Power, Trust, and Pleasure: Relationship Components of Contraceptive Negotiations

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With contraception playing an ever-larger role in people's sexual lives throughout the world, both in the prevention of pregnancy and the limiting of sexually transmitted diseases such as HIV, it is increasingly important to understand how people make decisions about contraceptive use. People's decisions about contraceptive use are presumably primarily motivated by the three main purposes of contraception: prevention of pregnancy, prevention of sexually transmitted infections (STI's), and menstrual and fertility regulation. Recent research has begun to pay greater attention to the role of couple dynamics in contraceptive decision-making and is well-integrated with work on fertility decision-making (for a review of older work, see Becker 1996). Unfortunately, this research has been less integrated with work on sexual decision-making, even though the sexual context is a major component of a couple's dynamic contraceptive decisions. Moreover, research on couple's contraceptive decisions has focused more on the methodological than the theoretical implications of studying couples. In this paper, I attempt to ameliorate these issues by introducing a theoretical perspective which addresses the sexual context of couple's contraceptive decisions. The theory of contraceptive decision-making and negotiation which I offer here focuses on three elements of sexual relationships—*power* relations and *trust* between partners, and the desire for *pleasure* by individuals and their partners. I argue that these factors ultimately mediate other important elements of relationships, such as gender, material resources, and

romantic love in determining if and when contraceptive negotiations take place, and their outcomes if they do.

In this paper, I initially review the theoretical implications of studying couples from their vantage point among several levels of analysis. Then I review a framework for understanding different types of preferences and negotiations among couples. Next I discuss the theoretical implications of studying power for contraceptive decisions and negotiations, incorporating insights from Foucault. The literature on power is much more extensive than the literature on trust and pleasure, so my attention to this topic is consequently greater, considering both the sources and techniques of power in intimate relationships. Then I consider trust, incorporating Giddens' work on the subject, looking at the sources and techniques of trust in relationships. Next I consider the theoretical importance of pleasure in contraceptive decisions. Then I look at the intersections of power, trust, and pleasure to explain why it is necessary to take into account all three elements together. Finally, I consider contraceptive hypotheticals in order to illustrate how this theoretical perspective, taking only couple-level factors into account, can be used to predict the success of potential contraceptive methods.

The theoretical perspective presented here is intended to be universally applicable for looking at relationship factors in contraceptive decisions and negotiations. I hope that it is relevant for both same-sex and opposite-sex couples in cultures around the world. Even sexual situations that involve simultaneous encounters with multiple partners should be affected by the same dynamics described here, although analyzing them becomes more complicated with each additional partner. However, researchers attempting to use this theory to analyze contraceptive decision-making should be aware

that the primacy of relationship factors compared to other concerns (particularly contraceptive access) differs greatly by context.

Couple Work and Levels of Analysis

Demographers have traditionally paid relatively little attention to the theoretical and methodological implications of levels of analysis in their work. Greenhalgh (1996) explains that demography as a discipline began with a focus on relatively abstract, macro-level issues, but rather quickly moved to a focus on micro-level concerns after the Cold War due to funding and political constraints. However, most of demography's theoretical advances occurred before the post-Cold War transition, when there was a stronger emphasis on the macro-level of analysis. As a result, demographers frequently have applied theories which were largely developed to explain macro-level trends to research done at the micro-level. In order to help explicate this distinction between micro and macro levels of analysis for contraceptive decision-making—which is essential for understanding the significance of the couple-level of analysis, because couples cross the line between the two to a limited degree—I illustrate this division in Figure 1. The outermost layer contains the macro-level, which encompasses studies examining large-scale, aggregate trends, and often addresses topics such as policy-related contraceptive agendas and societal acceptance of contraception. At the macro level, widespread social perceptions and political policy influence contraceptive decisions. The next level is the meso level (about which there is relatively little research), which includes studies of community and institutional programs' influence on decision-making, as well as neighborhood studies. Then there is a level between communities and individuals, which looks at the influence of significant others—family, friends, and peers—on contraceptive

decisions. The final level contains the individual members of a couple, who overlap to form a relationship; the members of the couple can be studied separately or as a couple unit. Each of these levels presumably exerts a significant degree of influence on the ultimate contraceptive decisions of individuals and couples, who make decisions together and individually.

Depending on the social context, members of the couple may have to engage in a series of major negotiations in order to actualize their contraceptive preferences. These negotiations may occur within the couple, between members of the couple and extended kin (particularly parents-in-law), and/or between members of the couple and institutional representatives, such as medical professionals or family planning advocates. Each of these levels influences a couples' contraceptive decisions and negotiations—from macro-level government decisions about which contraceptive methods are legal, to friendly acquaintances recommending particular methods. However, the theoretical perspective presented in this paper will focus exclusively on the couple as the unit of analysis, and the factors of the couples' relationship which affect their contraceptive decisions. A complete, multi-layered theory of contraception would have to take all of these levels of analysis into account at once, which is beyond the scope of this paper.

