

Original article

Condom Use with “Casual” and “Main” Partners: What’s in a Name?

Celia M. Lescano, Ph.D.^{a,*}, Elizabeth A. Vazquez, Ph.D.^a, Larry K. Brown, M.D.^a,
Erika B. Litvin, B.A.^a, David Pugatch, M.D.^b, and Project SHIELD Study Group^c

^aBradley/Hasbro Children’s Research Center and Brown Medical School, Providence, Rhode Island

^bMiriam Hospital and Brown Medical School, Providence, Rhode Island

^cFor affiliations see Project SHIELD Group listing below

Manuscript received August 1, 2005; manuscript accepted January 16, 2006

Abstract

Objective: This study examined adolescents’ attitudes about and behaviors toward condom use with “casual” vs. “main” sexual partners.

Method: Participants were sexually active adolescents aged 15–21 years (n = 1316) recruited from primary care clinics and through outreach activities in three major cities in the United States. Assessment of condom use within the past 90 days, relevant attitudes, substance use, and demographic data were obtained via audio computer-assisted self-interview (ACASI).

Results: Participants were divided into two groups: the 65% who reported main partners *only* (MP group) and the 35% who had at least one casual partner (CP group). Adolescents in the MP group were more likely to be female, whereas males were significantly more likely to report casual partners. Race/ethnicity, age, education level, household income, and sexually transmitted infection (STI) history were unrelated to group status (i.e., sexual partner type). Greater substance use and riskier attitudes were reported by teens in the CP group. The number of unprotected sex acts in the past 90 days was substantial and equivalent between the main and casual partner groups (19.2 vs. 21.5, respectively). Regression analyses revealed that perceptions of main partner attitudes toward condom use and condom use expectations were significantly related to condom use with MPs, but that attitudes were not related to condom use with CPs.

Conclusions: Adolescents with either casual or main partners may be at continued risk for contracting human immunodeficiency virus (HIV) and STIs, given high rates of unprotected sex. Interventions that do not target attitudes and practices related to casual partners as compared with main partners may miss an opportunity to change risk behaviors. This study demonstrates the importance of understanding an adolescent’s perception of partner types in order to design effective interventions. © 2006 Society for Adolescent Medicine. All rights reserved.

Keywords: Adolescent; Attitude; Condom use; Casual partner; Main partner

*Address correspondence to: Dr. Celia Lescano, Bradley/Hasbro Children’s Research Center, 1 Hoppin Street, Suite 204, Providence, RI 02903.

E-mail address: clescano@lifespan.org

^c Project SHIELD Group Principal Investigators: Larry Brown, M.D., Rhode Island Hospital, Providence, Rhode Island; Ralph DiClemente, Ph.D., Emory University, Atlanta, Georgia; M. Isabel Fernandez, Ph.D., University of Miami, Miami, Florida; Timothy Flanigan, M.D., Miriam Hospital, Providence, Rhode Island; Deborah Haller, Ph.D., Virginia Commonwealth University, Richmond, Virginia; Lori Leonard, Sc.D., University of Texas, Houston Health Science Center, Houston, Texas; Lydia O’Donnell, Ed.D., Education Development Center, Inc., Newton, Massachusetts; William E. Schlenger, Ph.D., Research Triangle Institute, Research Triangle Park, North Carolina; Barbara J. Silver, Ph.D., Substance Abuse and Mental Health Ser-

vices Administration, Rockville, Maryland. Project SHIELD Group Site Investigators: Caryl Gay, Ph.D., University of Miami, Miami, Florida; Janet Knisely, Ph.D., Virginia Commonwealth University, Richmond, Virginia; Celia Lescano, Ph.D., Rhode Island Hospital, Providence, Rhode Island; Kevin Lourie, Ph.D., Rhode Island Hospital, Providence, Rhode Island; Louise Masse, Ph.D., University of Texas, Houston Health Science Center, Houston, Texas; Janet O’Connell, MPH, Miriam Hospital, Providence, Rhode Island; David Pugatch, M.D., Miriam Hospital, Providence, Rhode Island; Eve Rose, Ph.D., Emory University, Atlanta, Georgia; Ann Stueve, Ph.D., Columbia School of Public Health, New York, New York; Leah Varga, M.A., University of Miami, Miami, Florida; Sue Vargo, Ph.D., Education Development Center, Inc., Newton, Massachusetts; Gina Wingood, Sc.D., MPH-Emory University, Atlanta, Georgia.

