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BRUCE KING PAMELA REGAN

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Preface

The many editions of this textbook have been a wonderful journey for me. Unhappy with the leading sexuality textbooks of the 1980s, I began work on my own book in 1985 resulting in two classroom testing versions coauthored with Cameron Camp. The first edition published by Prentice Hall appeared in late 1990, and I was the sole author for editions two through seven. I have always believed that a human sexuality book should be not only factual and thorough but also readable and interesting. My writing style is purposely conversational in many places, and the book has always included numerous case studies (most contributed by students) to personalize the coverage of scientific studies.

I am now in my 70s, and thus, for the eighth edition I added Pam Regan as a coauthor. Pam has been an outstanding scholar in the field of sexuality since the 1990s. In addition to her earlier work on the role of hormones, she brings considerable expertise to the book in the areas of relationships, sexual desire, and love. Pam shares my views on the purpose and style of a sexuality textbook. For this current ninth edition, Pam revised Chapters 4 and 11 through 16. I am turning the book over to Pam for the next edition but hope to continue to contribute wherever I can.

There has never been a greater need for comprehensive human sexuality education. Compared to many other nations, the United States has very high rates for sexually transmitted infections and teenage pregnancies, yet it is rare that, at the beginning of a semester, more than 30% of the students indicate that they have ever had a meaningful discussion with their parents about sexuality. As a result, there is much ignorance and misinformation about the topic (King, 2012). Unfortunately, a lot of information has been presented in a negative way. While one of our goals is for students to understand the relevant facts in order to make responsible decisions in their daily lives, an equally important goal has been to present the information in a warm, nonthreatening manner that leaves students with positive feelings about sex and their own sexuality.

—Bruce King

New in the Ninth Edition

Each chapter in this new edition contains the latest data and research findings. In addition, here is a detailed list of additions and updates:

Chapter 1. Why a Course in Human Sexuality?

- Condensed section "What Influences Our Attitudes About Sexuality Today"
- Extensively revised section "Sexuality Education"

Chapter 2. Our Sexual and Reproductive Anatomy

- Correlated Learning Objectives more closely with chapter

Chapter 3. Hormones and Sexuality

- Moved section "Regulation of Male Hormones" based on reviewer suggestions
- Rearranged and added Learning Objectives
- Updated coverage with new research and citations

Chapter 4. Similarities and Differences in Our Sexual Responses

- Expanded discussion of types and measurement of sexual responses; updated presentation of male and female sexual response cycles
- Expanded discussion of female genital mutilation
- Updated depiction of linear sexual response cycle to include five phases

Chapter 5. Sexually Transmitted Infections and Sexually Related Diseases

- Updated content with new research and citations
- Streamlined HIV/AIDS section
- New graph showing worldwide HIV cases and deaths

Chapter 6. Birth Control

- Condensed sections on birth and abortion
- Updated figures and tables to include latest statistics

Chapter 7. Pregnancy and Childbirth

- New images throughout

Chapter 8. Gender Identity and Gender Roles

- Several new images throughout
- Updated coverage of gender identity disorder and gender incongruence
- Updated information on gender roles

Chapter 9. Sexual Orientation

- Updated research on prevalence of homosexuality and bisexuality
- Updated research on attitudes toward marriage and parenting

Chapter 10. Life-Span Sexual Development

- Updated research on puberty and hormone therapy
- Updated statistics on sexual behavior of teenagers

Chapter 11. Adult Sexual Behaviors and Attitudes

- Updated research and citations throughout
- New table on sexual behaviors of U.S. men by self-identified sexual orientation

Chapter 12. Love and Relationships

- Updated research and citations throughout
- New table on styles of loving

Chapter 13. Sexual Problems and Therapy

- Revised and updated discussion of sexual problems and treatment
- New information on sexual disorders (DSM and ICD) as well as hypersexuality and sex addiction

Chapter 14. Paraphilias and Sexual Variants

- New discussion of the distinction among sexual variants, paraphilias, and paraphilic disorders
- Updated discussion on BDSM subculture
- New discussion about origins of paraphilias and why they are more commonly observed among men

