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The Pleasure Principle: The Effect of Perceived Pleasure Loss Associated with Condoms on Unprotected Anal Intercourse Among Immigrant Latino Men Who Have Sex with Men

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Abstract

Sexual pleasure has been identified as an important consideration in decision-making surrounding condom use. We examined the impact of perceived pleasure loss associated with condom use on recent history of insertive and receptive unprotected anal intercourse (UAI) among Latino men who have sex with men (MSM) living in the United States. A total of 482 Dominican, Colombian, and Brazilian immigrant MSM were surveyed regarding sexual attitudes and practices via computer-assisted self-interviewing technology with audio enhancement (ACASI). Participants rated the pleasure they derived from protected and unprotected anal intercourse in each position (insertive and receptive) and also reported their HIV status, relationship status, and recent sexual history. Men who had engaged in both positions, with and without condoms ($n = 268$), perceived a greater pleasure loss associated with condoms during anal intercourse in the insertive versus receptive position. Logistic regression analyses controlling for HIV status, relationship status, and age revealed that men who perceived greater pleasure loss from condoms were more likely to have engaged in UAI over the past 3 months (n[insertive] = 297; n[receptive] = 284). Findings indicate that the pleasure loss associated with condoms may be a key deterrent for their use in either sex position among Latino MSM. Therefore, pleasure needs to be prioritized in the development of condoms and other sexual safety measures as well as in the promotion of their use.

Introduction

Latino men who have sex with men (MSM) account for over 80% of newly diagnosed HIV infections among Latino men living in the U.S.[1] Further, within the MSM community, Latinos are disproportionately burdened by HIV/AIDS, with a national HIV diagnosis rate approximately three times that of White MSM overall and five times that of White MSM within the 13–19 age bracket.[2] Paradoxically, Latino MSM tend to show comparable or higher rates of condom use relative to their White counterparts.[3–7] Regardless, many still opt to forgo condoms during anal intercourse, as evidenced by a recent Internet-based study of 14,750 MSM in the U.S. reporting that 49%, 46%, and 63% of Latino participants assuming the insertive, receptive, or both positions, respectively, did not use condoms during their most recent episode of male-partnered anal intercourse.[5] Given that male condoms continue to be the only method of preventing HIV transmission during anal intercourse (apart from abstinence) sanctioned by the U.S. Centers for Disease Control and Prevention,[8] greater understanding of barriers to their use among this high-risk group is needed.

Qualitative research has highlighted the role of physical and emotional pleasure in decisions to forgo condom use during anal intercourse among Latino MSM.[9,10] Consistent with past research on MSM samples of mixed[11–13] and other (e.g., Dutch[14]) ethnic compositions that implicates physical and/or emotional aspects of pleasure in sexual decision-making, Latino MSM report desire for greater physical sensation and partner intimacy relative to sex with condoms to be a primary source of motivation to engage in intentional unprotected anal intercourse (UAI).[9,10] However, quantitative research on condom-related pleasure in relation to UAI among Latino MSM is lacking. Moreover, studies examining this phenomenon among other groups of MSM are often methodologically compromised. First, past studies have

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commonly operationalized pleasure in absolute terms.[12,15] For example, although condoms are mentioned as standards of comparison in 2 of 9 items on Halkitis and colleagues'[12] Benefits of Barebacking Scale (e.g., "Barebacking is sexier than sex with condoms"), the remaining items offer no such reference points, but rather measure pleasure derived from barebacking in absolute terms (e.g., "Barebacking increases intimacy between men.") However, UAI decision-making is based upon perceived discrepancies between condom use and non-use, and thus, the pleasure associated with UAI should be conceptualized relative to the pleasure associated with protected anal intercourse (PAI).[11,16] In a study of sexual pleasure and condom use during vaginal intercourse, Randolph and colleagues[16] advocated the use of a pleasure decrement score, stating, "To establish whether condom use is associated with perceptions that condoms reduce pleasure, rather than a disposition to perceive sex, both protected and unprotected, as highly pleasurable, it is important to examine the difference in pleasure ratings between protected and unprotected sex."[16] Even those items that did reference sex with condoms in Halkitis and colleagues'[12] scale failed to quantify the discrepancy between sex with and without condoms. A more precise method of measurement is to solicit judgments of both PAI and UAI from participants and to calculate within-subject discrepancy scores. For example, using their Pleasure and Emotional Connectedness subscale of their Decisional Balance to Bareback self-report questionnaire, Bauermeister and colleagues[11] calculated the loss in pleasure/emotional connectedness associated with "bareback sex" versus "sex with condoms" by presenting items in pairs (e.g., "Bareback sex makes me feel close to my partner," "Sex with condoms makes me feel close to my partner") and calculating the discrepancy between item scores within each.

