**Research Update**

Latex condoms are a very effective barrier method for preventing transmission of HIV and other STDs, and the most popular and commonly used form of protection against them. Despite strong arguments in favor of condom use, many people at risk for HIV infection do not regularly use condoms during sex.

Among the reasons people give for not using condoms are: dislike of them; insufficient or inaccurate knowledge of HIV infection or condoms; psychological and emotional conflict about using condoms; and social influences.

**Disliking Condoms**

Some people find condoms to be uncomfortable, inconvenient to use, or a deterrent to being sexually aroused. They may have once used condoms for an extended period and stopped. Many people who always use condoms also report not liking them, but continue to do so primarily because the reasons—for instance, to avoid infection with HIV or other STDs, to avoid pregnancy, or to obtain partner or peer approval—outweigh the drawbacks.

**Information Challenges**

If people lack knowledge about the risk of HIV transmission through unprotected sex, they will be less motivated to use condoms. Confusion about what are “safe” and “unsafe” sexual practices can contribute to this ignorance. For example, if a female client believes she can be infected only through receptive anal intercourse, she may not feel motivation to use protection during vaginal intercourse.

Inaccurate information also affects motivation to use condoms. A telephone survey of more than 5,000 heterosexuals in U.S. cities showed that, while 96% of respondents believed condoms to be effective in preventing STDs and 83% said that condoms were effective for preventing pregnancy, more than half the respondents believed that condoms might fail during sex.

In fact, the rate of breakage or slippage of condoms when properly used is less than 2 percent. More common are failures that result from condoms that are used incorrectly.

A nationwide survey of men between the ages of 20 and 39 showed that the highest average condom breakage and slippage rates were experienced by infrequent and
Related Issue: Latin Americans and Acculturation in the United States

Although Latin Americans make up less than 10 percent of the U.S. population, Latinos accounted for nearly 20 percent of adult AIDS cases reported in the United States in 1995. Also, general population surveys have often found lower rates of condom use among Latinos in the United States than among non-Latinos. Researchers suggest that cultural factors and the absence of prevention messages and interventions targeted and accessible to Latinos, particularly early in the epidemic, may help explain disproportionately high rates of infection and unsafe sex.

Culture encompasses the values, norms, attitudes, and expectations that can shape the people who are a part of that culture. Acculturation, the process by which people adapt their attitudes and behaviors to more closely resemble those of the mainstream society they are in at a given time, appears to strongly affect HIV risk behaviors. One study showed that as women from Latin-American countries became more highly acculturated in U.S. cultures, they were more likely than less acculturated women to have multiple sex partners. The survey showed that men from Latin American countries, on the other hand, became likely to have fewer partners as they became more acculturated. The survey’s researchers suggest that, as they acculturate, Latinas and Latinos may begin to take on the sexual attitudes and behaviors of mainstream U.S. cultures, which differ from those of Latino cultures. Often, expectations in Latin American cultures restrict the number of partners that women have, while expectations may encourage men to have multiple partners.

Surveys show that Latin Americans who are more highly acculturated in U.S. cultures identify with risk-reduction messages, which are generally targeted to and designed for European Americans rather than Latinos. Those who are more acculturated in U.S. cultures are also more likely than those who are less acculturated to have knowledge of prevention strategies and adopt these strategies. In one survey, for instance, Latinas who were less acculturated—a group defined by researchers in this study as those who spoke Spanish when surveyed—were less likely than other Latinas to ask their partners to use condoms. Studies show that conditions such as ethnic prejudices can keep some Latinos from seeking or receiving services provided by some non-Latino organizations.

Being aware of acculturation can help counselors understand a person’s belief system. It is essential, however, to remember that generalizations about the effects of acculturation on groups of people cannot be applied to specific individuals; the ways in which any individual is affected by acculturation vary with each person. In addition, while mainstream cultures exist, specific social, regional, and ethnic populations are made up of many interrelated cultures. Finally, the effects of acculturation can depend on numerous factors, for instance the length of time a person has been in a particular culture and the level of or desire for acculturation held by one’s family or peers.

inexperienced users. In a study of gay men, the probability of condom failure during a single episode of receptive anal intercourse was less than 1 percent for those who had used a condom for this behavior more than 10 times in the previous year; for those who had used a condom only once during receptive anal intercourse in the previous year, 15 percent experienced condom failure in that episode.

Surveys indicate that a basic knowledge of how HIV is transmitted and how it may be prevented is generally widespread across racial, ethnic, socio-economic, and sexual orientation groups. This data indicates that a majority of people at risk for infection have at least some awareness of their risks. As several studies of health-related behavior models have shown, however, knowledge of health risk does not necessarily result in healthy behavior. Clearly, if accurate knowledge about HIV exists among those who are still placing themselves at risk by not using condoms, other obstacles are affecting behavior.

