optional, because she would not have sex if it was unprotected. Practicing safe sex is a conscious decision to be responsible and proactive about avoiding negative consequences. Leah is very aware of these consequences, because she has had direct experience with both pregnancy and STD scares. Because of these real experiences, the possible threats of pregnancy and STDs are concrete fears that could actually happen, rather than abstract threats that are “out there.” She chooses to use dual method protection -- condoms and pills -- to provide extra protection against STDs and pregnancy.

Leah believes very strongly that premarital pregnancy is wrong. Personally, she is not ready for pregnancy and is not willing to deal with it right now. Her traditional, Catholic family has had a significant influence on these beliefs. Growing up, she learned that premarital sex is wrong, that pregnancy before marriage is a “tragedy,” and that promiscuity is “voodoo.” She also internalized a value from her family to be responsible for health more generally.

Leah is comfortable being sexually active because she is in a committed relationship with someone she could see herself marrying, characterized by love, trust, and responsibility to each other. She believes that sex should occur only in these types of relationships, and thinks casual sex -- characterized by lust and physical gratification -- is wrong. Practicing safe sex in this relationship is easy because of her open communication with her partner. She can talk to him about anything, which has facilitated intimacy and strengthened their relationship.
Redescribed Statements for Interview 2, Cara

1. **Concern with Pregnancy**
Cara does not want to get pregnant at this point in her life. Pregnancy now would be emotionally disturbing, would compromise her future, and would be unfair to the child to have parents who are not ready or responsible for parenthood. For these reasons, Cara decided what was best for her in terms of practicing safe sex before she became sexually active.

2. **Integral Aspect of Sex**
For Cara, safe sex is an integral part of sex because she wants to avoid negative consequences. Because of the sexual education she received, she believes that using contraception is a matter of common sense. She compares unprotected sex to another health-compromising behavior, brushing your teeth without a toothbrush.

3. **Trust**
Safe sex for Cara is highly connected to trusting her partner to not put her in any danger. Cara is not concerned about STDs because she was a virgin before she met her partner, and because he told her he was “clean,” that is, did not have any STDs. She trusted him because he was open and honest about his sexual history. This openness built her trust in him. Those characteristics of trust, openness about all aspects of their relationship (including sex), and honesty contribute to her ability to practice safe sex.

4. **Why Condom Use**
Condom use was Cara’s first choice for contraception because it’s easy and inexpensive. Because her family is against premarital sex and because they will go through her personal belongings, she needs to use contraception that is disposable and easily hidden. The only barrier to using condoms is the annoyance at running out of them.

5. **Compromise**
Cara believes that safe sex involves compromising for a partner, rather than only practicing safe sex the way that she wants. As an example, Cara’s boyfriend does not like using condoms, and has convinced Cara to switch to spermicide without condoms. Cara explains that this new method satisfies both of their preferences.
Situated Structural Description for Interview 2, Cara

For Cara, the experience of practicing safe sex is one of necessity because she does not want to get pregnant at this point in her life. Although Cara wants children eventually, an unplanned pregnancy right now would be emotionally distressing, would compromise her own future, and would be unfair to the child. For these reasons, Cara had thought about and made her decision to practice safe sex before she became sexually active.

Because of her wish to avoid the negative consequences of unsafe sex -- primarily pregnancy -- Cara refers to safe sex as an integral aspect of sex. Her knowledge from sex education that negative consequences could happen leads Cara to report that using contraception is easy, straightforward, and common sense.

Sexually transmitted diseases are not something Cara worries about because she was a virgin before her current partner, and because he told her that he did not have any STDs. Openness and honesty about his past sexual relationships -- including his 10 year marriage -- led Cara to trust him to have her best interests in mind and to not put her in any danger. Cara describes this trust, honesty, and open communication about all aspects of the relationship, including sex, as characteristics of the relationship that facilitate practicing safe sex.

Cara’s decision to use condoms was based on the fact that they are easy to use and inexpensive. In addition, because her family does not accept premarital sex and will invade her personal belongings, she needs to use a form of contraception that is disposable. The only challenge so far has been annoyance at running out of condoms. Recently, she has started using spermicide without condoms because her boyfriend does not like using condoms. Spermicide is a compromise that satisfies both of their preferences. Therefore, safe sex for Cara involves selecting a method that her and her partner both agree upon, rather than insisting on a method that only she prefers.
Redescribed Statements for Interview 3, Kate

1. Not Optional
Having unsafe sex is not an option for either Kate or her partner, and the commitment to practice safe sex is shared by both of them. Currently, they use both the birth control pill and condoms, although they use condoms only 70% of the time, and exclusively as a back-up protection against pregnancy.

2. Integral Aspect of Sex
Practicing safe sex is a “given” for Kate, and a natural and integral part of sex that, most of the time, she does not consciously think about. Even the first time she had sex with her partner, condom use was not uncomfortable or awkward, but rather matter-of-fact.

3. Negative Experience
Kate’s insistence on safe sex comes from an experience of unplanned pregnancy from not using any contraception at age 16. She calls this a “horrible, life-changing” experience. After her abortion, sex equaled pregnancy in Kate’s mind, and she was not sexually active for four years. The decision to become sexually active again was very difficult, and when she did she always used the birth control pill and condoms.

4. Partner’s Characteristics
Kate’s partner insisted on condom use until she got tested for HIV. Prior to his relationship with Kate, he contracted chlamydia from a long-term partner who had been unfaithful. Although Kate says that in general her partner is very responsible, she attributes his insistence on condom use and the HIV test to this previous experience of contracting an STD.

5. Self Protection
For Kate, the primary motive in practicing safe sex is to protect herself from getting pregnant. Kate believes her partner places his self-protection first as well. Even though they care about each other’s well-being, this motivation to protect a partner is secondary.

6. Responsibility / Benefits
Currently, Kate feels more responsible for contraception because the pill is their primary method. This sometimes annoys her, because philosophically she believes that contraceptive use should be an equally shared responsibility. However, personally she likes being in control of the contraception, because knowing that she is protected enables her to feel safe and enjoy being sexual, rather than worrying about pregnancy.

7. Characteristics of Committed Relationships
Kate believes that practicing safe sex in a long-term relationship is easier than in a short-term relationship, because partners know each other better and are more comfortable talking to each other about safe sex decisions. She describes her own relationship as very strong, characterized by open communication and love. These characteristics make the daily practice of safe sex easier.
Situated Structural Description for Interview 3, Kate

Practicing safe sex is not optional for either Kate or her partner. It is a natural and integral aspect of sex that she typically does not even think about. Even at the beginning of their relationship, condom use was never uncomfortable. Currently, they use both the birth control pill and condoms, although their condom use is only about 70%. Kate and her partner have both been tested for STDs, so condom use provides back-up pregnancy protection in case the pill fails.