Chapter 15. Sexual Victimization: Rape, Coercion, Harassment, and Abuse of Children

- Reorganized discussion of and updated research on sexual assault/victimization
- New section on the personal, interpersonal, and social factors implicated in sexual assault victimization and perpetration

Chapter 16. Selling Sex: Social and Legal Issues

- Expanded discussion of sexually explicit media and the Internet, as well as a detailed exploration of the distinction among pornography, erotica, and obscenity
- Extensively revised and expanded throughout to include research exploring the link between pornography viewing and personal well-being, relationship satisfaction, and sexual violence
- Significantly revised sections on prostitution and sex trafficking
- New discussion of the legal status of prostitution around the world as well as the contributing factors and personal and social consequences

of sex work

Revel™

For the first time, the ninth edition of this text is available in Revel—educational technology designed for the way today's students read, think, and learn. When students are engaged deeply, they learn more effectively and perform better in their courses. This simple fact inspired the creation of Revel. Built in collaboration with educators and students nationwide, Revel is the newest, fully digital way to deliver respected Pearson content.

Revel enlivens course content with media interactives and assessments—integrated directly within the authors' narrative—that provide opportunities for students to read about and practice course material in tandem. This immersive educational technology boosts student engagement, which leads to better understanding of concepts and improved performance throughout the course.

Human Sexuality Today, 9e features many of the dynamic interactive elements that make Revel unique. In addition to the rich narrative content, *Human Sexuality Today* includes the following:

- Audio recordings of the text narrative help students who prefer to listen to the narrative to better absorb the content.
- Videos reinforce concepts, provide additional information, and keep students fully engaged.
- Key terms with pop-up inline definitions allow students to see the meaning of a word or phrase while reading the text, providing context.
- Hands-on, interactive activities connect students in an immediate and personal way, helping to improve their understanding and retention of the content.
- Practice exercises and key term flashcards aid with study and retention.
- Graded multiple-choice end-of-module and end-of- chapter quizzes test students' knowledge and comprehension.
- Journal prompts provide ample opportunity for students to write about topics and concepts and further explore themes presented in the chapter.
- Shared Writing prompts provide peer-to-peer feedback in a discussion board, facilitating the development of critical thinking skills and helping to foster collaboration

Learn more about Revel at www.pearsonhighered.com/revel/.

Features of the Ninth Edition

Human Sexuality Today includes the following pedagogical features:

- Special sections on "Cross-Cultural Perspectives" and "Sexuality and Health" are presented throughout the book to provide students with a global perspective and to familiarize them with the impact of cultural and ethnic factors.
- End-of-chapter Study Guides featuring interactive reviews and true/false, matching, and fill-in-the-blank questions provide students with self-contained, self-assessment tools (answers are provided at the end of the book).
- Learning Objectives at the beginning of each chapter, boldfaced key terms, and marginal glossaries provide students with tools to help them focus and build their understanding of the material.
- Numerous case histories provided by students draw students into the content and make the material more relevant.

Supplements

Instructor's Manual and Test Bank

Thoroughly updated to reflect the new research included in this edition. The Test Bank, prepared by the authors, Bruce M. King and Pamela C. Regan, contains between 75 and 100 test questions per chapter. The Instructor's Manual and Test Bank are available to adopters at www.pearsonhighered.com.

MyTest

The Pearson MyTest is a powerful assessment-generation program that helps instructors easily create and print quizzes and exams. Questions and tests can be authored online, allowing instructors ultimate flexibility and the ability to efficiently manage assessments anytime, anywhere. For easy access, this software is available via www.pearsonhighered.com.

PowerPoint Presentation

This completely revised PowerPoint presentation has been created specifically for the ninth edition and incorporates text art and outlines key points

for each text chapter. The PowerPoint presentations are available to adopters at www.pearsonhighered.com.

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Finally, we cannot thank enough the thousands of students who provided us with chapter reviews and/or case histories. This book was written with students in mind. We hope it helps them to lead healthier, happier, and more fulfilling lives.

