

Always, Never, or Sometimes: Examining Variation in Condom-Use Decision Making Among Black Adolescent Mothers

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Accepted 6 May 2011

Abstract: Our purpose in this study was to describe Black adolescent mothers' decisions regarding condom use and non-use with their male sex partners, including their children's fathers. Research on partner type and condom use has been insufficiently focused on understanding the specific influence that the biological father of the baby has on condom use among adolescent mothers. We conducted five focus groups and three interviews with 31 predominantly African-American mothers. We found that their decisions to use condoms always, never, or sometimes were based on partner type and on emotional and relationship factors. The "baby daddy" was the only partner with whom they never used condoms. HIV/STI prevention interventions for adolescent mothers must address risk taking with their children's biological fathers. © 2011 Wiley Periodicals, Inc. *Res Nurs Health*

Keywords: partner type; condom use; sexual health; teen mothers; adolescent pregnancy

The vast majority of heterosexually transmitted human immunodeficiency virus (HIV) infections among US adolescents occur in females (Centers

for Disease Control and Prevention [CDC], 2004). Overall, the incidence of HIV and other sexually transmissible infections (STIs) among female

We would like to thank Dr. Ellen Volpe, Tamayia Bell Betts, Natalie Pierre, Natur Haile, and Patricia Coury-Doniger for their operational support of the study, including recruiting, interviewing, group facilitation, and providing space to conduct the research.

Contract grant sponsor: National Institute of Nursing Research award; Contract grant number: F31NR008964.

Contract grant sponsor: University of Rochester Susan B. Anthony Institute for Gender and Women's Studies.

Contract grant sponsor: Frederick Douglass Institute for African and African American Studies, University of Rochester.

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Published online in Wiley Online Library
(wileyonlinelibrary.com). DOI: 10.1002/nur.20445

adolescents remains higher among non-Hispanic Blacks than among other racial/ethnic groups (CDC, 2009a; Forhan et al., 2009). Sixty-nine percent of HIV diagnoses among females ages 15–19 were among Black females (CDC, 2009a). Black adolescent females are also overrepresented in non-HIV STI morbidity. The presence of an STI (e.g., gonorrhea, chlamydia) significantly increases an infected person's risk of acquiring HIV (Zetola, Berstein, Wong, Louie, & Klausner, 2009). Black females represent 73% of reported gonorrhea cases and 52% of chlamydia cases among females ages 15–19 (CDC, 2009b).

Despite the development and implementation of HIV/STI prevention interventions, condom use remains alarmingly low among African-American adolescent females (DiClemente et al., 2004). African-Americans and other Black adolescent mothers are even less likely to use condoms during sexual intercourse than their adolescent counterparts who are not mothers (Crosby, DiClemente, Wingood, Sionean, et al., 2002; Meade & Ickovics, 2005). This is not entirely surprising given that pregnant adolescents and adolescent mothers are more likely than non-pregnant adolescent females and adolescent females who are not mothers to have negative attitudes about methods to prevent pregnancy (Crosby, DiClemente, Wingood, Harrington, et al., 2002; Crosby, DiClemente, Wingood, Rose, & Lang, 2003; Crosby, DiClemente, Wingood, Sionean, et al., 2002). These data highlight the importance of conducting research aimed at understanding factors that influence HIV/STI sexual risk behaviors among adolescent mothers.

A number of factors have been found to be associated with condom-use behaviors among female adolescents, including relationship power (Seth, Raiford, Robinson, Wingood, & DiClemente, 2010; Tschann, Adler, Millstein, Gurvey, & Ellen, 2002), relationship trust (Brady, Tschann, Ellen, & Flores, 2009; Jones, 2004), relationship intimacy (Aalsma, Fortenberry, Sayegh, & Orr, 2006; Sayegh, Fortenberry, Anderson, & Orr, 2005), and condom-use communication self-efficacy (Bowleg, Valera, Teti, & Tschann, 2010; Halpern-Felsher, Kropp, Boyer, Tschann, & Ellen, 2004). Even with the large research literature on factors associated with condom use, little is known about the factors that may be distinctively associated with condom use among adolescent females who have borne children (Nelson & Morrison-Beedy, 2008). Much of what is known about these condom-use factors is derived from studies of adult females (Jones, 2004; Morrison-Beedy, Carey, & Lewis,

2002; Seth et al., 2010). Those studies that included samples of adolescent females were not specifically focused on Black adolescent mothers (Aalsma et al., 2006; Morrison-Beedy, Carey, Crean, & Jones, 2010).

