Measures of Attitudes Toward and Communication about Condom Use: Their Relationships With Sexual Risk Behavior Among Young Black MSM

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**Abstract**

**Objective**: To construct and test measures of psychosocial mediators that could be used in intervention studies seeking to promote safer sex behavior among young Black men who have sex with men (YBMSM).

**Methods**: YBMSM (N=400), ages 16 through 23 years, were recruited from an STI clinic, located in the Southern U.S. All of the men had engaged in penile-anal sex with a male partner as a “top” at least once in the past 6 months. Men completed an audio-computer assisted self-interview in a private area and provided specimens used for NAAT testing to detect gonorrhea/Chlamydia. Four scales were constructed (Safer Sex Communication, Condom Turn-Offs, Condom Pleasure, and Discussed Condoms With Partner Before Sexual Arousal) and tested for criterion validity.

**Results**: With the exception of Safer Sex Communication, all of the measures showed criterion validity for both unprotected anal insertive, and unprotected anal receptive, sex. With the exception of the Condom Turn-Offs, the three other measures were supported by criterion validity for oral sex. Both the Condom Turn-Offs and Condom Pleasure scale were significantly related to whether or not men reported multiple partners as a “top” but only the Condom Pleasure scale was associated with reports of multiple partners as a “bottom.” Only the Condom Turn-Offs scale was positively associated with having been diagnosed with either gonorrhea or Chlamydia.

**Conclusion**: The findings provide three brief scales and a single item that can be used by other researchers in intervention studies targeting YBMSM. Perceptions about condoms a turn off and about condoms enhancing pleasure showed strong association with sexual risk behaviors.

**Introduction**

Despite representing an estimated 2% of the United States population, gay and bisexual men account for an estimated three-fourths of all new HIV infections.1 Young, Black men who have sex with men (YBMSM) have experienced a far more rapid escalation of the HIV/AIDS epidemic than MSM who identify as White or Latino or any other sub-population in the U.S.1-6 YBMSM have a one-in-four chance of becoming infected with HIV by the time they reach 25 years of age.7

Behavioral interventions designed to promote safer sex behaviors for YBMSM are a public health priority.8 A key task in the design of these programs is the identification of targeted psychosocial mediators. Key mediators from studies of young Black men include communication with their partners about condom use and safer sex and issues men may have with condoms being antithetical to sexual arousal and sex.9-11 Communication with partners about condom use may be especially important given that sex and sexual negotiations may be complicated by condom use. Aspects of condom use that lead to sexual “turn offs”12 are potentially important psychosocial mediators. Conversely, an unexplored but potentially important mediator of condom use involves heightened perceptions of sexual pleasure when condom protection is used.13

Several scales have been created to measure condom attitudes/barriers to condom use, with the most commonly used the UCLA Multidimensional Condom Attitudes Scale,14 the Condom Barriers Scale 15 and the Multi-Factor Attitude Toward Condoms Scale.16 Although many of these scales have undergone psychometric assessment, the samples used have mainly been young, college-aged heterosexual students.17, 18 The Condom Barriers Scale15 (from which one of our scales was developed) has been used with a range of populations including high-risk African-American heterosexual men,19 but not with men who have sex with men. Some authors have acknowledged that their findings with these measures may not be similar for men who have sex with men.16 Peterson et al.20 developed a 5-point scale to assess attitudes about condoms among gay and bisexual African-American men but to our knowledge, no validated scales on barriers to condom use exist that been validated with African American men who have sex with men.

The purpose of this study was to construct and test measures of psychosocial mediators that could be used in intervention studies seeking to promote safer sex behaviors among YBSM. Specifically, after collecting the data, we tested the scales for inter-item reliability and for criterion validity, using multiple behavioral outcomes.

**Methods**

Study Sample

A convenience sample of 400 YBMSM was recruited for participation in an NIH-funded randomized controlled trial of a safer sex intervention program. Only baseline data was used for this study. Recruitment occurred in a federally supported clinic designated specifically for the diagnosis and treatment of HIV and other sexually transmitted infections. The clinic was located in a mid-size southern city experiencing extremely high incidence rates of HIV. Inclusion criteria were: 1) self-identification as Black/African American; 2) aged 15 to 29 years; 3) attending the clinic to be tested for HIV or other STIs, 4) engaging in penile-anal sex with a male partner as a “top”, at least once in the past 6 months, and 4) the ability to speak and comprehend English.

