Examining interest in secondary abstinence among young African American females at risk for HIV or STIs

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Abstract

Sexually active African American females are at increased risk for acquiring HIV or STIs. However, some reduce their risk by abstaining from sex for various periods of time following initiation, a practice known as secondary abstinence. Although this may be a valuable mechanism for reducing HIV or STI rates in this population, little is known about those interested in secondary abstinence. Baseline data were obtained from a sample of African American adolescent females, ages 14–20 years, prior to participation in an HIV-risk reduction intervention trial (N = 701). Differences in individual-level and interpersonal-level factors, as well as sociodemographic variables were examined between participants who reported strong interest in secondary abstinence and those who did not. 144 (20.5%) participants reported strong interest in secondary abstinence. Young women with strong interest in abstinence had higher odds of reporting a history of STIs and feeling negative emotions following sex because of their religious beliefs. They also had higher odds of believing their partner may be interested in abstinence and being less invested in their relationship with their main partner. Additionally, adolescents reported less interpersonal stress and more social support. African American females who are interested in practicing secondary abstinence and those who are not differ in their sexual health education needs. Findings from this study characterizing young women interested in secondary abstinence can help researchers provide more targeted health education by identifying those who may be more responsive to abstinence-promoting messages.

Introduction

Both sexually transmitted infections (STIs) and unintended pregnancy remain highly prevalent within the African American community. With over 19 million new STI diagnoses each year, it is estimated that almost half are among individuals under the age of 24 years, of whom young African American females are most significantly affected [1]. The racial disparity across STIs is noteworthy. In 2008, African American females 15–24 years had the highest rates of gonorrhea and chlamydia compared to all other ethnic groups [2]. Similar to STI acquisition, unintended pregnancy presents a challenge to this vulnerable subgroup. African American adolescents (15–19 years) consistently have one of the highest birth rates among all ethnic groups. In 2007, preliminary birth rate estimates among this group exceeded the national average by approximately 20% (64.3 versus 42.5 per 1,000, respectively) [3]. Furthermore, it has been reported that at least one in six births to young...
African American mothers (≤19 years of age) is a second-order birth or higher [4].

Although abstaining from sex can decrease adolescents’ risk of exposure to STIs and unintended pregnancies, interventions focusing exclusively on abstinence have been largely ineffective [5]; and those that show promise have been conducted mainly with younger, sexually inexperienced adolescents [6–9]. Less is known about the utility of promoting abstinence among sexually experienced individuals. A recent survey found that 60% of adolescents with sexual experience wish they had waited [10]; and some intentionally abstain from sex following sexual debut, a practice known as secondary abstinence. Although estimates are scarce, the prevalence of secondary abstinence was approximated between 8% and 12.5% in large samples of high school [11] and college students [12], and 13% in an adolescent clinic-based sample comprised mostly of African American females [13]. A few recent studies have examined the practice of secondary abstinence [12, 14, 15]. However, little is understood about factors associated with interest in secondary abstinence, without regard to whether an individual has successfully adopted secondary abstinence.

It is likely that sexually experienced adolescent females interested in secondary abstinence and those who are not differ in their sexual health education needs. For example, successful practice of secondary abstinence necessitates avoidance of sexual intercourse. Thus, secondary abstainers must implement personal and environmental safeguards in order to avoid or be well equipped to handle situations where sex could occur. However, for those choosing to practice safer sex the emphasis is not placed on avoiding sexual activity but rather altering sexual practices to reduce exposure risk for STIs or pregnancy. Therefore, the behavioral skills required for this group are those related to correct and consistent condom use.

Young women and girls who differ in their interest in practicing secondary abstinence may also differ in how receptive they are to messages encouraging abstinence. The Theory of Reasoned Action [16] suggests one’s attitude toward performing a behavior influences the intent to do so and, in turn, whether the behavior is adopted. If being receptive to messages encouraging abstinence precedes the practice of secondary abstinence, it should not be surprising if efforts to promote abstinence among sexually experienced young women who are not motivated to abstain are unsuccessful. Therefore, it would be beneficial for researchers to be able to characterize those who are interested in secondary abstinence in order to identify those who may be more responsive to abstinence-promoting programs.