Bruce M. King

Pamela C. Regan

About the Authors

Bruce M. King

Bruce M. King received a B.A. in psychology from UCLA in 1969 and a Ph.D. in biopsychology from the University of Chicago in 1978. He taught for 29 years at the University of New Orleans and is presently in the Department of Psychology at Clemson University. He has taught human sexuality to over 60,000 students. In addition to conducting research in the field of human sexuality, he has published numerous papers in peer-reviewed journals on the biological basis of feeding behavior and obesity and has coauthored a textbook on statistics (B. M. King, P. J. Rosopa, & E. W. Minium, *Statistical Reasoning in the Behavioral Sciences*, 6th ed., John Wiley & Sons, 2011). Dr. King is a Fellow in the Association for Psychological Science, the American Psychological Association, and the International Behavioral Neuroscience Society. He shared his thoughts about 30-plus years of teaching human sexuality in an article published in *American Journal of Sexuality Education* (2012, vol. 7, pp. 181–186). In 2017, Dr. King authored a paper on the prevalence of human sexuality and gender/women's studies courses in U.S. higher education (*Health Behavior and Policy Review*, vol. 4, pp. 213–223).

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Human Sexual Desire (Sage, 1999). In 2007, she was honored with the Outstanding Professor Award by her university for excellence in instructional and professional achievement.

Chapter 1 Why a Course in Human Sexuality?

> Certainly no aspect of human biology in our current civilization stands in more need of scientific knowledge and courageous humility than that of sex. . . . As long as sex is dealt with in the current confusion of ignorance and sophistication, denial and indulgence, suppression and stimulation, punishment and exploitation, secrecy and display, it will be associated with a duplicity and indecency that lead neither to intellectual honesty nor human dignity.

—Alan Gregg, quoted by Goldstein (2010)

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 1.1 Describe cultural perspectives, other than our own, with regard to sexual behaviors and attitudes.
2. 1.2 Explain the historical influence of Judaism, Christianity, the Victorian era, and the sexual revolution on contemporary attitudes about sexuality.
3. 1.3 Explain the process of socialization and explain how one socializing agent, the media, has become an omnipresent influence on sexual socialization.
4. 1.4 Explain the contributions of Sigmund Freud, Henry Havelock Ellis, Alfred Kinsey, and Masters and Johnson to the field of sexuality.
5. 1.5 Explain the uses and limitations of scientific methodology.
6. 1.6 Summarize the history of sexuality education.

Sexuality is an important part of our lives. We need only to look at the world population of over 7 billion people to see that sexual motivation is very strong. Although sex is necessary for procreation, it is doubtful that many people think of this on more than just an occasional basis when having sexual intercourse. Sex can be a source of great physical and emotional pleasure, enhancing our sense of health and well-being. It can relieve tensions and anxieties. It can boost self-esteem and make us feel more masculine or feminine. It is also the vehicle through which couples can express their affection for one another. In fact, there are a couple hundred reasons people give for having sex (Meston & Buss, 2007).

So why are you taking a course in human sexuality? Surely someone in your life took the time and responsibility to educate you about this important topic? Surveys in our course have consistently revealed that fewer than one third of the students each semester have ever had a serious and meaningful discussion with their parents about sex. This is typical throughout the United States (Cox et al., 2014; Lindberg et al., 2016). For many teens whose parents did talk to them about sex, it was just a single discussion—one "birds and bees" talk that was supposed to prepare them for life. Here are a few comments that we have received from students regarding their prior sex education. They are typical of the many comments we have gotten on end-of-semester course evaluations:

"My father thinks this class is a waste because he feels people instinctively know how to deal with their sexuality. Maybe I'm just a freak of nature, but I've never had any instincts explaining any of this to me."

"Until now my parents never spoke to me about sex. I'm from a very strict family. They made me feel as though it was a sinful subject to talk about."

"I remember my mother finding a book my sister was reading and screaming at her, so everyone in the house could hear about what an awful, dirty book it was. It wasn't pornography. It was a book on sex education. She just wanted to learn something correctly."

"When I was young the word sex was never brought up. My mother had one short talk with me, and that was to explain what a period is."

(All examples are from the authors' files.)