Research findings suggest that adolescents differentiate types of sexual partners, such as main (steady) partner and casual partner (Macaluso, Demand, Artz, & Hook, 2000; Rosengard, Adler, Gurvey, & Ellen, 2005; Smith, 2003). These partner-specific distinctions are important because they are associated with differential levels of HIV sexual risk (Lansky, Thomas, & Earp, 1998; Rosengard et al., 2005). Most research on partner differentiation has been focused on main and casual partners. Findings from these studies indicate that female adolescents are more likely to use condoms during sex with casual partners and less likely to do so with main partners (Macaluso et al., 2000; Morrison-Beedy, Carey, & Lewis, 2002; Williams et al., 2001).

Researchers have identified that a mother may also regard the biological father of her child as a distinct type of sexual partner (Blythe, Fortenberry, Temkit, Tu, & Orr, 2006; Johnston-Briggs, Liu, Carter-Pokras, & Barnett, 2008; Singer et al., 2006). Adolescent mothers commonly use the term “baby daddy” to describe this partner (Nelson, Morrison-Beedy, Kearney, & Dozier, 2011; Singer et al., 2006). The identification of this partner type indicates that the range of potential sexual partners for adolescent mothers extends beyond the categories of main and casual partner. Accordingly, condom use among adolescent mothers might also be influenced by the paternal status of the male partner (Nelson & Morrison-Beedy, 2008). To our knowledge, there have not been studies conducted to explore how condom use among adolescent mothers is influenced by the “baby daddy.” In addition, we have found no studies focused on comparing adolescent mothers' condom-use decisions with their “baby daddy” and other sex partners. Therefore, our purposes in this study were to describe whether and how partner types (including their children's fathers) figured into Black adolescent mothers' rationale for using or not using condoms.

METHODS

Setting and Recruitment

The study took place in Rochester, New York, a moderate-size urban city in the western part of the

state. To be eligible for inclusion in the study, participants had to be female, be 15–19 years old, have given birth to a currently living child, and self-identify as Black. We defined Black as domestic or foreign-born descendants of Africans, as well as those not of African-lineage but who, through acculturation, identified as Black. Participants who met these initial criteria were excluded if they were unable to speak English, currently married to or living with a male sexual partner, or not sexually active with at least two male partners (including the biological fathers of their babies) within the past 6 months. Participants were recruited using referral and peer-driven techniques (Heckathorn, 1997). Each enrolled participant was provided with three referral coupons and was informed that she could use these coupons to recruit other young mothers to the study. The peer recruiter received a \$5 incentive for every referral made to the study that was accompanied by a coupon bearing the peer recruiter's unique alphanumeric identifier (up to a maximum of \$15 for three referrals).

At the time of the study, the first author had 5 years of experience working as a public health nurse in the community where the study took place. Largely because of their history of successful collaborative clinical and community development work with the first author, and their appreciation for the relevance of the research topic, community-based health, and human service agencies were keen to advertise the study to young Black mothers who visited their clinics and programs. We also hired as a peer research assistant an unmarried African-American adolescent mother who was referred to us by the manager of a local leadership development program for teens. In addition to recruiting, she also used her knowledge of the socio-cultural sensitivities of Black adolescent mothers to help inform aspects of the study. For example, she advised us that not only did we have to allow mothers to bring their children to the focus groups, which we had already planned to do, but we also needed to make it possible for the children to be in the room while the focus groups took place, which we had not planned to do. She understood that mothers would be reluctant to leave their children in the care of a stranger unless they could still see the children; this prompted us to set up a child care area in the same room as the focus groups.

All participants provided written informed consent or assent. Parental consent was waived for participants under age 18. An adult advocate, unaffiliated with the research study was available

by telephone to discuss the risks and benefits of the study with participants for whom parental consent was waived. Participants were provided with lunch or dinner and \$25 cash incentives for attending the focus groups and interviews. The University of Rochester Medical Center Institutional Review Board approved this study.