Couples and the Sexual Context

I have provided a detailed theoretical description of the role of sex in contraceptive and fertility decision-making elsewhere (Fennell 2006) which I will only briefly summarize here. Traditionally, when demographers have acknowledged the role of sex in fertility processes, they have typically emphasized the biological role of sex—using terms like "coital frequency" or "sexual exposure," rather than emphasizing its

social roles. Sex is an inherently social process, in that it requires at least two people in order to occur, and its sociality is complicated by an array of norms which dictate the appropriate context and scripts for sexual activity. Sex within the context of marriage, for example, has an entirely different social script compared with sex as an explicitly commercial transaction. In addition, sex has diverse social meanings and serves many social functions which are mostly independent of its implications for fertility, including as an expression of love and intimacy (Giddens 1992). Sex and sexual expression affect a person's relationships with significant others—including family, friends, co-workers, and, of course, lovers—and are closely linked to conceptions of self and identity (Williams and Stein 2002). Due to these major social implications, sexual activity and interactions are typically governed by a stringent set of social norms and taboos which often prevent partners from open communication about their fertility and contraceptive preferences (Gómez and Marín 1996). Thus people's sexual behavior is guided by many social concerns other than their fertility and contraceptive goals, and the social context of sexual interactions can explicitly interfere with the achievement of fertility goals.

These cultural sexual scripts have been developing for centuries, while contraception is still a relatively new technology. People have to find ways to work contraception into their sexual encounters with partners if both people are to knowingly contracept. It seems fair to say that sexual scripts in most cultures still do not readily accommodate the introduction of contraception into a sexual encounter. If responsibility for contraception were a purely individualistic process, it would doubtless be much easier for people to use.

Active and Passive Preferences and Negotiations

Major demographic fertility theorists such as Becker (1960) and Friedman, Hechter, and Kanazawa (1994) have made the key assumption that fertility and contraceptive decision-makers are (and perceive themselves to be) reasonably well-informed about their options, and that they behave in accordance with their knowledge and desires. I refer to this type of *decision-making*, in an ideal type, as "active" decision-making. This style of decision-making is accompanied by precise and known preferences within an individual. For example, a man might know that he wants to have a baby in the next year and that he dislikes condoms and would prefer his wife to use hormonal contraception; a less-defined, but still active, preference might be to use contraception, but to have no method preference. I refer to such *preferences* as "active" preferences. They may or may not be accompanied by a process of "active" negotiation with a partner to actualize preferences. Active partner negotiation does not have to involve verbal communication, but verbal communication presumably is the most effective negotiation strategy. Non-verbal communication is more difficult to categorize, particularly if it is subtle and the partner is obviously not getting the message. Obvious non-verbal communication (such as handing a partner a condom, or simply putting a condom on without discussion) is clearly active negotiation; however, it is possible to imagine extremely subtle negotiation strategies (such as repeatedly leading a partner in the direction of the family planning aisle of the drug store) which can be less clearly labeled "active."

In contrast to active decision-making, preferences, and negotiation, there is "passive" decision-making[1], preferences, and negotiation. Recent qualitative evidence

[1]In using the terms "active" and "passive," I do not wish to invoke my own evaluation of these decision-making and negotiation styles; nevertheless, the terms do correlate well with larger American cultural

from researchers like Carrillo (2002) and Johnson-Hanks (2006) suggests that decision-making pertaining to fertility, disease, and contraception is often not as carefully planned and calculated as traditional demographic theories of active decision-making have suggested. Instead, individuals in these accounts often describe themselves as simply "going with the flow" and admit that they have not seriously considered the consequences of their actions, even when they knew what those consequences were. They might have vaguely formed preferences, such as, "Condoms don't really bother me," but they also might have difficulty articulating those preferences to themselves, an interviewer, or a partner. Since they do not have well-defined preferences, they are probably less likely to actively discuss contraception with their partners. All other things being equal, they are more likely to do whatever a partner with active preferences decides. If they are with a partner who also has passive contraceptive preferences, they are less likely to use contraception at all, because passive preferences should be more likely to encourage passive strategies of negotiation: the most passive strategy of negotiation is to avoid negotiation.

Individuals have active and passive contraceptive preferences which they must communicate to their partners in order to actualize their preferences. This process entails negotiation, as explained above, which may also be active or passive. Together, the two people create a contraceptive preference for the relationship. However, different types of preferences and negotiation strategies may be preferred by each partner—there is nothing inherent in active or passive preferences which compels individuals with active preferences to partner with others with active preferences and vice versa. Consequently, as illustrated in Fig. 2:

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evaluations.

- one partner may have an **active** preference, be an *active* or *passive* negotiator, and the other partner may have an **active** preference and be an *active* or *passive* negotiator
- one partner may have a **passive** preference, be a *passive* negotiator, and the other partner may have an **active** preference and be an *active* or *passive* negotiator
- one partner may have a **passive** preference, be a *passive* negotiator, and the other partner may have a **passive** preference and be a *passive* negotiator

The myriad possibilities here suggest some of the complications of doing couple research. It is possible that people with similar (or opposite) preferences may be drawn to one another, but that is a testable empirical question. Theoretically, however, the complexities remain. Furthermore, it is important to keep in mind that there is not a simple dichotomy between active and passive decisions, preferences, and negotiation strategies, but rather, these descriptions represent ideal types to help us understand that not everyone knows exactly what they want in terms of fertility and contraception, and even when they know what they want, they may not know how to get it.