Age-eligible Black males were approached in clinic waiting areas and asked about their interest in participating in an HIV prevention study. Those expressing interest were screened for eligibility. A total of 733 men were screened; of these, 485 were eligible. Eighty-five YBMSM who were eligible declined, yielding a participation rate of 82.5%. The Institutional Review Boards of the University of Mississippi Medical Center and the Mississippi State Department of Health and the University of Kentucky approved all study procedures.

Study Procedures

After providing written informed consent men completed an online questionnaire, using Qualtrics software, in a private office not physically connected to the clinic. The questionnaire collected information about men’s sexual risk behaviors using a 90-day recall period. The questionnaire also included four measures specifically developed or adapted for this population. Subsequently, men were evaluated for Chlamydia and gonorrhea in three anatomic locations. Urethral and rectal infections were detected through nucleic acid amplification testing (NAAT) performed on a rectal swab; oral infections were detected through NAAT testing of a bucosal swab. For those not already HIV-positive, a blood sample was collected to test for HIV using OraSure.

## Measures

*Behavioral outcomes.* Whether or not men had engaged in unprotected anal insertive sex (UAIS) unprotected receptive anal sex (UARS, and unprotected oral sex (UOS) were assessed and coded yes/no with the percent yes reported in Table 1. The number of times men engaged in UAIS (listed as UAIS x in the Table) and UARS (listed as UARS x) during the past 90 days was calculated. Additionally, whether men had multiple partners as a “top” (MSP-I) or as a “bottom” (MSP-R) was assessed and coded as yes/no, with the percent yes reported in the Table. Finally, as a marker of sexual risk behaviors we also tested for Chlamydia or gonorrhea (tested positive coded as yes/no).

*Safer Sex Communication Scale.* This scale was a revised version of a 5 item Partner Communication Scale developed by Milhausen, Sales, and DiClemente.21 We deleted one item (discussing how to prevent pregnancy) and changed the reporting period from six months to the past 90 days. The remaining four items assessed the frequency of communication with sex partners about using condoms, preventing AIDS/STDs, and the sexual history of participants and their partners. The first item read: “During the past 90 days how many times have you and your male sex partner(s) discussed how to use condoms?” The subsequent items were similar, with the last part of the question being replaced by 2) …discussed how to prevent AIDS, 3) discussed how to prevent STDs, 4) discussed your partner’s and your sex history. Response options were provided on a 4-point scale ranging from 1 (never) to 4 (7 times or more). The scale had excellent inter-item reliability, yielding a Cronbach’s alpha of .87.

*Condom Turn-Offs Scale.* This scale was an abbreviated adaptation of the Condom Barriers Scale,15  with 5 items assessing men’s perceptions regarding condoms being a turn off during sex. These items were: 1) Condoms rub and make me feel sore, 2) Condoms don’t feel good, 3) I get turned off when a partner suggests we use a condom, 4) Condoms spoil the mood, and 5) Condoms feel unnatural. Response options were provided on a 5-point scale, with higher scores representing greater agreement. The scale produced excellent inter-item reliability (Cronbach’s alpha = .80).

*Condom Pleasure Scale.* This scale was designed by the research team and had 5 items: 1) Condoms help me intensify orgasm, 2) Condoms help me feel better about having sex after it ends, 3) Condoms help me have better sex, 4) Condoms help me let go of my fears, and 5) Condoms help me enjoy sex. Response options were provided on a 5-point scale, with higher scores representing greater agreement. The scale produced a Cronbach’s alpha of .84.

*Discussed Condoms with Partner before Sexual Arousal.* The final measure was a single item: “In the past 90 days, how often did you discuss condom use with male partners before you became aroused?” Response options were provided on a 6-point scale ranging from 1 (always) to 6 (never).

