



Published in final edited form as:

AIDS Educ Prev. 2018 August ; 30(4): 335–349. doi:10.1521/aeap.2018.30.4.335.

Characterizing sexual agreements with one's most recent sexual partner among young men who have sex with men

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Abstract

Men who have sex with men (MSM) often create sexual agreements with their partners, but little is known about agreements with serious versus casual partners. We used data from 472 young MSM to examine agreements with one's most recent partner, individual differences across types of partnerships and agreements, and predictors of condomless anal sex (CAS). Two-thirds of participants did not have agreements. Monogamous agreements were most common among those who were seriously dating their partner, but also present among those who were casually dating their partner and those who were not dating their partner. Participants who were seriously dating their partner reported the most frequent sexual health communication. Participants without agreements reported the lowest frequency of and comfort with sexual health communication. Participants who were seriously dating their partner and those with monogamous agreements were most likely to report CAS. HIV prevention should address communication with serious and casual partners.

Keywords

sexual agreements; men who have sex with men; gay; bisexual; HIV; communication

In 2016, men who have sex with men (MSM) accounted for 67% of all new HIV infections (CDC, 2018a) and 91–92% of all new HIV infections among male adolescents and young adults (CDC, 2018b). It has been estimated that 80% of new HIV infections among young MSM are contracted from main/steady partners (Sullivan, Salazar, Buchbinder, & Sanchez, 2009) and most condomless anal sex (CAS) among young MSM occurs with serious partners (Mustanski, Newcomb, & Clerkin, 2011; Newcomb, Ryan, Garofalo, & Mustanski,

2014). These findings call attention to the importance of considering risk in the context of relationships. In addition to behavioral and biomedical HIV prevention strategies (e.g., condoms, pre-exposure prophylaxis), it is common for male couples to create agreements describing the conditions under which, if any, they are allowed to have sex with outside partners. These agreements can be monogamous (i.e., sex with outside partners is not allowed) or open (i.e., sex with outside partners is allowed either with or without restrictions). It remains uncertain whether sexual agreements reduce HIV risk, but several HIV prevention programs include the development of a sexual agreement as a risk reduction strategy (Kippax & Kinder, 2002; Newcomb et al., 2017; Sullivan et al., 2014). Still, most research on sexual agreements among MSM has focused on serious relationships and has relied on samples with large age ranges (e.g., 18 and older). As such, little is known about sexual agreements with casual partners, especially among young MSM (ages 18–29).

Sexual agreements are common among MSM and there are various reasons for creating them (e.g., to be honest, build trust, strengthen one's relationship, protect oneself and/or one's partner; Hoff & Beougher, 2010; Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010). The proportion of male couples with a sexual agreement varies widely across studies ranging from 58% to 100% (Cuervo & Whyte, 2015; Gass, Hoff, Stephenson, & Sullivan, 2012; Hoff & Beougher, 2010; Hoff et al., 2010; Mitchell, Harvey, Champeau, Moskowitz, & Seal, 2012; Mitchell, Harvey, Champeau, & Seal, 2012; Mitchell & Petroll, 2013; Parsons, Starks, Gamarel, & Grov, 2012). Further, the proportion of male couples with specific types of agreements also varies across studies ranging from 31% to 64% for monogamous agreements, and from 27% to 64% for open agreements (Gass et al., 2012; Hoff & Beougher, 2010; Mitchell, Harvey, Champeau, Moskowitz, et al., 2012; Mitchell, Harvey, Champeau, & Seal, 2012; Mitchell & Petroll, 2013; Parsons et al., 2012).

In the broader field of relationship science, there is a growing interest in casual sexual relationships (i.e., those outside of committed romantic relationships), including hook-ups, friends-with-benefits, booty-calls, fuck buddies, and one-night stands (Claxton & van Dulmen, 2013). Most studies on casual relationships have focused on psychosocial predictors and consequences, but a few have examined rule negotiation (e.g., Bisson & Levine, 2009; Hughes, Morrison, & Asada, 2005; Rodrigue et al., 2015). These studies have demonstrated that sexual agreements are not exclusive to serious relationships; they are also used to define expectations and rules with casual partners among heterosexual college students (Bisson & Levine, 2009; Hughes et al., 2005) and young adults (Rodrigue et al., 2015). However, sexual agreements tend to be absent or assumed with one-night stands and in casual relationships characterized as “mostly about sex,” whereas they are more common in casual relationships characterized as “intimate and sexual” (Rodrigue et al., 2015). Wentland and Reissing (2011) also found that discussions about monogamy were absent with one-night stands, booty-calls, and fuck buddies, whereas they were more important with friends-with-benefits. In sum, although casual relationships are often characterized by a lack of commitment (Claxton & van Dulmen, 2013), that does not preclude rule negotiation. Despite evidence that sexual agreements are not exclusive to serious relationships, little is known about sexual agreements among young MSM with different types of partners. It is particularly important to examine sexual agreements with casual partners because young

