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Condom Failure: Examining the Objective and Cultural Meanings Expressed in Interviews With African American Adolescents

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Abstract

The purpose of this study was to explore the meaning and context of self-reported "condom failure" among sexually active African American adolescents. Semistructured interviews regarding methods of protection from pregnancy and sexually transmitted disease (STD) with 124 youth (ages 14–19 years) were content analyzed. The findings suggested three meanings of condom failure. First, condom failure represents a legitimate and important risk related to sexual activity. Second, it can serve as an excuse repertoire for adolescents who engaged in unprotected sex and later experienced either pregnancy or a STD. Third, it may serve as an explanation for males who deceive their partners into having unprotected sex. The findings are discussed with regard to their implications for HIV or STD prevention and research.

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Male condom use is more prevalent among those who have HIV and sexually transmitted disease (STD) risk awareness, positive attitudes toward condoms, and intentions and motivations to use them (DiClemente & Peterson, 1994; Fisher & Fisher, 1992; Terry, Gallois, & McCamish, 1993). Research has also shown that condom use is a highly effective disease and pregnancy prevention method (Cates, 2001). Yet, a limited, but growing, research literature indicates that inconsistent or incorrect condom use compromises the potential benefits of condoms (Crosby, DiClemente et al., 2005; Grimley, Annang, Houser, & Chen, 2005). Studies that define “condom failure” as breaking, leaking, or slipping off during penetrative sexual activity have found that lifetime prevalence of experiencing at least one occasion of condom breakage ranges from 1% to 33% (Crosby, DiClemente, Wingood et al., 2002; Lindberg, Sonenstein, Ku, & Levine, 1997; Shlay, McClung, Patnaik, & Douglas, 2004; Spruyt et al., 1998). Although manufacturing flaws may account for a very small number of condoms breaking (Macaluso et al., 1999), such manufacturing flaws and mechanical breakage are believed to be extremely rare. Indeed, the strict controls over condom manufacturers including water leak tests, air burst tests, and tensile (strength) property testing “virtually eliminate the possibility of product failure as the cause of breakage” (National Institute of Allergy and Infectious Diseases [NIAID], 2001).

One possible explanation for the relatively high prevalence of condom failure is condom misuse or error. Recent studies have linked the likelihood of condom failure to a number of user errors, such as using an oil-based lubricant (e.g., Vaseline®) and completely unrolling the condom before application (Crosby, DiClemente, Yarber, Snow, & Troutman, 2008). Furthermore, researchers have linked condom failure to characteristics of condom users, including inexperience with condoms and younger age (Crosby, Graham, Yarber, & Sanders, 2004; Crosby, Sanders, Yarber, & Graham, 2003; Crosby, Yarber, Sanders, & Graham, 2005). Overall, adolescents are more likely than adults to have a condom break or slip off during sexual intercourse (for a comprehensive review, see Graham, Crosby, Sanders, & Yarber, 2005).

Purpose of This Study and Analytical Framework

The primary purpose of this study was to gain an improved understanding of condom failure in a particular high-risk population—namely, African American adolescents. Indeed, research has shown that there are racial and ethnic differences in sexual behaviors, attitudes, and norms. For instance, although African American youth are more likely to hold favorable attitudes toward condoms (Mizuno, Lennedy, Seals, & Myllyluoma, 2000) and to report condom use at higher rates than any other group (Hoff, Greene, & Davis, 2003), research shows that they have a high risk of acquiring STDs (Centers for Disease Control [CDC], 2006a, 2006b, 2006c). Epidemiological evidence further suggests that African American youth initiate sex at an earlier age and are more likely to have multiple sex partners than other groups (CDC, 2005). Particularly interesting in this context is evidence from a nationally representative U.S. study showing that young African American males are four to five times more likely to experience condom failure than males of other races (Grady & Tanfer, 1994).

Overall, research on condom failure is scarce, and this is particularly true when it comes to high-risk populations. Furthermore, research on condom failure is predominantly quantitative (for an exception, see Crosby, Graham et al., 2004). Although this provides valuable information about general patterns, quantitative studies do not facilitate a more detailed and nuanced understanding of the meaning of condom failure. Using data from qualitative interviews with urban African American adolescents, this study set out to provide a deeper understanding of condom failure by investigating how African American adolescents talk about and characterize the experience.