Students also provided the following comments regarding the usefulness of a human sexuality course. Apparently, it is never too late to learn:

"I'm glad I registered in the class. I sure thought I knew it all and found I knew very little. I've been married 6 years and knew little about my own body, much less about my husband's."

"I am a 46-year-old student with four children from 13 to 38. I knew nothing about sex before this course. I will now make sure my kids do."

"When selecting this course, the thought came to me that it would be a very easy class because I knew everything about sex because Mother told me. After all, there are 18 of us in the family. Boy, was I wrong. I've learned more in one semester than Mother could teach me in 20 years."

"I was very surprised at the amount of material I learned. I thought it was going to be just about sex. There is a lot more to sex than just sex."

(All examples are from the authors' files.)

Where, then, did most of us learn about sex? Today's teens and college students say that they received most of their sex education from friends and the media rather than parents (American Academy of Pediatrics, 2010; Sprecher et al., 2008).

“My friends learned most of what they knew from their friends…and the Internet.”

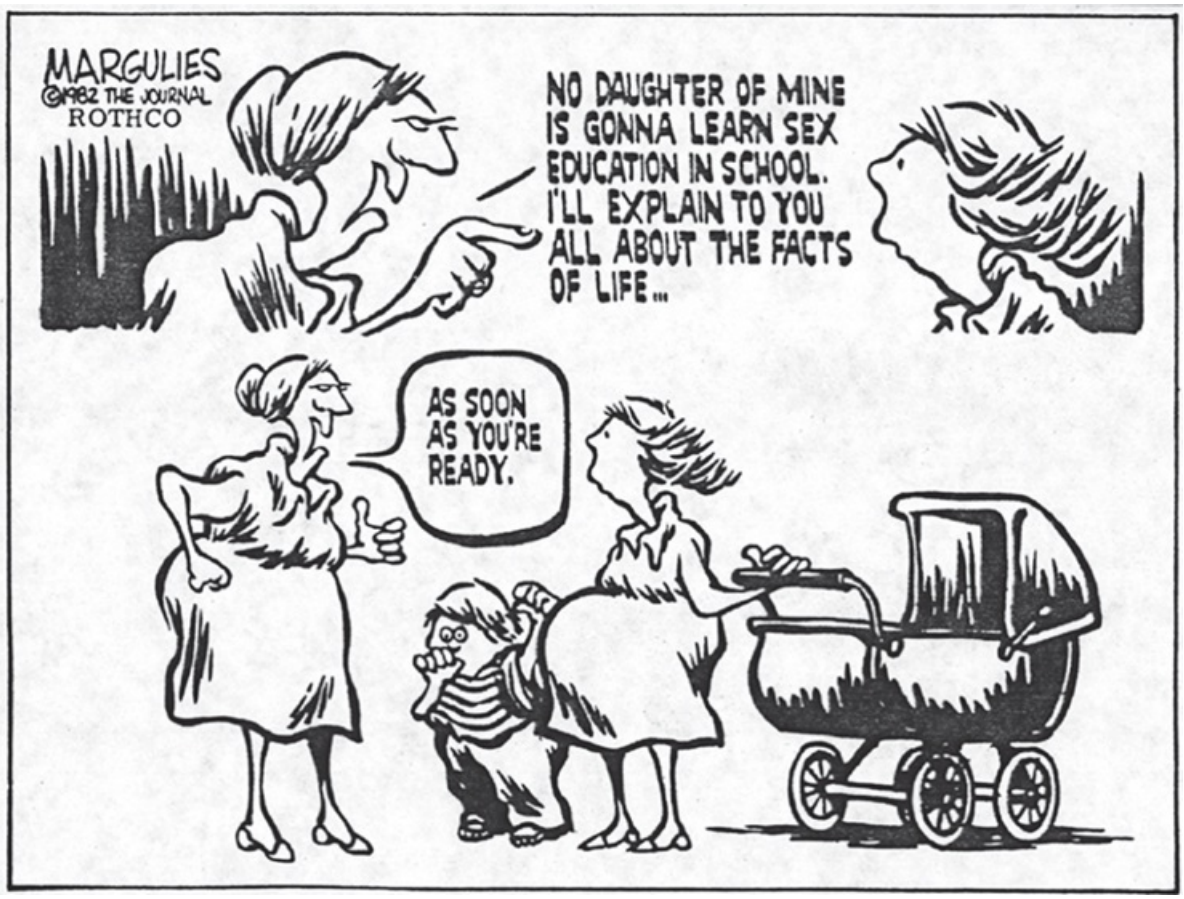
(from the authors’ files)

