Pleasure, Power, and Inequality: Incorporating Sexuality Into Research on Contraceptive Use

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We know surprisingly little about how contraception affects sexual enjoyment and functioning (and vice versa), particularly for women. What do people seek from sex, and how do sexual experiences shape contraceptive use? We draw on qualitative data to make 3 points. First, pleasure varies. Both women and men reported multiple aspects of enjoyment, of which physical pleasure was only one.

Second, pleasure matters. Clear links exist between the forms of pleasure respondents seek and their contraceptive practices. Third, pleasure intersects with power and social inequality. Both gender and social class shape sexual preferences and contraceptive use patterns. These findings call for a reframing of behavioral models that explain why people use (or do not use) contraception. (*Am J Public Health.* 2008;98:1803–1813. doi:10.2105/AJPH.2007.115790)

Despite the addition of "sexual" to the sexual and reproductive health agenda[1,2] and the increasing attention paid to how gendered power differentials influence sexual behaviors, public health research has yet to adequately explore the needs and purposes that sex fulfills. Research with both heterosexual and homosexual men has taken into account how the goal of physical pleasure shapes risk taking,[3–8] and a parallel body of work for heterosexual women has explored the relative importance of economic need and the desire for intimacy to risk taking.[9–11] Each of these bodies of work, however, are themselves bound by gender stereotypes—specifically by the assumptions that women do not have sex for pleasure and that men do not have sex for intimacy. Unintended pregnancy, sexually transmitted infections (STIs), and HIV are among the most pressing issues in public health both in the United States and abroad. It is more important than ever to understand the array of factors contributing to sexual risk taking and risk reduction, including sexual goals and sexual pleasure.

Sexual health research within public health has largely failed to explore how pleasure and positive sexual functioning affect sexual risk and risk-reduction practices,[12,13] particularly for women.[14,15] This void is especially evident in the field's approach to male condoms and women. Public health programs target women to carry out sexual risk reduction through condom use (even though women do not "use" or "wear" male condoms) despite research showing that women may lack the power to press their partners to use condoms[16–20] and that even when women are able to negotiate for condom use, they may refrain from doing so out of the desire for sex that is "close," loving, and monogamous.[10,11,21–23] We still know little, however, about women's sexual experiences with male condoms and how their perceptions of the way condoms feel physically affect their risk behaviors (for 2 exceptions, see Holland et al.[24] and Ehrhardt et al.[25]). There is a critical need for research that examines how a desire for sexual pleasure—or more broadly, the full range of reasons women have sex—shapes women's willingness to encourage condom use.

Many studies of hormonal contraceptives also fail to systematically assess how these methods affect sexual functioning or pleasure or how women's sexual goals shape their patterns of use.[26–28] However, several recent studies have suggested that a desire for sexual enjoyment can play a role in women's contraceptive behaviors. US women and men ranked pleasure as equally important in evaluating a contraceptive's acceptability in one study.[29] Other research associates method continuation to the reductions in or enhancement of sexual experience caused by oral contraceptives,[26] injectables,[30] tubal ligation,[31] and especially, the female condom[32–34] and microbicides.[35–39]

These studies suggest that the initiation and continuation of contraceptive methods (including male and female condoms) is influenced by how they make sex feel and that sexual experience and contraceptive experience may shape each other reciprocally. However, few of these studies have explored multiple forms of contraception simultaneously, and none has gone beyond individual experience to situate pleasure more broadly within social processes. Furthermore, as evident in the data we present, "pleasure" contains multiple overlapping categories. Work to date has not adequately explored variation in people's ideas about what makes sex feel good or the varying weight given to this "feeling good" relative to other valued qualities in the sexual encounter.

We used an ethnographic, inductive approach to explore the range of sexual motivations and goals—that is, what sex is for or what needs it fulfills—expressed by a sample of individuals in urban Atlanta, Georgia, and we analyzed the relationship between these sexual goals and contraceptive practices. We had 3 research questions: (1) What do people seek from and experience within their sexual encounters and relationships? (2) How do these expectations and experiences shape contraceptive use? and (3) How are sexual goals shaped by gender, social class, and other forms of structural social inequality?

METHODS

Sample Strategy and Construction

We used theoretical sampling to recruit 36 respondents (24 women, 12 men) from metropolitan Atlanta. Like purposive or quota-driven sampling, theoretical sampling[22,40] and systematic ethnographic sampling[41] select

participants based on the variables most likely to affect the outcomes of interest, based on the literature and previous experience with the population. The variables are used to create "cells" within a sampling frame that must be filled as recruitment progresses.

In this case, gender and social class served as the primary sample stratifiers. As the focus of this project, women (N=24) composed the majority of the sample. Men (N=12) were included for comparative purposes. Similarly, given the strong and persistent social class differentials in reproductive health outcomes in the United States,[42,43] we sought a mixed-class sample to explore whether there were class-based differences in women's experiences of sexual pleasure and, if so, whether these differences might help explain disparities in unintended pregnancy and STIs.

Our approach to social class differed from most public health research, which depends on education level[44,45] or percentage of the poverty level[46] to capture social class.[47] In keeping with sociological and anthropological approaches to social inequality, we included financial and cultural resources in our approach.[48,49] Individuals usually develop the tastes, skills, and preferences associated with a particular class through socialization processes when they are children. These cultural dimensions of class may be as important as, if not more important than, income and education in shaping sexual behavior.[50] Cultural resources may be identified in part through participants' upbringing and social class of origin, current neighborhood and habitat, and occupational class (e.g., an employee of a nonprofit agency may have the same salary as but different class position from a grocery store clerk).