From the outset, we recognized that sexual behavior has an objective physical reality, as well as a constructed, normative, and cultural meaning. Thus, we expected that a number of youth in our sample would have experienced condom failure, and that we could learn more about the causes of these failures by understanding the contexts in which condom failure occurs.

However, we also assumed that reports of condom failure need to be analyzed as a social and normative construct, not only as a physical reality. Viewed from this perspective, condom failure is important to analyze for its symbolic and cultural meanings as well. We hypothesized that condom failure is a phenomenon that reaches beyond the physical dimension of actual breakage, leakage, or slippage and that it can tell us something about the cultural dimension of condom use among African American adolescents.

To assist in our analysis, and particularly in reaching an understanding of the socially constructed dimension of condom failure, we have relied on theories of impression management. Since Goffman's (1973) seminal work on self-presentation, it has become well-recognized that people do not simply react to their social environments; instead, they try to structure and influence their environments, in part, by constructing beneficial self-impressions. Accompanying this view has been an acknowledgment that interpersonal communication involves more than just expression and description. Indeed, expressions such as "the condom broke" may do more than simply describe lived experiences; they may also serve to influence impressions of others, for instance, by moving the blame of unprotected sexual intercourse away from the individual in question.

As people construct desired identities in social life, they confront threats, such as failed performances and unwelcome feedback from others. With respect to sexual behavior, unplanned pregnancies and infection with HIV and STDs may reflect sexual inexperience, poor decisions, and risky sexual practices. Furthermore, and particularly in African American adolescent friendship networks where condom use is generally valued (Harper, Gannon, Watson, Catania, & Dolcini, 2004), unprotected sex may lead to shaming. Indeed, a qualitative study by Harper et al. found that members of African American friendship groups encouraged condom use among their peers through giving condoms to close friends and encouraging them to always carry condoms. Furthermore, Harper et al. noted that young males would mock friends who had had unprotected sexual intercourse by reminding them they would probably get an STD, AIDS, or a baby.

In these, and similar instances, impression management in the form of concealment, telling deceptive stories, or explanations for blameworthy behavior may help individuals to cope with the threat of a stigmatized identity (Goffman, 1963). From this perspective, stories about condom failure might not be based only on objective experiences of true condom failure. Indeed, it is also likely that reports of condom failure are sometimes part of people's "excuse repertoire" that helps them present themselves as responsible individuals. Following this conceptual framework, we attempted to understand condom failure both as an objective event that is experienced by some, as well as a social and cultural construct. Our analysis examines narratives of condom failure with particular attention to *how* African American teens may try to influence self- and /or other-presentations through the manner in which they describe and talk about condom failure. In this process, we examine the possibility that condom failure not only concerns potential flaws in the product or condom misuse but also is an instance of impression management.

Method

Data Collection Process

This study uses qualitative data collected during formative research for a mass-media sexual risk reduction campaign (see Horner et al., 2008; Vanable et al., 2008). To develop themes for

mass-media sexual health messages, we conducted semistructured interviews with 124 adolescents during which topics of relationships and sexual risk reduction were discussed. The informants were recruited through community-based organizations and alternative school settings serving at-risk youth in two U.S., mid-sized cities. Interviewees were 14 to 19 years of age ($M=15.9$ years). Most self-identified as African American; 3 self-identified as biracial. Fifty-nine males and 65 females were interviewed. Written parental consent was obtained for adolescents under age 19, and participants were compensated \$20 each. Institutional review boards at each associated university approved the study protocols.

The four members of the research staff (2 in each city) who conducted the interviews had prior experience with substance abuse interventions, health education, or HIV-positive case management among urban teens. Each was trained in qualitative interview techniques by the principal investigators at the start of the project. All four interviewers self-identified as African American, and each interviewed participants of his or her own gender. At the start of each interview, participants were assured of the confidentiality of their responses, and were asked to give written assent or consent (depending on the participant's age) to be interviewed and audio recorded. To establish rapport, interviewers began with an unstructured discussion of the teen's daily activities and interests.

