AN EXAMINATION OF SELF REPORTS OF YOUNG ADULTS’ TALK ABOUT
SAFER SEX IN DATING RELATIONSHIPS: HEALTH, RELATIONSHIP AND
EMOTIONAL OUTCOMES

DISSERTATION

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By

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ABSTRACT

The purpose of this study was to examine the process of the first safer-sex talk between young adults in dating relationships. The study employed face management theory, sexual compliance-gaining, script theory, appraisal theory, and existing empirical findings from public health to collect baseline data about safer-sex talk. A total of 405 young adults from a large Midwestern university completed an online survey to assess how young adults talk about safer sex (strategies), when they initiate the talk in the dating relationship (before and after the initial sexual intercourse event), how long into the relationship the sex talk occurred, topics of the safe sex conversation, and outcomes for the young adults’ health, relationship, and emotions. Open-ended responses from the participants yielded data regarding strategies for initiation strategies that were collaborative in nature and not persuasive (more dialogic compared to compliance-gaining strategies). The open-ended responses were coded inductively and deductively using existing typologies from the sexual compliance gaining literature. Additional categories were added as necessary. Scaled responses (face management, self-efficacy, and reasons for not talking about safer sex) were analyzed using MANOVA. There were five major findings in the study. First, young adults with higher levels of self-efficacy in
talking about safer-sex were more likely to talk about safer-sex than those with lower levels. Second, talking about safe-sex exhibited positive relational and emotional outcomes for the participants in the study. Third, although hypothesized, face management did not have a significant effect on whether young adults talk about sex because most respondents did not find sex talk very face-threatening. Fourth, there were no gender differences in initiating talks about safer-sex and reasons for not talking about safer-sex which alludes to changing cultural scripts. Finally, the number of previous partners, history of sexually transmitted infections (STI), testing for STIs, and birth control were common topics that emerged during the first safer sex talk. Drug use and homosexual experiences were not mentioned as topics during the safe-sex talk. The findings of this dissertation suggest that young adults should be encouraged to talk about safer-sex given the positive emotional, relational, and health benefits. This dissertation advances the literature on safer-sex talk by (a) including additional strategies for talking about safer-sex, (b) highlighting the role of self-efficacy of talking about safer-sex, and (c) acknowledging the ever-changing nature of cultural scripts for sexual behavior.
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CHAPTER 1

INTRODUCTION

Sexually transmitted infections (STIs) are a growing concern among young adults (Center for Disease Control and Prevention, 2005). Public health officials and researchers have been actively working to reduce the prevalence of STIs and HIV by encouraging awareness, by encouraging young adults to talk with each other, and encouraging condom use. Three recent meta-analyses about safer sex practices suggest that safer-sex talk is related to safe health behaviors such as condom use (Allen, Emmers-Sommer & Crowell, 2002; Noar, Carlyle & Cole, 2006; Sheeran, Abraham, & Orbell, 1999). In spite of these findings, very little is known about how talk facilitates this behavior and the outcomes of this talk. The goal of this study is, therefore, to examine the safer-sex talk between young adults in dating relationships, when safer-sex talk occurs in relationships, and why some young adults do not talk about safer sex with their partners. The study also examines the role of face concerns during safer-sex talk, the role of efficacy, and the relational, emotional and behavioral outcomes of engaging in safer-sex talk.

The literature on safer-sex behavior is synonymous with condom use, which is a combination of atheoretical variable analytic research and models that seek to predict condom use. The literature on safer-sex talk is disjointed at best. In communication research, the literature on safer-sex talk commenced with the use of sexual compliance
gaining literature, which is replete with typologies of strategies individuals use to induce compliance. Although typologies are useful; without a theoretical framework they are seen as disparate (Edgar & Fitzpatrick, 1990). Script theory (Simon & Gagnon, 1987) has provided the theoretical framework to help ground research on sexual compliance gaining. Further, scholars in interpersonal and health communication have put out a call to study safer-sex talk in the context of relationships because of the relational and identity implications of such talk (Afifi, 1999). Empirical findings also suggest that face concerns and impression management are key features of safer-sex talk as research indicates that these are the reasons young adults do not talk about safer-sex (Cline & McKenzie, 1994).

To the best of my knowledge no study has employed relevant theories that have looked at the communicative phenomenon of safer-sex talk. Hence, this endeavor is not so much a testing of the predictive properties of specific theories but an attempt to accumulate baseline knowledge regarding safer-sex talk.

Given the above mentioned theoretical lacunae, I employ script theory, compliance gaining literature, extant findings from Public Health, face management theory and appraisal theory to examine the process, and the relational, emotional and behavioral outcomes for safer-sex talk.

In this chapter I provide an overview of the proposed study by first discussing the prevalence of sexually transmitted infections in young adults and the health threat they pose to young adults. I then enumerate the STI knowledge levels of young adults. The Center of Disease Control and Prevention’s (CDC) response to this health threat is presented next. I conclude the chapter by arguing the need for a clear conceptualization of safer-sex talk, and provide a preview of the subsequent chapters including the review
of relevant literature, the methods used, the results of the study, and finally, discussions related to the findings, limitations and suggestions for future research.

Prevalence of Sexually Transmitted Infections

Sexually transmitted infections (STIs) are infections passed from person to person during sexual activity, including vaginal intercourse, anal intercourse and oral sex. Young adults are vulnerable to a host of STIs such as Genital HPV infection, Chlamydia, Gonorrhea, Syphilis, Trichomoniasis, and HIV (CDC, 2005). In 2003, 877,478 cases of Chlamydia were reported in the United States, making it the nation’s most commonly reported STD. Gonorrhea is the second most commonly reported infectious disease in the U.S., with 335,104 cases reported in 2003 and an estimated 718,000 new infections occurring each year. In 2002 the incidence of infectious syphilis was highest in women 20 to 24 years of age and in men 35 to 39 years of age. Genital HPV infection, caused by human papillomavirus (HPV), currently affects 20 million people. At least 50 percent of sexually active men and women acquire genital HPV infection at some point in their lives and by age 50, at least 80 percent of women will have acquired genital HPV infection.

Even though most STIs are treatable (except for HPV that does not have a cure as yet), most of these are asymptomatic (i.e. without obvious symptoms) and are therefore not reported and treated. Most of these STIs are harmful for men and women because if left untreated, STIs can cause infertility in men and women, and pelvic inflammatory disease, tubal or ectopic pregnancy, and chronic pelvic pain, cervical cancer, in women and perinatal or congenital infections in infants born to infected mothers (Deal, Cates, Peeling & Wald, 2004). People who have STIs are prone to getting HIV if they come into contact with a person who has HIV. Therefore STIs are considered to be global and
national health priorities because of their effect on women and infants and the interrelationships with HIV and AIDS (CDC, 2005).

Young adults, particularly college students are now identified as at-risk populations because they participate in sexual activities without condoms, have multiple partners, experiment with drugs and consume large amounts of alcohol preceding sex (Cline, Freeman, & Johnson, 1990; Fisher & Misovich, 1990). It is important to note that “having multiple partners” in the literature denotes the practice of serial monogamy; while young adults may not have sexual relationships with more than one partner at a time, they are likely to be in successive monogamous relationships (Reinisch, Hill, Sanders & Ziemba-Davis, 1995). When young adults do not practice monogamy and have secondary partners, not all of them use condoms with these secondary partners, a proportion which decreases with increasing number of partners (Binson, Dolcini, Pollack, & Catania, 1993). These habits make young adults particularly susceptible to contracting sexually transmitted infections (STIs), including HIV. HIV/AIDS continues to have a significant impact on teenagers and young adults in the United States. People under 25 are estimated to make up half of all new HIV infections occurring in the U.S. and HIV remains a leading cause of death among young people. Many teens and young adults who are infected are unaware about their infections (Kaiser Family Foundation, 2000).

Young Adults’ STI Knowledge Levels

It is acknowledged that college students tend to have more HIV-related knowledge than STI-related knowledge (DiLorio, Dudley, Lehr, & Soet, 2000; Vail-Smith, 1992). Researchers are also not sure about young adults’ levels of awareness about the different STIs. This could be because most of the studies in the literature
investigate whether young adults have or have not discussed AIDS or STIs in general (Baer, Allen & Braun, 2000). Testing and treatment of STIs can be an effective tool in preventing the further spread of STIs and HIV, but in order to promote prevention of STIs, researchers believe HIV prevention programs need to focus on specific skills (e.g. negotiating condom use) for reducing sexual risk behaviors (e.g. Robin et al., 2004). However, intervention programs designed to promote condom use by providing knowledge about STIs and role play exercises with young adults have suggested an increase in young adults’ STI-related knowledge without any subsequent increase in reported condom use (Jaworski and Carey, 2001; Tulloch, McCaul, Miltenberger & Symth 2004). Such findings are consonant with survey research, which suggests that even though college students have high levels of knowledge about HIV/AIDS, they do not personalize the risk and they do not practice safe sex (e.g., Opt & Loffredo, 2004; Anastasi, Sawyer & Pinciaro, 1999).

**CDC Recommendations for Safer Sex Behaviors**

In response to the growing HIV rates and STIs prevalence in sexually active young adults, the US General Surgeon adopted the A-B-C model to manage HIV and AIDS in the United States. The ABC model promotes: A (abstinence), encouraging young adults to delay sexual activity; B, reminding those in relationships to be faithful and monogamous; and C (condoms), encouraging those who engage in high-risk behavior to use condoms consistently and correctly each time they have sex (US General Surgeon Report, November 13, 2003). Each component of the ABC model is next discussed.

Although abstinence is considered to be the most effective HIV sexual risk reduction strategy by public health officials, research suggests that abstinence is not
practiced by most young adults. In fact, Robin et al. (2004) reviewed programs implemented in the 1990s in the US related to reducing HIV and STD incidence and pregnancy among young adults and adolescence (ages 13-19) and found that programs designed to encourage “delaying sexual initiation” had null or negative results. In addition, they also found that effects and programs with “condom use” as their outcome behavior had the most consistent impact.

The second recommendation, mutual monogamy between two HIV-negative partners, is not a typical practice for adults (see Seal & Ehrhardt, 2004 for a discussion). Across survey research, up to 80% of men report multiple sexual partners over time (Seal & Ehrhardt, 2004 p. 214). Similar statistics are prevalent in college students who are reported to first experience vaginal intercourse at age 17, with males reporting an average of eight female partners and females reporting an average of six male partners (Reinisch et al., 1995). Some researchers acknowledge that interventions that encourage long-term monogamy among young adults fail to capture the realities of sexual lives (Binson et al., p. 272, 1993).

The third alternative, consistent condom use, is considered to be the best form of HIV and STI protection for sexually active people (e.g. Exner, Gardos, Seal, & Ehrhardt, 1999). Once again, national surveys have found that this behavior is not practiced by most adults. For example, Leigh, Temple and Trocki (1993) surveyed a nationally representative sample of adults in the United States (N = 2058) and found low rates of consistent condom use. The authors found that the inconsistent condom use could be distinguished by number of sexual partners such that among respondents who reported more than one sexual partner in the previous year (n = 271), only 23 (8%) used condoms
every time they had sex. In a supplementary analysis they also found that 181 adults had sex with non primary partners and 41 (23%) of these individuals reported using a condom every time with their non primary partners. Laumann, Gagnon, Michael, and Michaels, (1994) also found that participants reported higher rates of condom use for new partners than for steady partners. Condom use among college age students is similar to that of older adults. In a random sample of college students, Reinisch et al. (1995) found that 75 % (N = 579) of college students were sexually active and one-third of these sexually active respondents reported not using any form of protection against STIs or pregnancy. Furthermore, only three in ten respondents reported using condoms and because of the lack of any barrier method, one in five males and one in three females had an STI such as Chlamydia, hepatitis B, herpes, and Pelvic inflammatory disease.

In 1986, The US Surgeon General had issued the “know your partner” advice that encouraged people to talk about AIDS and learn about the sexual histories of their potential sexual partners. This included sharing with one’s partner information about number of partners, history of drug usage and history of STIs. Communication scholars conducted research in the early 1990s to discern whether young adults had taken heed to the aforementioned advice by examining whether young adults were talking about AIDS and their sexual histories with their partners (e.g. Cline, Freeman & Johnson, 1990). The logical reasoning behind the “know your partner” advice was that individuals would make careful decisions about having sexual relations with partners and make appropriate prevention choices. Three recent meta-analyses offer a glimpse of the research conducted in the 90s and early 2000s that examine the relationship between communication and safer-sex practices, which are summarized next.
Summary of Meta-Analyses

Three recent meta-analyses suggest the importance of communication in safe sex practices, specifically the communication between partners about sex and health outcomes. Sheeran, Abraham and Orbell’s (1999) meta-analysis of psychosocial correlates of condom use found communication about condom use to be the strongest correlate of condom use. This particular variable was a stronger correlate with condom use than variables such as attitudes towards condom use, barriers to condom use, and subjective normative beliefs about condom use. Allen, Emmers-Sommer and Crowell’s (2002) meta-analysis of the impact of conversation and gender on safe sex behaviors indicated that (a) the persons who talked about condoms prior to sex were more likely than non-talkers to use condoms, and that (b) the women were more likely than the men to engage in safer sexual communication. However, the authors note that both effects were heterogeneous indicating the existence of a moderator variable (Allen et al., 2002, p. 272). Noar, Carlyle and Cole’s (2006) meta-analysis suggests an association between sexual communication and condom use. Specifically, communication about condom use had the strongest relation to condom use ($r = .25$) and communication about sexual history was nearly as large ($r = .23$). Also these two variables were more strongly related to condom use than communication about safer sex ($r = .18$).

The three meta-analyses suggest that communication is indeed pivotal to HIV and STI prevention, especially talk between partners within a relationship. However safer-sex talk has not been conceptualized in the literature (e.g. Troth & Peterson, 2000). It has been operationalized in different ways and used sometimes synonymously with safer sex
communication (e.g. Troth & Peterson, 2000). Scholars employing terms such as “safer sex communication” and “sexual communication” have also not offered clear conceptual definitions (except for Metts & Spitzberg, 1996), although these terms have been operationalized to mean discussions about HIV and AIDS, discussions about sexual histories, discussions about condom use, or some combination of these discussions (e.g. Clawson & Reese-Weber, 2003; Dilorio, Dudley, Lehr & Soet, 2000; Edgar, Freimuth, Hammond, McDonald, & Fink, 1992; Lear, 1995).

Sexual communication, defined by Metts and Spitzberg (1996, p. 49) is, “the means by which individuals come to select potential partners for sexual relations, and through which the meanings, functions, and effects of sexual relations are negotiated.” On the basis of this definition, Quina, Harlow, Morokoff, and Burkholder (2000) operationalized sexual communication as expressing sexual desires and gathering HIV risk information. While expressing sexual desires consisted of conveying needs for specific sexual acts, gathering HIV risk information entailed asking partner questions about sexual history such as number of partners and use of injected drugs (Quina et al., 2000, p. 525). Quina et al. found that gathering HIV risk information was associated with safer sex behavior (i.e. condom use) and there was no association between expressing sexual desire and condom use. Others have also found that asking partners about past sexual histories was reported significantly with condom use (Mays & Cochran, 1993). Quina et al. suggest that the two aspects of sexual communication, that is, sexual desire and sexual gathering HIV risk information, tap into different dimensions of communication.
The perceived outcomes of safer-sex talk are at best equivocal in existing literature. For example, on one hand, safer sex talk, operationalized across several studies as verbally proposing condom use, is perceived by some young adults to be fun and empowering because it allows people to communicate openly and be creative about sex (Lear, 1995), is considered to be responsible behavior (Hocking, Turk & Hollinger, 1999; Lear, 1995), and is looked upon favorably rather than unfavourably by individuals of either sex (Davidson-Harden, Fisher, & Davidson, 2000). On the other hand, when safer sex talk is operationalized as ‘talk about HIV/AIDS and sexual histories,’ it does not occur between young adults because of several reasons: fear of being labeled “promiscuous” (Cline et al., 1990), no risk perceived from partner (Seal & Palmer-Seal, 1996), implications of a lack of trust (Lear, 1995), and privacy concerns (Nichols, 2005). The lack of a clear conceptualization of “safer-sex talk” and varying operationalizations of safer sex talk may have influenced the results of the above mentioned studies. Hence, a conceptual definition is warranted.

In this study safer-sex talk is defined as talk that occurs when partners talk about number of previous partners, history of sexually transmitted infections, types of sexual acts, history of drug usage, sharing of STI and HIV testing information, and condom use. This definition is in alignment with the US General Surgeon’s (1986) definition of “knowing your partner” advice or the questions that prospective sexual partners should ask each other prior to becoming sexually active.

Despite the nebulous picture of how young adults perceive safer sex talk, research suggests that young adults do disclose topics related to sex including STIs to their dating
partners, which they consider as highly personal (Mathews, Derlega, & Morrow, 2006). Given the health benefits of such talk (mainly condom use) and the existence of reticence by some young adults to have these talks with their dating partners, it is necessary to examine the process of safer-sex talk. By process I mean who initiates safer-sex talk, what topics constitute safer-sex talk (beyond what is recommended by the US General Surgeon) and what are the relational, emotional and behavioral outcomes of safer-sex talk. By learning why some young adults talk about safer-sex and why many young adults do not talk about safer-sex, I hope to offer practical applications for the encouragement of safer-sex talk as a means of STI and HIV prevention.

To present the full rationale for the research questions, chapter two presents the review of literature related to safer-sex talk framed by face management theory, script theory, compliance gaining literature, the role of self-efficacy, appraisal theory and health literature. The reasons why young adults do not talk about safer-sex are also enumerated. The chapter also provides an assessment of the literature and how this study proposes to address some of the gaps in the literature. The chapter concludes with the specific rationale for the specific hypotheses and research questions.

In chapter three, I first enumerate the method of my proposed research, which includes recruitment of participants, and the design of the study, including the management of issues related to reliability. After summarizing the procedures of the study, I provide the measures and tasks with evidence of reliability and validity. Finally, I describe the coding system for the open-ended questions and outline the statistical
procedures. In chapter four, I describe the results of the study. Finally, in chapter five I discuss the implications of the findings, mention the limitations of the study and offer suggestions for future research.
CHAPTER 2

LITERATURE REVIEW

Theoretical Frameworks

This study uses Script theory (Simon & Gagnon, 1987), Compliance gaining literature (Wheeless, Barraclough, & Stewart, 1983), Face management theory (Brown & Levinson, 1987; Cupach & Metts, 1994), the concept of self-efficacy drawn from Social Cognitive theory (Bandura, 1977), and draws upon present health literature to examine (a) process of the first talk about safer-sex between young adults in dating relationships, (b) the role of face threat and self-efficacy (c) the emotional, relational and behavioral outcomes, and (d) the reasons why some young adults do not talk with their partners about safer-sex in dating relationships.

Specifically, both script theory and compliance gaining literature provide the framework for understanding the process of first talk. Process in this endeavor includes “how” young adults talk about safer-sex, or the types of strategies used. Process also includes “when” talk is initiated in terms of time into a relationship plus sexual activity (i.e. before or after first sexual interaction). The topics of talk constitute the “what” of this process. Finally, both the theories are helpful in understanding if there are sex differences during this process of talk.
Face management theory is invoked to examine the face concerns that pervade talk about safer-sex especially as face concerns have identity and relational consequences. The concept of self-efficacy is used to investigate how an individual’s confidence in the ability to talk about safer-sex relates to actual occurrence of talk. Appraisal theory provides the backbone for analyzing the emotional outcomes of safer-sex talk. Finally the study draws upon the health literature to examine why some young adults do not talk about safer-sex with their partners.

It must be noted that there is a large body of work that examines safer-sex behavior; however this literature predominantly focuses on condom use and does not privilege talk practices. The review of each of the theories is offered next. While the review is not exhaustive, it presents conceptual definitions and relevant findings across studies pertaining to the theories utilized in this dissertation. Each section pertaining to a particular theory ends in relevant research questions and hypotheses. The review begins with the literature guided by the CDC recommendations and public health.

Public Health Literature Relevant to Safer-Sex Talk

Existing literature in Public Health related to safer-sex talk is atheoretical. Nonetheless, it provides guidelines for safer-sex behavior including talk about safer sex between sexual partners. CDC guidelines provide a foundation for examining the timing as well as the topics of safer-sex talk.

Timing of Safer-Sex Talk

On the basis of Center of Disease Control (CDC) guidelines safer-sex talks should ideally occur between partners prior to first sexual interaction. In addition to being a
way of evaluating potential risks of STDs and HIV, research indicates that once in relationships, bringing up safer-sex may be perceived as inappropriate due to connotations of having an affair or being promiscuous (e.g. Cline & McKenzie, 1994). The timing of safer sex talk is not well addressed in the literature (Noar, Carlyle, and Cole 2006). While Edgar and Fitzpatrick (1993) found that safer-sex talk occurred when sex is imminent, recently Faulkner (2006) found that safer-sex talk occurred at various times in the course of relationships, from six months to a year after a couple has been a relationship. Therefore, it is possible that partners are talking about safer sex after their first sexual interaction. It is possible that partners could be talking about safer-sex several times and this could be before their first sexual interaction, after first sexual interaction or a combination of times.

Timing is an important component of safer-sex talk because Noar et al. (2006) suggest that when partners talk about safer sex one person might ask the other to use a condom, and by extension any of the other health protective acts proscribed by the US General Surgeon. Furthermore, timing of safer-sex talk is crucial because many young adults practice contraceptive switch at the end of their first month of dating. This phenomenon includes making a “switch” from condoms to birth control pills and this action is a symbol of the change in the status of a relationship from causal to dating or an exclusive one (Civic, 2000; Ku, Sonenstein, & Pleck, 1994).