Our final social class variable was thus defined using the following 4 categories: (1) level of education; (2) occupation or, in some cases, homemaker or unemployment status; (3) current financial situation or needs (if any) for housing, food, clothing, or other basics; and (4) social class of origin, including early home environment and upbringing and current financial and cultural resources.

During the screening call, we asked participants about their education level (any college or no college), occupational status (white collar, blue collar, unemployed, and homeless), and neighborhood. We assigned the most prevalent class of the 3 markers (at least 2 out of 3) using labels of either socially advantaged (middle class) or less socially advantaged (working class and poor). During the interviews, we collected information on the remaining social class criteria. If the first interview revealed information that contradicted our original assignment, particularly on the fourth factor (family upbringing or social class of origin), we reassigned the class label accordingly. Reassignment occurred in only 2 cases. These were women whose current circumstances corresponded to the working-class category (e.g., working at a coffee shop with poverty-level income, living in a poor neighborhood) but whose family of origin and cultural capital (e.g., having graduated from a private elite university, reading *The New Yorker*) placed them in the socially advantaged category. Ultimately, we sought 24 women and 12 men who were strategically divided into these 2 class categories.

In keeping with theoretical sampling, we also selected participants to represent a range of other variables theorized to influence contraceptive use and unintended pregnancy: race/ethnicity, age, marital status, and parity.[51–54] Thus, within each of the 4 main categories of the sample (socially advantaged women, less socially advantaged women, socially advantaged men, less socially advantaged men), we deliberately tried to capture both parents and nonparents, Whites and African Americans, and a range of ages. Table 1 provides a demographic overview of the respondents.

Recruitment

Participants were recruited through several mechanisms: notices sent through Internet listservs, referrals from other participants, and flyers dispensed in numerous Atlanta neighborhoods that captured the social class distributions of interest (i.e., middle class, working class, or poor, ideally with both Whites and African Americans in each and a combination of both single- and multiple-person households). Interested participants called a telephone number associated with the study and were informed by J.A.H. of the study-inclusion criteria: participants had to be 18 years or older and had to have used some type of pregnancy prophylaxis in the past 12 months. Individuals also provided information on the sampling variables of interest, such as gender, social class, race/ethnicity, age, and parity. We filled in the sampling frame's cells as recruitment progressed.

All those screened for eligibility and selected for the final sample consented to participate, although 1 person failed to appear for her first interview and could not be reached to reschedule. Another respondent with a similar demographic profile was quickly identified to replace this individual.

Interview Protocol

Respondents read and signed a consent form at the first meeting. The study protocol and interview instruments were reviewed and approved by the institutional review board at Emory University, our home institution at the time of data collection. At the completion of the entire interview, which usually took place over 2 or 3 separate sessions, participants were paid $40.

Interviews were conducted in participants' homes or in public places near their homes or workplaces. This allowed not only greater rapport but also observation in people's homes and neighborhoods, which provided contextual information on class differences in housing, neighborhoods, and community geographies. Each interview took approximately 3 hours to complete. A total of 104 hours of interviews were digitally recorded and transcribed.

The semistructured interview guide contained sections on health care history, reproductive and contraceptive histories (including likes and dislikes about various contraceptive methods and their effect on sexual functioning and pleasure), current and previous romantic and sexual relationships, sexuality education (i.e., where and from whom the participant learned about sex), sexual stereotypes, sexual preferences, and positive and negative sexual experiences. The guide was designed so that topics moved from less to more sensitive as a way to enhance rapport and data validity. Respondents were asked about lifetime experience with unintended pregnancy, STIs, and HIV/AIDS. However, part of our research framework was not to impose models of disease versus pregnancy prevention onto participants. Instead, we wanted to elicit their contraceptive motivations in their own words and frameworks. Finally, we also administered close-ended questionnaires to collect information on income level, public assistance, and highest level of education completed.

TABLE 1—Demographic Overview of Respondents Surveyed for Sexual Goals and Contraceptive Practices: Atlanta, GA, 2007

	Less Socially Advantaged Women (n = 12)	Socially Advantaged Women (n = 12)	Half Advantaged, Half Less Advantaged Men (n = 12)	All (N = 36)
Married (now or past), no.	4	3	5	12
Never married, no.	8	9	7	24
Age, y, mean (range; SD)	36 (19–51; 14.2)	34 (20–45; 7.3)	32 (19–49; 9.1)	35 (19–51; 10.7)
Whites, no.	3	8	6	17
People of color, no.[a]	9	4	6	19
Have children, no.	6	4	3	13
Do not have children, no.	6	8	9	23

[a]The sample contained 1 Latina; African Americans accounted for the remainder of this subgroup.

Qualitative Analysis

J.A.H. read, reread, and summarized the transcripts and her field notes based on each participant. In the use of a single coder, we diverged from public health researchers within a positivist tradition. Within a positivist framework, bias is addressed by using multiple coders, who presumably offer a check on the possible bias of any 1 coder. However, within the tradition of interpretive social science research used in both anthropology and sociology, the best analyzer of the data is often the person(s) who collected the data, given her access to different types of "data," for example, and deeper understanding of the social and emotional context of the interview and familiarity with its tones and meanings.