The interview protocol consisted of seven topics of discussion. First, the participant was asked about his or her experiences in a current or past relationship of a romantic or sexual nature. A relationship was defined as "a relationship that you might be having now, or one that you may have had in the past, with someone who you may have been sexually attracted to. When I say a relationship, you can interpret that any way you like. Can you tell me about the most recent person like that?" The interviewer avoided gendered pronouns so as not to preclude same-sex relationships, but all participants talked about a particular relationship with someone of the opposite sex. The remaining sections of the interview addressed experiences or expectations of sexual intercourse in a current or past relationship, attitudes about sexual behavior in general, attitudes about and experiences with condoms, beliefs about pregnancy, experiences with sexual health care, and recommendations for educating young people about sexual health. Each discussion topic included open-ended questions, as well as optional probes. On average, the interviews lasted 47 min (range=20–90 min). Following the interview, the adolescents completed a self-administered questionnaire regarding their sexual experiences and contraceptive behaviors, family structure, and media use.

Data Analysis and Management

The interviews were recorded as digital sound files and transcribed by a professional transcription service. Two coders read through the transcripts while checking them for accuracy against the sound files. Errors were corrected.

Most of the discussions of condom failure came in response to the interviewer's request to list things that were "bad" about condoms. For those who did not mention breakage as a "bad thing," the interviewer added a probe asking whether the participant had ever heard of condoms breaking, and open-ended prompts asking whether the participant had experienced condom failure or heard about it from peers. In addition to condom failure narratives prompted by questions in the protocol, discussions of condom breakage that occurred spontaneously in other sections of the interview were also selected for analysis.

In the context of discussions of condom failure, participants offered explanatory accounts of instances of condom failure during sexual intercourse between heterosexual partners. Some accounts described the experiences of peers or friends. Others described personal experiences with condom failure. These narratives were the focal point for analysis in this article.

We employed the software program Nvivo (QSR International, 2002) to conduct the analysis using the constant comparative method (Glaser & Strauss, 1967), a core aspect of grounded theory (Corbin & Strauss, 1990). More specifically, we used a systematic methodology for data analysis. When coding the material, the parts of the interviews that dealt with condom failure were first extracted. Each part was then read and sorted along dimensions of similarity, or themes, defined as theoretically relevant concepts that convey an underlying pattern in the content of the participants' discussion (Sandelowski & Barroso, 2003). Three specific issues were identified, creating the following subconcepts: (a) the detection of condom failure, (b) the causes of condom failure, and (c) condom failure as an excuse repertoire. Although the themes are analyzed separately, they over-lapped in the interviews, and these dynamics should be considered when reading the quotes of informants.

Results

The Detection of Condom Failure

For many of the African American adolescents interviewed for this study, the possibility of a condom breaking during intercourse was a primary concern. This was true for informants with and without personal experience of condom breakage. When asked to list things that are bad about condoms, 83 informants (68%) answered spontaneously that condoms can break, bust, or pop:

Researcher (R): Okay. So we talked about the good things about condoms, what are some of the bad things about condoms?

Informant (I): They easy to bust.

R: Has that ever happened to you?

I: Not really, no sir.

R: Do you know anybody it's happened to?

I: No, sir.

R: Okay. So what makes you think that they're easy to bust then?

I: I heard some people talking about it.

R: What were they saying?

I: They were sayin' like they was inside of a girl and the condom bust and they pulled out and they didn't know the condom had bust until they came out.

R: Oh.

I: And it was everywhere.

R: What did you think about that when you heard that?

I: It made me think that sometimes a condom could bust. Sometimes you gotta keep a close eye on it. (male, age 15)

Of the 77 adolescents in our sample who had experienced vaginal sex, 27 (35%) mentioned personally experiencing a condom break during intercourse. Nineteen of these were male, and 8 were female:

We were going and it popped and I felt something funny. So I made a funny face and a movement. And then we didn't pay attention to it. We kept on going. But then I stopped and he pulled out. And he could see that it was broke, and so he changed.
(female, age 17)

Implicit in the previous young informant's narrative was the sense that a mutual decision was made to ignore the "funny" feeling ("we didn't pay attention to it"), not yet recognized as a break. Her decision to stop resulted in the mutual realization that the condom had broken.

