INFORMATION TO USERS

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

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

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

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6” x 9” black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
RUBBERS AND ROMANCE: HETEROSEXUAL CONDOM USE IN THE U.S.

by

Shelly Dee Adrian

A Thesis Submitted to the Faculty of the
DEPARTMENT OF ANTHROPOLOGY
In Partial Fulfillment of the Requirements
For the Degree of
MASTERS OF ARTS
In the Graduate College
THE UNIVERSITY OF ARIZONA

1997
STATEMENT BY AUTHOR

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

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

SIGNED: [Signature]

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Ana M. Ortiz
Professor of Anthropology

[Signature] 12/11/97

Date
# TABLE OF CONTENTS

I. LIST OF TABLES...............................................................4

II. ABSTRACT........................................................................5

III. INTRODUCTION...............................................................6

IV. BACKGROUND: HISTORY AND CONTEXT OF CONDOM PROMOTION...8

   History of Condom Promotion...............................................9
   Condom Promotion Today: AIDS & the Evolution of Meaning.........21
   AIDS, Gender and Condom Use..............................................30

III. PRESENTATION AND ANALYSIS OF DATA.........................35

   Bodies and Emotions: What Do Condoms Feel Like?................48
      Etiology of Physical Sensations........................................49
      Appropriate Treatment of Bodies.......................................55
      Emotional Correlates of Bodily Experience..........................63
   Doing Sex is Doing Relationships and Gendered Identity................66
   Romance, Dating, and Gender as Doxa..................................67
   Agency..............................................................................83
   Navigation: Ambiguity, Risk, and Play..................................87
   Learning and Sharing.........................................................91
   Narratives and Identity.....................................................94

IV. CONCLUSIONS AND RECOMMENDATIONS.............................98

APPENDIX A. INTERVIEW SCHEDULE....................................104

REFERENCES.........................................................................106
LIST OF TABLES

TABLE 1. Effectiveness of Contraceptives...............16
TABLE 2. First Sexual Intercourse: ambience, planning, and partner.................................70
TABLE 3. First Condom Use: ambience, planning, and partner............................................71
ABSTRACT

This paper explores the meaning of condoms for six sexually active, college-educated women. Analysis of ethnographic interviews addresses four facets of their experiences with condoms. This report discusses (1) the condom in relation to the (female) body, and (2) condom use as a conjunction of doing sex and gender identity. Informant-generated topics are (3) the learning and sharing of condom knowledge, and (4) the mention of condoms in life stories. To contextualize these highly individual experiences, the author initially presents popular and historical meanings of condoms. After a brief review of condoms in historical discourses of birth control and sexually-transmitted diseases, condom meanings in current AIDS-inspired research are presented. The conclusion suggests how this qualitative data could inform sexual health education and condom promotion campaigns.
I. INTRODUCTION

Although everyone knows the importance of using condoms in today's world, individuals willingly admit that they do not use condoms as often and as consistently as they should. Clearly knowledge does not translate neatly into action. Condom use is motivated not only by what people 'know' about condoms, but also by what they feel and think about condoms, by what a particular sexual encounter means to them, and by their own sense of agency in pursuing condom use.

Condom use is more complex than it has been portrayed by much public health research. The orientation of public health is towards scientific and technical progress; program failures are explained by 'cultural obstacles' to behavior modification or to the implementation of a technical solution. Ethnography has often led to innovative solutions to and redefinitions of 'cultural obstacles.' In this case, historical discourses and embodied practices involving condoms shape the potential futures of condom use. At the same time, such questions entail investigations into culture, exploring the intersection of artifact, meaning, and power at the site of the body, and the naturalization of some sexual behaviors (like intercourse) but not others (such as condom use). This study situates condom use in its social context of sex, and seeks to understand it as a
meaningful cultural practice within a framework of power relations.

Ethnographic interviews with a small, homogeneous sample of women provide both a broad range of meanings related to condom use and a virtual consensus on some gendered dynamics of condom use. Analysis considers four facets of condom use: embodied and sensual aspects, intersubjectivity, socialization, and condom use as a narrative element in an individual’s life story.
II. BACKGROUND: HISTORY AND CONTEXT OF CONDOM PROMOTION

Individual-level ethnographic data is interpretable in conjunction with the historical context and social meaning of condoms and their use. Foucault employs the term 'discourse' for bodies of knowledge combining ideology, practice, and power; discourses are practices that systematically form the objects of which they speak (Foucault 1990). Birth control discourse yields the condom as contraception. Concurrently, the discourse of sexually transmitted diseases (STDs) constructs the condom as disease prophylaxis. These existing ideas and practices of condoms are the playing field of individuals' condom use today, and the resources from which contemporary interest groups attempt to frame new condom meanings. The history of condom promotion yields discourses on what condoms are 'good for' and for whom they are appropriate and available.
History of Condom Promotion

A condom is a material artifact; however, the symbolic and moral associations, stigma, and accessibility of condoms are socially constructed through the context of condom use (and non-use), and by the domains of knowledge which refer to condoms. "A social construction reveals tacit values, it becomes a symbol for ordering and explaining aspects of human experience" (Brandt 1985:5). In the history of condom promotion, interests -- primarily those of the state, physicians, the social purity and birth control movements -- battle over the frame of meaning for condoms. The debate is about defining the condom itself (Gamson 1990).

Condoms are found in two discursive domains: those of birth control, and sexually transmitted disease (STD) prevention. The controversy surrounding condom use in each of these domains derives from condoms' role in the other domain. The ambivalence in defining condoms solely as either

1 Aside from two short articles focusing on condoms in particular (Gamson 1990; Valdiserri 1988), the history of condom use is found in histories of sexually transmitted disease (Brandt 1985; Fee 1989) and of the birth control movement (Gordon 1974; Reed 1978; Ward 1986).

In the 19th and early 20th centuries, syphilis and gonorrhea were referred to as 'venereal disease' or 'VD.' For consistency, the term 'sexually transmitted diseases' or 'STDs' is employed throughout this paper to cover syphilis, gonorrhea, AIDS, and other infections transmitted primarily through sexual contact.

The domain of birth control discourse includes what is euphemistically termed 'family planning.'
contraception or STD prophylaxis appears as a struggle to frame condoms as a moral or a medical issue. Historically, there are two condom technologies (if we understand technology to include the total body of knowledge associated with a material tool). Overall, contraception and STD prophylaxis have been separate issues, providing condoms-in-use with separate contexts, functions, and meanings. In practice, however, condoms may be employed for both functions simultaneously, or the dual discourses may offer more and less legitimate and morally preferable explanations for condom use. For example, a study on drug-using women and their long term sexual partners found that two HIV+ women "insist their partners use condoms with the explanation that they do not want more offspring" rather than mention their serostatus as a reason to use condoms (Pivnick 1993). Ironically, in the late nineteenth century a couple motivated by contraceptive concerns could legally procure condoms only as prophylaxis to protect the wife's fertility from the husband's contact with prostitutes.

The first recorded use of condoms in Europe is in 1564 (Valdiserri 1988). By the 18th and into the 19th century, the condom was recognized as preventing STDs in the context of prostitution. The prevailing double standard of the 19th century which restricted women's sexuality to marriage, while accepting prostitution as a necessary outlet for male
desires, was challenged by social purity movements\(^2\) in late 19th century. Social purity advocates opposed abortion, condoms, and contraception in general because these were thought to aid the vice of sexual immorality, i.e., prostitution. Concurrently, the Comstock Act of 1873 forbade the mailing, transport, and import of obscene and 'foul' literature, including contraceptive devices and information.

An amendment to the Comstock Act in 1881 signalled the medicalization of the condom: the law allowed men to have condoms to protect themselves from STDs. The acceptability of condoms, like other STD prophylaxis, was contested in the medical community: is the physician's responsibility to the individual, or to the community? At the end of the 19th century, physicians' self-perceived responsibility was to protect the institution of marriage from STDs through confidential treatment of infections (Brandt 1985:17). Thus condoms became acceptable through their use as STD prophylaxis. In the 20th century, this concern with the

---

\(^2\) The social purity movement grew out of earlier temperance, moral reform, and abolitionist efforts. The National Purity Association, and many feminists such as Elizabeth Cady Stanton wanted to protect motherhood from the consequences of male lust. The central concern was upholding sexual morality; specifically, they sought to keep sexuality within the nuclear family. From the 1880s, they opposed the legalization of prostitution. In the early 1900s, social-purity advocates pushed for the abolishment of prostitution to solve the VD problem. Gordon (1974:116-126) describes the social purity movement in brief. For more information, see David Pivar's Purity Crusade, Westport, CT: Greenwood, 1973.
impact of STDs on the future of the family allied physicians with the eugenics movement, and led doctors to lobby for 'eugenics marriage laws' requiring pre-marital syphilis testing (Brandt 1985:19).

The fear that prophylaxis and treatment promote vice is a recurring theme in American history, and such controversies mark the frontline of medicalization. With the discovery of penicillin after WWI, syphilis could be cured and, as with abortion, the medical profession could erase the 'wages of sin' (Fee 1989; Gordon 1974). The condom protected against two physical consequences of sex: pregnancy and STDs. Clearly, doctors could have applauded the condom as a technological fix to both STDs and the risk of unwanted pregnancy; however, in the late 19th century, physicians were not willing to argue for the medical necessity of birth control against those who claimed it as sinful.

From the late 19th century into the first decades of the 20th century, contraceptives were unreliable and relatively inaccessible to most people. Advertisements hawked condoms for STD prevention, and simultaneously sold powders, douches, etc. as 'feminine hygiene' which was widely (mis)understood to function as birth control (Reed 1978:240). Pessaries and the silk coil, precursors to the diaphragm and IUD, were available from Europe but, as with
condoms, were illegal for contraception in the US, though nevertheless obtained by middle-class women through sympathetic family physicians. Early birth control activist Margaret Sanger initially conceived of the birth control movement as a 'free speech' issue of disseminating contraceptive information and devices in defiance of the federal Comstock Act and its state-level incarnations (Reed 1978).

Sanger wanted to liberate women from the biological slavery of unintended motherhood. She believed that control over their fertility would allow women, especially poor women, to improve their lives. Hence she was primarily interested in 'woman-controlled' methods of contraception, rather than condoms. By the 1920s, Sanger had shifted from a free speech approach toward popularizing the recently perfected spring-loaded diaphragm through birth control clinics. But diaphragm fitting required trained physicians. Birth control remained an unsavory topic for the medical profession as a whole and was deemed too risqué for support by the middle-class feminists of her era; however, Sanger did manage to garner medical support. Her clinics provided employment for female physicians, for whom the prestige of a medical career was already compromised by their gender.

The medicalization of contraception continued though condoms remained marginal in this discourse. The conversion
of birth control 'from private vice to public virtue' resulted from the convergence of Sanger’s efforts with the interests of physicians and entrepreneurs in the late 19th and early 20th centuries. Dr. Robert L. Dickinson sought to make contraception a 'recognized and valuable medical science' (Reed 1978:181). Family stability and healthy marital relations depended on birth control, according to Dickinson. His Committee on Maternal Health promoted empirical research on contraceptive effectiveness, and functioned as a clearinghouse of information for medical professionals. As a precursor to modern issues of linking reproductive health with family planning (Cates 1993), Dickinson suggested that the birth control clinic, particularly by providing a routine pelvic exam, brought medical services to women 'who would never receive medical attention through any other means' (Reed 1978:185).

The philanthropist Clarence Gamble shared the fears of many Americans that differential fertility between classes was a source of social disorder. He sponsored research for inexpensive contraceptives such as lactic acid jelly, though data showed it to be ineffective. Gamble also encouraged the use of 'cheap backyard methods' (including condoms and douches) where organized medicine was not available, a stance in conflict with most physicians and Sanger’s clinic movement.
Overall, the birth control movement's legacy for condoms is an increased acceptance and the medicalization of contraception in general, though condoms in particular are backgrounded as a 'folk method' of birth control (Ward 1986:48; Reed 1978). From their beginning, birth control clinics have promoted development and distribution of female-controlled methods requiring medical supervision: the diaphragm since 1920, the IUD and birth control pill in the early 1960s, the recent development of new hormonal contraceptive delivery systems (Norplant, Depo-Provera), and the 'abortion pill,' RU-486. In terms of birth control, the condom was characterized as more effective than douches, yet problematic because it was not female controlled.

Today, Sanger's legacy, Planned Parenthood, suggests that any other contraception is a potentially more effective contraceptive than condoms (see Table 1). Used properly, condoms may be more effective than the diaphragm, periodic abstinence (i.e., the rhythm method) and over-the-counter birth control (i.e., female condom, sponge, foams, films). However, the three most prevalent contraceptives among women 15-34 years old are abstinence, the Pill and the condom (US

---
3 Ratcliff (1989), Ehrenreich and English (1978) and others portray the history of women's health as a process of medicalization, the encroaching claims of the medical profession on what were previously social, moral, and otherwise non-medical issues.
TABLE 1. Effectiveness of Contraceptives

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous abstinence</td>
<td>100.0%</td>
</tr>
<tr>
<td>Norplant</td>
<td>99.9%</td>
</tr>
<tr>
<td>Depo-Provera</td>
<td>99.6% - 99.8%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>97% - 99.2%</td>
</tr>
<tr>
<td>The Pill</td>
<td>97% - 99.2%</td>
</tr>
<tr>
<td>The IUD</td>
<td>88% - 92%</td>
</tr>
<tr>
<td>Condom</td>
<td>82% - 94%</td>
</tr>
<tr>
<td>Diaphragm or cervical cap</td>
<td>72% - 97%</td>
</tr>
<tr>
<td>female condom, sponge, foam, film</td>
<td>80% - 97%</td>
</tr>
<tr>
<td>Periodic abstinence, fertility awareness</td>
<td>80% - 97%</td>
</tr>
</tbody>
</table>

Statistics from Planned Parenthood Federation of America, Inc. 'Your Contraceptive Choices' [pamphlet]. revised 1994.