Examination of factors that influence sexually transmitted infections (STI) and human immunodeficiency virus (HIV) risk among adolescents is a priority because of the prevalence of STIs and risk behavior [1]. Condom use, a primary method of sexual safety, has been associated with a variety of individual characteristics and condom-related attitudes, such as self-efficacy, personal beliefs, and perception of peer norms [2]. There are other motivations and attitudes that may shape condom use. For example, how adolescents define their partners (i.e., “main” vs. “casual”) may play a crucial role in determining their use of condoms [3–6].

Definitions of “main” and “casual” partners have varied. For example, Rosengard et al [6] defined “main” as “someone you have sex with and you consider to be the person you are serious about” and “casual” as “anyone you have sex with but you do not consider to be a main partner to you.” Another study asked participants to rate their partners along a continuum from “just met” to “spouse” [7]. These studies have shown that condoms are used significantly more often with “casual” partners than with “main” partners, regardless of how partner type is defined and how condom use is measured [4,7–9]. In one study, 48% of adolescents said they always used condoms with casual partners, but only 23% said they always used them with main partners [9]. This pattern is generally true among adults as well, although the attitudes that underlie it have not been systematically investigated [10]. There is no standard definition of partner type because there are many potentially important qualities and characteristics of partners such as the emotional connection, length of relationship, future plans, time spent with partner, and the perceived safety of the partner.

Several factors that influence condom use among adolescents based on partner type have been suggested. Adolescents may trust a “main” partner and, therefore, do not think they need to use condoms. In contrast, adolescents may perceive a greater health risk with casual partners than with main partners and use condoms for safety [5,8,9]. For example, Rosengard and colleagues [6] found that stronger intentions to use condoms with casual partners were associated with higher scores on a scale of personal health values. Finally, research has shown that positive attitudes about condoms (i.e., using condoms is “pleasant,” “healthy,” “comfortable,” etc.) predict their use regardless of partner type [9]. Taken together, research suggests that level of trust, perception of health risk, and general condom use attitudes may play a role in determining condom use with partners of different types. This study attempts to extend previous findings by looking at (1) attitudes specific to partner type and (2) focusing on a sexually active, at-risk sample.

Study hypotheses based on previous literature were: (1) Adolescents’ behaviors and attitudes toward condom use would be associated with partner type (i.e., more frequent

condom use with casual than main partners). (2) The perception of more favorable *main* partner attitudes toward condom use would be significantly, and uniquely, related to higher rates of condom use with *main* partners. (3) It was similarly predicted that perception of more favorable *casual* partner attitudes toward condom use would be uniquely related to higher rates of condom use with *casual* partners. (4) General condom attitudes not related to partner type (i.e., pleasure expectancies, peer norms) were predicted to be associated with condom use with both types of partners. (5) Perception of a partner’s HIV/STI risk was hypothesized to be most associated with condom use with casual partners.

Methods

Study sample and design

Adolescents were enrolled in a multi-site study of HIV-related behavior [11,12]. Adolescents (aged 15–21 years) were recruited from primary care clinics and through outreach activities (e.g., street outreach, posters, flyers, referral from friends) in three cities in the United States: Atlanta, Georgia; Providence, Rhode Island; and Miami, Florida. Inclusion criterion was sexual activity (vaginal or anal intercourse) within the past 90 days. Adolescents who were knowingly HIV positive, currently pregnant, attempting to become pregnant, or who had delivered a baby within the past 90 days were excluded from the project.