In another informant's narrative on personal experience of condom failure, the narrator made clear that she needed to be in control to reduce STD or pregnancy risk after the condom broke:

R: Now has this [condom breakage] ever happened to you?

I: Yes.

R: Okay. And how did that, how did that turn out?

I: When it bust, he tried to keep going but I pushed him off. (female, age 17).

Each of these narratives suggests that condom failure is not necessarily something that is discovered after male ejaculation and withdrawal. To the contrary, responses from female informants indicate that condom failure is something that they feel and recognize during intercourse. Furthermore, the narratives show that the female informants recognize a condom failure as a situation in which renegotiation of continued sex and condom use may occur.

Similar experiences were also expressed by male adolescents. One male informant described his experience of condom failure: "I feel that hole and I feel that pop.... Like, I come right out, and I grabbed another one, I'm like Whoa!" (age 18). Another informant specified, "You could feel it when it broke" (age 17); several other male adolescents described reacting to a break by putting on a new condom, whereas others discontinued intercourse in reaction to a condom breaking: "I just stopped" (age 14). "I just pulled it out, like fast, [when] I felt it pop" (age 15).

In contrast to narratives of immediate action to ensure continued safer sex, a male adolescent said: "I just kept going 'cause I couldn't stop. It wouldn't stop. I tried to stop but it wouldn't stop" (age 17). Another female informant mentioned that she once had made a conscious decision to continue unprotected sex after a condom break: "When it broke it wasn't any big deal to me, 'cause I was like, 'Okay, just take it off and let's keep going.' But that's when I got pregnant so I was like, wow, maybe I should have said, 'Put another condom on'" (age 16).

Furthermore, in contrast to the awareness of condom failure, a minority of the informants expressed explicitly or implicitly some expectation that one or both partners might not notice a condom break; in such cases, condom breakage goes unnoticed until after the intercourse is completed. In describing his experience of condom breakage, which led to an STD, for example, one young man explained: "It [condom breaks] happened to me; that's how I got burnt. I didn't even feel it when it broke." Another female informant described a situation in which she thought she knew the condom had broken, but was not able to convince her partner that this was the case until after intercourse had ended: "Because the boy put on a condom and I thought I heard it rip or snap, and he said it was just him. So when he took it off it had a hole in it" (female, age 14).

Another male informant told us his story about a time a condom had failed during oral sex, but it was not discovered until after he had ejaculated:

R: Has that ever happened to you, having a condom break?

I: Yeah.

R: It did, what did you do?

I: I didn't know until she took it out of her mouth.

R: And that...

I: And she was like making noises and I'm like what are you talking about and she had her mouth full of something...

R: Of something...?

I: And then "I don't know where you get that from." Then she spit it out. I told her that the condom broke. I was like "oh" then.

R: So what do you do then?

R: Well I was done, so. (male, age 18)

In addition to showing how condom failure is not necessarily detected during a sexual act, this quote also reveals the important point that condom use and failure may occur during oral sex as well as vaginal sex. Furthermore, and although no one in the sample mentioned condom breakage during anal sex, the occurrence of this is, of course, possible. Indeed, breakage during anal sex might even be more likely than during vaginal sex due to decreased lubrication and increased friction.

The Causes of Condom Failure

The informants were not always asked direct questions about how condom failure occurs, and it was not often articulated in the interviews. Nevertheless, a few informants offered their view on this:

R: Ok. And like why, do you know why they break? Did they use it wrong or it just happened or what?

I: Just happens.

R: Yeah? Ok. But you do hear about it a lot like that?

I: Yeah. (female, age 16).

Another informant told this story about her friend who had experienced a condom break:

My friend, she was like, "The condom broke but we just kept going." I'm like, "Did it get stuck in you?" And she's like, "No." I'm like, "Oh." And I said, "Did you put it on the wrong way?" She was like, "Probably." (female, age 16)

These two quotes highlight that some of the informants are uncertain about the reasons for condom failure, which might be one reason why this topic rarely appeared in the interviews.