Both Kate and her partner are firmly committed to safe sex because of negative experiences they each had before they met. Kate’s partner insisted on condom use until Kate was tested for HIV, because he had contracted chlamydia from a long-term girlfriend who cheated on him, and he is now very concerned about STDs. Kate is very concerned, instead, with pregnancy, because she got pregnant at age 16 from not using any contraception. Kate refers to this experience as horrible and life-changing. After her abortion, in her mind sex equaled pregnancy, and she was not sexually active for four years. Her decision to have sex again was very difficult, and at this point she decided upon dual method use.

Because of each of their negative experiences, Kate suggests that both she and her partner engage in safe sex to protect themselves first and foremost. For Kate, her primary concern is that she does not become pregnant, and any concern about her partner’s well being is secondary.

Kate feels primarily responsible for contraception, since their primary method is the birth control pill. Sometimes she resents being “in charge” of contraception, since philosophically she believes that contraception should be equally shared. However, being in control enables her to relax and enjoy sex, rather than to constantly worry about pregnancy. Characteristics of her relationship also allow Kate to enjoy sex, including being in love and having open communication about sexuality with her partner. Because of her experience, she thinks that practicing safe sex is easier in long-term than short-term relationships, where the partners may not know each other or be comfortable talking about safe sex.
Redescribed Statements for Interview 4, Janice

1. Responsibility
For Janice, being sexually active means that she is ultimately responsible for her own health and well-being. She is uncompromising about her beliefs regarding safe sex, and would not have unsafe sex. For example, she has insisted on using both condoms and the birth control pill with every act of intercourse in her current relationship, has been tested for STDs, and has encouraged her partner to get tested as well. Further, she is “level-headed” during sexual encounters, and will not have sex if condoms are not available, even though she is on the pill, and both her and her partner have received STD tests. Responsibility about sexual health also includes being knowledgeable about her body and about the rates and characteristics of the different STDs, so that she would be able to recognize symptoms of an STD if she contracted one.

2. Concern with Pregnancy
Janice consciously thinks about the risks of using none or only one form of contraception, and the benefits she receives from using two forms. She uses dual protection because she does not want children at this time in her life. Condoms provide back-up pregnancy protection, because the pill is not 100% effective against pregnancy, and she is not willing to risk the 1% chance that she could get pregnant on the pill.

3. Benefits
The benefits of using dual protection include not having to worry or be “paranoid” about pregnancy. Her peace of mind and enjoyment of sex are priorities, and she can achieve these only by using dual protection.

4. Negative Experience / Fear
A strong motivation in using dual protection is fear, based on a negative personal experience. Janice had a pregnancy scare her senior year of high school when a condom broke. Because she was not using hormonal contraception at the time, she went to Planned Parenthood for the morning-after pill. Janice describes the experience as traumatic, and she was not sexually active for five months afterwards. This was why she started the birth control pill.

5. Partner’s Characteristics
Janice’s boyfriend has been her only sexual partner who insisted on condom use from their first act of intercourse. She thinks she is extremely unique, because “most other guys” pressure to not use condoms. Janice attributes his attitude to two characteristics: (1) his Catholic upbringing; (2) the fact that he likes his independence, freedom, and school success, and realizes he may lose that were she to get pregnant. Therefore, she does not have to remind him to use condoms.
Responsibility is the primary feature in the experience of safe sex for Janice. She believes that ultimately she is responsible for her sexual well being, for avoiding negative consequences, and for ensuring that contraception is used. Because of this belief, Janice insists on dual contraceptive use (the birth control pill and condoms) with her partner, and says that she would never consider unsafe sex. Responsibility for Janice has also involved making sure that both she and her partner were tested for STDs and HIV; being knowledgeable about the symptoms of STDs and about her body so that she could quickly recognize an STD if she were infected; and being level-headed during sex so she does not forget to use a condom in the heat of the moment.

Janice is fearful of pregnancy, because she experienced a pregnancy scare during high school when a condom — the only form of contraception she used at the time — broke during sex. She remembers that experience as extremely traumatic, and explains her current dual method use as a result of that scare. Janice knows that neither the pill nor condoms are 100% effective against pregnancy. By using two methods she has a back-up in case one of these methods fail. This is important to her because she does not want children at this point in her life. However, enjoyment of sex is also very important to Janice, and she realizes that dual method use allows her to relax during sex, rather than worry about pregnancy.

Even though Janice is firmly committed to practicing safe sex, her partner's attitudes make this practice significantly easier. Janice thinks her boyfriend is very unique, and considers herself lucky, because he has been her only sexual partner who never objected to or complained about condom use. Her boyfriend wants to use condoms until he is married, which Janice thinks has to do with his strict, Catholic upbringing. She also believes that her boyfriend is so supportive of safe sex because he enjoys the freedom and success of his life right now, and realizes this would change if he had to deal with an unplanned pregnancy.
Redescribed Statements for Interview 5, Samantha

1. Not Optional
Samantha firmly asserts that she would never have unprotected sex. The decision to use contraception is not an option for her. Samantha is extremely conscientious in her practice of safe sex, and is inflexible in her insistence on using two forms of protection. Samantha has researched the characteristics and failure rates of the different choices of contraception, and has tried different combinations of hormonal and barrier methods. Currently, she uses the birth control pill and condoms because the combination is extremely reliable.

2. Benefits
Using two forms of contraception allows Samantha to feel safer than if she were just using one form, because she always has a back-up in case one method fails. Because she feel safer, she is more comfortable having sex, and thus can relax and enjoy sex, rather than worry about pregnancy.

3. Concern with Pregnancy
Samantha is extremely “paranoid” about pregnancy. She does not want to get pregnant, does not ever want children, and thinks she physically and emotionally could not handle an abortion if she did get pregnant.

4. Self-Protection
Because her boyfriend had previous partners, Samantha became worried about STDs. She was using condoms, but she knew that condoms do not completely eliminate the risk of infection. She wanted to protect herself, so she expected her boyfriend to get tested for STDs -- including HIV -- which he did. Now, she is not concerned at all about STDs, because she trusts that he is monogamous.

5. Beliefs about Sexual Relationships
Samantha holds very specific beliefs about “appropriate” sexual relationships. She was raised in an extremely religious household to believe that “sex is bad” and that “awful” people have premarital sex. She struggled with feelings of guilt and shame when she decided to have sex. Samantha now believes that sex is acceptable in healthy, long-term, monogamous relationships when the partners are in love and committed to each other. However, she has very negative views of casual sexual relationships, and says that personally she could not ever have one because she would feel too guilty, and because her enjoyment of sex comes from being emotionally close and in love with her partner.