There are two aspects to timing. The first being how long into a relationship the talk occurs. The second being when does safer-sex talk occur in relation to sexual activity. As mentioned, young adults are talking about safer-sex at different times in their
relationship (Faulkner, 2006). However, we don’t know much about the occurrence of safer sex talk with respect to sexual activity. In the literature it is assumed that talking about safer-sex before first time sex is an important HIV/STI prevention tactic. However, it is possible that young adults talk about safer-sex after first time sexual interaction or even after having sex multiple times. Hence, the first two research questions address the issue of timing:

\[ \text{RQ}_1a: \text{How long into the relationship do young adults report engaging in their first safer-sex talk?} \]

\[ \text{RQ}_1b: \text{When do young adults report initiating their first safer-sex talk with their partners with regards to sexual activity in dating relationships?} \]

While the extant public health literature guides the questions pertaining to the timing of safer-sex talk, the literature on scripts enables us to view both the larger picture of young adult’s sexual behavior particularly questions related to initiation of safer-sex talk, as well as to address gender differences in the process of initiation.

\textit{Script Theory}

The script approach claims that sexual scripts influence sexual behavior and these scripts are consequences of socialization. Simon and Gagnon (1987) are one of the first to employ scripts as explanatory mechanisms of human sexual behavior. Behavior outcomes are a function of sexual scripts operating at three levels: cultural, interpersonal, and intrapsychic. Cultural scripts are the abstractions about sexuality that individuals learn through collective life, providing a framework for understanding how people enter, exit, and enact sexual roles. Interpersonal scripts allow for the translation of abstraction into
performance. Individuals tailor the generic script to a specific context as new elements are added to each scenario. Intrapsychic scripts mediate one’s multiple goals and desires related to sexuality, and they help define the sexual “I” in a manner consistent with cultural expectations and interpersonal behavior. These scripts enable a person to link individual sexual desires, arousal, eroticism, and fantasy to social meaning.

It is important to note that scripts are not static entities that guide sexual behavior. Individuals are socialized in particular historical and social milieus and when situations call forth people to enact out certain scripts, people sometimes modify scripts to meet the demands of a particular situation (Gagnon, 1990, p. 11). Thus the context of a situation including the people and the relationship between them can all lead to modifications of a prevalent script. The research on scripts suggests the prevalence of a gendered script. Gagnon (1990) observed that both the Kinsey research and other studies done in the 1950s found that men and women had different scripts for their sexual encounters. Even though Kinsey had initially attributed these differences to some differences in the brains of men and women, in the 1970s the differences were reinterpreted as the differential social approval granted to male and female sexuality and freedom of sexual expression rooted in the cultural and social milieu (Gagnon, p. 15).

In the context of relationships, script theory has been employed to understand sexual encounters between men and women in the context of one-night stands as well as dating relationships. Script research has shed light on some of the sexual practices of young adults, such as the presence of a prototypical sequence of acts that leads to sexual activity (Edgar & Fitzpatrick, 1993), initiation of sexual activity (Edgar & Fitzpatrick,
1993; Perper & Weis, 1987), the lack of discussions about safer-sex (Edgar & Fitzpatrick, 1993; Hynie, Lydon, Cote, & Wiener, 1998; Ortiz-Torres, Williams, & Ehrhardt, 2003; Perper & Weis, 1987), and the presence of both a traditional gender script and a non-traditional gender script (Dworkin & O’Sullivan, 2005; Ortiz-Torres et al., 2003; Seal and Ehrhardt, 2003).

Edgar and Fitzpatrick (1993), through a series of studies, examined young adults’ sexual script for the presence of a prototypical sequence of events that leads to sexual intercourse, and the presence of condom use discussion within a one night stand scenario. They asked respondents to write out a typical sequence that would occur when two young adults (male and female) met for the first time and the attraction between them led to the two being alone in one of the individual’s bedroom. They found that college students produced typical sequence of events that end in sexual intercourse between unacquainted individuals within a one night scenario. Respondents reported that when couples meet in a public setting such as a party, they first engage each other in exchanges that are verbal and nonverbal in nature. They then dance and/or compliment each other, perhaps touching one another in a social way. This social touching then leads to intimate touching and kissing. Then they initiate leave-taking behavior that enables them to move from a public to a more private setting (such as a bedroom). Once they are alone, they enact behaviors (foreplay) that culminates in sexual intercourse. This prototypical sequence was marked by the absence of a “protection act,” as respondents did not identify or indicate talking about or using contraception such a condom. Contrary to the researcher’s
hypothesis, sexually experienced respondents did not discuss condom usage early in the script.

Metts and Spitzberg (1996) review of the script literature also suggests gender differences in sexual practices. They note the predominance of a traditional sexual script in their review of the sexual script literature, in which males play the role of the initiator and the females play the role of the regulator or the gatekeepers of sexual intercourse, which includes women’s perception that it is their responsibility to ensure condoms are used (Baus, Ksobiech, & Cunningham, 2001). Even when college-going women reported initiating sexual interaction, their scripts had no mention of contraception or safer-sex talk (Perper & Weis, 1987).

Wasserheit (1991) believes that such differences in sexual practices of men and women reflected in sexual scripts are due to cultural values about gender roles that may influence how men and women interact in sexual situations and also how sexual behavior is negotiated. In addition, Metts and Fitzpatrick (1992) argue that while sexual scripts provide a basis for anticipating and interpreting role-defined sexual behavior, sexual scripts do not provide adequate guidance for appropriate behavior in “novel”, and “emergent” situations - the kind of scenarios in which people find themselves when they want to have sex with an unfamiliar sexual partner (p. 5). Metts and Fitzpatrick argue that if the prevailing sexual script does not prepare individuals for the contingency of discussing condoms or how “safe” is a partner, then individuals may find themselves limited to two options: having unprotected sex or abstaining from sexual intercourse with that partner. Additionally, Metts and Spitzberg (1996) have observed that “explicit
communication” about sex does not usually occur in early dating relationships. Instead, young adults rely upon nonverbal behavior for interpreting sexual intent. Direct communication is more likely when individuals refuse to participate in sexual intercourse with another than when young adults are willing participants. Because there is ambiguity in the traditional sexual communication courtship script, Metts and Spitzberg believed that the possibilities for exploitation, deception, and coercion are substantial including health consequences such as STIs and AIDS (p. 73).

Scholars have also employed script theory to uncover the social norms concerning sexual interaction including condom use specifically within the context of relationships. For example, Hynie et al. (1998) examined men and women’s interpersonal scripts in terms of the social norms of both genders, specifically the extent to which the scripts represented a “relational” orientation. Relational orientation was conceptualized as the extent to which respondents associated sexuality with love and commitment in a relationship. Specifically, Hynie et al. conducted three studies to examine (a). women and men’s expression of social norms of sexual interaction, (b). women’s internalization of relational sexual norms, and (c). the relationship between endorsement of social norms and the expression of behaviors symbolic of these norms.

In study one, participants were given a detailed scenario about a heterosexual couple Anne-Marie and Eric, who return together to one of their apartments after a party and sexual intercourse was imminent. The participants had to imagine that the couple had sex at night and to continue the story up to the point where the couple had intercourse, describing the interaction in as much detail as possible. Scripts were coded for condom
mentioned and used, condom mentioned but not used and no condom mentioned. The findings from all three studies confirmed Hynie et al.’s hypotheses that young adults perceive condom use as a practice that is prevalent in casual rather than romantic (serious) relationships; that women are perceived to be more relationally oriented than women; and that scripts that reflect a stronger endorsement of relational sex would also be less likely to include condom use (p. 372).

Specifically, from the results of study one, Hynie et al. concluded that because a large number of scripts mentioned condoms but not their use perhaps condoms are not well integrated into relational scripts. Study two’s results suggested that women varied in the extent to which they had internalized the importance of relational standards. Study three suggested that an endorsement of the relational ideal by women was associated with less positive attitudes towards condoms. Women who did not use a condom during their last intercourse had higher scores on their relational ideal scale those who did use a condom. Women who more strongly endorsed the relational ideal were less likely to have used condoms during their more recent act of intercourse and, ad less positive attitudes towards condoms.

More recently, scholars have acknowledged that changing gender roles could impact sexual scripts. Recent studies support the co-existence of a traditional as well as a non-traditional script among men and women (Dworkin and O’Sullivan, 2005; Ortiz-Torres et al., 2003; Seal and Ehrhardt, 2003). For example, Dworkin and O’Sullivan (2005) extended the notion of scripts by interviewing men to examine how men reflexively make sense of current sexual practices and experience a “disconnect” between
enacted practices and actual desires. Participants were asked to reconstruct interactions that occurred in sexual encounters during the preceding three weeks including the initiation of sexual activity and condom use. Results suggested that even though most men practiced male-dominated patterns of initiation, they sought more egalitarian sexual initiation that included preferences to be an object or desire to female partners or to share the labor of sexual initiation. The authors suggest that because “men are increasingly seeking to be desired through sexual initiation, it may be strategic for women to negotiate safer sex protection as part of their own sexual initiation practices, as opposed to when their male partner initiates sex” (p. 156).

Seal and Ehrhardt (2003) interviewed men about their perceptions of the scripts guiding their courtship, romantic, and sexual experiences with women. Like Dworkin and O’Sullivan (2005), the participants included men from urban neighborhoods and of different ethnicities and young adults accounted for one-third of the sample. The results of this study indicate that many of the narratives did not adhere to the traditional script of men as the initiator of courtship, romance and sex. Even though these men were receptive to women as initiators of sex, sexually aggressive women were considered as “unsuitable” long-term partners (p. 309). The narratives painted a picture of a “combination of traditional and non-traditional gender role and gender script adherence” (p. 313). The narratives also are evidence of the prevalence of double-standards (e.g., it is more acceptable for men than women to have casual partners and multiple or serial concurrent sexual partners). Finally, the narratives reflect “negative” or “ambivalent”
attitudes toward women as initiators of sex outside the context of a committed and on-going sexual relationship (p. 313).

While Seal and Ehrhardt and Dworkin and O’Sullivan examined men’s scripts, Ortiz-Torres et al., (2003) looked at women’s scripts about their ideal romantic encounters including relationship initiation, the context (where does the couple decide to go or do on their first date), verbal communication (topics that emerged), and nonverbal communication (such as hugging) in the flirtation and sexual phase. Nearly two-thirds of the urban sample (n = 130) consisting of women between the ages of 18 to 30 years did not mention safer sex. One-third stated that they would discuss safer sex right before intercourse and only few said that they would discuss it right away after either the partner or they have expressed sexual interest. Only twenty percent stated that they would bring up a safer-sex discussion early in the relationship. Finally very few participants perceive their partners as introducing safer sex topics.

Similar to Seal and Ehrhardt (2003), Ortiz-Torres et al., (2003) also found both traditional and non-traditional gender scripts in women’s narratives. For example, the narratives suggest that majority of the women in this sample endorsed the traditional gender script of men being initiators of romantic and sexual encounters and women as the “acquiescent” partners (p.13). At the same time, the narratives suggest a changing gender script because women who endorsed the traditional gender script also mentioned the importance of having their own needs met. The women who challenged the traditional
gender script did not want to just replace it with a “woman-initiator” script; instead they wanted a balance between their partner and their own participation in the sexual interaction (p. 13).

Another key finding of Ortiz-Torres et al. (2003) was the phase-dependent communication that has implications, according to the authors, for HIV prevention (p. 14). Most of the risk-reduction messages encourage early safer sex discussions; however, most women in the study not only did not include safe sex in their gender scripts, but when probed by the interviewer, they also said that they would bring up the topic just before the sexual encounter. Given that the findings suggest that non-verbal communication is preferred to verbal communication during the sexual phase, Ortiz-Torres et al. raise a valid question when they ask if a discussion about safer sex likely to occur when sex is imminent? (p. 14). A key limitation of the study was that women were responding to a hypothetical situation and were not asked to report on an actual first date sexual interaction.

To summarize, cumulative findings from earlier and more recent research suggests that talk about safer-sex is not a component of sexual scripts. In terms of gender differences, recent studies suggest the co-existence of a traditional as well as a non-traditional script that could point out to the tenuous sexual expectations that young adults have, which they would need to negotiate given a particular context.
Implications for Safer Sex Talk

As mentioned previously, research on cultural scripts suggests that safer-sex talk is not part of the sexual scripts of young adults (Edgar & Fitzpatrick, 1993). Metts and Spitzberg (1996) observed that “explicit communication” about sex does not usually occur in early dating relationships and a recent study found that participants reported that they would bring up the topic of safer-sex just before the sexual encounter (Ortiz-Torres et al., 2003). However, recent research in cultural scripts suggests some changes such that women are initiating sexual activity and men want women to take on the responsibility of initiating sexual activity (e.g. Seal & Ehrhardt, 2003; Ortiz-Torres et al., 2003). It is possible that young adults are initiating talks about safer-sex and having such talks early on in relationships. To date scholars have not systematically examined who initiates talk about safer-sex (Noar, Zimmerman, & Atwood, 2004). This leads to the next research question:

*RQ2a*: Do young adults report that either they or their given partner initiated their first talk about safer-sex or is the first safer-sex talk reported to be mutually negotiated?

Despite some changes in the cultural scripts, double standards do exist such that it is more acceptable for men than women to have casual partners and multiple or serial concurrent sexual partners (Seal & Ehrhardt, 2003). The next research question investigates this ambiguity:

*RQ2b*: Are there sex differences in the initiation of the first safer-sex talk?
Although the Script theory provides a backbone for understanding sexual practices of young adults and the possible gender differences in these practices, the sexual compliance gaining literature can provide a lens for understanding verbal and non-verbal strategies that young adults use to influence a partner to talk or not talk about safer-sex.

Compliance Gaining Literature

Compliance gaining is defined as a “communicative behavior in which an agent engages so as to elicit from a target some agent-selected behavior” (Wheeless, Barraclough, & Stewart, 1983, p. 111). Compliance gaining has been employed to examine influence within various interpersonal contexts such as parent-child, physician-patient, and supervisor-employee relationships. It is important to note that even though the term compliance has been differentiated from persuasion or social influence (Wilson, 2002), the three terms have been used interchangeably in the safer-sex literature. Wilson notes persuasion has traditionally focused on public communication contexts, whereas compliance gaining focuses on influence within interpersonal contexts. Also, persuasion scholars focus on message effects, whereas compliance gaining scholars focus on message choices.

The early sexual compliance literature developed on the basis of three studies that led to the development of influence taxonomies (see Edgar & Fitzpatrick, 1990 for a review). Jesser (1978) and McCormick (1979) carried out the early studies, each using different approaches for their investigations. Jesser employed a checklist created from the then existing literature and McCormick asked participants to respond to a hypothetical
seduction. Perper and Weis (1997) asked their female sample to respond to an open-ended question regarding strategies they would use to initiate or respond to sexual initiation in a hypothetical scenario. The strategies across these three studies can be broadly classified as direct, indirect and sequenced (Edgar & Fitzpatrick, 1990) and are briefly explained.

Direct strategies imply that the intent of the message for compliance is clear. Jesser labeled this strategy as “ask directly” and found that majority of males and over half of the females used this strategy to have sex. Perper and Weis found that about 20% of the female respondents indicated that they would just “ask” their partners to have sex. McCormick found that six of the ten message strategies were direct verbal strategies and found little difference between males and females’ use of direct message strategies. The six direct strategies were labeled reward (providing services or gifts in exchange for compliance), coercion (punishing or threatening to punish for non-compliance), logic (using rational arguments), information (asking for sex in a straightforward manner), moralizing (telling the date that the persuader has a legitimate or sanctioned right to have sexual intercourse), and relationship conceptualizing (talking about the relationship and expression concern for the date’s feelings). Indirect strategies are those in which the intent of the message for compliance is ambiguous. Most of the strategies in this category were nonverbal except for McCormick who found manipulation (subtle changing of appearance or setting) and deception (false information). Sequenced messages involve the performance of both verbal and nonverbal messages that ends in sexual intercourse.
Edgar and Fitzpatrick (p. 113) observe that while McCormick conceptualized the sequenced message as a compliance strategy only from the persuader’s perspective, Perper and Weis viewed message sequences as being “interactive” in nature in which both partners are participants in the sexual encounter. Since these studies were conducted, in the last decade, scholars have examined the message choices college students’ use to influence their partners to use and/or talk about condoms and the reactions to these strategies (Debro, Campbell & Peplau, 1994; Edgar et al., 1992; Reel & Thompson, 1994; Sheer, 1995) thus moving beyond the examination of compliance gaining strategies that looked at initiating sexual interaction and/or seducing one’s partner for sexual activity. Some studies suggested sex differences in the choice of message strategy used (Edgar et al., 1992; Debro et al., 1994).

Edgar et al. (1992) surveyed college students to learn about the types of influence strategies commonly used to persuade a partner to use condoms and the partner’s reactions to strategies used. The authors developed nine strategies from interpersonal influence literature and education materials constructed by Grieco (1987, cited in Edgar at al., 1992). The types of strategies were (a) me – the force for compliance comes from within the persuader, (b) you – the force for compliance comes from within the target of compliance, (c) activity – the force to comply focuses on the activity itself, (d) us – the force to comply comes from the relationship between the two people involved, (e) external - the force to comply comes from a source outside the immediate relationship, (f) power (reward) – influence derives from the exertion of control when the persuader
can punish the target of compliance, (h) *direct* – the message is a straightforward request for compliance, and (i) *deception* – the message is a lie.

The authors found that males and females preferred different strategies of condom use. Overall females were more likely to use a direct approach and power strategy ("no condom, no sex"), and males tend to use nonverbal strategies (men reported using condoms without consulting their partners). Men were also more likely to ask women their preference (e.g., "he asked if I wanted him to put a condom on"). Respondents were also asked to provide their partner’s reactions to strategies they had used to initiate condom use. In 83% of the interactions, the response was compliance, in 5% of the interactions, the respondents agreed reluctantly and in only 4% or six instances was there continued resistance. Further, a comparison of strategies used by users and nonusers of condoms revealed a tendency of both sexes of condom users to prefer messages that focus on health concerns ("I care about you very much and don’t want anything to happen to you") rather than giving or receiving pleasure. However, the authors point out that this could be an artifact of the study because pleasure messages are not socially widely acceptable and may be communicated nonverbally that the participants were not directed to report.

Debro, Campbell and Peplau (1994) study was a departure from Edgar et al. in that they tested categories developed by Raven (1992) and McCormick (1979) (as cited in Debro et al., 1994) to examine not only the strategies used to persuade a new sexual partner to use condoms but also the strategies employed to “not use” condoms as well as the effectiveness of the strategies. Of the five categories adopted from Raven and
McCormick, reward (statements in which one partner promises positive consequences if the other complied) and deception (giving a partner a reason to use condoms when the real reason is different) are conceptually similar to Edgar et al. categories.

Three categories that emerged in the data include the following: emotional coercion (when one partner threatened negative emotional consequence for non compliance); risk information (when one partner emphasizes the risks of unprotected sex); and seduction (the use of sexual arousal to distract the partner to gain compliance). Additionally, Debro et al. found a sixth category which they labeled “withholding sex,” where a partner simply refused to have sex unless a condom is used.

In addition to examining the approaches used by young adults to ensure condom use, De Bro et al. also tested how effective each of the strategy was in influencing a partner to use condoms and how comfortable respondents would be using each of the approaches in a second study. Varying levels of support were found for the six approaches, with women having rated withholding sex as more effective than other strategies in influencing a dating partner to use a condom. Moreover, they were most comfortable using this particular strategy. Men, however, gave deception highest ratings on effectiveness and comfort. In terms of past experience with each of the strategies, more women reported using threatening to withhold sex, while more men reported using seduction for influencing a partner to use a condom. When asked which of the six strategies had been used to avoid condom use, both men and women reported using seduction than other strategy although significantly more men than women had used this strategy.
Sheer (1995) developed six hypothetical persuasive appeals (health, fear, threat, caring, responsibility, pleasure) on the basis of Edgar et al. (1992) categories to test how appealing each statement was, change in overall attitude towards condom use, and the likelihood of using condoms in each of the above the situation (intention). Sheer’s main goal was to test these appeals in the context of sensation seeking; however, some of the findings are pertinent to the compliance gaining literature. Overall respondents ($N = 205$) not only favored caring (“I care about you, so let’s use a condom), pleasure (“I think putting on a condom can be a real turn-on for both of us. Let’s try it.”), and responsibility appeals (“I really think we should be responsible for each other. So let’s use a condom.”), but also considered these appeals as the most effective. Respondents reported that they are susceptible to but disliked health, threat and fear appeals. These responses suggest that college students should persuade partners to use condoms without hurting the relationship.

Reel and Thompson (1994) solicited strategies young adults’ use to discuss AIDS or condoms and to find out the effectiveness of the strategies. Unlike previous studies, the authors asked respondents to provide strategies that they had used to discuss AIDS or condoms with partners. Thirty thematic categories were created from messages used by participants to use condoms. Fear of pregnancy was the most frequently used message, followed by mutual agreement to use condom. The third most frequently used strategy was one partner requesting that condom be use. Similar to Sheer (1995), Reel and
Thompson found that respondents preferred to use messages that have a relational “we” focus about being responsible, and being safe than sorry over other strategies. Finally, the authors found that women were more likely than men to employ certain messages. Among the nine types that they identified, four had a relational “we” focus (e.g., we should find out about safer sex measures), one expressed fear of AIDS (I’m really afraid of AIDS), one message was couched in seriousness (This isn’t a joke to me), one focused on the protection that a condom provides to both partners (A condom protects us both) and finally, two stressed on using condoms as a sign of respect for the other (e.g., If you don’t respect me enough to use a condom, then I’m with the wrong person).

Most recently, Noar, Morokoff and Harlow (2002) extended previous work by designing and testing a condom influence strategy questionnaire, which examined the relationship between the strategies and condom use. They tested strategies from previous literature and found that heterosexually active men and women use six strategies to persuade their partners to use condoms including: withholding sex, direct request, seduction, relationship conceptualizing, risk information, and deception. Of these strategies, the effect sizes for withholding sex, direct request, and seduction indicated that they were strongly related to condom use.