Personal Challenges

Emotional and psychological factors can complicate a person’s decisions about using condoms. Perhaps the greatest challenge is that using condoms involves negotiation and agreement between at least two people. Such negotiation requires that partners communicate effectively about sexual behavior.

Several factors can inhibit this. Most prominently, people may have difficulty discussing sex. If the issue of HIV infection is introduced, it is often difficult for people not to feel blamed or persecuted by partners. In addition, mistrust may arise when one partner asks another to use a condom. Faced with these potential complications, a person may decide to face the risks of having unprotected sex rather than enter into a dis-
cussion that may feel confrontational. Many people have not developed the communication skills and self-confidence necessary to negotiate condom use. Many people have not developed the communication skills and self-confidence necessary to negotiate condom use.8

Insecurity stemming from low self-esteem or personal fears might also be an obstacle to using condoms. A person with particularly low self-esteem may not feel deserving of protection, and could be poorly motivated to pursue condom negotiation.9

Cultural and Societal Challenges

Challenges to condom use may also arise from a person’s social environment. Cultural factors that relate to family, religious, ethnic, or racial experience can affect beliefs about condom use and experiences with condoms. Socio-economic factors also affect condom use.10 For example, people who are homeless or socioeconomically disadvantaged often lack goods and services, including access to education and health care. A person may not have the means to obtain and use condoms or may not see that he or she has options for self-protection.

A person’s ability to make decisions regarding condom use can be influenced by his or her perceived or actual status of power in a sexual relationship. Women in heterosexual relationships, for instance, may

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<td>A Group of Sexually Active Young People Reported the</td>
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<td>Following Negative Experiences Related to Condom Use</td>
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<td>Always aware condom was on</td>
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<td>Reduced feeling or sensation</td>
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Related Issue: African American Cultures and Condoms

After years in which there was little research on condom use among African Americans, several recent studies have focused on the subject. Some have found that the frequency with which African American men and women engage in unprotected sexual intercourse is slightly higher than for European Americans of similar socioeconomic backgrounds.21

While a significant number of African Americans face societal and institutional challenges to condom use—such as lack of economic resources and lack of access to and trust in health care services and information—researchers say the disproportionate rise in HIV infection among African Americans suggests that some specific cultural challenges to condom use also exist.

Such generalizations about African American culture do not take into account specific differences of each individual. They can, however, provide a framework for exploring cultural influences that African Americans may face.

Anthropologists have characterized African American culture as a mix of African heritage and historic experience in the United States. Characteristics of this mix include the importance of extended family, emphasis on collectivism instead of individualism, respect for older people, humanitarianism, and “religiosity” and spirituality.22 Researchers state that these characteristics could affect perceptions regarding condom use. For instance, concerns for family and community might complicate a person’s decision to use a condom.

African American women accounted for more than half the total number of AIDS cases reported among women in the United States during 1995.23 Classism, sexism, economic factors, and gender roles may significantly affect condom use for many women.

Many African American men who have sex with men do not identify as homosexual and may engage in unprotected heterosexual sex without disclosing their risks from sex with men.24 Because many prevention messages have not reached them, African American men may not have accurate information about their risks. Studies show, for instance, that African American men are more likely than white men or Latin American men to believe that condoms are not effective.25

Another challenge to condom use among African Americans is the experience that HIV prevention efforts, when they do exist, have often been designed by non-African Americans.26 Researchers state that feelings of suspicion, anger, fear, and mistrust inhibit the acceptance of condom use. Further, health care services are often inaccessible to African Americans.27 However, in recent years, grass roots prevention efforts within African American communities, including community, social, and religious organizations, have received greater funding and achieved new levels of success.
Related Issue: Approval of New Condoms

The federal Food and Drug Administration (FDA) has traditionally approved the use of condoms only for use during vaginal intercourse to protect against pregnancy or sexually transmitted diseases, including HIV. As a result, many prophylactic barriers have either not been available or they have been sold without FDA approval for the purposes for which people use them.

Polyurethane Condoms

While at an earlier time, only latex condoms were considered effective in preventing pregnancy or infection with HIV and other STDs, polyurethane is a new material for condoms. Two polyurethane products have now been released. One is similar in form to a latex condom and is applied to the penis like a latex condom; the other is inserted in the vagina.

Avanti is the brand name of the polyurethane condom worn on the penis. In 1994, following limited testing, the FDA approved the marketing of Avanti to consumers who experience sensitivity to latex. The product packaging states that Avanti’s effectiveness in prevention pregnancy or infection with HIV and other STDs is not yet known. The condom’s distributor is currently seeking broader FDA approval. Marketers promote the Avanti condom as thinner, more durable, and more conductive of heat and sensitive to touch than latex. However, research also shows that the Avanti may break more often than latex condoms. A series of studies showed that 9.6 percent of the Avanti condoms broke during sex, compared to fewer than two percent of latex condoms.