6. Partner Characteristics
Samantha extensively praised her partner because his attitudes about contraceptive use makes practicing safe sex easier, and makes sex more enjoyable. He never questioned whether they would use condoms. Samantha considers herself lucky to find such a unique boyfriend, since most guys complain about condoms. He recognizes her fear of pregnancy, and wants to make her feel as comfortable and safe as he can. Samantha sees this attitude as a sign that he cares for and loves her, because he is willing to sacrifice the better feel of sex without a condom for her happiness.
This attitude allows her to relax and enjoy sex more because she knows that using condoms will not be a struggle.

**Situated Structural Description for Interview 5, Samantha**

Samantha would not have sex if there were not safe sex. Her first priority is to avoid pregnancy because she does not ever want children, and is scared of and emotionally unprepared for both childbirth and abortion. Her overarching concern with pregnancy has led Samantha to become knowledgeable about and experiment with different combinations of contraceptive use. She currently uses the birth control pill and condoms. Samantha asserts that she would never have sex just using one form of contraception, because she needs to have a back-up method in case one method fails. Using dual protection allows Samantha to feel safer and more comfortable during sex, thus enabling her to enjoy sex more than if she was constantly concerned about pregnancy.

Another factor that facilitates Samantha’s enjoyment of sex is her partner’s attitudes about safe sex. Her boyfriend has never objected to condom use, which Samantha finds unique compared to other guys who typically complain about condoms. Samantha’s boyfriend recognizes her fear of pregnancy, and has told her that he wants to do whatever makes her most comfortable and happy. For example, he agreed to get tested for STDs to alleviate Samantha’s concern about his past sexual experiences. Samantha interprets his willingness to make her comfortable by readily using condoms as a sign of his love and concern for her. This contributes to her enjoyment of sex because she knows condom use will not be a struggle.

Even though Samantha is now comfortable having sex with her partner, when she first became sexually active she experienced significant guilt and shame. She attributes those feelings to the fact that she was raised in an extremely religious household to believe that premarital sex is very wrong, and that people who engage in it are bad. She has resolved many of those feelings by accepting that premarital sex is okay as long as it occurs in the context of a serious, committed, monogamous relationship, and as an expression of love. Samantha contrasts this to casual sex, which she views as morally wrong.
Redescribed Statements for Interview 6, Gretchen

1. Dual Method Use
Gretchen currently practices dual method contraceptive use: she is on the birth control pill and she uses condoms. She likes the pill because it controls acne and regulates her menstrual cycle, but she questions the reliability of it for pregnancy prevention, and knows it does not protect against STDs. Gretchen states that she uses the pill in case a condom breaks, and thus it is her secondary form of contraception. Condom use is her primary choice of contraception, and she has consistently used condoms since the beginning of her current relationship.

2. Concern with STDs / Negative Experience
Gretchen's primary concern is sexually transmitted diseases. She states that she wants to protect herself from any diseases that her partners may have. Several years ago, she was sick for a year with serious, recurrent urinary tract infections. Even though her doctor did not diagnosis her with an STD, she knows that the infections could have been caused by unsafe sex. Since then, she has been consistent about using condoms, and she is tested for HIV on a regular basis.

3. Communication
Gretchen is very uncomfortable talking about sexual histories with her current partner, and has been uncomfortable talking as well with past partners. She has never had a discussion with her boyfriend about safe sex or STDs. However, she knows that he donates blood on a regular basis, and thus feels secure that he does not have HIV. Using condoms allows her to not talk about sexual histories.

4. Self-Protection
Using condoms has, in the past, meant that she can “keep her body to herself.” In other words, she has been able to have multiple partners without worrying about getting pregnant or any STDs. Thus, she has protected herself from negative consequences of unprotected sex, while engaging in fun, casual sexual relationships. At times, condom use was difficult when she really wanted to have sex with someone, but she learned to tell her partners that she would not have sex without a condom.

5. Committed Relationships
Gretchen believes that in loving, committed relationships using condoms is challenging because the reason for condom use is not as obvious as in short-term relationships. For example, she if fairly certain that her current partner loves her, is monogamous, does not have HIV, and would support her if she got pregnant. In this situation, “keeping your body to yourself” feels wrong to Gretchen, and so she is considering stopping condom use. However, she is still somewhat concerned about his monogamy, and continues to use condoms until she feel reassured about his fidelity to the relationship.

6. Characteristics of Partner
Gretchen’s boyfriend never objected to using condoms. She never actually asked him if he would use condoms, but rather she just used them the first time they had sex. She thinks that he is unique in this respect, because most of her previous partners were opposed to using them. She refers to condom use with him as “normal” because she does not ever have to tell him to use them.
Situated Structural Description for Interview 6, Gretchen

Gretchen primarily associates the term “safe sex” with condom use. She has used condoms since the beginning of her current relationship, and says she has learned to tell partners that she will not have sex without a condom. She never asked her partner if he wanted to use condoms, but rather assumed they would use them. Although Gretchen is on the birth control pill for other health reasons, she is not certain how effective it is for pregnancy, and knows it does not provide protection against STDs. Therefore, she thinks of condom use as her primary form of safe sex.

Gretchen has used condoms in her past relationships as well, although not as consistently as in her current relationship. She likes condom use because it has allowed her to have multiple, casual sexual partners, without having to wait to get to know their sexual histories. Gretchen is very uncomfortable communicating with her partners about safe sex, or STD testing, and so using condoms is a way of avoiding those conversations.

Gretchen reports being aware of and concerned with sexually transmitted diseases. Before becoming monogamous with her current partner, she experienced a year of recurrent urinary tract infections, which she knows could have been caused by unsafe sex. Because of this experience, she is more careful about condom use, and is tested for HIV regularly. She explains that condom use means that she can have sex, but still feel protected against diseases or pregnancy. Gretchen does not feel that she truly shares her body with someone unless she has sex without a condom.

For Gretchen, condom use makes more sense in casual relationships, where partners may not know each other well, than in committed relationships. Now that she and her partner have decided to be monogamous, and since she is in love with him and knows he would support her if she got pregnant, condom use feels wrong because there is not such a perceived need to protect herself. She has considered stopping condom use, but struggles with the decision because she knows it would mean that she’d have to discuss safe sex with him.
Redescribed Statements for Interview 7, Abby

1. Not Optional
Unsafe sex is not an option for Abby because of the risks presented by STDs and pregnancy. Much before she became sexually active she decided that — regardless of the partner — if she engaged in sex it would be protected with a condom. Abby believes that she alone exerts choice and control over her body, and therefore any potential partner does not have a voice in condom use.

2. Dual Method Use & Benefits
Currently Abby uses both the birth control pill and condoms with every act of intercourse. She prefers using concurrent methods because she knows neither method alone is 100% effective against pregnancy. By using two methods she always has a back-up in case one failed. Dual method use reduces her worry and anxiety during sex, as well as at the end of each month, about pregnancy. Because she is confident that she will not get pregnant, she is able to be comfortable and enjoy sex.