A second methodological concern is that participant position (receptive or insertive) is infrequently taken into account in measuring sexual pleasure among MSM, even though both the site of physical stimulation (penis or anus) and the potential risk of HIV transmission vary by position. For example, while Bauermeister and colleagues[11] distinguished insertive UAI from receptive UAI in terms of behavioral outcomes, they failed to specify position within their questions about pleasure, asking about "sex" without stipulating "insertive anal" or "receptive anal." Items could be worded in a way that distinguishes between positions, as in Davidovich and colleagues' study[14] (e.g., "I find it more pleasurable to fuck my steady partner without a condom," "I find it more exciting to get fucked by my steady partner without a condom").

Failure to specify sexual position in survey questions may lead to the confounding of position and pleasure. For men assuming the insertive position, the discrepancy in penile sensation for PAI versus UAI may be particularly salient, as loss of sensation is one of the most common forms of discomfort expressed by men with regard to wearing condoms.[17] Despite ongoing efforts by condom manufacturers to improve condom fit and feel, a recent study[18] of HIV-positive men's physical comfort with condoms revealed that a sizeable minority of men continue to experience problems with condom length (13% "too long," 16% "too short") and fit (21% "too tight," 9% "too loose"), with only 63% reporting satisfactory fit. A sample of African American MSM of unspecified serostatus reported comparable proportions of condom discomfort (7% "too long," 18% "too short," 21% "too tight," 9% "too loose") and adequate fit (61% "often" or "always").[19] In a convenience sample of U.S. men,[20] 58% reported condom fit to be "OK," whereas the remainder (42%) reported problems with condom length and/or width. Similarly, in a sample of undergraduate men, 29% expressed problems with condom fit or feel for themselves and/or their partner(s) in the last 3 months.[17] Problems with condom fit and feel have been associated with reduced sexual pleasure, erection problems, difficulty reaching orgasm, dryness during sex, and penile irritation.[20] Thus, given the prevalence of condom discomfort and its relevance to physical functioning and quality of sexual experience, condom fit and feel are likely to be central determinants of perceived pleasure during PAI versus UAI for the insertive partner.

In the receptive position, condom fit is not directly relevant if the insertive partner is the condom wearer, but other aspects of physical sensation could come into play. As one HIV-positive Latino man described in Balan and colleagues' study[9] of factors associated with barebacking, "The exchange of fluids…the feeling of when somebody comes inside…it's more personal, the beauty of it, the beauty of sex."[9] In another qualitative study,[10] an HIV-negative man expressed a similar sentiment, stating, "The feel of a guy releasing inside me is a turn on."[10] In addition to the sensation of partner ejaculation, discomfort with anal penetration could vary with condom use; for example, some men have described receptive PAI as being more painful than receptive UAI due to drying out.[9] This could, in turn, affect judgments of pleasure for receptive PAI versus UAI.

In sum, quantitative research on the pleasure associated with PAI as it relates to UAI is needed, particularly among the Latino MSM community. Separate measurement of pleasure associated with PAI and that associated with UAI would yield a more accurate estimate of pleasure loss associated with condoms. Further, perceptions of condom-related pleasure loss are likely to vary by position given the different sensory experiences condoms affect, and measurement should be sensitive to this factor. Thus, the objectives of the current study were to (1) compare the perceived loss in pleasure associated with condom use in insertive versus receptive positions to verify the importance of stratification by position and (2) examine the relationship between perceptions of pleasure loss and UAI among Latino MSM. HIV status, relationship status, and age were controlled in the analyses predicting UAI given past reports linking these factors to condom use.[7,12,22–26] We did not formulate a specific hypothesis about the amount of pleasure loss associated with condoms for the insertive position compared to the receptive position, as complaints about condoms inhibiting physical sensation and interfering with emotional connectedness have been voiced from both stances. With regard to our second objective, we hypothesized that greater perceived pleasure loss would be related to a higher likelihood of UAI in both positions.