The Reality brand condom lines the inside of the vagina for vaginal sex. It was approved by the FDA for this use in 1994. The Reality condom can be worn for up to eight hours. Women can have greater control over their own protection using this product instead of condoms applied to the penis. A potential drawback is that some women have reported that the condom, which includes an outer plastic ring, feels awkward.

For some, the cost of these new condoms may be prohibitive; in stores, each Reality costs about $3 and each Avanti about $2.40, while the average price for latex condoms that cover the penis is less than $1.

Anal Intercourse

The Female Health Company, maker of the Reality condom, is seeking FDA approval for a condom that has the same general design as the Reality condom and is inserted into the anus for anal intercourse. The pouch design of this condom, to be called the Aegis, can be attractive to men who have trouble maintaining erections during sex or those who do not want to stop sexual foreplay to apply a condom to the penis. An increasing number of people, especially gay men, now use the Reality condom for anal sex. Some public health departments distribute the Reality for this, and the Female Health Company offers a free sample by calling 800-274-6601.
Implications for Counseling

A discussion of condom use, similar to the exploration of nearly any topic related to behavior and risk, requires that counselors individualize the discussion for each client. This begins in the assessment of a client’s sexual behaviors and, if relevant, condom-use; thoughts and feelings about condoms; and motivation to avoid infection with HIV or other sexually transmitted diseases (STDs).

Through this assessment, counselors are likely to discover a range of client experiences. They may, for example, find that clients do not like the sensation or smell of condoms, that they do not see themselves at risk through unprotected sex, or that they do not feel they have a right to discuss condom use with their partners. Knowing such specifics, counselors can assess the relevance of each to the client’s behaviors and establish priorities for the counseling session. Counselors can then help clients more thoroughly consider obstacles to use and strategies that might lead them to engage in safer behaviors.

Assessment

A client may begin disclosing his or her views about condoms at the outset of the risk assessment session. For instance, the client may state that he or she hopes to receive a negative test result in order to begin engaging in unprotected sex with a primary partner.

Remain open throughout the risk assessment session to any statements that may reveal clients’ views toward condoms, and recognize that clients may make statements that appear conflicting. For a client who does not always use condoms, assess his or her level of motivation to change behavior.

Awareness and Information

In some cases, clients do not have knowledge about condoms and condom use. They may not know how to use condoms, that condoms are effective in blocking HIV, or what type of lubricant to use. Discussing basic information may be essential for some clients. Its content and thoroughness will depend on the client’s ability to understand educational messages. Clients may try to conceal their lack of knowledge because they are embarrassed by it. Explain that many people lack this knowledge, and create an atmosphere where clients can feel comfortable acknowledging their limitations.

When clients who have received counselor education in the past appear to have little knowledge about condoms, explore whether previous counseling provided some foundation of knowledge. Assess clients’ abilities and motivations to learn, then structure messages so that clients will understand them. Language barriers or reading difficulties may affect clients’ ability to retain information. Or, clients literally may not comprehend information that contradicts their beliefs or values. Assess this possibility by discussing how clients view their own condom use.

Considering that counselors and others have been providing information about condoms for several years, counselors may feel frustrated when clients express that they lack information. However, it is important to remember that at different times people have various levels of ability or motivation to receive such information. For instance, a client may be sexually active for the first time and has had little reason before now to consider condom use.

Personal Views about Condoms

When clients express negative views about condoms—such as that condoms are uncomfortable to wear or that they reduce sexual sensation or the spontaneity of sex—learn more about these views. Ask, through open-ended questions, what aspect of condom use is uncomfortable and in what ways condoms reduce sexual sensation. If clients hesitate to respond during this discussion, be careful not to answer questions for clients. Instead, acknowledge that a client may feel vulnerable in this personal discussion, and explore the client’s feelings about his or her discomfort. Allowing clients to overcome their reticence in the counseling session may enable them to do this in a setting in which they might discuss condom use with partners.

Clients may question the effectiveness of condoms. For instance, they might say that they do not use condoms at all because condoms are not 100 percent effective. Acknowledge the truth in this statement, point out that only by abstaining from sexual intercourse can a person entirely eliminate the risk of sexual transmission of HIV infection, and state that condoms are the most useful protective barrier against HIV for people who do engage in sex. Be alert to the possi-

A Counselor’s Perspective

“I can never presume a client’s reasons for not using condoms. What I can do is ask questions, listen, and assess the relevance of various factors. I need to be aware of these factors and make sure the client feels safe in this discussion.”
bility that clients might question the effectiveness of condoms, yet have other reasons for not using them; for instance, their partners may be unwilling to use condoms.

**Views about Risks**

Clients may not view their behaviors as risky enough to use condoms. Or, if they view themselves as being at risk, they may express a lack of concern about becoming infected. In some cases, clients may not want to acknowledge to themselves their risks or behaviors.