Bureau of the Census 1996). Of all contraceptive choices, only abstinence and condoms also protect against STDs.

Devalued as a contraceptive, the condom had not acquired a stigma associated with other forms of birth control. In the 1930s, the image of the birth control movement shifted due to growing support of eugenicists. This alliance led to fears that birth control efforts among poor communities of color were motivated by genocidal intentions. In the 1960s the term 'birth control' was replaced by the more neutral 'family planning' to suggest concern for childbearing as well as contraception. Because the eugenicists were concerned with the 'excessive' reproduction of populations which they deemed incapable of controlling their own fertility, the doctor-supervised female-controlled methods were preferred means of birth control. Condoms are a
part of this discourse only in their absence: as a contraceptive method, they were thought by eugenicists to require too much self-discipline to be promoted among irresponsible populations (their irresponsibility evident from their poverty and prolific childbearing).

Despite research, promotion, and changing medical opinion about contraception, the distribution of contraceptive information and devices remained illegal though contested. A Connecticut case in 1942 ruled that condoms could not be sold as contraception even to save the life of the mother from dangerous childbirth, although they were legally available as STD prophylaxis. Five years after the first birth control pill, Enovid, was on the market, the Supreme Court ruled in Griswold v. Connecticut (1965) that contraception was legal within marriage. The federal Comstock laws were rewritten in 1970 to remove contraceptive information from the list of 'foul' and obscene literature. In 1972, Supreme Court case Eisenstadt v. Baird gave unmarried people the right to use contraception legally. Since 1977, the advertisement of contraceptives is no longer banned.

While the history of medicalization, legalization, and popularization of birth control impacts condom use, condoms remained a 'minimal birth control practice' (Ward 1986:145). When condoms attained center stage, it was in relation to
syphilis. In the 1920s, syphilis and gonorrhea rates increased despite the supposed availability of condoms for STD prevention. Associated with immorality, deaths from syphilis were often attributed to other causes. The quality of condoms was very poor until the 1930s when the introduction of latex increased the production and decreased the cost of condoms. Epidemic proportions prompted the Surgeon General’s campaign against syphilis in the late 1930s. For the first time, condoms were subject to the regulations of the Federal Trade Commission against false advertising which tested condoms for defects, and prompted product improvements (Reed 1978:244). A clear shift toward medicalization had occurred between the World Wars: during WWI, the US military encouraged abstinence in soldiers, but condom use was promoted for soldiers in World War II (Brandt 1985).

The history of syphilis is often cited as analogous to the current AIDS situation (Bibel 1989; Fee and Fox 1988). The moral stigma associated with the condom as prophylaxis for syphilis is one foundation for how we think of condoms in the era of AIDS.

Since the late nineteenth century, venereal disease has been used as a symbol for a society characterized by a corrupt sexuality. Venereal disease has typically been used as a symbol of pollution and contamination, and cited as a sign of deep-seated sexual disorder, a literalization
of what was perceived to be a decaying social order (Brandt 1985:5).

As a means of avoiding syphilitic punishment for sexual irresponsibility, condom use itself was morally questionable. With the medicalization of STDs (before and since AIDS), condom use has become a socially responsible act in what may otherwise be an irresponsible encounter. Gamson (1990) argues that in the 1980s, as in the 1930s, condom use is distanced from pleasure and reproduction; it is defined as a health exception to a moral discourse.

Used properly, condoms have been shown to reduce the risk of numerous STDs (MMWR 1993, 1988), and STD prevention is therefore a dominant meaning of condoms, carrying a contingent construction of morally questionable 'others' who engage in the sorts of sinful behavior requiring condom prophylaxis to protect the public at large. The dual discourses of birth control and STD prophylaxis created the opportunity for access in the guise of STD prevention, allowing 'illegal' condom use for contraception. The extent to which individuals embraced or resisted particular meanings of condom use, and how they reconciled their personal (non)use with public opinion is unknown.

---

In addition to "substantially" reducing the risk of HIV infection, latex condoms reduce the risk of gonorrhea, herpes simplex virus, genital ulcers, pelvic inflammatory disease, hepatitis B, and Chlamydia trachomatis (MMWR 1993).
Historically linked with morally questionable 'others' such as prostitutes and adulterers, condoms partake in moral discourse about the body politic (Scheper-Hughes & Lock 1987) which constructs subjectivities, a process which Foucault (1977) termed biopower. Biopower refers to the effect of ideas and practices upon individuals’ bodies (Lock 1993). The historical discourses of birth control and STDs contribute to how condoms are perceived and employed today: specifically, the extent to which they are thought to 'feel natural,' which uses are normal or unusual, and who needs condoms. Biopower processes of normalization and differentially structured accessibility link public morality and individual practice.
Since the mid-1980s, condoms have claimed, once again, center stage in STD prevention. AIDS was recognized as a disease entity in the mid-1980s, and attention was focused on preventing further spread of the epidemic. According to the World Health Organization (WHO) Global Programme on AIDS:

The greatest public health challenge facing all AIDS prevention programs is to reduce, to the maximum extent possible, the transmission of HIV (Chin and Mann 1990:141).

According to scientific etiology, AIDS is caused by HIV, transmitted from one infected human body to another individual by direct contact of body fluids (blood, semen, vaginal secretions, and breastmilk) where one of the fluids is blood in a threshold amount (Kelly 1995:7). The public health framework of AIDS prevention is the primary force behind the promotion and marketing of condoms.

A major research question in the public health domain concerns 'obstacles' to condom use: condoms, as noted, are historically identified with STD prevention, and now AIDS is popularly known as an STD, so why are not people using condoms to reduce the risk of HIV infection? KAP-surveys

4 KAP-surveys, a prevalent public health research tool, gather "questionnaire-elicited data from samples of individuals regarding knowledge, attitudes, behaviours and practices" (Smith
repeatedly confirm that men's and women's knowledge that condoms reduce the risk of HIV is not correlated with reported condom use. Such studies are less successful, however, in describing the rationale and motives behind this discrepancy.

The development of prevention programs, with the focus on condom use is based on epidemiologically defined risks and scientifically appropriate solutions. In scientific terms, condoms are a simple technological answer: they provide a barrier between the blood, semen, and/or vaginal secretions of one individual and another. Condoms are a focal element of programs across the epidemiologically diverse HIV/AIDS profile worldwide.

An artifact of AIDS epidemiology is the typology of sexual activity and individuals as either 'heterosexual' or 'homosexual.' Such categories are normative and assume coherence of behavior, meaning, and risk. These terms often carry a moral valence: heterosexuality is usually considered normal and 'good,' while homosexuality is presented as deviant, e.g. abnormal and 'bad.'

The trend to treat deviance as illness is addressed in the literature on medicalization. See Joseph W. Schneider and Peter Conrad, 'The medical control of deviance: contests and consequences,' Research in the Sociology of Health Care, v.1, pp.1-53, 1980, for medicalization as the social control of deviance, and see Foucault (1977) for the more subtle concept of
The global HIV/AIDS presence is defined epidemiologically in terms of the dominant mode of transmission in a region. Initially recognized in the US and other industrialized countries, HIV/AIDS was predominant among homosexual men and injection-drug users (IDUs). This became known as Pattern I transmission. AIDS prevention programs target male homosexual activity and injection-drug use, and promote condom use, partner reduction, and, of course, cessation of risky behaviors (anal sex, drug use).

Later recognized in sub-Saharan Africa and increasingly in Latin America, the HIV/AIDS presence had a different profile. In Pattern II, alleged heterosexual and perinatal transmission predominate. Programs in these countries have focused on heterosexual transmission by targeting primarily prostitutes, and encouraging them to use condoms. Programs addressing perinatal transmission, STD control, and transmission in health care settings have emerged more recently (Schopper 1990).

Increasing rates of HIV/AIDS in other countries are now associated with tourism and increasing prostitution. Pattern III countries (in Asia, Eastern Europe, North Africa, and

normalization as productive power. Samuel Butler's Erewhon (1872), in which disease is an criminal offense and crime is treated as illness, provides a thought-provoking illustration of medicalization and deviance.
the Middle East) have had low incidence of HIV/AIDS, no 'dominant' mode of transmission, and few prevention programs. Travelers from industrialized countries are advised by pamphlets to practice safe sex, primarily condom use, while vacationing.

Since the late 1980s, the HIV/AIDS profile in the US has been changing: HIV infection through injection-drug use has increased among marginal populations and a higher incidence of heterosexual transmission is emerging. Heterosexuals 'without any other risk factors' are the fastest growing group of AIDS cases in the US, and women in particular have a rapidly increasing rate of HIV seropositivity (Aral 1993:452). Condom promotion for heterosexual populations in the US is relatively recent because designation of heterosexual contact as a risk factor is relatively recent. The precedents for programs targeting heterosexuals, particularly women, are threefold: the early responses to homosexual HIV transmission in the US, the prostitution-focused programs against African heterosexual transmission, and the anti-syphilis campaign in early 20th century US which focussed on heterosexual men.

---

6 The exposure categories are: male homosexual contact, injection-drug use, both male homosexual contact and injection drug use, received blood transfusion, hemophilia, and heterosexual contact without injection-drug use (Kelly 1995).
Scientific studies have found the risk of acquiring HIV through heterosexual intercourse varies by several factors (Aral 1993). Risk increases with the number of sexual exposures, and with specific behaviors, including receptive anal intercourse, oral sex, sex during menses, and 'dry' sex (sex with minimal lubrication of the vagina; see Brown et al. 1993). These behaviors are risky with an infected partner. Clinical symptoms of AIDS or the presence of other STDs increase risk while male circumcision and condom use reduce risk.

However, scientific and epidemiological data may "play less of a role in determining policy than do the societal values" that shape our reading of such data (Ratcliffe and Wallack 1986:216). A predominant value in US culture is individual responsibility. Hence the means of AIDS prevention programs is individual behavior modification, or what Ratcliffe and Wallack (1986) describe as health promotion, rather than health protection. Risk is attributed to lifestyle, and prevention entails persuading individuals, through a range of educational and behavioral approaches, to forgo their risk-taking, self-destructive habits (Ratcliffe and Wallack 1986:218).

Two facts ignored by this perspective are likely bases for program failures: there are factors such as poverty and violence which may be beyond the control of the individual,
and lifestyle 'choices' are often powerfully influenced by social organization and cultural values. Further, behavioral modification approaches assume that knowledge leads to changes in behavior without questioning what counts as knowledge, which behaviors 'count,' the consistency among individuals' beliefs and practices, as well as the processes by which individuals construct consistency between their beliefs and practices.

This combination of scientific data and health promotion orientation has resulted in AIDS prevention programs which provide information as to why individuals should change their behavior. In addition, groups deemed 'high risk' for HIV and STDs in terms of sexual behavior (e.g., prostitutes) or age (e.g., schoolgirls, reproductive-age women) or relationship with an HIV+ partner are specifically targeted for behavioral interventions (Schopper 1990). The same tactic is prescribed in heterosexual as well as homosexual programs in Africa and the US: namely, condom use and partner reduction (Aral 1993). These generalized solutions are incorporated into local demographic and cultural contexts, coordinating with existing health systems (Chin and Mann 1990). Serious program failure in a cross-cultural context or marginal population may be attributed to 'cultural obstacles,' in partial recognition that individual behavior is more complex than a mere lifestyle choice.
Therefore, the condom in relation to AIDS prevention is presented as a simple, scientifically appropriate, adaptable technology to be smoothly incorporated into one’s lifestyle as a precaution against HIV risk.

But condoms have not easily and smoothly been incorporated into the sexual routine of heterosexual women. KAP studies seek individual and cultural obstacles to condom use. Yet, just as a health promotion orientation ignores structural risk factors, the assumptions built into KAP surveys themselves may preclude understanding of condom non-use.

Morality is embedded in scientific knowledge about AIDS and condoms. In constructing KAP surveys,

researchers’ conceptualization of risk factors appears to derive more from a generalized notion of ‘deviance’ than from anything we know about the epidemiology of HIV (Smith 1993:7).

Attributions of risk to types of sexual behaviors tend to parallel attributions of deviance. Hence anal sex is risky, vaginal sex is usually not so listed. Smith (1993) notes that oral sex and pornographic videos have been investigated as risk factors. Interestingly, oral sex has become designated as relatively less risky (unless one has oral cuts, sores, or has just brushed one’s teeth), while sex research finds increasing prevalence of the practice of oral sex as well as the belief among adolescents that oral sex is
not as intimate or dangerous as intercourse (Lewin 1997). The impact of cultural ideas of deviance is also demonstrated by implementation efforts around the CDC definition of 'safer sex behavior.' The CDC defines the following as safer sex practices: total abstinence from sexual intercourse, self-masturbation, mutual masturbation, use of latex condoms, and use of latex condoms with spermicidal foam or jelly. Mass media campaigns have emerged around abstinence and condom use, but self- and mutual-masturbation have received little attention and no promotional campaigns.

Premarital sex, extramarital sex, and sexual behavior among adolescents are considered risky and somewhat deviant. Of course, this notion that 'normal' sex is 'safe,' epitomized by the suggestion that married couples need not "forgo pleasures of unfettered sexual expression" (Remis 1987), is betrayed by the fact that even married women get STDs and AIDS (Duncan 1994). While it is good to move away from the 'risk-group' framework, in which homosexuals and IDUs are stigmatized as inherently at risk, the 'risk behavior' approach is problematic because risk is associated with deviant behavior. More conducive to successful programs is research on sexual 'networks' and risky contexts where an

---

7 Joycelyn Elders' mention of masturbation caused a public outcry that led to her dismissal.
individual is likely to encounter an infected person (Kane 1991; Klovdahl 1985; Zwi and Cabral 1991).