Sample

Based on our review of previous focus group research on sexual health topics with adolescent females (Morrison-Beedy, Carey, Côté-Arsenault, Seibold-Simpson, & Robinson, 2010) and the methodological literature (Côté-Arsenault & Morrison-Beedy, 2005), we estimated that we would need to conduct at least four groups to achieve data redundancy. Three focus groups were conducted. We then assessed the data collected to identify gaps and make adjustments to the focus group guide. The research team continued enrolling participants and conducted two additional focus groups and three individual interviews (one with two mothers) to reach data redundancy.

A total of 31 mothers participated in the study: 27 in the focus groups and four in interviews. Of the 31 participants, 28 identified themselves as African-American and three as Black and Latina. The mothers ranged in age from 15 to 19 years with an average age of 17.5 years (*SD* 1.4). All of the participants were single (not married), had at least one living child, and reported having had sex with two or more male partners within the previous 6 months, one of whom was the biological father of her child(ren). Group/interview-specific demographic information is shown in Table 1.

Data Collection

Data were collected using focus groups and interviews, lasting up to 2 hours each. All focus groups and interviews were conducted in a private conference room of a local public health clinic. Based on the scheduling preferences of adolescent mothers that we learned about from a pilot study conducted in the same community, we held groups and interviews either on Friday early evenings or mid-morning on Saturdays (Nelson & Morrison-Beedy, 2007). We also learned that Black adolescent mothers in this community did not have a preference for the race/ethnicity of group facilitators, but that they would be concerned that the facilitator was female, non-judgmental,

Table 1. Sample Characteristics and Distribution of Condom-Use Decision Categories

	Group 1	Group 2	Group 3	Interview 1	Interview 2	Interview 3	Group 4	Group 5
Size	n = 3	n = 4	n = 4	n = 1	n = 1	n = 2	n = 9	n = 7
Age of participants range (mean)	15–19 (17.3)	15–19 (18.0)	17–19 (17.5)	19	17	16–18 (17.0)	15–18 (17.0)	16–19 (18.1)
No. of sex partners in past 6 months range (mean)	2–3 (2.3)	2	2	2	2	2	2	2–4 (2.2)
Condom decisions								
Always use condoms			●	●	●	●		●
Never use condoms			●	●	●	●		●
Sometimes use condoms	●	●		●	●	●	●	●
Depends on love	●	●		●	●	●	●	●
Depends on trust	●	●		●	●	●	●	●
Depends on relationship seriousness				●		●	●	●

The circular dots indicate the sessions (column) from which codes were derived and used to arrive at the condom-use decision making category (row). Focus groups one, two, and four were not significant sources of data supporting mothers use of condoms always or never; thus, no dots for these groups are contained in the rows for always or never condom use. Focus group 3 was not a significant source of data supporting sometime condom use among mothers in the sample.

experienced in working with urban youth, and respectful of their culture—including not trying to mimic their vernacular (Nelson & Morrison-Beedy, 2007). A White female nurse practitioner with 10 years of clinical practice experience in the primary care of urban adolescents conducted the focus groups and interviews. The first author, an African-American male nurse practitioner, attended all the groups and assisted with logistics, note-taking of non-verbal group data, and co-facilitation as needed. The first author also attended the paired interview, but not the one-on-one interviews, so as not to overwhelm the interviewees. All groups and interviews were digitally audio-recorded. Each person could participate in only one focus group or one interview.

Focus Groups. Focus groups were chosen because of their demonstrated suitability in studies of sexual health (Farquhar & Das, 2001; Morrison-Beedy, Carey, Aronowitz, Mkandawire, & Dyne, 2002) and the preference that African-American adolescent girls in general, and African-American adolescent mothers in particular, have shown for discussing sex-related topics in groups as opposed to individually (Morrison-Beedy, Carey, Aronowitz, et al., 2002; Nelson & Morrison-Beedy, 2007). We also wanted to capitalize on the spontaneous conversational interaction that occurs in groups, whereby participants’ stories both converge—highlighting common elements of their social experiences related to the discussion topic—and collide, highlighting within-group differences that often necessitate clarifications in meaning (Clark, 2009). We developed a semi-structured discussion guide for conducting the focus groups (Krueger & Casey, 2000). Focus groups began with general introductory questions. Verbal prompts were used as necessary to help move the conversation along. Sample questions from the discussion guide are included in Table 2. The questions were designed to gain an understanding of the participants’ general reasoning for condom use while allowing some latitude for exploring personal stories by using specific prompts to elicit more detailed accounts.

