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Creating Lasting Love: An Ethnographic Study of Sexual Pleasure, Intimacy and Contraception

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Sexual pleasure and intimacy are key reasons why people have sex, yet it remains underexamined in our understanding of how people make decisions about contraception. This paper draws on ethnographic research of the intersections between sexual pleasure, intimacy and contraception among women using specialist contraceptive services in central London. I describe how contraceptive use and choices are intertwined with how women assess intimacy in their sexual relationship, and not solely a desire to avoid pregnancy. How and when women use contraceptives relays their concerns about creating and maintaining pleasure and intimacy in their sexual relationships. Moreover, this ethnographic account illustrates how women draw on various contraceptive methods in their decision making and use them to increase communication and trust, distinguish relationships and potentially enhance sexual pleasure, which is indexical and necessary for enduring intimate connections. Considering intimacy alongside sexual pleasure also allows us to consider the relational dimensions of contraceptive choice and how these are far from static, one-off decisions. These empirical insights into intimacy illustrate that contraceptive choice is both a reflection of the perceived intimacy in a relationship and is also a "practice of intimacy", particularly when people are navigating the various forms of intimacies available.

Keywords: *Contraceptive decision-making, pleasure, intimacy, London, ethnography*

Introduction

In attempting to understand contraceptive choices, public health professionals and researchers often look at people's motivations to use contraception (or not), and the canon is teeming with studies exploring the relationship between pregnancy intentions and contraceptive choices. Yet the role of sexual pleasure and intimacy in contraceptive choices is rarely examined. This is confusing as sexual pleasure and intimacy are crucial reasons why people have sex in the first place. Jennifer Higgins and Jennifer Hirsh (2007) aptly refer to this theoretical and programmatic oversight as the "pleasure deficit" - the paucity of attention paid to the effects of positive sexual experience on women's contraceptive choices and how seeking pleasure influences these choices.

Even more absent from discussions surrounding contraceptive choices is how they relate to intimacy. Several studies have found that condoms (non)use is often a strategy to find and maintain a primary relationship, establish trust, increase intimacy and distinguish kinds of relationship (Corbett et al., 2009, Hall et al., 2018, Manning et al., 2009). Further research has found that contraceptive choices, e.g., the choice of contraceptive methods, is linked to relationship status (Kusonoki and Upchurch, 2011, Kusonoki and Barber, 2020, Manlove et al., 2014, Harvey et al., 2018; Upadhyay et al., 2016). Though this body of work is insightful, it tends to reduce intimacy to survey categories of relationship status (e.g., married, engaged, living together in a sexual relationship, going steady, or some kind of casual encounter) that are untethered from contemporary theoretical debates and understandings of intimacy.

How we understand intimacy, sexuality and pleasure has evolved over the last thirty years and is hotly contested. Much of our contemporary understanding of intimacy derives from the seminal work of Anthony Giddens (1992) that outlined how intimacy has transformed. He traces how intimate relationships, both conjugal and familial, have transformed from obligatory marital and famil-

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ial relations centred on conjugal sex to reproduce into affective connections between couples and between family members. Giddens, moreover, situates changes in our understanding of intimacy within broader economic and demographic changes that have transformed personal relationships in the service of social reproduction into more egalitarian connections based on emotional attachments, compatibility and sexual satisfaction, what he termed 'pure relationships'. Intimacy is now the outcome of an active and ongoing negotiation of emotional and sexual satisfaction between purportedly equal partners. Central to the transformation described by Giddens is the separation of sex from reproduction (with the assistance of modern contraceptives) in such a way that sexuality takes on its own existence and becomes a means to forge connections with others. Sex has become part of the active process of generating and sustaining emotional, sexual, and social attachment in which sex and sexual pleasure are both the means and outcomes of a good relationship. Sexual relations with a relatively unknown partner may potentially lead to a more serious and emotionally fulfilling relationship: "Sex is, as it were, a sparking device, with romance as the quest for destiny (Giddens, 1992:51)." Counterposed to this understanding of intimacy is Eva Illouz's (2007) notion of 'cold intimacies' where she describes how capitalism has transformed our emotional lives and how the commodification of love and intimacy often shapes our expectations and behaviors in both sex and relationships. Illouz posits that the separation of sex and reproduction under advanced capitalism has resulted in the marketization of sex where more consumerist principles of seeking personal pleasure led to sexual interactions (e.g., one-night stands, hook up, fuck buddies) that do not build intimacy or anticipate a future connection or relationship. In this social arena, sexual encounters are a personal voluntary choice, yet they generate uncertainty and insecurity as there is no potential, or expectation of, future connection. Sexuality and pleasure in this context are ego-centric and work against the formation of intimacy.