Finally, there is a methodological issue to address. Population-level data (epidemiological patterns and KAP surveys) which focus on behavior alone ignore the individual features of meaning and context which create HIV risk (Smith 1993). At the most profound level of programming, partner reduction and condom use will only reduce the risk of infection if there is infection; for example, the relative risk of anal intercourse to vaginal intercourse is irrelevant in very low prevalence populations, and anal intercourse infrequently with one known partner is less risky than vaginal intercourse often with many anonymous partners. The primary risk factor is sex of any kind with an infected partner (Smith 1993). Interviews are better suited for this sort of information on networking and context.
AIDS, Gender and Condom Use

Despite the limits of KAP-style research which have been mapped above, KAP studies and anthropological research on AIDS, condom use, and gender provide valuable information. Every study finds that men and women 'know' that the risk of HIV infection can be reduced by condom use. However, studies also show that women do not use condoms for AIDS prevention during heterosexual intercourse, not even with a new (and therefore 'riskier') partner. Women respond to both survey and ethnographic inquiry that they do not consider themselves to be a person 'at risk' for AIDS. Ironically, this recognition reveals the successful stereotyping of 'at risk' populations by early HIV/AIDS research on 'risk groups' (Clatts 1995). Women (and men) have adopted the knowledge that gay men, IDUs, and certain ('other') ethnic populations are 'at risk,' but may not recognize their own risk as the partner of an IDU (Kane 1991) or participant in anal sex as a heterosexual woman (Clatts 1995). A public health corrective is 'sexual self-defense' (Nelson 1991) whereby a woman is told to assume she is always at risk, and therefore advised to use condoms in every situation. Mass media campaigns and condom advertising

---

8 I have yet to find an exception.
pitch universal susceptibility and recommend universal condom use.

However, risk of HIV transmission is not universal. One is at risk through sex with an infected person, thus the role of partner selection is significant. Women do not always use a condom with a new partner. Even a study that found an overall increase in condom use among college women noted "the majority of sexually active women surveyed did not report their [condom’s] regular use" (DeBuono 1990). Women’s motivations for non-use and inconsistency was not investigated.

Ethnographic research shows the varied ways in which women deduce a partner’s history of possible exposure, enabling her to choose partners selectively and thereby reduce the perceived need for condom use. Some women consciously choose partners that are ‘clean;’ neat appearance, responsible lifestyle, and moral character are read as indicators of physical health (Balshem et al. 1992). In Spain, men claimed 'you can tell by looking' if a prostitute has an STD; they defined themselves as not at risk if the prostitute was ‘clean’ or a ‘friend’ (Hart 1995).

Some categories of partners are considered de facto risk-free. Boys and men may choose virgins and ‘schoolgirls,’ believing they are low-risk sexual partners.
Women often consider a monogamous or marriage partner as 'safe;' however, the 'riskiness' of monogamy and marriage are relative to their actual practice, not just the ideal. Obviously, monogamous or married status in itself is not preventive, any more than loudly proclaiming oneself 'not at risk.' Serial monogamy, like any previous sexual experience, and extramarital relations create risks.

Risk perception and attitude toward condoms vary by gender. Moore and Rosenthal (1991) found female teens have greater 'favorability' to condoms than male adolescents, and any reluctance to use condoms is associated with concern for the male's pleasure. A study of women finds they say they would not use condoms if their partner were HIV+ (Harrison 1991). A KAP survey of Canadian college students found

... those who more often initiate sexual intercourse, the males, ... are significantly less concerned with practicing safe sex (Hobart 1992:430).

Yet another study suggests that males are nevertheless prepared to practice safe sex: 81% of males and 92% of females who used a condom during their first sexual encounter report that it was the male who brought the condom to the encounter (Leigh et al. 1994). This study found that among adolescents, boys' desire for sex exceeded their

9 Differences by age and/or generation have not been addressed. Condom use research addresses either 'adult' or 'adolescent' populations.
expectations for the next year, but girls expected to have sex even when they did not particularly want to (Leigh et al. 1994:124). The extent of sexual control, and therefore the ability to make men wear condoms, varies with the relationship context: marriage, dating, sex work, abusive relationships, rape. Advising women to use a condom may place some women in the unenviable position of knowing their risks and yet not being able to ameliorate them because of men's resistance or because of the social risks involved in negotiating condom use. To understand women's condom use, we need to hear more about risk perception and individuals' attempts to employ condoms.

Emotional and relationship factors figure strongly in condom (non)use. Women who do use condoms acknowledge condoms' function as STD prevention, but claim their own use is contraceptive. They feel their partner is less threatened and more willing to use a condom if it is a reproductive concern rather than an issue of disease prevention (Pivnick 1993). Condoms, like the STDs with which they are associated, raise the issue of trust and responsibility (Adrian 1996). Studies have found that among sex workers, non-use is a way of asserting intimacy and commitment in a personal relationship (Pivnick 1993; Worth 1989). On the other hand, the use of a condom can designate responsibility and symbolize caring, particularly if a partner is known to
have an STD. Condoms are believed to decrease 'feeling,'
pleasure, and romance (Beaman and Strader 1989). Recent
anthropological work looks at the impact of emotion on safer
sex, the role of sexual attraction in risk assessment, and
the issue of consistency vs. intermittent condom use
(Lindenbaum 1996).

The multivocality of condoms is to be expected as
residue of multiple condom discourses, the social dynamics
of condom use, gender differences in attitude and practice,
and the public health lens through which much policy-
oriented knowledge about condoms is produced and implemented
in AIDS prevention programs. The facts of condom use are
clear: universal knowledge of condoms as AIDS prevention has
not led to consistent or sufficient condom use. The
campaigns to prevent AIDS through condom use have created
the condom as a symbol of AIDS which may or may not be
superimposed on perception of condom as a symbol of casual
sex and STDs, and the reality of the condom as a
contraceptive. Closer examination of the meaning of condoms
as interpersonal signs and cultural symbols and the practice
of condom use are called for by the research on gender
differences, risk perception, partner selection, and the
role of emotions in condom use.
III. PRESENTATION AND ANALYSIS OF INTERVIEW DATA

The goal of this study is to explore the meanings of condoms and condom use for participants in sexual contexts. As background, the first part of this paper has sketched a broad history describing the two dominant discourses of popular condom meanings, namely disease prevention and contraception. Are these the dominant meanings for individuals? How are condoms experienced and understood physically and socially? To address this goal, this research sought phenomenological accounts and reflexive comments about condom use in encounters where both pregnancy and disease are potential risks.

Rather than statistical representation, this study looks to document the subjective understanding and practice of condom use, and to identify avenues of investigation and analytic categories relevant to safe sex education. The primary data is interviews with six women. O’Nell’s study, also based on a small number of interviews
deleted text

O’Nell conducted thirty-three interviews for her study of identity and depression in a Native American population (O’Nell 1996:227).
accounts about the phenomenological realities" (O’Nell 1996:227, fn2).

Qualitative data was elicited through semi-structured interviews. The construction of the interview schedule (see Appendix A) was guided by the background research on domains of condom discourse, the interviewer’s familiarity with the campus community, and the desire to include as many facets of meaning as possible; it is intended to be both non-judgmental and thought-provoking. The semi-structured interview format was chosen to ensure the collection of comparable data (Bernard 1994:209-210), and at the same time, to allow for the open-ended discussions which are critical to eliciting personal experiences.

I wanted to talk to women about their heterosexual encounters, not only because both pregnancy and STDs are potential risks, but also because male cooperation is required for condom use. How does a woman communicate to her male partner the importance of condom use? What if he insists that condoms are not an option? How does gender appear in the encounter? Heterosexuality as a social fact which incorporates idealized identities and normalized practices of masculinity and femininity emerged from the interviews. The standards of romance and dating invoke this heterosexuality.
For several reasons, I chose to interview female college students. First, young women are the fastest growing population of people with HIV. Health promotions and condom advertising are targeting women. Whether or not women encountered sex education in high school, it is difficult to avoid AIDS prevention and safer-sex information on the college campus and in dormitories. Furthermore, they are treated as individuals in the academic community, they may be relatively free of parental supervision for the first time, they have numerous new options, resources, and opportunities, and their investment (even if it is their parent's money) in college confronts them with the choice of career or family or both.

Because of the intimate and sexual nature of the interview topics, I drew on the rapport, trust, and legitimacy I had established at the campus Women's Resource Center to recruit informants. Four of the women had attended one or more regular meetings of the Women's Resource Center. The two other women, Sharon and Ann, were acquaintances who had expressed interest in my research. They also had feminist concerns and activist experience.

All the women were interviewed in Spring 1993. The women chose the location of the interview: Wendy, Ann, and Pat came to my apartment, Jayne was interviewed at her own home, Sharon chose to be interviewed at a coffeehouse in
earshot of her friends, and I spoke with Leigh amidst the general hubbub of the Women's Resource Center itself. Interviews were generally accompanied by tea, coffee or lunch, and lasted one to two hours with much laughter, a few serious moments, and personal disclosure by the interviewer in an effort to put the interviewee at ease, as well as to reciprocate sharing of personal sexual stories.

Though there was no formal follow-up, the interviewer has had some contact with Leigh, Sharon, Jayne, and Ann in the four years subsequent to the interviews. The relationship status of these women has changed in expected and unexpected ways.

To contextualize the opinions and experiences described by the informants, I accessed various sources. I asked male informants for their opinion of condoms, particularly in terms of pleasure, and what they thought of women who suggest condom use. Research into topics of dating, romance, and gendered identity was prompted by the interviews. In the summer of 1995, participant-observation of college students and the bar scene provided information on identity and risk-taking aspects of meeting someone.

From 1994 through Spring 1996, mention of my research interests at social gatherings usually prompted group discussions (both mixed-sex and all-female). Embarrassed and/or disinterested individuals would walk away, leaving
participants to discuss 'what is dating,' argue the pros and
cons of condoms, reveal personal experiences, and attract
others into the conversation. These sessions were not
audiotaped, however I made notes to myself the following day
of comments that clarified or confused issues. Lastly,
Glamour magazine serve as a touchpoint for cultural norms."

The interviews asked women why they liked or disliked
condoms, and invited them to talk about sexual encounters
where condoms were an issue. Their stories highlight four
aspects of condom use: bodily feelings and emotional experi­
ences related to condoms; the intersubjectivity (or 'negoti­
ation') of condom use; learning (and teaching) of the value
and practice of condom use; and narratives referencing
condom practice and transformation of moral identity over
time.

The interviewer pursued two themes in particular.
First, interviews delved into issues of sexual
'negotiation:' the communication (or noncommunication or
miscommunication) between partners which involves
perceptions and constructions of risk and responsibility.
Research into such patterns and logics is useful for
evaluating the potential salience of condom promotion
campaigns. The second intentional theme of the interviews is

Glamour has recently won recognition as a frank and
accurate source on sex and health topics.
more exploratory: what is the meaning of condom use at the level of the individual physical and emotional body? Informal talk about condoms invokes 'how condoms feel' to explain why men do not like to use condoms. The interviews ask 'what condoms feel like' to women both at the physical site of the vagina, and their impact on how the relationship 'feels.'

In the course of the interviewing and analysis, two other themes emerged. Individuals mentioned parents, peers, and school programs as sources of information about condoms, yet their stories clearly illustrate that lovers and their own personal experiences are very influential to their condom beliefs and practices. Lastly, narratives demonstrate that patterns of condom use over the course of one’s sexual life index the progressive trajectory toward better, more responsible sex and attainment of a more confident self-identity.

Demographically, the sample was homogeneous: census categories would classify all of the women as white, middle class, and heterosexual. However, women were more creative in their self-classification, specifying heritage (e.g., part French, etc.), and sexual potential (e.g., ‘human’).

---

12 One woman identified herself as bisexual, but she was active heterosexually at the time of the interview.
Brief sketches will highlight other differences and introduce the informants.

Leigh is a very vivacious, outspoken woman. She is 23 years old, single, Jewish, bisexual, and a student and activist. She says she has been a 'condom queen' since high school: promoting and distributing condoms to friends even before she was sexually active herself. She has had several brief sexual relationships. Usually very conscientious, she describes two incidences of 'risky sex' with men. In one instance, she was on a cruise with her parents; she was 'horny' and although she had decided she was a lesbian, she had unprotected sex in a shower with a male employee of the cruiseship who had made advances on her. The other occasion of risky sex was with 'the gas station guy' and will be described later. She described herself now as 'bisexual' and mentioned sex with women as a 'safer' practice and as an experience that expanded her concept of sexual behavior. At the time of the interview, she was 'in love' with a boyfriend who despised condoms. She was very conflicted: feeling guilty when not using a condom, yet delighting in her new-found pleasure of condom-less sex. I occasioned upon her several years after the interview; she had graduated college and entered the work world. The intense love relationship with the boyfriend which she described in the
interview had been short-lived, and she was no longer involved in any particular relationship.

Sharon is very outspoken and likes to play devil's advocate. She is 21 years old student, employed in sales, has had one abortion, and claims no ethnic identity. She states her sexual identity is 'vicariously bisexual, heterosexual' and her marital status is 'single forever.' Sexually active since high school, she describes short-term, though often intensely intimate, sexual encounters. After an abortion, she now admits her earlier ideas about the consequences of sex are unrealistic: she thought she would just move to a tropical island and eat fruit on the beach if she ever had a baby. She said that thinking about STDs (or cancer) will attract it, so it is best not to think about prevention too much. The 'era of AIDS' and her experience with many lovers, including some drug-users, has made her more cautious. She is the only informant to identify AIDS as a real risk for herself. She tells of learning from lovers, and insisting on condoms now, to the extent that she has become a 'ruiner of moments.' Several years after the interview, she has quit smoking and presents a more mainstream image.

Wendy is a determined woman with a leadership ability evident in her narrative style, as well as her résumé. She is a 24 year old student employed in a work-study position
on campus. She is single, bisexual, and describes her ethnicity as 'truly American, a product of assimilation' of European and Native American ancestries. 'Promiscuous' when she first started having sex at 17 years old, she had recently broken up with Paul, a boyfriend of three years at the time of the interview. She is diligent in her desire to use condoms because she has genital warts, a form of HPV or human papilomavirus. After an informative aside on HPV (analyzed in Adrian 1997), she describes how having HPV complicated the already rocky long-term relationship with Paul. When he refused to use a condom despite the HPV, she got pregnant and had a miscarriage. She describes herself at the time of the interview as much more confident and knowledgeable about her body and her desires than she had been in high school. I have not seen her since the interview.