Interviews. Data were also collected via interviews. These interviews initially were not intended but occurred because of low attendance at several of the planned focus groups. On two occasions only one mother appeared; we interviewed each of them individually. On one occasion, only two mothers appeared; we interviewed them together. Everyone we interviewed was asked the same questions as the focus group participants; however, the mothers in the interviews provided more intimate answers about their

Table 2. Excerpt of Semi-Structured Interview Guide

Topics and Primary Questions	Prompts
<p>Sexual partner type</p> <p>What are the different types of sexual partners that young mothers your age have?</p>	<p>Do you have different categories for your male sexual partners?</p> <p>How do you know which category a sexual partner should belong to?</p> <p>In what ways are these different sex partner categories different?</p> <p>In what ways are these different sex partner categories the same?</p>
<p>Relationships and sex</p> <p>What sorts of things about the relationships between young mothers and their sexual partners do you think is important for us to understand?</p>	<p>Do young mothers your age do different types of sexual activities (oral, anal, vaginal) depending on the type of partner?</p> <p>What are some examples of sexual acts that young mothers would do with some partners and not with other partners?</p> <p>What are some examples of sexual acts that young mothers would do with their baby daddies and not with other partners?</p> <p>What are the reasons that some young mothers do different things depending on who is the sexual partner?</p>
<p>Condom use</p> <p>Do young mothers' decisions about using condoms during sex depend on the type of partner?</p>	<p>Tell us about situations that you've been in, or that you know about, when your decision to use a condom depended on the type of partner it was?</p> <p>What other factors influence young mothers' decisions to use or not use condoms with male partners?</p> <p>What is different about your relationships with your babies' daddies that might lead you to make different decisions about using condoms with him than you would with someone who isn't your baby daddy?</p>

own experiences, whereas those in the focus groups talked more about the experiences of adolescent mothers in general, although there were some personal accounts shared in the groups as well (Michell, 2001).

Data Analysis

Research assistants transcribed all focus group and interview data verbatim. During transcription all identifying information was removed; speakers were noted in the transcript only as S1, S2, S3, and so on. Notes on group interaction and other non-verbal data were integrated into the transcripts contextually to situate the data (Halkier, 2010; Warr, 2005). For example, we noted in the transcripts how one participant rolled her eyes and responded in a sarcastic tone and that, consequently, the others laughed (at the

facilitators), in order to capture that the participant was annoyed when she made her particular statement and that the others were, on some level, in solidarity with her. Incorporating these types of interactions was important for being able to re-present the data (Vicsek, 2007). The first author reviewed all transcribed data from the paired interview and all focus groups to correct any errors or misrepresentations that may have been made during transcription. The interviewer, who conducted the two individual interviews, reviewed those transcripts for accuracy. After uploading data into ATLAS.ti version 5.0, they were subjected to qualitative content analysis (Hsieh & Shannon, 2005) and arranged in a data display table (Miles & Huberman, 1994).

We approached the analysis with the question, "What do they say are the factors influencing their condom use?" as our frame of reference. We read each transcript and used ATLAS.ti's open coding

function to bracket text that described factors that influenced condom use. Codes were arranged in the display table by either group or interview. We examined the text associated with each code, consolidating the codes that were similar, pruning those that were superfluous, and clustering codes that fit together. We reviewed the clusters, across groups and interviews, to determine how these data answered our research question. The research team met regularly for ongoing analysis. Preliminary results were also presented to a standing qualitative data analysis group of clinicians and researchers engaged in work with high-risk children and youth. Members of this group provided critical feedback on our work. After a series of refinements, we then presented our results to a reference group of nine adolescent mothers who generally agreed that these results captured their views of condom use as it related to partner-types. The reference group was recruited from the community and selected based on the same criteria for eligibility as the other adolescent mothers who participated in the study.