MSM rapidly progress to believing that relationships are serious, which is then associated with discontinuing condom use (Newcomb et al., 2014).

Additionally, despite the inherent role of communication in creating a sexual agreement, little is known about sexual health communication among young MSM, including whether it differs based on type of agreement. The available evidence suggests that communication is similar among male couples with different agreements. For example, Hoff et al. (2010) found that constructive and avoidant communication did not differ between male couples with monogamous and open agreements, and Parsons et al. (2012) found that sexual communication did not differ among male couples with different agreements. Still, the average ages of these participants were outside of emerging adulthood (the period from the late teens through the twenties; Arnett, 2000) and the average relationship lengths were 4–6 years. Therefore, it remains unclear if findings generalize to young MSM in shorter relationships whose communication skills may be less developed. Further, other aspects of communication (e.g., frequency of and comfort with sexual health communication) may still differ based on type of agreement. Previous research has demonstrated that communication about condom use is associated with less CAS among MSM (Lo, Reisen, Poppen, Bianchi, & Zea, 2011; Molitor, Facer, & Ruiz, 1999; Wilson, Diaz, Yoshikawa, & Shrout, 2009), whereas comfort with sexual health communication is associated with less condom use among presumably heterosexual adolescents (Widman, Noar, Choukas-Bradley, & Francis, 2014). Despite their implications for HIV prevention, it remains unknown if frequency of and comfort with sexual health communication differ based on type of partnership and agreement.

In sum, little is known about sexual agreements among young MSM, especially in the context of casual relationships. Additionally, despite evidence that sexual health communication can influence condom use, it remains unclear if the extent to which young MSM communicate about sexual health with their partners differs based on type of partnership and agreement. Using baseline data from a subset of 472 young MSM (ages 18–29) recruited to participate in an online HIV prevention trial (citation blinded for review), we conducted an exploratory study to characterize the types of agreements that young MSM had with their most recent sexual partners, including partners who they were seriously dating, casually dating, and not dating. We also examined differences in individual and relationship characteristics (including frequency of and comfort with sexual health communication) across types of partnerships and agreements, and individual and relationship characteristics as predictors of CAS with one's most recent partner.

Methods

Participants and Procedure.

Young MSM ages 18–29 were recruited to participate in [intervention name blinded for review], an online HIV prevention program (citation blinded for review). Participants were recruited in three ways. First, staff at community-based organizations in three US cities (Atlanta, Chicago, and NYC) described the study after delivering an HIV-negative test result. Second, project staff conducted in-person and online recruitment in all three cities. Third, a nationwide advertisement was placed on a geospatial smartphone application for

MSM. All potential participants completed a screener and received an HIV test to determine eligibility. The HIV test could be completed in-person or at home using a self-test. Those who used the self-test were mailed an FDA-approved test (OraQuick) and were required to provide a photograph of the result to confirm their HIV-negative status. Those who met the eligibility criteria were invited to complete the baseline assessment, which included a series of online questionnaires.

In order to participate, individuals were required to meet the following criteria: (1) 18–29 years old; (2) assigned male at birth and identified as male; (3) HIV-negative based on an HIV test at the baseline assessment; (4) reported CAS with a man in the past six months; (5) able to read English at an 8th grade level; and (6) had a valid e-mail address. Additionally, participants could not be in monogamous relationships for longer than six months because the intervention was designed for individuals rather than couples. A total of 1,113 participants met the inclusion criteria and completed baseline measures prior to the RCT. Baseline data were collected between June 2013 and December 2015. All participants were compensated \$30 for completing the baseline assessment and those who completed it at a university site or a health department clinic received an additional \$20. All procedures were approved by the affiliated Institutional Review Boards. Participants were included in the current analyses regardless of whether or not they enrolled in the RCT after completing the baseline measures.