Methods

Participants

A total of 482 sexually active, self-identified MSM of Dominican, Colombian, and Brazilian origin were recruited in the New York City metropolitan area as part of a larger study concerning contextual factors affecting sexual risk.[27] Targeted sampling was used to recruit participants from gay venues,

community organizations, and Latino cultural events in the New York City metropolitan area. Participants from this geographic location were also recruited via online advertisement (Craigslist.com), referral from other participants, and past study participation. Over 1000 flyers were distributed to potential participants, introducing the study and inviting them to call for more information and to schedule an appointment. Eligibility criteria included having been born in Brazil, Colombia, or the Dominican Republic, residing in the New York City metropolitan area, being at least 18 years of age, having had sex in the last 6 months, and having had sex with men.

Measures

Perceived pleasure loss. Pleasure derived from protected and unprotected anal intercourse was rated separately for insertive and receptive positions using items developed by the authors for the purpose of this study. Participants completed 4 parallel items pertaining to 1. Insertive PAI (e.g., How pleasurable do you find anal sex with a condom as a top [your penis in his anus]?"); 2. Insertive UAI; 3. Receptive PAI; and 4. Receptive UAI. A 5-point scale ranging from "Not pleasurable at all" (1) to "Extremely pleasurable" (5), with a "Have not done this" alternative response option, was used. Discrepancy scores were calculated as indicators of the pleasure loss associated with condom use in each position within the subsets of participants who had previously engaged in that position both with and without condoms. For example, the discrepancy score representing perceived pleasure loss associated with condoms during *insertive* anal intercourse was calculated by subtracting a participant's response to the item "How pleasurable do you find anal sex without a condom as a top [your penis in his anus]?" from his response to the item "How pleasurable do you find anal sex with a condom as a top [your penis in his anus]?"

Unprotected anal intercourse. History of UAI with a male partner within the 3 months preceding survey administration was self-reported as "Yes" or "No" for insertive and receptive positions (e.g., "In the last 3 months, have you had insertive anal sex with a man without a condom? [You were the top; your penis was in his anus; you didn't use a condom]").

Sociodemographic characteristics. Age, country of birth, age of immigration, education, monthly income, employment, sexual orientation, HIV status, and relationship status were self-reported by participants. Participants designated their HIV status as "Positive," "Negative," or "I don't know." The variable was subsequently dichotomized as "Positive" (1) or "Negative" (0), and all participants who responded "I don't know" were excluded from regression analyses ($n=43$). Participants indicated their current involvement in a relationship by answering "Yes" (1) or "No" (0) to a single item asking, "Do you have a main partner now? (That is, a person with whom you have an ongoing intimate sexual and emotional relationship, for example, boyfriend, spouse, lover)."

Procedures

All procedures were approved by the university-affiliated Institutional Review Board at the outset of the study. Enrolled participants were surveyed regarding their sexual attitudes and behaviors via computer-assisted self-interviewing technology with audio enhancement (ACASI). The survey was administered in English, Spanish, or Portuguese according to participant preference, and a bilingual research assistant was on hand to provide initial instructions and answer any questions that arose during the course of survey administration. Participants received $50.00 as compensation for their time and effort plus a $15.00 stipend to cover travel expenses.

Analysis

Data were analyzed using The SAS System for Windows (Version 9.1). For the purposes of data analysis, the sample was divided into overlapping subsamples based on participants' reported sexual practices. First, a single-sample t-test was used to compare perceived pleasure loss in the insertive position versus the receptive position among the subset of participants who had engaged in all four of the following behaviors over the course of their lifetime: Insertive PAI, receptive PAI, insertive UAI, and receptive UAI ($n=268$).