Negotiations, Preferences, and Relationship Dynamics

The discussion above is neutral with regards to the contextual factors that influence an individual and couple's preferences and negotiation strategies. As sociologists, however, we should be reluctant to assume that contraceptive preferences and negotiation strategies are fixed characteristics of individuals. Rather, we need to examine the contexts in which individuals are more likely to indicate a particular preference (and preference style) and more likely to use particular styles of negotiation to achieve those preferences. For example, an individual might think abstractly that she does not want a child in the near future, but any number of circumstances may constrain her from actualizing that preference: economic limitations may prevent her from buying

the contraception she wants, medical and legal limitations might prevent her from acquiring the contraception she wants, the potential disapproval of family and friends might prevent her from actively seeking the contraception she wants, and—most relevant to this discussion—she might fear any necessary partner negotiations required to use the contraception she wants.

It is important to recall that, as a medical technology, contraception brings with it related, but distinct, biological and social constraints. Biologically, women have greater power over the contraceptive technologies currently available for preventing pregnancy, for they have a greater selection of reversible contraceptive methods, and they can (theoretically) take them without any negotiations with their partners. Men do not have access to the most effective reversible methods of pregnancy prevention without engaging in negotiations with their female partners. On the other hand, social constraints may limit women's biological advantage, since in many cultures a husband's permission is officially or unofficially required in order for a woman to obtain contraception, or women may be forced to ask their male partners for money to buy these contraceptives (Agadjanian 2002; Bankole 1995; Bankole and Singh 1998; Blanc 2001; DeRose, Dodoo, and Patil 2002; Dodoo 1998; Ezeh 1993; Kaler 2003). Thus men are universally disadvantaged biologically in pregnancy prevention, but their social advantage or disadvantage depends on the cultural context. However, men have greater power over male condoms, which gives them a biological and social advantage in disease prevention, since women must negotiate with them if they want to use condoms. At this point, women are universally socially and biologically disadvantaged in disease prevention, since they do not have access to methods which are entirely within their

control for disease prevention[2].

The research cited above indicates overwhelmingly that in developing contexts, men generally have more power[3] than women over the prevention of disease and pregnancy. But the question of how much power men have in contraceptive decisions among couples in developed contexts—where men's and women's general equality is typically greater—is less decided. Heterosexual couples in the US are more likely to report that men have more power, overall, in relationships (Felmlee 1994), with longitudinal data indicating that these perceptions are stable across time (Sprecher and Felmlee 1997). However, experimental evidence suggests that women may have more power in contraceptive decisions than men (Gerrard, Breda, and Gibbons 1990). Self-report, on the other hand, suggests that husbands' and wives' relative influence over the contraceptive decision-making process varies according to the contraceptive method (Miller and Pasta 1996), while US men report that they share equal responsibility with women for contraceptive decision-making (Grady et al. 1996). Forste and Morgan (1998) show that after controlling for the characteristics of US men's female partners, the characteristics of the man were still significant predictors of contraceptive use. Thus the question of how gender affects the distribution of contraceptive decision-making power among couples in the U.S., at least, remains an open question.

Researchers have considered the effect of power on contraceptive use in general, but they have focused most intently on condoms for reasons that will be discussed later. A survey scale designed to measure power in relationships for women in the US

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[2]Contrary to its creators' intentions, the female condom is awkward and still requires male cooperation.
[3]For the purposes of this discussion, I shall define power using Weber's (1953) traditional definition of the ability to enact one's will over or against the will of others. Other power researchers generally seem to be using a similar definition.

(Pulerwitz, Gortmaker, and Dejong 2000) showed that women with more power in their relationships are more likely to use condoms (Pulerwitz et al. 2002). Bowleg and colleagues (2004) point out that researchers tend to assume that, even in the US, women push for condom use and men refuse it. But their interviews with African-American women suggest that some women discourage condom use for their own sakes, because these women felt that condoms decreased intimacy and physical pleasure; these results indicate that male-female power differentials are not the only important components of the condom decision-making process.