Interpretivist researchers instead achieve scientific rigor through attention to the issues of positionality and representation. That is, the researcher attempts to address bias by analyzing the implicit assumptions she brings to the project and the way her positionality in relation to the respondents shapes the respondents' representations. For example, we remained attuned to how J.A.H.'s social position detracted from her insider, or "emic," understandings of male respondents or less socially advantaged respondents. Similarly, we were mindful of how participants' responses may have been influenced by social desirability, such as wanting to appear contraceptively responsible or, as in the case of some men, wanting to portray themselves as good lovers.

We then came up with a list of codes based on the research questions of interest, the literature, and J.A.H.'s reading of the data. An ethnographic, grounded theory approach was used in analyzing the data. The analysis was informed by both preexisting themes from the literature and the research questions and by themes that arose from the data. Examples of preestablished codes included "contraceptive use," "experience(s) of unintended pregnancy," and "preferred sexual activities." Examples of codes established during analyses included "vaginal dryness" and the types of pleasure described in this study, including "concerns for partner's pleasure" and "eroticization of safety."

We then used the codes to compare and contrast phenomena and individuals. Coding types involved the collection of coded blocks of text and the creation of new thematic data files capturing various dimensions of the key themes, for example, frequency, duration, size, specific vocabulary, and differences in intensity and emphasis.[55] We compared and contrasted both individuals and subgroups based on gender and class, also known as descriptive cross-case analysis and analytic cross-case analysis.[56] Themes explored included contraceptive and condom use over time, pregnancy history and desires, sexual negotiation, sexual preferences, and experiences with STIs.

RESULTS

Seeking Various Types of Pleasures

Our results present the physical and emotional attributes women most often seek in sex and comparison data from men when relevant. We describe the 5 prominent themes related to these attributes. Of course, these categories are not mutually exclusive. Nor do we wish to suggest that these 5 themes represent an exhaustive list of types of sexual activity people seek. Rather, they represent the topics that arose from our interviews that seemed the most salient in terms of contraceptive use. Table 2 presents an overview of the results, including summaries of the most prominent sexual goals and how those goals shaped contraceptive practices.

Physical pleasure and lack of discomfort. As expected, respondents sought sex that felt good in terms of sensation. At times for women and almost always for men, physical enjoyment entailed orgasm. More frequently for women, physical enjoyment involved sufficient arousal, the desired amount of lubrication, and in many cases, appealing smell, taste, and touch. Maximizing sexual enjoyment and comfort also meant minimizing discomfort. Vaginal dryness or contraceptive side effects such as heavy bleeding or nausea can all quell sexual pleasure.

Spontaneity and sexual flow. Respondents commonly highlighted how one of the pleasures of sex was its opportunity for spontaneity. By using such terms as "letting go" or "giving way" to the sexual "flow" or to "the heat of the moment," respondents adopted narratives of abandon and disinhibition. They suggested that ideal sex should be a spontaneous and smooth flow of erotic events, uninterrupted by contraception.

Closeness. Most respondents described the pleasures of "closer" sex. Sex could represent a union of 2 bodies and sometimes 2 hearts. To facilitate the closeness of intercourse and the intensity of this union, many people preferred sex that involved skin-on-skin contact, including genital contact. Close sex was particularly important for those in long-term relationships.

Pleasing one's partner. For many, part of the appeal of sex was to give pleasure to one's partner. Particularly for women, sexual enjoyment encompassed her partner's fulfillment at least as much as her own. They also desired mutual sexual attraction and enjoyed sharing physical pleasure as well as emotional intensity. For example, many women said their preferred sexual activity was vaginal intercourse even

TABLE 2—Five Forms of Pleasure, Effects on Contraceptive Use, and Effects of Class and Gender Among Respondents Surveyed for Sexual Goals and Contraceptive Practices: Atlanta, GA, 2007

Component of Pleasure	Examples	How Pleasure Relates to Contraceptive Use	Examples	Effect of Class and Gender
Physical pleasure and lack of discomfort	"All that sexual stuff feels good, touchin', kissin', rubbin', especially if he smells good." (woman) "Sometimes I get so dry that sex gets uncomfortable." (woman) "I have sex to feel good . . . to feel that physical release." (man)	Respondents sought contraceptives that enhanced physical pleasure or lessened discomfort. Male condoms exacerbated vaginal dryness and detracted from sensation for many women. Hormonal side effects such as weight gain, breast tenderness, or nausea could detract from women's sexual experiences and make sex less appealing.	"If I don't use condoms, it's not because it's more exciting it's because it's more comfortable." (woman) "I hate the way [male] condoms feel, I hate the way they taste, I hate the way they smell." (woman) "On the pill, I felt less comfortable in my body and so sex was harder for me to enjoy." (woman)	Gender: More women than men complained about the physical displeasures of male condoms. Women were also more likely to experience contraceptive side effects, because most methods are designed for women's bodies. Class: Less socially advantaged women were more likely to have experienced more-extensive side effects from longer-acting methods, which detracted from their sexual enjoyment and contributed to discontinuation.
Spontaneity and sexual flow	"The best sex is when you get caught up in the heat of the moment . . . when you really let go and just kind of lose your mind a little bit." (woman) "Once you get going, it's like a train that starts and can't stop." (man)	Respondents disliked methods that interrupted the sexual "flow," such as barrier methods.	"You get carried away in the moment, and you don't feel like stopping to put a condom on." (woman) "Now, on the pill, we just move from touching into sex into orgasm without worrying afterwards that we're stupid, or that it wasn't a safe time, or whatever." (woman)	Few observed gender and class differences.
Closeness and intimacy	"Sex is the closest that we can get." (woman) "You've gotta feel the person's whole body." (woman)	Most respondents, especially those in long-term relationships, preferred contraceptives that allowed skin-on-skin contact.	"This IUD thing is fantastic! He can come inside me, there's skin-on-skin contact. . . . The sex has never been this good." (woman) "Now that we've switched to the ring [from condoms], the sex is much closer and more connected." (man)	Few observed gender and class differences.
Pleasing one's partner	"[With vaginal intercourse], we can both feel pleasure and intensity at the same time, plus it's the surest way he's going to orgasm, which is important to me." (woman) "I worry about how it feels for him, even when he doesn't complain." (woman)	Women in particular wanted to maximize their partner's pleasure by abandoning condom use.	"I dislike condoms because he can't feel as much." (woman) "Sometimes you want to say to him, 'don't go get a condom.'" (woman) "As women, we always find ways to let men know how special it is." (woman)	Gender: Women were much more likely to focus on the influence of contraception on their partners' sexual enjoyment. Few men had the knowledge or language to report how methods may have detracted from their partners' sexual pleasure, even when specifically prompted.
Eroticization of safety and deeroticization of risk	"For me, sex equals pregnancy. I am always linking the two in my mind. I used to worry about it so much that I had trouble enjoying sex." (woman)	Some respondents could not experience maximum pleasure unless properly protected. Contraception became a prerequisite to sexual enjoyment.	"This one time, I didn't use a condom. I just freaked out." (woman) "Sex is downright unsexy without a condom." (woman)	Class: The socially advantaged were more likely to eroticize safety because of the perceived costs of unprotected sex. Fear of unintended pregnancy, especially at sexual initiation, contributed to effective contraceptive use.