On the other hand, there were a few exceptions. Indeed, a few informants articulated concrete reasons for why a condom might break, and these reasons were often attributed to user error: "Usually when it breaks it's [because] you didn't put it on right or it's the wrong size. 'Cause if it just breaks then that's a lawsuit" (male, age 17). "Some of the condoms that you use

probably won't fit you. You probably try to use it and it will pop" (male, age 18). One informant, when asked whether he had experienced condom failure, replied, "Never happened to me. I ain't gonna let it" (age 17).

Apparent in these statements is that some of the informants understood condom reliability to be dependent on user behavior, which, in turn, implies that they understood lack of knowledge and experience to be attributable to condom failure:

R: Do you think most guys know the right way of putting them on?

I: I don't think so. I don't know.

R: You don't know...do you know how to put them on?

I: Not really. Like they showed us how to do it, but I don't remember how to. (female, age 14).

One female informant clearly articulated that it might be beneficial for females to learn how to use a condom to be able to ensure protected sexual intercourse:

Yeah, some guys are nasty like that, or you can put a hole in your condom by not putting it on right. So. That's why it's better for a girl to learn how to put a condom too. Because it's, I mean, if you want to do it, they shouldn't have a problem with you putting it on. So, it won't be no problem. So. No babies, no STDs or nothing. You ain't got to worry about it. You can just enjoy your sex. (female, age 17)

Although user error was sometimes understood as an explanation for condom failure, a few informants also expressed concern that some brands do not perform as well as others:

R: Ok. Do you hear that a lot like about condoms breaking and popping or ripping?

I: Like different brands, yeah. Like this brand Durex1, any time I hear of somebody using it, it breaks.

R: Oh really?

I: It's no good. I mean I've had that happen to me, Durex break. And so I'm like that brand, there's like some brands that don't, well places don't do what they supposed to do to make sure they work. And brands, just some of them are no good.

R: Yeah? So Durex is one you know do less.

I: Yeah. Stay away from those. (female, age 17).

R: Okay. Has that (condom break) ever happened with you?

I: Yeah.

R: It has?

I: That's where I learned now when you use Trojan that you put two on at one time. (male, age 14).

Another informant expressed the view that multiple factors can cause condom failure, including user behavior and unfavorable conditions in which condoms are stored:

They could expire; if you don't pay attention to them and you like you can't have them too hot or they could pop. Somebody could put one on the wrong way. (female, age 14)

Condom Failure as an Excuse Repertoire

To this point, it appears that condom breakage was a concern for many of the adolescents interviewed and, furthermore, that the causes of condom breakage were sometimes attributed to user and product error. However, in contrast to the narratives that recognized condom failure as a legitimate and real sexual health risk, several informants (mostly female) expressed the view that condom breakage is part of an excuse repertoire for failed protected sexual behavior.

When discussing condom failure, some adolescents offered that they did not think that condoms broke often, and others qualified their answers by saying that young people sometimes claimed that a condom broke instead of admitting they did not use one: "like, girls that's already pregnant, [say] 'the condom broke.' No, I say you just didn't wear one" (female, age 18):

"Girl, the condom broke." But I mean, it be so many saying it, it's just, "Wow, all you-all's condoms broke?? You're lying." ... That's a lot of girls' excuse. "The condom broke." Where really you didn't use one. (female, age 17)

My other best friend, she did not use a condom because she got pregnant. She lied to me at first about using one and she said it broke, but she finally told me that she didn't use a condom until she got pregnant. (female, age 17)

The idea that condom failure served as a convenient "excuse" for teenage pregnancy was expressed in the context of larger discussions of the drawbacks of condom use. The academic literature on excuses has its roots in Goffman's (1973) work on impression management in that excuses have been defined as attempts to attenuate the link between the actor and some undesirable event (Schlenker & Weigold, 1992). This is accomplished by trying to reduce personal responsibility or by shifting causal attributions from the self to external elements (Higgins, Snyder, & Berglas, 1991). Good excuses—those that offer the best protection of selfidentity—are those that attribute failure to external uncontrollable or unintentional causes instead of internal and controllable causes (Henderson & Hewstone, 1984; Tollefson, Hsia, & Townsend, 1991). Examined from this perspective, condom failure may indeed function as a good excuse for couples who experience unplanned pregnancies, as it conveniently places blame on the condom rather than on the persons involved. Furthermore, and as the previous quote implies, some girls may, in fact, allow themselves to become pregnant but are unable to be honest about this, possibly due to stigma attached to teenage pregnancies. Also in this situation, condom breakage may serve as a good excuse.