Two related concerns have emerged in this literature. The first is a persistent focus on the gendered power dynamics of (heterosexual) couples, rather than a focus on power more generally. While gender inequities may be the most visible ones in many developing contexts, this focus on gender inequality as the most important aspect of power imbalances *may* be less useful in developed countries and same-sex relationships. Carrillo's (2002) research on Mexico indicates that many of the same issues affect opposite-sex and same-sex relationships in decisions about condom use, and men and women in both kinds of relationships voice nearly identical fears about introducing and using barrier contraception in their relationships. If the same issues affect the decisions of women in sexual relationships with men, and men in sexual relationships with men, then the most important issue curtailing condom use (and potentially other contraceptive use as well) is perhaps not the inequality between men and women. The second concern is a specific concern with condom use. Because power researchers interested in contraception have focused on the inequality between men and women (with the assumption that women have less power in contraceptive decision-making), the most

obvious research consideration is a focus on the single reversible method which biologically disadvantages women, and the only method that prevents the spread of HIV—condoms. However, I argue that we must understand condom use in the larger context of contraceptive use—especially since heterosexuals in low-HIV societies still primarily use condoms to prevent pregnancy, not disease (Cooper, Agocha, and Powers 1999; Hammer, J.C. et al. 1996)—if we want to truly understand how decisions about condom use are made. Doing so forces us to expand our conceptualization of power in relationships as something men have and women lack.

Foucault and "Relational Power"

Rather than succumbing to a simplistic understanding of power in terms of "haves" and "have nots," we can look to Foucault for insights into a more nuanced reading of power, which Foucault refers to as "relational power" (1980, 1990). Foucault's formulation of relational power—which he originally theorized at the macro level, but which I am arguing can also be helpfully applied to the micro level—argues that no individual or group simply "has" power, while other individuals and groups lack it. Rather, in any interaction between groups or individuals, one group or individual almost always has *more* power than another to do certain things. The theory of relational power indicates that it would be a mistake to assume that just because a partner has more power in one realm of the relationship (e.g. material resources), that that partner consequently has more power in the realm of contraceptive decision-making. A strictly traditional gendered division of labor within a relationship, for instance, might give men more economic power in the relationship, but women more power over decisions pertaining to family life, such as contraception. In a relationship, it would be extremely

uncommon to see one person have complete power over his or her partner in every aspect of their relationship. The theory of relational power allows us to imagine that women, particularly in societies where they have little power generally, may actually have very carefully guarded realms that they maintain power over—and this realm is often the family. Most importantly, this theory implies that using proxies for power in relationships (such as age, education, or income disparities), which assume that power is the same in any realm of the relationship, may not be helpful for understanding the real dynamics of power with regards to family decisions.

In addition to Foucault's theory of relational power, I also want to apply his concept of techniques of power—which he only applies at the macro level—to relationships. In Foucault's vocabulary, "techniques of power" refer to the strategies that agents have for enacting power on others. Perhaps most importantly for the context of intimate relationships, the "deployment" of these techniques of power does not have to be strategic or deliberate, but it may nevertheless occur. Considering the techniques of power in relationships gives us further insight into the sources of power in relationships.

Sources and Techniques of Power in Relationships

If we want to look beyond gender to understand power in relationships (or even just to better understand gender), then we must consider the multitudinous sources of power in relationships. Biological, individual, and social needs all dictate that certain resources are necessary or greatly valued, and the threat of their withdrawal can be a means to power. In cultures where relationships are formed around an ideal of romantic love (which is an increasingly large percentage of them (Smith 2001), the threat of losing the loved one, and thus the relationship, may be tantamount to losing one's self. Many—

perhaps most—romantic relationships are characterized by an unequal investment by one partner (Vaughan 1990), and the less interested partner frequently has more power in many relationship decisions; this is referred to as the Principle of Least Interest (Harvey et al. 2002). At least one US study of adolescent relationships found that what appear to be differences by gender in contraceptive decision-making power are mediated by the Principle of Least Interest—that is, the least interested partner in the relationship has more contraceptive decision-making power (Tschann et al. 2002). The authors argue that women in American culture are likely to value relationships more than their male partners, and thus become disempowered in many decision-making realms, including contraception. The technique of power here is the threat of one partner leaving the other, which may or may not be explicitly invoked between the members of the couple.

The threat of leaving can represent more than the denial of emotional sustenance and comfort, however. It can also represent the implicit loss of other major resources: children, economic and material resources, and social capital in the form of kin and friends. The threat that these resources may be lost can be even more salient than the threat of losing the relationship.

Furthermore, many resources can represent a source of power in and of themselves, even without the threat of their withdrawal. If a man makes more money than his wife, for example, she may defer to him in many decision-making realms out of respect for his greater income (particularly in situations that involve spending money). Likewise, a woman who lives near her kin may have more power in fertility decisions in a relationship because of their influence over her partner, not because her leaving threatens her partner with their loss. Educational differences between partners may also

produce power differentials, since the more educated partner is assumed to know more about certain subjects than the less educated partner. And finally, socialization processes which cultivate super- and subordination (such as class differences, racial/ethnic differences, and even gender differences between the partners) may be a source of power to the member of the more socially advantaged group, since the less advantaged partner will have been socialized to habitual deference. These different resources might be invoked by the more powerful partner to establish his or her authority, or they may create a habit of deference in the less resourceful partner.