Data Analysis

To determine criterion validity, the obtained distributions for each scale were tested for normality. Distributions lacking the assumptions for normality were then dichotomized by performing a median split. None of the three scale measures yielded normal distributions. Next, the eight outcome measures were used to evaluate the criterion validity of each scale. Chi-square tests of association were used to assess dichotomous outcomes and independent groups t-tests were used to evaluate continuous outcomes (UAIS x and UARS x). Additionally, Chi-squared tests were used to determine whether HIV status was related to any of the four scale measures; none of these associations approached significance (p-values were also .25 or greater) so they were omitted from the paper.

**Results**

Sample Characteristics

Average age was 22.58 (sd = 3.13). Men’s average monthly income ranged from less than $500 per month (19.6%), to $500-$1,000 (28.0%), to $1,001-$1,500 (20.6%), to $1,501-$2,000 (15.0%), to greater than $2,000 per month (16.8%). Just under one-third (29.1%) reported having received food stamps in the past 12 months. Most (60.3%) reported they were currently employed. More than one-half (58.8%) reported having education beyond high school graduation and 47.0% indicated current enrollment in a school or college. About one-half (50.6%) reported they were currently in a meaningful relationship with someone. The number of male sex partners (lifetime) reported ranged from 1-1000, with a median of 8. In the past 90 days, the mean number of sex partners when enrolled men were the top was 2.68 (sd = 7.1) and the mean number when enrolled men were the bottom was 2.31 (sd = 4.7). More than one-third of participants (37.0%) tested positive for Chlamydia or gonorrhea and one-quarter (25.6%) were HIV-positive at study enrollment.

*Safer Sex Communication Scale*

The first scale produced a range of 4 to 16 (with higher scores indicating more frequent communication with partners about prevention). The distribution yielded a median of XX and a mean of 8.74 (sd = 3.57). The median split resulted in 208 (54.2%) men being classified as having infrequent communication (scores at or below the median) and 176 (45.8%) classified as having frequent communication.

As can be seen in Table 1, for 357 men reporting sex as Tops, significantly fewer (24.1%) of those classified as having frequent communication had any unprotected anal insertive sex (UAIS) compared to those classified as having infrequent communication (33.0%). For 285 men reporting sex as bottoms, fewer (trend toward significance) of those classified as having frequent communication (29.9%) had any unprotected anal receptive sex (UARS) compared to those having infrequent communication (39.7%). Finally, among those classified as having frequent communication, significantly fewer (73.8%) reported any unprotected oral sex in the past 90 days compared to those classified as having infrequent communication (84.4%). None of the other outcomes were significantly different across communication groups.

*Condom Turn-Offs Scale*

The second scale produced a range of 5 to 25 (with higher scores indicating issues/barriers related to condom use). The distribution yielded a median of XX and a mean of 8.57 (sd = 4.20). The median split resulted in 209 men (scores at or below the median) being classified as low in issues/barriers with condom use and 175 (45.6%) classified as in the high issue/barriers group.

When a top, significantly more (35.6%) of those in the high issue/barriers group (i.e., these men did find condoms to be a turn off) had any UAIS compared to those scoring low on this scale (23.4%). (See Table 1) When treated as a continuous distribution, the mean number of times men scoring above the median engaged in UAIS was 1.91 compared to .71 for those scoring below (t = 2.85, df = 355, P = .009). When a bottom, significantly more (44.3%) of those scoring high on condom issues/barriers had any UARS compared to the percentage (27.3%) for those scoring low.

Among all men in the sample scoring above the median, significantly more (51.5%) reported having multiple sex partners as a top compared to those scoring below the median (36.2%). Prevalence of Chlamydia/gonorrhea also varied as a function of classification status based on this scale. Prevalence was 42.3% among those scoring high on issue/barriers to condom use versus 32.0% among those scoring low. None of the other outcomes were significantly different across condom turn-off groups.

*Condom Pleasure Scale*

This scale produced a range of 5 to 25 (with higher scores indicating greater pleasure from condom use). The distribution yielded a median of XX and a mean of 18.01 (sd = 5.32). The median split resulted in 189 men being classified as low (at or below the median) in pleasure from condom use and 195 (50.8%) classified as high.