Jayne is a responsible student. She is 30 years old, single, Anglo, and 'primarily heterosexual.' She lamented that she was not as sexually active as she wanted to be. She described her sexual encounters as more 'matter-of-fact' than passionate, and birth control was just part of the procedure. After a painful abortion, birth control became indispensable. At the time of the interview, she had a long-distance boyfriend with whom she hoped to become more regularly and intimately involved. Several years later, she
has married the boyfriend but found condom use physically difficult.

Ann is a mellow college graduate. She is single, 30 years old, employed in sales, and has aborted two pregnancies. She described her ethnicity as 'White, Anglo-Saxon' and her sexual identity as 'human' then 'heterosexual.' She has had two long-term relationships, in which she measures a man's character by his ability to take responsibility and be flexible to meet her needs. Her earlier lover told her that only 'bad girls' use birth control, yet blamed her when she got pregnant. Her lover at the time of the interview preferred her to use a female barrier method but used condoms when she requested, despite some physical difficulty for him. Several years after the interview, she has married this lover and is considering having children.

Patricia is a responsible and involved student. She is 22 years old, bisexual, white/caucasian, and described marital status as 'none.' She remembers an excellent sex education program in high school, and an open, non-judgmental atmosphere around teenage sex. She tells the 'it' story of how her boyfriend pursued her until she agreed to have sex, then he planned the occasion. She has had several sexual relationships since high school including a boyfriend
at the time of the interview. I have not seen her since the interview.

Because informants were recruited on the basis of having engaged in sexual intercourse with a condom, the reproductive history of this group is not average. Four of the women told me they had been pregnant, but none are mothers. Sharon and Jayne have each had an abortion. Ann had two abortions. Wendy decided to carry an unplanned pregnancy to term but miscarried. Sharon, Jayne, and Ann implied that the pregnancy was fairly early in their reproductive history and say their pregnancy and abortion experiences motivated their use of contraception.

The interviews reveal how women think about condoms and engage in condom use: how condoms ‘fit’ in their life, what

13 In 1990, 26% of 15-24 year-old women had not had sexual intercourse. Also in 1990, only 14% of women 15-24 years old (and 11% of women age 25-34) used condoms (US Bureau of the Census 1996:84).

14 In 1991, approximately 33% of pregnancies among 15-19 year olds ended in abortion. Among 20-24 year olds, about 26% of pregnancies were aborted, and 14% of the pregnancies among women age 30-34 were terminated by abortion (US Bureau of the Census 1996:84).

15 In 1991, 28% of women obtaining an abortion had one prior induced abortion (US Bureau of the Census 1996:86).

16 In 1991, 20% of abortions were done on women age 15-19 years old, 34% of abortions were performed on women age 20-24 years old, 22% of abortions involved women age 25-29, and 14% of abortions were done on women age 30-34. These numbers have remained fairly constant since 1985 (US Bureau of the Census 1996:86).
meanings they access, and which social relations they perpetuate and represent. Fundamentally, condoms are understood in the context of sex and relationships, rather than through the domains of disease and family planning which were described in Section II. Each woman identified the public discourses that condoms are intended for STD prevention and birth control, but talk about condoms from their personal experience rarely elaborated on STDs. Even when condoms were discussed in the context of birth control options, the concerns were about effects on bodies and impact on relationships, rather than effectiveness rates compared to other methods of family planning.

Overwhelmingly, the benefits of condom use are presented as related to disease prevention, birth control, and health and hygiene issues; thus the historical and cultural ideas about condoms presented in Section II are overtly expressed. At the same time, condoms are said to be unsexy, disgusting, unnatural, and uncomfortable to use. Women are ambivalent about condoms; "I have mixed feelings about them," said Wendy.17 They are referred to as a 'necessary evil' by Ann

17 Interviews were tape-recorded and transcribed. For this paper, minor alterations were made to the form of the quotes in the interest of readability. The following features have been deleted: false starts, marginal vocalizations (mhmm, um, y’know), and some instances of the word ‘like.’ Leigh, in particular, sounds like a 'Valley Girl' despite these deletions. I use some eye-dialect (for example, 'kinda' for 'kind of') to maintain the colloquial flow of their language.
and (three times!) by Sharon. The discourses of birth control, STDs, and AIDS were relevant but not sufficient for expression of these women's experiences with condoms. Perspectives on the condom as an artifact of sexual intercourse also includes emotions of responsibility, guilt, 'naturalness,' and comfort.
Bodies and Emotions: What Do Condoms Feel Like?

The body ... is the point at which individual experience and collective ideologies intersect (Das 1990:43).

Since the 1970s, the body has become an analytic focus in medical anthropology (Lock 1993). The body is 'good to think with' as a metaphor for society, hence the association in popular imagery of increased rates of syphilis in the early 20th century, and the onset of the AIDS epidemic in the 1980s, with the moral breakdown of society.

The body is also an object created by power/knowledge relations through the process of normalization (as briefly reviewed in Section I). Biopower is invoked when women speak of the 'natural' and the 'normal.' How does one's body feel 'normally' and which sensations signal illness or abnormality? What does it mean that sex feels 'natural' but condom use does not? Mapping this terrain reveals links to historical discourses, and suggests the possibility of future permutations on what is 'natural' and 'normal.'

But culture is not only about what is in our heads and what we do, it is also about how we are, about being. The embodiment paradigm foregrounds the importance of lived experience, and how we attend to and with the body from a subjective position in a world of attentive bodies (Csordas 1993, 1994).
Persons actively body forth the world; their bodies are not passively shaped by or made to fit the world's purposes (Jackson 1989:136).

Rather, they are shaped through intersubjective navigation and intrasubjective dialectics of agency and resources from competing discourses in the broadest sense of the term. Habitus refers to the embodiment of culture as "an interplay of habitual body sets, patterns of practical activity, and forms of consciousness" (Jackson 1989:119-120). The habits of sexual practice 'body forth' gendered identity, contest notions of 'normal,' link behaviors with emotions, and provide both obstacle and resource for safer sex.

Condom use, like sex itself, is an embodied and sensual practice. Women spoke of the relationship of condom use to the body in three ways, each a dimension of the intersection of individual experience and collective ideology: the etiology of physical sensations, the appropriate treatment of bodies, and the emotional correlates of bodily experience.

**Etiology of physical sensation**

Women described physical symptoms at the site of individual bodies and ideas of how these are linked to condom use. An etiology is an ideology of disease origin, symptoms, trajectory, and meaning. Although college educated, women's explanations did not always match with
scientific etiology. Sometimes, medical science 'catches up' with women's knowledge from lived experience; for example, clinical trials verify the old wives' tale that drinking cranberry juice reduces occurrence of urinary tract infections (Glamour magazine, May 1997).

Women linked condom use with changes in reproductive health: specifically, the incidence of yeast infection with condoms vis-à-vis other forms of birth control.

Jayne: I didn't used to like condoms very much. They gave me a yeast infection but that was because they were not lubricated. For some reason buying the lubricated ones seemed kinda nasty.

This association counters the STD discourse which Jayne had herself mentioned, as well as recent studies (Park et al. 1995), that condoms prevent infection.

The perceived impact of condoms on bodies depends on the ethnophysiological ideas which one holds -- that is, notions of how one's body functions and how it is supposed to 'feel.' For example, the reduced blood flow from oral contraceptive use is perceived negatively in conjunction with the Egyptian ethnophysiological notion that menstrual flow cleanses the body of pollution; therefore, women using oral contraceptives experience 'weakness' as a result (DeClerque et al. 1986). Further comments from Jayne speak to an ethnophysiology:

Jayne: [Condoms] used to give me yeast infections. We used pull-out before that. ... I didn't have
that irritation of the condoms, I found that they kinda soaked up my lubrication.

She understands yeast infections are derived from the friction of minimally lubricated sex, and non-lubricated condoms are experienced as a desiccant.

American ethnophysiology of reproduction underlies not only ideas of disease (yeast infection) and the mechanics of sex (lubrication), but also provides the logical basis for condom (non)use. Sharon did not trust condoms as protection against AIDS because, she explained, condoms have very tiny holes which the HIV virus, smaller than sperm, can penetrate. Inquiry into body concepts concerning reproductive physiology (Sheldin 1979) would provide background for further discussion of the mechanics of bodies and condoms and thus the potential of increasing safer sex behavior.

One limit of ethnophysiological research is lack of vocabulary available for speaking of bodily processes; however, this dearth may lead to creative imagery and metaphors. What if informants claim they 'just don’t know' physiology? What if they can relate no 'experience,' only objective knowledge of the body?

Wendy: I think women’s genitalia, because it’s internal, is mystifying. When you think about it, it’s the very center of our bodies [and] we walk around alienated from it.
In a culture where the 'normal' body is male and the female body is 'different' (Eisenstein 1988), alienation from the female-ness of their bodies may be a strategy to maintain a sense of 'normal' self. Alienation from one's body is a way to resolve the conflict which Tolman (1994) identified in adolescent girls, between embodied sexual feelings and the perception that these are problematic in the social context of their lives.

The embodiment paradigm challenges the Cartesian dichotomy of mind/body, so it is paradoxical that gendered embodiment entails alienation of the body, its parts and experiences, from the self. Among British teenage mothers interviewed by Lawson (1993), the vagina is separate from the self; sex happens to the body, not to or by the self. In another study, women aged 35-55 years spoke as if "their bodies had a momentum or subjectness of their own" (Saltonstall 1993:9). Lee (1994) argues that menarche is when females' bodies become linked with cultural ideas of gender and sexuality, and thus their bodies become problematic, objectified, and uncomfortable. Body/self contradictions in female identity have implications for the negotiation of sexual relationships.

Whether or not they are alienated from their own body, it is culturally acceptable for women to consider the point of view from male bodies, which is assumed to differ from
women's. What women think that men feel can preclude suggesting condom use; women claim as a truism that men do not like to use condoms. Consideration of male pleasure may even take precedence over female discomfort and inconvenience:

Ann: The guy I'm with right now, says ... the diaphragm is so much better than the condom because sensitivity is increased.

I: His sensitivity?

Ann: Yah. His sensitivity is increased; mine really isn't. [I] feel [his penis] banging against the diaphragm. Sometimes I just feel uncomfortable. Then I have to wear the damn diaphragm. You have sex at night then you have to wear it for six hours, and [again] in the morning, so you have to wear it another six hours. Then you're at work, and before you know it you've worn the damn thing for 18 hours. <laugh> And it's just really messy, too, because ... the diaphragm jelly is coming out of you all the time, and that feels kinda gross.

The following exchange between Patricia and the interviewer also highlights the weight women give to their perception of male sensations in considering condom use:

I: What are condoms for?

Patricia: For birth control purposes and to prevent STDs and also, I think, for comfort <laugh>, no.

I: What did you mean by 'for comfort'?

P: Everyone always says that they are uncomfortable. The men always complain that they're uncomfortable. <laugh> I was just thinking

---

18 In quoted passages, the notation I: will mark the words of the interviewer and author of this paper.
[about] physical comfort for a minute -- wouldn’t that be wonderful!

I: [Sex would feel] better or something?

P, assuming a different voice: Oh wow! The sensation is incredible!

Patricia thought the idea that condoms could increase male sexual pleasure was even more fanciful than her wish that condom use could be ‘comfortable.’

Women also read male dislike of condoms from the difficulty, sometimes inability, which some partners had in maintaining an erection when confronted by condom use. Women variously attributed the troubles of condom-ed penises to age, anxiety, shyness, de-sensitization, discomfort, and inexperience. While some men have agreed with this picture, a few related that condom use improved sexual performance in terms of duration, and the ease of mind that one is acting responsibly.

Two women suggested that male difficulty with condom use arose from ‘body issues’ or alienation from their male sexuality.

Jayne: I figure if somebody’s having trouble using condoms there are a lot more issues that are going on. Like with someone who gets flaccid using condoms, I don’t think they are very comfortable with their sex and sexuality.

The solution, according to Jayne, is for a man to practice feeling sexual with a condom:
Jayne: I've had some boyfriends who ... took the responsibility for it, and, you know, would go and jack off with a rubber. [This] is what I tell guys to do. [It's] good practice. ... [For] a lot of guys, you know, it just shrivels <laughing> [because they feel about condom use that] 'it's just too weird.'

In the following excerpt, Ann explains that her partner's difficulty with condoms would increase if he knew that she was observing his body:

Ann: There's only one thing I really like about condoms. I kinda get turned on by watching a guy touch himself. So it's kinda sexy to see a guy put a condom on, just because he's touching himself, you know? ... I haven't been with this partner for very long and also I know he has a hard time with a condom, so I don't look. <laugh>

I: [You are] just waiting for the day?

Ann: <laugh> Just waiting till I can watch! <laugh>

Women in informal conversation suggested that touching the erect penis to apply the condom reminded men of masturbation, which could lead to embarrassment in a heterosexual situation; men rejected this explanation. The relationship between embodiment, male identity, and sexuality remains to be explored.

**Appropriate treatment of the body**

Condoms were imbricated in talk about moral and symbolic dimensions of what is done to, or with, one's body. Women spoke of what is 'natural' for the body regarding sex
and condoms. The physicality of condom use is defined by its difference from actual or idealized physicality of non-condom sexual interaction.

Heterosexual intercourse is seen as a 'natural' behavior; it is inherently complete, comfortable, and good.

Jayne: I do think people complain about [condoms]. [Condom use] interrupts the whole sex act. It just feels unnatural. I'm talking mostly on the part of female friends.

For Leigh and Sharon, the naturalness of sex in the context of being 'in love' carries a connotation of spiritual depth, of being in tune with the world of nature.

Leigh: One of the most amazing things [about] sex ... is when we're in one certain position, I don't even [feel] that it's in there, ... [like we are] totally connected. ... It really does feel more natural [than condom use], like we're really together.