The media as sex educators? Nearly three fourths of television shows contain talk about sex or show sexual behavior (Eyal et al., 2007; Kunkel et al., 2007). Over two thirds of television shows include sexual content, averaging 5.9 scenes per hour. Every year, the typical teenager sees 15,000 references about sex just on television (Strasburger, 2012). Many R-rated movies have sexually explicit scenes. At least half of teens have visited a sexually explicit website on the Internet (Braun-Courville & Rojas, 2009). Many stores have erotic magazines on open display. Advertisements frequently use sex (e.g., seductively dressed models) to sell products (Reichert, 2003). Sex is everywhere, and children are exposed to it all day long.

In the presence of all this, many parents continue to be silent with their children on the subject of sex. However, this, too, is a source of sex education. Making something mysterious only makes adolescent children want to know more about it—yet much of the information they receive from their friends is incorrect. As a result, a majority of Americans are amazingly ignorant about sexual behaviors and sexual health (Frost et al., 2012; King, 2012; Moore & Smith, 2012). Many believe, for example, that people over 60 do not have sex, that masturbation is physically harmful, or that you cannot get AIDS if you are heterosexual.

What all this adds up to is that many people do not fully understand or appreciate the consequences of engaging in sexual relations. Nationally, about 41.2% of all high school students have had sexual intercourse, including 58.1% of 12th graders (Kann et al., 2016). Three fourths of Americans have had sex by age 20 (Finer, 2007). Each year, over 550,000 pregnancies occur among girls aged 15 to 19, and 19.7 million Americans (of all ages) contract a sexually transmitted infection (Centers for Disease Control and Prevention [CDC], 2016; Kost & Maddow-Zimet, 2016). Many young people, including college students, believe that they are knowledgeable about sexually transmitted infections, but most do not know the symptoms of sexually transmitted infections and do not know where to turn if they think they have one (e.g., Lim et al., 2012; Moore & Smith, 2012).

So, once again, why are you taking a course in human sexuality? Probably because you desire factual information about a subject that plays, or will play, an important role in your life. If parents are not going to assume the responsibility, the next best alternative is the schools. Surveys consistently show that over 85% of Americans support the teaching of comprehensive sexuality education in public schools (see Constantine, 2008, for a review). This includes a large majority of all religious, age, ethnic, educational, and income groups. The purpose of taking human sexuality courses is much more than just learning about reproduction and sexually transmitted infections. People want to feel comfortable with their own sexuality and to feel good about themselves. Knowing about their bodies and understanding their feelings and emotions can help people achieve this. No part of our bodies should be shrouded in mystery. Understanding our partners’ bodies will help with communication and prevent unnecessary problems. Appreciating that all people are sexual beings can give us a greater understanding of our children, parents, grandparents, and friends. Studies show that sexuality education courses in schools also result in a more tolerant attitude toward others (SIECUS, 1992). Understanding that people are different from ourselves, without condemning them, is an important part of getting along with others.



Source: Jimmy Margulies

1.2-1 Full Alternative Text

Personal Reflections

From whom (or from where) did you acquire most of your information about sex (e.g., parents, friends, the media, teachers, the Internet)? Did your parents discuss sexuality with you? If not, why do you suppose they did not? From whom do you hope your children will learn about sexuality?

A Sexual Knowledge Quiz

Many of you may already be sexually experienced, and as a result, you may think that you do not need a course in human sexuality. There is more to sexuality, however, than engaging in sexual intercourse. See how well you do on the following 50-question quiz. Do not be afraid to admit that you do not know the correct answer (don't guess)—no one but you will see the results. The answers are at the end of the quiz.