When examining differences between sexually experienced adolescent females interested in abstaining and those who are not, it is important to extend the focus beyond characteristics of the individual such as attitudes toward abstinence. Researchers suggest that aspects of one’s situation or environment can provide context for understanding sexual decision-making and behavior and should be included in investigations [17–19]. For example, characteristics of a young woman’s relationship such as length of the relationship or type of partner have been associated with condom use (or non-use) among young African American females [20–23]. It is equally likely that interests and desires that precede behavior are also influenced by context.

Since tailoring messages and promoting secondary abstinence could prove valuable in reducing STIs and unintended pregnancy among young African-American females, it is useful to estimate the proportion of high-risk, sexually experienced African American adolescent females that may be interested in abstaining and identify characteristics of these young women. Therefore, the purposes of this study are to (i) identify contextual factors at the individual and interpersonal levels associated with interest in becoming abstinent and (ii) examine the prevalence of interest in secondary abstinence among sexually experienced African American adolescent females at increased risk for HIV or STIs and unintended pregnancy.
Methods

Participants
Participants were 701 sexually experienced African American adolescent females, ages 14–20 years, enrolled in a randomized trial evaluating an HIV risk-reduction intervention. Adolescents were recruited from three clinics in Atlanta, Georgia providing sexual health services for free or on a sliding scale. Adolescents were approached in the clinic waiting room by a female recruiter who provided an overview of the study and invited them to be screened for eligibility. Eligibility criteria were as follows: self-identified as African American, were 14–20 years old, and reported having vaginal sex without a condom at least once in the past 6 months. Adolescents were not eligible for the study if they were married, pregnant or attempting to become pregnant. Written informed consent was obtained for all participants. Emory University’s Institutional Review Board approved all study protocols.

Procedures
Baseline data were collected from 2005 to 2007. Prior to being randomized, participants completed a 60-min survey administered via audio computer assisted self-interview (ACASI). ACASI technology was utilized to address potential literacy issues [24] and reduce social desirability bias in reporting of sensitive information [25]. Participants received $75 compensation upon completion of the baseline survey and intervention workshop.

Measures
Outcome measure
Interest in abstinence was assessed by asking participants to respond to a single item: ‘Tell me which statement best describes you.’ Participants classified themselves using the following response options: ‘I am very interested in becoming abstinent’, ‘I am somewhat interested in becoming abstinent’, ‘I am not at all interested in becoming abstinent’. Responses were re-coded as very interested (1) or other (0).

Sociodemographic measures
Age was assessed by asking, ‘How old are you (in years)?’ Participants were also asked to describe their living situation and were classified as living with their partner (0) or not living with their partner (1).

Individual-level measures
The following measures assessed characteristics within individuals.
Self-esteem. The 10-item Rosenberg Self-Esteem Scale [26] measured global self-esteem. Possible scores ranged from 10 to 40, with higher scores indicating higher levels of self-esteem. Cronbach’s alpha was 0.86.
Perceived interpersonal stress. 13 items, modified from the African American Women’s Stress Scale were used to measure perceived interpersonal stress [27]. Questions assessed the amount of stress an individual feels in various interpersonal relationships. Participants rated their stress level from potential stressors, such as ‘relationships with family or friends’ using a scale from 0 to 5. Possible total scores ranged from 0 to 70, with higher scores reflecting higher levels of stress. Cronbach’s alpha was 0.87.
Perceived peer norms. Perceived peer norms supporting abstinence were measured by asking participants how many of their peers believe ‘it’s okay to be abstinent that is choose not to have sex’. Response options were none, few, some, most, and all. Responses were recoded to create a dichotomous variable where ‘all’ and ‘most’ were combined to indicate norms more supportive of abstinence.
Personal religious beliefs about sex. Religious beliefs about sex were assessed using a single item, ‘Because of my religious beliefs I feel bad when I have sex’. Respondents rated their level of agreement using a 5-point Likert scale of strongly disagree (1) to strongly agree (5). Responses were recoded to create a dichotomous variable: agree
(strongly agree or agree) or other (neutral, disagree or strongly disagree).