**Implications for Safer-Sex Talk**

In all of the above reviewed studies, students were asked about the use and effectiveness of individual strategies with regards to condom use. These researchers have provided a useful way of categorizing influence strategies. Yet as De Bro et al. (1994) note, “in real-life interactions partners often try a combination of approaches or use
several strategies in sequence” (p. 180). Most young adults on college campus’ have not personalized the threat of getting HIV/AIDS (Edgar, Freimuth, & Hammond, 1988; McCormack, Anderton, & Barbieri, 1993). However, because young adults as a demographic group are considered “at risk,” I next examine the talk about condoms between young adults who are identified at risk outside the purview of the college campus.

Bird, Harvey, Beckman and Johnson (2001) interviewed HIV/STD at risk heterosexual couples ($N = 90$) from three US cities where a couple-based intervention program was to be implemented (Atlanta, $n = 30$; Los Angeles, $n = 39$; and Oklahoma City, $n = 21$). Couples were asked to identify strategies they would use to get their partner to use condoms for disease prevention. The majority of the participants reported the use of verbal and nonverbal strategies. The nonverbal strategies included putting on a condom themselves, buying condoms, or presenting condoms to their partners. The verbal strategies included (a) persuading partners to use condoms or suggesting condom use, (b) commanding or asserting their desire for condom use, and (c) threatening to withhold sex if condoms were not used (p. 236). The use of non-verbal strategy is consonant with Edgar et al. (1992) and the use of verbal strategies corresponds with strategies reportedly favored by young adults in Edgar et al. (1992), Debro et al. (1994) and Reel and Thompson (1994).

An important distinction between this study and the others is that majority of the men and women in this study reported that they would use “bilateral” verbal techniques to influence their partners to use condoms for preventions of STDs and HIV. These
strategies are bilateral because it “involves interaction between partners” and allows partners to “engage in conversations” about disease prevention, pregnancy prevention and condom use (p. 236). This finding questions the assumption that safer-sex practices between young adults are always compliance-gaining endeavors where one partner unilaterally wants the other partner to use a condom. Thus, there is a need to uncover talk between young adults about safer-sex in real life interaction. Also, recent research has examined strategies young adults use to talk about condoms or sexual histories, but not the entire gamut of topics that constitute safer-sex talk. In addition, the responses to these strategies also have not been assessed (Reel & Thompson, 2004). Therefore, the following research questions are posed:

*RQ*\(_{3a}\).* What types of strategies do young adults use in their first talk about safer-sex with a given partner?

*RQ*\(_{3b}\).* What topics do young adults reportedly raise when they first talk about safer-sex with their partners?

*RQ*\(_{3c}\).* How do partners reportedly respond to efforts to engage in their first talk about safer-sex?

*RQ*\(_{3d}\).* Do young adults reportedly talk about different topics of safer-sex after the first talk about safer-sex?

Adding to the complexity of talking about safer-sex are face concerns that is addressed by face management theory.
**Face Management Theory**

Goffman (1967) is recognized as having developed the concept of “face” or public identity that individuals strive to maintain in an interaction. Since then, scholars have examined how people communicatively manage face and employed different labels for that process such as facework (Cupach & Metts, 1994), impression management (Tedeschi, 1981), identity management (Schlenker, 1984), and politeness (Brown & Levinson, 1987). Brown and Levinson (1987) equate face with two “wants” that people seek in interactions- “the want to be unimpeded and the want to be approved of in certain respects” (p. 63). The first want is referred to as negative face and the second want is referred to as positive face. Brown and Levinson posited that all speakers and hearers in an interaction have negative face and positive face needs. Because face consists of wants that can only be met with actions of others, it would be mutually beneficial for interactants to maintain each other’s face.

Threats to face arise when an individual’s desired identity is challenged in an interaction (Cupach & Metts, 1994). Specifically, positive face is threatened when messages doubt someone’s abilities and negative face is threatened when messages interfere with one’s actions (Cupach & Metts, p. 5). To avoid face threats, people have to create messages that satisfy both positive and negative face. Thus facework is defined as the communication designed to counteract face threats to self and others (Goffman, 1967).
Facework is crucial in interpersonal relationships because it (a) enables partners in an interaction to be competent, (b) allows for establishing identities, and (c) encourages mutual respect between interaction partners (Cupach & Metts, 1994, p. 15). Afifi and Lee (2000) similarly argued that although individuals in an interaction would be generally concerned about facework three “concerns” in an interaction make facework salient. The three concerns include the following: “the behavior reflects on highly valued aspect of the self; successful performance is tied to vital positive or negative consequences; and behavior reflects directly on highly valued rules of conduct” (p. 286).

The three aforementioned concerns are present in the context of broaching safer-sex talk. The present literature suggests that sometimes young adults don’t bring up safer sex because it is embarrassing (Cline, Johnson & Freeman, 1992), can arouse suspicion (Cline & McKenzie, 1994) and is presumptuous especially if partners have not had sex as yet, thus, threatening one’s self image (Afifi, 1999; Cline, Johnson & Freeman, 1992). Not bringing up the topic may also be seen as a tactic for not offending one’s partner by displaying a lack of trust (Lock & Ferguson, 1998) and consequently not incurring any negative consequences such as damaging the relationship (Afifi, 1999; Cline & McKenzie, 1994), or limiting the chances of having sex. Finally, there is empirical and theoretical evidence to suggest that the rules of conduct in relationship regarding sex and talking about safer sex is that it is a taboo topic (Baxter & Wilmot, 1985; Cline & McKenzie, 1994) that can threaten the positive face-wants of the hearer (Brown & Levinson, 1987).
Talking about safer-sex is inherently a face threatening act and is considered to be a taboo topic between new partners and partners in a relationship (Baxter & Wilmot, 1985). As just mentioned, taboo topics can threaten the positive face-wants of the hearer (Brown and Levinson, 1987). In fact one-third of the respondents in Baxter and Wilmot’s study reported that they found talking about sex to be embarrassing; when people feel embarrassment it is, according to FMT, an experience of losing face (Cupach & Metts, 1994, p. 1).

Implications for Safer-Sex Talk

Face management is a reason why young adults are not able to bring up the topic of safer-sex. Cupach and Metts (1994, p. 44) suggest that talking about sex is emotionally dangerous because it involves disclosing or sharing information that has implications for how one is judged, (e.g., promiscuous, deviant or even aggressive). Young adults are concerned about the impressions they give off when talking about condoms in a sexual interaction. However, in three recent studies that examined perceptions of those who propose condom use, young adults seemed to hold favorable impressions of those who propose condom use.

Bryan, Aiken and West (1999) found that young adults generally seem to have a favorable impression of condom usage, although these impressions differed by the sex of the respondent. For example, men who proposed condom use were perceived to be nicer and more mature than those who did not propose condom use. Women believed that men who verbally propose condom use (ask their female partners if they want to use a
condom) are mature and least promiscuous. While the women made appraisals related to the impression they had of men who propose condoms, the men believed that the introduction of a condom decreases the probability of sexual intercourse.

Hocking, Turk and Hollinger (1999) found that after first time sex, participants in a role playing scenario felt more responsible, less at-risk, and less worried when a condom was used than when no condom was used. Participants evaluated their partner as more responsible, more caring, and less likely to have a STI when a condom was used. Further more, when a condom was used, the relationship was evaluated as enhanced, closer, more intimate, and more likely to be long lasting. Similarly, Davidson-Harden, Fisher and Davidson (2000)’s experimental study found that in general young adults looked more favorably on individuals of either sex who initiated condom use. Moreover, the only effect for sex of the participants was that males viewed the male character as having had fewer sexual encounters if he initiated condom use than if he was not the initiator; the negative implication being that men who use condoms are sexually inexperienced. All three mentioned studies were experiments and only Davidson-Harden et al. (2000) situated the scenario that was provided to participants in a relationship context. It is possible that the hypothetical nature of the scenario encouraged participants to respond favorably to condom usage.

Reel and Thompson (2004) investigated the message characteristics about condom usage in the framework of politeness theory. Results suggested that verbal messages were evaluated as more socially appropriate than the more direct, nonverbal messages and even the baldly-on-record messages were rated as more appropriate than
saying nothing. Nonverbal messages (attempting to put on condom) were seen as less likely to result in condom use than were verbal messages. Interestingly enough “did not perform the FTA” or not talking about condom use did not protect the requester’s positive face. The authors suggest that there are negative consequences of not suggesting a condom despite the potential for causing embarrassment. They conclude that verbal strategies are a good mix of being effective (resulting in condom use), and appropriate (in the context of the rules of conduct) and are able to provide face/relationship protection.

Theoretically, initiating safer-sex talk is face-threatening yet recent studies suggest that young adults are likely to have favorable impressions of partners who suggest condom use. It is plausible that the threat of getting an STI/HIV (health safety issues) overrides the concern for managing impressions and initiating talk about safer-sex. Even though there is some evidence related to perceptions of those who initiating condom use, there is scarce evidence related to the non-initiators or the receivers of safer-sex talk. Theoretically it should be less face threatening if safer-sex talk is mutual. The aforementioned reasoning guides the next hypothesis.

\( H_1: \) Young adults who first talk about safer-sex before first sexual interaction will perceive more face threat than young adults who first talk about safer-sex after first sexual interaction.

Many young adults establish intimacy after having sexual intercourse. This is one of the recognized paradoxes that people are often more comfortable talking about personal issues such as past sexual histories after they have had sex rather than prior to
having sexual intercourse. Knobloch and Solomon (2006) argue that intimacy can ease the risks of engaging in relationship talk. This leads to the next research question:

\[ H_2: \text{Young adults who first initiate safer-sex talk will perceive more face threat than young adults who do not initiate safer-sex talk and when first safer-sex talk is mutually negotiated.} \]

Many scholars believe that changing cultural scripts play a role in more equitable heterosexual relationships among college students in the U.S. Research on double standards is equivocal with regards to expectations for men and women. In non-college samples we know that there has been a slight shift in the traditional sexual norms according to which men are the initiators of sexual activity and women are the gatekeepers of sex (Ortiz-Torres et al., 2003; Seal and Ehrhardt, 2003). Therefore,

\[ RQ_4: \text{Are there any differences in the face threat experienced by females and males with respect to talking about safer-sex with partners?} \]

Aside from face-concerns that exist during talks about safer-sex, the confidence to talk about safer-sex or self-efficacy is a crucial element in the process of safer-sex talk, which is next discussed.

**Self-Efficacy and Safer-Sex Talk**

Self-efficacy is defined as an individual’s belief in his/her ability to initiate actions that will be successful in the production of desired outcomes (Bandura, 1977). This sense of “agency” is a key component of Social Cognitive Theory, as Bandura observed that perceptions of self-efficacy influence how much effort an individual would put into a given task and how much the individual would persevere in the midst of
challenges he/she faces during a given task. Task is being used here to denote a given activity of context in which self-efficacy is conceptualized. Self-efficacy has been employed in the safer-sex literature with regards to condom use. Researchers who study condom usage in young adults have argued that it is not enough for individuals to be willing to talk about condoms; rather, individuals should believe that they have the necessary skills to initiate condom use (Brafford & Beck, 1991; Crowell & Emmers-Sommer, 2000).

Studies show that communication self-efficacy has a direct effect on condom use (Dilorio, Dudley, Lehr & Soet, 2000) and discussions of safer-sex with partners (Basen-Enquist, 1992; Dilorio et al., 2000). Specifically, Dilorio et al. (2000) found that participants who reported higher levels of confidence in discussing safer sex with their partners and expected more positive outcomes for doing so were more likely to discuss safer sex with partners. Basen-Enquist (1992) had also found that a higher level of discussion self-efficacy was related to both intentions to discuss as well as related to actual discussion of safer sex with sexual partners. These findings corroborate a major proposition of social cognitive theory that a person’s confidence in performing a behavior is an important predictor of that behavior (Dilorio et al., 2000).

**Implications for Safer-Sex Talk**

In the context of safer-sex talk and STI/HIV prevention, the more efficacious an individual perceives he or she is with regards to talking to one’s partner about safer-sex, the more likely it is that he or she would bring up the topic and persist in the face of a partner’s protest. Likewise, the more an individual lacks self-efficacy, the less persistent
one would be if a partner resists or denies an opportunity to talk, thereby reducing greatly the intention to practice safer-sex (Perloff, 2001). In fact, Seal and Palmer-Seal (1996) found that a lack of perceived self-efficacy for safer-sex discussion was related to not initiating talk about condom use. Similar findings were reported by Crosby et al. (2002) in the context of African American adolescents’ (ages 14 – 18) infrequent communication about safer-sex. In particular, adolescents’ fear of negotiation condom use and their low perceived ability to negotiate condom use were significant correlates of infrequent sexual communication. Adolescents who were classified as infrequently communication with their sex partners were about 50 % more likely to report a lack of condom use during the most recent sexual episode. The aforementioned empirical findings and rationale guide the next two hypotheses:

\[ H_3: \text{Young adults who talk about safer-sex have higher self-efficacy than those who do not talk about safer sex.} \]

\[ H_4: \text{Young adults who initiate safer-sex talk have higher self-efficacy than those who do not initiate safer-sex talk and when safer-sex talk is mutually negotiated.} \]

Thus far, the review has introduced several theoretical frameworks to examine the process (initiation of safer-sex talk, topics, strategies, responses and gender differences) of safer-sex talk as well as the role of face-concerns and self-efficacy. Next, theoretical and empirical frameworks are enumerated to investigate the emotional, relational and behavioral outcomes of safer-sex talk.
Emotions and Safer Sex Talk

Emotions are considered to be crucial to the formation, maintenance and dissolution of relationships, yet there is a consensus among scholars that there is a dearth of research examining the role of emotions in relationships (see Planalp, 2003). Anderson and Guerrero (1998) argue that interpersonal communication is both an “ elicitor,” and a “response” to emotion, and thus there is a need to incorporate emotions in communication research. In fact, Dillard, Kinney and Cruz (1996) stated, “emotional responses warrant research attention simply because feelings are such a fundamental aspect of human existence” (p. 105). Vangelisti and Crumley (1998, p. 174) observed that emotions can affect how conversations are enacted – “facilitating” some and “inhibiting” others. Given that safer-sex talk could be a relational turning point and is considered a “taboo” topic that involves a certain degree of impression management, emotions elicited during and after talk needs to be examined. Scholars have noted the lack of attention given to emotions in relation to safer sexual behavior (e.g., Noar, Zimmerman, & Atwood, 2004).

Since no study to date has investigated the emotional outcomes of safer-sex talk, a conceptual definition of emotions is offered after reviewing some of the popular ways emotion has been defined in other literatures. Following Batson, Shaw, and Olson (as cited in Guerrero, Anderson & Trost, 1998), Guerrero et al., explain the differences among affect, emotion and mood as being: “…affect refers to the general valence of an
emotional state, emotion refers to specific types of clusters of feelings that occur in response to particular events, and moods refer to relatively enduring and global states of pleasant or unpleasant feelings” (p. 5).

Emotions have been conceptualized using three approaches: the discrete or basic emotions approach (e.g., Ekman, 1992a, 1992b), the dimensional approach (e.g., Russell, 1980), and the prototype approach (Rosch, 1978). Each one is briefly discussed next.

Ekman (1992a, p. 550) posits that emotions are a product of human evolution, although he does not discount the role of culture and social learning in how people cope with and evaluate and express emotions. Ekman (1992a) notes that much of the research in the last thirty years that favors the discrete approach has used facial expression to find support for the presence of six emotions – happiness, surprise, fear, sadness, anger, and disgust/contempt. Additional inclusion criteria for being considered as a basic emotion include rapid, spontaneous onset and automatic appraisal, and a unique feeling state (Ekman 1992b as cited in Guerrero et al.).

Guerrero et al. point out the presence of disagreement among researchers over emotions that fit the criteria of basic emotions (Cf. Guerrero et. al. 1998). For example, Izard (1977) (as cited in Guerrero et al., 1998) proposed several universal emotions including interest, joy, surprise, sadness, anger, disgust, contempt, fear, shame, shyness and guilt. The discrete emotion approach, according to Guerrero et al., proposes that non-basic emotions are “blends” of the basic emotions. For example, rage may be a blend of anger and fear, and jealousy may be a blend of fear, anger, and sadness (p. 11).
While the discrete emotion approach is directed towards characteristics that “distinguish” emotions from each other, the dimensional approach concerns itself where the emotion is “placed” on a valence (i.e. positive or negative, or aroused – relaxed) dimension (Guerrero et al., p. 13). Finally, the prototype approach enables us to get an idea about the hierarchical structure of generic or prototype categories of emotions (Shaver, Schwartz, Kirson, & O’Connor, 1987). In this study, emotions are conceptualized using the discrete emotion approach and appraisal theory is used as the explanatory mechanism to investigate the emotional outcomes of the first safer-sex talk between young adults.

Appraisal theory proposes that emotions are experienced after people are exposed to some stimulus (e.g. an event or situation) that they evaluate. Scholars have investigated how emotions influence communication strategies in some context such as uncertainty in relationships (e.g. Knobloch & Solomon, 2003) and how people’s emotional responses to events reflect the quality of their relationships (e.g. Vangelisti & Crumley, 1998). Theorists of emotions and appraisal theory maintain that intense emotions are experienced by individuals when they form, maintain, disrupt, or dissolve relational ties (Bowlby, 1979 as cited in Anderson & Guerrero, 1998).

Implications for Safer-Sex Talk

In the context of safer-sex talk, talking about safer-sex could be one such event that elicits emotions in young adults. To be specific, how partners’ initiate talk and respond to each other would impact the emotion/emotions felt by partners. Guided by the
discrete emotions approach, seven emotions were identified for this endeavor – Happiness, Sadness, Anger, Fear, Surprise, Disgust and Contempt. In addition, three other emotions were also added to this empirical investigation – Jealousy, Shame and Guilt. Among these emotions, empirical and theoretical evidence suggest that anger, fear and sadness can all be induced, among other factors, by a feeling of rejection and loss of a relationship (Canary, Spitzberg, & Semic, 1998; Shaver, Schwartz, Kirson, & Connor, 1987). Talking about safer-sex involves identity management due to the fear of being rejected. Anger and sadness can both be experienced by young adults if one person’s sharing of sexual history disappoints the other partner’s expectations.

Jealousy, according to Anderson and Guerrero (1998, p. 62) is an emotion that is associated with a “real, anticipated, or imagined relational behavior.” Like anger, a person could get jealous after learning about the other partner’s previous romantic and sexual interactions. Also, once jealousy is elicited, other emotions such as hurt, anger, sadness and fear become an integral part of this experience (Fischer & Tangney, 1995 as cited in Anderson & Guerrero).

Guilt and shame belong to a category of emotions that are linked to feelings of being self-conscious of having hurt or failed to help someone (Vangelisti & Sprague, 1998). Specifically, guilt is experienced if one partner deceives another (Metts, 1994) or if a partner induces guilt in another for compliance gaining (Vangelisti, Daly, & Rudnick, 1991). In the context of safer-sex talk, one partner could feel guilty if she or he is not forthcoming about sexual history or a partner could guilt the other to practice or not practice safer-sex.
The emotions associated with talking about safer-sex have yet to be examined. Consequently the following research questions are proposed:

*RQ*$_5$: *Is there a difference in young adults’ experience of emotions when they initiate the first safer-sex talk, do not initiate safer-sex talk and when the first safer-sex talk is mutually negotiated?*

*RQ*$_6$: *Which of the ten emotions is most experienced by young adults after they talk about safer-sex with their partners for the first time?*

**Relational Outcomes of Safer-Sex Talk**

Given that a sexual interaction is considered to be a turning point in relationships, I argue that talk about safer-sex has relational outcomes. Sexual encounters, after all, are dyadic interactions that have relational and identity implications (Afifi, 1999; Laumann et al., 1994). Gavin (2000) notes that there is a “tacit” understanding among young adults such that talk that divulges sexual history can threaten a relationship. Gavin, through interviews with men, found that relationships are threatened due to risk of rejection and risk that this knowledge will go beyond one’s partner. Also, that these risks affect men and women differently: While sharing sexual information may damage a woman’s reputation and cause her to be labeled as ‘promiscuous,’ men do not share the same fears. Divulging sexual histories connote different meanings of trust for men and women. Gavin’s interviews suggested that for a man to lose the trust of his partner means that he
can no longer be trusted to be discreet about sexual activities. For a woman to lose trust of her partner means that she no longer embodies “trustworthiness,” and is no longer “the embodiment of a risk free partner” (p. 129).

Although talking about safer-sex could damage one’s sense of self and consequently the relationship, it is possible that this talk could be a turning point in a couple’s relationship that has a positive impact on the relationship. Talking about safer-sex might symbolize moving the relationship to the next level. Also, talking about safer-sex could have different implications depending upon when this talk occurs. One of the reasons why young adults do not talk about safer-sex early on in a relationship is the fear of turning off a partner or appearing confident that sexual activity will occur. Concurrently we know that young adults feel intimate once they are sexually active and thus could feel more comfortable to talk about safer-sex. Similarly, being an initiator of safer-sex talk has identity and relational implications. Thus, the following research questions are offered:

**RQ7**: Is there a difference in the relationship outcomes reported by those young adults who report engaging in their first talk about safer-sex before their first sexual interaction and those young adults who report engaging in their first talk after their first sexual interaction?

**RQ8**: Is there a difference in the relational outcomes when young adults initiate first talk about safer-sex, when their partner initiates first safer-sex talk and when first safer-sex talk is mutually negotiated?
RQ9: Which of the four relational outcomes do young adults report to experience the most after they talk about safer-sex for the first time with their partners?

RQ10: What is the relationship between how long into the relationship do young adults reportedly first talk about safer-sex and relational outcomes of safer-sex talk?