	True	False	Don't Know
1. Erections in men result, in part, from a bone that protrudes into the penis.			
2. Sperm can be produced only in an environment several degrees lower than normal body temperature.			
3. A child's gender identity is caused primarily by the way he or she is raised.			
4. The inner two thirds of the vagina is very sensitive to touch.			
5. Many men experience nipple erection when they become sexually aroused.			
6. Most men and women are capable of multiple orgasms.			
7. Breast size in women is related to the number of mammary glands.			
8. Before puberty, boys can reach orgasm, but they do not ejaculate.			
9. During sexual intercourse, orgasm in women results from direct stimulation of the clitoris by the penis.			
10. Menstrual discharge consists of sloughed-off uterine tissue, blood, and cervical mucus.			
11. For hygiene reasons, you should avoid sex during menstruation.			
12. Ovulation generally occurs just before menstruation.			
13. After a vasectomy, a man can reach orgasm but does not ejaculate.			
14. AIDS is the diagnosis for people who have human immunodeficiency virus (HIV).			
15. A girl can get pregnant as soon as she starts having menstrual periods.			
16. The combination birth control pill works primarily by preventing implantation of a fertilized egg.			
17. Taking the oral contraceptive pill results in fewer serious health problems than do pregnancy and childbirth.			

Answers

1. false
2. true
3. false
4. false
5. true
6. false
7. false
8. true
9. false
10. true
11. false
12. false
13. false
14. false (only in the final stages)
15. true
16. false
17. true
18. false
19. true
20. false (homosexuality does not cause AIDS)
21. false
22. true
23. false
24. false
25. true
26. false
27. true

28. false

29. false

18. Women show a dramatically higher level of sexual desire than usual at the time of ovulation.
30. false

31. true
19. There are over 19 million new cases of sexually transmitted infections in the United States each year.
32. true

20. The major cause of AIDS is homosexuality.
33. false

34. false
21. If gonorrhea is not treated, it can sometimes turn into syphilis.
35. false

22. Most women do not show symptoms in the early stages of gonorrhea or chlamydia.
36. false

37. false
23. Gonorrhea, syphilis, and herpes can be successfully treated with antibiotics.
38. false

39. true
24. In vitro fertilization involves a process where part of fetal development occurs in a test tube.

40. true
25. It is usually safe to have sexual intercourse during the 7th and 8th months of pregnancy.
41. true

42. true
26. "Prepared childbirth" (e.g., Lamaze) refers to delivering a baby without the use of drugs.

43. false
27. Most healthy people in their 60s or older continue to engage in sexual behavior.
44. false

45. false
28. Men's descriptions of orgasm are different from women's descriptions of orgasm.

46. false
29. Excessive masturbation can cause serious medical problems.
47. false

48. false
30. The birth control pill gives women some protection against sexually transmitted infections.
49. true

31. Condoms are very effective in blocking the transmission of HIV (the virus that causes AIDS).

	True	False	Don't Know
18. Women show a dramatically higher level of sexual desire than usual at the time of ovulation.			
19. There are over 19 million new cases of sexually transmitted infections in the United States each year.			
20. The major cause of AIDS is homosexuality.			
21. If gonorrhea is not treated, it can sometimes turn into syphilis.			
22. Most women do not show symptoms in the early stages of gonorrhea or chlamydia.			
23. Gonorrhea, syphilis, and herpes can be successfully treated with antibiotics.			
24. In vitro fertilization involves a process where part of fetal development occurs in a test tube.			
25. It is usually safe to have sexual intercourse during the 7th and 8th months of pregnancy.			
26. "Prepared childbirth" (e.g., Lamaze) refers to delivering a baby without the use of drugs.			
27. Most healthy people in their 60s or older continue to engage in sexual behavior.			
28. Men's descriptions of orgasm are different from women's descriptions of orgasm.			
29. Excessive masturbation can cause serious medical problems.			
30. The birth control pill gives women some protection against sexually transmitted infections.			
31. Condoms are very effective in blocking the transmission of HIV (the virus that causes AIDS).			