Table 1. Sociodemographic Characteristics of Participants Who Engaged in Insertive and/or Receptive Unprotected Anal Intercourse ($N=380$)

Characteristic	% (n)
Age of immigration	
0–5 years	12.4 (47)
6–15 years	14.0 (53)
16–25 years	32.6 (124)
26 years or older	41.1 (156)
Country of birth	
Dominican Republic	34.5 (131)
Colombia	35.3 (134)
Brazil	30.3 (115)
Education	
Less than high school diploma	12.6 (48)
Completed high school or trade school	16.6 (63)
Some college	28.7 (109)
Completed college	26.8 (102)
Graduate education	15.3 (58)
Monthly income	
Less than $401	16.6 (63)
$401–$800	22.4 (85)
$801–$1600	27.4 (104)
$1601–$2400	16.6 (63)
$2401 or more	17.1 (65)
Employment[a]	
Full-time	49.7 (189)
Self-employed	14.0 (53)
Unemployed	9.7 (37)
Sexual orientation[a]	
Gay	84.5 (321)
Bisexual	17.4 (66)
HIV status	
Positive	28.7 (109)
Negative	60.0 (228)
Unknown	11.3 (43)
Relationship status	
Main partner	45.0 (171)
No main partner	55.0 (209)

[a]Participants could endorse multiple response options; percentages for only the more commonly endorsed response options are reported here.

Subsequently, separate analyses were conducted for the subset of participants who had engaged in both insertive PAI and insertive UAI ($n = 297$), and for the subset who had engaged in both receptive PAI and receptive UAI ($n = 284$). Within each subset, logistic regressions were used to examine perceived pleasure loss relative to participation in UAI with a man within the past 3 months controlling for HIV status, relationship status, and age.

Results

Of the 482 men who completed the survey, 380 reported ever engaging in both UAI and PAI in one or both positions. Participants ($n = 380$) ranged in age from 20 to 70 years ($M = 36.3$, $SD = 9.56$). See Table 1 for additional sociodemographic characteristics.

Perceived pleasure loss associated with condom use in the insertive position ($M = 0.62$, $SD = 1.44$) was significantly greater than perceived pleasure loss associated with condom use in the receptive position ($M = 0.42$, $SD = 1.47$) among the subset of participants who had engaged in PAI and UAI in both positions ($M_{\text{difference}} = 0.20$, $SD = 1.33$), $t = 2.47$, $p < 0.05$. Logistic regression analyses revealed that perceived pleasure loss was positively related to participation in UAI for both insertive and receptive positions, such that participants who reported greater perceived pleasure loss associated with condoms were more likely to report engaging in UAI in that position with a man in the past 3 months (Table 2). Additionally, younger participants (in both positions) and partnered participants (in the receptive position only) were more likely to have engaged in UAI. HIV status was not significantly related to UAI.

Discussion

Findings of the current study indicated that a greater loss of pleasure associated with condoms was perceived in the insertive position relative to the receptive position among MSM who had enacted both positions with and without condoms. Additionally, results showed that greater perceived pleasure loss associated with condoms in each position predicted incidence of recent UAI in that position.

The finding that a greater discrepancy in pleasure loss was perceived for insertive versus receptive anal intercourse may be due to the physical properties of standard (male) condoms, which stifle sensation for the insertive partner to a greater extent than the receptive partner by nature of their design. Further, the association between perceived pleasure loss and UAI reported by men in the insertive position is consistent with other literature tying condom use to condom fit and feel; condom discomfort by condom wearers has been linked to incomplete condom use during intercourse (e.g., early condom removal),[17,20,28] lower motivation for condom use,[17] and lower likelihood of condom use during anal intercourse.[18]

Manufacturing companies' continued improvements in male condom texture, lubrication, and other physical properties as well as their production of condoms that vary by size and shape will help to accommodate diversity in tactile preferences and genital dimensions across male condom wearers.[29] In addition, such enhancements could simultaneously address condom-related complaints of MSM in the receptive position (e.g., longer-lasting lubrication to reduce "drying out" during PAI). Further, public health efforts to make the diverse range of condoms already in production more accessible to men by (a) revising medical standards that impose sizing restrictions on condoms made available to the public,[30] and (b) providing a wider selection of those sizes and styles that currently meet such standards within local markets, community clinics, and other condom distribution sites, would allow men to discover more comfortable and pleasurable options relative to others they have previously tried. Hopefully, access to more comfortable condoms would reduce perceived pleasure loss, thereby increasing likelihood of use.