In this paper, I use ethnographic material about contraceptive practices in London to reflect on ideas about intimacy, sexual pleasure and contraceptive choice. I bring together conversations about relationships and contraceptive choice with these debates surrounding contemporary forms of intimacy to see if and how they illuminate each other.

Methods

The following analysis is based on ethnographic fieldwork in a public-funded contraceptive service in London. I conducted participant observation in 5 clinics, along with interviews and life histories with people attending the clinics, as well as the healthcare workers and administrative staff that were supporting them and archival and document research on service and commodity related materials. As many of the initial set of respondents were pre-parturient, additional fieldwork was carried out with ante-natal groups and mother-and-baby groups to ensure a wider range of participants were represented. The interviews were a central part of the research and focused on mapping women's encounters with contraceptives, from their sexual 'debuts' until their then-present practices. Sitting in a private room after completing the consent process (REC Reference: 05/Q0511/72), I would start a conversation by asking why they used contraception. This simple question triggered an outpouring of stories, ideas and concerns that touched different public and private social domains and institutions such as family, work, sex and intimacy. Interviews were audio recorded and transcribed, pseudonyms were added, and identifying details were removed. A total of 69 interviews were collected and transcribed, 42 with those attending the clinic and 17 with those providing services. I used a grounded approach to construct theoretical findings from data through comparative process that informed an iterative coding frame. The codes were driven by inductive reasoning and therefore focused on the categories raised by the respondents in the course of our conversations. The author alone carried out the coding process and across the transcripts, identified the following four main domains of codes emerged: (1) pregnancy, parenthood and contraceptive use; (2) sex, sexuality, relationships and contraception, (2) bodily effects, menstruation and contraception use, and (4) contraceptive effects and embodiment. Cutting across these four broad categories was the gendered tension between private and public lives. In this paper, I present the analysis of the interview data related to the domain of sex, sexuality and contraception use. Of the 42 respondents interviewed, 33 respondents' transcripts (78%) included codes related to sex, sexuality and contraceptive use. Of the 9 respondents who did not comment on this domain, 6 were recruited at mother and baby groups which suggests they had life course-specific concerns that dominated the conversations. I must state my positionality to ensure transparency around my analysis and provide readers with insights into how my experiences, beliefs, and values may influence the framing of my arguments and the selection of supporting evidence. I approach this topic as a cis-gender, white British woman, and my experiences undoubtedly shape my interpretation of the materials discussed here. In addition, my training in British social anthropology has equipped me with a particular lens through which I view and analyze these conversations. Given this, I am open to diverse perspectives and critique of my interpretation.