These questions were not intended to be tricky or difficult. They are representative of the type of material that is covered in this book. How did you do? The typical student in our classes can answer 40 or more questions correctly at the beginning of the semester. Fewer than half get 30 or more correct. Did you really know all the ones that you got right, or did you just make a good guess on some of them? If you were not certain of the answers to some of the questions, then that is sufficient reason to read this book.

32. The frequency of sexual relations is highest for married couples aged 25 to 35.

33. Adult male homosexuals have lower-than-normal levels of male hormones.

34. Douching is an effective method of birth control.

35. Recent evidence indicates that environmental factors are the most important in determining men's sexual orientation.

36. Serious sexual problems are uncommon in people under age 40.

37. Most convicted rapists committed their crimes because of an uncontrollable sex drive.

38. There is a demonstrated link between the availability of pornography and sex crimes.

	True	False	Don't Know

39. Until recently, it was against the law in many states for a married couple to engage in sexual behaviors other than penile–vaginal intercourse.

40. Most cases of child molestation involve an acquaintance or relative of the child.

41. A pregnant woman can transmit syphilis to the unborn baby.

42. A woman's fertile period is 5 days before ovulation to 1 day afterwards.

43. Nocturnal emissions ("wet dreams") are often an indication of a sexual problem.

44. Alcohol is a central nervous system excitant that enhances sexual performance.

45. Humans can crossbreed with animals with the use of artificial insemination techniques.

46. Women's sexual desire decreases sharply after menopause.

47. Vaginal infections can be prevented by regular use of feminine hygiene products.

48. A woman's ability to have orgasms is related to penis size.

49. Oral herpes can be transmitted to another person's genitals by oral-genital sexual relations.

50. Unless testosterone is present during embryonic development, nature has programmed everyone to be born a girl.

Cross-Cultural Comparisons

1. 1.1 Describe cultural perspectives, other than our own, with regard to sexual behaviors and attitudes.

It should come as no surprise that people are different. Some people like short hair, while others like it long. Some people like to dress up; some like to dress down. People's sexual attitudes and behaviors differ as well. Some people, for example, have sexual intercourse only in the missionary position (i.e., the woman lying on her back with the man on top—so called because Christian missionaries instructed people that other positions were unnatural). Others prefer a variety of positions. Some people are most aroused by looking at breasts or a hairy chest. Other people become highly aroused by looking at legs or buttocks.

We learn to accept that other people in our own culture are different from ourselves, and we do not regard them as abnormal when their behavior falls within what we consider the "normal" range of responses. What is normal, however, is defined by the community in which we live. An outsider, such as a person from a different country, is often regarded as very strange by many people. Unfortunately, Americans have a reputation around the world of being ethnocentric—that is, viewing our own culture's behaviors and customs as correct or as the way things ought to be (a perception leading to the image of the "ugly American"). We must not lose sight of the fact that if we traveled to another country *we* would probably be regarded as strange. One country's customs and beliefs should not be regarded as correct or normal and another's as incorrect or abnormal.

The topics covered in some chapters of this book are the same for all peoples of the world (e.g., anatomy, physiology). When you read about behaviors and attitudes, it will be primarily from the perspective of people in the United States. Behaviors of people in other cultures will be presented in special boxes. However, before going on, here is a brief introduction to sexual attitudes and behaviors in a few other cultures around the world. Some of them may seem strange, but remember, *we seem just as strange to them as they seem to us*.

1.1.1 Sexual Attractiveness

Cultures differ with regard to which parts of the body they find to be erotic. In the United States, most people have negative thoughts about armpits, but Abkhazian men are highly aroused at seeing women's armpits. The sight of a navel is considered highly arousing in Samoa, while a knee is considered to be erotic in New Guinea and the Celebes Islands. When anthropologist Martha Ward visited New Guinea in the early 1970s, she de-boarded the plane wearing a miniskirt, blouse, and brassiere, customary clothing for American women at that time. She caused quite a ruckus. She wrote the following letter to one of her colleagues in the United States:

Dear Len,

I have had to change my manner of dressing. . . . The minidresses and short skirts you all are wearing in the States cause quite a stir here. It seems that breasts are regarded as normal female equipment and useful only for feeding babies. Clothing for many women consists of a large towel or three-yard length of brightly colored cloth. This is worn around the waist inside the house or in the yard. . . . [In public] if you have on a bra, you don't need a blouse. Bras are considered proper dress for women. . . . When Americans are not around, it is sufficient to cover oneself only from the waist down. . . .