3. Fear of Negative Consequences
Abby is concerned with both pregnancy and STDs. Although she is pro-choice, abortion is not a personal option for her. Abby never wants children, and so she is extra cautious about becoming pregnant. Because both her and her boyfriend were virgins, rationally Abby knows that STDs are not a threat to their health. However, she vividly recalls the "STD slides" in high school, which disgusted and scared her. Now, she automatically associates not using condoms with contracting an STD infection.

4. Health Behavior
Abby believes that people should act in a way to prevent any negative health behaviors, whether it be wearing a seatbelt or wearing condoms. She does not understand why someone would choose to be unprepared for a potentially negative experience.

5. Family Influence / Communication
Abby attributes her ability to discuss and use contraception with her boyfriend, her accurate knowledge about her body and sex, and her commitment to practice safe sex all to her communication with her mother. Growing up, Abby had open communication with her mother about sex, and knew that her mother thought premarital sex — in the context of a long-term, committed, monogamous relationship — was okay as long as condoms were used. Abby suggests that the reason she and her partner discussed safe sex early in their relationship and agreed to wait to have sex until later in the relationship was because of the "practice" she received by talking with her mom.

6. Characteristics of Partner
From the beginning of their relationship, Abby's partner agreed with her choice to practice dual method use. Abby attributes his beliefs to the fact that he does not want to get pregnant either, and to his being a polite and good person who is extremely respectful of who she is and her values. She believes her boyfriend is very unique, and compares him to other guys who are dominant, controlling, put their physical gratification before a partner's health, and interpret condom use as damaging to their manliness.
Situated Structural Description for Interview 7, Abby

Abby feels in control of her body and her choices about contraception, and does not believe that any partner has the right to question or challenge this control. She attributes much of her knowledge about sex, her commitment to condom use, and her ability to assert her needs to her mother, who talked openly about these issues with Abby when she was growing up. Although her mother approves of premarital sex, she made it clear to Abby that sex should occur within a committed, long-term relationship, and should always be protected with condom use.

Abby protects herself during sex with dual method contraceptive use. She feels more comfortable knowing that if one method fails, she has back-up pregnancy protection from the other method. Using condoms and the birth control pill reduces her anxiety about pregnancy, and therefore allows her to enjoy sex. Abby is concerned about pregnancy because she never wants children, and yet abortion is not a personal option. Abby also admits to being unrealistically scared of STDs. Even though she knows she should not worry about STDs since both she and her boyfriend were virgins, she inextricably associates a lack of condom use with STD infection. Abby attributes this linkage to the slides that she in high school of STD infections, which significantly scared her.

Abby's boyfriend never objected to her contraceptive choices, not only because he wants to avoid pregnancy as well, but also because he is extremely respectful of her and of her values. She calls her partner a responsible, decent human being, and sees him as unique when compared to other guys who are controlling, lack respect for women's wishes, and put their own physical gratification first.

Finally, Abby feels that safe sex, in general, is analogous to any health behavior that prevents potentially negative outcomes. She does not understand why anyone would not do everything they could to prevent negative health outcomes.
Redescribed Statements for Interview 8, Serena

1. Women's Responsibility
Serena believes that, in general, women are more responsible about sexuality than are men, who typically just want to have fun. Being responsible includes thinking about the potential consequences of unprotected sex, such as dealing with pregnancy without the support of a partner, or contracting an STD that could damage a woman's fertility. Serena believes that women have to be more aware of the consequences, because most often women are the primary caretakers of children. Therefore, they need to be concerned with protecting their health, so that they can support themselves and existing or future children.

2. Protecting Self
Serena protects herself by using the birth control pill and condoms. She started using the pill before she was sexually active for other reasons, but now relies on it as her primary method of pregnancy prevention. Because her boyfriend had previous sexual partners she told him she wanted to use condoms and suggested that they both get tested for HIV. They were both HIV negative, but after becoming sexually active Serena did have an experience with a bacterial infection that could have been transmitted sexually from her boyfriend. Using condoms allows her to feel safer because she does not come in contact with his body fluids.

3. Communication
Serena told her partner before they were sexually active that she wanted to use condoms and get HIV tests. The ability to openly communicate with her partner about sex makes contraceptive use easier because they both understand how the other person feels, and can therefore be sensitive to the other person's needs.

4. Characteristics of Partner
Even though Serena's boyfriend did not perceive a need to use condoms since he knew his previous partners did not have HIV, he agreed to use condoms anyway because of Serena's wish to do so. Serena says her boyfriend is sensitive to her in other ways, such as understanding her need to wait six months before having sex, since her relationship with him was her first sexual experience of any kind. Serena says that he does not complain about condom use like other men do, but nonetheless would be happy to stop using them.

5. Making Condom Use Fun
Because Serena knows that her boyfriend only uses condoms to please her, she tries to make condom use and sex fun for him, and not let it get boring or routine. For example, she will buy novelty condoms, or surprise him with silly sex-related gifts. She also does things to make their relationship fun and spontaneous. Serena believes that having a sense of humor and making safe sex fun will make it easier for her partner to use condoms, since it would not be his choice to use them.

6. Characteristics of Relationships / Stopping Condom Use
Serena believes that eventually she will stop using condoms, but remain on the pill for pregnancy prevention. Her comfort in stopping condom use is based on building trust and love over time with her partner. The trust that Serena wants to build is both trusting that her partner is monogamous
and does not have any STDs, and trusting that the relationship is strong and has a realistic, long-term future ahead.

**Situated Structural Description for Interview 8, Serena**

For Serena, safe sex is something she feels is important for protecting herself and for being responsible for her own sexual health. In general, Serena believes that women have to be more aware of long-term consequences of unsafe sex -- such as pregnancy or STD infection -- than do men, who just want to have fun. Women's responsibility comes from knowing that, as primary caretakers of children, they have to keep themselves healthy to support their families.

Serena currently uses the birth control pill to protect herself against pregnancy. She also uses condoms, since her boyfriend had previous sexual partners. Serena suggested that they both get tested for HIV; their results were negative. However, Serena did experience an infection after becoming sexually active with her boyfriend that could have been sexually transmitted. Using condoms allows her to feel safer and better protected from his bodily fluids.

Serena had told her partner before they became sexually active that she wanted to use condoms. Serena suggested that her ability to communicate with her partner makes practicing safe sex easier because they each can understand and be sensitive to the other person's needs. For example, her partner did not perceive a need to use condoms, but does so anyway because it is important to Serena. He does not complain about using condoms, but would be happy to stop. Because Serena knows her partner would prefer to not use condoms, she attempts to make condom use and sex fun and spontaneous, and not let it get routine. Serena believes that by having a sense of humor and fun with sex, it is easier for her partner to use condoms.