Finally, one of the most frequently mentioned sources of power is physical strength, with its accompanying technique of power—violence and the threat of violence (Blanc 2001). The fear of pain, injury, or even death may be sufficient to ensure compliance from partners who have every other advantage. As work on gay and lesbian partnerships reveals, intimate violence is not restricted to opposite-sex partnerships (Renzetti and Miley 1996), but research strongly indicates that throughout many cultures, violence by men against women is a major factor in perpetuating gender inequality. However, the threat of violence does not have take place within the confines of the relationship in order for it to be a source of power to a member of the relationship. Threatening a partner's children, parents, or other kin may be even more effective as a technique of power than threatening the partner directly. Others outside the relationship (e.g. kin) may also threaten individuals with violence for failing to comply with their partner's wishes. In many contexts around the world, partner violence appears to be the major technique of power; on the other hand, in most developed countries, the threat of losing children, economic resources, and emotional support seems to generally be more

important than violence as a technique of power.

Power differences affect contraceptive decisions and negotiations in two main ways: (1) in encouraging or discouraging the initiation of contraceptive negotiations between the partners, and (2) when the partners are willing to negotiate contraception but have different preferences. Partners who feel empowered in the contraceptive decision-making process should be more likely to initiate contraceptive negotiations (either verbal or non-verbal) than partners who feel disempowered, while less empowered partners might be waiting for their more empowered partners to take the lead. Fear of violence or other repercussions (particularly some unclear consequence from "offending" the other person) seems to prevent less powerful partners from introducing contraception. Power differences are also apparent when unequal partners do actually engage in contraceptive negotiations, but have different desires (different method preferences, or different preferences about whether to use contraception at all). All other things being equal, the more powerful partner's preferences are likely to prevail. This scenario is frequently invoked in discussions of condom use negotiations (Bowleg, Lucas, and Tschann 2004), with women presumed to be asking more powerful men to use condoms, and men refusing. Since all other things are so rarely equal, I suggest that two other factors—trust and pleasure—are at least as important in determining the outcome of a condom or other contraceptive negotiation as power. While eliminating power inequality is a laudable goal, the time required to achieve this goal makes looking for alternative strategies preferable in contexts where contraceptive interventions are needed now.

Trust

Trust, in general, refers to the degree to which people are willing to depend on

others to do something—a "vesting of confidence in the other" (Giddens 1990). Giddens (1990) has argued that trust is multi-layered, and that trust can exist between individuals, or between individuals and institutions. In the context of contraceptive decisions and negotiations, partners' decisions are based on the degree to which they trust their partners to remain sexually faithful, to use a contraceptive method appropriately, and to remain partnered to them in the long-term (which primarily indirectly affects contraceptive preferences through fertility preferences). It is difficult—and probably unnecessary—to distinguish between the effect of trust and romantic love in relationships; however, trust is a broader category than romantic love, and the effect of romantic love on contraceptive decisions seems to operate entirely through trust. Individuals might engage in sexual encounters with close friends whom they are not "in love" with, but whom they trust deeply (Carpenter 2005).

Sources and Techniques of Trust in Relationships

The most obvious source of trust in relationships is relationship length; how long people have known each other affects the likelihood that they will trust each other (Larzelere and Huston 1980). As suggested above, we will have an incomplete picture if we only consider how long the couple has been together in a sexual or romantic relationship, since people may have known each other intimately for years before entering a sexual relationship with one another. Communication is also a major source of trust in relationships. The more individuals feel they know their partners, the more likely they are to say they trust them (Larzelere and Huston 1980). In keeping with the tie between communication and trust, promises (and lies) are important techniques of trust in relationships. For example, the promise to remain sexually monogamous should promote

sexual trust, but such a promise which is later discovered to be false is likely to seriously damage trust in the relationship—more so than the discovery of multiple sexual partners without such a promise. To the best of my knowledge, there is no work that looks at the compartmentalization of trust in relationships, thus answering the question do individuals trust their partners generally, or do they only trust them to do certain things? If trust is compartmentalized, does trust in apparently unrelated realms of a relationship promote trust in other interactions in the relationship? For example, a person might theoretically trust her partner to balance the checkbook honestly, but not to remain sexually faithful.

Like power, trust is both an individual and relationship characteristic. Trust can be unevenly distributed between the partners in a relationship, so that one partner trusts the other one deeply, while the other does not return the trust. Like the Principle of Least Interest, the less trusting partner may have more power in contraceptive decisions than the more trusting partner. Otherwise, it is unclear how trust inequities might affect contraceptive decision-making and negotiations.

While it may be unproductive to distinguish between love, romantic love, and trust, the belief that one loves someone certainly appears to promote trust in that person. Qualitative work suggests that feelings of love may outweigh all other considerations in people's decisions about condom use because romantic love and trust are so closely connected (Carrillo 2002; Larzelere and Huston 1980) that to have one without the other causes cognitive dissonance for most people. Affirmations of love and commitment (e.g. saying "I love you," or promising, "I don't need anyone but you") are the primary techniques of trust which support romantic love.