Given the focus on agreements with one's most recent sexual partner, we restricted the analytic sample to those who reported at least one sexual partner during the reporting period (i.e., the past three months); this excluded 88 participants. Then, given that participants could not be in monogamous relationships for longer than six months based on the RCT inclusion criteria, we restricted the analytic sample to participants whose relationships with their most recent sexual partners were not longer than six months. This enabled us to compare participants with different types of agreements without confounding relationship length. This excluded 553 participants. Our final analytic sample included 472 young MSM ages 18–29 ($M = 23.83$, $SD = 2.93$ years). Participants identified as gay ($n = 407$; 86.2%), bisexual ($n = 58$; 12.3%) and other ($n = 7$; 1.5%). Participants also identified as White (35.2%), Black (23.1%), Latino (32.8%), and other (8.9%).

Measures

Demographics.

Participants reported their age, sexual orientation, and race/ethnicity. Participants who identified their sexual orientation as “other” were excluded from analyses focused on sexual orientation due to low endorsement ($n = 7$).

Partnership characteristics.

Participants were asked several questions about their most recent sexual partner in the past three months. First, they were asked, “What was your relationship with this partner?” Options included: (1) serious relationship (boyfriend) or someone you dated for a while and feel very close to; (2) casually dating but not serious; (3) sleeping with this person (fuck

buddy or booty call) but not dating; (4) one-night stand; and (5) stranger/anonymous person. Second, they were asked, “What is the current agreement you and this partner have about sexual encounters outside of the relationship?” Options included: (1) both of us cannot have any sex with an outside partner (monogamous); (2) we can have sex with outside partners, without any conditions or restrictions (hereafter referred to as open without rules); (3) we can have sex with outside partners, but with some conditions or restrictions (hereafter referred to as open with rules); and (4) we do not have an agreement. One person was missing data for type of sexual agreement. Third, they were asked, “During the time you were having sex with this partner, were you having sex with other people?” Fourth, those with agreements were asked, “Did you and this partner clearly or openly discuss your current agreement?” Participants were also asked about the length of their partnership and their partner’s known or perceived HIV status (dichotomized as HIV-negative versus HIV-positive/unknown for analyses).

Sexual health communication.

Participants were asked four questions from the HIV-Risk Assessment for Sexual Partnerships (H-RASP; Mustanski, Starks, & Newcomb, 2014) about sexual health communication with their most recent partner. First, they were asked, “Thinking about the last 3 months, how often did you talk to this partner about... (1) using condoms during sex; and (2) HIV/AIDS or STIs?” Items were rated on a 4-point scale (1 = never, 4 = a lot) and averaged. Second, they were asked, “Thinking about the last 3 months, how comfortable did you feel when you talked to this partner about... (1) using condoms during sex; and (2) HIV/AIDS or STIs?” Participants were only asked about their comfort if they endorsed talking to their partner about that topic. Items were rated on a 4-point scale (1 = very uncomfortable, 4 = very comfortable). Responses were averaged for participants who responded to both questions, whereas individual item scores were used for participants who only responded to one question. The analytic sample was reduced from 472 to 412 for analyses that included comfort with sexual health communication because 60 participants did not endorse talking to their most recent partner about either topic. There was a positive correlation between frequency of and comfort with sexual health communication ($r = .15, p = .002$).

Condomless anal sex (CAS).

As part of the H-RSAP (Mustanski et al., 2014), participants reported the number of times they had CAS with their most recent sexual partner during the previous three months. Responses were dichotomized for analyses. Two people were missing data for CAS.

Results

Descriptive statistics for the analytic sample are presented in Table 1. The largest proportion of participants described their most recent sexual partner as someone they were not dating ($n = 236$; 50.0%) followed by someone they were casually dating ($n = 144$; 30.5%) and someone they were seriously dating ($n = 92$; 19.5%). None of the participants in the analytic sample described their partner as a one-night stand or a stranger/anonymous person. The largest proportion of participants did not have a sexual agreement with their partner ($n = 308$; 65.4%), whereas 20.0% ($n = 94$) had monogamous agreements, 7.9% ($n = 37$) had open

agreements with rules, and 6.8% ($n = 32$) had open agreement without rules. Participants who had open agreements with and without rules were combined for analyses due to relatively low endorsement ($n = 69$, 14.6%). A chi-square test indicated that type of agreement differed across types of partnerships (see Table 2). Participants who were seriously dating their partner were significantly more likely to have monogamous agreements than those who were casually dating their partner and those who were not dating their partner. Those who were casually dating their partner were also significantly more likely to have monogamous agreements than those who were not dating their partner. In contrast, the proportion of participants who had an open agreement with their partner did not differ based on the type of partnership.