though their partners were much more likely than they were to reach orgasm through this activity.

Eroticization of safety and responsibility. A number of respondents could not "let go" or get caught up in the heat of the moment unless properly protected from disease and unwanted pregnancy. These respondents experienced a certain type of pleasure in taking responsibility or, alternately phrased, a displeasure in not being protected. For risk-averse respondents for whom avoiding pregnancy or disease was imperative, effective prophylaxis was a precondition for enjoying sex to its fullest. This eroticization of safety was not a factor in why, but rather how, people had sex. It also provides an example of how social inequality intersects with sexual and contraceptive practices.

Relationships Between Sexual Goals and Prevention Practices

Now we explore how each of the 5 elements we described shaped contraceptive preferences and practices. We should note that our findings do not regularly distinguish between pregnancy prevention and disease prevention; for the purposes of this exploratory study, we were more interested in how contraceptive methods of all types shape the sexual experience and vice versa.

Contraceptive effects on women's sensation and well-being. Respondents preferred contraceptive methods that allowed for as much physical pleasure as possible and that did not cause discomfort. Most notably, when women rejected male condoms it was to feel more sexual sensation or to be more physically comfortable. (This differs from avoiding condoms out of a desire for closer, skin-on-skin sex.) Indeed, the majority of women respondents said they disliked the physicality of condoms. They criticized the way condoms felt in terms of sensation and not just what they signified in terms of trust, intimacy, and love. In the words of 3 women: "I don't like that condoms decrease sensation for *both* of us" (aged 37 years, socially advantaged); "With condoms, it's like something's covering you during sex; you can't feel as much" (aged 25 years, less socially advantaged); "I *hate* the way condoms feel!" (aged 23 years, less socially advantaged).

At least some women rejected the way condoms felt because they exacerbated vaginal dryness. Over one third of the women respondents complained about occasional or regular dryness during sex; these women were especially attuned to how condoms and, occasionally, other methods can "dry up" the sexual encounter. Maya (aged 23 years, less socially advantaged) indicated that condoms aggravated her vaginal dryness and that, as a result, she was much more likely to resist condom use than her male partners were. "*I'll* be the one to take it off in the middle of sex," she said. "If I don't use condoms, it's not because it's less exciting [with them], it's because it's *uncomfortable*." She consistently declined condoms, not to attain more pleasure but to experience less discomfort. Two women also reported that oral contraceptives decreased their ability to become as lubricated as desired during sex. Among those women who regularly experienced insufficient lubrication, minimizing discomfort could be a more conspicuous goal than maximizing pleasure or than protection against pregnancy or HIV and STIs.

We should note that although the majority of women complained of being insufficiently lubricated during sex, at least 2 women disliked excess wetness caused by some methods. One woman (aged 23 years, less socially advantaged) complained of "too much wetness" while on the NuvaRing, which she planned to discontinue. Other respondents complained about excess "messiness" caused by such methods as foam and withdrawal.

For a number of women, contraceptive practices were shaped by the side effects of hormonal methods that can alter the physical experience of sex. Side effects such as breast tenderness or nausea diminished both women's physical relationship with their bodies and their interest in sexual activity. So did hormone-associated weight gain, which both women and men reported could interfere with women's ability to fully enjoy sex. Beth (aged 37 years, socially advantaged) said she felt "less attractive" on the pill because of weight gain, which affected her interest in sex. "I was glad when I finally went off it," she said. Matthew (aged 27 years, socially advantaged) spoke about the "significant" amount of weight his partner gained while on oral contraceptives. "She already had low self-esteem, and the body changes made her feel even worse," he said. "This dramatically affected our sex life." As a result, he reported that he was hesitant to have future partners use oral contraceptives.