**History of STI.** History of STI was assessed using a single item that asked, ‘Have you ever had a positive STD test result?’ Response choices were yes (1) and no (0).

**History of forced vaginal or anal sex.** History of sexual violence was determined based on two questions assessing forced vaginal intercourse or forced anal intercourse: ‘Has anyone ever forced you to have vaginal sex when you didn’t want to?’ and ‘Has anyone ever forced you to have anal sex when you didn’t want to?’ Response choices were yes (1) and no (0).

**Interpersonal-level measures**

Aspects of individuals’ relationships with partners, peers and others were assessed using the following measures.

**Currently have a boyfriend.** Current relationship status was assessed by asking, ‘Do you have a boyfriend?’ Response choices were yes (1) or no (0).

**Currently have a casual sex partner.** Currently having a casual sex partner was assessed by a single item, ‘Do you currently have a casual sex partner(s)?’ Response choices were yes (1) or no (0). Casual partner was defined as someone other than the respondent’s boyfriend or main partner, with whom she had sex but was not in a committed relationship.

**Investment in future of relationship.** Investment in future of relationship with boyfriend or main partner was measured with four-items developed by Wyatt and colleagues [28]. Items were as follows: ‘I see myself marrying my current boyfriend’; ‘I’ll stay with my current boyfriend until someone better comes along’; ‘It would be nice if my relationship succeeded, but I won’t do much more than I’m doing to help it succeed’; ‘It doesn’t matter if my relationship succeeds. I refuse to do anymore than I’m doing now to keep the relationship.’. A 4-point Likert scale was used for each statement, where 1 indicated strong disagreement and 4 indicated strong agreement. ‘I see myself marrying my current boyfriend’ was reverse coded. Scores ranged from 4 to 16; higher scores reflected lower investment in the future of the relationship. Cronbach’s alpha was 0.64.

**Perception of partner’s interest in abstinence.** Perception of partner’s interest in abstinence was assessed by asking participants to classify their partners as very, somewhat, or not at all interested in becoming abstinent. Partners were then coded as having any interest (1) or no interest (0).

**Parent–Adolescent Communication Scale (PACS).** The PACS is composed of five items assessing adolescents’ frequency of communicating about sexually related topics with their parents [29]. Each item required a response based on a 4-point Likert-type scale: 1 (never) to 4 (often). Higher values indicated more frequent parent-adolescent communication. Cronbach’s alpha was 0.91.

**Social support.** Perceived social support was measured with a 12-item scale developed by Zimet and colleagues to assess three sources of support: family (FA), friends (FR) and significant other (SO) [30]. Sample scale items include, ‘My family really tries to help me.’ A 4-point Likert scale was used for each statement, where 1 indicated strong disagreement and 4 indicated strong agreement; scores ranged from 11 to 44. Responses were coded so that higher scores reflected higher levels of perceived social support. Cronbach’s alpha was 0.90.

**Data analysis**

Descriptive statistics were used to summarize sociodemographics and interest in secondary abstinence for the entire sample. In addition, bivariate analyses examined differences between young women very interested in secondary abstinence and all others on sociodemographic variables, individual-level and interpersonal-level measures. Differences were assessed using independent samples t-tests for continuous variables and Chi-square analyses for categorical variables. All significant variables identified in bivariate analyses were entered into a
multivariate logistic regression model to determine which variables remained significantly associated with interest in secondary abstinence when adjusting for the other associations.

Results

Descriptive analyses

The mean age of participants was 17.6 years (SD = 1.67). Most (60.9%) were high school students. More than one-third had graduated from high school (18.5%) or completed some college (16.3%). The majority (79.5%) reported being in a relationship [mean (SD) length of relationship, 14.4 (14.9) months]. Nearly one-third (34.5%) had a casual sex partner. Twenty-two percent reported having both a main partner and a casual sex partner. Only 6.7% (n = 47) lived with their partner. The average age of participants who were living with their partner was 18.72 (SD = 1.26).

Approximately 21% (n = 144) of the sample was very interested in becoming abstinent. Adolescents who were interested in becoming abstinent were younger (mean of 17.38 years versus 17.71 years; P = 0.038). Additionally, fewer young women who were living with their partner had strong interest in secondary abstinence (P = 0.004).