Differences across types of partnerships

We used chi-square tests (for categorical variables) and ANOVAs (for continuous variables) to examine differences in individual and relationship characteristics across types of partnerships (see Table 3). There were significant differences in age, reports of concurrent sexual partners, whether participants had openly discussed their agreements (among those who had them), and frequency of sexual health communication. First, participants who were seriously dating their partner were significantly younger than those who were casually dating their partner and those who were not dating their partner. Second, participants who were seriously dating their partner were significantly less likely to report concurrent sexual partners than those who were casually dating their partner and those who were not dating their partner. Those who were casually dating their partner were also significantly less likely to report concurrent sexual partners than those who were not dating their partner. Third, participants who were seriously dating their partner and those who were casually dating their partner were significantly more likely to have openly discussed their agreements than those who were not dating their partner. Fourth, participants who were seriously dating their partner reported significantly more frequent sexual health communication than those who were casually dating their partner and those who were not dating their partner. Those who were casually dating their partner also reported significantly more frequent sexual health communication than those who were not dating their partner. In contrast, there were not significant differences in sexual orientation, race/ethnicity, partner's known or perceived HIV-status, or comfort with sexual health communication.

Differences across types of sexual agreements

We used chi-square tests (for categorical variables) and ANOVAs (for continuous variables) to examine differences in individual and relationship characteristics across types of agreements (see Table 4). There were significant differences in age, partner's known or perceived HIV-status, reports of concurrent sexual partners, frequency of sexual health communication, and comfort with sexual health communication. First, participants with monogamous agreements were significantly younger than those with open agreements and those without agreements. Second, participants with monogamous agreements were significantly less likely to have an HIV-positive/unknown partner than those with open agreements and those without agreements. Third, participants with monogamous agreements were significantly less likely to report concurrent sexual partners than those with open agreements and those without agreements. Fourth, participants with monogamous and open

agreements reported significantly more frequent sexual health communication than those without agreements. Participants with monogamous agreements also reported significantly more comfort with sexual health communication than those without agreements. In contrast, there were not significant differences in race/ethnicity, sexual orientation, or whether participants had openly discussed their agreements.

Predictors of condomless anal sex with one's most recent partner

Finally, we used logistic regression to examine individual and relationship characteristics as predictors of condomless anal sex (CAS) with one's most recent partner (see Table 5). Type of partnership, type of agreement, and reports of concurrent sexual partners were significantly associated with CAS. First, participants who were seriously dating their partner were significantly more likely to report CAS than those who were casually dating their partner and those who were not dating their partner. Second, participants with monogamous agreements were significantly more likely to report CAS than those with open agreements and those without agreements. Third, participants who reported concurrent sexual partners were significantly less likely to report CAS than those who did not report concurrent sexual partners. None of the other individual or relationship characteristics were significantly associated with CAS. In a post-hoc analysis, we included the three significant predictors in the same model (see Table 5). Type of partnership and reports of concurrent sexual partners remained significant, but type of agreement was no longer significant.

Discussion

Most research on sexual agreements among MSM has focused on serious rather than casual relationships and has relied on samples with large age ranges (e.g., 18 and older). To address this, we examined the types of agreements that young MSM had with their most recent sexual partners, including partners who they were seriously dating, casually dating, and not dating. We also examined differences in individual and relationship characteristics across types of partnerships and agreements as well as predictors of CAS with one's most recent partner. Although only one-third (34.6%) of the young MSM in our sample had a sexual agreement with their partner, most of those who were seriously dating their partner had a sexual agreement (80.2%). Still, those who were seriously dating their partner only represented 19.5% of the analytic sample. Therefore, the overall prevalence of agreements in our sample was lower than the range reported in previous studies (58%–100%; Cuervo & Whyte, 2015; Gass et al., 2012; Hoff & Beougher, 2010; Hoff et al., 2010; Mitchell, Harvey, Champeau, Moskowitz, et al., 2012; Mitchell, Harvey, Champeau, & Seal, 2012; Mitchell & Petroll, 2013; Parsons et al., 2012), but the prevalence of agreements among those who were seriously dating their partner was within that range.