Behavioral Outcomes of Safer-Sex Talk

Recent meta-analyses suggest that talking about condoms has a relationship with condom use. It is possible that the outcomes of talking about safer-sex are different – sometimes condoms are used; sometimes condoms are not used if partners share testing results; or sometimes a decision is taken to get tested – outcomes that have health protective outcomes. The behavioral outcomes may differ depending upon when this talk occurs. In other words the behavioral outcomes could depend upon whether this talk occurs before first time sex or after first time sex. Thus, the next two research questions are offered:

RQ11a: What are the behavioral (health protective) outcomes reported by young adults after their first safer-sex talk?

RQ11b: Is there a difference in the behavioral (health protective) outcomes reported by those young adults who report engaging in their first talk about safer sex before their first sexual interaction and those young adults who report engaging in their first talk after their first sexual interaction?
The final section in this chapter addresses the reasons why young adults do not talk about safer-sex. The chapter concludes with a summary of the enumerated research questions and hypotheses.

**Reasons Why Young Adults Do Not Talk About Safer Sex**

The US Surgeon General’s (1986) “Know your partner” advice meant to encourage young adults to learn more about one’s partner’s sexual history before engaging in sex with them. However, three main reasons can be attributed to young adult’s reluctance to talk about safer-sex. The first reason being self and relationship preservation (Afifi, 1999; Cline et al., 1992; Cline & McKenzie, 1994), the second being perceptions of being promiscuous (Cline & McKenzie, 1994) and third, subjective assessments of partner risk (Civic, 2000; Keller, 1993; Maticka-Tyndale, 1991; Seal & Palmer-Seal, 1996).

As mentioned earlier, much of the quantitative research suggests that young adult have not personalized the HIV/AIDS risk (e.g. Edgar et al., 1988; McCormick, 1993; Reel & Thompson, 2004). However, Maticka-Tyndale (1991) found that young adults are aware of the risks and believe they take adequate prevention by having sexual activities with partners who are “safe.” This finding is substantiated in subsequent research, which proffered that subjective assessments of partner safety often serve as a substitute for protection against potential STI (Civic, 2000; Keller, 1993) and is presented next.
Williams Kimble, Covell, Weiss, Newton, Fisher & Fisher (1992) conducted focus group interviews with 169 college students to learn about how students make judgments of the “riskiness” of their sexual partners. Participants relied on certain rules to label someone as “risky” for HIV such as: risky people dress provocatively; are those who one meets in bars; and, who are anxious for sex (p. 926). The authors note that partners whom students “like” and “know” (irrespective of HIV testing) are perceived to not be risky. As one respondent said “When you get to know the person…as soon as you begin trusting the person…you don’t really have to use a condom” (p. 926). Such implicit personality theories (Williams et al., 1992) are used to manage “risk,” specifically by more men than women, who tend not to question partners about their sexual histories but instead use appearance to evaluate a potential partner (Lear, 1995; Seal, & Palmer-Seal, 1996). Another example of college students’ use of subjective assessments is the work of Swann and colleagues (Swann, De La Ronde, & Hixon, 1994; Swann, Silvera, & Proske, 1995).

Swann et al. (1995) conducted two studies to examine the impressions that college students form of their potential sexual partners that leads to underestimating the health risks of those sexual partners. In the first study, the participants had to detect when a potential target partner was lying to them about their sexual histories. The experiment was designed such that targets represented “high” and “low risk” sexual partners and answered eight questions that participants asked them. After “interviewing” each target, the participants had to guess whether the target had lied or told the truth.
Then the participant indicated how likely it was that his or her guess was correct on a scale ranging from 0% to 100% (p. 176). Results of the first study indicated that participants guessed correctly 51.9% of the time while they had estimated that they had correctly identified target’s response as a lie or truth 70% of the time.

In study two, the participants were in five groups such that the control group saw the target momentarily; participants in the mere-exposure condition saw the target for a minute; in the familiarity condition, participants witnessed the target discuss her background and interests for a minute; in the fourth group the target discussed for a minute her account of infection with the HIV virus; and, in the fifth group the participants saw material from the third and fourth conditions. In all conditions, after viewing tape, participants rated the probability that the target was HIV positive, how much they liked her, thought they knew her and felt similar to her. The main finding was that by merely watching the tape of the third condition in which the target shared some facts about her self, participants reported that the target was not a risky sexual partner.

These two experimental studies support survey research that indicates that college students use subjective ways to assess risk. These findings then also raise the question of whether the prevalence of such “truth bias” (participants believed that target was telling the truth 70 % of the time) is the reason why so many young adults are willing to trust potential sexual partners they have recently met.

As mentioned previously, many young adults use subjective criteria such as how a person looks or the type of clothes a person wears to make decisions about the potential risk of a partner. Such subjective assessments of partner safety often serve as a substitute
for protection against potential STIs (Civic, 2000; Keller, 1993). Implicit personally
theories (Williams et. al. 1992) can influence perceptions that a partner is risk free (Seal
& Palmer-Seal, 1996) and prevent young adults from bringing up the topic of safer-sex
with their partners. Additionally, young adults do not broach the subject of safer-sex
with their partners for fear of projecting the impression that they think a potential partner
is promiscuous or that they themselves are promiscuous that may lead to a loss of trust
between partners. Talking about safer sex with new or prospective partners could also
imply a lack of trust (Lear, 1995) and bringing up this topic only after the relationship is
established could also raise questions about a lack of trust (Lear, 1995). And young adults
may also not bring up the topic of safer-sex out of self and relationship preservation. This
leads to the following research questions:

RQ12: Which reasons do young adults consider the most important when deciding not to
talk about sexual histories?

RQ13: Is there a gender difference in reasons for not talking about sexual histories?

RQ14: Is there a difference between talkers and non-talkers with regards to the reasons
why they might not have talked with their partner about safer-sex?

Restatement of the Research Questions and Hypotheses

RQ1a: How long into the relationship do young adults report engaging in their first safer-
sex talk?

RQ1b: When do young adult’s report initiating their first safer-sex talk with their partners
with regards to sexual activity in dating relationships?

RQ2a: Do young adults report initiating their first safer-sex talk more than their
partners?
RQ_{3b}: Are there sex differences in the initiation of the first safer-sex talk?

RQ_{3a}: What types of strategies do young adults use in their first talk about safer-sex with a given partner?

RQ_{3b}: What topics do young adults raise when they first talk about safer-sex with their partners?

RQ_{3c}: How do partners reportedly respond to efforts to engage in their first talk about safer-sex?

RQ_{3d}: Do young adults reportedly talk about different topics of safer-sex after the first talk about safer-sex?

H_{1}: Young adults who first talk about safer-sex before first sexual interaction will perceive more face threat than young adults who first talk about safer-sex after first sexual interaction.

H_{2}: Young adults who first initiate safer-sex talk will perceive more face threat than young adults who do not initiate safer-sex talk and when first safer-sex talk is mutually negotiated.

RQ_{4}: Are there any differences in the face threat experienced by females and males with respect to talking about safer-sex with partners?

H_{3}: Young adults who talk about safer-sex have higher self-efficacy than those who do not talk about safer sex.

H_{4}: Young adults who initiate safer-sex talk have higher self-efficacy than those who do not initiate safer-sex talk and when safer-sex talk is mutually negotiated.
RQ5: Is there a difference in young adults’ experience of emotions when they initiate the first safer-sex talk, do not initiate safer-sex talk and when the first safer-sex talk is mutually negotiated?

RQ6: Which of the ten emotions is most experienced by young adults after they talk about safer sex with their partners for the first time?

RQ7: Is there a difference in the relationship outcomes reported by those young adults who report engaging in their first talk about safer-sex before their first sexual interaction and those young adults who report engaging in their first talk after their first sexual interaction?

RQ8: Is there a difference in the relational outcomes when young adults initiate first talk about safer-sex, when their partner initiates first safer-sex talk and when first safer-sex talk is mutually negotiated?

RQ9: Which of the four relational outcomes do young adults report to experience the most after they talk about safer-sex for the first time with their partners?

RQ10: What is the relationship between how long into the relationship do young adults reportedly first talk about safer-sex and relational outcomes of safer-sex talk?

RQ11a: What are the behavioral (health protective) outcomes reported by young adults after their first safer-sex talk?
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RQ_{12}: Which reasons do young adults consider the most important when deciding not to talk about sexual histories?

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RQ_{14}: Is there a difference between talkers and non-talkers with regards to the reasons why they might not have talked with their partner about safer-sex?
CHAPTER 3

METHOD

In this chapter, I first enumerate the design of the study that includes the sampling plan to recruit participants. After summarizing the procedures of the study I provide the measures and tasks with evidence of reliability. Finally, I describe the coding system for open-ended questions and outline the statistical procedures I used to answer my research questions and hypotheses.

Design

Participants were asked to complete a secured online survey in the privacy of their homes. The survey was divided into four main sections. In the first section, respondents were asked an open-ended question about safer-sex talk they have had with their most recent dating partner. Participants were asked to describe the first conversation they had with their partner about safer sex. Participants were requested to write the script in the form of a dialogue/script, indicating who said what. Then participants were asked questions regarding the talk such as who initiated the talk and how long into the relationship did the talk occur. In the second section, participants were asked questions pertaining to relational, behavioral and emotional outcomes of the talk. In the third section participants were measured on self-efficacy and face concerns. Demographics were measured in the last section.
Participants

The purpose of this study was to gain an understanding of self-reports of the first safe-sex talk of young adults in relationships. Hence a purposive sample of individuals who are in relationships or who were in relationships (at any time) were solicited from a large Midwestern University. The sample consisted of 405 young adults whose ages ranged from 18 to 25 years, with a mean of 20.5 ($SD = 1.3$). Three hundred and thirty nine participants were Caucasian, twenty-nine African-American, nineteen Asian, seven Hispanic, two Pacific Islander, one Native American, and four participants identified themselves as Biracial, Black/White, Asian American and Indian. Two participants did not indicate their ethnicity. A hundred and thirty six participants were sophomore, a hundred and eight juniors, ninety five seniors, and sixty six freshmen. Two hundred and forty-eight respondents were female, and a hundred and fifty-seven were male. Forty-one respondents lived together and two hundred and eighty respondents considered their relationship to be exclusive.

Procedures

Following approval by the Institutional Review Board (IRB), participation was solicited in classrooms in the School of Communication in a Midwestern university. Students were directed to surveymonkey.com, a secured online website to take the survey. Students provided consent online before taking the survey. The link to the website as well as the responses of the respondents was encrypted as extra security measure.
At the very end of the survey, participants were provided with a list of websites that they could visit to learn more about safer-sex practices. Students were awarded extra credit for participating in the study.

**Measures**

The following concepts were measured in the study: Safer-sex talk, the outcomes of safer-sex talk, which were emotional outcomes, behavioral outcomes, and relational outcomes, self-efficacy, face concerns, and reasons why some young adults did not talk about safer-sex with their partners. Each one is discussed in the order just mentioned.

**Safer-Sex Talk**

Safer-sex talk was measured in two ways in the study. First, respondents were asked to write about the first conversation regarding safer-sex they had with their current or most recent dating partner. Second, respondents were asked close ended questions about whether they had talked to their current or most recent partner about condoms, sexual history, STI testing, birth control, drugs, and homosexual experiences. Specifically, the first of the two ways that safer-sex talk was measured was in the form of an open-ended question that solicited participants to describe the first conversation they had with their partner about safer-sex. An open-ended question asks respondents to use their own words in answering questions (Frey, Botan, & Kreps, 2000) and is useful when researchers are exploring sensitive topics (Sudman & Bradburn, 1974) and little understood issues (Fink, 1995). The definition of safer-sex talk was provided and respondents were asked if they have talked about safer-sex with their partners. Safer-sex talk was defined as having explicit discussions around condom use, sexual histories,
sexually transmitted infections, past sexual activities (oral/anal/vaginal sex), drug use and pregnancy. This definition is in alignment with the US General Surgeon’s (1986) definition of “knowing your partner” advice or the questions that prospective sexual partners should ask each other before first time sexual interaction. A partner was described as “someone you are currently dating, or are in a serious relationship with, or someone you had sex with once. This also includes someone you are dating but with whom you have not engaged in sexual activity.” After providing these definitions, respondents were asked, “Have you talked about safer-sex with your partner?”

If participants indicated that they have talked with their partners about safer-sex, they were directed to recall and construct the conversation in the form of a script/dialogue, indicating who said what. Next, respondents were asked which partner initiated the conversation. Respondents were next asked to indicate when the talk about safer-sex occurred and were provided with following five options: A while (several hours/days/weeks) before first sexual interaction; immediately prior to first sexual interaction; A while (several hours/days/weeks) after the first sexual interaction; immediately after the first sexual interaction and an “other” category. Finally, respondents were asked how long into the relationship they had this talk. Except otherwise noted the findings reported in this study pertain to the 280 respondents who answered “yes” to the very first question and provided details regarding the first talk about safer-sex they had with their partner as well as the outcomes of the talk.

The second way that safer-sex talk was measured was by asking participants if they have talked with their partners about using condoms, birth control, sexual history,
STI testing, drug use and homosexual experiences. For each topic, respondents were asked *When* they talked about it and were provided with the following five options: A while (several hours/days/weeks) before first sexual interaction; immediately prior to first sexual interaction; a while (several hours/days/weeks) after the first sexual interaction; after multiple sexual interactions; and, I have not talked about this.

*Emotional Outcomes*

Similar to Knobloch and Solomon (2003), a list of discrete emotions was provided with a seven point scale ranging from 1 (*not at all*) to 7 (*very strongly*) and respondents rated the extent to which they experienced emotions such as “happiness,” “shame,” “sadness,” “anger,” “fear,” “surprise,” “disgust,” “contempt,” “jealousy,” and “guilt.”

*Behavioral Outcomes*

Respondents were asked to choose from a list of behavioral outcomes (of safer-sex talk) that were created for the purpose of this dissertation. The outcomes provided were: male condom use, female condom use, got tested for HIV/AIDS, got tested for sexually transmitted infections (STIs), decided to use a contraceptive pill, and shared HIV/STI testing results. A blank or other category was also provided in the event the respondent wished to report a behavioral outcome that was not provided in the list. It must be noted that negative outcomes or unintended outcomes are also possible and were not directly measured in this study.
Relational Outcomes

Following Afifi and Metts (1998) and Knobloch, Solomon and Theiss (2006), perceptions of the relational outcome is operationalized as a seven item measure ranging from 1 (strongly disagree) to 7 (strongly agree) with the first four items measuring the importance of the safer-sex talk to the relationship and the last three items measuring the influence of safer-sex talk on the relationship: (a) “This talk was an important event in my relationship”; (b) “This talk made me think about my relationship”; (c) “This talk was a minor event in my relationship”; (d) “This was a major occurrence in my relationship”; (e) “This talk changed the way I think about my relationship”; (f) “This talk influenced the understanding of my relationship”; (g) “The definition of our relationship changed because of this talk.” The first four items were adapted from Afifi and Metts (1998) and the last three items adapted from Knobloch et al. (2006).

Knobloch et al. (2006) had used all the seven mentioned items and because a second-order CFA indicated that the items were unidimensional, the authors created a composite variable in their analysis by averaging importance and influence scores of participants. However, in this study a principal axis factoring (PAF) with oblimin rotation was conducted on the 7 items. Item c (“this talk was a minor event within my relationship”) was recoded prior to running the analysis. The choice of which items to retain was determined by three criteria for each item: component loadings (≥ 0.50); distance between loadings if loaded on multiple items (of at least .2); and the conceptual fit of the items. Using these criteria, item (f) “this talk influenced the understanding of
my relationship” was dropped because it had high loadings on both factors. A PAF was run again and a two factor structure was retained. The two components explained 76% of the total variance, with “Relational importance” accounting for 55.4% of the variance and “Relational influence” accounting for 20.5% of the variance.

Component loading for all items within a component were >0.60 (Table 3.1). Each subscale showed good internal consistency (Nunnally, 1978) with Cronbach’s alpha being .86 for the Relational Importance scale and .81 for the Relational influence scale.

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<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
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<tbody>
<tr>
<td>This talk was an important event within my relationship</td>
<td>.891</td>
<td></td>
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<tr>
<td>This talk made me think about my relationship</td>
<td>.799</td>
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<tr>
<td>This talk was a major occurrence within my relationship</td>
<td>.740</td>
<td></td>
</tr>
<tr>
<td>This talk was a minor event within my relationship</td>
<td>.696</td>
<td></td>
</tr>
<tr>
<td>This talk changed the way I think about my relationship</td>
<td></td>
<td>.908</td>
</tr>
<tr>
<td>The definition of this relationship changed after this talk</td>
<td></td>
<td>.755</td>
</tr>
</tbody>
</table>

Table 3.1: Principal Axis Analysis with Direct Oblimin Rotation Factor Loadings for Importance and Influence subscales of Relational Outcomes Scale
In addition to these two subscales, two single item scales were used to measure the impact of the first safer-sex talk on the relationship: “This talk strengthened the relationship between us” and “This talk damaged the relationship between us.” Participants answered on a 7-point Likert scale that ranged from 1 (strongly disagree) to 7 (strongly agree). Table 3.2 displays item means and standard deviations of all four subscales.

<table>
<thead>
<tr>
<th>Relational Outcomes</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance</td>
<td>4.87</td>
<td>1.57</td>
</tr>
<tr>
<td>Influence</td>
<td>3.61</td>
<td>1.83</td>
</tr>
<tr>
<td>This talk strengthened the relationship between us</td>
<td>5.49</td>
<td>1.58</td>
</tr>
<tr>
<td>This talk damaged the relationship between us</td>
<td>1.47</td>
<td>1.10</td>
</tr>
</tbody>
</table>

Table 3.2: Mean, Standard deviations of Relational Outcome Subscales

**Face Concerns**

Face concerns were measured by adopting 12 items from Cupach and Carson (2002) face management scale, which measures positive and negative face threats. Participants were provided with the following instructions: “Please tell us how you felt about your partner’s actions during the conversation about safer-sex you just described.” The answer stem was “My partner’s actions” and the items included: were polite, were
rude, were insensitive, showed disrespect towards me, were justified, were hostile, showed contempt towards me, were tactful, constrained my choices, took away some of my independence and invaded my privacy. Response options ranged from 1 (strongly disagree) to 7 (strongly agree). An example of a positive face threat item is “My partner’s actions were insensitive.” An example of negative face-threat is “My partner’s actions invaded my privacy.” Scale reliabilities reported by Cupach and Carson (2002) were alpha = .88 for positive face threat and alpha = .68 for negative face threat.

A principal axis factoring (PAF) with oblimin rotation was conducted on the 12 items. The first item “were polite” was recoded so that higher score indicated that actions were not polite. Six items were deleted from the original 12 item scale. “Invaded my privacy,” “Took away some of my independence,” and “constrained my choices” were dropped because they were meant to originally measure negative face threat; instead they all loaded on the positive face threat factor. Showed contempt towards me, Actions were justified, and Actions were tactful were deleted due to loadings being less than .5 and not having a gap of .2 when loaded on both components. Thus, a one factor component was retained as the best supported solution containing were polite, were rude, were insensitive, showed disrespect towards me and were hostile. This component accounted for 63 % of the total variance. Table 3.3 displays factor loadings. The scale was labeled Positive face threat (Mean = 1.75, SD = 1.61) and showed good internal consistency (Nunnally, 1978) with Cronbach’s alpha being .84.
Table 3.3: Principal Axis Analysis with Direct Oblimin Rotation Factor Loadings for a One Factor Positive Face Scale

<table>
<thead>
<tr>
<th>Items in Positive face scale</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>My partner’s actions were rude</td>
<td>1.000</td>
</tr>
<tr>
<td>My partner’s actions showed disrespect towards me</td>
<td>.950</td>
</tr>
<tr>
<td>My partner’s actions were hostile</td>
<td>.748</td>
</tr>
<tr>
<td>My partner’s actions were insensitive</td>
<td>.733</td>
</tr>
<tr>
<td>My partner’s actions were polite</td>
<td>.645</td>
</tr>
</tbody>
</table>

Self-Efficacy

Bandura (1977, 1997 as cited in Choi, Fuqua & Griffin, 2001) argued that in measuring self-efficacy researchers should keep in mind the specific context in which self-efficacy is being measured. In other words, it will be more useful to measure the self-efficacy of a specific activity rather than measuring global self-efficacy. Thus, a seven item scale that takes into account all seven topics that comprise safer-sex talk was created to measure safer-sex talk self-efficacy (see table 3.4). A PAF suggested a one factor solution that accounted for 61.9% of the variance. The self-efficacy scale, thus, consisted of seven items ($M = 5.85, SD = 1.19$) and had an alpha reliability of .88. Table 3.4 displays factor loadings.
<table>
<thead>
<tr>
<th>Items in the self-efficacy scale</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident in my ability to talk about sexually transmitted infections (STIs/STDs) with my partner</td>
<td>.860</td>
</tr>
<tr>
<td>I am confident in my ability to talk about getting tested for STIs and HIV/AIDS with my partner</td>
<td>.859</td>
</tr>
<tr>
<td>I am confident in my ability to talk about Birth control with my partner</td>
<td>.744</td>
</tr>
<tr>
<td>I am confident in my ability to talk about condoms with my partner</td>
<td>.733</td>
</tr>
<tr>
<td>I am confident in my ability to talk about sexual history (number of previous partners) with my partner</td>
<td>.699</td>
</tr>
<tr>
<td>I am confident in my ability to talk about drugs with my partner</td>
<td>.690</td>
</tr>
<tr>
<td>I am confident in my ability to talk about homosexual experiences with my partner</td>
<td>.624</td>
</tr>
</tbody>
</table>

Table 3.4: Principal Axis Analysis with Direct Oblimin Rotation Factor Loadings for One Factor Self-Efficacy Scale
Reasons for Not Talking about Safer-Sex

Concerns related to identity and relationship protection were measured by adopting some of the Afifi and Guerrero’s (1998) items used for measuring self-protection (a desire to avoid feeling vulnerable and avoiding criticism) and relationship protection (a desire to avoid conflict or destruction of the relationship) reasons why people avoid topics in relationships. The items adapted to this study include the following: “I would be vulnerable”; “Talking about safer-sex could lead to conflict between us”; and “Talking about safer-sex might ruin our relationship; “Talking about it might make my partner angry.” In addition the following items were constructed for the purpose of measuring issues of trust and being perceived as promiscuous: “I would be embarrassed to talk about it”; “My partner may judge me”; “My partner may think that I am not trustworthy”; “My partner may think that I do not trust her/him”; “My partner may perceive me as being promiscuous”; and, “My partner may perceive me as being promiscuous.” Finally the following items were adapted from previous studies (i.e., Civic, 2000; Keller, 1993) with college students as reasons why some young adults do not talk about safer-sex with their partners: “I just knew my partner was safe”; “I know my partners sexual history.” Responses for all the above items were collected using a Likert-type scale that ranged from 1 (strongly disagree) to 7 (strongly agree).