RESULTS

We found that the mothers' decisions to use condoms were either always, never, or sometimes based on various combinations of partner type, and emotional and relationship factors. Table 1 displays how these condom-use decisions were distributed across the focus groups and interviews.

When Condoms Were Always Used

The mothers described situations in which they always used condoms. They always insisted on using condoms with partner types referred to as "one-night stands" and "pop-offs" (or "jump-offs"). A "one-night stand" was a short-term encounter in which sex occurred and in which no pre-existing relationship existed or was expected. These partners typically were not well known to the mothers, as their first meeting was usually on the same night that the sexual encounter occurred. "Pop-off" referred to men that were known throughout the community as being willing and eager to have sex, and for being particularly skilled at sexual activities.

Condom use with "one-night stands" and "pops" was mandatory. The mothers were emphatic about this; for example, when the facilitator probed to identify if there might even be occasional instances that they would have sex

without a condom with a "pop-off" or "one-night stand," one mother shouted, "Heck, you use a condom with that pop [or] he ain't getting none" (Group 5). The mothers discussed condom use insistence with an emphasis and certainty that made it very clear that the practice was non-negotiable with these partners. Another example of this was reflected when one participant inquired of another (who was noticeably quiet up to this point) about whether she would have sex without a condom with a "one-night stand" or "pop-off." She emphatically interjected:

Definitely not! I'm not doing nothing without a condom [because] you know they have a sex partner on the other days of the week they not with you, or sometimes it might be a week before you see them. They gonna mess with somebody else (Group 3).

The mothers' decisions always to use condoms was primarily organized around partner type; however, the character of the relationships that the mothers had with these partners was a secondary determinant that helped to explain this categorical condom-use decision. Insistence on condom use with these partners was related to the inherent lack of trust and fidelity in the relationships with these males. They described their relationships with these partners as characterized by sex, not romance or emotional intimacy. Aside from sex, they had no interests in these men and thus no motivation to develop any substantial background knowledge about the men beyond their sexual skills. Consequently, they had no reason to reconsider their positions on condom use in their encounters with "pop-offs" and "one-night stands." An example of this sentiment is reflected in one of the individual interviews during which the mother disclosed that she had a sexual encounter with a "pop-off" in which she insisted on using a condom. When the interviewer tried to explore what the factors were that led her to use a condom with this partner, she replied simply, yet just as emphatically as the mothers in the group "because I didn't know him!" (Interview 1).

When Condoms Were Never Used

The mothers also described situations in which they never used, or even considered using, condoms with a male partner. The "baby daddy" was the only partner with whom the mothers reported any willingness categorically to forego condom use. When those in groups talked of condom non-use with the biological fathers of their children, they described normative, almost

taken-for-granted understandings of foregoing condom use with the fathers. For example, when the facilitator posed one question to a group about condom use with their children's fathers, one participant was surprised and slightly annoyed (as evidenced by her eye-rolling gesture and sarcastic tone) at being asked a question that to her had an easy and straightforward answer: "Your baby daddy?? That's obviously somebody you ain't using a condom with. . ." (Group 5). Undoubtedly, when the others in the group burst into laughter it was partially due to the humor and sarcasm in the one mother's response and partly because they too believed it was a silly question as not using condoms with your baby's daddy was "obvious."

In the interviews, the mothers disclosed that they would routinely forego condom use during sex with the biological fathers of their children. The responses from mothers in the interviews were just as reflective of surprise as were the responses from those in the focus groups. In the following quotation, the mother had made the categorical decision to forego condom use with her child's father. For her, it was so taken for granted; she had not even previously contemplated "why" she did not use condoms with him:

I never thought about it like that before. But, he is the father of my daughter, why would I make him use a condom? If I had to think about it like that. . . Um, my first daughter, um, it was kind of the same way. Like I wouldn't force him to [use a condom] 'cause that was the father of my child. I don't know. . . I just didn't feel like he had to (Interview 1).

The belief that not using condoms with the baby's father was "okay" because you already have children together was also expressed in focus groups. For example, during a group discussion of condom-use practices one mother observed: "With your 'baby daddy' you might feel like you can, um, do that [not use a condom] with him. That's how your baby got there anyways so most of the time, for me, it wasn't a problem" (Group 3).