Only one male informant suggested that condom failure could be used as an excuse for teenage boys who did not want to tell the truth about how they had become fathers:

I: I know one boy that use that as an excuse...his condom bust, he got a baby.

R: Huh?

I: He got a baby, at school.

R: Oh he says that?

I: Um hum. (male, age 15).

Although the adolescent females we interviewed often expressed the idea that condom failure was an excuse for other girls, they also occasionally told stories of boys using condom failure

as an excuse as well. In describing the experience of a friend who became pregnant in the seventh grade, one female informant said, “Something happened, I don’t know. He had it on, but then he took it off, so he told her it bust but come to find out it never was on or something” (female, age 14). Three female informants expressed concerns about males “flipping off” the condom during intercourse without telling their female partners.

I: A lot of times you can’t tell if a boy takes the condom off while you all doing it.

R: So do you think a lot of them sneak it off in the middle or something?

I: I don’t know. They might, or they might make up some little excuse. You know, it broke or some junk. (female, age 17).

I have heard about them bursting. And then sometimes if you’re not careful, ’cause I had a friend in that same situation also if you’re not careful, a guy can get you trapped ’cause they can flip off the condoms. My uncle had told me about it. So, I mean some females don’t think about that, you know. They’ll say they might be put on another condom but they’re not. You should watch them. (female, age 17)

Another female informant explained that a male partner might know the condom had broken, “but they won’t say it when you’re doing it. They’ll wait ‘til afterwards. Then they’ll tell you that the condom popped” (female, age 17).

Clearly, a few female informants expressed concern that condom failure was in reality the result of deliberate manipulation on the part of male partners who resisted using condoms. In this respect, condom breakage as an excuse takes on a variety of meanings. On the one hand, it highlights the possibility that girls may use condom failure as an excuse to conceal or deny the fact that they were deceived by their partners. Alternatively, it is also possible that girls use “being tricked” as an excuse when the decision not to use a condom was actually consensual. Last, the notion of tricking someone into unprotected sexual intercourse suggests that, in some situations, condom failure may be used as an excuse by boys who do not want to disclose unprotected sexual encounters.

In instances of deception by male partners, condom failure as an excuse takes on a slightly different meaning than in the other scenarios. Certainly, in the other mentioned scenarios, the excuse strategies are potentially used by girls with the intention of saving face and presenting themselves as responsible. When males deceive their partners about their lack of condom use, this excuse might be designed to avoid a partner’s anger; in addition, the excuse might be used for the goal of positive self-presentation. In this way, such excuses are important for the maintenance of a relationship (Hodgins, Liebeskind, & Schwartz, 1996; Weiner, Amirkhan, Folkes, & Verette, 1987). From the perspective of the female partner, however, the use of the excuse derives from the male partner’s report and is, therefore, not something that was under her control. Upon non-disclosure of condom failure or deliberate and concealed non-condom use during intercourse, males might need an excuse to save face and to protect the relationship.

Discussion

Opponents of comprehensive sexual education for adolescents often use condom failure to advocate for abstinence-only sexual health education arguing that condoms are not safe to use (Clymer, 2002; Sternberg, 2002). However, ample data from the mechanical testing of condoms suggest that breakage due to condom malfunction or manufacturing imperfections is quite rare (Carey, Lytle, & Cyr, 1999; NIAID, 2001). Hence, it is likely that most instances of condom failure are related to incorrect use, or *non-use*, rather than to imperfections in the product itself (Crosby, DiClemente, Yarber, Snow, & Troutman, 2007; Crosby et al., 2008;

Crosby, Salazar, & DiClemente, 2004; Crosby et al., 2003; Crosby, Yarber, et al., 2005). To better understand condom failure, we asked sexually experienced African American adolescents to describe the conditions and contexts in which such failures occur.