A PAF suggested a three factor solution that accounted for 73.5% of the variance. The first factor was titled Protection and the protection sub-scales consisted of six items consisting of reasons related to protecting one’s identity and relationship (Mean = 2.12, SD = 1.31). The second factor was titled Promiscuity and included four items related to
<table>
<thead>
<tr>
<th>Items</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking about safer-sex could lead to conflict between us</td>
<td>.897</td>
</tr>
<tr>
<td>Talking about safer-sex might ruin our relationship</td>
<td>.885</td>
</tr>
<tr>
<td>My partner may judge me</td>
<td>.843</td>
</tr>
<tr>
<td>I would be embarrassed to talk about it</td>
<td>.792</td>
</tr>
<tr>
<td>Talking about it might make my partner angry</td>
<td>.787</td>
</tr>
<tr>
<td>I would feel vulnerable</td>
<td>.768</td>
</tr>
<tr>
<td>My partner may think I am not trustworthy</td>
<td>-.813</td>
</tr>
<tr>
<td>My partner may think that I do not trust her/him</td>
<td>-.797</td>
</tr>
<tr>
<td>My partner my perceive me as being promiscuous</td>
<td>-.700</td>
</tr>
<tr>
<td>My partner may perceive I think her/him to be promiscuous</td>
<td>-.644</td>
</tr>
<tr>
<td>I just know my partner is safe</td>
<td>.809</td>
</tr>
<tr>
<td>I know my partners sexual history</td>
<td>.758</td>
</tr>
</tbody>
</table>

Table 3.5: Principal Axis Analysis with Direct Oblimin Rotation Factor Loadings for Three Factor Scale of Reasons Why Young Adults Do Not talk about Safer Sex
issues to mistrust and being judged promiscuous ($\text{Mean} = 2.74, \text{SD} = 1.42$). The third factor was labeled Oblivious and consisted of two items related to just knowing one’s partner’s sexual history ($\text{Mean} = 5.16, \text{SD} = 1.71$). All three sub-scales were reliable (Cronbach’s alpha = .92, .82, .77). See Table 3.5 for factor loadings.

**Data Analysis**

The Statistical Package for Social Sciences (SPSS) was used for computing descriptive statistics, correlations, reliability coefficients (Cronbach’s $\alpha$), t tests, analyses of variance, multivariate analysis of variance and covariance, and exploratory factor analysis.

The open-ended responses were coded using coding criteria developed specifically for this study. The decision regarding coding categories was arrived at inductively and deductively. After initially reading the scripts multiple times, two coders jointly created the categories for coding. Coding categories included emergent as well as categories employed in previous compliance gaining literature. The self reports of safer-sex talk provided by respondents were mostly in the form of an exchange or conversation. Others were statements reflecting a unilateral or a compliance gaining strategy and others were hard to tell (because they were written in reported speech without explaining the utterance sequence). The talk was written in either a “he said, she said” form, or written in reported speech. Four categories were created. The first category was considered a higher order category and consisted of: “collaborative,” “non-collaborative” and “cannot tell.” The second category consisted of strategies adopted from Noar et al. (2002) and Bird et al. (2001). Changes were made to the definitions of
these categories such that they extended from “persuading” a partner to use a condom to include all aspects of safer-sex talk as defined in this study. The category strategy included reward, emotional coercion, risk information, seduction, deception, withholding sex, relationship conceptualizing, autocracy, directive, direct request, and disclosing information. The coding sheet consisted of definitions of each of the strategies as well as examples. The third category consisted of the response – agreement or objection – to the previous strategy. The fourth category was the topic or topics (i.e. condom, birth-control, sexual history, STI testing, drug use, homosexual experience) that emerged in the talk. The unit of coding was an utterance if it was written in the form of a dialogue or a sentence if it was written in the form of reported speech.

The decision rules guiding the two coders were as follows: a) if sentence begins with “we just” and goes on to elaborate the sentence, ignore that first sentence; b) When coding for topics, if respondent used a term that was not in our coding sheet, we used respondent’s own language unless specified otherwise; c) If a talk had pair parts such that a request was followed by refusal or non-compliance, then this talk would be considered non-collaborative; d) When a respondent wrote a one-line as a response to the question and where we did not know the utterance sequence, coders would code that sentence/one-liner as cannot tell; and e) Some of the one liners or sentences that were too ambiguous to interpret were only coded for the higher-order category (collaborative, non-collaborative, cannot tell).
Intercoder reliability was calculated to check for agreement between coders. The initial agreement between the coders (each coder coded 25% of the open-ended responses) was low, reliability co-efficient = .69. After further refining the categories, the coders coded another 25% of the sample each and the agreement was higher at .91.
CHAPTER 4

RESULTS

The overarching purpose of this study is to gain a better understanding of safer-sex talk between young adults in dating relationships. This includes the process of safer-sex talk, the outcomes of the first safer-sex talk that young adults have with their partners in dating relationships, and reasons why young adults do not talk about safer-sex with their partners. Specifically, questions about the timing, initiation, topics and types of talk, the response to the talk as well as face management concerns that constitute talk about safer-sex. The outcomes included relational, emotional and behavioral outcomes. In this chapter, the findings related to the process of safer-sex talk will first be enumerated. This will precede the findings on the role of face concerns and self-efficacy, the relational, emotional and behavioral outcomes of safer-sex talk and reasons why safer-sex talk does not occur between young adults.

Prior to analyzing the research questions and hypotheses, the relationships among the variables in this study were examined (Table 4.1).
### Table 4.1: Correlation Matrix for all Nominal Variables

<table>
<thead>
<tr>
<th></th>
<th>How Long</th>
<th>Positive Face-scale</th>
<th>Self-efficacy</th>
<th>Importance</th>
<th>Influence</th>
<th>Strengthened Relationship</th>
<th>Damaged Relationship</th>
<th>Oblivious</th>
<th>Protection</th>
<th>Promiscuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long</td>
<td>1</td>
<td>-.024</td>
<td>.132*</td>
<td>.021</td>
<td>-.119</td>
<td>.068</td>
<td>-.061</td>
<td>.063</td>
<td>-.149*</td>
<td>-.175**</td>
</tr>
<tr>
<td>Positive face scale</td>
<td>-.024</td>
<td>1</td>
<td>-.334**</td>
<td>-.114</td>
<td>.054</td>
<td>-.464**</td>
<td>.829**</td>
<td>-.137*</td>
<td>.319**</td>
<td>.317**</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>.132*</td>
<td>-.334**</td>
<td>1</td>
<td>.175**</td>
<td>.016</td>
<td>.317**</td>
<td>-.301**</td>
<td>.438**</td>
<td>-.505**</td>
<td>-.349**</td>
</tr>
<tr>
<td>Importance</td>
<td>.021</td>
<td>-.114</td>
<td>.175**</td>
<td>1</td>
<td>.401**</td>
<td>.352**</td>
<td>-.106</td>
<td>.076</td>
<td>-.022</td>
<td>-.174**</td>
</tr>
<tr>
<td>Influence</td>
<td>-.119</td>
<td>.054</td>
<td>-.016</td>
<td>.401**</td>
<td>1</td>
<td>.139*</td>
<td>.079</td>
<td>-.139*</td>
<td>.124*</td>
<td>.018</td>
</tr>
<tr>
<td>Strengthened</td>
<td>.068</td>
<td>-.464**</td>
<td>.317**</td>
<td>.352**</td>
<td>.139*</td>
<td>1</td>
<td>-.400**</td>
<td>.267**</td>
<td>-.200**</td>
<td>-.354**</td>
</tr>
<tr>
<td>relationship</td>
<td>-.061</td>
<td>.829**</td>
<td>-.301**</td>
<td>-.106</td>
<td>.079</td>
<td>-.400**</td>
<td>1</td>
<td>-.015</td>
<td>.233**</td>
<td>.272**</td>
</tr>
<tr>
<td>Damaged</td>
<td>.063</td>
<td>-.137*</td>
<td>.438**</td>
<td>.076</td>
<td>-.139*</td>
<td>.267**</td>
<td>-.105</td>
<td>1</td>
<td>-.280**</td>
<td>-.235**</td>
</tr>
<tr>
<td>relationship</td>
<td>-.149*</td>
<td>.319**</td>
<td>-.505**</td>
<td>-.022</td>
<td>.124*</td>
<td>-.200**</td>
<td>.233**</td>
<td>-.280**</td>
<td>1</td>
<td>.428**</td>
</tr>
<tr>
<td>Oblivious</td>
<td>-.175**</td>
<td>.317**</td>
<td>-.349**</td>
<td>-.174</td>
<td>.018</td>
<td>-.354**</td>
<td>.272**</td>
<td>-.235**</td>
<td>.428**</td>
<td>1</td>
</tr>
</tbody>
</table>

*. P < .05, **. P < .01
The Process of Safer-Sex Talk

In this section, results related to timing, initiation, sex differences in initiation, strategies or types of safer-sex talk, and topics uncovered in the open-ended responses are reported.

To glean how many young adults talk about safer-sex two questions were posed. Firstly, respondents were asked “Have you talked about safer-sex with your partner?” Safer-sex was defined as having explicit discussions around condom use, sexual histories, sexually transmitted infections, past sexual activities (oral/anal/vaginal sex), drug use and pregnancy. This definition is in alignment with the US General Surgeon’s (1986) definition of “knowing your partner” advice or the questions that prospective sexual partners should ask each other before first time sexual interaction. A partner was described as “someone you are currently dating, or are in a serious relationship with, or someone you had sex with once. This also includes someone you are dating but with whom you have not engaged in sexual activity.” Of the 405 young adults in the sample, 69% (280) reported to have talked about safer-sex with their partners. Of these, 63.9% (179) were female and 36.1% (101) were male.

The second way safer-sex talk was measured was by computing how many individuals answered “I did not talk about this” when they were asked individually whether they had talked about condoms, sexual history, history of STIs, birth control, getting tested for STIs, homosexual experiences and drug use. Calculated this way, only 3.7% (15) of the young adults reported to have not talked about a topic of safer-sex.
In other words, 96.3% (390) of the young adults in the sample have talked with their partner about one or several or all of the seven topics that constitute safer-sex talk.

A chi-square analysis suggested that there are no differences between females and males with regards to the likelihood of one gender talking about safer-sex with their partners (females, n = 179, males, n = 101), $\chi^2 (1, N = 280) = 2.774, p = .096$.

**Timing of safer-sex talk**

The first research question had two parts to it. The first part was to do with how long into the relationship do young adults reportedly talk about safer-sex and the second part was when safer-sex talk is initiated with regards to sexual activity in dating relationships. Results suggested a wide range of time with regards to when respondents reportedly talked about safer-sex for the first time with their partners. This time ranges from one week into a relationship to four years of having dated. Of the 229 valid responses, the average time when young adults reportedly talked about safer-sex with their partner for the first time was 4 months ($Mdn = 1.5$ months, $Mode = 1$ month, $SD = 7.4$).

For the second part of the question, that is the timing with regards to sexual activity, 261 respondents answered this question. Nearly sixty-six percent (65.4%) of young adults reported to have had their first safer-sex talk with their partners prior to first time sexual interaction and 25.7% reported to have talked with their partner about safer sex for the first time after having sex for the first time. The remaining 2.1% ($n = 6$) of the respondents reported to have discussed with their partners about not being sexually active until marriage. Nineteen respondents did not answer this question.
Safer-Sex Talk Initiation

Fifty-three percent of respondents reported to have initiated safer-sex talk (RQ2a). Nearly thirty percent of respondents reported that their partner’s initiated safer-sex talk. Twelve percent reported that both partners initiated the talk. Two respondents were unsure of who initiated the talk and twelve respondents did not answer the question.

Thirty-eight percent (103) of females reported initiating safer-sex talk whereas seventeen percent (46) of males reported initiating safer-sex talk. A chi-square analysis indicated that there were no significant differences with regards to initiation between the two groups, $\chi^2(3, N = 268) = 7.833, p = .050$ (RQ2b).

Strategies of Safer-Sex Talk

One of the goals of this study is to examine whether talk strategies between young adults are unilateral (persuasive), or bilateral (collaborative) with respect to safer-sex (RQ3a). To address this question, coding categories were developed by two coders after reading all the open-ended responses ($n = 250$). Coding categories were developed inductively as well as deductively as mentioned earlier in the methods section. Of the 250 participants who answered this question, four were non-interpretable, one response was irrelevant and two respondents wrote that they could not remember. Thus 243 responses were coded for the four categories. Of these 243 responses, 213 were “collaborative”, 18 were coded as “cannot tell,” and 12 were coded as “non-collaborative.” Among the types of talk, directly or indirectly asking questions were used the most (70), followed by disclosing information (66) and directive (66). Direct request was found 46 times and
withholding sex occurred 31 times. Risk information (19) and autocracy (11) were the least common types of talk. Finally there were only two instances when respondents reported using relationship conceptualizing (See table 4.2 for examples and frequencies).

Topics of Safer-Sex Talk

The open-ended responses were coded for topics that are reportedly brought up during the first talk about safer-sex (RQ3b). These responses were coded inductively as well as deductively. In other words, I coded for the seven topics that I use in the definition of safer-sex talk and also made a note of emergent topics. Of the seven topics, homosexual experiences and drug use did not come up. The most talked about topic was condoms followed by birth control. As mentioned above, in addition to the seven topics, the scripts were also coded for topics that emerged from the scripts and were labeled “other topics”. Some respondents reported talking about the consequences of being sexually active and abstaining from sex. Several respondents reported to have talked about “protection” (Table 4.3). This topic seems to have been used in a generic way to imply being cautious of getting an STI as well as preventing pregnancy.

The open-ended were also examined for the content of talk regarding condoms to get an idea of what young adults talk about within the topic of condoms because condoms were talked about the most. There were topics that were discussed between 10 to 23% of the time that are first described. Then topics that were not talked about very frequently (i.e. less than 10 %) are mentioned. Many young adults reported to have talked with their partners about using condoms in conjunction with birth control pills. They also reported that either they or their partner told them that they would not have sex without condoms.
<table>
<thead>
<tr>
<th>Type of talk</th>
<th>Definition</th>
<th>Example</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly or indirectly asking</td>
<td>Person asks partner if they have been tested for STIs and/or number of</td>
<td>*Have you ever had sex with anyone else other than me, and if</td>
<td>77</td>
</tr>
<tr>
<td>questions</td>
<td>partners/ on birth control/ used condoms etc</td>
<td>you did you wear a condom?</td>
<td></td>
</tr>
<tr>
<td>Disclosing information</td>
<td>Person shares information related to past sexual history, condom use,</td>
<td>*Him: well I am a virgin so I will put full faith into you. Myself: I</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>STI testing etc plus current information regarding use of pills with</td>
<td>have been with others, but I am clean so we don’t have to worry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>partner</td>
<td>about that.</td>
<td></td>
</tr>
<tr>
<td>Directive</td>
<td>Person requests the use of condoms/share STI results etc in a direct,</td>
<td><em>I want to have sex but we definitely need to use a condom</em></td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>straightforward manner usually in the form of a statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct request</td>
<td>Person asks partner what they would like. Person usually uses “would”</td>
<td><em>Do you want me to use a condom?</em></td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>or “should.”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* These frequencies do not add up to 100 as respondents reported more than one strategy in an utterance.
Table 4.2 Continued

<table>
<thead>
<tr>
<th>Type of talk</th>
<th>Definition</th>
<th>Example</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withholding sex</td>
<td>Person states or threatens that sexual activity will be withheld if (a) partner does not use a condom/ some form of contraception (b) talk about talk about condoms/ STIs/sexual history/STI testing/drug use (c) share STI test results</td>
<td><em>We aren’t having sex without a condom.</em></td>
<td>31</td>
</tr>
<tr>
<td>Risk information</td>
<td>Person presents information about the risks of STDs/ AIDS/ pregnancy to persuade partner to (a) use a condom/some form of contraception including the pill/ get tested for STI, (b) talk about condoms/ STIs/sexual history/STI testing/drug use</td>
<td><em>I don’t want to end up like the rest of my family, 18 with a baby, let’s be careful so I can be the first to graduate college.</em></td>
<td>19</td>
</tr>
<tr>
<td>Autocracy</td>
<td>Person uses authority, claims greater knowledge, flatly insists on condom use</td>
<td>Partner 1: <em>I won’t have sex unless we use protection.</em> Partner 2: <em>Isn’t the fact that you are taking birth control pills good enough? P1: No. because that doesn’t protect from other diseases, or even 100% from pregnancy.</em></td>
<td>11</td>
</tr>
</tbody>
</table>

*Note: These frequencies do not add up 100 as respondents reported more than one strategy in an utterance.*
Several respondents expressed their concerns about pregnancy to their partners as the reason for wanting to use condoms. For example, a respondent told her partner, “I always use protection; I do not want a kid.” Several respondents reported either asking or telling partners to use a condom, for example, “Do you want me to use a condom?” Such talk seems to have occurred when sex was imminent as reported by the respondents. In addition to directly asking or telling partners to use condoms when sex is imminent, some young adults seem to have general discussions about using condoms when they were talking about having sex in the near future or taking their relationship to the next level. In these discussions respondents would talk about either using or not using condoms when sexually active. For example, “We need to use condoms if we're going to have sex.” Finally, young adults reported to have insisted on using condoms every time they had sex (Table 4.4).

There were other topics that young adults reported to have talked about with regards to condoms, which were reported by less than 10% of the participants. Condom use came up when partners were discussing sexual histories, including how often and if condoms were used. One partner would also insist on using condoms when the other partner was not taking birth control pills or had not taken them properly. Three respondents reported to have talked about using condoms with partners in order to “just be safe.” Two of the female respondents reported to have asked their partners to share in the cost of buying condoms. Even though several respondents reported to have talked about STIs only one expressed fear of STIs, as a reason for wanting to use condoms.
Finally, six young adults reported to have talked about not using condoms. Four of them and their partners did not use condoms because the female partner was on the pill, one reported to have not used a condom because it lessens the experience and one reported to talking about not using condoms because it was the first time for one of the partners and the other one had always used condoms in the past. It must be noted that there were other respondents who talked with their partner about how condoms lessen the experience; however, they had decided with their partners to always use condom to protect each other from pregnancy and STIs (see table 4.4 for frequencies and examples).

The topic of birth control was the second most frequently occurring among topics that young adults reported to have talked about with their partners. Many young adults reported to have discussed using birth control pills either as a form of contraception or used with condoms as “added protection.” In addition, some young adults reported to have talked about birth control explicitly as a method of preventing pregnancy or not wanting children. The topics that did not occur frequently were visiting a doctor to talk about options regarding the pill, pulling out as a method of birth control, vaginal contraception and not getting drunk before sex as it could lead to partners forgetting to take the pill. (See table 4.3 for frequencies)
<table>
<thead>
<tr>
<th>Topic</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use</td>
<td>143</td>
</tr>
<tr>
<td>Birth control</td>
<td>127</td>
</tr>
<tr>
<td>Birth control pills</td>
<td>104</td>
</tr>
<tr>
<td>Preventing pregnancy</td>
<td>16</td>
</tr>
<tr>
<td>Visiting a doctor</td>
<td>3</td>
</tr>
<tr>
<td>Pulling out</td>
<td>2</td>
</tr>
<tr>
<td>Vaginal contraception</td>
<td>1</td>
</tr>
<tr>
<td>Not getting drunk before sex</td>
<td>1</td>
</tr>
<tr>
<td>Sexual history (number of partners)</td>
<td>30</td>
</tr>
<tr>
<td>Testing for STIs/HIV</td>
<td>30</td>
</tr>
<tr>
<td>History of STIs</td>
<td>25</td>
</tr>
<tr>
<td>Contraception/protection</td>
<td>7</td>
</tr>
<tr>
<td>Consequences of having sex</td>
<td>5</td>
</tr>
<tr>
<td>Abstaining from sex until marriage</td>
<td>2</td>
</tr>
<tr>
<td>Vaginal contraception</td>
<td>1</td>
</tr>
<tr>
<td>Remaining exclusive</td>
<td>1</td>
</tr>
<tr>
<td>Male sterility</td>
<td>1</td>
</tr>
<tr>
<td>Missing period</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note:* These topics are not exclusive categories because some participants reported talking about multiple topics.