Sharon: When I was with the long-term relationship, there was the idea that we wanted to have a spiritual relationship and sometimes I feel like we were mating. ... It wasn't the sensuality of sex; it was mating.

Conversely, sex with a condom was described as clinical, artificial, and unnatural. Referring to sex with a condom:

Leigh: It doesn't feel like sex. It feels like a stick in a hole. ... The reason I hate condoms is because it doesn't feel like a body to me. Like I said, it feels like a stick in a hole.

Ann and Patricia describe how condoms interrupt the sensuality of making love; for Patricia, the necessary
abruptness of concluding condom use recalls the intentionally nonsexual situation of social distance experienced with a gynecological pelvic exam:

Ann: It's really nice when you make love and the guy just stays in you, and you just lay there. Some penises get like really small fast after sex. And if you're using a condom, you need to pull out right away. So that's sort of a drag.

Patricia: The only thing that makes me feel further from someone is when they immediately pull out and take off the condom. Like 'we're done now.' And that's what you're supposed to do, and logically it makes sense. But emotionally, it's like at the gynecologist: 'ok, you can put your legs back together and go get dressed now.' It gives you that weird feeling for a split second that this wasn't what you thought it was a minute ago. But it just flashes in front of my mind, then it's like 'that's stupid,' this is the way it is. This is what you have to do.

However, the easy moral dichotomy of 'good' natural sex-love versus 'bad' clinical, unnatural sex with a condom is not definitive. 'Natural' sex entails a messy commingling of body fluids; Leigh spoke about the 'wetness' of sex contributing to the sense of togetherness. Other women preferred the cleanliness of sex with a condom; Ann and Jayne preferred segregation, rather than sharing, of body fluids.

Jayne: [With condoms] I didn't have all that nasty semen in me.

Ann: [Condom use] makes me aware of my body. It isolates my own fluids.
'Messy' sex is juxtaposed to the symbolic value of 'cleanliness.' Not only is 'cleanliness next to godliness,' a 'clean' person is disease-free, drug-free, and morally good (Balshem 1992); ironically, a 'clean' partner is one with whom a condom is not necessary. Clean condom-ed sex could be a micro-study in 'purity and danger.' Douglas (1984) analyzes the body as metaphor for society, focusing on the importance of maintaining boundaries to avoid the dangers of contamination. Ann and Jayne have reversed the tables in one respect; rather than the anthropologically classic blood of menstruation and childbirth, the 'contaminant' is now 'nasty semen.'

In addition to competing values (clean vs. natural), the concept of what is 'natural' in the world of sex is contested. Indeed, assumptions about what 'counts' as sex also affects condom use. The message to use a condom for safer sex is limited in its impact if non-vaginal practices (anal sex and fellatio) are not conceptualized as sex by the participants. For many, sex in the unmarked form refers to 'vaginal penetration with the man as the prime mover and actor' (Holland et al. 1994b:127); Wendy challenged this norm:

Wendy: My attitude toward sex has evolved to the point [that] I want [sex] to be holistic... If your whole focus is on the penis you’ve lost it, you know -- on the penis, and whether the penis is happy, you know. <laughing> That’s a void right
there and that's the way it was with Paul a lot. His whole attitude was whether his penis was getting what it wants. And we had terrible arguments.

Such comments suggest that actual sexual practice and working definitions of 'normal' cover a wider range than do cultural norms.

What is considered 'sex' and what it means to participants may also change throughout an individual's life path. Leigh says that her fondness for the wetness of sex started when she had sex with women, and later she brought this appreciation to sexual encounters with men. Her experiences have changed what 'counts' as sex for her.

Leigh: It has to do with my having sex with women. [It] eliminates the pregnancy thing, pretty much eliminates the disease thing, so that really has influenced my idea of the body. Being more comfortable with my sexuality is definitely a factor in what I'm willing to accept as a sexual experience.

Subsequent knowledge and experience can cause reconsideration of an event.

Leigh: It's hard to think back to the first time I had sex because the guy turned out to be gay. And so, since then I question everything that happens. I'm questioning his motivations and my motivations all the time, especially since I thought for a while that I was gay too. So I'm just bisexual, whatever the fuck that means.

Is it 'normal' sex if the participants are not heterosexual? Can there be 'normal' sex if money is involved? The latter is usually considered prostitution. Clearly, the normative
construction of sex invokes motivations and contexts, not just a particular physical configuration. How does condom use articulate with that construction?

Women presented condom use as responsible to body integrity and to the self. Even though it is not 'natural and nice' to the body, condom use is a means and symbol of showing respect to one's body.

Leigh: I still prefer [condoms] as my form of birth control. [They are] the neatest, and the least infectious, the least penetrating of my natural systems, so if it didn't feel like such shit I'd probably still be using them. If I wasn't disgusted by the way it feels I would still be using it, because it does make the most sense. I mean as far as being not too invading of the body, and nice and neat.

Unlike other contraceptives, the condom is 'non-invasive' and therefore respectful of body boundaries.

Leigh: I don't want to put jellies up my body.

Sharon: It's a point of respect for my body. There's the lack of research. With any kind of drug -- lithium or Prozac -- the medical profession likes to experiment with women especially. You have to be careful. I have a real mistrust of anything that comes out of a doctor's mouth about what I should do with my body. Putting it in your body every day -- hormones -- is important to how you think. I was pregnant once and it changed how I thought. I got moody, more moody than usual.

Wendy: When I started having sex I was 17, and I went on the pill for several months. And I was not pleased with it chemically. I didn't feel right and I went off it. I haven't used it since.
Oral contraceptives were experienced as invasive of the total self, affecting emotions and overall body chemistry.

As noted previously, condoms protect the body's integrity from contamination by other bodies. They also protected the emotional self:

Leigh: I just didn't feel as comfortable with the male body, at all, when I first started using condoms. The condom served as a shield for me. It was a shield and it was nice and I even preferred it. ... Now that I'm comfortable with my body and their body and everybody's body, I just don't need it anymore.

If condoms protect both the body and the self from insult, then condom use is self-respect as well as respect for one's body.

Habitual condom (non)use is a measure of self-respect, and reflects a general attitude toward life.

Leigh: I think [condom use] has a lot to do with self-respect. Like I told the story about the gas station guy, 19 I couldn't have done that if I had any respect for myself. I had no respect for myself from that point on. I was living at home, hating school, hating life, hating everything. I think everybody goes through that period. My friend, Clara, who had no self-respect whatsoever doesn't use condoms at all.

A person with self-respect is a 'responsible' person who avoids putting their body (or another's body) at risk.

Wendy: I have a sexually transmitted disease, which is genital warts. It causes cervical cancer

19 Leigh went to the house of the gas station guy at three in the morning and told him to take off his clothes. They had sex without a condom.
in women, or at least it’s been linked to that. So now I have the added responsibility ... of knowing that I have something I could give to someone else. Therefore I know that I won’t have sex without a condom.

Condom use is a feature of moral identity, of being a responsible person, and may be prioritized over considerations of how sex should feel.

Patricia: To me, [condom use] doesn’t really matter one way or the other for physical pleasure. That’s not a concern. If I’m having sex with someone that I haven’t had a relationship with in the past, and don’t know their history, then I would probably be inclined to use a condom -- to give [me] the mental security.

‘Mental security’ also comes from control. Like Sanger’s birth controllers and the eugenicists (discussed in Section I), Patricia views female-controlled contraceptives as providing greater ‘mental security’ that one is avoiding risks.

Patricia: I think a lot of women don’t trust men when it comes to birth control or STD prevention. ... The whole fact that you have to rely on their decision and their comfortableness with it. I don’t think that women think men are that reliable in that respect.

Unfortunately, female-controlled contraceptives do not reduce the risk of STDs, so women’s potential attainment of self-respect and responsibility, their efforts to treat their body appropriately, requires male participation or simple denial of STD risk.
Emotional correlates of bodily experience

Condoms and bodily experience of sexuality entails an embodied practice cued to emotions. The study of 'erotics,' or sexual excitement, analyzes the culturally patterned dimensions of what is 'sexy' or 'disgusting' (Herdt and Stoller 1990). Sexiness incorporates features of 'natural' sex.

Sharon: I like body skin. The rhythm method [has appeal].
There is a sexy sensuality which condoms are thought to preclude:

Leigh: How many different ways can you express lusciousness in rubber forms?

For Leigh, there are myriad pleasures with 'natural' sex, and no luscious barrier methods (condom, diaphragm, sponge).

However, condoms are not considered unequivocally 'disgusting.'

Wendy: I think that condoms can be incorporated into sex in a nice, innovative way. Putting them on a person can be a sexual act in and of itself. It can be an erotic thing in and of itself.

Sexiness can be contradictory:

Leigh: I used to have fascinations of putting condoms on with tongues, and roll it down with my tongue. I thought it was really sexy. It's totally sexy, but it feels disgusting.

The contradiction that condoms can be both sexy and disgusting suggests the complexity of embodied desire.
Risk-taking is another source of sexiness. Leigh says unprotected sex with a "heavy-metal I’m-in-a-band-in-Chicago working-at-a-gas-station driving-a-Firebird loser" was thrilling specifically because it was an irresponsible act in her otherwise (to that point anyway) responsible life.

Leigh: I think that in a way sometimes condoms serve as a sign of a pathetic sex life. [For some friends] having sex was just a function, something they thought they were gonna do, should do, if they were gonna have a relationship. So she didn’t have any orgasms or anything, poor woman. It seems like a function. Sometimes having sex with a condom just seems functional.

From this point of view, habitual condom use is responsible rather than risky and sexy.

Condoms were mentioned as an indicator of the emotional (non)commitment of one’s partner. Ideas of love, romance, lust, shame, and trust are employed to evaluate the status of relationships by drawing connections between sensation, emotions, and expectations. Issues around condom use and the dynamics of relationships will be addressed later; here the focus is condoms and the physical aspects of how relationships ‘feel.’ These issues culminate in the distinction that many individuals make between ‘having sex’ and ‘making love.’ Not only does the emotional motivation differ, but making love reportedly feels different than having sex. As Leigh and Sharon explained it (above), making love involves a spiritual sense of connection.
In conclusion, embodiment has implications for safer sex suggestions, condom promotion, and contraceptive technology in general. The link between physical sensation, emotion, and experience highlights the suggestion by Hardon (1992) that women's perspective on contraceptive safety, efficacy, and acceptability are necessary for contraceptive development and promotion. In addition to 'side effects' (such as infection or dryness) and the attributes of access, circumstances, and cost addressed by Polgar and Marshall (1976), cultural acceptability of condoms encompasses suitability in terms of erotics and gendered embodiment.
Many researchers have approached sexual behavior as communication.

[Sexual behavior is] both reflective and reflexive, subject to interpretation that varies according to the individual and created interactively within and between sexual partners (Lear 1995:1311).

Condom use is an intersubjective practice because sexual intercourse is intimate and interactive. Condom use impacts the way sex is done, and therefore may influence communication. Condom use, like sex, is a negotiation.

Negotiation occurs on many levels. Overt negotiation is direct and often verbal. The more diffuse communication pursuant to image management in the context of societal norms entails second-guessing of how potential partners perceive each other in terms of the discourse of romance, dating, femininity, and love. 'Negotiation' is the often-used term. However, I think a metaphor of 'navigation' provides a better understanding of the verbal and non-verbal interactions which constitutes a relationship: balancing one's own identity, desire, and intentions vis-à-vis the perceived values, meanings, and expectations of one's partner, family, peers, and society at large. It is far more complex and subtle than rational discussion of contractual obligations, and condom use is not necessarily (in fact,
seems rarely to be) verbal, equally motivated, or part of a 'contract.'

While a woman may use hormonal contraception, and a man may employ a condom without his partner's active participation, a woman who chooses condom use must communicate with her partner. AIDS prevention programs also suggest frank discussion between partners of sexual health and sexual history. Pliskin (1997) argues that presentation of self and the politeness-communication codes appropriate to dating and romance relationships make such open communication difficult. The structure of the dating relationship and the ideologies of romance and gender are the 'doxa' or commonsense field of condom use. Sexual choices are not made in a vacuum, but rather in a cultural context on a field of power which includes issues of identity (e.g., Rebhun 1994).

Despite the evident difficulty of frank communication and the structural disincentives to condom use, women (and men) do successfully navigate condom use. Condom use is achieved through appeals to responsibility, through adamancy (the 'no glove, no love' approach), and through the playful ambiguity permitted in the navigation process which allows for creative image presentation.

Romance, Dating, and Gender as Doxa
Bourdieu (1977) uses the term 'doxa' to refer to the taken-for-granted universe of practice. Like 'hegemony' (Gramsci 1971), doxa naturalizes arbitrariness; people experience and defend a social situation as 'natural,' even if it is not to their benefit. Both terms refer to a naturalization of power relations and practices, as well as to ideologies. But they differ in analytical focus.

Analysis of the 'romantic love complex' (Macfarlane 1995) or the 'codification of intimacy' (Luhmann 1995) looks at the social, historical, and economic interconnections that sustain and develop 'romance' as hegemonic. Romantic love, which "places the wishes of the individual above those of the wider group," flourished with the rise of capitalism and individualism (Macfarlane 1995). In the last century, romantic love has become only "the feeling of being there for each other," rather than the "irrational, even pathological lack of responsibility" and "love-induced suffering" of traditional amour passion (Luhmann 1995:139,144,145). The gender asymmetry in the discourse has decreased, and love in intimate relationships has become a "validation of self-portrayal" which anyone can attempt; the world is no longer restricted to 'Great Loves' (Luhmann 1995:142-143).

Like the discourses of family planning and STD prevention explored in Section I, this level of analysis of
romance is an important grounding for how and why people engage in romance today. However, what is relevant to participants in sexual relations are the implications of romance for their individual pursuits. Doxa is the practice-centered counterpart to hegemony. The key mechanism of naturalization is

the dialectic of the objective chances and the agents' aspirations, out of which arises the sense of limits, commonly called the sense of reality (Bourdieu 1977:164).

The focus is the (common)sense of opportunities and constraints perceived in light of the discourses of condoms, the ideology of romance, and the possibilities of dating relationships.