As can be seen in Table 1, when having intercourse as a top, 18.2% (significantly fewer) scoring high (condoms intensified pleasure) had any UAIS compared to 39.2% for those scoring low on this scale. When treated as a continuous distribution, the mean number of times men scoring above the median engaged in UAIS was significantly lower than those scoring below, .68 compared to 1.83 (t = 2.73, df = 355, P = .007). When a bottom, significantly fewer (29.8%) of those scoring high on condom pleasure had any UARS versus 41.8% for those scoring low. When treated as a continuous distribution, the mean number of times men scoring above the median engaged in UAIS was significantly lower (.96 compared to 2.74) than that for those scoring below (t = 2.60, df = 283, P = .01).

Among all men in the sample scoring above the median on the pleasure scale, 38.0% (significantly fewer) reported having multiple sex partners as a top compared to 48.4% among those scoring below the median. Among all men scoring above the median, 46.7% (significantly more) reported having multiple sex partners as a bottom compared to 33.3% among those scoring below the median. (This last comparison was in the opposite direction to what would be expected). Scores on the condom pleasure scale were also associated with unprotected oral sex, with 72.2% (significantly fewer) of those scoring above the median on the pleasure scale reporting UOS compared with 82.5% of those scoring below the median. Prevalence of Chlamydia/gonorrhea did not vary as a function of Condom Pleasure Scale classification status.

*Discussed Condoms With Partner Before Sexual Arousal*

Among those who had discussed condoms with a partner before sexual arousal, 15.5% (significantly fewer) engaged in any UAIS as a top compared to 41.5% who did not discuss condoms before arousal. Among those who discussed condoms before arousal, the mean frequency of UAIS was significantly less (.54 times compared to 1.92 times) among those who had not discussed condoms before arousal (t = 3.40, df 355, P = .001).

Among those who discussed condoms before sexual arousal, 21.2% (significantly fewer) engaged in any UARS compared to 48.0% of those who had not discussed condoms before arousal. Among those who discussed condoms before becoming aroused, the mean number of times of of UARS was .77 compared to 2.69 times among those who did not discuss condoms before sex (t = 2.93, df 283, P = .004).

Finally, among those who discussed condoms before arousal, 72.0% (significantly fewer) engaged in unprotected oral sex compared to 86.3% among those who did not discuss. None of the other outcome variables differed by whether or not men discussed condoms with their partner before arousal.

**Discussion**

Of the four measures examined in this study, three – the Condom Turn-Offs scale, the Condom Pleasure scale, and the one item measure on whether or not discussion with a partner about condom use before becoming sexually aroused took place – showed associations with sexual risk behavior. These associations provide strong evidence of criterion validity for these measures. Thus, these measures may be useful in the context of intervention research conducted among YBMSM. It is important to consider the relevant merit of each of these measures in regards to the behaviors used to judge their criterion validity.

All four measures, with the exception of Safer Sex Communication (for which there were trends in the expected direction), were supportive of criterion validity for both UAIS and UARS. Specifically, men who scored higher on safer sex communication, lower on condom turn-offs, higher on condom pleasure, and almost always or always discussed condoms with a partner before becoming sexual aroused, were less likely to report UAIS and UARS. All of the men in this study (by virtue of the selection criteria) reported UAIS during the past six months but approximately 80% had also engaged in UARS during that period. What is interesting is that these associations with attitudes toward, and communication, condom applied for both UAIS and UASR.

Regarding the multiple partner variables, both the Condom Turnoffs and Condom Pleasure scale were significantly related to whether or not men reported multiple partners as a top. Only the Condom Pleasure scale, however, was associated with reports of multiple partners as a bottom, with more men scoring high on this scale (i.e., believing that condoms intensified pleasure) reporting multiple partners compared with those who scored lower. There were no significant associations between reporting multiple partners and scores on the Safer Sex Communication or the single-item communication measures.