At the opposite end of the spectrum is trust in an institution, not a person. The

primary relevant institution here is marriage, which seems to inspire a type of trust all its own. Anthropologists looking at a variety of countries around the world are reaching the conclusion that marriage presents one of the greatest risk factors for HIV for women in developing countries, because of the trust men and women place in the institution of marriage (Hirsch et al. 2006). They appear to trust *marriage*—not their husbands and wives—to protect them from disease, thus negating the need for condoms when having sex with their spouses. My own work with Nancy Luke in Kenya indicates that many men also regard marriage as an abstract sexual safety net, but our work found extra-marital sex rates among married men in the past year around 40%. In these instances, people do not trust an individual, but a role occupied by that individual. The technique of trust used here is social and cultural affirmation—other people's ideas about the nature of the relationship inspire trust in the partners.

Researchers have described some of the effects of trust on condom use. Both qualitative and quantitative work suggests that people in the US are most likely to use condoms when their relationships involve less intimacy and trust. In particular, people are more likely to use condoms with partners who are new or short-term (Civic 1999; Galligan and Terry 1993; Gómez and Marín 1996), and whom they consequently trust less. Women older than thirty stated that they often found it difficult to use condoms because they violated the implied trust of their long-term relationships (Maxwell and Boyle 1995). Condom use is correlated with a reduction in intimacy and trust for two reasons: first, it is seen as implying that a partner has a disease and thus further implying that they are either dirty or unfaithful[4] (Browne and Minichiello 1994; Carrillo 2002);

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[4] These studies show that whichever partner introduces condoms is not viewed as having a disease him or herself, but instead implying that the *other person* has a disease.

second, condoms reduce physical intimacy by setting up a literal physical barrier between partners that also reduces emotional intimacy (Browne and Minichiello 1994).

While trust is most conspicuous in negotiations about condoms, since condoms have come to imply a lack of sexual faithfulness and thus distrust to many people, we also need to consider how trust affects contraceptive decision-making and negotiations for methods other than condoms. For all methods, greater trust seems to increase the likelihood that contraception will be used at all, and presumably this increase is due in large part to the partners' willingness to engage in contraceptive negotiations. In particular, people appear to need to trust that their partners will correctly interpret their intentions (for example, people frequently mention the fear that by discussing contraception at all, they have implicitly agreed to have sex (Carrillo 2002)). Trust also affects which methods each partner prefers. With less relationship trust, condoms are more likely to be preferred. However, if the couple decides to use "invisible" methods of contraception (hormonal contraception, IUDs, or sterilization), then one partner generally must trust the other to tell the truth and to use the method correctly. When using reversible contraception, male partners have to trust that their female partners are using their methods appropriately, unless the male partners involve themselves with an intensity that could imply either distrust or great intimacy (e.g. reminding and watching a woman take her pill every night, or reminding and helping her change a vaginal ring). However, power and trust are not the only relationship considerations people take into account when deciding on a contraceptive method.

Aspects of Pleasure

Policy work which tries to persuade us that promoting women's equality (power)

and communication between partners (trust) will significantly increase condom use is, I fear, misguided because it fails to take into account the third—and possibly the most important—factor affecting couple's contraceptive decisions: pleasure. To the best of my knowledge, no social theorist except Carrillo (2002) has seriously considered the implications of pleasure in contraceptive decision-making. Contraception is only relevant when people are having sex for pleasure, since if they are having sex to procreate, they would not consider using it. Consequently, any contraceptive method that interferes with pleasure is not likely to be popular.

Cultural (and sub-cultural) evaluations of pleasure differ widely, with "dry sex" valued in many African cultures (Kaler 2003), and a mix of pleasure and pain valued in the sado-masochistic subcultures of many western countries (Kleinplatz and Moser 2006). Thus it is necessary to paint a broad picture of what pleasure is, and to theorize its many aspects. The most obvious type of pleasure relevant for contraceptive decision-making is physical sexual pleasure, which includes physical arousal and orgasm. While it is the most obvious, it may not be the most important aspect of pleasure valued by people in romantic unions, for many people describe the psychological pleasure of sexual union with someone they feel close to to be their greatest sexual pleasure (Free, Ogden, and Lee 2005). This psychological pleasure results from the joy of giving one's self to another, and also from bringing pleasure to another person. It is closely associated with physical pleasure, but neither is necessary to achieve the other. Finally, there is general pleasure and comfort. This pleasure does refer to sexual pleasure, but rather to the goal of a physically and psychologically comfortable life. Any form of contraception which interferes greatly with a person's general pleasure is as unlikely to be popular as any form

of contraception which interferes with sexual pleasure.