As Serena increasingly builds trust over time with her partner, she anticipates eventually stopping condom use. Trust, for Serena, refers to both knowing her partner is monogamous and does not have any STDs, and having a sense of permanency and future in the relationship. Once Serena feels comfortable with these characteristics of the relationship, condom use will not be necessary.
Redescribed Statements for Interview 9, Kristan

1. Responsibility
For Kristin, safe sex is about responsibility. She believes that people who decide to be sexually active should be prepared by using contraception, or be prepared to deal with the consequences if contraception is not used. Kristin knows that she is ultimately responsible for protecting herself against pregnancy and STDs, and thus would rather be proactive about safe sex than deal with negative consequences that are the result of her own irresponsibility.

2. Not Optional
Kristin has used condoms consistently during her six year relationship with her partner. She says that since the beginning of their sexual relationship, they both assumed that condoms would be used. It has never been a question to not use condoms, because using condoms is not optional for either of them. Kristen describes condom use as automatic, something she does not even think about, and the easiest part of the relationship.

3. Why Condoms
Kristin uses condoms because they are inexpensive, convenient, and easy to use. The only reason she does not use the birth control pill is because they have had a long distance relationship for three years, and it does not seem necessary when she sees him so infrequently. If they did live together and she started the pill, they might try sex without a condom to see what it was like, but then would use dual protection to be extremely safe.

4. Concern with Pregnancy
Kristin’s main concern is pregnancy; she knows that she cannot handle a pregnancy at this time in her life. Kristin explains that she values the relative freedom she has to pursue her goals and figure herself out, and does not want anything to interrupt that. Because both she and her partner are monogamous and trust each other, STDs are not a concern.

5. Characteristics of Partner
Kristin’s boyfriend shares her feelings about safe sex, and about being responsible. Because he feels the same as her, she has never had a problem getting him to use condoms, and he does not complain about condom use like most other men. Kristin believes his responsibility comes from: (1) watching his older brother, who modeled what not to do by being promiscuous and not using contraception; and (2) being goal-oriented and successful, and wanting to do the right thing. Kristin feels lucky to have him as a boyfriend, because his attitudes make condom use easy.

6. Love & Contraceptive Use
Condom use is also easy for Kristin because she and her boyfriend are in love and committed to each other. Kristin believes that safe sex is easier when partners love and care for each other, because physical gratification is less important than respecting a partner’s values and being concerned for his/her well being. In addition, condom use is easier in committed relationships because any negative consequence resulting from unsafe sex is shared and becomes both partners’ problems.
Situated Structural Description for Interview 9, Kristan

The most important element of safe sex for Kristin is responsibility. She believes that to be sexually active means she must be prepared to use protection, or else be prepared to deal with the consequences. Safe sex is not an option for her; it is a requirement. She has consistently used condoms during the entire course of her six year relationship. Kristin uses condoms primarily to prevent pregnancy. Because she feels so strongly about practicing safe sex, she says condom use is just automatic, not at all difficult, and the easiest part of the relationship. Currently, Kristin does not use the birth control pill, because she and her partner -- who lives in a different state -- do not see each other frequently enough to warrant its use. However, if they did not have a long distance relationship and had sex regularly, she would use the pill and condoms, because she is not willing to risk one method failing.

Condom use is easy for Kristin because her boyfriend feels the same way that she does about responsibility and safe sex. He has never objected to or complained about condom use. Kristin feels lucky that he acts this way, since most men do complain about condoms. Kristin believes his responsibility comes from both watching a promiscuous older brother be extremely irresponsible about contraception, and from being successful, goal-oriented, and wanting to do the right thing. Kristin, as well, does not want an unplanned pregnancy to interrupt the current freedom she has to pursue her goals.

Finally, Kristin says that condom use is easy because she and her boyfriend are in a committed relationship and love each other. Being in love means that respecting a partner's values and concerns for his/her well being are more important than physical gratification or being momentarily irresponsible. Being committed also makes condom use easier because both partners know that any negative consequence would be a shared problem.
Redescribed Statements for Interview 10, Tricia

1. **Not Optional**
   Practicing safe sex is not optional for Tricia. She never questioned whether or not to use contraception, because she wanted to be as safe as possible. Tricia describes herself as extremely stubborn in that she would not have sex with someone who refused to use a condom.

2. **Dual Method Use**
   Tricia’s partner told her that their choice in contraception was ultimately her decision, but he did agree that using dual methods was the smartest choice. Originally, they only used condoms because condoms were the easiest and most convenient form of protection. However, Tricia quickly started the birth control pill as well to regulate her menstrual cycle so they could be secure in knowing each month that she was not pregnant. Tricia knows that no contraception is 100% effective against pregnancy, and so she likes the safety of using two forms.

3. **Natural Aspect of Sex / Habit**
   Currently, Tricia says there is no reason not to use condoms. She describes condom use as natural, a habit, and an unconscious part of their sexual relationship. Other than being occasionally frustrating to interrupt sex to put on a condom, Tricia does not even think about using condoms.

4. **Concern with Pregnancy**
   Tricia is primarily concerned with not becoming pregnant because she feels she is too young, is still in college, and needs to work. In addition, her boyfriend could not support her now since he is in boot camp. Tricia had friends in high school who became pregnant and had abortions, and Tricia decided she did not want to be in that situation. Although she admits struggling a bit with feeling invulnerable to any negative consequences, she realized it was safer and smarter to take precautions to prevent anything from happening.

5. **Characteristics of Partner**
   Tricia’s partner is equally concerned about pregnancy, because pregnancy would be an enormous stress for him, and he could not support her while he is away in boot camp. Tricia describes her boyfriend as very concerned about her in general, and very caring. He encourages them to have open communication, which facilitates practicing safe sex because they both understand each other’s feelings about it.

6. **Trust**
   Tricia does not worry about STDs. She and her boyfriend both have been tested for HIV, and completely trust each other to be monogamous. She emphasizes that using condoms is not interpreted by either of them as a sign of not trusting the other person, but rather simply as an extra precaution against pregnancy.

7. **Sex Education**
   Growing up near San Francisco, Tricia was inundated with sex education. She describes the information as very accessible and available. Messages conveyed were concerned with self-protection, the danger of necessarily trusting a partner, and basic information about STDs and safe
sex. Because she received sex education repeatedly throughout middle and high school, Tricia explains that it just becomes automatic and second-nature to protect yourself by using condoms.

Situated Structural Description for Interview 10, Tricia

For Tricia, practicing safe sex is a natural and habitual aspect of being sexually active, and something she does not even consciously think about. The decision of whether or not to practice safe sex was never a question, because she considers it a mandatory part of sex, and she would not have sex unless it was safe sex. Tricia attributes much of her outlook to the sex education she received growing up near San Francisco. She describes the information as so comprehensive and pervasive that it becomes second nature to protect yourself.