Multivariate analysis

Many factors at both the individual- and interpersonal-level were significant in multivariate logistic regression analysis. The regression model, which included all variables significantly associated with interest in secondary abstinence in bivariate analyses (Table I), explained 24% of the variance in interest in secondary abstinence (X^2 (10, N = 701) = 91.62, P < 0.001, Nagelkerke R^2 = 0.24) (Table II). The odds of reporting strong interest in abstinence were nearly two times greater for those who had an STI in the past compared to those who had not (P = 0.019). For those who experienced negative feelings about engaging in sex because of their personal religious beliefs, the odds of strong interest in secondary abstinence were approximately 4.5 times higher than those who did not experience these feelings (P < 0.001). Additionally, the odds of strong interest in secondary abstinence were higher for adolescents who had less stress and more social support (P = 0.032; P = 0.019, respectively). In regards to romantic or sexual partners, the odds of strong abstinence interest were three times higher for adolescent females who believed their partner had some interest in abstinence (P < 0.001). Being less invested in the future of the relationship with one’s main partner also increased the odds of reporting strong interest in abstinence (P = 0.005). The odds of strong abstinence interest were approximately five times greater for adolescent females who did not live with their partner compared to those who did (P = 0.033). Being younger, communicating with a parent about sex more frequently, and perceiving most or all of their peers were supportive of abstinence were not significantly associated with a strong interest in secondary abstinence in the model.

Discussion

Among this sample of sexually active, African American adolescent females, approximately one in five were strongly interested in practicing secondary abstinence, suggesting that promoting secondary abstinence may be a viable option in STI and unintended pregnancy programs for this population. Importantly, similar to previous work documenting the importance of developing a contextual understanding of sexual decision-making [31], we found several individual- and interpersonal-level factors that differentiated those adolescents who were very interested in becoming abstinent from those who were not.

Specific to the individual-level, young women who were very interested in secondary abstinence were less likely to live with their partner than those with no interest in abstinence. Additionally, they were more likely to report a history of STIs and to feel negative emotions following sex because of their religious beliefs. Interestingly, the majority of these factors are rarely amenable to change in HIV or STI or pregnancy prevention interventions.
However, collectively, these findings suggest that messages promoting secondary abstinence as a risk-reduction strategy might be best received if they are tailored and delivered to certain subpopulations. For example, since those who have contracted an STI in the past may be more open to considering secondary abstinence to prevent subsequent infections, it could be beneficial to

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### Table I. Differences in individual and interpersonal-level factors by interest in secondary abstinence among African American adolescent females

<table>
<thead>
<tr>
<th></th>
<th>Strong interest (n = 144)</th>
<th>Other (n = 557)</th>
<th>Test statistic</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>17.38 (1.69)</td>
<td>17.71 (1.66)</td>
<td>−2.08</td>
<td>0.038</td>
</tr>
<tr>
<td>Not living with boyfriend/partner</td>
<td>142 (98.6)</td>
<td>512 (91.9)</td>
<td>8.19</td>
<td>0.004</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>34.33 (5.20)</td>
<td>33.82 (5.05)</td>
<td>1.09</td>
<td>0.277</td>
</tr>
<tr>
<td>Perceived interpersonal stress</td>
<td>28.43 (14.16)</td>
<td>31.82 (13.56)</td>
<td>−2.65</td>
<td>0.008</td>
</tr>
<tr>
<td>Feeling bad about sexual activity due to religious beliefs</td>
<td>49 (34.0)</td>
<td>96 (17.2)</td>
<td>19.67</td>
<td>0.001</td>
</tr>
<tr>
<td>History of STI</td>
<td>93 (64.6)</td>
<td>304 (54.6)</td>
<td>4.66</td>
<td>0.031</td>
</tr>
<tr>
<td>History of forced vaginal or anal sex</td>
<td>34 (23.6)</td>
<td>144 (25.9)</td>
<td>0.30</td>
<td>0.582</td>
</tr>
<tr>
<td><strong>Interpersonal (partner)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has current casual sex partner</td>
<td>54 (37.5)</td>
<td>188 (33.8)</td>
<td>0.711</td>
<td>0.399</td>
</tr>
<tr>
<td>Has current boyfriend</td>
<td>107 (74.3)</td>
<td>450 (80.8)</td>
<td>2.95</td>
<td>0.086</td>
</tr>
<tr>
<td>Lower investment in future of relationship with main partner</td>
<td>8.8 (2.62)</td>
<td>7.96 (2.52)</td>
<td>3.08</td>
<td>0.002</td>
</tr>
<tr>
<td>Perception of partner’s interest in abstaining</td>
<td>78 (54.2)</td>
<td>182 (32.7)</td>
<td>22.65</td>
<td>0.001</td>
</tr>
<tr>
<td><strong>Interpersonal (other)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>36.89 (6.11)</td>
<td>35.7 (5.73)</td>
<td>2.19</td>
<td>0.029</td>
</tr>
<tr>
<td>Parent-adolescent communication</td>
<td>14.58 (4.94)</td>
<td>13.11 (4.98)</td>
<td>3.18</td>
<td>0.002</td>
</tr>
<tr>
<td>Perception of peer support for abstinence</td>
<td>50 (34.7)</td>
<td>145 (23.9)</td>
<td>6.98</td>
<td>0.008</td>
</tr>
</tbody>
</table>