Table 4.3: Frequencies of topics of Safer Sex Talk
<table>
<thead>
<tr>
<th>Content of talk regarding condoms</th>
<th>Frequency</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use condoms along with birth control pills</td>
<td>33</td>
<td>“I am on birth control but we should still use condoms”</td>
</tr>
<tr>
<td>Avoid sex unless condom use</td>
<td>23</td>
<td>“I am not going to do it unless we use a condom”</td>
</tr>
<tr>
<td>Use condoms to avoid pregnancy</td>
<td>17</td>
<td>“We talked about using condoms in the fear of pregnancy”</td>
</tr>
<tr>
<td>Telling or asking partner to use condoms</td>
<td>21</td>
<td>“Let’s use a condom”</td>
</tr>
<tr>
<td>Having general discussions about condoms (using or not using them)</td>
<td>12</td>
<td>“Before we started having sex we discussed the need to buy condoms so what when we were ready there would be nothing holding us back”</td>
</tr>
<tr>
<td>Using condoms every time couples have sex</td>
<td>14</td>
<td>“She told me to make sure I always wear a condom”</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Content of talk regarding condoms</th>
<th>Frequency</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use with previous partners</td>
<td>7</td>
<td>“Have you ever had sex with any one else other than me, and if you did, did you wear a condom?”</td>
</tr>
<tr>
<td>Use condom when female partner not on the pill/pill not taken properly</td>
<td>4</td>
<td>“I’m on birth control pill, but its not going to be effective for 3 weeks, so let’s keep using condoms”</td>
</tr>
<tr>
<td>Use condoms to be safe</td>
<td>3</td>
<td>“We just spoke of condoms... we should use them just to be safe”</td>
</tr>
<tr>
<td>Asking partner to share cost of purchasing condoms</td>
<td>2</td>
<td>“My parents are paying for the birth control (pill) and that would be great if you would just pay for condoms”</td>
</tr>
<tr>
<td>Use condoms because scared of STIs</td>
<td>1</td>
<td>“I am freaked out about STDs. I want to use a condom.”</td>
</tr>
</tbody>
</table>

**Talk about not using condoms**

<table>
<thead>
<tr>
<th>Content of talk regarding condoms</th>
<th>Frequency</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not use condoms because female partner on the pill</td>
<td>4</td>
<td>“I don’t have a condom.” “Its okay I’m not birth control”</td>
</tr>
<tr>
<td>Takes away from the experience</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not use condoms when having sex for first time</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.4: Content of Talk Regarding Condom Use
The responses to the types of talk were also assessed (RQ3c). While not every open-ended description of the safer-sex talk included a response, of those that did write out the response of their partner or their own response (if partner had initiated the talk) it was found that there was more agreement or compliance ($n = 114$) than disagreement ($n = 9$).

The purpose of this study was to also learn about the different topics of safer-sex that respondents may have talked about with their partners in addition to the talk about their first ever talk about safer-sex with their partners (RQ3d). Respondents were asked if they had talked with their current partner about the following topics: condoms, sexual histories (i.e., number of previous partners), testing for STIs, history of STIs, drug use, homosexual experiences (if heterosexual), and birth control. Respondents were also asked “when” they had talked about each topic and were provided with five options: A while (hours/days/or more) before first sexual interaction; Immediately prior to first sexual interaction/in the heat of the moment; After first sexual interaction; After multiple sexual interactions; and I have not talked about this.

Overall ($N = 405$), respondents reported talking most about condoms, sexual histories and birth control. Respondents reported talking less with their partners about getting tested for STIs, homosexual experiences, history of STIs and drug usage respectively. Within each topic, respondents talked more with their partners about that topic before rather than after having sex for the first time (Table 4.5)
Table 4.5: Frequencies, Percentages of the Timing of Topics of Safer Sex Talk

<table>
<thead>
<tr>
<th>Topics of talk</th>
<th>A while before first sexual interaction</th>
<th>Immediately prior to first sexual interaction</th>
<th>After first sexual interaction</th>
<th>After multiple sexual interactions</th>
<th>I have not talked about this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>127 (31)</td>
<td>184 (45.4)</td>
<td>70 (17.3)</td>
<td>40 (9.9)</td>
<td>49 (12.1)</td>
</tr>
<tr>
<td>Sexual history</td>
<td>196 (48.4)</td>
<td>41 (10.1)</td>
<td>83 (20.5)</td>
<td>63 (15.6)</td>
<td>65 (16)</td>
</tr>
<tr>
<td>Birth control</td>
<td>153 (37.8)</td>
<td>65 (16.0)</td>
<td>88 (21.7)</td>
<td>47 (11.6)</td>
<td>97 (24.0)</td>
</tr>
<tr>
<td>Suggested testing for STIs</td>
<td>92 (22.7)</td>
<td>28 (6.9)</td>
<td>52 (12.8)</td>
<td>38 (9.4)</td>
<td>202 (49.9)</td>
</tr>
<tr>
<td>STI history</td>
<td>101 (24.9)</td>
<td>29 (7.2)</td>
<td>47 (11.6)</td>
<td>36 (8.9)</td>
<td>183 (45.2)</td>
</tr>
<tr>
<td>Drug use</td>
<td>216 (53.3)</td>
<td>26 (6.4)</td>
<td>51 (12.6)</td>
<td>37 (9.1)</td>
<td>100 (24.7)</td>
</tr>
<tr>
<td>Homosexual experiences</td>
<td>61 (15.1)</td>
<td>11 (2.7)</td>
<td>16 (4.0)</td>
<td>10 (2.5)</td>
<td>188 (46.4)</td>
</tr>
</tbody>
</table>

Thus far, the findings pertaining to the process of safer-sex talk have been enumerated. Next, the findings pertaining to the role of face concerns are provided. In the next section, the findings related to reasons why young adults do not talk about safer-sex are discussed. To recount, there were two hypotheses and a research question related to face concerns and safer-sex talk. The hypotheses proposed that (H1) Young adults who first talk about safer-sex before first sexual interaction will perceive more face threat than young adults who first talk about safer-sex after first sexual interaction and (H2) Young adults who first initiate safer-sex talk will perceive more face threat than young adults.
who do not initiate safer-sex talk and when first safer-sex talk is mutually negotiated. The research question enquired if there are any differences in the face threat experienced by females and males with respect to talking about safer-sex with partners (RQ4).

Neither of the hypotheses was supported. An independent sample T test was conducted and no differences were found in the face-threat means of those who talk about safer sex before first sexual interaction (Mean = 1.70 SD = 1.10) and after first sexual interaction (Mean = 1.94 SD = 1.31), t (253) = -1.434, p = .153 (H1).

Similarly, a one-way ANOVA revealed that there were no significant differences among the face-scale means of the three groups (H2). Given that the groups were not equal; the data were checked for homogeneity of variance. The Levene statistic was not significant, suggesting that the group variances are equal, T (2, 263) = 1.118, p = .329.

Next, descriptive statistics were examined. The mean score of positive face scale for partner initiated was higher than self initiated, which was higher than both initiated (See table 4.6). However, these differences were not significant. The means were compared and the F statistic indicated that the average positive face scores are equal across the three groups, F (2, 263) = .627, p = .535.

Finally, a chi-square test was employed to detect if there are any differences in the face threat experienced by females and males with respect to talking about safer-sex (RQ4). No differences were found in the face threat, with regards to safer-sex talk, experienced by males and females, χ² (25, N = 279) = 26.541, p = .379. In a post-hoc
Table 4.6: Means, Standard Deviations of Positive Face Scale for Self-initiated, Partner-initiated, Mutually negotiated talk.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self initiated</td>
<td>149</td>
<td>1.70</td>
<td>.98</td>
</tr>
<tr>
<td>Partner initiated</td>
<td>83</td>
<td>1.87</td>
<td>1.37</td>
</tr>
<tr>
<td>Mutually initiated</td>
<td>34</td>
<td>1.68</td>
<td>1.36</td>
</tr>
<tr>
<td>Total</td>
<td>266</td>
<td>1.75</td>
<td>1.17</td>
</tr>
</tbody>
</table>

Analysis, when face threat was examined in the context of exclusivity, those in exclusive relationships perceived face threat to be less than those who reported being in non-exclusive relationships.

*Self-efficacy and Safer-Sex Talk*

Aside from learning about the process of safer-sex talk and the role of face-threat young adults experience after talking about safer-sex with their partners, this endeavor also gauged the role of self-efficacy. Particularly, it was hypothesized that (H3) young adults who talked about safer-sex had higher self-efficacy than those who did not talk about safer-sex, and (H4) Young adults who initiate safer-sex talk have higher self-efficacy than those who do not initiate safer-sex talk and when safer-sex talk is mutually negotiated.
Table 4.7: Means, Standard Deviations of Self-Efficacy for Self-initiated, Partner-initiated, Mutually Negotiated Talk.

<table>
<thead>
<tr>
<th>Self efficacy scale</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent initiated</td>
<td>147</td>
<td>6.11</td>
<td>1.10</td>
</tr>
<tr>
<td>Partner initiated</td>
<td>83</td>
<td>6.12</td>
<td>.85</td>
</tr>
<tr>
<td>Mutually initiated</td>
<td>33</td>
<td>6.25</td>
<td>.79</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>6.13</td>
<td>.99</td>
</tr>
</tbody>
</table>

Those who talked about safer-sex had higher self-efficacy ($Mean = 6.1, SD=1.0$) than those who did not talk about safer-sex ($Mean = 5.1, SD=1.3$). An independent sample T-test suggested a significant difference in self-efficacy between the talkers and non-talkers ($t(398) = 6.9, p<.001$); thus H3 was supported.

To assess the next hypothesis, a one-way ANOVA was run with self-initiated, respondent initiated and mutual talk as the between subject factors and self-efficacy as the within subject factor. Given that the groups were not equal (Self-initiated, $n = 147$; partner-initiated, $n = 83$; mutual, $n = 33$), the data were checked for homogeneity of variance. The Levene statistic was not significant, suggesting that the group variances are equal, $T(2, 260) = 3.9, p = .02$. Next, descriptive statistics were examined. The mean score of self efficacy for mutually initiated was higher than self – and partner – initiated
However, these differences were not significant. The means were compared and the $F$ statistic indicated that there are no significant differences among the average self-efficacy scores across the three groups, $F (2, 260) = .27, p = .76$ (H4).

**Outcomes of Safer-Sex Talk**

In addition to examining the process of safer-sex talk, and the role of self-efficacy and face concerns, this study also uncovered the emotional, relational and behavioral outcomes of safer-sex talk. The findings concerning each of these outcomes are presented next.

**Emotional Outcomes of Safer-Sex Talk**

In order to learn about the emotional outcomes of safer-sex talk, two research questions were posed. The first one scrutinized if there were differences in young adults’ experience of emotions when they initiate the first safer-sex talk, do not initiate safer-sex talk and when the first safer-sex talk is mutually negotiated (RQ5). The second research question assessed which of the ten emotions was experienced most by young adults after talking with partners about safer-sex for the first time (RQ6). The outcomes of each are offered.

Research question five was answered using a 3 X 10 factorial design with initiator, receiver and mutual being the between subject factors and the ten emotions being the within subject factors. Prior to running the MANOVA, the data were checked for assumptions of multivariate analysis that include violations of assumptions of normality and homogeneity. First, descriptive statistics were run to examine for outliers using $z$-scores. Using the criteria of $z = \mid 3 \mid$, Box-plots indicated the presence of outliers.
for six of the 10 dependent variables in all three groups except for fear, surprise and contempt.

Each of the ten “emotion variables” were tested for normality in the three groups. A shapiro-wilks test suggested that this assumption was violated for each of the 10 variables in all three groups. Through histograms, the data were checked for kurtosis and skewness. Except for the emotion Happiness, the other nine emotions were moderately positively skewed. Q-Q plots substantiated these deviations. Additionally, the data were also tested for assumptions of homogeneity. Box’s M statistic was calculated and it suggested that the variance-covariance matrices of the dependent variables are not equal among the three groups Box’s M = 230.127, $F(110, 24655.748) = 1.906, p = .000$

Levene’s test was calculated to test if the error variance of the dependent variables across the three groups is equal. A separate test was performed for each dependent variable. The F statistic was significant for the variables Disgust ($F = [1, 258] = 5.139, p = .006$) and Jealousy ($F = [2, 258] = 3.205, p = .042$).

Square root transformations were used due to the presence of outliers and skewness on nine variables except for Happiness that had slight negative skewness (skewness = -.88) and slight kurtosis (0.51). It must be noted that all the other variables were skewed to about the same moderate extent and improvements of analysis with transformations are often marginal (Tabachnik & Fidell, 2001, p. 81). Box’s T was still violated, Box’s M = 191.470, $F(110, 24655.748) = 1.586, p = .000$; Levene’s test of error variances suggested that the error variances for disgust and jealousy were once again significantly different, Disgust ($F = [2, 258] = 6.029, p = .003$) and Jealousy ($F = [2,
The data was also checked for violations of normality and the square root transformations did not reduce the violations of normality. However, given that a MANOVA is robust to normality with large sample size, it was decided to continue with the square root transformations and a lower alpha level (the alpha was reduced from .05 to .01).

Next, a factorial MANOVA with the three groups (self-initiated, partner-initiated, mutual) as between subjects and the ten emotions as the within subjects was run to examine if there is a main effect of being in one of the three groups. To adjust for the unequal cell sizes (self-initiated, \( n = 148 \), partner-initiated, \( n = 82 \), mutual, \( n = 31 \)) the GLM was run by SSTYPE(1) method instead of the default METHOD=SSTYPE(3) in SPSS. This adjustment is appropriate for non-experimental research and when main effects have equal priority (Tabachnick & Fidell, 2001, p.297). There was no multivariate effect for the group with Wilks \( \lambda = .87, F(20, 498) = 1.68, p = .031, \eta^2 = .064, \) power = .882. In other words, the emotional outcomes of safer-sex talk did not differ on the basis of whether the respondents initiated the talk, the partner initiated the talk or the talk was mutual.

To examine which of the emotions is most experienced by the respondents (RQ6), a within subject repeated measure MANOVA was run. Tests of Within-Subjects contrasts were examined to glean if there are differences between one emotion and the next. All but two of the contrasts were significant. In other words there was no difference between the experience of Jealousy versus Shame and between Shame and Guilt. The MANOVA was run without and with square root transformations. Because the results were the same,
<table>
<thead>
<tr>
<th>Emotion</th>
<th>Type III SS</th>
<th>Df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happiness vs. Sadness</td>
<td>3604.630</td>
<td>1</td>
<td>3604.630</td>
<td>644.458</td>
<td>.000</td>
</tr>
<tr>
<td>Sadness vs. Anger</td>
<td>14.538</td>
<td>1</td>
<td>14.538</td>
<td>17.309</td>
<td>.000</td>
</tr>
<tr>
<td>Anger vs. Fear</td>
<td>139.286</td>
<td>1</td>
<td>139.286</td>
<td>61.732</td>
<td>.000</td>
</tr>
<tr>
<td>Fear vs. Surprise</td>
<td>197.158</td>
<td>1</td>
<td>197.158</td>
<td>44.957</td>
<td>.000</td>
</tr>
<tr>
<td>Surprise vs. Disgust</td>
<td>709.158</td>
<td>1</td>
<td>709.158</td>
<td>205.895</td>
<td>.000</td>
</tr>
<tr>
<td>Disgust vs. Contempt</td>
<td>88.004</td>
<td>1</td>
<td>88.004</td>
<td>36.770</td>
<td>.000</td>
</tr>
<tr>
<td>Contempt vs. Jealousy</td>
<td>80.234</td>
<td>1</td>
<td>80.234</td>
<td>29.342</td>
<td>.000</td>
</tr>
<tr>
<td>Jealousy vs. Shame</td>
<td>5.571</td>
<td>1</td>
<td>5.571</td>
<td>3.852</td>
<td>.051</td>
</tr>
<tr>
<td>Shame vs. Guilt</td>
<td>1.059</td>
<td>1</td>
<td>1.059</td>
<td>1.440</td>
<td>.231</td>
</tr>
</tbody>
</table>

Table 4.8: Tests of Within-Subjects Contrasts of Emotions

The figures from the non-transformed variables are reported for parsimonious interpretation. See table 4.8 for the within-subjects contrasts. The estimated marginal means table (table 4.9) and profile (4.1) indicated that the emotion Happiness had the highest mean, followed by Sadness, Contempt, and Shame. Anger, Jealousy, Surprise and fear had lower means and guilt had the lowest mean.
<table>
<thead>
<tr>
<th>Emotion</th>
<th>$M$</th>
<th>$SE$</th>
<th>99 % Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower bound</td>
</tr>
<tr>
<td>Happiness</td>
<td>5.505</td>
<td>.084</td>
<td>5.289</td>
</tr>
<tr>
<td>Surprise</td>
<td>1.872</td>
<td>.083</td>
<td>1.656</td>
</tr>
<tr>
<td>Fear</td>
<td>1.641</td>
<td>.076</td>
<td>1.444</td>
</tr>
<tr>
<td>Contempt</td>
<td>2.355</td>
<td>.100</td>
<td>2.096</td>
</tr>
<tr>
<td>Sadness</td>
<td>3.205</td>
<td>.112</td>
<td>2.915</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.593</td>
<td>.075</td>
<td>1.398</td>
</tr>
<tr>
<td>Shame</td>
<td>2.161</td>
<td>.104</td>
<td>1.891</td>
</tr>
<tr>
<td>Anger</td>
<td>1.619</td>
<td>.076</td>
<td>1.421</td>
</tr>
<tr>
<td>Jealousy</td>
<td>1.762</td>
<td>.082</td>
<td>1.549</td>
</tr>
<tr>
<td>Disgust</td>
<td>1.824</td>
<td>.085</td>
<td>1.603</td>
</tr>
</tbody>
</table>

Table 4.9: Estimated Marginal Means of the Ten Emotions

Relational Outcomes of Safer-Sex Talk

Four aspects of relational outcomes were inspected in this study. First, is there a difference in the relationship outcomes reported by those young adults who report engaging in their first talk about safer-sex before their first sexual interaction and those young adults who report engaging in their first talk after their first sexual interaction? (RQ7). Second, is there a difference in the perception of relational outcomes when young adults initiate first talk about safer-sex, when their partner initiates first safer-sex talk and
Note: 1 = happiness, 2 = surprise, 3 = fear, 4 = contempt, 5 = sadness, 6 = guilty, 7 = shame, 8 = anger, 9 = jealousy, 10 = disgust

Figure 4.1: Plot Profile of Estimated Marginal Means of the Ten Emotions

when first safer-sex talk is mutually negotiated? (RQ8). Third, which of the four relational outcomes do young adults report to experience the most after they talk about safer-sex for the first time with their partners? (RQ9). Fourth, what is the relationship between how long into the relationship do young adults reportedly first talk about safer-sex and relational outcomes of safer-sex talk? (RQ10). As a reminder, relational
outcomes of safer-sex talk are conceptualized as having four components: perceived as strengthening the relationship, perceived as damaging the relationship, perceived as an important event; and perceived as changing the definition of the relationship for young adults. The results pertaining to each of the questions follow. Research question seven was answered using a factorial MANOVA with talk before first sexual interaction and talk after first sexual interaction as the between subject factors and the four relational outcomes as the within subject factors.

Prior to running the MANOVA, the data were examined for assumptions of multivariate analysis. First univariate normality was checked through Shapiro-Wilks tests, Q-Q plots and box-plots. Z-scores were examined for outliers. The Shapiro-Wilks test for both the groups across all four relational outcomes was significant suggesting that the assumption of normality was violated. Using the criteria of $z = |3|$, Box-plots indicated that there were extreme scores ($>= |3|$) in both the groups for the relational outcome “damaged the relationship.” The data set was carefully examined for any errors in data input (i.e. if a respondent was over the age of 25 or if the value entered was more than offered on the scale). Q-Q plots also suggested that the distribution of all of the four relational outcomes in both groups was not normal.

Histograms of the four outcomes without grouping them were also examined for skewness and kurtosis. Relational importance and strengthened the relationship were moderately negatively skewed and relationship influence and damaged the relationship were moderately positively skewed (Tabachnick & Fidell, 2001). Next, bivariate scatterplots of each group also indicated violations of bivariate normality (the plots were
not elliptical). Next, the data were tested for assumptions of homogeneity. Box’s M statistic suggested that the variance-covariance matrices of the dependent variables (i.e. four relational outcomes) are not equal between the two groups, $\text{Box’s } M = 26.061, F(10, 85528.27) = 2.54, p = .005$. Levene’s test was calculated to test if the error variance of the dependent variables across both groups is equal. SPSS performs a separate test for each dependent variable. The F statistic was significant for the variable damaged the relationship between us, $F(1, 247) = 4.57, p = .03$.

Square root transformations were run for each of the four relational outcome variables (Tabahnick & Fidell, 2001). Because of the presence of negative skewness in the variables relational importance and strengthened the relationship, I adopted to reflect the two variables and then applied the appropriate transformation (Tabachnick & Fidell, 2001). To reflect a variable, the largest score in the distribution is found and one is added to form a constant that is larger than any other score in the distribution. Then a new variable is created by subtracting each score from the constant. By doing this, a variable with negative skewness is converted to one with positive skewness prior to transformation. Thus, in both the distributions of relational importance and strengthened the relationship, the score 7 was the largest score. The constant “$K$” for both the variables was thus “8.”

After running transformations, the new variables were examined for violations of normality and homogeneity. All four relational outcome variables had significant Shapiro-Wilks statistics suggesting a violation of assumptions of normality. Box-plots indicated that there were no extreme outliers while the detrended Q-Q plots suggested
violations of normality in all four of the relational outcome variables. The bivariate scatterplots also suggested violations of normality in each of the cells. Box’s test was significant although the value was much lower than prior to transformation, Box’s $M = 19.093, F(10, 85528.275) = 1.866, p = .045$. Levene’s test of equality of error variances was significant only for the transformed variable Damaged the relationship, $F(1, 247) = p = .023$. Overall, the square root transformations did not help much to correct for violations of normality although the violations of homogeneity (Box’s M) was greatly reduced. Because a MANOVA is robust to violations of normality with larger sample sizes, it was decided to continue with the square root transformations and a lower alpha level (.01).