Eligible adolescents ($n = 1867$) were invited to participate in the study. Informed consent was obtained from adolescents aged 18 years or older. Assent and parental consent were obtained for adolescents aged 15–17 years. Per the consent and assent protocol, parents and adolescents were informed that adolescents’ responses to sexual behavior and drug use items would be kept confidential and, therefore, would not be available to the parents. The University or Hospital Institutional Review Boards at the respective institutions approved all study protocols. A total of 1412 adolescents enrolled in the study and completed assessments, yielding a participation rate of 76%. Of those enrolled, 1321 (94%) indicated that they had a sexual partner in the past 90 days at the time of the initial assessment. Five of these participants were males who reported having sex with males, and because this small number precluded analyses of their sexual behavior, these participants were dropped from the analyses. Therefore, the final sample includes only those who report heterosexual activity. Of the remaining 1316 participants, 563 (43%) were male and 753 (57%) were female. The average age of the sample was 18.21 years ($SD = 1.8$). Twenty-four percent were Hispanic. Racial composition was 49% Black or African-American, 23% White, 20% More than One Race, and 8% Other.

Data collection

The baseline interview was administered by audio computer-assisted self-interview (ACASI) in order to increase confidentiality, allow for complex skip patterns, and to decrease literacy burden. It was largely derived from measures used in Project LIGHT, a National Institute of Mental Health (NIMH)-funded multisite trial of HIV prevention for high-risk young adults. These measures demonstrated good internal reliability and sensitivity to intervention impact [13]. All measures of behavior were assessed using a 90-day recall period. Adolescents were compensated \$50 for their participation.

Demographic information included gender, age, race, ethnicity, education, income, current living situation (i.e., are you living with your sexual partner?), and self-reported history of STI in the past 90 days. Sexual intercourse was defined as: “when a man inserts his penis into a woman’s vagina” (vaginal sex) and “when a man puts his penis into a man’s or woman’s anus or butt” (anal sex). Sexual and drug use behaviors were assessed as follows: the number of intercourse acts (vaginal and anal) in the past 90 days and total number of times condoms were used during those intercourse acts (asked for each partner) were used to calculate a total number of Unprotected Sex Acts (USAs). Proportion of condom use was derived by dividing the number of times a condom was used during intercourse acts by the number of intercourse acts (vaginal and anal) in the past 90 days. In describing Partner Type, subjects were asked whether each partner was a “main partner—that is, someone with whom you had an ongoing relationship—like a spouse, lover, or boyfriend or girlfriend.” If the subject answered no, the partner was classified as a “casual” partner. Adolescents were asked how many days in the past 30 days they drank alcohol or used any form of marijuana. Thus, scale scores ranged from 0 to 60 (days used alcohol in past 30 + days used marijuana in past 30). Because of skewed distribution in number of days used, scores were converted to 0 = 0 days, 1 = 1–4 days, and 2 = 5 or more days for each of marijuana and alcohol use, yielding combined Alcohol and Marijuana Use Scale with a summed range of 0–4. Adolescents were also asked about Other Drug Use using four questions (0 = no, 1 = yes) related to lifetime use of (1) heroin or other narcotics, (2) cocaine or other stimulants, (3) inhalants, and (4) needles to inject drugs. A summed scale score, with a range of 0–4, was derived by adding responses to these items, with higher numbers indicating greater drug use.

The interview also included questions regarding attitudes and perceptions about condom use, which were used to create scales measuring social-cognitive variables. For all scales, a higher score indicates a greater level of risk. The Condom Expectancy Scale (alpha = .74) reflected pleasurable and unpleasurable expectations regarding condom use (e.g., “Sex with condoms doesn’t feel natural”). The Per-

ceived *Main Partner Reaction to Condom Use Scale* (alpha = .64) and the Perceived *Casual Partner Reaction to Condom Use Scale* (alpha = .68) included questions regarding perceptions of partner’s reactions to discussions of condom use as well as the actual use of condoms (e.g., “My main partner would get mad if I said we had to use a condom”; “A casual partner would prefer that we use condoms during sex”). The Condom Use Expectancy Scale, Perceived Main Partner Reaction to Condom Use Scale, and Perceived Casual Partner Reaction to Condom Use Scale were scored on a Likert Scale from 1 (Strongly Disagree) to 5 (Strongly Agree). The Peer Norms Scale (alpha = .71) included questions regarding perceptions of peer values about abstinence, sexual activity, and condom use (e.g., “How many of your friends think that it’s fine to have vaginal or anal sex without a condom?”). Responses on this scale ranged from 1 (None) to 5 (All). The Partner Risk Checklist was the summed frequency of perception of partners with different probable STI risks in the past 90 days (e.g., “Did you have vaginal or anal sex with someone you knew or suspected had HIV or AIDS?”). The range for this scale is 0–7.