Monogamous agreements were most common among those who were seriously dating their partner, but also present among those who were casually dating their partner and those who were not dating their partner. Consistent with previous research on heterosexual college students (Bisson & Levine, 2009; Hughes et al., 2005) and young adults (Rodrigue et al., 2015), some young MSM may choose to define expectations and rules with partners who they are casually dating and partners who they are not dating. In our sample, 15.2% of those

who were casually dating their partner and 5.9% of those who were not dating their partner reported monogamous agreements, suggesting that monogamy is not exclusive to serious relationships. Previous research has found that young MSM in serious relationships describe monogamy as a reason for not using condoms (Greene, Andrews, Kuper, & Mustanski, 2014). In light of our findings, it is important for sexual health researchers and providers to recognize that monogamy is not exclusive to serious relationships.

Although none of the young MSM in our sample described their most recent partner as a one-night stand or a stranger, half were not dating their most recent partner. As such, they may have preferred ongoing sexual partnerships to one-time sexual encounters. Previous research has demonstrated that sexual agreements tend to be absent or assumed with one-night stands (Rodrigue et al., 2015; Wentland & Reissing, 2011), and young adults tend to assume that relationships with fuck buddies are not monogamous (Wentland & Reissing, 2011). However, in our sample, some participants reported monogamous agreements with partners who they were not dating (e.g., fuck buddies, booty calls). Given that casual sexual relationships have been defined in different ways (Wentland & Reissing, 2011), it will be important for future research to operationalize them across multiple dimensions (e.g., frequency of sexual and non-sexual activities). Further, given that MSM report diverse reasons for creating agreements (Hoff & Beougher, 2010; Hoff et al., 2010), future research could examine whether reasons for creating agreements with serious versus casual partners differ. For example, young MSM may be motivated to create agreements with serious partners to build trust and strengthen their relationship, whereas they may be motivated to create agreements with casual partners to protect themselves.

We found limited evidence of individual differences in types of partnerships and agreements. Within our restricted age range, there were small but significant differences in age across types of partnerships and agreements. Young MSM who were seriously dating their partner were younger than those who were casually dating their partner and those who were not dating their partner, and young MSM with monogamous agreements were younger than those with open agreements and those without agreements. Several previous studies have found that open agreements are more common among older MSM (Mitchell, 2014; Stephenson, White, & Mitchell, 2015; Wheldon & Pathak, 2010). Given that we found this pattern in a sample of young MSM ages 18–29, it will be important for future studies to examine developmental changes related to agreements. Additionally, we found that young MSM with monogamous agreements were less likely to have an HIV-positive/unknown partner than those with open agreements and those without agreements. This is likely due, in part, to those without agreements being less likely to talk to their partners about HIV-status. Further, given that we focused on agreements with one's most recent partner, those with open agreements may have been less likely to know their most recent partner's HIV-status if that person was not their primary partner.

In regard to communication, we found a small but significant difference in frequency of sexual health communication based on type of partnership. Young MSM who were seriously dating their partner reported more frequent sexual health communication than those who were casually dating their partner and those who were not dating their partner. Those who were casually dating their partner also reported more frequent sexual health communication

than those who were not dating their partner. Further, among participants who had agreements, those who were seriously dating their partner and those who were casually dating their partner were more likely to have openly discussed their agreement than those who were not dating their partner. In contrast, comfort with sexual health communication did not differ based on type of partnership. These findings suggest that young MSM may be less likely to discuss condom use and HIV/STIs with partners who they are casually dating and partners who they are not dating (compared to partners who they are seriously dating), but comfort with sexual health communication may not be a barrier. One possible explanation is that young MSM may perceive discussing sexual health with partners who they are casually dating and partners who they are not dating as less important than discussing it with partners who they are seriously dating. These findings may also reflect young MSM spending less time with partners who they are casually dating and partners who they are not dating (compared to partners who they are seriously dating), leading to fewer opportunities to discuss sexual health.