When Condoms Were Sometimes Used

The mothers' described situations in which they sometimes used condoms. Their decisions to use or not use condoms were contingent upon emotional and relationship factors, but were influenced by partner type as well. The mothers' accounts of their condom-use practices were generally characterized by an "if. . . , then. . ." logic. For example, in one account of this

conditional nature of condom-use decisions, one mother spoke very plainly that her decision to use condoms was based on relational and emotional contingencies. She stated: "If it's somebody like that you got a relationship with, or some kind of feelings for, then you'll probably be more lenient to not use protection" (Group 4).

The main contingencies for condom use were love, trust, and the seriousness of the relationship. With the exception of "one-night stands" and "pops," these contingencies were applicable to any of the mothers' male partners, including the biological fathers of their children.

Sometime condom use depends on love. The mothers believed that love exerted a strong positive influence on decisions to forego condom use. Many of them were unable to describe or define "love" in any further detail beyond the word itself, although they clearly expressed that it was love and not other motivations that influenced their condom-use decisions. For example, when one mother was asked why she and her male sexual partner had sex without consistently using condoms she pointedly responded, "We doing it because we love and care about each other, not because [of] other reasons, and not because of lust" (Interview 2). They also described feeling obligated to have sex without using condoms as expressions of love or to maintain relational ties with their male partners. In one group, the mothers were discussing peers they knew who were not using condoms despite being knowledgeable about the health risks of these practices. When the facilitator asked the group members to share their thoughts on why those mothers did not use condoms, one responded that "they is doing this for love and they're like, you don't need a condom" (Group 1).

The mothers in the interviews also described feeling pressure to prove their love for male partners by engaging in sex without using condoms. One of them reflected on how she and her peers sometimes succumbed to pressures to forego condom use as follows

I've been pressured before, a lot of girls they do, when they feel pressure they just, they just go ahead [and skip condoms] because the guys in there are like "I love you" and "come on let's do it" and "you know we'll be together" (Interview 1).

When asked by the interviewer why she succumbed to pressure to forego condom use to prove she loved her partner, one of the mothers in the paired interview replied, "If you don't do it somebody else will. . ." (Interview 3); she went on

to add that in these pressured situations she sometimes thought to herself, “so, maybe I should do it, because that’s showing how much I care about him” (Interview 3).

Sometime condom use depends on trust. The influence of trust applied generally to the mothers’ various sexual partners with the exclusion of “pop-offs” and “one-night stands” for whom they expressed no trust at all. If they trusted their male sex partners, then they were more willing to have sex without condoms. An example of this reasoning was played out in the paired interview when one of the mothers respectfully rejected the other’s claim that condoms should always be used with all sex partners and offered instead that condom use should be contingent, at least in part, on trust. As she explained:

It really depends who you with. If you trust them, [then], you know what I’m saying. . . it’s cool. But either way you should wrap it up (use a condom) anyway because you don’t want to get yourself into a situation you can’t get out of (Interview 3).

This particular account highlights how even though the mothers expressed ambivalence regarding whether trust was a reliable factor on which to base decisions about condom use, they simultaneously held that trust was still an important factor in deciding whether to use condoms.

Being infected with an STI was a major threat to trust between the mothers and their male sexual partners. An STI diagnosis was usually sufficient to stimulate them more seriously to contemplate future condom use, and increase their frequency of condom use, at least temporarily. The impact that an STI diagnosis had on partner trust is reflected in one mother’s detail of how being infected increased her threshold for trust of male partners and for foregoing condom use:

I learned to use condoms; you know what I’m saying. You may think that you can trust somebody or whatever, and stuff like that. Like with my baby father. . . he slipped up and gave me something, you know what I’m saying. And so after that, I’m thinking if my baby father can do that, then the next dude can do it too. . . (Interview 3).