Because of the gendered asymmetry of romance and dating, women often have a different understanding, or sense of limits, than do men regarding potential sexual encounters and condom use. Nonverbal 'second-guessing' of how a partner will interpret a move or a request relies on the expectation of shared doxa. In this way, historically constructed domains of discourse about condoms are interpolated into a relationship. Navigating condom use links love, romance, and femininity with individual expectations and desires.

The interviews asked each woman to recall the first time she 'had sex' (see Table 1). Though some had described elsewhere in the interview prior experiences of kissing and
TABLE 2: First Sexual Intercourse: Ambience, Planning, Partner

Leigh
Leigh and a friend planned to have romantic sex on the beach. She gave him glow-in-the-dark boxer shorts and a matching glow-in-the-dark condom. He wrote her a poem. They ended up at a 'cheezy' motel.

Sharon
They had sex in the car and went to the grocery store after to get condoms because she was concerned with getting pregnant. No mention of romance, planning, or the nature of her relationship with her partner before they had sex.

Wendy
She told a very good friend that she wanted to have sex with him. He said he did not have a condom, and she said she wanted to do it anyway. The experience was 'beautiful.'

Jayne
Her boyfriend sneaked into her house. When they were fooling around, he 'slipped it in.' It was uncomfortable, and the hymen did not break but she felt she was 'no longer a virgin.' She's fairly certain there was no condom.

Ann
Ann had sex with a friend of a friend whom she did not really like because she was lonely and did not want to be a virgin anymore. He 'probably' used a condom but she did not look at his penis and he did not say anything about it.

Patricia
Her boyfriend had been pressuring her to have sex. When she assented, he planned a romantic evening. She wanted to 'get it over with.' He brought a condom with him, which they used.
<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leigh</td>
<td>(see first sexual intercourse)</td>
</tr>
<tr>
<td>Sharon</td>
<td>Before sex, her partner suggested using a condom. They went to the convenience store where he chose and bought the condom. This became a 'ritual.'</td>
</tr>
<tr>
<td>Wendy</td>
<td>Wendy cannot remember the first time she used a condom.</td>
</tr>
<tr>
<td>Jayne</td>
<td>With a new partner, the main focus for Jayne was breaking the hymen. They 'probably' used a condom the first time she had sex with him. It was very painful, but they 'finally broke the damn hymen.' It was a 'three to five week' relationship.</td>
</tr>
<tr>
<td>Ann</td>
<td>(see first sexual intercourse)</td>
</tr>
<tr>
<td>Patricia</td>
<td>(see first sexual intercourse)</td>
</tr>
</tbody>
</table>
petting, each responded to the 'first sex' question with reference to a heterosexual encounter where she lost her virginity. Half of the women link first condom use with their first sexual encounter (see Table 2). Leigh and Patricia experienced planned sexual initiations which included condoms; they were the only two to mention their first sexual encounter as a romantic occasion. Sharon and Wendy considered condoms shortly before or after their first sexual encounter, but did not actually use one during the encounter. Jayne and Ann say that they were focussed on other issues (breaking the hymen; losing virginity), and they cannot be certain about whether they used condoms or not.

Many messages about sexuality are directed at young adults. Brooks-Gunn et al. identify three prevalent discourses (Brooks-Gunn and Furstenberg 1990; Brooks-Gunn and Paikoff 1993). First, morality involves responsibility and rejecting sex outside of marriage. Because it is wrong to plan to be immoral, planning for sex outside of marriage is to be avoided. Second, sex is dangerous for girls. Female’s bodies and reputations are victims of male desires. Boys are victims of their own hormones triggered by female dress and behavior. Third, portrayals of sexual desire are rampant (especially in movies and music) yet no message is given about managing desire vis-à-vis STDs, pregnancy, and
moral prescriptions. The pro-sex orientation of 19th century utopian movements and more recent feminisms, emphasizing a women's right to sexual pleasure and the ideals of mutuality in sexual relationships, is addressed to adults not adolescents (see DuBois and Gordon 1984). In modern American culture, romance is the uncontested realm of messages about desire, morality, and sexuality, appropriate to people of all ages.

Romance is about finding the right and enduring partner. Teens and adults share the 'Myth of Romantic Marriage:' "the ideal of finding a lifelong partner for an erotic and nurturing relationship" (Lawson 1993:110). Such a relationship is heterosexual and procreative, and strives for both sex and verbal communication. The unwritten scripts of romance are strongly gendered. It 'goes without saying because it comes without saying' (Bourdieu 1977:167) that the Prince wakens Sleeping Beauty, not vice versa, that men with roses in hand ask women to wed, and that, for women, no sacrifice 'for love' is too great. Romance specifies appropriate gender roles.

To meet romantic expectations, women must cultivate the inscription of femininity and feminine sexuality (Holland et al. 1994:68). Femininity means "learning to respond to the world indirectly through the filter of relationships" (Lee 1994:350). Attaining the romantic relationship itself is
prioritized over sexual satisfaction and open communication, the purported attributes of an ideal romantic relationship. Holland et al. (1994) find that in pursuit of romance, young women sacrifice their own desires:

She makes him happy because she loves him, and so she meets what she sees as his needs, and defines her own satisfaction in terms of a general contentment with the relationship, in which her sexual satisfaction is unnecessary (Holland et al. 1994:68).

The female sexuality constructed and maintained by romance devalues female sexual pleasure and encourages female ignorance of sex. Expected to control their weight and appearance rather than their sexual encounters (Holland et al. 1994), women learn to be responsive to the emotional and sexual needs of men, either by submitting to or setting the limit on male advances.

Teenagers generally act as if men are entitled to sex and lack responsibility for the fruits of sexual intercourse (Lawson 1993:114).

This is difficult terrain for encouraging safer sex practice among young women.

Dating is the supposedly fertile grounds for initiating and nurturing romance. Dating relationships anticipate romance; therefore, the ideology of romance shapes the dating encounter, which becomes a game of self-presentation and second-guessing. Males plan (and hope) for sex, and females resist or 'let' sex happen to them:
Men are expected to initiate the first sexual encounter, with women deciding how far things will go, and being responsible for contraception or refusal (Lear 1995:1313).

Romance and dating, like the messages about sexual desire and dangers of sexuality,

make it more difficult to carry on negotiations in anything but a highly sex-stereotypic fashion (i.e., boys wanting sex and girls saying no) (Brooks-Gunn and Furstenberg 1990:76).

Even though Patricia distances herself from romance, the gendered behavior of her initial sexual intercourse replicates the dating dynamic of the male in pursuit and the female setting limits:

Patricia: He’d been pressuring me into having sex. It’s a funny story actually. We called it ‘it’. He was passing around ‘i’. He kept handing me the ‘i’’s in school and finally I just got fed up with it and so I handed him a ‘t’ and that was the sign we were going to have sex. So we finished writing the word ‘it’ so let’s do ‘it’. ... He wanted it to be something that was special because he knew it was going to be my first time, and he had been upset with his first time. It was in a field with some girl he didn’t know and he wanted it to be special [for me]. He planned it all out and you know there was wine and stuff like that and romancing and dancing. My feeling to the whole thing was ‘ok, here we go, we’ll just get this over with,’ so that I can say we’ve finally gone this far. It wasn’t something I was really planning about, but he took care of all of that.

Patricia’s boyfriend had previous experience with condoms and included a condom in the romantic encounter which he planned for Patricia.
On the other hand, Leigh’s description suggests her initial sexual intercourse was mutually planned, and she was an active participant expressing her desires and providing the condom.

Leigh: We had planned [it]. The first time we had sex was the most bizarre fucking thing. I can’t believe I did this. ... I was a poet and I decided I wanted to have sex on the beach even though it’s forty degrees outside. ... We’ll bring enough blankets and it won’t be a big deal. And we go there anyway and the beach is totally closed and we are in the car already messing around. It’s like totally sappy and romantic. The night before he had asked me -- he had told me he wanted to make love to me. ... We’re fooling around for fifteen minutes in my car ... and the police came and told us we had to leave...

And I had a present for him too. I had bought him boxers, specifically, glow-in-the-dark boxers. I think I bought a glow-in-the-dark condom for him... I was prepared. I was just like, ‘let’s do it up -- the whole thing.’ ... Then we had to find this thing called the TipTop Motel and it was like this really cheezy cheezy cheezy motel. CHEEZY. I’m mean I’m talking ‘let’s just go into the cheeziest motel.’ I still hadn’t even given him his present yet and I was just so excited, like ‘this is so cool,’ and he wrote me a really cheezy poem. I mean it was the cheeziest experience, probably, in my entire life. I’d have to say it was definitely really cheezy.

Nevertheless, as she tells it, the male had been the one to suggest ‘making love’ in the first place, enacting the central gendered dating dynamic.

None of the women interviewed mentioned fears or discussion of STDs with their initial sexual encounter, though Sharon and Jayne did note concerns with pregnancy. People are reluctant to talk about STDs during ‘passion’ (in
bed) or on a date, because it would 'ruin romance' (Pliskin 1997:99).

Premised on the gendered behavior that males always want to go further sooner sexually, and females' responsibility is to keep males within limits, the timing of sex within a dating relationship is meaningful to female identity. Refusal is scripted -- women are supposed to say 'no' and set the limits. According to the norms of dating, sex in a long-term relationship is more acceptable for women than sex 'on the first date' or outside the dating scenario. Females in the latter situation are 'sluts' or "girls who lose control over their desires" (Tolman 1994:332). Evincing the double standard, a man who has sex 'too early' in a relationship thereby reveals the woman as a 'slut' without incurring any negative status himself (Lear 1995; Holland et al. 1994b).

The specific ambiguity of 'long-term relationship' relates to attaining a level of commitment and familiarity, like engagement and marriage. However, actual discourse still refers to units of duration: 33% of women said they would consider having sex after three or four dates, 30% say after dating someone exclusively for three months, and 13% said they would consider sex on the first date³⁰ (Glamour

³⁰ The other 24% would consider having sex only after exclusive dating for 6 months, engagement, or marriage.
Accordingly, 'short-term' sexual relationships are conflated with casual sex, and long-term with serious or committed sexual relationships.

Condoms are often associated with casual, short-term sex. Indeed, the STD discourse (reviewed in Section II) finds condoms historically associated with prostitutes, the 'loose women' who have sex with soldiers, and promiscuous gay men. Condoms pre-empt the supposed benefits of a long-term relationship: monogamy and the ability to talk about sexual health. Individuals feel that condoms replace the need for (usually uncomfortable) discussion of sexual history (Pliskin 1997). The women interviewed and other informal conversation with both male and female college students reveals an expected normal progression from condom use with 'one night stands' and in initial sexual encounters, to use of the birth control pill when partner commitment or familiarity is attained.

If the difference between 'short-term' and 'long-term' is relative, the distinction in practice between 'casual' and 'serious' relationships is also difficult to discern. 'Casual' relationships may become 'serious.' The stigma against 'casual' sex may encourage women to consider any relationship a nascent 'serious' relationship. The designation 'boyfriend' may indicate a claim for such legitimacy.
Because the interviews did not examine the exact typologies of relationship labels and implications, it was not possible to compare the navigation of condom use in long-term relationships with condom use negotiated in casual sex. However, Lear (1995) finds that people distinguish between 'casual' relationships (of strangers or friends) and 'romantic dating' relationships (including three months or more of 'dating' before sexual intercourse), and

[W]omen tended to evaluate risk in terms of the type of relationship more often than men, i.e., whether the encounter would be casual or was part of a romantic relationship (Lear 1995:1320).

The romance doxa, specifically the conflation of duration, commitment, and potential mutuality, is used as a basis for assessing risk.

Condom use itself can be read as an indicator of the relationship status. Despite the homogeneity of the interview sample and the similar assumption that 'a good man cares,' there was dramatic variation in the interpretation of condom use. On the one hand, sex without a condom indicated love, 'natural' sex, and 'closeness.' On the other hand, sex with a condom indicated caring.

Wendy: [W]hen I look back upon him saying 'I don't have a condom,' I think that's [saying] 'I care about you and I care about what happens, and happens in the right way ... and that no bad side effects occur because of it.' ... I see that as distinctively different than other sexual experiences who didn't care about me. I don't know why I slept with them. <laugh> Like why did I do
that? They weren’t there the next day. It was totally worthless. There’s nothing that I got out of it except probably HPV.

Ann: I really think that if a guy is using a condom it means he cares a bit because he’s asserting some responsibility to prevent pregnancy or whatever. Yah, I think it shows he’s a sensitive New Age kinda guy.

I: So if he doesn’t want to use it, does that mean he doesn’t like you that much? or it depends on the guy?

Ann: Yah, I kinda think it does. If he doesn’t want to use them, it seems like he’s kinda selfish.

Jayne adamantly claimed that love and caring have nothing to do with the presence or absence of a condom.

The moral inflection on females’ appearance and practice in relation to sexuality is strongly perceived by women.

[G]irls’ subjective sense of themselves as maturing women at menarche develops simultaneously with a process of sexualization whereby young women experience themselves as sexualized, and their bodies are produced as sexual objects (Lee 1994:343).

A young woman may experience a ‘crisis of connection:’ discord between how to be herself, and how to stay in relationships with family and friends who have differing anxieties and expectations about her sexuality (Tolman 1994:324). Women contested, negotiated, and claimed the sexual identities imbricated in romance ideology: virgin, good girl, bad girl, and slut.
In terms of romance, the virgin exemplifies total control of self and male desire, the opposite of the slut's loss of control over her desires and the situation. Yet Ann and Wendy initiated sexual encounters because they did not want to remain virgins.