Data analysis

Subjects were divided into two groups based on report of Partner Type in the past 90 days. Subjects in the Main Partner (MP) group indicated having one or more main partners and *no casual partners*, whereas subjects in the Casual Partner (CP) group indicated having *one or more casual partners* and may also have had main partner(s). Sexual behavior outcome analyses for the CP group were restricted to only behavior with a CP. Analyses were initially conducted with two other classification methods: (1) those with *only* main partners vs. those with *only* casual partners, and (2) restricting the sample to those who had both main and casual partners, behavior with main partners was compared to behavior with casual partners. The outcomes of these two analyses were not substantially different from that described below, so the details are omitted.

Univariate and bivariate analyses were conducted for categorical and continuous variables using chi-square analyses and *t*-tests. Multiple linear regressions were conducted to determine significant associations between predictor and outcome variables. In order to compare the association of attitudes with behavior with specific partners after accounting for other significant factors, predictor variables were entered in blocks, first demographic variables were entered, followed by substance use variables, and finally, measures assessing attitudes.

Results

Relationships among partner type and demographic variables are shown in Table 1. Of the 1316 participants, 35% reported CPs, with those in the CP group more likely to be male. Those in the MP group were more likely to be female.

Table 1
Demographic comparisons by sexual partner type

Variable	Main (n = 860)	Casual (n = 456)	χ^2	df	p
Gender					
Male	34%	61%	88.8	1	.000
Female	66%	39%			
Race/ethnicity					
Black	53%	47%	3.97	3	.264
Hispanic	23%	26%			
White	19%	22%			
Other	5%	6%			
Living with partner					
Yes	21%	10%	27.27	1	.000
No	79%	90%			
Education level					
< High school	50%	49%	.43	2	.807
High school or GED	27%	26%			
> High school	23%	25%			
Annual household income (\$)					
< 10,000	37%	31%	9.25	4	.055
10,000–19,999	18%	16%			
20,000–29,999	15%	16%			
30,000–49,999	14%	15%			
50,000 or more	16%	22%			
Diagnosed with an STI past 90 days					
No	93%	92%	1.01	1	.314
Yes	7%	8%			

STI = sexually transmitted infection.

As expected, the number of partners was greater in the CP group (3.24 vs. 1.34; $t [496] = 11.58, p = .000$). Additionally, 14.6% of teens reported that they had more than one MP. Significantly more adolescents in the MP group, as compared with the CP group, lived with a partner (21% vs. 10%). Age (MP = 18.23, CP = 18.19; $t [1299] = .34, p = .73$) was unrelated to group status (i.e., partner type) as was race/ethnicity, education level, household income, and STI history.

Condom behavior was examined with two variables:

proportion of condom use and the number of USAs. In both the CP and MP groups, only approximately 50 males and females reported anal sex; therefore, the sample size was too small to permit analyses or modeling of these behaviors. Anal sex was therefore combined with vaginal intercourse behaviors to determine unprotected vaginal/anal sex acts and proportion of condom use during vaginal/anal sex. Consistent with the first hypothesis, the CP group reported using condoms a greater percentage of the time than the MP group (47% vs. 37%, respectively; $t [956] = -4.56, p = .000$). However, the mean number of unprotected sexual acts reported by the MP group was not significantly different from the CP group (MP = 18.9 [SD = 28.0] vs. CP = 21.5 [SD = 131]; $t [1204] = -.52, p = .60$), reflecting the greater frequency of vaginal/anal sex with CPs.

Findings regarding group differences in attitudes and substance use behavior are presented in Table 2. Marijuana, alcohol, and other drug use (in the past 30 days) were greater among the CP group. The CP group reported riskier attitudes on the Condom Expectancy Scale, Peer Norms Scale, Partner Risk Checklist, and the Perceived Casual Partner Reaction to Condom Use Scale.