Only the Condom Turn Offs scale was positively associated with having been diagnosed with either Chlamydia and/or gonorrhea. This association, however, is strong evidence of criterion validity, given that the actual acquisition of these infections represents a culmination of multiple risky behaviors.

With the exception of the Condom Turn-Offs scale, the three other measures were supported by criterion validity of unprotected oral sex. Rarely have studies had enough variance in this outcome for comparisons to be made between those using and not using condoms for oral sex.

A striking finding in this study was the high prevalence of condom use during oral sex (approximately one in five men reported condom use during oral sex). In contrast, nationally representative, predominantly heterosexual samples in the U.S. and Sweden found rates of condom use during oral sex of approximately 5%.22,23

Another noteworthy finding was the high proportion of men in this sample who endorsed perceptions that condoms enhanced pleasure. To our knowledge, no previous studies have constructed and tested a scale that assesses pleasure associated with condom use.

Limitations

Because data for this study came from a larger randomized trial that only recruited men who had been tops at least once in the last six months, this sample was highly selected.

Conclusions

Given that the purpose of the study was to identify measures of psychosocial mediators for safer sex behaviors, the findings provide three brief scales and a single item that can be used by other researchers in intervention studies targeting YBMSM. Perceptions about condoms a turn off and about condoms enhancing pleasure showed strong association with sexual risk behaviors.

**References**

1. Centers of Disease Control and Prevention. HIV among gay and bisexual men. Available at: <http://www.cdc.gov/hiv/topics/msm/index.htm>.

2. Centers of Disease Control and Prevention. DHAP annual report 2011: Accelerating progress, investing for impact. Available at: <http://www.cdc.gov/hiv/strategy/pdf/DHAP_AnnualReport.pdf>.

3. Office of National AIDS Policy. National HIV/AIDS strategy for the United States. 2010; Available at: <http://www.whitehouse.gov/administration/eop/onap/nhas>. Accessed July 20, 2012.

4. Centers for Disease Control and Prevention. HIV/AIDS Surveillance, 2012 (year end edition). US Department of Health and Human Services: Atlanta, GA. Available at: <http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf#Page=66>.

5. National Institutes of Health. NIH fiscal Year 2007 plan for HIV-related research. Available online at: <http://www.nih.gov/od/oar/public/pubs/fy2007/VIII_RacialEthnic.pdf>.

6. Centers for Disease Control and Prevention. HIV/AIDS among African Americans. Fact Sheet. Available on-line at <http://www.cdc.gov/hiv/pubs/facts/afam.htm>.

7. Black AIDS Institute. Back of the line: The state of AIDS among Black gay men in America 2012. Available at: [http://www.Blackaids.org/index.php?option=com\_content&view=article&id=1284&Itemid=198](http://www.blackaids.org/index.php?option=com_content&view=article&id=1284&Itemid=198).

8. NHAS

9. Graham CA,Crosby RA, Yarber WL, Sanders SA. Incomplete use of condoms: The importance of sexual arousal. AIDS Behav 2011;15, (7): 1328-1331.

10. Crosby RA, Shrier L, Charnigo R, Sanders SA, Graham CA, Milhausen RR, Yarber WL. Negative perceptions about condom use among a clinic population: Comparisons by gender, race, and age. Int J STD AIDS 2013; 24: 200-105.

11. Flood M. Lust, trust and latex: why young heterosexual men do not use condoms. Cult Health Sex 2003; 5: 353**–**69.

12. Crosby RA, Milhausen RR, Yarber WL, Sanders SA, Graham CA.Condom “turn offs” among adults: An exploratory study. Int J STD AIDS 2008; 19: 590-594.

13. Higgins JA, Hirsch JS. Pleasure, power, and inequality: incorporating sexuality into research on contraceptive use. Am J Public Health2008; 98 (10): 1803-1813.

14. Helweg-Larsen M. UCLA Multidimensional Condom Attitudes Scale. In TD Fisher, CM Davis, WL Yarber, SL Davis (Eds.) Handbook of Sexuality-Related Measures. New York: Routledge, 2010.