Ongoing development of alternative methods of prevention may circumvent condom fit issues affecting pleasure in the insertive position, as well as other physical properties that interfere with pleasure in the receptive position or both positions. Establishing the safety and efficacy of the "female" condom for use during anal intercourse among MSM is important, as it may present a more feasible or desirable alternative for some MSM. In fact, one study found that 54% of MSM who had used the female condom for anal intercourse reported it to be more pleasurable than the male condom,[31] suggesting its promise as a pleasurable method of protection. However, other MSM have described problems such as burning, bunching, bleeding, and other forms of discomfort with the original model (i.e., Reality™ female condom [FC1])[32,33] and resolution of these issues with the second generation (i.e., FC2) of female condoms remains to be documented among MSM. Thus, further research is needed to establish the safety and efficacy of the female condom for anal intercourse among men, as well as to inform improvements in product design in the future. Furthermore, efforts to develop alternative methods of HIV prevention that do not impose solid physical barriers (e.g., vaccines, pre- and post-exposure prophylaxis, rectal microbicides), allowing direct physical

Table 2. Logistic Regression Analysis Predicting Unprotected Anal Intercourse (UAI) During the Past 3 Months

	Insertive UAI (n = 297)					*Receptive UAI* (n = 284)				
Variable	*B*	*SE*	*Wald* X^2	*OR*	*95% CI*	*B*	*SE*	*Wald* X^2	*OR*	*95% CI*
Perceived pleasure loss	0.30	0.08	12.32[c]	1.35	[1.14, 1.59]	0.23	0.09	7.10[b]	1.26	[1.06, 1.50]
HIV status	0.20	0.27	0.54	1.22	[0.72, 2.09]	0.31	0.28	1.20	1.36	[0.79, 2.36]
Relationship status	0.18	0.24	0.54	0.84	[0.52, 1.35]	0.57	0.25	5.00[a]	0.57	[0.35, 0.93]
Age	−0.43	0.13	10.41[b]	0.65	[0.50, 0.85]	−0.27	0.13	4.27[a]	0.76	[0.59, 0.99]

CI, confidence interval; OR, odds ratio.
[a]$p < 0.05$; [b]$p < 0.01$; [c]$p < 0.001$.

contact between partners and eliminating problems associated with barrier methods (e.g., drying out/pain during PAI), should be continued.

Since no specific definition was offered for the term "pleasure" in our survey, we cannot assume that participants were responding solely with regard to their physical/sensory experiences, as they may also have been considering their mental/emotional experiences. Excitement, intimacy, and emotional connectedness have been identified as factors motivating UAI[9,11,13,14] and are likely to have colored retrospective judgments of pleasure during UAI versus PAI in our study. Accordingly, public health efforts to promote condoms as pleasurable should be two-pronged; in addition to continuing product enhancements and improving accessibility of condom sizes and styles that optimize physical sensation, emphasizing pleasure and intimacy in condom-related public health campaigns and interventions should be prioritized, broadening the focus beyond risk and disease. Such pleasure-focused messaging may translate to more positive condom-related cognitions and enhanced mental/emotional experiences of condom use.

There are several limitations of this study that are worthy of mention. First, the data were collected cross-sectionally and retrospectively, so causality cannot be established. Second, we did not solicit male partner characteristics relative to behavioral data because data were measured in aggregate over 3 months as opposed to per event. Thus, while we controlled for participant relationship status and serostatus, we did not control for partner relationship or seroconcordance specific to acts of UAI or PAI. This may account for the nonsignificant relationships between (1) relationship status and insertive UAI and (2) serostatus and both insertive and receptive UAI. Third, we used the term "condom" without specifying "male" or "female" design. Even though "female" condoms have not received U.S. Food and Drug Administration approval as an effective method of HIV protection during anal intercourse, reports of off-label use by MSM have emerged since the late 1990s.[31–34] However, given that rates of reported use with male partners remain low (e.g., lifetime use of 5% among a sample of HIV-positive MSM,[31] lifetime use of 17% [15% with male partners] among men seeking services at a gay health care organization in NYC[34]), we presume that most participants were indeed responding to our questions with regard to male condoms.