Contraceptive effects on sexual spontaneity and flow. Methods that required preparation, application, or adjustment were largely unpopular because they created interruptions that disturbed the "natural" course of sex. Barrier methods in particular threatened the sexual flow. These attributes did not always prevent people from using these methods, but they led to negative associations and, in some cases, intermittent or improper use. Other researchers have written about the desire for sexual spontaneity. In fact, this has always been acknowledged as part of the enormous appeal of hormonal methods. Here, however, we place spontaneity within a broader model of pleasure—that is, pleasure as more than just a physical sensation.

Charlotte (aged 31 years, socially advantaged) said she and her sexual partners would often initiate intercourse without a condom and only apply one after several minutes, if at all. "You get carried away in the moment, and you don't feel like stopping to put a condom on," she said. "You know you shouldn't, but . . . it's just so . . . *disruptive*." Knowing her proclivity for uninterrupted sex, she started taking oral contraceptives. Although relatively protected from pregnancy, she remained at risk for HIV and STIs, particularly given her current number of lovers and relatively long list of lifetime sexual partners.

Alex (aged 27 years, socially advantaged), who had used a diaphragm with her former partner, said she would often become so "lost in [sex]" that she would not stop to insert her diaphragm. Instead, her partner would withdraw before ejaculating or ejaculate inside her if she thought it was a "safe" time, such as during her menstrual period. Eventually, she experienced an unintended pregnancy. After seeking an abortion, she started taking oral contraceptives. Even though she reported that the pill reduced her libido, she valued the spontaneity it facilitated. "I *love* how I don't have to worry when he comes anymore," she said. Alex, Charlotte, and other respondents preferred methods that allowed for maximum flow and minimal disruption.

How the desire for closeness and intensity shaped contraceptive use. Many participants sought methods that enhanced both the physical and emotional pleasures of closer, skin-on-skin sex. Lydia (aged 33 years, socially advantaged), who had an intrauterine device (IUD) inserted after the birth of her second child, reported, "Oh my God, this IUD thing is *fantastic.* Why didn't I hear more about it before? Why don't they encourage more women to get these things? The sex is fantastic. There's skin on skin contact, [my husband] can come inside me, and I'm not worried about it. . . . The sex has never been this good!" This quote captures both the desirability of skin-on-skin contact and the emotional benefits of her partner ejaculating inside her. The closeness and connection facilitated by the IUD sealed her acceptance of the method.

The contraceptive practices of Susan (aged 49 years, less socially advantaged) similarly reflect a search for closeness with her long-term partner. She estimated they used condoms during approximately half their episodes of sexual intercourse. When asked what types of factors precipitated those occasions of nonuse, she said, "I'm not sure, really. Sometimes it's just that they're not handy. [pause] But other times, you know, you're just feeling really close and connected and in love and you don't want to be all covered up." Within the context of this 17-year relationship, the importance of closeness meant that she and her partner often abandoned condom use.

Women's concern with men's pleasure. Women respondents stated that sex was most often fulfilling when their partners felt good. Thus, women were sometimes disinclined to press for condoms or withdrawal, not necessarily to facilitate feelings of closeness and trust but to facilitate men's, and thus their own, enjoyment of sex. Melanie (aged 33 years, socially advantaged) reported, "I dislike condoms because of the way they make my husband feel." Similarly, Margie (aged 41 years, socially advantaged) said that with condoms, "I get concerned for him. I know it feels better for him not to use it even when he doesn't complain or say anything." Margie recently had sought a tubal ligation so her husband would no longer have to wear condoms.

Rashani (aged 25 years, socially advantaged) was taking oral contraceptives and almost always asked her long-term partner to use a condom as well. Occasionally, however, they abandoned barrier methods and relied on oral contraceptives alone. When explaining these latter occasions, she said,

> It may just be a heat of the moment thing, a passion thing. Another possibility is that as women, we always try to find ways to let men know how *special* it is. You want to have one time where you don't say, "Go get a condom." This one time, you might give him a bit more of yourself.

Rashani said she ultimately felt responsible for whether a condom was used, even though she was not the one to wear it. Sex became more pleasurable when she could make her partner feel loved by "giving herself" fully to him in the form of condomless sex.

Protecting oneself as requisite for sexual enjoyment. By contrast, some respondents could not actually "let go" or get caught up in the heat of the moment unless properly protected. Contraceptives may not have led directly to more exciting, passionate sex, but they did contribute to sex that was relatively free from worry and therefore more enjoyable. Elizabeth (aged 31 years, socially advantaged) was taking oral contraceptives and still asked her partner to wear a condom each time they had sex ("because you never know with men," she said). She described how sexual enjoyment depended on proper prophylaxis:

> Sex definitely isn't hotter *without* [contraception]. Or definitely not *less* pleasurable. Is it more enjoyable because it's more comfortable, more secure? Perhaps. I think more . . . it's just part of sex now. It's hard to imagine sex without contraception of some sort.

For risk-averse women like Elizabeth, contraceptives did not make sex "hotter" or more exciting, but neither did they undermine sexiness or eroticism, given that prevention practices had become so instrumental to the sexual encounter. Rather, it was hard to imagine "letting go" without prophylaxis. Or, in the words of another consistent contraceptor in the study (aged 25 years, socially advantaged woman), "Sex is downright unsexy without a condom."

How Pleasure Intersects With Power and Social Inequality

In this section, we discuss examples of how social inequality—in this case, participants' gender and social class—seemed to be associated with sexual pleasure seeking and contraceptive use. We explore in particular how gender and social class intertwine with physical pleasure, the pleasure of pleasing one's partner, and the eroticization of safety. We observed fewer gender- and class-based patterns in terms of how respondents spoke about the other elements of pleasure: spontaneity and closeness.