*Mean (SD) presented, test statistic is t-test

*bFrequency (%) presented, test statistic is chi-square.

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### Table II. Adjusted odds ratios for the logistic regression model examining interest in secondary abstinence among African American adolescent females (n = 557)

<table>
<thead>
<tr>
<th></th>
<th>Adjusted odds ratio</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.90</td>
<td>0.77, 1.04</td>
<td>0.142</td>
</tr>
<tr>
<td>Not living with boyfriend/partner</td>
<td>5.23</td>
<td>1.14, 23.97</td>
<td>0.033*</td>
</tr>
<tr>
<td>Perceived interpersonal stress</td>
<td>0.98</td>
<td>0.96, 0.998</td>
<td>0.032*</td>
</tr>
<tr>
<td>Feeling bad about sexual activity due to religious beliefs</td>
<td>4.59</td>
<td>2.57, 8.20</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>History of STI</td>
<td>1.80</td>
<td>1.10, 2.95</td>
<td>0.019*</td>
</tr>
<tr>
<td><strong>Interpersonal (partner)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower investment in future of relationship with main partner</td>
<td>1.15</td>
<td>1.04, 1.26</td>
<td>0.005*</td>
</tr>
<tr>
<td>Perception of partner’s interest in abstaining</td>
<td>3.17</td>
<td>1.92, 5.22</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td><strong>Interpersonal (other)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>1.06</td>
<td>1.01, 1.10</td>
<td>0.019*</td>
</tr>
<tr>
<td>Parent-adolescent communication</td>
<td>1.03</td>
<td>0.98, 1.09</td>
<td>0.261</td>
</tr>
<tr>
<td>Perception of peer support for abstinence</td>
<td>1.57</td>
<td>0.93, 2.63</td>
<td>0.089</td>
</tr>
</tbody>
</table>

CI = confidence interval. Asterisk indicates statistical significance at alpha level 0.05. Regression model excludes participants with no response to future of relationship with main partner scale.
include stronger abstinence-promoting messages in interventions that target this group. Activities could explore potential benefits and drawbacks of secondary abstinence and develop practical skills needed to abstain when motivated to do so. Secondary abstinence knowledge and skills-building discussions could also be integrated into individualized counseling delivered by healthcare providers during patients’ STI-related visits.

Additionally, some adolescents with strong interest in secondary abstinence reported ‘feeling bad’ because their sexual behavior was not consistent with their personal religious beliefs. Thus, it would be valuable to help them remove this dissonance by equipping them to adopt secondary abstinence. Faith communities may provide an ideal setting for secondary abstinence-promoting initiatives. Creating partnerships between researchers and faith communities can facilitate the development of abstinence-promoting interventions, counseling, or other initiatives that are both scientifically sound and culturally appropriate.