Future research examining the implications of pleasure derived from UAI for participation in UAI and other sexual health outcomes would benefit from measuring pleasure associated with both UAI and PAI directly and calculating the discrepancy between the two values; such a discrepancy score provides a precise measure of pleasure loss associated with condoms that is superior to absolute measures of pleasure derived from UAI or perceptions of condom-related pleasure loss. In addition, given our finding that pleasure loss associated with condoms is greater for insertive versus receptive anal intercourse, stratification by sexual position is important when conducting research with MSM. Lastly, future replication of this study using event-level behavioral data is recommended, as event-level analysis would allow for partner-specific variables (e.g., partner relationship, seroconcordance) to be controlled.

In sum, consistent with previous research highlighting the salience of sensation and sexuality in condom-related cognitions among MSM,[35] the current study suggests that pleasure perceptions may be highly influential in the condom use decision-making process. Therefore, sexual pleasure needs to be a central priority in product development and dissemination for HIV prevention efforts to be successful. Shifting the emphasis to pleasure promotion could have far-reaching implications for the health and well-being of Latino MSM and the broader MSM community.

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Author Disclosure Statement

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References

1. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. HIV among Latinos. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/hiv/resources/factsheets/pdf/latino.pdf. Accessed March 5, 2012.
2. Hall HI, Byers RH, Ling Q, Espinoza L. Racial/ethnic and age disparities in HIV prevalence and disease progression among men who have sex with men in the United States. Am J Public Health 2007;97:1060–1065.
3. Halkitis PN, Brockwell S, Siconolfi DE, et al. Sexual behaviors of adolescent emerging and young adult men who have sex with men ages 13-29 in New York City. J Acquir Immune Defic Syndr 2011;56:285–291.
4. Harawa NT, Greenland S, Bingham TA, et al. Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the United States. J Acquir Immune Defic Syndr 2004;35:536–536.
5. Rosenberger JG, Reece M, Schick V, Herbenick D, Novak, DS, Van Der Pol B Fortenberry JD. Condom use during most recent anal intercourse event among a US sample of men who have sex with men. J Sex Med 2012;9:1037–1047.
6. Warren JC, Fernández MI, Harper GW, Hidalgo MA, Jamil OB, Torres, RS. Predictors of unprotected sex among young sexually active African American, Hispanic, and White MSM: The importance of ethnicity and culture. AIDS Behav 2008;12:498–468.
7. Wilton L, Halkitis PN, English G, Roberson M. An exploratory study of barebacking, club drug use, and meanings of sex in Black and Latino gay and bisexual men in the age of AIDS. *J Gay Lesbian Psychotherapy* 2005;9:49–72.
8. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. HIV among Latinos. HIV Transmission. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/hiv/resources/qa/transmission.htm. Accessed March 5, 2012.
9. Balán IC, Carballo-Diéguez A, Venuneac A, Remien RH. Intentional condomless anal intercourse among Latino MSM who meet sexual partners on the Internet. *AIDS Educ Prev* 2009;2:14–24.