Physical pleasure and lack of discomfort. Gender shaped respondents' physical experiences with condoms in unexpected ways. As described above, the majority of women respondents mentioned disliking the physicality of condoms and not just what they symbolized in terms of intimacy. To be sure, men also spoke of how condoms decrease sensation. "It's like having sex with a garden hose on," said Martin (aged 38 years, less socially advantaged), who estimated that he used condoms in roughly 1 in 3 sexual encounters. However, men were far less likely than were women to criticize the way condoms decrease sensation; for the most part, they presented themselves as resigned to the feeling. In the words of Miles (aged 42 years, socially advantaged), "Sensation is lessened with condoms, but the interruption is no big thing." Other men indicated that although condoms certainly do not enhance sexual pleasure, they make sex possible and are therefore to be tolerated. By contrast, proportionally more women resisted the way condoms feel.

Gender and social class also influenced respondents' experiences of contraceptives in terms of discomfort and overall physical wellness. As we mentioned, contraceptive methods can detract from women's sex lives through discomfort and unpleasantness. Whereas men sometimes complained about "pinching" or generally decreased sensation, women sustained comparatively major changes in and on their bodies because of contraceptives. Because most contraceptives are designated for female bodies, women were much more likely than were men to experience sex-shaping side effects such as weight gain, heavy bleeding, mood disturbances, and discomfort or even pain.

Within this gender asymmetry, class also played a role. Poorer women seemed accustomed to sexual discomfort and to ill health

more generally, which contraceptives could exacerbate. Among the less socially advantaged, women of color especially were more likely to have been inappropriately matched with methods by clinicians and more likely to have experienced severe contraceptive side effects than were wealthier women.

Frances (aged 47 years, less socially advantaged) had an IUD inserted first when she was 14 years old at her mother's insistence and then again after the birth of her first son at her doctor's urging. She experienced "cramping, pain, and pinching" from this method. In both cases, after several months Frances had it removed and decided to "use [her] head" instead—a homegrown combination of withdrawal, periodic abstinence, "and luck." Although she knew this was less effective than the IUD, she was weary of the pain and irritation.

Destiny (aged 25 years, less socially advantaged), whose doctor told her she would not remember to take a birth control pill every day, said her Depo-Provera shots led to side and back pain. The deep discomfort described by these and other socially disadvantaged women often meant that they would discontinue contraceptive use, putting them at greater risk for unintended pregnancies.

Several factors may help to explain this classed pattern of contraceptive side effects. First, less socially advantaged women had fewer and shorter visits with clinicians, and their contraceptive profiling often was conducted over the course of 1 visit versus years of a doctor–patient relationship. Whereas most poorer women saw a different clinician every time they went to the clinic, several middle-class respondents had seen the same obstetrician gynecologist for several years.

Second, in keeping with national patterns,[57] less socially advantaged women were more likely to have used long-acting, more intrusive methods, such as Depo-Provera, Norplant, and the IUD. These methods are associated with more side effects than are barrier methods or oral contraceptives.[58]

Finally, researchers have argued that the chronic stress caused by poverty and racism exacerbate poor African American women's ill health.[59,60] Indeed, poorer women respondents suffered from far more physical ailments than did the wealthier women. Maladies included arthritis, diabetes, depression, headaches, pain throughout the body, and tremors. Socially advantaged women also experienced hormone-based side effects, but these embodiments were comparatively less intense (e.g., the NuvaRing bumping up against one's cervix during sex). Further, with better access to reproductive health care, middle-class women could more quickly find a more suitable method if necessary.

Pleasing one's partner. The sexual enjoyment associated with pleasing one's partner was highly gendered. Many women in this study said that their concern for their partner's sexual pleasure and enjoyment was a primary determinant of their contraceptive use or lack thereof. For these respondents, sexual enjoyment amounted to mutual, relational eroticism, and for many, attending to men's physical and emotional needs often took the form of abandoning male condom use.

To be sure, women and men spoke equally about the importance of sexually pleasing one's partner(s). However, this attention to partners' pleasure was less connected to contraceptive use for men than it was for women. Men were much less likely to mention concern with how contraceptive methods, including condoms, limited their partners' ability to enjoy sex or experience maximum pleasure.

Numerous men worried about whether they were sexually pleasing their partners; men seemed keenly aware of the social pressures on them to be skilled and experienced lovers. A number of men had formed their attitudes about condoms based on how they were able to perform sexually when using them. Some men said they liked that they could last longer during sex with condoms, whereas others struggled to maintain erections while using condoms and therefore disliked them.

Very few men, however, associated contraceptives with diminished sexual fulfillment for women, even when specifically prompted (i.e., "Did you notice that your partner's sexual enjoyment increased, decreased, or stayed the same on X method?"). Some did mention that their partners' libido had decreased while using certain methods. Yet as we have argued, many women described a wide range of unwanted sexual side effects, not only decreases in libido.

Eroticization of safety and the socially advantaged. Class seems to be a critical factor shaping respondents' inability to "let go" unless they were protected against pregnancy and disease. Because the perceived consequences of unprotected sex seemed dire to them, socially advantaged respondents were much more likely to eroticize safety than were socially disadvantaged respondents. The opportunity costs of unintended pregnancy served as a strong motivation for middle-class women to be skilled contraceptors. Pregnancy fears were especially acute at sexual initiation. Several socially advantaged women spoke of using 2, if not 3, methods at first vaginal intercourse and nonetheless fretting that their menstrual periods might not come. "I was on everything but roller skates when I had [vaginal intercourse] for the first time," reported Lydia (aged 33 years, socially advantaged), who used the sponge, oral contraceptives, and the male condom. "I could *not* have dealt with a baby at that point in my life—I had just started college, and I had big plans." Successful contraceptive use was seen as a requisite step on the path to college and, presumably, rewarding employment.