15. Lawrence JSS, Chapdelaine AP, Devieux JG, O'Bannon RE, Brasfield TL, Eldridge GD. Measuring perceived barriers to condom use: Psychometric evaluation of the Condom Barriers Scale. Assessment 1999; 6(4): 391-404.

16. Reece M, Herbenick D, Hollub AV, Hensel DJ, Middlestadt SE. A psychometric assessment of the Multi-Factor Attitude toward Condoms Scale (MFACS). Int J Sexual Health 2010; 22(2): 119-129.

17. Hill BJ, Amick EE, Sanders SA. Condoms and US college-aged men and women: briefly assessing attitudes toward condoms and general condom use behaviours. *Sexual Health 2011;* *8*(3): 372-377.

18, Hollub AV, Reece M, Herbenick D, Hensel DJ, Middlestadt SE. College students and condom attitude: validation of the Multi-Factor Attitude toward Condoms Scale (MFACS). J Am College Health 2011; 59(8), 708-714.

19. Charnigo R, Crosby RA, Troutman A. Psychosocial constructs associated with condom use among high-risk African American men newly diagnosed with a sexually transmitted disease. *Ann Behav Med* 2010; *39*(3): 303-310.

20. Peterson JL, Coates TJ, Catania JA, Middleton L, Hilliard B, Hearst N. High-risk sexual behavior and condom use among gay and bisexual African-American men. Am J Public Health 1992; 82(11):1490-1494.

21. Milhausen RR, Sales JM, Wingood GM, DiClemente RJ, Salazar LF, Crosby RA. Validation of a partner sexual communication scale for use in HIV/AIDS prevention interventions. J HIV/AIDS Prev Children Youth, 2007; 8(1), 11-33.

22. Leichliter JS, Chandra A, Liddon N, Fenton KA, Aral SO. Prevalence and correlates of heterosexual anal and oral sex in adolescents and adults in the United States. *J Infect Dis* 2007; *196*(12): 1852-1859.

23. Swedish study on condom use during oral sex.

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|  | Scales | | | | | | | | | | | |
| Risk Behavior | Safer Sex Communication | | | Condom Turn Offs | | | Condom Pleasure | | | Discussed Condoms Before Sexual Arousal | | |
| Infreq | Freq | P | Low | High | P | Low | High | P | No | Yes | P |
| UAIS % | 33.0 | 24.1 | .06 | 23.4 | 35.6 | .0001 | 39.2 | 18.2 | <.0001 | 41.5 | 15.5 | .001 |
| UAIS *x* | 1.23 | 1.21 | 50 | .71 | 1.91 | .009 | 1.83 | .68 | .007 | 1.92 | .54 | .001 |
| UARS % | 39.7 | 29.9 | .08 | 27.3 | 44.3 | .003 | 41.8 | 29.8 | .04 | 48.0 | 21.2 | .001 |
| UARS *x* | 1.55 | 2.01 | .86 | 1.60 | 1.96 | .60 | 2.74 | .96 | .01 | 2.69 | .77 | .004 |
| MSP-I% | 45.1 | 40.8 | .40 | 36.2 | 51.5 | .003 | 48.4 | 38.0 | .04 | 43.5 | 42.8 | .89 |
| MSP-R % | 40.4 | 39.8 | .90 | 40.2 | 40.0 | .97 | 33.3 | 46.7 | .008 | 37.8 | 42.9 | .34 |
| Chlamydia/  Gonorrhea | 38.5 | 34.7 | .45 | 32.2 | 42.3 | .045 | 40.1 | 33.5 | .18 | 37.8 | 35.7 | .68 |
| UOS % | 84.4 | 73.8 | .014 | 76.6 | 82.8 | .16 | 82.5 | 72.2 | .01 | 86.3 | 72.0 | .001 |

Table 1. Scale score differences by selected sexual risk behaviors

Note. Groups (Infrequent/Frequent; Low/High) determined by median split. UAIS = Unprotected Anal Insertive Sex; UARS = Unprotected Anal Receptive Sex; MSP-I = Multiple Partners as an Insertive Partner; MSP-R = Multiple Sex Partners as a Receptive Partner; UOS = Unprotected Oral Sex