Those in the focus groups similarly framed the influence of trust in terms of their belief that their partners would not intentionally transmit sexual infections to them or that the partners would somehow take care to prevent the sexual transmission of an infection. For example, in explaining her rationale for not using condoms with one of her

male sexual partners, one mother said, “I trust him; I know he wouldn’t bring me nothing” (Group 2). In the same group, someone else described how she too trusted that her male partner would not sexually transmit an infection to her. Her low perceived risk for an STI only made it necessary for her to take precautions to prevent pregnancy, as evidenced by her statement that “like with my baby daddy I only use birth control because I trust him like that” (Group 2).

Sometime condom use depends on the seriousness of the relationship. Relationship seriousness was an important influence on the mothers’ decisions sometimes to forego condom use. Unlike all of the other previously discussed decision categories, the discussion of relationship seriousness as a factor in condom use did not originate in a focus group but emerged in a one-on-one interview (after three groups had already been conducted). In this interview, the mother expressed very clearly how beliefs that a relationship is increasing in seriousness was linked to increases in frequency of sex and decreases in condom use as follows: “A girl probably will have sex more and probably not use a condom at the point they feel like their relationship is progressing or [that] they’re at another stage, another level in their relationship” (Interview 1).

The mothers considered the male partners’ expressions of desires to impregnate them as markers of relationship seriousness. These expressions were regarded as major evidence that the males were serious about being committed to relationships with them and were usually sufficient to cajole them out of using condoms. For example, one mother described to the group how a male’s invitation for her to “have his child” signified, however inaccurately, that he wanted to be in a serious relationship and how this prospect influenced her decision to forego condom use. As she noted:

Some girls will need that. . . I used to fall into a lot of stuff like that. Boy will tell me they want to have a child of mine. I’m thinking they want to be with me, but I give it up to them [and then] they gone (Group 5).

Another important marker of relationship seriousness was “having history” with a male partner. Having history had a temporal component that involved an elapsed, usually extended period of time of familiarity or association that did not necessarily need to include time in a formal, committed relationship. When we tried to verify whether having history, or being together with someone for a long time, meant that

the relationship was serious one mother responded, “Yeah” (Group 5)! A participant with a concurring perspective stated, “If ya’ll been together for a year and some change, yeah; other than that, well...no” (Group 5). Still another added “Well if they’re with you so long that means they made some kind of commitment” (Group 5). There was no consistency among groups or interviews regarding the time frame that constituted “serious,” yet time itself was consistently regarded as a factor.

DISCUSSION

Our purpose was to describe Black adolescent mothers’ decisions regarding condom use with various partner types, including the biological fathers of their children. We found that mothers always used condoms during sex with “one-night stands” and “pop-offs,” which entailed relationships described as primarily sexual and lacking in trust or emotional intimacy. Mothers reported that they never used condoms during sex with males who were also the biological fathers of their children. The mothers’ sometime use of condoms depended upon a mix of factors related to partner type, and emotional and relationship considerations.

“One-night stands” and “pop-offs” were the only partner types identified in which mothers said that they would, in all circumstances, refuse to have sex without using a condom. This finding is consistent with reports in the literature that adolescent females use condoms more consistently with “one-night stands” (Ellen, Cahn, Eyre, & Boyer, 1996) and other partner types that are typically classified as casual (Morrison-Beedy, Carey, Lewis, et al., 2002; Seage et al., 2002). Our findings advance the adolescent HIV/STI prevention science by highlighting an interesting strength in adolescent females’ perceived self-efficacy for condom use with certain partner types. Most research on condom-use self-efficacy has involved a view of it as a function of behavioral skills acquisition for the negotiation and actual physical use of a male or female condom (Morrison-Beedy, Carey, & Aronowitz, 2003; Soler, Quadagno, & Sly, 2000). The results from our study suggest that there may be a considerable degree of situational variation in condom-use self-efficacy among Black adolescent females that is more related to sex partner classification than to the mastery of specific condom-use techniques or negotiation skills.