Separate regression analyses were conducted within each group for number of unprotected sexual acts and proportion of condom use. Demographic variables, followed by substance use variables and finally, attitudinal scales, were entered. Multiple linear regression analyses conducted for the MP group with unprotected sexual acts as the dependent variable (Table 3) indicated that, after accounting for demographics and drug use, riskier attitudes on the Condom Expectancy Scale and Perceived Main Partner Reaction to Condom Use Scale were associated with more USAs (model $F[11, 702] = 19.18, p < .01$). Contrary to hypotheses, less riskier attitudes on the Perceived Casual Partner Reaction to Condom Use Scale was associated with more USAs. Similar analyses for the CP group found that no attitude variables were significant (model $F[11, 393] = 2.52, p < .01$).

Multiple linear regression for the MP group using propor-

Table 2
Drug use and risk attitudes by sexual partner type

	Main M (SD)	Casual M (SD)	Range	t	df	p
Substance use						
Pot and alcohol use	1.75 (1.42)	2.37 (1.44)	0–4	-7.37	1281	.000
Other drug use	.29 (.75)	.45 (.91)	0–4	-3.15	783	.002
Attitudes						
Condom Expectancy Scale	19.57 (5.17)	20.73 (4.93)	8–40	-3.93	1299	.000
Peer Norms Scale	22.44 (5.16)	24.64 (5.17)	8–40	-7.31	1292	.000
Perceived Casual Partner Reaction to Condom Use Scale	16.81 (5.52)	18.21 (5.69)	8–40	-4.27	1260	.000
Perceived Main Partner Reaction to Condom Use Scale	20.20 (5.29)	20.68 (5.52)	8–40	-1.52	1300	.128
Partner risk	1.05 (.10)	1.15 (.14)	0–6	-13.10	675	.000

For all scales, a higher number = greater risk attitudes or behaviors.

Table 3
Multiple linear regression for unprotected sexual acts by partner type

Variable	Unprotected sexual acts		
	β	t	p
Main partner group			
Block 1: Demographics			
Gender	-.015	-.422	.673
Race	.016	.437	.663
Age	.003	.791	.939
Living with partner	.211	7.12	.000
Block 2: Substance use			
Alcohol and marijuana use	.053	1.40	.162
Other drug use	.152	3.99	.000
Block 3: Attitudes			
Condom Expectancy Scale	.158	4.05	.000
Peer Norms Scale	.072	1.84	.066
Perceived Casual Partner Reaction to Condom Use Scale	-.077	-2.07	.038
Perceived Main Partner Reaction to Condom Use Scale	.205	5.08	.000
Partner risk	-.015	-.428	.669
Casual partner group			
Block 1: Demographics			
Gender	-.030	-.556	.572
Race	.131	2.28	.023
Age	.008	.149	.882
Living with partner	.164	3.25	.001
Block 2: Substance use			
Alcohol and marijuana use	-.008	-.139	.890
Other drug use	-.016	-.267	.790
Block 3: Attitudes			
Condom Expectancy Scale	.038	.652	.515
Peer Norms Scale	-.101	-1.79	.074
Perceived Casual Partner Reaction to Condom Use Scale	.088	1.53	.126
Perceived Main Partner Reaction to Condom Use Scale	.043	.750	.454
Partner risk	-.035	-.684	.494

tion of sexual acts with a condom as the dependent variable (Table 4) demonstrated that Condom Expectancy Scale, Peer Norms Scale, and Perceived Main Partner Reaction to Condom Use Scale were significant in block 3 (model $F[11, 702] = 34.15, p < .01$). For the CP group, the only variable significant in block 3 was perception of MPs reactions to condom use (model $F[11, 393] = 13.43, p < .01$).

Discussion

This study demonstrates the importance of an adolescent's perception of their relationship with their partner and its association with sexual risk behavior. In this large, ethnically and racially diverse sample, one-third of adolescents indicated having a "casual" partner. In addition, males were significantly more likely to report having casual partners, similar to other

research [9]. These findings suggest that females may perceive, define, or have goals that differ significantly from males with respect to dating relationships. Indeed, theorists suggest that females seek attachment and intimacy and that males seek to have instrumental needs met [14,15].