Ann: I felt like I was the oldest virgin on the face of the earth. I was fifteen. <laugh>

Since 1970, the percentage of 15-19 year old girls who have had sex has increased from 29% to 55% in 1990\(^2\) (New York Times 1997). Research is needed on what exactly it means for a woman to be a virgin in American culture, and why Ann, Wendy, and other young women so want to escape it.\(^3\)

The contradictions of sexuality, morality, and responsibility leave a large role for chance in trying to attain 'good girl' status. Ann says her lover told her that "nice girls don't take the pill," so she did not. Then,

\(^{21}\) Per 1995 data, this statistic has decreased to 50%, the first decline in 20 years (New York Times 1997). On the other hand, census data on contraceptive use notes that 26% of 15-24 year olds don't use contraception because they have not had intercourse (US Bureau of the Census 1996:84). This begs the question of what counts as 'sex.'

\(^{22}\) A recent Dear Abby column offers anecdotal evidence of that virginity is about more than breaking the hymen or sexual initiation. A 21-year-old Mormon woman wrote asking if she was still a virgin after suffering a rape. Other readers wrote in to confirm her virgin status. "She is still a virgin. She did not give herself to anyone," explained one. Another replied, "Yes, you are still a virgin. You have lived a clean and godly life" (Arizona Daily Star 1997).

\(^{23}\) In a 1990 contraceptive use study, only 3% of women age 25-34 say they don't use contraceptives because they have never had sexual intercourse (US Bureau of the Census 1996:84). Clearly there is an age-related significance to virginity.
Ann: The guy is taking me to motels and screwing me but he wants to protect my virtue. And in the meanwhile I get pregnant and get an abortion...
I: So how are you supposed to be a nice girl and not use birth control and not get pregnant at the same time?
Ann: <laugh> ... He was such a nag. But, I suppose, if nice girls don’t take birth control pills, imagine how that makes you feel about getting an abortion.

Leigh put this catch-22 about morality and responsibility in sociological terms:

Leigh: [B]irth control is not a priority for this society right now, because they expect women to be the babymakers, so there’s no birth control or disease control. Because if you’re a good person, a responsible person, you’ll get AIDS tested, and get married and have babies and that’s the end of it.

In the logic of morality discourse, responsible women do not need birth control because they do not have sex outside marriage. Using birth control admits that one is engaging in sex. Sharon: A girl I knew in high school ... had a bunch of them [condoms] sitting by her bed. It seems so glaring, so glaringly real. I didn’t want to admit it, to admit that I had sex.

Not using birth control allows denial of sexual activity, but also incurs the risk of acquiring the concrete markers of sex: pregnancy and AIDS.

Parents, especially, may fear their daughters will take this risk, but cannot be supportive of responsible sexual practice either. Sharon refused contraception and subsequently became pregnant.
Sharon: I felt I was a young naïve little girl and felt like I was doing what my dad told me girls do.

After her abortion, Sharon became more adamant about contraception, but her father was not supportive:

Sharon: He said, 'you're a slut.' I think he saw all the condoms.

In a perverse application of the idea that condom use betrays 'excessive' sexual desire, a grand jury in Texas declined to indict a man of rape because the woman's offer of a condom implied consent to sexual intercourse (Facts on File 1992).

A common sentiment among the women interviewed was that men in general are not trustworthy in regard to responsibility for sex or condom use; women felt that birth control and setting limits were their own responsibility. These responsibilities are attained or compromised by weighing male expectations and limits, against the woman's own resources. To take this responsibility, women have to admit that they are having sex, and thereby embrace a 'bad girl' identity to some extent.

Agency

---

24 After 100 demonstrated at the courthouse, a second grand jury indicted the man of rape.
Clearly, women do not always do what is doxically expected of them. Nor is physically coerced sexual activity, in the contexts of rape and abusive relationships, the norm -- although the extent of emotional, social, and physical pressure on adolescent girls to engage in sex may be underestimated (Holland et al. 1992). Rather, women make sexual decisions and reproductive choices.

The literature on reproductive decision-making and choice of contraception informs the problem of women's non-use of condoms but often omits restraints of a doxic nature, -- that is, the perceived sense of limits or commonsense. Just as people do not explain and treat illness as a Rational Man (Young 1981), women do not make reproductive and sexual decisions as Rational Men.25

Using or not using a condom is not a simple practical question about dealing rationally with risk ... The idea that women are free to choose the most rational form of protection ignores the material and symbolic nature of condoms and their place in relationships between men and women (Lear 1995:1314).

In addition to emotions and embodied experience, the context of decision-making includes subjective goals, expectations,

---

25 Rational Man thinking assumes that language is a clear vehicle of intentions, knowledge is consistent and empirically based, knowledge is organized by inductive or deductive reasoning (rather than symbolism), and ideas about causality allow prediction and control on a pragmatic level (Young 1981:318).
plans, and imagined consequences of a course of action (Nardi 1983).

Many of the interviews describe compromises or capitulations to men’s desires, but a strong sense of agency in terms of autonomy and control of the situation is evident in two scenarios. First, Leigh exhibited a sense of agency in seducing the gas station guy.

Leigh: I met this guy at a gas station ... I mean your basic loser, heavy-metal I’m-in-a-band-in-Chicago working-at-a-gas-station driving-a-Firebird loser, y’know. The fact that he was such a loser attracted me to him ... and I was in a really bizarre mood and he was totally easily manipulable. Not to sound evil or to be a bitch but I think that I am. I went over to his house at three in the morning and said ‘take your clothes off now’ and he did ... I’d been so responsible for so long about having casual sex, I just wanted to be irresponsible. ... This was something I was so excited about. How irresponsible it was! [I met him] at a gas station -- not to be classist or anything -- but at a gas station!

I: You didn’t think he was going to give you a disease or get you pregnant?

Leigh: No, I didn’t see him as such a threat because he was such a numskull, a ninny. I felt in control of the situation, and out of control at the same time. It was a really bizarre experience for me. It was just so much fun to be ridiculously irresponsible.

Leigh attributes the sexual excitement of seducing the gas station guy to the ‘riskiness’ of the situation, that is, the fact that she did not know this guy and was not using a condom. However, the perceived risk is mitigated by her sense of control over the situation, particularly her
ability to manipulate this 'numskull.' Leigh's experience contradicts the assumption that women will employ risk-reducing behaviors (such as condom use) if they have the capacity to do so. In Leigh's case, a sense of control over the situation reduced the perception of vulnerability to pregnancy and STDs, rather than prompting her to pursue condom use.

The second scenario in which women exhibit a sense of agency involves adamancy about condom use when confronted with pleas of romance, familiarity, or commitment. Wendy and her boyfriend Paul repeatedly fought about condom use. Leigh also described the erosion of her willpower to use condoms over the course of a long-term relationship.

Sharon suggests that condom use is "easier if it's a one night stand," and tells how she became a "ruiner of moments."

Sharon: He [told poems] and took me to a hotel. [We] talked all night long. It was sexual but we weren't having sex. And then he grabbed me and I grabbed him and it was right in the moment and I said, 'you need to put a condom on,' and he got pissed.

... Once you get to know somebody you learn how enigmatic they can be or how lying and how much they can change. And so as I got to know more and more I got less and less trustful of the truth of what he was saying: that the likelihood that he gets killed by a car is more than the likelihood that he has AIDS or is going to give me AIDS ... He thought we should have this close interconnection and we shouldn't have or need condoms.
... And so we just didn’t have sex that night. He was a rationalizer. He could come up with excuses, and I was just ‘no, we’re not going to have sex without a condom’ and of course it destroys the moment. That’s why I felt like a ruiner of moments. He was Oscar Wildean and 19th century, and allowed himself to be taken away, and I felt like a stick in the mud because I was thinking about condoms.

Because she was not investing in a long-term relationship and maintained distrust of her partner, Sharon’s sense of responsibility for her health was a basis for action which challenged the doxa of romance.

**Navigation: ambiguity, risk, and play**

To summarize, doing sex is doing relationships and gendered identity because sex behavior (including condom use) is communication and, necessarily, negotiation. It is communication through image management, and a multi-faceted negotiation within and about discourses of romance, femininity, and love. The dating structure and associated ideals of romance -- namely, that men pursue, and women set the limits -- pattern the sense of limits and gendered ‘commonsense’ which pertains in relationships, although other discourses (relating to danger, fun, and morality) provide resources for interactions. Norms of femininity are about how to communicate, how to do relationships, and the expectations of relationships. The facets of a relationship -- whether it is long- or short-term, casual or
committed, involves condoms or not, etc. -- constitutes communication about the relationship and about gender.

However, the meaning and dimensions of relationships are not always as clear as a discussion of doxa might imply; sexual relationships also entail ambiguity and playfulness. Ambiguity is about 'avoiding the sureness of signification' (Minh-ha 1985). Dating provides the structural opportunity for ambiguity: participants behave 'as if' they were in a romantic relationship to determine whether they are compatible, while maintaining a polite deniability. Lear (1995) suggests that the need for face-saving ambiguity bolsters the normative structure of dating.

Communication is rather non-verbal and coded. Ambiguity is deliberately maintained in case one of the partners decides not to proceed (Lear 1995:1313).

The subjective nature of identifying romantic potential allows ambiguity in defining an encounter as 'a date.' When a group of female college students on vacation suggested that I talk to Debbie (a pseudonym) because she was just back from a date, Debbie quickly tried to dispel this rumor:

Debbie: It wasn't a date. He's a friend. And friends don't date friends.

The notorious question of whether friends can date and remain friends is another level of ambiguity to the dating relationship.
The extent to which romance, dating, and sex constitute 'play' also lend ambiguity to the meaning of a relationship. Play is metacommunication which may have a ritualized form (Bateson 1954). Is romance a play frame? Is dating a game? Or is it only a game in the eyes of 'players' and still a serious endeavor for good girls and sensitive guys? Ironically, the recognition of the AIDS threat may not remove sex and dating from a play frame so much as transform the type of play to gambling, --- that is, playing with risk. Leigh's experience with the gas station guy (described above) is an example of the thrill of gambling.

On one hand, play functions as performance. A female college student at a bar left her circle of friends, and asked a male stranger to dance. She told him, "My friends think I shouldn't be dancing with you." Risk-taking for image-management involves playing at misbehavior, like teenage girls who pretend to men to be more sexually experienced than they are (see Holland et al. 1994:68), or girls who date boys of whom their parents disapprove.

On the other hand, play is also a vehicle of socialization, of what is expected and of how to perform. In general, children's play is about learning social

26 'Player,' a term usually applied to males, is similar to 'stud' in indicating someone who dates or has sex excessively and shallowly.
negotiation and achieving a sense of mastery (Brownlee 1997). While kissing, hugging, looking, and holding hands are regarded as play in preadolescents, in adolescence they become expressions of sexuality. These behaviors are considered to be infused with more serious intent and a sense of danger after puberty (Lawson 1993:112).

Paradoxically, adolescents may find that male-female relations are a 'whole new game' at a point when they feel pressure to give up 'playing' and become seriously responsible.
Learning and Sharing

What counts as sex and how sex is imagined, negotiated, and accomplished are cultural behaviors, learned even when not explicitly taught. School, family, and media are normative influences on values and practices of appropriate sex and love. Mothers and peers are reported as major influences on condom use (Beaman and Strader 1989). The women interviewed mentioned their parents, peers, and school sex education programs as sources of information about condoms and sex.

I: Do you talk to [your brothers and sisters] about their birth control? about AIDS? about sex?

Jayne: About birth control.

I: About what works for them, or about your experience?

Jayne: About my sister’s experience with birth control. She went off the Pill. She was having a miserable experience with the Pill. When they were thinking about, in the future, having a baby, they went to rubbers. With my brother, I know he uses rubbers. My brother liked to talk about sex a lot until he started having it, then it was taboo. <laugh>

But by the time that explicit sex education, family planning, and AIDS/STD prevention programs are offered, sexual values and even sexual practices may be already embodied and naturalized. As a consequence, the resources and values provided by sexual health programs may be experienced as exotic and/or uncomfortable, unless they
reinforce or build from naturalized notions of sex, love, and contraception.

The interviews suggest that women acquire practical knowledge from their partners and through experience, in addition to the objectified knowledge learned from parents, peers, and school. Interestingly, partners in sexual encounters were rarely mentioned as a source of information, although they obviously serve as such a resource. Recall that it was Leigh’s having sex with women that influenced her ideas of the body and sex. Sharon’s partner shared a safer sex strategy which influenced her sex life:

Sharon: I was with another man. He was a smart motherfucker, and he didn’t have sex with anybody. He would mutually masturbate. He didn’t want to get AIDS. He didn’t want to get any venereal disease, so everything was vicarious — on the outside.

I: Do you think that’s a good strategy?

Sharon: Uh-huh. I thought he was smart. I thought he was real smart. He influenced me. He influenced my sex life. He was also more honest about his fears, just in general. And admitting that he’s afraid of AIDS is getting over that rebel-without-a-cause phase.

In women’s magazines, generally, mention of information-sharing between sexual partners refers to either pre-coital sexual histories for risk assessment, or verbally and non-verbally communicating pleasure techniques and preferences.
Condom use, like sexual negotiation, is also learned through doing it. Ethnographic research on sexual negotiation among men who have sex with men indicates that there is nothing so effective as learning by doing, especially if the 'mentor' is a very competent person (Henriksson and Mansson 1995).

As with heterosexual dating and sexual activities among young adults, the nonverbal, ritualized, and often ambiguous nature of sexual encounters complicates the application of the objectified knowledge gained through family, peers, and sexual health programs. Partners and personal experience are rich sources of knowledge about sex, sexuality, and condom use; particularly in terms of what counts as sex, and how to navigate condom use.
Discourse about condoms is not just about condoms, sex, and disease. Speaking about condoms and the context of condom use can also serve a narrative function for the speaker. Narrative chunks experience into meaningful units called events.

Narratives of the self are more than a story, a chronology, a history of the self (however defined); they are taken to be a means of knowing the self (Crapanzano 1996:108).

Life stories are told to make a point about the speaker to herself and to others. Life stories are evaluative, linking one's experience with what Linde (1987, 1993) calls 'ideology,' what has herein been included in the terms discourse and doxa.

As excerpts from a life story, the interviews about condom use 'make a point' about the speakers. Wendy was the most explicit in describing condom use as a marker of character transformation.