The mothers reported categorically forgoing condom use with sexual partners who were the biological fathers of their children. The “baby daddy” was the only partner type associated categorically with never using condoms. This phenomenon has received scant attention in the research literature. The few reports of partner type studies published on this topic only marginally reflect this phenomenon; in these studies, condom use was negatively associated with being in a sexual relationship with the father of the baby. In a recently published study of 107 African-American adolescent mothers, Johnston-Briggs et al. (2008) found that inconsistent condom use was associated with reports of being sexually active with the baby’s father ($p = .05$). Although the mothers in our study reported that they made categorical decisions to forego condom use with the fathers of their children, the underlying reasons for the decisions were not well articulated. This coincides with results from sociological studies in which researchers encountered difficulties eliciting clear and cogent narratives from individuals regarding the reasoning for their observed or reported behavior, even when it was behavior that presumably occurred regularly. For example, regarding participants in her study, Angus (2005, p.899) stated that:

People are often remarkably inarticulate when asked to explain or describe specific reasons for some everyday decisions or activities because the underlying logics are part of an assumptive order that facilitates rapid decision making.

More in-depth research is needed to determine if there are underlying assumptions that ground condom non-use behaviors that adolescent mothers’ may exhibit with the biological fathers of their children.

There are partner-related risks for Black adolescent mothers that exist at the intersection of sexuality and paternity. These risks highlight the need for more research into understanding how co-parent status influences adolescent mothers’ compartmentalization of sexual risk with the fathers of the children so that effective HIV/STI prevention interventions can be developed to address these distinct needs. The finding from our study regarding the categorical forgoing of condom use both challenges and advances the literature regarding the influence of trust on condom use by highlighting the limits of its impact with regard to sexual encounters with “baby daddy” sexual partners (Jones, 2004; Kershaw, Ethier, Niccolai, Lewis, & Ickovics,

2003; McNair & Prather, 2004; Williamson, Buston, & Sweeting, 2009). Decisions to forego condom use with “baby daddy” partners were sometimes moderated by trust; nonetheless, trust did not appear to override, or even mediate, the influence of this partner-type on adolescent mothers’ condom use. More research is needed aimed at understanding the unique influence of the father of the baby on sexual risk behaviors of Black adolescent mothers as well as whether and why factors that influence condom use with other partners do not hold true for this partner.

Love, trust, and relationship seriousness were distinct from each other, yet their influences on condom-use decisions were likely interactional. For example, young mothers could be in serious relationships with male partners, yet condom use could still have been moderated by the level of trust she had for the partner at the time of the sexual encounter. They could also be in relationships with male partners that they trusted but did not love, or that they loved but did not fully trust. We were unable to distill from these data exactly how the multitude of configurations of these factors specifically influenced condom use in our sample. The influence of relationship factors on condom use signifies a need for more research with adolescent mothers, that is, focused on factors influencing sexual risk at the relationship dyad level versus the individual level (Karney et al., 2010). Dyad-level HIV/STI prevention interventions with adult heterosexual (El-Bassel et al., 2003) and men who have sex with men (Wu, El-Bassel, McVinnay, Fontaine, & Hess, 2010) samples have been effective at reducing sexual risk behaviors by targeting the relationship as the site of intervention. HIV/STI prevention intervention research targeted to co-parent dyads (adolescent mothers and their children’s fathers) may offer promise in making gains similar to those seen in other target populations.

LIMITATIONS

We recruited a high-risk sample of adolescent females with a history of pregnancy and who reported having two or more sex partners in the past 6 months. Therefore, our findings may not have the same relevance for adolescent females with lower risk sexual behavior profiles. Additionally, although our findings represent adolescent mothers’ perspectives on their behaviors with their male sex partners, we did not have the perspectives of the male partners

themselves. Future research aimed at preventing the heterosexual transmission of HIV/STIs among adolescent parents must include male–female dyads as the focus of investigation better to understand how gendered perspectives intersect to influence sex and condom use.

CONCLUSION

Black adolescent mothers make distinctive kinds of condom-use decisions that may necessitate tailored risk-reduction intervention content and strategies. In order to provide effective interventions, such as individual or group-level counseling, healthcare providers also need to understand the factors that influence condom-use decision making among adolescent mothers. The results from our descriptive study could be used to develop a behavioral survey aimed at assessing condom-use variance among a larger and more ethnically diverse sample of adolescent mothers. The results of this study could also be used to help inform the development of HIV/STI prevention interventions for Black adolescent mothers that more fully take into account the influence of “baby daddy” partners on condom use. Future research with this population must be focused on examining the ways that sexuality and parenthood intersect to influence condom-use behaviors between adolescent mothers and the biological fathers of their children.

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