However, the socially advantaged were not the only ones to eroticize safety, even though their sexual motivations and life opportunities were more likely to be associated with effective contraceptive use. Lashana (aged 51 years, less socially advantaged), one of the study's most consistent contraceptive users, had compelling personal reasons to protect herself from HIV: she had lost her daughter to AIDS almost 10 years earlier, and she had become the primary caretaker for her HIV-positive granddaughter. Lashana had eroticized condoms in a way that made their use not just bearable, but enjoyable. This eroticization was facilitated in part by her excellent relationship with a health clinic doctor, with whom she spoke openly about her sex life. At regular intervals, the doctor would send Lashana batches of scented condoms. Lashana spoke glowingly about the doctor as well as the evocative condom scents:

> You got wildfire . . . cherry blossom . . . lemon lime. . . . That wildfire is something else. The smell is something else. That really makes me wear 'em out then! I insist that they be used. My doctor says, "You insist." I got that vanilla; oo Lord, that vanilla. That wild cherry. I just line 'em up on the counter.

Lashana's sexual goal was to enjoy sex, but strictly within the confines of disease prevention.

Lashana turned the scent of the condoms into a reason to "wear 'em out"—a method by which she enlisted her partners in her prophylaxis strategy.

DISCUSSION

The overwhelming majority of women in this study were more likely to consistently use contraceptives that maximized sexual enjoyment—however they defined it—while minimizing sexual discomfort and interruption. Pleasure, then, seems to matter. However, how it matters is complex, as are the meanings and shades of pleasure itself.

Many respondents sought sex that was felt as close and natural as possible (i.e., skin-on-skin), spontaneous and free flowing, or disinhibiting (i.e., a way to "let go"). As such, our respondents upheld Carrillo's suggestion[61] that one of sex's most appealing aspects—its flow, or *enegra*—tarnishes the appeal of coitus-dependent contraceptives such as condoms, other barrier methods, and withdrawal. Respondents' strong preference for uninterrupted sexual flow represented a further obstacle to HIV prevention methods, such as the male and female condom, as well as methods in development, such as microbicides and new barrier methods such as the Duet.

Yet for some respondents, sexual abandonment depended on proper prophylaxis; they could only "let go" sexually if sufficiently protected against pregnancy and disease. Socially advantaged respondents were particularly likely to eroticize contraceptive use, because they viewed contraception as essential to take full advantage of the perceived educational and professional opportunities afforded to them.

Gender also shaped the sexual processes in which contraceptive use occured. Both women and men sought sex that reinforced closeness and intimacy, tending to prefer methods that allowed skin-on-skin contact. However, women were much more likely than were men to report how their partners' sexual enjoyment influenced their own pleasure and thus their contraceptive use. Women were sexual agents who wanted to enjoy sex, but like women in other studies of sexual risk taking,[62] sometimes they were more focused on pleasing their partners than on maximizing their own erotic fulfillment. By contrast, men rarely commented on the sexual detraction of methods for women, even when specifically prompted.

Hormone-based methods and the IUD, which are designed for female bodies only, also caused a number of indirect detractions from sexual enjoyment in women. Weight gain, vaginal bleeding, and other common side effects interfered with women's desire for—let alone enjoyment of—sex.

Women in this study were also more resistant to the physicality of male condoms than were men. Women spoke consistently of the physical and esthetic detractions of condoms (e.g., "I hate the way they smell, I hate the way they taste, I hate the way they feel . . . "); they also commonly mentioned that condoms exacerbated vaginal dryness. Our findings add a physical, sensational layer to previous research, which has focused primarily on the symbolic and emotional aspects of women's resistance to condoms. As such, this study highlights a perplexing gender paradox of condom promotion efforts: women are concerned with men's pleasure, and they often dislike how condoms feel, yet heterosexual women remain the targets of condom promotion programs more so than do heterosexual men.

Limitations

Given the exploratory nature of this study, we did not exhaustively differentiate between STI and HIV and pregnancy prevention. We wanted people to use their own categorizations of motivation for contraceptive use, and the difference between disease and pregnancy prophylaxis rarely seemed salient to respondents. Rather, people overwhelmingly spoke about contraception in terms of the role it served at a particular moment in the course of a relationship. Most relationships began with a focus on disease prevention, then transformed either into no prophylaxis or a contraceptive method that better facilitated closeness (e.g., "When I started dating Bobby, we used condoms at first. Later, when we knew each other better, I started taking the pill."). Future studies may benefit from systematically collecting and analyzing data in a way that explores differences in pregnancy or disease prevention, because pleasure may relate differently to each one.

Nor have we exhaustively explored the various ways that social inequality, or the "power" in our title, shaped sexual and contraceptive experiences. We mentioned disparate motivations to avoid unintended pregnancy between the socially advantaged and disadvantaged and the subsequent eroticization of safety. We also reported differences in reproductive health services for socially disadvantaged women and the matching and mismatching of bodies with contraceptive methods. However, these are only 2 examples of how social inequality influences sexuality, and they can hardly explain all the variance in sexual health outcomes.