The decision to use both condoms and the birth control pill was primarily Tricia’s choice, although her boyfriend agrees that dual protection use is the smartest and safest decision, given that no method is 100% effective against pregnancy. Pregnancy is the main concern for both Tricia and her partner, because she is still in school and needs to work. In addition, because her boyfriend is away in the military, they both recognize that he could not support her now if she were to get pregnant. Tricia admits struggling with feelings of invulnerability regarding any negative consequences, but then realized that taking precautions to prevent negative consequences is a much better decision.

Tricia describes an extremely important characteristic of the relationship as trust. She is not worried about STDs because she and her partner both trust each other completely to be monogamous, and both have been tested for STDs. Neither Tricia nor her partner interprets condom use as a sign that the other has been unfaithful, but rather simply as an extra precaution against pregnancy.
Redescribed Statements for Interview II, Colleen

1. Not Optional
Colleen informed her partner before they were sexually active that she would not have sex without a condom, even though she was on the birth control pill. During the beginning of their relationship, he did not understand why she felt it necessary to use condoms. He would try to persuade her not to use one, and try to have sex with her without a condom. When faced with these situations, Colleen refused sex.

2. Fear of STDs
Several months before she started dating her boyfriend, one of Colleen's very close friends contracted herpes from a long-term partner who cheated on her. Colleen supported her emotionally, and by going with her to all the treatment appointments at the health center. Colleen learned about STDs from reading the pamphlets at the health center. This knowledge, combined with watching how much physical and emotional pain her friend endured from the herpes, significantly frightened Colleen. Because she was scared of STDs, she made sure in her relationship that her partner was tested for HIV and other STDs. His results were negative, but Colleen was not reassured that he is completely disease-free, because she knows that the tests are not always 100% accurate, and that some STDs can remain dormant in the body.

3. Concern with Pregnancy
Growing up, Colleen learned from her family that premarital pregnancy was socially unacceptable. Colleen also strongly believes that it is unacceptable to have children when parents are not emotionally prepared for the responsibility, a belief she attributes to the fact that her father left her family when she was young. Colleen does not want to become pregnant at this time in her life. In addition to the reasons above, she does not want an unplanned child to disrupt her own future and the career goals she has set for herself.

4. Protecting Self
Colleen uses condoms as a back-up to the pill to protect herself against pregnancy. Mostly, however, she uses condoms to protect herself against the medical and emotional consequences of contracting an STD. Her ultimate concern is she does not contract whatever a partner could have. Colleen states that she would only stop using condoms if she were married. She knows she and her partner would get re-tested for HIV if they were married, which comforts her. More importantly, marriage symbolizes a financial and emotional commitment in which two people decide to share their lives. Only at that point would Colleen want to share the intimacy of not using a condom with someone.

5. Control
Condoms give Colleen a sense of control over her body, her health, and her life. By having sex with condoms, Colleen feels as though she is keeping her body and her sexuality to herself. Colleen explained that she views her sexuality as "hers," because she controls if anything happens to it. She describes her sexuality as pure and untainted, because she has never contracted an STD, and it has not been harmed in any other way.
6. Educating her Partner
Colleen's boyfriend had a poor understanding of the risks and long-term consequences of STDs when they started dating. He belittled Colleen's concern about STDs, and did not respect her wishes to consistently use a condom. Colleen tried to educate him about STDs by sharing her knowledge. Her friend with herpes facilitated this process for Colleen, because she explained to Colleen's boyfriend how she felt having an incurable STD, something Colleen could not convey as powerfully. After a several month transition period, he is now consistent with condom use, always prepared to use a condom when they have sex, and does not complain. Colleen describes their contraceptive use as natural and easy, and a regular aspect of sex. She is proud of his increased responsibility and maturity.

7. Trust
The fact that Colleen's friend contracted herpes from an unfaithful partner reaffirmed her feelings that men cannot always be trusted to be honest about their sexual history. Colleen questioned whether her boyfriend could be trusted to be monogamous, to use a condom, or to support her if something bad happened. Colleen felt more secure once they moved in together, because she has "permanent tabs" on him. Until she completely has that trust in someone — which would be necessary for marriage — she intends to keep using condoms.

Situated Structural Description for Interview 11, Colleen

Using condoms is something absolutely necessary for Colleen within her relationships. She has insisted upon condom use with her current partner, even though in the beginning of their relationship he was very resistant to using them. He lacked knowledge about the risks and consequences of STDs, and therefore belittled Colleen's concern about condoms. Colleen describes a transitional period, when he slowly began to understand and accept her desire to use condoms. Now, a year into their relationship, he consistently initiates condom use without complaining, which Colleen feels demonstrates his increased responsibility and maturity.

Colleen uses condoms for two reasons. First, she uses condoms as an extra protection against pregnancy, in combination with the birth control pill. Colleen does not want to become pregnant, because right now in her life she is very goal-oriented and is focused on finishing college and beginning a career. She also believes that premarital pregnancy is socially unacceptable. Secondly, condom use is not optional for Colleen because she is highly motivated to protect herself against STDs. A very good friend of Colleen's contracted herpes from a long-term partner. Colleen supported this friend by going with her to the doctor's appointments for treatments, and by providing emotional support. The experience of watching the physical and emotional pain her friend endured as a result of contracting herpes from someone who cheated on her caused Colleen a great deal of fear. She brought this fear into her current relationship, and even though her boyfriend has been tested for HIV and other STDs, Colleen is not reassured. She knows
that the tests are not always 100% accurate, and that some STDs will not be detected if they are in a dormant stage in the body. Therefore, Colleen imagines herself using condoms for a very long time.

Trust does not come easily for Colleen. Watching her friend experience such physical and emotional hurt from an unfaithful partner reaffirmed Colleen's feelings that men cannot always be trusted to be monogamous, to use condoms, or to have their partner's health in mind. Colleen has struggled with being able to trust her partner, and only feels comfortable because she has "permanent tabs" on him from living together.

Condom use for Colleen symbolizes control over her body and her future. She actively protects herself from any negative medical or emotional consequences that could result from engaging in unprotected sex. Colleen feels that as long as she uses condoms her sexuality is her own, and it is pure and untainted by any partner potentially harming it. Colleen speculates that she would stop using condoms only when she gets married, which is a symbol for her of trusting another person enough to financially and emotionally share your life with them. Only at that point would she choose to share the intimacy of not using a condom. Therefore, for Colleen, sharing her body and her sexuality does not happen merely with the act of intercourse itself, but rather with the act of intercourse without a condom.
238

Redescribed Statements for Interview 12, Tanya

1. Negative Experience
One of Tanya’s closest childhood friends died of AIDS. This same friend also had an unplanned pregnancy in high school, and dropped out of school to have the child. Tanya was extremely saddened by her friend’s pregnancy. However, Tanya refers to the experience of watching her die as “unbelievable” and completely different than learning about STDs from books or sex education classes. This experience made Tanya believe that AIDS can happen to anyone.