Three important meanings of condom failure emerged from our work. First, and consistent with previous research (Crosby, DiClemente, Holtgrave, & Wingood, 2002; Grady & Tanfer, 1994), condom failure represents a legitimate and important risk related to African American adolescent sexual behavior. Second, and placed in a slightly different contextual frame, condom failure serves as an explanation for African American adolescents who intentionally or unintentionally have had unprotected sexual intercourse. Third, condom failure may serve as an explanation for African American males who deliberately trick their partners into having unprotected sexual intercourse.

Seen from the perspective of meaning and representation (Fairclough, 1988, 2003), condom failure reports cannot be taken at face value. Our results highlight that condom failure is sometimes used to transform socially unacceptable behavior into acceptable behavior or excusable behavior because it was nonvolitional. This implies that some teens recognize that unprotected sexual intercourse is stigmatized and use condom failure to avoid embarrassment or stigma. In fact, based on relevant research, one may hypothesize that this face-saving strategy is particularly useful for African American teens among whom condom use is generally valued and unprotected sex is stigmatized (Grady & Tanfer, 1994).

Teenage pregnancies represent another example for why condom failure as an excuse may have been so prevalent in our interview material. Indeed, teenage pregnancies are usually inconsistent with mainstream societal demands for attaining adulthood through education, work experience, and financial stability (Luker, 1996). Furthermore, since the 1990s, efforts to prevent teenage pregnancy have increased (Kirby, 2001), and more effort has been devoted to teaching teenagers to protect themselves from unintended pregnancy. Despite the economic burden, reduction in educational and occupational options, and social stigmatization, teenage pregnancies still occur, and this is particularly true among African Americans (Brindis, 1999; Henshaw, 1998; Kirby, 1997). One possible reason is related to economic disparities that follow racial divides and the positive correlation that prevails between teen pregnancy and coming from low-income backgrounds. Luker (1996), for instance, suggested that despite the well-known negative impacts associated with teen pregnancies, having a child while still living with parents may provide support for low-income teenagers not equally available later in life. Placed in this context, condom failure among African Americans may serve as a particularly useful excuse for unapproved sexual behavior.

Another possible reason as to why condom failure as an explanation was so dominant in our sample is bound up in the fact that adolescent females do not control condom use. They might be unaware of or tricked into unprotected sex. In other words, adolescent females might not fully realize what their male partners are doing (or not doing) during intercourse. In both scenarios, condom failure might serve females the purpose of face saving, although in this case it is more in the service of the male partner's desire to avoid conflict with his partner.

The finding that condom failure as an excuse was recognized primarily by females further highlights the importance of sex roles in sexual behavior—that is, that females need to do more work to achieve respectable sexual identities than do men. Researchers have noted that females are more likely to suffer loss of respectable identities as a result of sexual encounters than are males (Lees, 1986; Tolman & Debold, 1993)—something that may make condom failure as an excuse more necessary for females than for males.

The notion that males might trick females into unprotected sex and use condom failure as a means of impression management brings further attention to the gendered nature of the male

condom. For heterosexual females, use of a male condom is mainly in the control of their male partners. Previous research provides evidence of women's lack of power in sexual encounters, preventing them from using a condom even when they would like to (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1991). Although some participants saw themselves as in control of sexual actions and described having the ability to ensure protected sexual intercourse, this perspective may not always align with reality; that is, condom use may not always be under the females' control. The interview material brings to the fore the argument that sexual risk practices need to be seen as part of a dyadic relation—one in which females may have less power to influence the course of action than do their male partners (Connell, 1987).

Implications for STD Prevention

From the perspective of sexual health education and risk reduction, these findings highlight the importance of the relationships in which sex is practiced and relevant cultural norms, rules, and rituals. Although interventions should encourage individuals to follow safer-sex guidelines, effective sexual risk reduction also requires cooperation in dyadic relations. Indeed, interventionists may consider the sexual relationship in its own right as the unit of change. Our results support Wingood and DiClemente's (2000) argument that for women to have true equality in protecting themselves from unsafe sex, societal norms and practices structured to preserve male power and regulate female sexuality must change. This is particularly true for young African American females who are more likely than their White counterparts to experience the social norms and socioeconomic risk factors relevant to the sexual division of labor and power that produces and reproduces gendered sexual health inequalities (Wingood & DiClemente, 2000). Indeed, African American females are not necessarily served by programs that emphasize condom negotiation without parallel recognition and articulation of gender-based expectations for women's sexuality, role in society, and gendered power relations.