Next, a factorial MANOVA with the two groups (talkers before first sexual interaction and talkers after first sexual interaction) as between subjects and the four transformed relational variables as the within subjects was run to examine if there is a main effect of talking about safer-sex before first sexual interaction. The MANOVA was run with adjustment for unbalanced cells (talk before first sexual interaction, $n = 178$; talk after first sexual interaction, $n = 71$). The MANOVA failed to detect a multivariate effect for belonging to either the “before” or “after” group with Hotelling’s Trace $T^2 = .024, F(3, 245), p = .117$, $\eta^2 = .024$, power = .274. In other words, there was no difference in the relational outcomes when safer-sex talk occurred before or after the first sexual interaction. It must be noted that the square root transformations did have a stabilizing effect on the dependent variables with standard deviations being approximately equal. Also Box’s test was no longer significant ($F = 1.86, p = .045$) (Stevens, 2002, p. 276).
Research question eight was examined using a 3 X 4 factorial design, with self-initiated, partner initiated and mutual as the three between subjects and the four relational outcomes as the within subject groups. Prior to running the MANOVA, the data were checked for violations of normality and assumptions of homogeneity. Shapiro Wilks tests were significant for all the $z$ scores of each group across all four dependent variables. Box-plots suggested the presence of several extreme outliers (i.e. $>|3|$), for the variable damaged the relationship in each of the three groups. Detrended Q-Q plots also suggested departure from normality for all the dependent variables in each group. Box’s M was significant with Box’s M ($F[20, 37777.39] = 1.697$) = 35.111, $p = .027$. However Levene’s test suggested that there was equality of error variances between dependent variables. Hence, it was decided to once again use square root transformations. The transformed data were again tested for homogeneity of covariance and Box’s M was not significant suggesting that this assumption was met (Box’s M = 28.547, $F[20, 37777.39] = 1.697$, $p = .119$). Homogeneity of error variances was also met. To adjust for the unequal cell sizes (self-initiated, $n = 145$; partner initiated, $n = 82$; mutual talk, $n = 34$), the MANOVA was run by SSTYPE(1) method instead of the default METHOD=SSTYPE(3) in SPSS. This adjustment is appropriate for non-experimental research and when main effects have equal priority (Tabachnick & Fidell, 2001, p. 297).

The MANOVA failed to detect any main effect for the groups, with Wilks $\lambda = .96$ $F(6, 512) = 1.572$, $p = .153$, $\eta^2 = .018$, power $= .607$. In other words, the relational
<table>
<thead>
<tr>
<th>Relational outcomes</th>
<th>Type III SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
<th>η²</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance vs.</td>
<td>433.795</td>
<td>1</td>
<td>433.795</td>
<td>121.330</td>
<td>.000</td>
<td>.309</td>
<td>1.000</td>
</tr>
<tr>
<td>Influence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence vs.</td>
<td>954.376</td>
<td>1</td>
<td>954.376</td>
<td>188.048</td>
<td>.000</td>
<td>.410</td>
<td>1.000</td>
</tr>
<tr>
<td>Strengthen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthened vs.</td>
<td>4408.180</td>
<td>1</td>
<td>4408.180</td>
<td>866.405</td>
<td>.000</td>
<td>.762</td>
<td>1.000</td>
</tr>
<tr>
<td>Damaged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.10: Tests of Within-Subject Contrasts of Relational Outcomes

<table>
<thead>
<tr>
<th>Relational Outcomes</th>
<th>M</th>
<th>SE</th>
<th>Lower bound</th>
<th>Upper bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance</td>
<td>4.886</td>
<td>.094</td>
<td>4.641</td>
<td>5.131</td>
</tr>
<tr>
<td>Influence</td>
<td>3.623</td>
<td>.111</td>
<td>3.335</td>
<td>3.912</td>
</tr>
<tr>
<td>Strengthened</td>
<td>5.496</td>
<td>.095</td>
<td>5.249</td>
<td>5.744</td>
</tr>
<tr>
<td>Damaged</td>
<td>1.471</td>
<td>.067</td>
<td>1.297</td>
<td>1.645</td>
</tr>
</tbody>
</table>

Table 4.11: Estimated Marginal Means of the Four Relational Outcomes

Outcomes of safer-sex talk does not differ on the basis of whether the respondent initiated the talk, the partner initiated the talk or if the talk was mutual.
To examine which relational outcome was most experienced by the respondents (RQ9), a within subject repeated measure MANOVA was run. Tests of within-subjects contrasts were examined to see if there are differences between each of the relational outcome. Again, these analyses were run with transformed and non-transformed variables and the
results were same. For the sake of easy interpretation, results from the non-transformed variables are reported here. All of the contrasts were significant. See table 4.10 for the within-subject contrasts. The estimated marginal means table and plot profile indicated (table 4.11, profile 4.2) that strengthened had the highest mean, followed by importance and influence. Damaged the relationship had the lowest mean.

Research question ten examined whether there was a relationship between each of the four relationship outcome variables (i.e. importance, influence, strengthened the relationship and damaged the relationship) and how long into the relationship did talk occur. Pearson correlations indicated that there was no relationship between how long into the relationship the talk occurred and the impact that safer-sex talk had on perceptions of how important the respondents felt this talk was \( r = .02, p = ns \), whether the talk changed the way they viewed or thought about their relationship \( r = -.11, p = ns \), and whether the talk strengthened \( r = .06, p = ns \), or damaged the relationship \( r = -.06, p = ns \).

*Behavioral Outcomes of Safer-Sex Talk*

With regards to behavioral outcomes, two questions were posed. The first one concerned the overall behavioral outcomes reported by young adults (RQ11a) and the second one examined the relationship between the behavioral (health protective) outcomes reported by those young adults who report engaging in their first talk about safer sex before their first sexual interaction and those young adults who report engaging in their first talk after their first sexual interaction (RQ11b). To reiterate, behavioral outcomes were conceptualized as the health protective behaviors that young adults
practice as a consequence of talking with their partners about safer-sex. Respondents reported using male condoms most often, followed by getting tested for STIS, abstaining from sex, sharing STI/HIV test results and using female condoms (RQ11a) (See table 4.12 for frequencies).

RQ11b proposed examining the relationship between the timing of safer-sex talk or when safer-sex talk occurs and the reported health protective or behavioral outcomes of such talk. For the purpose of this analysis, two categories were created, “Before” and “After” the first sexual interaction. The before category was created by adding “A while (several hours/days/weeks) before first sexual interaction” and “Immediately prior to the first sexual interaction.” The after category was created by adding “A while (several hours/days/weeks) after first sexual interaction” and “Immediately after the first sexual interaction.”

<table>
<thead>
<tr>
<th>Behavioral outcomes</th>
<th>Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used male condoms</td>
<td>224</td>
</tr>
<tr>
<td>Got tested for STIs</td>
<td>48</td>
</tr>
<tr>
<td>Abstained from sex</td>
<td>37</td>
</tr>
<tr>
<td>Shared STI test results</td>
<td>27</td>
</tr>
<tr>
<td>Used female condoms</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note: Respondents could choose more than one option*

Table 4.12: Frequencies of Behavioral Outcomes for Safer Sex Talk
The most commonly reported protective behavioral outcomes of talking about safer-sex *before* first time sexual interaction were the use of male condoms, getting tested for STIs, abstaining from sex, sharing STI test result and using female condoms. The commonly reported protective behavioral outcome of talking about safer-sex *after* first time sexual interaction were using male condoms, getting tested for STIs, sharing STI test results, abstaining from sex and using female condoms. Using male condoms seems to be the favored health protective outcome for respondents both when respondents had talked about safer-sex *before* first sexual interaction as well as *after* first sexual interaction (see table 4.13 for frequencies).

<table>
<thead>
<tr>
<th>Frequencies of behavioral outcomes</th>
<th>Timing of safer-sex talk</th>
<th>Used male condoms</th>
<th>Used female Condoms</th>
<th>Abstained From sex</th>
<th>Got tested For STIs</th>
<th>Shared STI test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before first sexual interaction</td>
<td>155</td>
<td>3</td>
<td>22</td>
<td>28</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>After first sexual interaction</td>
<td>59</td>
<td>2</td>
<td>6</td>
<td>17</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Respondents reportedly chose more than one option*

Table 4.13: Frequencies of Behavioral Outcomes for Safer-Sex talk Occurring Before and After First Sexual Interaction
Reasons for Not Talking About Safer-Sex

The final goal of the study was to find out why young adults do not talk about safer-sex. All the respondents had an opportunity to answer this question. Specifically, the question was: “There might have been times when you wanted to find out about your partner’s sexual history and you did not ask. To what extent does each of the statements characterize the reasons you did not find out your partner’s sexual history.” Thus respondents could keep anyone in mind and answer the questions. The underlying goal was to unravel the reasons why young adults do not (have not) ask their partner(s) about sexual histories. The following three research questions were posed: (RQ12) which reason do young adults consider the most important when deciding not to talk about sexual histories; (RQ13) do young men and women differ in their reasons for not talking about sexual histories; and (RQ14) Is there a difference between talkers and non-talkers with regards to the reasons why they might not have talked with their partner about safer-sex? As a reminder, three sets of reasons were identified. The first one titled “protection” is concerned with protecting one’s identity and relationship. The second reason titled “promiscuity” relates to issues of mistrust and being judged promiscuous. The third reason titled “oblivious” pertains to the subjective assessments that young adults make about “just knowing” that a partner is “clean.” The findings to each research question are presented next.
To examine which reason is considered by young adults to be the most important when deciding not to talk about safer-sex (RQ12), a within-subjects repeated measure MANOVA was run on the entire sample (N = 396). Tests of within-subjects contrasts were examined to glean if there are differences among the three reasons. It must be noted that the analyses were run both without and without square root transformations. The estimated marginal means ranked in the same fashion whether the analyses were run with or without transformations. The estimated marginal means and profile indicated that the reason Oblivious had the highest mean, followed by the reason Promiscuous and finally Protection. Because it is usually difficult to interpret transformed variables, the non-transformed estimate marginal means and profile plots are reported here. However, there was a difference in the within-subjects contrasts such that without the transformation both contrasts were significant, that is between Oblivious versus Protection and Protection versus Promiscuity. When the variables were transformed, the difference between Oblivious versus Protection was not significant while the difference between Protection and Promiscuity was significant.

<table>
<thead>
<tr>
<th>Reasons</th>
<th>$M$</th>
<th>$SE$</th>
<th>99 % Confidence Interval Lower bound</th>
<th>Upper bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oblivious</td>
<td>5.167</td>
<td>.086</td>
<td>4.944</td>
<td>5.389</td>
</tr>
<tr>
<td>Promiscuous</td>
<td>2.746</td>
<td>.072</td>
<td>2.560</td>
<td>2.932</td>
</tr>
<tr>
<td>Protection</td>
<td>2.117</td>
<td>.066</td>
<td>1.947</td>
<td>2.287</td>
</tr>
</tbody>
</table>

Table 4.14: Estimated Marginal Means of Reasons for Not Talking about Safer Sex
The estimated marginal means and profile indicated that the reason *Oblivious* had the highest mean, followed by the reason *Promiscuous* and finally *Protection*. See table 4.14 for estimated marginal means.

To examine whether men and women differ in the reasons for not talking about safer-sex (RQ13), a 2 X 3 factorial design was used with gender as the between subject factor and protection, promiscuous and oblivious as the within subject factors. Prior to running the General Linear Model, the data were checked for violations of normality and assumptions of homogeneity. Shapiro Wilks tests were significant for all the \( z \) scores of both the males and females across all three dependent variables. Box-plots suggested the presence of an extreme outlier (i.e. \( |z| > 3 \) ), for the males and one for the females in the protection group, and one for females in the promiscuous group. Graphically, Q-Q plots suggested slight departure from normality for both males and females for Oblivious and Promiscuity and a moderate departure from normality for both males and females for Protection. Protection had more outliers than Promiscuity and Oblivious for both males and females. Through histograms slight positive skewness for Protection, moderate positive skewness for Promiscuity and moderate negative skewness for Oblivious were detected. Bivariate scatterplots also suggested departure from normality since the plots were not elliptical (Stevens, 2001). However, the assumption of multivariate homogeneity was met with Box’s M \( (F[6, 710780.3] = 1.478) = 8.947, p = .181 \) and Levene’s test suggested that there was equality of error variances between dependent variables.
Because of the presence of outliers and skewness, it was decided to once again use the square root transformations. Because *Oblivious* had negative skewness, the variable was reflected before the square root transformation. The transformed data were again tested for normality and homogeneity. The square root transformations resulted in the absence of extreme outliers although the tests of normality suggested violation of this assumption for both females and males in each of the three dependent variables. The assumption of multivariate homogeneity was met. It was decided to lower the alpha level to .01 and run the MANOVA.

To adjust for the unequal cell sizes (males, \( n = 154 \); females, \( n = 242 \)), the GLM was run by SSTYPE(1) method instead of the default METHOD=SSTYPE(3) in SPSS. This adjustment is appropriate for non-experimental research and when main effects have equal priority (Tabachnick & Fidell, 2001, p. 297).

Results indicated that there was no multivariate effect of gender, Hotelling’s Trace = .01, \( F(2, 393) = 2.11, p = .12, \eta^2 = .011 \), power = .21. In other words there is no difference between the average scores of males and females with regards to not talking about safer-sex whether it is for self and relationship protection, perceptions of promiscuity and having confidence that one knows one’s partners sexual history.

Finally, to examine any differences between talkers and non-talkers with regards to the reasons why they might not have talked with their partner about safer-sex (RQ14), a MANOVA was executed with talkers and non-talkers as the fixed factors and the three reasons as the dependent variables. Because the assumptions of multivariate homogeneity
was met with Box’s M \( F = [6, 380821.7] = .99 \) = 6.0, \( p = .43 \), and Levene’s test suggested there was equality of error variances between dependent variables, it was decided to run the analyses without transformations. Due to unequal cell sizes (talkers, \( n = 272 \); non-talkers, \( n = 124 \)), the GLM was run was run by SSTYPE(1) method instead of the default METHOD=SSTYPE(3) in SPSS. A significant multivariate main effect was found for the group safer-sex talkers, Wilks \( \lambda = .92 \), \( F(3, 392) = 10.19, \eta^2 = .07 \), power \( = .99 \). Oblivious and Protection had significant univariate effects for safer-sex talkers; \( F(1, 394) = 26.03, p = .001, \eta^2 = .06 \); and \( F(1, 394) = 11.9, p = .001, \eta^2 = .02 \), respectively. Safe-sex talkers’ reports of Oblivious reasons were higher than non-talkers \( [M(SD)_{Talkers} = 5.45 (1.63), M(SD)_{Non-talkers} = 4.53 (1.71)] \) and safer-sex talkers reports of Protection reasons were lower than non-talkers \( [M(SD)_{Talkers} = 1.96 (1.23), M(SD)_{Non-talkers} = 2.44 (1.39)] \). However, because there was a high correlation between all three reasons for not talking about safer-sex and self-efficacy, the MANOVA was run again with self-efficacy as a covariate. No significant multivariate effects were found for safer-sex talkers; Wilks \( \lambda = .98 \), \( F(3, 389) = 1.92, p = .12, \eta^2 = .01 \).
CHAPTER 5

DISCUSSION

The overarching purpose of this dissertation was to amass baseline knowledge about young adults safer-sex talk in dating relationships. Specifically, four goals were identified and pursued on the basis of relevant theoretical and empirical evidence. Firstly, script theory and compliance gaining literature were invoked to understand the process of safer-sex talk. That is, when safer-sex talk occurs, who initiates it, how do young adults talk about safer-sex, what topics emerge during this talk and how does one partner respond to another partner’s attempts to talk about safer-sex. Secondly, social cognitive theory and face management theory were employed to examine the roles of self-efficacy and face concerns during safer-sex talk. Thirdly, appraisal theory and empirical evidence from the Public health literature were used to investigate the emotional, relational and behavioral outcomes of safer-sex talk. Finally, existing scholarly evidence regarding relationship, face concerns and implicit personality theories was drawn upon to uncover the reasons why some young adults do not talk about safer-sex with their partners.
In this chapter, the findings pertaining to each of the aforementioned goals and the implications for theory and practice are enumerated. After discussing the implications, limitations of the study are mentioned. The chapter ends with suggestions for future research.

The first goal of this study was to assess the process of safer-sex talk and types of talk using script theory and compliance gaining literature. This study provides us with details regarding how many young adults talk about safer-sex, when they talk about, how they talk about it and the responses to efforts to talk about safer-sex. One of the major findings of this study is that that majority of the young adults in this sample have talked about safer-sex with their partners. However, the wording of the question “have you talked about safer-sex?” elicited different responses. When provided the definition as supported by the US General Surgeon, 70 out of the 405 respondents reported to not have talked about safer-sex. This number decreased to 15 when respondents were asked individually whether they had talked about condoms, birth control, sexual history (number of previous sexual partners), STI history, getting tested for STI and HIV/AIDS, drug use and homosexual experience. It is possible that the respondents assumed that talk about safer-sex included all the topics that were included in the definition. It is also possible that given that the literacy levels of some college age young adults in the US is equivalent to 10th graders (McGrew & Murray-Johnson, 2004), future research needs to use appropriate language to study this phenomenon in young adults. Hence, it seems that how the question is worded elicits starkly different responses.
Not only have most of the young adults in the study reportedly talked about some component of safer-sex, but they also have reportedly talked about it prior to first time sexual interaction. This finding is heartening given the US General Surgeon and health researchers emphasis on the timing of safer-sex talk. In terms of how long into the relationship safer-sex talk occurs, the finding of this study supports previous research in that within a month young adults make the contraceptive switch. Even though the average time of talk occurring in this study was four months, there were several young adults who have been in relationships from two to four years, and thus, the mode is a better indicator of the measure central tendency for this particular question. In fact, the mode was one month, meaning that majority of the young adults reported to have talked about safer-sex within a month of dating.

In addition to the timing of safer-sex talk, this study also found that 80% of the talk that occurred was initiated by either the respondent or their partner and in 12% of the times talk was mutual. This finding is important in the light of the absence of gender differences. Given that women are considered to be the gatekeepers of sexual activity, the finding that twice as many females than males initiated safer-sex talk is almost intuitive but not only was this difference not significant, but it also paralleled the number of females who reported talking about safer-sex. This finding perhaps points to a narrowing of gender differences among young adults on college campuses and changing cultural norms about sexual behavior among young adults. Therefore, the results of this study
reflect a change in cultural scripts to the extent that talking about safer-sex is occurring before sexual activity and after sexual activity and there are no gender differences in initiation of safer-sex talk.

Prior research has conceptualized safer-sex behavior, particularly condom use, as a persuasive endeavor in which a partner uses strategies that ensure condom use. While this body of research is rich and provides a solid foundation on persuasive appeals, researchers need to recognize that talking about safer-sex is not just an attempt in gaining compliance, but that this talk between partners is and can be collaborative. By collaborative, I mean the process best described as a discussion between partners in which options and likes and dislikes of using different methods of contraception are discussed. For example, as one respondent wrote:

Partner brought about the topic of birth control and if I was on any form of control that I preferred and how I felt about having sex in a relationship. Me: told him the type of birth control method I prefer and how I felt about having sex at this point in our relationship.

The collaborative process also includes sharing information about sexual histories and testing information. As another respondent wrote:

Before having sex for the first time, my partner and I discussed our previous sexual relationships as well as the possibility of either of us having STDs. We also discussed preventing pregnancy by using condoms and birth control.

Finally, the responses of young adults indicated decision making about not having sex (yet being prepared for it) until a further point in time or relationship:
Before we started having sex we discussed the need to buy condoms so that when we were ready there would be nothing holding us back. Me: do you think that it would be a good idea to buy condoms incase we start having sex sometime soon? Him: Are you sure you are ready to take a big step like that? Me: just because we are buying condoms doesn’t mean we have to have sex. Him: Ok well I will go to CVS tomorrow.

The above responses illustrate that talking about safer-sex needs to be conceptualized as a distinct talk practice that occurs at varying times with regards to sexual activity and relationship length. One of the limitations of this study is that the length of relationship was not measured; however the study was still able to glean how long into the relationship talk occurred. Thus far, sexual compliance gaining literature has not taken into account the dynamic nature of talk practices. Partners may use different compliance gaining techniques at different times of a relationship. Even though the typologies from extant sexual compliance gaining literature were used to assess types of talk, this typology was extended to suit analysis of safer-sex talk rather than just examining strategies of talk geared towards condom use compliance. Overall it would be appropriate to suggest a reconceptualization of safer-sex talk.

Additionally, most scholars have relied on hypothetical scenarios to generate strategies that young adults are most likely to employ when they want condoms to be used in their sexual interactions. This method of enquiry often generates a one-sided response (i.e. what one partner said or did to ensure that condoms were used) giving the
impression that talk about safer-sex is a persuasive attempt. However, in this study young adults were asked to construct the first talk related to safer-sex that they had with their current or most recent partner. This provided them with an opportunity to report the responses of their partners from which this study suggests that most of these talks were collaborative supporting similar findings by DeBro et al. (1994).

By examining self reports of young adults safer-sex talk, these results also shed light on the types of talk or how young adults talk about safer-sex. Adelman (1991) had suggested that talk about sex is often coded, yet the results of this study suggest to the contrary as *directly or indirectly asking questions* about testing information, sexual histories and birth control was the most frequently reported type of talk. Adding another layer to this surprise finding is that the next most frequently found type of talk was *disclosing information*, or the voluntary sharing of information about one’s sexual history, condom use, STI testing and use of birth control pills, given that Nichols (2005) found that privacy is one of the reasons why young adults do not want to share their sexual histories with partners.

This study also addressed a gap in the literature pertaining to the responses of the partners (Reel & Thompson, 2004). One hundred fourteen partners responded in agreement versus nine instances of disagreement or non-compliance. Agreement was captured as having many forms. For example, sometimes the reported talk was brief such as: “Me: Let’s always use a condom when having sex although I’m on birth control. Him: Okay sounds good.” Other times respondents reported pair part sequences:
Partner 1: Are you on birth control? Partner 2: No that is why we need to use a condom. Partner 1: Ok as long as you are not on the pill we need to use protection. Partner 2: Agreed.