2. Protecting Self / Not Optional
Practicing safe sex and using condoms is not optional for Tanya. She does not care about her partner’s feelings toward condom use, because her decision is inflexible. Tanya told him before they had sex that condoms are a necessity. In addition, because her boyfriend had previous partners she told him that she would not have sex until he was tested for STDs. His test results were negative, but she is not reassured because she knows the tests are not 100% accurate. She does not imagine a time when she would not want to use condoms.

3. Concern with Pregnancy / Future Plans
Tanya is very concerned with pregnancy. She is firmly committed to the career goals she has set for herself, which currently are focused on attending graduate school after she graduates from college. Tanya states that abortion is not an option for her if she did get pregnant. Having a child at this point in her life would compromise her plans for further education. Tanya wants children at the right time in her life, after she has finished graduate school, is married, and is financially secure.

4. Benefits of Dual Method Use
Using birth control pills and condoms enables Tanya to feel a sense of control over her health and her future. Dual method use makes her feel safer and alleviates, at least to an extent, worry about pregnancy or STDs. Because she is actively involved in protecting herself, and because she knows that her chances of experiencing these negative consequences are low, she is better able to enjoy sex and typically does not think about these consequences on a regular basis.

5. Control
One aspect of exercising control over her health for Tanya involves being level-headed and responsible during sexual encounters. Tanya believes that many people have difficulty using condoms because they get caught up in the heat of the moment during sexual encounters. Even though these people may have good intentions, they do not think about condom use when it counts, or are not able to distance themselves from the situation to insist upon condom use. Tanya has been in that situation several times with her partner, and had the discipline to stop and tell him she needed to use a condom. Tanya also believes that being level-headed involves never making any exceptions regarding condom use, even at the most tempting situations.

6. Characteristics of Partner
Even though Tanya is firmly committed to condom use, her boyfriend’s attitudes make contraceptive practice easier. Tanya describes her boyfriend as understanding about her concern and fears about pregnancy and STDs. He has been sensitive to her experience with her friend. He
was not insulted at her request that he get tested for HIV, and has accepted that she still wants condom use even though his results were negative. Tanya believes that her happiness and comfort are priorities for him.

**Situated Structural Description for Interview 12, Tanya**

The experience of safe sex, and particularly condom use, is one about which Tanya has extremely strong feelings. Her feelings originate from a tragic experience. Tanya’s very close childhood friend died of AIDS. This friend also had an unplanned pregnancy in high school, and dropped out to have her child. For Tanya, this life changing situation of watching a close friend die of a preventable disease has influenced her practice of safe sex, such that it is an inflexible aspect of being sexually active. Tanya would not engage in sex without condoms, even though she also uses the birth control pill. She let her partner know this before becoming sexually active with him, and also told him that she would not have sex unless he was tested for STDs. Although his results were negative, Tanya is not reassured because she knows that tests are not 100% accurate. She cannot imagine a time that she would not want to use condoms.

Pregnancy is a concern for Tanya. She describes herself as goal-oriented and does not want anything to disturb her future plans of attending graduate school. Abortion is not a personal option for Tanya, so if she became pregnant she would have the child. Tanya is not willing to risk her future plans and goals because of a mistake that is preventable.

Tanya describes her boyfriend as very sensitive and understanding about her concerns and fears regarding pregnancy and STDs. She has not had problems convincing him to use a condom, because she believes he would do anything to make her feel comfortable and happy. His attitudes and behaviors make the practice of safe sex considerably easier.

Using dual protection is a way for Tanya to feel in control of her health and her future. Control for Tanya also includes being level headed during sexual encounters, and having the discipline to stop in the heat of the moment to insist on condom use. Further, control involves being committed to not making any exceptions to condom use. By controlling the sexual relationship in this way, Tanya is protecting her health. Consequently, she is better able to enjoy sex, rather than constantly worrying about pregnancy or STDs.
APPENDIX C: Recruitment Flyer / Posted Advertisement
WOMEN IN RELATIONSHIPS PROJECT

Looking for unmarried women aged 18-23 to participate in a University of Arizona Division of Family Studies research project on women's safe sex experiences.

Criteria -- If you...

- Are involved in a committed, monogamous, heterosexual relationship at least 3 months in length
- Practice consistent condom use

YOU MAY BE ELIGIBLE FOR PARTICIPATION.
All participation is completely confidential and voluntary.
Participants will be compensated for their time.

If interested, please contact Meghan Raymond, M.S., for more information.

626-7656
(Please say you are calling regarding the Women in Relationships project.)
APPENDIX D: Sociodemographic Survey
WOMEN IN RELATIONSHIPS PROJECT

Information Form

AGE
Your age: ____________________
Age of partner: ____________________

ETHNICITY
Your ethnicity: (Check one)
___ White (Caucasian, non-Hispanic)
___ Hispanic (Mexican-American, Latino)
___ African-American
___ Native American
___ Asian American
___ other (please specify ________________ )

Ethnicity of partner: (Check one)
___ White (Caucasian, non-Hispanic)
___ Hispanic (Mexican-American, Latino)
___ African-American
___ Native American
___ Asian American
___ other (please specify ________________ )

RELIGION
Your religious affiliation: (Check one)
___ Protestant (specify denomination ____________ )
___ Catholic
___ Jewish
___ Non-denominational
___ I don't identify with any religion.

I consider myself (please circle one):

Not at all A little Pretty Very
Religious Religious Religious Religious
Partner's religious affiliation:  
(Check one)  
___ Protestant (specify denomination _________)  
___ Catholic  
___ Jewish  
___ Non-denominational  
___ He does not identify with any religion.

My partner would consider himself (please circle one):  
Not at all  A bit  Pretty  Very  
Religious  Religious  Religious  Religious

EDUCATION & EMPLOYMENT
Do YOU attend college / university?  
(Check one)  
___ Yes. 2-year college  
___ Yes. 4-year college/university  
___ No

IF YES....  
What year in college / university are you?  
______________________________

Major: __________________________  Approximate GPA: ______________

Highest level of education expected:  
___ Some college / university  
___ Finish 2-year college  
___ Finish 4-year college / university  
___ Some post-secondary education  
___ Finish post-secondary education (e.g., MA, M.D., Ph.D.)

Are YOU employed?  
___ Yes, full-time (32 hours/week or more)  
___ Yes, part-time (31 hours/week or less)  
___ No

Please provide a brief description of your job: ____________________________

________________________________________

Does YOUR PARTNER attend college / university?  
(Check one)  
___ Yes. 2-year college  
___ Yes. 4-year college/university  
___ No

IF YES....  
What year in college / university is he? ________________________________
Major: ___________________________  Approximate GPA: __________

Highest level of education expected:
  ( ) Some college / university
  ( ) Finish 2-year college
  ( ) Finish 4-year college / university
  ( ) Some post-secondary education
  ( ) Finish post-secondary education (e.g., MA, M.D., Ph.D.)