Considering the role of sexual pleasure in contraceptive decision-making reveals two problems for traditional rational-choice theory. Experimental and self-report data indicate that young men's contraceptive decisions (particularly decisions about condoms) are affected by their state of sexual arousal (Ariely and Loewenstein 2005). That is, the state of sexual arousal causes the pursuit of sexual pleasure to assume greater primacy in young men's decision-making priorities, over concerns with pregnancy or disease, than when they are not aroused. These data suggest that people's rational faculties may be inhibited by sexual situations. Furthermore, traditional rational-choice theory is based on the assumption that one person's need fulfillment is not based on another's (Folbre 1993). The psychological pleasure derived from giving another person pleasure—and the need to pleasure another person in order to secure one's own pleasure—does not easily fit into a traditional rational-choice framework. For example, a person whose pleasure is unaffected by condoms might choose not to use them because his/her partner's pleasure is. By acknowledging the role that pleasure plays in contraceptive decision-making and negotiations, we must also acknowledge that doing so requires modifications, at the very least, to traditional rational choice frameworks.

The importance of pleasure affects contraceptive decisions about every method. If condoms did not interfere with many men's sexual pleasure (Browne and Minichiello 1994), then the gendered division of power would be much less important for determining the outcome of a condom-use negotiation. Likewise, women would probably accept hormonal contraceptives much more readily if they were not often accompanied by side effects that can include mood alteration and even—ironically—loss

of libido. Contraceptive researchers frequently complain that contraceptive users compare their feelings and state of health using contraception to their feelings and health when not using it, while the researchers compare their state of health on contraception to their state of health while pregnant. The actual situation is slightly more complicated: if the user sees the point of having sex as deriving pleasure, but the contraceptive prevents pleasure, then what exactly is the point of using the contraceptive?

Intersections between Power, Trust, and Pleasure

The intersections between the three relationship dynamics of power, trust, and pleasure make it difficult to study one adequately without the other; each aspect of the relationship affects other aspects of the relationship, with the distribution of power inevitably affecting the dynamics of trust, and subsequently the production of pleasure within the relationship. In the case of contraceptive negotiations, the more powerful partner's pleasure is likely to be favored when two partners' contraceptive preferences are in conflict, while trust and power work together to determine whether contraceptive negotiations are ever initiated at all.

The most important contraceptive interaction which combines power, trust, and pleasure is deception. Partners may lie and claim to be using contraception or sterilization when they are not, or they may lie and claim *not* to be using contraception when they in fact are. In developed countries, where fertility rates are low, people are more likely to suspect their partners of the former, and in less developed countries, where fertility rates are high, male partners are more likely to suspect their female partners of the latter. When an out-of-wedlock pregnancy used to be a ticket to marriage in many cultures, men would sometimes accuse their unmarried female partners of faking

contraceptive use, and then using a pregnancy to secure marriage. These different deceptions can be a way of secretly gaining power in the relationship, by gaining the "upper hand" and knowing the truth about the couple's contraceptive use. They may also be a way of deliberately violating a partner's trust in order to hurt them; or they may be a means of temporarily securing a partner's trust in oneself by telling the partner what is expected. And finally, they may be a means of securing sexual pleasure by telling a partner what she or he wants to hear to ensure the sexual interaction proceeds according to plan. Deliberate contraceptive deception may be one or all of these things at once.

Contraceptive Hypotheticals and Technological Fixes

The most unfortunate conclusion from this paper is that condoms, which trigger power inequalities and interfere with expressions of trust and pleasure, are unlikely to become popular in long-term relationships; this conclusion is not especially innovative, but I have provided a theoretical justification for it. Furthermore, by offering this theoretical justification, I can produce some insights into a method of contraception to prevent STI's which might prove more acceptable. Some people may argue that "technological fixes" for the STI epidemic around the world are impractical, but all contraception is a technological fix for the "problem" that people are unwilling to live without sexual pleasure, and vaccines and cures are as much technological fixes as new forms of contraception; the question is, is it more practical to expend resources to try to persuade a reluctant populace to use an unpopular and inefficient technology (i.e. condoms), or to expend more resources on the development of more effective and user-friendly technologies? No one has an answer to this question, but in my opinion, based on the theoretical arguments I have presented in this paper, condoms will *never* solve the

HIV/AIDS crisis in Africa.

So let us consider the effects of the relationship dynamics of power, trust, and pleasure on some hypothetical STI-prevention technologies which are being and could be developed. For example, disease-killing vaginal microbicides will probably be available within the next decade (Darroch and Frost 1999). These microbicides would presumably be female-controlled, which would remove some of the gender and sex disadvantage women currently experience with condoms. Their distribution would also mean that both men and women had access to methods of STI prevention which they themselves control. In contexts where lubricated sex is valued as pleasurable, these microbicides might not be perceived as interfering greatly with sexual pleasure, although contexts that value "dry sex"—which happen to include many cultures where women are disempowered in many areas of life—are likely to perceive microbicides as interfering with sexual pleasure. Furthermore, like spermicides, microbicides are likely to include some physical discomfort for the woman, and inconvenience in use which might still make them an unpopular option in high-trust relationships. Thus microbicides present advantages in terms of resolving power inequalities, but they would probably still not be used in high-trust relationships, and perceived decreases in pleasure could also interfere with their popularity.