The present study also revealed that, consistent with hypotheses and previous literature, the proportion of condom use was greater with casual partners [3–6]. Teens may alter their behavior slightly because they perceive their partner to be "casual" and at risk for STIs, but the behavior change is not sufficient to ensure safety because condoms were used only about half of the time. Because the CP group reported sex more frequently, even though they used condoms more often, the number of unprotected sex acts was equivalent between the main and casual partner groups. Thus, condoms, if not used consistently, may be associated

Table 4
Multiple linear regression for proportion of condom use by partner type

Variable	Proportion of condom use		
	β	t	p
Main partner group			
Block 1: Demographics			
Gender	.078	2.41	.016
Race	-.031	-.901	.368
Age	-.115	-3.62	.000
Living with partner	-.098	-3.10	.002
Block 2: Substance use			
Alcohol and marijuana use	.080	2.30	.022
Other drug use	.000	.011	.992
Block 3: Attitudes			
Condom Expectancy Scale	-.162	-4.52	.000
Peer Norms Scale	-.090	-2.51	.012
Perceived Casual Partner Reaction to Condom Use Scale	-.025	-.732	.465
Perceived Main Partner Reaction to Condom Use Scale	-.420	-11.30	.000
Partner risk	.032	1.01	.313
Casual partner group			
Block 1: Demographics			
Gender	.215	4.60	.000
Race	-.017	-.342	.733
Age	-.032	-.690	.490
Living with partner	-.048	-1.07	.285
Block 2: Substance use			
Alcohol and marijuana use	.021	.425	.671
Other drug use	-.121	-2.35	.019
Block 3: Attitudes			
Condom Expectancy Scale	-.089	-1.74	.082
Peer Norms Scale	-.066	-1.32	.186
Perceived Casual Partner Reaction to Condom Use Scale	-.078	-1.54	.124
Perceived Main Partner Reaction to Condom Use Scale	-.352	-6.90	.000
Partner risk	-.019	-.412	.681

with continued sexual risk. In fact, no differences were found between the main and casual partner groups in their history of STIs. Perhaps adolescents overestimate the safety of using condoms “most of the time” with a casual partner and underestimate the risk of unprotected sex with a “serious” partner. These sets of perceptions can have different determinants, but result in a similar relative health risk.

Consistent with hypotheses, after accounting for demographic and substance abuse variables, perceptions of main partner attitudes toward condom use were significantly related to teens’ behavior with main partners. That is, perception of partner attitudes was linked to behaviors with that type of partner. Teens with main partners who perceived negative reactions by their main partners about condom use were less likely to use condoms with a main partner. Findings also revealed that condom use with main partners was significantly associated with pleasant and unpleasant expectations about condom use. No consistent association was found between these attitude variables and sexual behaviors with casual partners. Finally, contrary to our hypothesis, perception of partner’s sexual risk history was not associated with increased condom use, despite the greater perception of partner risk in the casual partner group. The scales assessed risk and attitudes of all recent partners, rather than individual partners. Attitudes may vary from one partner to the next, leading to difficulty averaging the attitudes and imprecise associations. For example, perceived risk may be a motivator for condom use with casual partners, but by not specifying partner type, teens may have provided information applicable to only main partners, the most frequent partner type.

Limitations of this study must be considered. These data are based on self report, which may be subject to inaccuracy. However, steps were taken in this study to prompt teens’ memories and promote accurate assessment of past behavior (i.e., a 90-day calendar was given with instruction). Assurance of confidentiality and visual and auditory administration of items in the ACASI increase data accuracy [16].

Although attitudes about type of partner were assessed, perceptions of the views of each specific partner or adolescents’ definitions of partner type were not. Greater specificity may reveal attitudes more strongly related to behavior. Further research can continue to explore the definitions of partner type, because “main” or “casual” may not match with current adolescent definitions. For example, defining a partner as “someone you are in love with,” does not necessarily indicate that there is an exclusive commitment or that both partners would describe the relationship in the same way. Indeed, 10% of those reporting having relationships with casual partners also reported living with a partner. Sexual health may be jeopardized when one partner views the relationship as a mutually committed one and the other partner does not. Given the high frequency of multiple partners, partner type (main partner or someone that one is

living with) does not confer safety. Additionally, some adolescents have a main partner for a brief time and then begin a relationship with another “main” partner and such “serial monogamy” furthers sexual risk. Unprotected sex, with any partner, places adolescents at high risk for STIs.