We also found small but significant differences in frequency of and comfort with sexual health communication based on type of agreement. Young MSM with monogamous and open agreements reported more frequent sexual health communication than those without agreements. Additionally, young MSM with monogamous agreements reported more comfort with sexual health communication than those without agreements. Therefore, feeling less comfortable discussing sexual health may present a barrier to creating an agreement. Of note, previous studies did not find differences in constructive and avoidant communication (Hoff et al., 2010) or sexual communication (Parsons et al., 2012) based on type of agreement. One possible explanation for these different findings is that young MSM may discuss condom use and HIV/STIs in the process of creating an agreement, but these discussions may not address other aspects of sexual communication beyond sexual health. Given that other types of communication (e.g., less constructive communication) are associated with breaks in agreements (Gomez et al., 2012), future research could examine whether frequency of and comfort with sexual health communication relate to these aspects of agreements.

Type of partnership and agreement were both associated with CAS. Consistent with previous research (Mustanski et al., 2011; Newcomb et al., 2014), young MSM who were seriously dating their partner were more likely to report CAS than those who were casually dating their partner and those who were not dating their partner. Also consistent with previous research (Greene et al., 2014), young MSM with monogamous agreements were more likely to report CAS than those with open agreements and those without agreements. However, when type of partnership and agreement were included in the same model, type of agreement was no longer a significant predictor of CAS. These findings suggest that, among young MSM, the designation of a relationship as serious may have more of an influence on condom use than one's agreement. Given that young MSM in serious relationships describe not using condoms to express intimacy (Greene et al., 2014), this motivation may drive CAS regardless of one's agreement. There was also a significant association between reports of concurrent sexual partners are decreased odds of CAS with one's most recent partner, which may reflect a risk reduction strategy used by young MSM who are having sex with multiple partners during the same period of time. Of note, although reports of concurrent sexual

partners were most common among participants who were not dating their partner as well as those with open agreements and those without agreements, 14.9% of participants with monogamous agreements also reported concurrent sexual partners. It is possible that some of these participants had concurrent sexual partners before creating their monogamous agreements, but it is also possible that some of them broke their agreements.

Finally, although several studies have found that communication about condom use is associated with less CAS (Lo et al., 2011; Molitor et al., 1999; Wilson et al., 2009), sexual health communication was not associated with CAS in our sample. Only one of these previous studies focused on young MSM (Molitor et al., 1999), their measure of communication primarily reflected perceived self-efficacy, and their measures of communication and CAS were not at the partner-level. Given that our measures of communication and CAS were both specific to one's most recent partner, they provide a stronger test of the extent to which communication with a given partner influences condom use with that partner. In this case, it is possible that factors other than sexual health communication have more of an influence on whether young MSM engage in CAS, such as labeling their relationship as serious (Mustanski et al., 2011; Newcomb et al., 2014) and using substances before sex (Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011; Vosburgh, Mansergh, Sullivan, & Purcell, 2012). It will be important for future research to examine whether sexual health communication interacts with additional factors to influence CAS among young MSM.

The current findings have important implications for HIV prevention. Although most of the young MSM in our sample who were seriously dating their partner had a sexual agreement, a sizeable proportion did not. Some young MSM may not recognize the potential value of creating a sexual agreement with their serious partner, in which case they may benefit from education about sexual agreements as an HIV prevention strategy and as a way to enhance relationship functioning (e.g., to increase trust, to meet emotional and sexual needs). Given that sexual agreements were less common among those who were casually dating their partner and those who were not dating their partner, young MSM may believe that casual partnerships are incompatible with rules or they may make assumptions about the exclusivity of casual partnerships. In our sample, young MSM were least likely to openly discuss sexual agreements with partners who they were not dating. Explicit discussions about sexual agreements with casual partners have the potential to reduce assumptions, clarify expectations, and ultimately reduce HIV risk behavior. HIV prevention programs may benefit from addressing the complexities of sexual agreements (e.g., when and how to create one, strategies to increase adherence, what to do if an agreement is broken), the role of biomedical prevention in agreements, and the value of rule negotiation with both serious and casual partners.