Wendy: There was a definite transformation of my character throughout the whole thing in which I was 'I'm not gonna do it without a condom,' obviously we did do it a couple times because I ended up pregnant.

Patricia also "feel[s] more adamant about condom use" now, and Jayne "tend[s] not to use nothing anymore."
Wendy pinpoints her transformation to her diagnosis of HPV, yet like the others, the transformation she describes corresponds with a feminist ideal of knowing and respecting one's body and self. Leigh says she had no self-respect back when she seduced the gas station guy. Wendy describes her pre-transformation self as uncomfortable and malleable.

Wendy: I wasn’t comfortable with myself. I wasn’t comfortable with defining or putting up my own boundaries. I was more at the whim of whoever wanted to have sex with me. And that wasn’t very good, I look back at that.

I: And if he said 'let’s use a condom'?

Wendy: Then I’d do it. If he didn’t mention it, I wouldn’t mention it, and if they didn’t want to use a condom, I wouldn’t, and that’s the way it was for a long time ... I wouldn’t be like that now. I finally feel confident that I’ve changed.

In each case, the theme is that the speaker has matured and become responsible and self-respecting.

Through such narratives, women not only justify their current behavior pattern, they construct themselves as agents willing and able to employ condoms (see Adrian 1997). The intersection of identity and emotion with life stories provides the basis for action. For example, the manner in which Wendy and others construct themselves as mature and responsible individuals allows them to overcome the gendered constraints of romance.

The context of these narratives is important to understanding the identities and sense of agency.
constructed. It is often difficult to talk about sex in American culture. The available vocabulary is medical, vulgar, or euphemistic (Lear 1995). Talk about sex is not part of romance, and sex talk is a point of embarrassment between adults and teens, as well as between males and females (Holland et al. 1994). Yet, women told the researcher about their sex lives.

Telling of one's personal experiences has been a conscious feminist strategy since the 1960s; consciousness-raising (CR) through speaking the unspoken assumes that commonality of experiences will be recognized and female solidarity will consequently develop. Participation in a study which collected menarche narratives was perceived as beneficial on an individual level as well, because women were "gaining control over the experience" by talking about it (Lee 1994:356). Women with some feminist experience, either activist or academic, were chosen for this study on the assumption that they would be familiar with, and comfortable with, sharing stories of their personal lives.

This study recruited women familiar with a feminist idiom of speaking the unspoken and telling of personal experiences, in a culture where there are few contexts for sex talk. Clearly, it should be no surprise that these interviewees chose to speak largely in a feminist idiom,
referring to life stories of increasing agency and adamancy about condom use.

However, the ease with which some of the women spoke, and the existence of creative terminology for describing aspects of sexual relations\(^2\) suggests that there are venues of sex-talk other than feminist CR and social science research. In what contexts do sex (and condom) talk appear spontaneously? To whom (besides researchers and CR groups) are narratives referencing sex and condoms told? What sort of agency does engaging in sex talk provide? Talk about weight, or 'fat talk,' is a ritualized discourse among white middle-class adolescent girls in which they present themselves as responsible about their appearance (Nichter and Vuckovic 1994). Is there also conventionalized exchange about sex, dating, and condoms? Which attributes and selves are presented in such sex talk?

---

\(^2\) Some terms that appeared in talk about 'good sex' include dick-drunk, deep sex, fluid-bonded, glow-on, vertical sex, and body rush (Hutton 1992).
IV. CONCLUSIONS & RECOMMENDATIONS

Detailed ethnographic interviews with six informants have yeilded substantial qualitative data. This relatively homogeneous set of women has diverse perspectives on the physical and emotional aspects of condom use. At the same time, identity and cross-gender communication are issues each of the women addresses. Interviews invited each woman to contextualize her condom use, providing the researcher with a more subjective view of the considerations and obstacles for condom use.

Historically, condoms carry predominantly negative associations: prostitution, STDs and AIDS, promiscuity, and 'last resort' birth control. Continuity with historical discourses was evident in the informants' associating condoms with 'casual' sex. But women did not present condoms as a 'last resort' contraceptive; rather, condom use was an improvement over non-contraception, whether the woman progressed to other methods of birth control or not. Contraception, rather than STDs and HIV/AIDS, was the primary concern motivating condom use for four of the six women. The interviews also revealed positive association

---

²⁹ Sharon was equally concerned with contraception and AIDS prevention. Wendy used condoms to prevent spreading her own HPV infection to others.
of condoms with cleanliness, responsibility, respect, and caring.

This research expands inquiry about condoms, exploring physical and emotional experiences and identifying contradictions. Sex is 'natural' but messy; condoms are clean and sometimes sexy but 'artificial.' Condoms prevent transmission of STDs yet they may cause irritation and discomfort. Condoms may or may not interfere with the physical experience of 'making love' or 'mating.' Her own physical sensation may not even be a consideration in condom use. Informants suggested other priorities: because a woman cares about her partner's feelings she may forego condoms for his pleasure. Or she may prioritize personal responsibility and self-respect, regardless of how condoms feel.

The interviews clearly show that sexual negotiation of condom use occurs in a context of gender which limits and patterns sexual interaction. Although the six informants are college-educated and aware of academic analysis of gender issues, heterosexuality -- ideals of feminine-masculine interaction -- is still the foundation of condom use. Initial sexual intercourse, in particular, is infused with norms of romance, dating, and good girl/bad girl stereotypes. The romance ideology scripts partner selection, evaluation, and interaction. The result is supposed to be
finding one's life-long mate with whom the sex is good and communication is easy. Ironically, the informants' experience showed that emotionally invested relationships were the more difficult terrain for negotiating condom use. Informants voiced their frustration with romance scripts, but only Sharon acknowledged the risks of STDs and HIV/AIDS possible in emotional relationships.

The last two themes raised by the interviews concern sexual knowledge and talkability of sex. The informants said they learned about and talked about sex with non-partners (parents, siblings, friends, and school) yet the interviews demonstrate they have also learned about doing sex from partners and from their own experiences. The latter path to knowledge was imitative and embodied rather than objectified and verbal.

Rather than spend more space demonstrating the links between historical and contemporary discourses on condom-related topics, this paper assumes the discourses serve as de facto resources for both individuals and public health programs. Indeed, rather than lament the social construction of the condoms as a marginal contraceptive, a facilitator to and marker of immoral sexual endeavors, and a universal precaution against HIV infection in at risk populations, a more productive perspective is to consider such
constructions as vectors for emergent personal and public frameworks for understanding condoms.

Implications of this research for condom promotion and sexual health education include:

1. Educating toward an algorithm of risky behaviors and risky partners is problematic because people tend to define themselves out of risk categories. Teaching recognition of risky situations may be more effective if accompanied by assessment of practical personal agency. Clearly, it cannot be assumed that the capacity to reduce risk will lead to risk-reduction.

2. When condom use is considered primarily in the context of sex, condom promotion -- identifying benefits of condom use and suggestions for operationalizing a desire for condom use -- needs to be placed in the context of sex, rather than primarily accessing discourse of birth control and STDs. The latter provide motivations for condom use, but are less helpful as vehicles for how to use condoms in an individual's life situation.

3. Exploring ethnophysiology, from notions of self/body to ideas about the mechanics of sex and condom, would foster
appropriate analogies for education and allow programs to focus on popular, rather than merely scientific, concerns. For our hygiene-obsessed American culture, presenting condoms as clean, but not antiseptic, may provide a positive image.

4. An underlying problem to condom use, is the difficulty of communication about sex between partners. Rather than forcing direct communication, it may be more effective to prompt individuals to examine modes of communication (gendered behavior, dress, etc.) and gender stereotypes, so that individuals can, in effect, learn the 'rules of the game' before they decide to play.

5. Emphasize that condoms are appropriate in a multitude of situations for a variety of reasons. Accept that one person's benefit of condom use is another person's drawback, and offer multiple messages to provide individuals with several options on motivations for condom use. Promote condoms as clean, as non-hormonal, as promoting duration of erections, or other positive aspects rather than fear of AIDS. Circumvent individual's denial of risk by pointing out other ways that condom use is desirable.
6. Incorporate gender analysis into sex education curricula. Include not only the 'birds and bees,' statistics on birth control effectiveness, and role-playing 'saying no'; also include role-playing from a cross-gender perspective to illuminate the perceived constraints.

7. Women's lack of self-respect and letting the guy do what he wants lead to risky behavior. In the transformation narratives, responsible sexual behavior was linked to acknowledging one's own sexual desire, respect for and knowledge of the female body, and the self-confidence to do the right thing despite the guy's wishes. STD and teenage pregnancy prevention efforts might focus on developing female self-esteem and self-confidence before they engage in sexual behavior. For girls who are already sexually active, encourage them to discuss and examine their experiences in terms of what they want, what they got, and how it's related to self-respect.
APPENDIX A: INTERVIEW SCHEDULE

Women and Condom Use

Sample Interview Questions:

1. What are condoms used for? Why would someone not want to use a condom?

2. Do you like or dislike using condoms? Why or why not?
   - In your experience what are the pros and cons of condom use?
   - How does the condom compare to other forms of birth control and disease prevention? (in terms of convenience, physical comfort, etc.)
   - Have you switched from condoms to another method, or from another method to condoms? Why? If not, have you considered switching methods? Why?
   - Does sex feel different with a condom? (physically? emotionally?)

3. Can you remember the first time you used a condom? If not, think about any occasion on which you used a condom.
   - Who initiated condom use? (you, your partner, or condom use was ‘taken for granted’ by both of you)
   - When did the decision to use a condom occur? (before intimacy, during foreplay, immediately before condom use)
   - Were you comfortable with the situation and the condom? Why, or why not?
   - Was your partner comfortable with the situation and the condom? Why or why not?
   - In your experience, is the situation you described a common scenario? How have your condom experiences varied?

4. Did you use a condom the first time you had sex? What was that like?
- If not, was condom use considered and then rejected?

Additional questions (these topics were discussed spontaneously by earlier interviewees, so I added them to the schedule for subsequent interviews):

5. Do you know people who have or had an unexpected pregnancy or sexually transmitted disease (STD)? Did that change the way you think about condom use?

- Did you know people who used condoms before you ever did? What did you think of them? (they were tramps, they were smart, etc.)

6. Do you discuss sex, AIDS, pregnancy, condoms, etc., with your brothers and sisters? What do you say? What do they say?

7. What did your parents tell you about sex and STDs? What do they think about condoms and people that use them? (Imagine what they might say if they’ve never actually said anything on the subject.)

8. If you had sex ed in school, what were you told about condoms?

Demographics were requested at the end of the interview:
D1. What is your occupation?
D2. What is your age?
D3. What do you consider to be your ethnic identity, if you have one?
D4. What do you feel is your sexual identity?
D5. What is your marital status?
D6. How many pregnancies and how many kids have you had?
REFERENCES

Adrian, Shelly
1996 Medical, Cultural, and Personal Meanings of Sexually Transmitted Diseases. MS, files of the author.
1997 Wart Talk: A Discourse Analysis of a Conversation About Humanpapilloma Virus. MS, files of the author.

Aral, Sevgi Okten

Arizona Daily Star
1997 Advice For Young Victims of Rape [Dear Abby column]. P. 8B.

Balshem, Martha et al.

Bateson, G.

Beaman, Margaret and Marlene Strader

Bernard, H. Russel

Bibel, Debra Jan

Bourdieu, Pierre
Brandt, Allan M

Brooks-Gunn, Jeanne and Frank F. Furstenberg, Jr.

Brooks-Gunn, Jeanne and Roberta L. Paikoff

Brown, Judith E, Okako Bibi Ayowa, and Richard C. Brown

Brownlee, Shannon

Cates, Willard

Chin, James and Jonathan M. Mann

Clatts, Michael C

Crapanzano, Vincent
Csordas, Thomas J.  

Das, Veena  

DeBuono, Barbara A  

DeClerque, Julia et al.  

Douglas, Mary  

DuBois, Ellen Carol and Linda Gordon  

Ehrenreich, Barbara and Deirdre English  
1978 For Her Own Good: 150 Years of the Experts’ Advice to Women. NY: Bantam.

Eisenstein, Z.  

Facts on File  
1992 Man Indicted in ‘Condom Rape’ Case. 52(2712):859.

Fee, Elizabeth  
Fee, Elizabeth and Daniel M. Fox, eds.  

Foucault, Michel  

Gamson, Joshua  

Glamour  

Gordon, Linda  

Gramsci, Antonio  

Hardon, Anita Petra  

Henriksson, Benny and Sven Axel Mansson  

Herdt, Gilbert and Robert J Stoller  

Hobart, Charles  
Holland, Janet et al.

Hutton, Julia
1995 Good Sex: Real Stories From Real People. 2nd ed. California: Cleis Press.

Jackson, Michael

Kane, Stephanie

Kelly, Jeffrey A

Klovdahl, Alden

Lawson, Annette

Lear, Dana

Lee, Janet
Leigh, Barbara C et al.

Lewin, Tamar

Linde, Charlotte

Lindenbaum, Shirley

Lock, Margaret

Luhmann, Niklas

MMWR

Macfarlane, Alan
Maynard-Tucker, Gisele

Minh-ha, Trinh T

Moore, Susan and Doreen Rosenthal

Nardi, Bonnie A

Nelson, Edward W

Nichter, Mimi and Nancy Vuckovic

New York Times
1997 Sexual Activity Among US Youth is Declining, a Report Shows. May 2.

O’Nell, Theresa DeLeane

Park, Byung Joo et al.

Pivnick, Anitra
Pliskin, Karen L

Polgar, Steven and John F. Marshall

Ratcliff, Kathryn Strother

Ratcliffe, John and Lawrence Wallack

Rebhun, L.A.

Reed, James

Saltonstall, Robin

Schepfer-Hughes, Nancy and Margaret Lock

Schopper, Doris
Sheldin, M.G.

Smith, Herbert L.

Sobo, Elizabeth

Tolman, Deborah

US Bureau of the Census

Valdiserri, R

Ward, Martha

Young, Allan

Zwi, A and A Cabral