This study highlights the frequent sexual risks that teens take with partners of every type and indicates how an adolescent’s understanding of their relationship with a partner relates to this sexual risk. Clinicians can emphasize the need for consistent condom use with all partners regardless of the patient’s feelings about the partner, the sense of commitment, or the length of the relationship. Substantial risk for sexually transmitted infections and unintended pregnancies exist with partners of all types, and emphasizing this risk may motivate some teens to use condoms consistently. Perception of main partners’ attitudes about condom use was found to be important in determining consistent condom use, so reminding teens that most partners approve of condoms and that their use can contribute to mutual safety may be a useful strategy.

In sum, the present study suggests that teens in either a “casual” or “serious” relationship are at risk for contracting an STI, including HIV, as a result of inconsistent condom use. Even though condom use was more frequent with casual partners, teens may have overestimated the safety of using condoms in casual relationships (only half the time) whereas those with main partners, who use condoms a third of the time, may have underestimated the safety of the relationship because it was felt to be emotionally significant. Adolescents perceive partners in different ways and this influences their behavior. This study underscores the importance and complexity of the emotional context of the relationship in determining safer sexual behavior.

Acknowledgment

This research was supported by SAMHSA Grant U10 SMS2073 to cooperating adolescent sites: Rhode Island Hospital, Miriam Hospital, Emory University, and University of Miami Project SHIELD Study Group.

References

- [1] Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2003. *MMWR* 2004;53(SS-2):1–96 [cited 2004 Nov 9]. Available from: www.cdc.gov/mmwr/preview/mmwrhtml/ss5301a1.htm.
- [2] Robin L, Dittus PJ, Whitaker D, et al. Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *J Adolesc Health* 2005;34:3–26.
- [3] Ford K, Norris AE. Factors related to condom use with casual partners among urban African-American and Hispanic males. *AIDS Educ Prev* 1995;7:494–503.
- [4] Plichta SB, Weisman CS, Nathanson CA, et al. Partner-specific condom use among adolescent women clients of a family planning clinic. *J Adolesc Health* 1992;1:506–11.

- [5] Reisen CA, Poppen PJ. Partner-specific risk perception: a new conceptualization of perceived vulnerability to STDs. *J Appl Soc Psychol* 1999;29:667–84.
- [6] Rosengard C, Adler NE, Gurvey JE, et al. Protective role of health values in adolescents' future intentions to use condoms. *J Adolesc Health* 2001;20:200–7.
- [7] Cooper ML, Orcutt HK. Alcohol use, condom use and partner type among heterosexual adolescents and young adults. *J Stud Alcohol* 2000;6:413–9.
- [8] Ellen JM, Adler NE, Gurvey JE, et al. Adolescent condom use and perceptions of risk for sexually transmitted diseases. *J Stud Alcohol* 2002;29:756–62.
- [9] Gebhardt WA, Kuyper L, Greunsven G. Need for intimacy in relationships and motives for sex as determinants of adolescent condom use. *J Adolesc Health* 2003;33:154–64.
- [10] Misovich SJ, Fisher JD, Fisher WA. Close relationship and elevated HIV risk behavior. *Rev Gen Psychol* 1997;1:72–107.
- [11] Crosby R, DiClemente RJ, Wingood GM, et al. Condom failure among adolescents: Implications for STD prevention. *J Adolesc Health* 2005;36:534–6.
- [12] Houck CD, Lescano CM, Brown LK, et al, Project SHIELD Study Group. "Islands of Risk": identifying subtypes of adolescents at risk for HIV. *J Pediatr Psychol* 2005;[Epub ahead of print].
- [13] NIMH Multisite HIV Prevention Trial Group. The NIMH multisite HIV prevention trial: reducing HIV sexual risk behavior. *Science* 1998;280:1889–94.
- [14] Maccoby E. Gender and relationships: a developmental account. *Am Psychol* 1990;45:513–20.
- [15] Shulman S, Scharf M. Adolescent romantic behaviors and perceptions: age- and gender-related differences, and links with family and peer relationships. *J Res Adolesc* 2000;10:99–118.
- [16] Schroder KEE, Carey MP, Vanable PA. Methodological challenges in research on sexual risk behavior: I. Item content, scaling, and data analytical options. *Ann Behav Med* 2003;26:76–103.