Results

The majority of women attending the clinic and participating in the research were white British, well-educated, middle-class, unmarried and childless women aged eighteen to forty-five who had migrated to London to study and/or work in the white-collar professions as policy advisors, lecturers, executives, etc. They attended the clinic because it was centrally located and had convenient opening hours that suited their busy work schedules. Across the respondents who spoke about sex, sexuality, relationships and contraception use, there were very similar themes and here I will focus on a handful of accounts to illustrate the emerging themes. Jasmine had recently turned 34 when we first met at the clinic when she was getting a repeat prescription. Sitting in an empty office, she explained that she had re-started the pill three months into her relationship with her then-boyfriend, whom she had been seeing for nine months. Before this point, they had been using condoms. This was the third time she had taken the pill since she was 17. When I asked why she decided to take the pill, she told me she had felt 'secure' with her boyfriend. This pattern of using condoms with a sexual partner until feeling 'secure' and 'trusting' them was the same as when she previously took the pill. She started to take the pill when she felt that a sexual relationship was no longer casual but a more committed and serious attachment. She explained that she came off the pill when a relationship ended because the next time she met someone; she did not want to "just fall into it" but wanted time to be sure about the relationship. She would start to retake the pill when she thought she was getting serious and that they might be together for a while. Taking the pill at this stage took away the anxiety and pressures typically associated with condoms, emergency contraception or the withdrawal method and relieved the potential threat of unintended pregnancy in a burgeoning relationship. For Jasmine, shifting from condoms to taking the pill was closely associated with her assessment of how her intimate relationship was evolving. On a more general level, the women I spoke to often associated taking the pill with the start of a more serious relationship and they often recalled episodes of taking the pill by recollecting their more serious sexual partners. Poppy, like a third of the women I interviewed, had been using the pill continuously without a break regardless of whether they were in a committed relationship or not. Even though she was always on the pill, she didn't reveal this to her sexual partners until she trusted them. She always used condoms with new or casual sexual partners. She told me,

> Remembering back, if you have met somebody and you go back with them, for me it is a no-brainer to use a

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> condom with them anyway. And I was on the pill anyway. It is about that you don't know this person and that makes it so much more personal. You have this barrier. Condoms feel clean. Whereas if you know the person and you love them, it is a very different feeling.

For Poppy, not knowing a partner prompted condom use, which, in turn, made sex less "personal", and condoms acted as a physical and emotional barrier. However, she did not use condoms with a known and loved partner because this was "a very different thing". Poppy added "This is going to make me sound old-fashioned, but I am usually, I am pretty certain about the person before I start sleeping with them. Because of that, I tend to know a lot about their [sexual] history, so it is not something that ever comes up. I usually go out with some for a couple of months, my last boyfriend it was three months before I even started sleeping with him. Because this is something I take quite seriously. Whereas the one-night stands at university, we always had a jar of condoms in our bathroom." In her account, changes in her contraceptive choices related to how the relationship with her sexual partner was progressing, Heather, 24 years old, told me about what was usually happening in her relationships when she was considering using the pill: "I always have a conversation with the person about their sexual history but it's not something you really want to talk about in the beginning of a relationship, so I would rather wait for a few months or so until you feel ready to talk about it. I just don't think it is an appropriate conversation to have within in the first few weeks of meeting someone, however necessary, you just don't want to hear". She critically reflected on how contraceptive choices changed as a relationship develops: "If it's somebody who you've been going out with for a year, and you have met them and the rest of their family, they are suddenly not an infection risk. Why is that? It doesn't make them any less of an infection risk, but one day, I don't know anybody who says, oh, I'm gonna go and get tested, and I'm gonna get my partner tested. Then I'm gonna make this commitment and I'm gonna throw the condoms out the window. I don't know anyone that does that. Everyone kids themselves when they do it, and that they would do it. And then they talk very quietly about how safe they are...But what they mean is, if they meet some guy in a nightclub, they'll be safe if they go out with them for six months. Then suddenly that person, because that person is familiar, and friendly, and trustworthy in other ways, suddenly they're not an infection risk. And I'm totally guilty of that." Here Heather comments on how time and knowledge about partner was more relevant to contraceptive choice than actual risk. This was a typical pattern for many respondents. If they were having sex with an unknown, new or casual sexual partner, they would use condoms, but if that sexual relationship evolved into a more serious relationship over time, through disclosing conversations and increasing involvement in each other's life, a degree of trust and stability was built that allowed for a shift from condoms to using the pill (or revealing that they were already on it). In this way, taking the pill can be seen as symbolic of a transforming sexual relationship from a fleeting encounter into something more secure. Changing contraceptive methods as part of a more committed relationship was seen as a "trust thing". Over and over, I was told by women that they had opted to take the pill or revealed they were taking the pill, only once they felt they could trust their partners. Saffron, aged 44 when we first met, explained the 'trust' thing more clearly: "Just being on the pill there is a different level of trust, it is not so much a physical thing actually, just the sort of intimacy. Whereas if you're using a condom or going through that sort of barrier, literally, and also the moment of getting, there's a difference about it. And in instances when I am in a relationship, however short, with somebody, they don't necessarily know I am on the pill. That's my kind of, as a kind of added, making it more obligatory to use the condom. So that the pill gets tucked in the bedside drawer and is not left on the bedside table for those occasions". The trust garnered through increasing communication and knowledge about a partner is indicative of a perceived deepening trust and 'specialness' between sexual partners over time. I would further suggest that using condoms was more than a symbolic reflection on the nature of a relationship but was part of the process of gaining knowledge and communicating with a sexual partner to assess whether a more committed relationship was possible (Holland et al., 1998). Condom use in increasingly frequent sexual relationships requires ongoing communication and collaboration that are more characteristic of enduring connections. This symbolic switch from condoms to taking the pill in increasingly secure relationships affected sexual sensation. On the whole, condoms detracted from sexual sensation in terms of interrupting the moment, concerns about effectiveness, dampening sensation and restricting sexual possibilities regarding availability and ease of use. The texture, smell, sensation and expense, as well as the restriction due to availability, the practicalities involved, and the constant worry they may break or come off, were seen to reduce pleasure, closeness, "romance" and "passion". This contrasts with the association with sex on the pill as uninterrupted, spontaneous, worry-free and intimate, which made women feel more "carefree", "confident" and "relaxed" during sex. For these women, sex on the pill was considered more pleasurable for them and for their partners. For the women I spoke to, taking the pill (or revealing it) was a highly symbolic moment that affected both the status and the sensations of their sexual relationships. It was a moment that showed that the relationship was "special" – the more impersonal and awkward sex using condoms in novel and/or casual relationships gave way to more pleasurable sex on the pill as part of more trusting and enduring sexual relationships. When relationships ended (or were about to end) many women stopped using the pill to mark the end of intimacy. Changing contraceptive method was more than just a symbol of trust and commitment, but a way of affecting choices.