However, we can move beyond current reality and imagine that a pill were developed which could prevent STI's, much like birth control pills prevent pregnancy. If this imaginary pill were unconnected to birth control—if it were purely disease control—then taking it would probably be an inconvenience which would inevitably become linked with issues of trust. That is, as relationships became more trusting and intimate,

the inconvenience of taking the pill, combined with the implication that one's long-term partner *might* have other partners, would probably lead to these pill's use declining over time. On the other hand, this imaginary pill would have the advantage of not requiring any partner negotiations, and might allow for deceptions, so that it could be taken privately. But if there were extremely unpleasant side effects associated with the pill—or if it interfered with sexual pleasure—it would probably not be very successful. If the pill required constant maintenance, it would probably be more successful if it were *both* a contraceptive and a disease-preventing mechanism, because then trust would be less of an issue. Ironically, based on what we know of condoms, it appears that the most successful way to market an STI prevention tool is to market it as birth control; once a product is understood as primarily for STI prevention, then issues of power and trust loom large. Yet in high fertility contexts, there would be great advantages to having pills which prevented STI's without also preventing pregnancy.

Conclusion

The invention of the pill and other hormonal contraceptives which women can (theoretically) take without the knowledge or approval of their male partners has created the theoretical illusion that contraception is practiced only by individuals, instead of by couples. While women do sometimes continue taking hormonal contraceptives when they are between relationships, making these methods partly individual methods, contraceptives are most important when individuals are sexually active and must incorporate these methods into their relationships. Relationships are highly complex sexual, romantic, and familial arrangements which may not easily incorporate the negotiations that are required in order for both partners to be involved in contraceptive

decision-making. Together, the relationship factors of power, trust, and pleasure affect whether or not contraceptive negotiations will happen, and the outcome of those negotiations if they do. In order to help prevent unintended pregnancy and the spread of STI's, we need to understand people's priorities in contraceptive decision-making, and we must try to mitigate the biological and social inequities that different contraceptive methods produce. If we want greater equality in contraceptive decision-making, then we need non-barrier reversible male contraception, and we need female-controlled methods of STI-prevention. We also need to be realistic about the advantages and disadvantages of current methods of contraception, which includes acknowledging that condoms are inconvenient and interfere with many people's sexual pleasure. The success of our policy interventions depends on our ability to understand how real people make contraceptive decisions, and to approach those decisions realistically and with respect.

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Fig. 1 Illustration of Levels of Analysis

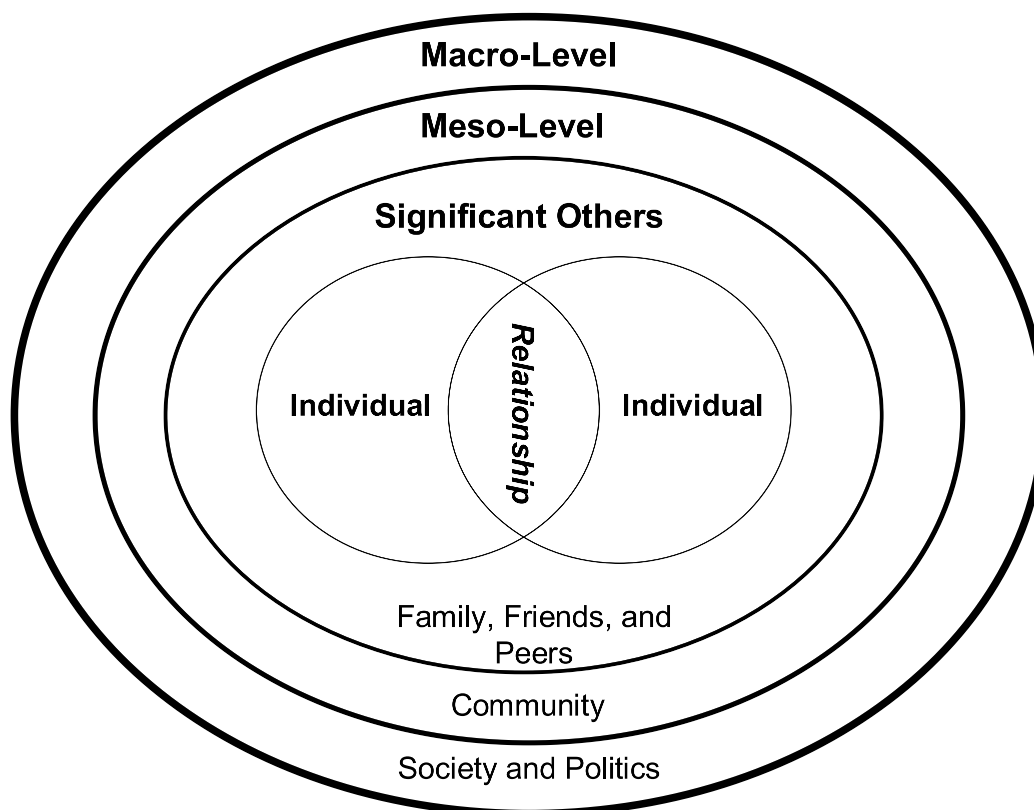

Fig. 2 Illustration of Possible Active-Passive Partner Pairings