The study also provided information with regards to the topics that came up during safer-sex talk. Young adults indicated that they talked about topics such as STI testing, test results, anal sex and the number of previous partners. This points to an increase in the repertoire of topics that constitute sexual practices from the early studies that found talk limited to topics of condom use and birth control. Despite this increase in the number of topics that are being discussed, two topics that did not come up in the open-ended response were drug use and homosexual experiences. In fact the few allusions to drugs were in the context of “dope” or marijuana. And the few references that were made to homosexual experiences were made by males to their female partners. The females interpreted these remarks as being asked as sexually arousing questions. None of the females reported to have asked their male partners about homosexual experiences. There is an assumption that young adults ‘know’ that their partners are heterosexuals who have never had homosexual experiences. Thus public health officials and communication scholars need to design messages to encourage young adults to talk about these experiences as a component of safer-sex talk.

This study also brought attention to the variation in the timing of when safer-sex talk occurs. Young adults in this sample reportedly not only talked about how to practice safer-sex when sex was imminent but also when sex was not imminent. Even though
many young adults reportedly talked about safer-sex before becoming sexually active, other young adults reported to have talked about safer-sex after first sexual interaction as well as after multiple sexual interactions. Some young adults reported to have talked about safer-sex with a partner even when they were not sexually active but the possibility of doing so existed in the near future. As one respondent reported “If we ever get to the point where we were comfortable having sex, some type of contraceptive, like birth control or a condom would need to be used.”

The second goal of this dissertation was to examine the role of face concerns and self-efficacy in the process of safer-sex talk. To be precise, on the basis of face management theory (Metts & Cupach, 1994) two hypotheses and a research questions were posed concerning face concerns and safer-sex talk. It was hypothesized that talking about safer-sex is more face threatening after than before first sexual interaction, and that it will be less face threatening for non-initiators and mutual talkers than initiators. The following research question was also proposed: are there differences in the face threat experienced by females and males with respect to talking with partners about safer-sex. Contrary to the hypotheses, young adults in this sample did not perceive talk about safer-sex to be more face threatening after than before sexual interaction. Similarly, there were no differences in the face threat when talk was initiated by respondents, or when the partner initiated or when talk was mutual. The means across the three groups were overall low suggesting that this talk was not perceived to be face-threatening; thus, the results did not support face management theory. Similarly, no differences were found in the face threat experienced by males and females.
However in a post-hoc analysis, when face threat was examined in the context of exclusivity, those in exclusive relationships perceived face threat to be less than those who reported being in non-exclusive relationships. This finding points out those young adults in one-night stands or who those who are dating more than one individual do perceive it to be face-threatening to talk about safer-sex. While most of the past research and scholarly thinking views having safer-sex discussions to be harmful for the health of a relationship (Buysse & Ickes, 1999; Mays & Cochran, 1993; Metts & Fitzpatrick, 1992), the findings of this study suggest to the contrary. Researchers have noted that it is imperative to examine safer-sex behaviors in the context of relationships (Ingham & Van Zessen, 1995; Miller, Bettencourt, DeBro & Hoffman, 1993; Noar et al., 2006). This finding reiterates the importance of relational contexts. In fact, there were no sex differences with regards to face threat in this sample. It is possible to infer that within young adults in college campuses, sex differences are not that pronounced but it is the exclusivity of the relationship that makes it acceptable to talk about safer-sex. Therefore it is recommended that exclusivity be considered when face management theory is used in future research with regards to safer-sex talk.

The findings also suggest that self-efficacy plays an important role in safer-sex talk as those individuals who reported to have talked with their partners about safer-sex also had higher self-efficacy than those who did not talk with their partners about safer-sex. Bandura (1977) explains that individuals not only model their behaviors by observing others but also by their experiences. The consequences of a certain action
would encourage, deter or result in behavior modification. When applied to safer-sex talk, we still do not know how individuals learn how to talk about safer-sex with partners. Therefore, it is pertinent to enquire if young adults in this study who had talked with their partners had talked with a previous partner in an earlier relationship. In fact self-efficacy trumped gender in terms of influencing talking about safer-sex as there was no difference between females and males with regards to talking about safer-sex with partners. On a theoretical level, it will behoove us to include self-efficacy in our future analyses of safer-sex talk. Future studies should also investigate the confluence of self-efficacy, sexual experience and relational characteristics such as exclusivity as predictors of safer-sex talk.

The third goal of this dissertation was to uncover behavioral, relational and emotional outcomes of safer-sex talk. The implication of the findings related to each outcome is enumerated in the above mentioned order. A common refrain in the safer-sex literature has been that talk about safer-sex is not important in itself unless it results in condom use or some equivalent health protective outcome (Cline et al., 1990; Edgar et al.; Noar et al.). Of the 280 young adults who reported on their first safer-sex talk, 224 or 80% used male condoms. Young adults also reported to have got tested for STIs, shared STI test results, abstained from sex, and five reported to have used female condoms. These findings suggest the importance of safer-sex talk in the sexual practices of young adults on college campuses.
That the female condom was used only in five instances suggests that it is still not considered a viable prophylactic by young adults. Even though women are considered to be the gatekeepers of sexual activity the act of using a male condom is a distinctly male prerogative. Given that the sexual norms concerning sexual activity are tenuous, the use of female condoms should be encouraged to create a more level field when it comes to making decisions about using condoms.

In addition to gaining a general idea of the behavioral outcomes of safer-sex talk, the relationship between the timing of safer-sex talk (i.e. after or before first sexual interaction) and the behavioral outcomes were examined. In both contexts, in descending order, respondents reportedly used male condoms, got tested for STIs, abstained from sex, shared STI test results and used female condoms. These results support the US General Surgeon’s (1996) advice to get to know one’s partner before getting sexually active due to the health benefits of talking about safer-sex.

Besides these behavioral outcomes, this study also sheds some light on how safer-sex talk impacts relationships. In particular, there were three aspects of relational outcomes that were of interest: (1) which among the four identified relational outcomes were most experienced by the respondents; (2) did the relational outcomes of talking about safer-sex differ when young adults talked before or after first sexual interaction; and (3) did the relational outcomes of safer-sex talk vary when the respondent initiated the talk, when the partners initiated the talk and when talk was mutual. The implication of each of the main findings is discussed next.
Firstly, results suggested that young adults perceived that talking about safer-sex strengthened their relationship rather than damaged the relationship. This finding is contrary to the existing evidence that talking about sex is taboo (Baxter & Wilmot, 1984) because of the potential harm such talk can cause a new and an established relationship. Secondly, there were no differences in the perceived relational outcomes on the basis of whether safer-sex talk occurred before or after first sexual interaction. Lastly, no differences were found by the type of initiator (that is, self, partner and mutual). These findings have practical implications for young adults in new relationships, who are not yet sexually active as well as for those who are in existing relationships and are sexually active. Both groups of young adults should be encouraged to talk about safer-sex with their partners given the behavioral and relational benefits.

The emotional outcomes of safer-sex talk signify the complexity of measuring emotions experienced by young adults during safer-sex talk. That is because, of the ten emotions that were measured, happiness had the highest mean (5.8) on a scale of 1 to 7. Sadness had the next highest mean (3.2) followed by contempt (2.3) and shame (2.1). The remaining emotions – surprise, fear, guilt, anger, jealousy and disgust – all had means less than 2. Although the discrete approach employed in this study enabled us to learn that a particular emotion such as happiness occurred during safer-sex talk, future research should also discern the valence, activity, and intensity of the emotional experience (Guerrero, Anderson & Trost, 1998) by using the prototype (e.g., Shaver et al., 1987) or
dimensional approaches (e.g. Plutchik, 1984), which recognize that emotions are multifaceted constructs that have predictive properties (Plutchik, 1984). Overall appraisal theory is a useful framework for understanding safer-sex talk.

The fourth and final goal of this dissertation was to learn why some young adults do not talk about safer-sex. Within this goal there were specifically three questions: (1) Which reasons do young adults consider the most important when deciding not to talk about safer-sex; (2) do talkers and non-talkers differ in their reasons for not talking about safer-sex; and, (3) do men and women differ in the reasons for not talking about safer sex. Among the three broad reasons for not talking about safer-sex, oblivious was the main reason for not talking about safer-sex (mean, 5.1) followed by concerns of seeming promiscuous (2.7) and then self and relationship protection (2.1). These results support previous findings that young adults make subjective assessments to assess risks (“I just knew my partner’s history” or “I just knew that my partner was safe”). Also these results support the findings of qualitative research that has suggested that issues of trust and promiscuity play a role in safer-sex talk although these issues as well as self and relationship protection had overall low means.

However, this picture changed when “talkers” (those who reported on the first safer-sex talk) and “non-talkers” (those who did not report their first safer-sex talk) were compared with regards to the three reasons for not talking about safer-sex with their partner. Talkers reported to claim to “know their partners history” more than non-talkers whereas non-talkers did not talk out of a need to protect their sense of self and relationship more than talkers.

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Finally, non-talkers also indicated more than talkers that reasons of mistrust and promiscuity prevented them from talking about safer-sex with their partners. However, when self-efficacy was used as a covariate in the MANOVA, there were no significant multivariate effects for talkers. These findings suggest that the construct of self-efficacy is crucial to safer-sex talk. It is plausible suggest that young adults with higher perceived self-efficacy to talk about safer sex as compared to those with lower self-efficacy are better able to manage relational, identity and face goals when talking about safer-sex. Thus, the relationship between self-efficacy and implicit personality theories need to be examined in future research concerned with safer-sex talk.

While this study provides insights into the first talk between young adults in dating relationships, it has limitations that need to be addressed. One of the limitations of this study is that it relied on self-reports although one would be remiss to not acknowledge the non-intrusive method of collecting sensitive data. Additionally, non-talkers or those who reported a “No” early on in the survey to the global question of have you talked about safer-sex were not directed to any of the questions related to the first talk about safer-sex they might have had with their partners and the behavioral, relational and emotional outcomes of that talk. Also, respondents were only asked to report on the very first talk they had with their partners about safer-sex. Some of the respondents in this study reported to have talked about condoms and birth control more than once. One respondent could not remember what was said the first time he talked about safer-sex
with his partner although he reported that his partner and he had talked about birth control (using the pill) the previous day. It is possible that as partners in relationships negotiate their relationships, they might also have to negotiate safer-sex. Thus, future research should try to capture the changes in the topics of talk as well as the outcomes of subsequent talk. Future research should also examine safer-sex talk in the context of non-exclusive relationships where face concerns and issues related to embarrassment seem to be more salient.

Examining safer-sex talk outside the young adult population would be valuable especially because gender roles are more equitable among young adults than older population groups, which could influence the scripts that guide social behavior. Future research would also benefit by investigating relationship characteristics such as length of relationship, trust, and intimacy in addition to individual level variables such as self-efficacy as predictors of safer-sex talk. Finally dyadic analyses as well as multilevel modeling procedures may be more sophisticated ways of analyzing the relationship among the relational and well as the individual level variables given the interdependence of data derived from college samples.

Conclusion

The findings of this study indicate that as scholars studying safer-sex talk behaviors of young adults we need to have consistent conceptual and operational definitions in order to better grasp the safer-sex talk practices of young adults. The findings are consistent with Reel and Thompson (2004) who asserted that most verbal
strategies should be encouraged because they accomplish multiple goals (that is, identity, relational and facework).

The continued use of Script theory, appraisal theory, and face management theory is encouraged given the importance of changing cultural scripts, and the presence of minimal negative emotions and positive face concerns during safer-sex talk. Young adults should be encouraged to talk about safer-sex, collaboratively or as having a dialogue, as they need not fear for potential relational consequences especially in exclusive relationships. Finally, instead of viewing safer-sex talk as a compliance gaining endeavor, it would be more appropriate to view and encourage safer-sex talk as a collaborative effort that can lead to health protective as well as positive emotional and relational outcomes.
REFERENCES


GENERAL INSTRUCTIONS

This survey asks you a series of questions about safer-sex talk that your partner and you may have had. By partner we mean someone you are dating, or are in a serious relationship with, or someone you had sex with once. The survey asks you to recount how it happened, what was said, and the reactions associated with the event. If you are not currently in a romantic relationship, please refer to your last relationship while answering the questions.

This conversation/talk might simply be a statement by you or your partner for example, about using a condom, or it might be a lengthy discussion.

If your partner and you have not talked about safer-sex, you can STILL TAKE other parts of the survey that will ask you questions about your relationship.

You must be at least 18 years old to participate.

Many of the questions on this survey are answered using rating scales provided to you. For these questions, you simply click on the answer choices that best reflect your feelings. In some places, questions are open-ended; for these, we ask that you type in your responses.

There is no right or wrong answer on this survey. We are simply interested in your feelings about your relationship.

You may skip any question asked on this survey and exit the survey at any time.

Your OSU ID and course information will be collected only as a means to give you extra credit in your course for completing this survey. That information is in a separate file and will be given to your instructor for extra credit purposes only. After sending the information to your instructor, the file will be destroyed. Your information will not be linked to your response in any way. Thus, the information you provide in this survey is confidential.

This survey should take you about 30 minutes to complete. If you have any questions about the survey please contact Dr. Laura Stafford at stafford.3@osu.edu or Karishma Chatterjee at chatterjee.23@osu.edu
Instructions: We are interested in conversations that college students have with their partners about safer-sex behaviors. For the purpose of this study sexual behavior includes vaginal, oral and anal intercourse. Sexual intercourse does not include holding hands and kissing. Even though the Center for Disease Control and Prevention (CDC) recommends that people should have safer-sex talk with potential sexual partners we recognize that this is difficult for many people to do.

Safer sex talk is defined as having explicit discussions around condom use, sexual histories, sexually transmitted infections, past sexual activities (oral/anal/vaginal sex), drug use and pregnancy. Some people have these talks before having sex with their partners and some people have these talks after having sex with their partners. We ask for your help to understand “why” some people talk about safer-sex with their partners and why sometimes they don’t.

A “partner” could be someone you are currently dating, or are in a serious relationship with, or someone you had sex with once. This also includes someone you are dating but with whom you have not engaged in sexual activity.

In other words, please keep the person who you indicated in the first question, in mind, when answering the rest of the questions in this survey.

Have you talked about safer-sex with your partner? Please check the appropriate option.

Yes
No

Q1. Please describe the FIRST conversation you had with your partner about safer sex. A “partner” could be someone you are currently dating, or are in a serious relationship with, or someone you had sex with once. This also includes someone you are dating but have not engaged in sexual activity with.

Q1a. Please indicate –as closely as possible – what each of you said. Please try and do this in the form of a dialogue/script, indicating who said what.

Q1b. Who initiated the conversation/talk about safer sex you just described, you or your partner?
Q1c. Please indicate when the talk you just described about safer-sex occurred. You may check as many options as appropriate.

A while (several hours/days/weeks) before our first sexual interaction
Immediately prior to our first sexual interaction
A while (several hours/days/weeks) after our first sexual interaction
Immediately after our first sexual interaction
Other (please specify)

Q1d. Could you please indicate how long into your relationship did your partner and you have this talk about safer-sex?

Instructions: Please tell us how you felt about your partner’s actions during the conversation about safer-sex that you just described.

My Partner's actions:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>were polite</td>
<td></td>
</tr>
<tr>
<td>were rude</td>
<td></td>
</tr>
<tr>
<td>were insensitive</td>
<td></td>
</tr>
<tr>
<td>showed disrespect towards me</td>
<td></td>
</tr>
<tr>
<td>were justified</td>
<td></td>
</tr>
<tr>
<td>were hostile</td>
<td></td>
</tr>
<tr>
<td>strengthened the relationship between us</td>
<td></td>
</tr>
<tr>
<td>showed contempt towards me</td>
<td></td>
</tr>
<tr>
<td>damaged the relationship between us</td>
<td></td>
</tr>
<tr>
<td>were tactful</td>
<td></td>
</tr>
<tr>
<td>constrained my choices</td>
<td></td>
</tr>
<tr>
<td>took away some of my independence</td>
<td></td>
</tr>
<tr>
<td>invaded my privacy</td>
<td></td>
</tr>
</tbody>
</table>
Instructions: Please think about how you felt after you talked about safer-sex with your partner (please keep in mind that is the conversation you just described). Rate the extent to which you experienced each of the following emotions after talking about safer-sex with your partner:

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Not at all</th>
<th>Very strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surprise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disgust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jealousy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Next, please indicate how much you agree with each of the statement regarding the time you and your partner talked about safer-sex (again, please keep in mind the conversation you described at the beginning of the survey).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>This talk was an important event within my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This talk made me think about my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This talk was a minor event within my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This talk was a major occurrence within my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This talk influenced the understanding of my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This talk changed the way I think about my relationship.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The definition of this relationship changed after this talk.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Instructions: After the time your partner and you talked about safer-sex, did you (your partner and you) do the following? Please check on the appropriate options. You may check more than one option. For this question also, please refer to the conversation you described at the beginning of the survey.

Used male condoms
Used female condoms
Abstained from sex
Got tested for Sexually Transmitted Infection
Shared STI/HIV test results
Other (please specify)
Instructions: We would like to know if there have been times when you wanted to talk about safer sex with your partner and did not talk to them. Please indicate whether you agree with the following statements regarding talking about safer-sex with your partner.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be embarrassed to talk about it</td>
<td></td>
</tr>
<tr>
<td>I would feel vulnerable</td>
<td></td>
</tr>
<tr>
<td>My partner may judge me</td>
<td></td>
</tr>
<tr>
<td>Talking about safer-sex could lead to conflict between us</td>
<td></td>
</tr>
<tr>
<td>Talking about safer-sex might ruin our relationship</td>
<td></td>
</tr>
<tr>
<td>Talking about it might make my partner angry</td>
<td></td>
</tr>
<tr>
<td>I would be comfortable asking my partner if she/he has been tested for HIV</td>
<td></td>
</tr>
<tr>
<td>I would be uncomfortable asking my partner about past her/his sexual history</td>
<td></td>
</tr>
<tr>
<td>I would be comfortable asking my partner to use condoms</td>
<td></td>
</tr>
<tr>
<td>I just know my partner is safe</td>
<td></td>
</tr>
<tr>
<td>I know my partner’s sexual history</td>
<td></td>
</tr>
<tr>
<td>My partner may perceive that I think her/him to be promiscuous</td>
<td></td>
</tr>
<tr>
<td>My partner may perceive me as being promiscuous</td>
<td></td>
</tr>
<tr>
<td>My partner may think that I do not trust her/him</td>
<td></td>
</tr>
<tr>
<td>My partner may think that I am not trustworthy</td>
<td></td>
</tr>
</tbody>
</table>
Instructions: Next, you will be asked questions regarding whether or not you have tried to find out information about specific topics from your partner.

If you are dating more than one person, please keep the person whom you feel closer to in mind while answering the questions.

If you are not dating and have had a recent hook-up please keep that person in mind when you answer the following questions.

If you are not currently dating but have dated in the past, keep in mind the most recent partner when you answer the following.

Once again, please keep the person/relationship that you indicated at the very beginning of the survey in mind when answering the remaining questions.

You may SKIP any question you don’t feel comfortable answering.

Please indicate if you have talked about using condoms with your partner. You may check more than one option.

- A while (hours/days/ or more) before our first sexual interaction
- Immediately prior to our first sexual interaction
- Immediately after our first sexual interaction
- A while (hours/days/ or more) after our first sexual interaction
- After multiple sexual interactions
- I have not talked about this
Please indicate if you have tried to find out about your partner's sexual history (number of previous partners). You may check more than one option.

A while (hours/days/ or more) before our first sexual interaction
Immediately prior to our first sexual interaction
Immediately after our first sexual interaction
A while (hours/days/ or more) after our first sexual interaction
After multiple sexual interactions
I have not talked about this

Please indicate if you have tried suggest or talk to your partner about getting tested for STIs/STDs and HIV/AIDS. You may check more than one option.

A while (hours/days/ or more) before our first sexual interaction
Immediately prior to our first sexual interaction
Immediately after our first sexual interaction
A while (hours/days/ or more) after our first sexual interaction
After multiple sexual interactions
I have not talked about this

Instructions: Please indicate whether you have tried to find out if your partner ever had an STI/STD. You may check more than one option.

A while (hours/days/ or more) before our first sexual interaction
Immediately prior to our first sexual interaction
Immediately after our first sexual interaction
A while (hours/days/ or more) after our first sexual interaction
After multiple sexual interactions
I have not tried to find out/talk about this
Instructions: Please indicate whether you have tried to find out if your partner ever tried/used drugs. You may check more than one option.

- A while (hours/days/ or more) before our first sexual interaction
- Immediately prior to our first sexual interaction
- Immediately after our first sexual interaction
- A while (hours/days/ or more) after our first sexual interaction
- After multiple sexual interactions
- I have not tried to find out/talk about this

Instructions: If you are heterosexual, please indicate whether you tried to find out if your partner ever had a homosexual experience. You may check more than one option.

- A while (hours/days/ or more) before our first sexual interaction
- Immediately prior to first sexual interaction
- Immediately after the first sexual interaction
- A while (hours/days/ or more) after first sexual interaction
- After multiple sexual interactions
- I have not talked about this
- N/A

Instructions: Please indicate whether you have tried to suggest or talked to your partner about using birth control. You may check more than one option.

- A while (hours/days/ or more) before our first sexual interaction
- Immediately prior to our first sexual interaction
- Immediately after our first sexual interaction
- A while (hours/days/ or more) after our first sexual interaction
- After multiple sexual interactions
- I have not talked about this
Finally, please tell us a little about yourself.

Your gender ______

Your partner's gender____

Would you consider your relationship to be exclusive? __________

Your age________

Your ethnicity________

Your academic status____

If interested in further information about safer sex, please see the following:

The student wellness center at Ohio State University: http://swc.osu.edu/

Centers for Disease Control and Prevention at: http://www.cdc.gov/std/


The New Women’s College Hospital, Canada
http://www.womenshealthmatters.ca/centres/sex/infections/safer_sex.html

Thank you for participating in the survey!