Is YOUR PARTNER employed?  
  ( ) Yes, full-time (32 hours/week or more)
  ( ) Yes, part-time (31 hours/week or less)
  ( ) No

Please provide a brief description of his job: __________________________________________

SEXUALITY & RELATIONSHIPS
Your age at first intercourse: ______

Partner's age at first intercourse (if known): ______

How long has your current relationship lasted? _____________ months
(Please report in months)

Have you ever participated in a sex education program?  
  ( ) Yes  ( ) No

If YES, please briefly describe where you received the program (e.g., high school health class) and the content / length of the program:

______________________________________________________________________________
______________________________________________________________________________

Please provide a phone number and address where you can be reached, should the principal investigator need to contact you again: ________________________________

THANK YOU FOR YOUR TIME!
APPENDIX E: Human Subjects Committee Approval Letter
9 June 1999

Meghan Raymond, Ph.D. Candidate
c/o Susan S. Koerner, Ph.D.
School of Family/Consumer Resources
Division of Family Studies
FCR Building, Room 210
PO BOX 210033

RE: A PHENOMENOLOGICAL EXPLORATION OF YOUNG WOMEN'S SAFE SEX EXPERIENCES IN COMMITTED RELATIONSHIPS

Dear Ms. Raymond:

We received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(2)] exempt this type of research from review by our Committee.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely,

[Signature]

UA Institutional Review Board Member
(Human Subjects Committee)

IRB/js
cc: Departmental/College Review Committee
APPENDIX F: Participant Consent Form
SUBJECT'S CONSENT FORM

Title of Project: Women in Relationships Project

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT. IF I CONSENT TO DO SO, SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE
I am being invited to participate voluntarily in the research project, Women in Relationships Project. The purpose of this project is to understand the safe sex experiences of young women in committed, monogamous, heterosexual relationships.

SELECTION CRITERIA
I am being invited to participate because I am an 18-23 year old woman currently involved in a committed relationship. Approximately 12 subjects will be enrolled in this study.

PROCEDURES
If I agree to participate, I understand that I will be asked to consent to the following: participation in an in-depth, one-on-one interview with the principal investigator, Meghan Raymond, MS; my interview will last approximately 1-2 hours. In my interview, I will be asked questions regarding my experiences of safe sex within my current relationship, and related questions regarding my feelings or attitudes about safe sex. I will also be asked to complete a short, sociodemographic information form. I understand that I may be contacted again and asked (a) to participate in a second interview, (b) to clarify any unclear points in my previous interview, or (c) for validation of study findings. The interviews will be audiotaped and later transcribed by the PI. I understand that my participation is completely voluntary, and that I am free to withdraw from the project at any time without causing bad feelings. Further, I understand that I have the following rights: (a) that I may turn off the tape recorder at any time during the interview(s); (b) that I may choose to not answer any interview or sociodemographic question; and (c) that I may request that a particular portion of the data be excluded from the study.

RISKS
I understand that my participation in the interview(s) may involve some minor risks. Because of the sensitive nature of the topic, I may feel anxious or distressed if certain themes arise during the interview(s). Although strong feelings of distress are unlikely,
there will be a referral list of campus and community health and mental health services available to me should these feelings occur. There is also the risk that information I give could be disclosed to outsiders; however, the Principal Investigator has taken appropriate steps to prevent this from happening -- see "Confidentiality" section below.

**BENEFITS**

No direct benefits can be guaranteed.

**CONFIDENTIALITY**

I understand that steps will be taken to ensure confidentiality: (a) I will be assigned a code number, to be used on audiotapes and interview transcripts; (b) names will not appear on any audiotapes or transcripts; (c) the master form linking names with code numbers will be secured in locked files with access restricted to the principal investigator, Meghan Raymond, MS, and her faculty advisor, Dr. Susan S. Koemer.

Further, I understand that every effort will be made to protect my identity, including: (a) the use of pseudonyms in the transcripts of the interviews for all persons mentioned during the interviews; (b) the use of pseudonyms in any research publications or presentations for any persons, schools, or cities mentioned during the interviews; and (c) the disguising of any other identifying information in publications and presentations based on this data.

Data generated from the interview(s) and any future contact may -- but not necessarily will -- be used in a variety of ways. The potential uses of data include: dissertation project, published research articles, conference presentations, and for applied program development purposes. Again, every attempt will be made to protect my identity within each of these forms of publication.

**PARTICIPATION COSTS AND SUBJECT COMPENSATION**

I understand that there is no cost to me other than time, and that I will receive $20 as compensation for my participation in the interview(s).

**LIABILITY**

Side effects or harm are possible in any research program despite the use of high standards of care and could occur through no fault of mine or the investigator involved. Known side effects have been described in this consent form (see "Risks"). However, unforeseeable harm also may occur and require care. To obtain further information from the principal investigator, Meghan Raymond, MS, I may call (520) 621-7127. If I have questions concerning my rights as a research subject, I may contact the Human Subjects committee office at the University of Arizona at (520) 626-6721.

**AUTHORIZATION**

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME
AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE.

I UNDERSTAND THAT THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, Meghan Raymond, MS OR AUTHORIZED REPRESENTATIVE OF THE Division of Family Studies. I UNDERSTAND THAT I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED FORM WILL BE GIVEN TO ME.

<table>
<thead>
<tr>
<th>Subject's Signature</th>
<th>Please PRINT Name</th>
<th>Date</th>
</tr>
</thead>
</table>

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in her participation and her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

<table>
<thead>
<tr>
<th>Signature of Investigator</th>
<th>Date</th>
</tr>
</thead>
</table>
APPENDIX G: General Interview Guide
Interview Guide

Question to participants the night before interview
• Think back over the course of your current relationship and talk about both how and why safe sex became an issue for you.

Opening Question
• Why don’t you describe for me how you and your current partner met.

Primary Question
• “Think back over course of current relationship. Why don’t you start at the beginning by talking about the first time that safe sex became an issue for you.”

Other Questions
• “Overall, when did safe sex first become an issue for you?”

• “Describe how and why you decided to use condoms as a safe sex practice.”

• “What would you say have been the primary challenges that you’ve experienced in practicing safe sex in this relationship? What would your partner say have been the primary challenges?”

• “In general, what are your feelings and attitudes about safe sex?”

• “What makes you able to consistently practice condom use?”
REFERENCES


Bondas-Solonen, T. (1998). How women experience the presence of their partners at the births of their babies. *Qualitative Health Research, 8*, 784-800.


cultures: Communities, values, and intimacy (pp. 239-260). New York: St. Martin's Press.


Popay, J., Rogers, A., & Williams, G. (1998). Rationale and standards for the systematic review of qualitative literature in health services research. Qualitative Health Research, 8, 341-351.