Several interpersonal-level factors also differentiated adolescents who were very interested in abstaining from those who were not. In particular, young women very interested in abstaining believed more often that their partner had some level of interest in abstaining and expressed less commitment to their partner. Thus, partner-related factors may exert significant influence in sexual decision-making. Since sexual relationships are dyadic, ideally the desires or preferences of each person in the relationship are taken into consideration as decisions impacting sexual health are made. For example, young women who believe their partner may be interested in abstaining may feel more comfortable considering secondary abstinence as an option. On the other hand, for young women who do not believe their partners have any interest in abstaining, desiring to do so could cause conflict in their relationships. Therefore, young women may be more likely to be interested in practicing secondary abstinence if they believe their desire maybe supported by their partner.

Differences in young women’s investment in the future of their relationship were also intriguing. Findings showed young women in our sample who had strong interest in abstinence were less committed to securing a future with their main partner. Perhaps those who are less invested in preserving their relationship are less interested in continuing to have sex because their feelings for their partner have changed. Additionally, young women who are less invested in their current relationship may not be highly motivated to avoid potential conflict that could arise from removing sex from their relationship. Similarly, young women who have experienced negative consequences from sexual involvement, such as STI acquisition, maybe less concerned about initiating or continuing sex in an effort to maintain a relationship.

Additional factors that provide contextual information include a young woman’s stress level (individual-level) and availability of support from significant people in her life (interpersonal-level). Since young women not interested in abstaining reported more stress, it is possible that young women may consider sex as a way to cope with negative emotions and stress [32, 33]. Conversely, young women interested in secondary abstinence reported more social support, a potential resource for coping, during times of need [34]. Becoming abstinent after one has initiated sex can be challenging, especially for those who have experienced failed attempts to abstain in the past. Other influential people, such as parents or friends, may provide the emotional support or informational support needed to make choices that are in the best interest of a young woman’s health [34, 35].

The present study highlights the importance of identifying factors contributing to interest in secondary abstinence. Our data from a sample of African American females add to the literature by suggesting that there are certain characteristics that are associated with interest in secondary abstinence, even among high-risk subgroups. Such characterization may enhance prevention efforts by allowing researchers and health professionals to identify those who maybe most receptive to abstinence-promoting interventions. Sexually experienced young women desiring to abstain would greatly benefit from gaining additional knowledge and...
skills to do so. However, since there is often limited time in HIV or STI risk-reduction interventions, many programs that include sexually experienced individuals focus predominately on enhancing safer sex knowledge and skills. Thus, if young women who are interested in secondary abstinence can be identified, prevention efforts can be tailored to match programming with the interest-level of young women. Such interventions could devote more time to enhancing secondary abstinence-specific knowledge and skills and teach participants how to apply those skills to other safer sex strategies (i.e. condom negotiation) if they become sexually active. As a result, the abstinence component of comprehensive programs can be strengthened to maximize intervention impact.

Although several important differences were identified, this study is not without limitations. This sample was intentionally homogeneous across sociodemographic characteristics for the purposes of the parent study. Findings from this study, conducted among a completely African American sample, may not be generalizable to larger populations with more diverse ethnic and demographic backgrounds. Also, the self-reported data may have been subject to both social desirability bias and recall bias. Such biases may result in an inaccurate representation of adolescents’ actual feelings, perceptions or experiences. Furthermore, although many constructs were included in the present study, they were not exhaustive. Additional variables of interest, such as past pregnancies, worry about becoming pregnant or acquiring HIV or STIs, and perception of negative effects of sex on one’s relationship with her partner or on her reputation with others should be considered when examining interest in secondary abstinence in future research. Also, it may be valuable to explore additional aspects of the relationship, such as power imbalances, that may impact one’s ability to make decisions about sexual behavior.

Improving our understanding of secondary abstinence can help researchers and practitioners develop tailored abstinence-based messages and strategies to better equip those interested in practicing secondary abstinence at various ages and developmental stages. Identifying factors associated with interest in secondary abstinence is one important component of enhancing that understanding. Additional research should be conducted to develop a more in-depth understanding of what motivates sexually experienced individuals to become abstinent as well as factors that facilitate and hinder secondary abstinence. Doing so may bolster efforts to reduce HIV or STI transmission and unintended pregnancy among young African American women.

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### Conflict of interest statement

None declared.

### References