Discussion

Contraceptive choice is a "practice of intimacy"

In these recounted narratives, women are strategically using contraceptives to signal and affect intimacy and pleasure in their relationships. This observation of contraceptive choice as indicative of the nature of a sexual relationship is not unique. Sophie Day's (2007) research among sex workers in London found that barrier methods like condoms were used in more impersonal sexual encounters with paying partners and not in personal and trusting sexual relationships. According to Day, contraceptive choice was seen to effect a separation of public and professional sexual relationships from the more private and personal ones. With more sexual partners in a lifetime, contraceptive choices are ways of distinguishing between multiple sexual relationships and are also part of creating committed attachments. This ethnographic example of a contraceptive choice is a practical illustration of how sex precedes commitment, as demonstrated in how contraceptive choices distinguish different 'kinds" of sex and sexual relationships and can be part of a process of generating intimacy as sexual partners disclose sexual histories and are incorporated into each other's life. Contraceptive choices can be seen as what Lynn Jamieson (2011) described as 'practices of intimacy', practices that enable, generate, and sustain a sense of closeness and "special" quality of a relationship between people. The association of condoms and the pill with the qualities of a relationship and its transformation illustrates the negotiable connection between sexual partners. Periods of using condoms can increase knowledge, communication and trust between partners that are "gambles on love" when people have multiple sexual partners. Later switching to the pill could facilitate more pleasurable, spontaneous, and satisfying sex, further engendering closeness. Through these contraceptive practices, sexual intercourse and pleasure act to hold together an evolving relationship; as a relationship becomes more intimate, sex can be made more pleasurable. In this way, intimacy guides contraceptive choices as contraceptives are used in such a way to build and evaluate affectionate and pleasurable attachments. As a practice of intimacy, contraceptives increase