People in a primary sexual relationship may see themselves as not being at risk for HIV infection. They may believe their primary relationship is monogamous, even if, in reality, it is not, or they may incorrectly believe that if sex is occurring outside the relationship, it is safer sex. Clients may hold these beliefs regardless of whether their partners have committed to monogamy or to having only safer sex outside the relationship.

For a client who values being in a primary relationship, validate this and acknowledge that trusting and committed relationships can and do exist. Explore the relevance of communication, commitment, and trust for people who express the desire or intention not to use condoms in these primary relationships. Talk about the importance of discussing these issues with partners. Acknowledge that such a discussion may not be easy, especially if they or their partners are not accustomed to talking about sex. Help these clients understand possible risks in primary relationships. While sex within a relationship in which both partners are uninfected and do not engage in unsafe behaviors outside the relationship does not pose a risk, state that people in relationships have been infected for various reasons. For instance, one partner may have been unaware of being infected or a partner may have become infected during unsafe sex outside the relationship.

**Social and Economic Influences**

The views of others can affect a person’s ability or willingness to use condoms. This can be particularly true for someone who struggles to assert personal desires, someone with low self-esteem, or someone who is ambivalent about using condoms. Assess the roles of

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**References**

23. CDC, 1996.
family members, friends, and other peers in a person’s life for the possible effects these influences may have on a client’s decisions. Clients may show the indirect influence of peers in statements such as, “Nobody uses condoms.” Clients may reveal pressure from partners through statements such as, “I can’t suddenly tell my partner that I want to start using condoms. My partner will get suspicious.”

Be alert to other factors that may affect condom use, for instance, economic challenges and privacy issues. Provide clients with options for getting condoms and lubricant at little or no cost. Explain that K-Y jelly is a water-based lubricant used for a variety of purposes and is often less expensive than other lubricants. Recognize that some people may not want those they live with to know they are having sex. In such a case, suggest ways in which clients can find a private place to store condoms.

**New Products**

Increased access to new products offers new options. Present polyurethane condoms (“Avanti” is the brand name) as an option when clients express concern about allergies to latex. The Reality brand condom may be a useful option for a female client whose male partner is unwilling to wear a condom himself. Because a client may find the Reality condom less easy or less comfortable to use, however, clients may need strong motivation to use protective barriers in order to use this condom.

**Client Responsibility**

When a client is not willing to use condoms for high-risk behaviors, acknowledge that the responsibility for using condoms ultimately rests with the client. Make sure the client understands his or her risks, assess whether he or she is willing to consider referrals to individual or group counseling settings, and provide referrals, if appropriate. In addition, assess whether there are others in the client’s life with whom he or she can discuss condom use.
Test Yourself

Review Questions

1. True or False: Most people believe condoms are ineffective in preventing transmission of STDs, and most believe them to be an ineffective form of birth control.

2. Condom breakage is mostly the result of a) flaws in the condom; b) over-aggressive sexual activity; c) misapplication by the user; d) too tight a fit.

3. True or False: Most sexually active young people have some awareness of HIV transmission risks and the fact that condoms can reduce risk.

4. True or False: For people who are sexually active, condoms are one of the least effective ways to protect against HIV infection.

5. People with low self-esteem a) may struggle to assert themselves in negotiating condom use; b) may not see themselves as worthy of protection with condoms; c) may fear rejection by partners if they insist on using condoms; d) all of the above.

6. True or False: In heterosexual relationships, women usually have more negotiating power than men when discussing condom use because traditional gender hierarchies give women such power.

7. True or False: Cultural factors can have a significant effect on a person’s decision to use condoms.

8. Condoms can be worn during a) vaginal sex; b) anal sex; c) oral sex; d) all of the above.

Discussion Questions

1. How can counselors help clients gain greater awareness about the value of condoms?

2. In what ways can counselors encourage the use of latex dams and other materials that are less commonly used than the traditional male condom?

3. How can counselors respond to clients who hold strong negative views toward condoms or express no desire to consider condom use?

4. When clients state several reasons for not using condoms, how can counselors assess which deserve the most attention during the counseling session?

5. Consider how counselors can respond to clients who have recently entered primary relationships and wish to engage in unprotected sex in these relationships. How can counselors respond to clients in long-term mutually monogamous relationships who feel a strong sense of trust and commitment to partners and wish to engage in unprotected sex with them?

Answers to Test Yourself

1. False. Studies show that a high percentage of people believe that condoms are effective in both preventing infection with STDs and unwanted pregnancy.

2. c.

3. True.

4. False. For people who are sexually active, condoms are the most effective means for preventing HIV transmission during sex.

5. d. All of the above.

6. False. Traditional gender roles often disempower women in sexual relationships.

7. True.

8. d. All of the above.
DID YOU KNOW?

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