Findings should be considered in light of limitations. First, we focused on agreements with one's most recent sexual partner. While this allowed us to examine agreements with serious and casual partners, it limits comparisons with previous studies and it is possible that someone's most recent sexual partner was not their primary partner. Future research could examine agreements with primary and outside partners to broaden our understanding of sexual agreements. Second, we excluded young MSM who had been in relationships for

more than six months. This allowed us to understand sexual agreements in the early stages of relationships, but it will be important for future research to examine developmental patterns related to sexual agreements. Third, we had data from individuals rather than couples and some couples report discordant sexual agreements (Hoff et al., 2010). Fourth, our measures of sexual health communication focused on communication about condom use and HIV/AIDS, and it will be important to include communication about biomedical prevention in future studies. Further, 60 participants were excluded from the analyses focused on comfort with sexual health communication because they did not endorse talking to their most recent sexual partner about condom use or HIV/AIDS. Finally, although we had data on whether participants endorsed concurrent sexual partners, we were not able to determine whether participants engaged in CAS with multiple partners during the same period of time. Limitations aside, the current findings broaden our understanding of the different types of sexual agreements that young MSM have with serious and casual partners. Further, findings highlight differences in individual and relationship characteristics across types of partnerships and agreements, which have implications for HIV prevention for young MSM.

Acknowledgements

This study was supported by grants from the National Institute on Drug Abuse (R01DA035145; R01DA035145–02S1). The first author's time was also supported in part by a grant from the National Institute on Drug Abuse (F32DA042708). The content of this article is solely the responsibility of the authors and does not necessarily reflect the views of the National Institutes of Health or the National Institute on Drug Abuse.

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Table 1.

Descriptive statistics for the analytic sample.

Categorical Variables	<i>N</i> (%)
Length of relationship with most recent partner	
Less than one month	135 (28.6)
1–3 months	206 (43.6)
4–6 months	131 (27.8)
Openly discussed agreement with most recent partner	137 (84.0)
Concurrent sexual partners	278 (58.9)
Most recent partner's known or perceived HIV-status	
Positive/unknown	129 (27.3)
Negative	343 (72.7)
Condomless anal sex with most recent partner	277 (58.7)
Continuous Variables	<i>M</i> (<i>SD</i>)
Frequency of communication with most recent partner	2.41 (.85)
Comfort with communication with most recent partner	3.54 (.67)

Note. The proportion of participants who openly discussed their agreement is based on the total number of participants who had an agreement ($N=163$).

Table 2.

The association between type of partnership and type of sexual agreement with most recent partner.

	Seriously dating N (%)	Casually dating N (%)	Not dating N (%)	χ^2 (df)
Type of sexual agreement with most recent partner				150.90 (4) **
Monogamous agreement	58 (63.7) ^a	22 (15.3) ^b	14 (5.9) ^c	
Open agreement	15 (16.5) ^a	23 (16.0) ^a	31 (13.1) ^a	
No agreement	18 (19.8) ^a	99 (68.8) ^b	191 (80.9) ^c	

Note. Different superscript letters indicate significant differences between column proportions ($p < .05$).

* $p < .01$,

** $p < .05$,

*** $p < .001$.

Table 3.
The associations between individual/relationship characteristics and type of partnership with most recent partner.

Categorical Variables	Seriously dating <i>N</i> (%)	Casually dating <i>N</i> (%)	Not dating <i>N</i> (%)	χ^2 (<i>df</i>)
Race				9.87 (6)
White	30 (32.6)	59 (41.0)	77 (32.6)	
Black	21 (22.8)	32 (22.2)	56 (23.7)	
Latino	35 (38.0)	35 (24.3)	85 (36.0)	
Other	6 (6.5)	18 (12.5)	18 (7.6)	
Sexual Orientation				5.14 (2)
Gay	79 (87.8)	133 (92.4)	195 (84.4)	
Bisexual	11 (12.2)	11 (7.6)	36 (15.6)	
Openly discussed agreement with most recent partner	65 (87.8) ^a	40 (88.9) ^a	32 (71.1) ^b	6.99 (2) [*]
Concurrent sexual partners	28 (30.4) ^a	77 (53.5) ^b	173 (73.3) ^c	52.78 (2) ^{***}
Partner's known or perceived HIV-status				1.04 (2)
Positive/unknown	22 (23.9)	38 (26.4)	69 (29.2)	
Negative	70 (76.1)	106 (73.6)	167 (70.8)	
Continuous Variables	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>F</i> (<i>df</i>)
Age	22.96 (2.7) ^a	24.07 (2.89) ^b	24.03 (2.97) ^b	5.12 (2, 469) [*]
Frequency of communication with most recent partner	2.73 (.72) ^a	2.49 (.82) ^b	2.23 (.87) ^c	13.35 (2, 469) ^{***}
Comfort with communication with most recent partner	3.58 (.68)	3.52 (.68)	3.54 (.66)	.22 (2, 409)

Note. The numbers of participants in each group were 92 (seriously dating), 144 (casually dating), and 236 (not dating). Different superscript letters indicate significant differences between column proportions ($p < .05$).