communication and trust, distinguish relationships and potentially enhance sexual pleasure, which is indexical and necessary for enduring intimate connections. These accounts also provide insights into current conversations about the "pleasure deficit", where the focus tends to be on the sexual and erotic sensation of the sex act itself as a discrete episode and less on the sex act in the context of an evolving relationship. Considering intimacy alongside sexual pleasure also allows us to consider the relational dimensions of contraceptive choice and of pleasure and how these are not static. Moreover, it also illustrates that women's decisions about contraception methods are not happening in isolation, but rather are interrelated and happening in progressing relationships that cannot be reduced to singular relationship categories. Moreover, the findings described here align with several quantitative studies of contraceptive method choice and relationship status, which found that more "serious" couples (characterized by length and self-reported commitment), are less likely to use condoms and are more likely to use hormonal methods (Kusunoki and Upchurch, 2011, Manlove et al., 2011, 2014, Upadhyay et al., 2016). Yet Kusunoki and Barber (2020) point out that none of these studies analyzed change over time in contraceptive use within relationships; rather, they used aggregate characteristics of relationships (e.g., currently cohabiting vs. dating, overall seriousness of the relationship) in relation to contraceptive use. Whereas this qualitative account illustrates the value of connecting contraceptive choices within the context of a specific relationship, not relationships in general.

What does this tell us about debates on contemporary understandings of intimacy?

These accounts also provide empirical insights into the mechanics and logic of contemporary intimacy. Women are engaging in multiple sexual encounters, ranging from more casual hook-ups to burgeoning serious relationships, and these are often distinguished and generated by contraceptive choices. Findings from the national population surveys of sexual lifestyles (Natsal-3) in Britain reveal that the sexual lives of women have changed substantially in the past 60 years–with increased sexual activity and diversity of practices with more male and female partners (Mercer et al, 2013). This would suggest some commonalties with Ilouz's assertion about the sexual lives associated with cold intimacies. Yet when we look at the purported "cold" sexual encounters, casual encounters are not necessarily at the expense of forming intimate relationships. Rather these accounts illustrate that casual encounters have the potential to evolve into something more intimate. Here we see that time is taken to cultivate and assess a relationship, talking and disclosing create security and trust, and physical closeness of sex on the pill aligns with intimacy as a process of engagement and negotiation. People are taking time to find and invest in highly emotionally and physically charged partners and diverse sexual encounters are 'gambles' on these potential connections. These accounts fall somewhere in between Giddens' "pure relationships" and Illouz's "cold intimacies" and suggest the two phenomena are at opposite ends of a possible continuum of intimacy and are not mutually exclusive. More useful is Helen Fisher's notion of "slow love" in which people want to take time to consider their relationship with a potential partner before committing more seriously (Fisher, 2015, Fisher & Garcia, 2018). According to Fisher, today's courtship consists of different forms such as being friends, friends with benefits, casual sex, and living together before marriage, as people are slowly transforming their informal sexual connections into long-term, formally committed relationships. Sex and contraceptive choices are part of the practices of slow intimacy that can create enduring relationships. One of the primary limitations of this study is it reflects a homogeneous sample, predominantly comprised of middle-class, educated white women in highly professional jobs. This characteristic might limit the generalizability of findings to a broader population. The experiences, perspectives, and behaviors of other demographic groups, including women of different racial and ethnic backgrounds, socio-economic statuses, sexual orientations, and relationship statuses, may not be represented in this research. The focus on this relatively privileged cohort may overlook the intersecting identities and complexities that influence individuals' experiences and could significantly impact the nuances of their experiences. Another limitation of this study is that I did not interview male partners. This analysis, thus, lacked information from the partners' point of view, which may be important for our understanding of contraceptive decisions, particularly for male-controlled methods like the condom.

Conclusion

How women talk about how and when to use contraceptives relay ideas about intimacy and how it can(not) evolve from a sexual encounter over time. The findings illustrate how contraceptive practices are part and parcel of mobilizing intimacy between sexual partners. More than this, it also helps us to better understand that multiple intimacies may co-exist, pure, cold, or somewhere in-between, and contraceptive choices not only signal relationship status but are also part of the practices of generating it.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author, Victoria Boydell. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

Ethical Clearance

This research was reviewed and approved by the Camden and Islington PCT Institutional Review Board REC Reference: 05/Q0511/72).

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