Noting that condom failure is used as an excuse does not mean that malfunctions do not occur. To the contrary, condom failure is likely to have occurred in our sample. In addition, our results show that condom failure is often detected during sex, which implies that lack of control over safer sex practices is part of sexual experiences even when condoms are used. Such consequences need to be anticipated during condom skills training programs, and as part of the act of protection. True condom failure during intercourse presents the individuals involved with a new challenge for negotiating safer sex. Although the most common reaction to a condom break in our sample was to replace the damaged condom or to stop intercourse, a few informants also mentioned that they continued intercourse without an intact condom, making clear that various reactions to a detected condom failure are possible. Moreover, the evidence as to what is or is not accomplished by replacing the broken condom in terms of either STD, HIV, or pregnancy protection does not exist and, likely, will never be available. This has implications for risk reduction educators because it highlights the need for continued communication and condom negotiation in the event of condom failure. In other words, adolescents should receive training not only in how to use a condom correctly and how to negotiate condom use prior to engaging in intercourse, but also in how to respond to a condom breakage during intercourse.

The fact that a relatively large portion of our sample had experienced condom failure, combined with some of the informants' view that user error is a likely cause for condom failure, suggests that one important part of sexual education programs may be to increase emphasis on how to use a condom correctly. Furthermore, and as already pointed out by Crosby et al. (2008), this may also be demonstrated in a meeting with health care providers. A meeting between a nurse or physician and a sexually active adolescent allows a "teachable moment" when a short demonstration of how to use and not use a condom might reduce disease transmission and

unintended pregnancy. Our findings about condom use and oral sex also highlight that risk reduction interventions should address the variety of situations in which condoms may be used, and that different precautions may be needed depending on the type of sexual behavior reported. For example, it is important to highlight that condoms can be more fragile during oral than vaginal sex because teeth may make holes in the condom.

Implications for Research

Our findings also have implications for research. From a methodological perspective, the issue of condom failure complicates the meaning of condom use self-reports. The possibility of condom failure indicates that assessment of condom use, especially among relatively inexperienced adolescents, should include assessment of condom failure. This more fine-grained assessment will help to understand the occasional discordant results sometimes reported in the literature. This is made particularly clear in the case in which a couple may choose to continue unprotected sexual intercourse despite detecting condom breakage. Investigators should not assume that self-reported condom use guarantees that the entire sexual intercourse was condom protected, and additional assessment may be appropriate. Certainly, based on the preceding analysis, condom use self-reports that do not address breakage may yield inflated estimates of “protected sex.”

To complicate the picture even further, our results suggest that it is possible that reports of condom failure are also inflated when some informants, particularly females, have been tricked into unprotected sex. The notion of deceiving a female into unprotected sex also highlights that informants may, to the best of their knowledge, report protected sexual encounters when this was not the case.

Based on these findings, evidence indicating that condom use does not provide 100% protection against STDs and unintended pregnancies (Deschamps, Pape, Hafner, & Johnson, 1996; Saracco et al., 1993; Zenilman et al., 1995) is more understandable. The explanation may lie within the way the condom is used, not the condom in its own right. From a methodological perspective, measures of condom use need to include questions about breakage and slippage, as well as incorrect and inconsistent use, to provide more accurate estimates of potential exposure to STDs. Such detailed assessment will enhance the precision of behavioral epidemiology and intervention evaluation.

Last, it should be noted that this study has relied on a convenience sample of African American adolescents in poor urban settings, and that the findings may be specific to this group. Our work with African American youth was motivated by the enormous disparities in the epidemiology of HIV and other STDs in this population subgroup. Nonetheless, to shed further light on the culture-specific implications of our findings, future research would be enriched by cross-cultural comparisons of the meaning and experiences of condom failure. Such research may, for instance, deepen our understanding of the differences and similarities of the meaning of condom failure in different racial and ethnic groups, which, in turn, may shed further light on culture-specific condom-related behaviors and intentions.

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