^{*} $p < .05$,

^{**} $p < .01$,

^{***} $p < .001$.

Table 4.

The associations between individual/relationship characteristics and type of sexual agreement with most recent partner.

Categorical Variables	Monogamous agreement		Open agreement		No agreement		χ^2 (df)
	N (%)		N (%)		N (%)		
Race							6.73 (6)
White	40 (42.6)		19 (27.5)		107 (34.7)		
Black	17 (18.1)		19 (27.5)		73 (23.7)		
Latino	30 (31.9)		27 (39.1)		97 (31.5)		
Other	7 (7.4)		4 (5.8)		31 (10.1)		
Sexual orientation							.40 (2)
Gay	82 (87.2)		58 (85.3)		266 (88.1)		
Bisexual	12 (12.8)		10 (14.7)		36 (11.9)		
Openly discussed agreement with most recent partner	79 (84.0)		58 (84.1)		-		1.00 (1)
Concurrent sexual partners	14 (14.9) ^a		54 (78.3) ^b		210 (68.2) ^b		96.93 (2)***
Partner's known or perceived HIV-status							15.96 (2)**
Positive/unknown	11 (11.7) ^a		17 (24.6) ^b		100 (32.5) ^b		
Negative	83 (88.3) ^a		52 (75.4) ^b		208 (67.5) ^b		
Continuous Variables	<i>M (SD)</i>		<i>M (SD)</i>		<i>M (SD)</i>		<i>f</i> (df)
Age	22.86 (2.65) ^a		23.99 (2.67) ^b		24.09 (3.01) ^b		6.60 (2, 468)**
Frequency of communication with most recent partner	2.81 (.74) ^a		2.62 (.86) ^a		2.23 (.82) ^b		21.14 (2, 468)***
Comfort with communication with most recent partner	3.67 (.56) ^a		3.64 (.65) ^{a,b}		3.47 (.70) ^b		3.67 (2, 408)*

Note. The numbers of participants in each group were 94 (monogamous agreement), 69 (open agreement), and 308 (no agreement). Different superscript letters indicate significant differences ($p < .05$) between column proportions.

* $p < .05$;

** $p < .01$,

*** $p < .001$.

Table 5.

Correlates of condomless anal sex (CAS) with most recent partner.

Categorical Variables	OR	95% CI
Type of partnership (reference: seriously dating)		
Casually dating	.37	.20, .68
Not dating	.28	.16, .49
Type of sexual agreement (reference: monogamous agreement)		
Open agreement	.45	.23, .87
No agreement	.38	.23, .64
Race/ethnicity (reference: White)		
Black	.94	.57, 1.54
Latino	.77	.50, 1.21
Other	1.29	.63, 2.63
HIV-positive/unknown partner (relative to HIV-negative partner)	.86	.57, 1.30
Bisexual (relative to gay)	.78	.45, 1.35
Openly discussed agreement with most recent partner	1.61	.69, 3.77
Concurrent sexual partners	.45	.30, .66
Continuous Variables		
Age	OR	95% CI
Frequency of sexual health communication with most recent partner	1.03	.96, 1.09
Comfort with sexual health communication with most recent partner	1.00	.81, 1.25
	1.04	.78, 1.40

Notes. OR = odds ratio; CI = confidence interval; 95% CIs that do not include 1 are significant ($p < .05$; indicated in bold font). In a post-hoc analysis, we included the three significant predictors of CAS in the same model (type of partnership, type of agreement, and concurrent sexual partners). Type of partnership remained significant; the adjusted OR for casually dating was .47 (.24, .92) and the adjusted OR for not dating was .40 (.21, .78). Concurrent sexual partners also remained significant; the adjusted OR was .58 (.37, .89). In contrast, type of agreement was no longer significant; the adjusted OR for open agreement was .87 (.41, 1.87) and the adjusted OR for no agreement was .80 (.42, 1.53).