Other contributing social class factors we encountered during data collection include the physical geography of poor versus socially advantaged neighborhoods, especially in urban settings, and its effects on the supervision of young people, sexual experimentation, and sexual pairings. Less socially advantaged respondents also reported much larger age gaps between sexual partners at sexual initiation, which is often linked to earlier sexual initiation and lower rates of contraceptive use.[63–65] Finally, we encountered social class differences in notions of sexual controllability and sexual refusal.[66] We hope future research in this area will deepen our understandings of how class, gender, and other forms of social inequality shape sexual practices and, in turn, sexual risk taking.

There were several other things we could not achieve within the constraints of this exploratory study. For example, our analysis was based on individual experiences and self-reports. Thus, we could not corroborate respondents' accounts with information at the clinical level (e.g., medical records or care practitioners' reports) or with their partners, nor could we fully explore how contraception was shaped by dynamics between the couple—as reported by both people involved.

Our analysis of race/ethnicity could not be thorough given that we chose to focus primarily on gender and social class in selecting our respondents. This was not a study intended to look primarily at the relationship between race and pleasure. Given our interest in social inequality and the specific landscape of urban Atlanta, it was inevitable that more of the poor respondents would be African American.

Future studies should examine the associations between race/ethnicity, sexual goals, and pleasure in greater depth.

Finally, we limited the sample to people who had been heterosexually active in the 12 months before the study, so sexual minority populations were not included. Research may also benefit from exploring the sexual goals and pleasure seeking of those primarily engaged in same-sex behavior and whether these influence disease prevention practices (as opposed to pregnancy prevention) in similar ways.

Implications for Research, Programs, and Policy

We suggest that future family planning research in both the United States and abroad begin with the assumption that women seek sex that feels as pleasurable, enjoyable, and comfortable as possible. Without a better understanding of how people prefer contraceptives that make sex better, or at least fail to make it worse, we have an incomplete knowledge of how structural and social factors influence contraceptive use, pregnancy prevention, and HIV and STI prevention. A pleasure-sensitive approach may strengthen both clinical studies of contraceptive research and development and behavioral studies of contraceptive decisionmaking.

As we have suggested, the need is great for more qualitative studies on how, or whether, pleasure seeking influences contraceptive use, not only with other US populations but also in populations globally. Such work will vitally delineate the various dimensions of women's and men's sexual goals, for example, how cultural setting may influence pleasure-seeking practices.

However, quantitative data on this topic are also imperative. At the time of data collection, we were unable to locate a public-use data set that would enable quantitative explorations of the associations between sexual enjoyment, pleasure seeking, and contraceptive use patterns in the United States. Such data from the developing world are even further from reach. Both domestic and international surveys of fertility behaviors, such as the National Survey of Family Growth or Demographic and Health Surveys, should include questions on sexual functioning and pleasure seeking, just as they include measures on sexual and physical violence. Even 1 or 2 simple questions could lead to significant developments in our understanding of these relationships (e.g., "While using X method, did your sexual enjoyment increase, decrease, or remain the same? What about your partner's sexual enjoyment?").

In terms of clinical research, little is known about how most current methods and those under development affect sexual interest and function in women.[26] By contrast, methods under development for men are extensively tested for their effects on men's sexual functioning.[67,68] Clinicians seem to be aware that weight gain, heavy bleeding, and moodiness are less desirable contraceptive side effects for women. However, researchers have inadequately explored the sexual components of these side effects. Weight gain and emotional fluctuations affect women's experiences of themselves not only as physical beings but also as sexual beings; they also affect women's feelings about and use of their methods.

Our findings support the notion that the marketing of contraceptive products matters.[69,70] People enjoy consuming contraception as they do other types of goods. Respondents spoke about how particular types of condoms can be "fun," especially those with novel scents, flavors, or other features. Socially advantaged women spoke about the pleasures of consuming hormonal contraceptives, particularly noncontraceptive benefits such as acne improvement and menstrual lightening and timing. Several mentioned "the pill that clears your skin"—a direct quote from a marketing campaign for Ortho Tri-Cyclen (Ortho-McNeil-Janssen Pharmaceutical, Inc, Raritan, NJ).

Pharmaceutical companies in particular can do more to market contraceptives in sexually appealing ways. Condoms have long been eroticized in corporate advertisements and public health condom promotion programs. Advertisements for Viagra (Pfizer, Inc, New York, NY) and other erectile dysfunction drugs have also broadcast sexy images of couples kissing or touching. Contraceptive advertisements, by contrast, often portray a highly sanitized, deeroticized version of sexuality, if they allude to sex at all. Contraceptives could be sexually marketed to women and men in the same way as condoms or Viagra (e.g., "The Patch: Increase your sexual spontaneity!") as a strategy to change how people think about them. Public clinics, and not just pharmaceutical companies, could advertise the sexual aspects of their products with printed materials, in counseling, and in community education sessions.

However, sex-savvy marketing and product development will do little to address social inequality. We need to remain attuned to the ways that gender and class inequality shape the sexual processes through which people develop more- or less-effective contraceptive-use patterns. We hope this analysis inspires further exploration of the association between sexual goals and gender, poverty, and other forms of social inequality, given that this association may help explain poorly understood but widely observed differentials in sexual and reproductive health. ■

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J.A. Higgins and J.S. Hirsch worked collaboratively on study design. J.A. Higgins collected the data and took the lead in analysis and writing. J.S. Hirsch supervised all aspects of the study, including the preparation of the article.

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