10. Carballo-Diéguez A, Miner M, Dolezal C, Rosser BRS, Jacoby S. Sexual negotiation, HIV-status disclosure, and sexual risk behavior among Latino men who use the Internet to seek sex with other men. *Arch Sex Behav* 2006;35:473–481.
11. Bauermeister JA, Carballo-Diéguez A, Ventuneac A, Dolezal C. Assessing motivations to engage in intentional condomless anal intercourse in HIV risk contexts ("bareback sex") among men who have sex with men. AIDS Educ Prev 2009;21:156–168.
12. Halkitis PN, Parsons JT, Wilton L. Barebacking among gay and bisexual men in New York City: Explanations for the emergence of intentional unsafe behavior. Arch Sex Behav 2003;32:351–357.
13. Mansergh GM, Marks G, Colfax GN, Guzman R, Radar M, Buchbinder S. 'Barebacking' in a diverse sample of men who have sex with men. AIDS 2002;16:653–659.
14. Davidovich U, de Wit JBF, Stroebe W. Men in steady relationships: Implications for prevention strategies. AIDS Educ Prev 2004;16:304–314.
15. Kelly JA, Kalichman SC. Reinforcement value of unsafe sex as a predictor of continued HIV/AIDS risk behavior among gay and bisexual men. Health Psychol 1998;17:328–335.
16. Randolph ME, Pinkerton SD, Bogart LM, Cecil H, Abramson PR. Sexual pleasure and condom use. Arch Sex Behav 2007;36:844–848.
17. Crosby R, Yarber WL, Sanders SA, Graham CA. Condom discomfort and associated problems with their use among university students. J Am Coll Health 2005;54:143–147.
18. Reece M, Briggs L, Dodge B, Herbenick D, Glover R. Perceptions of condom fit and feel among men living with HIV. AIDS Patient Care STDS 2010;24:435–440.
19. Reece MR, Dodge B, Herbenick D, Fisher C, Alexander A, Satinsky, S. Experiences of condom fit and feel among African-American men who have sex with men. Sex Transm Infect 2007;84:454–457.
20. Crosby RA, Yarber WL, Graham CA, Sanders SA. Does it fit okay? Problems with condom use as a function of self-reported fit. Sex Transm Infect 2010;86:36–38.
21. Elford J, Bolding G, Maguire M, Sherr L. Gay men, risk and relationships. AIDS 2001;15:1053–1055.
22. Koblin BA, Chesney, MA, Husnik MJ, et al. High-risk behaviors among men who have sex with men in 6 US cities: Baseline data from the EXPLORE study. Am J Public Health 2003;93:926–932.
23. Poppen PJ, Reisen CA, Zea MC, Bianchi FT, Echeverry JJ. Serostatus disclosure, seroconcordance, partner relationship, and unprotected anal intercourse among HIV-positive Latino men who have sex with men. AIDS Educ Prev 2005;17:227–237.
24. Mustanski B, Newcomb ME, Clerkin EM. Relationship characteristics and sexual risk-taking in young men who have sex with men. Health Psychol 2011;30:597–605.
25. Crepaz N, Marks G, Mansergh G, Murphy S, Miller LC, Appleby, PR. Age-related risk for HIV infection in men who have sex with men: Examination of behavioral, relationship, and serostatus variables. AIDS Educ Prev 2000;12:405–415.
26. Pappas MK, Halkitis PN. Sexual risk taking and club drug use across three age cohorts of HIV-positive gay and bisexual men. AIDS Care 2011;23:1410–1416.
27. Zea MC, Reisen CA, Poppen PJ, Bianchi FT. Unprotected anal intercourse among immigrant Latino MSM: The position of characteristics of the person and the sexual encounter. AIDS Behav 2009;13:700–715.
28. Yarber WL, Crosby RA, Graham CA et. al. Correlates of putting condoms on after sex has begun and removing them before sex ends: A study of men attending an urban public STD clinic. Am J Mens Health 2007;1:190–196.
29. Reece M, Herbenick D, Dodge B. Penile dimensions and men's perceptions of condom fit and feel. Sex Transm Infect 2009;85:127–131.
30. Cecil M, Nelson AL, Trussell J, Hatcher R. If the condom doesn't fit, you must resize it. Contraception 2010;82:489–490.
31. Wolitski RJ, Halkitis PN, Parsons JT, Gómez CA. Awareness and use of untested barrier methods by HIV-seropositive gay and bisexual men. AIDS Educ Prev 2001;13:291–301.
32. Gross M, Buchbinder SP, Holte S, Celum CL, Koblin BA, Douglas JM Jr. Use of Reality "female condoms" for anal sex by US men who have sex with men. Am J Public Health 1999;89:1739–1741.
33. Renzi C, Tabet SR, Stucky JA, et al. Safety and acceptability of the Reality™ condom for anal sex among men who have sex with men. AIDS 2003;17:727–731.
34. Kelvin EA, Mantell JE, Candelario N, et. al. Off-label use of the female condom for anal intercourse among men in New York City. Am J Public Health 2011;101:2241–2244.
35. Scott-Sheldon LAJ, Marsh KL, Johnson BT, Glasford DE. Condoms + *pleasure* = safer sex? A missing addend in the safer sex message. AIDS Care 2006;18:750–754.

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