Breasts are not really erogenous, but legs are. Particularly that sexy area on the inside of the knee! No more miniskirts for me. Fitting in and observing local customs means that I have lengthened my skirts to below the knee. . . .

The American men watch women with nothing on above the waist. The Pohnpeian men comment on American women with short skirts. I am now dressed to please the standards of two cultures. . . .

(excerpt from *Nest in the Wind: Adventures in Anthropology on a Tropical Island,* by Martha C. Ward. Copyright © 1989 by Waveland Press, Inc. Reprinted by permission.)

This is not to say that men in New Guinea do not have preferences about breasts—they do. They generally prefer larger breasts with large, darkly pigmented areolas, whereas men in New Zealand prefer not as large breasts with medium-sized, medium-pigmented areolas (Dixson et al., 2011).

Just as in New Guinea, there are many areas of the world where women's naked breasts have no erotic significance (see Figure 1–2). They are important only to hungry babies. On the other hand, American men find female breasts so sexually arousing that women cannot even breast-feed in public. Here is an experience of one of our students, an African woman from Chad, shortly after she arrived in New Orleans:

"One day my husband was driving and I was sitting in the back nursing my baby. The police stopped us and arrested me. . . ."

(from the authors' files)

Polynesian men are as fascinated with the size, shape, and consistency of women's genitals as American men are with breasts (Marshall, 1971). In some African cultures, a woman's labia minora are considered to be the most erotic part of her body (Pérez et al., 2014).

Many groups of people find body weight to be an important determinant of sexual attractiveness. There is a great deal of pressure in our culture, for example, for men and women to remain thin (Brown & Slaughter, 2011). It is no coincidence that fashion models are very thin and that movie stars who are considered to be "sexy" have small waistlines. In many other countries, however, these people would not be considered attractive. For example, women who would be considered obese by most American men are found highly attractive in some other cultures. Adolescent girls are sometimes kept in huts and fed high-calorie diets in order to become more attractive (Gregersen, 1982).

What is considered to be sexually attractive can also change over time. Plump women, for example, were also considered to be very attractive in Western cultures a few centuries ago. If you do not believe this, just look at some famous paintings of naked women that were done 300 to 400 years ago (see Figure 1–1).

Figure 1–1

Rubens' *The Three Graces* is a good example of how cultural ideals change over time. While thinness is admired today, a thin woman in Rubens' time would have been thought unattractive.

Source: The Three Graces, c.1636, Museo del Prado, Madrid, Spain, Erich Lessing/Art Resource, New York

Although walking around naked in public would be considered highly deviant by most people in the United States, there are some cultures in New Guinea and Australia where people go about completely naked. They do, however, have firm rules about staring at other people's genitals. The Zulus of South Africa also have public rituals that call for people to be naked. They believe that a flabby body results from immoral behavior, and thus if someone refuses to undress for these rituals, it is taken as a sign that the person is trying to hide his or her immorality (Gregersen, 1982). These attitudes about the human body are in marked contrast to those that prevail in Islamic societies, where female sexuality is suppressed and women must cover their entire body and most of their face when they leave the privacy of their homes.

In some cultures people carve holes in their lips, while in others they stretch their lips or necks or wear needles through their noses. In parts of Indonesia, the Philippines, and Malaysia, it is common for men to insert objects (e.g., ball bearings, precious stones, rings) in their penises (Hull &

Budiharsana, 2001). In Borneo, for example, it is common for men to wear a rod through the end of their pierced penis. The rod, called a penis pin, has protuberances (e.g., gemstones, feathers, pig's bristles) at each end, which the men believe enhances women's pleasure during intercourse (Brown, 1990). Elaborate abdominal scars are considered to be very sexually attractive on women of the Kau culture in Sudan. It is obvious from the lack of universal standards that attitudes about the human body, and what is considered to be sexually attractive, are culturally learned responses.

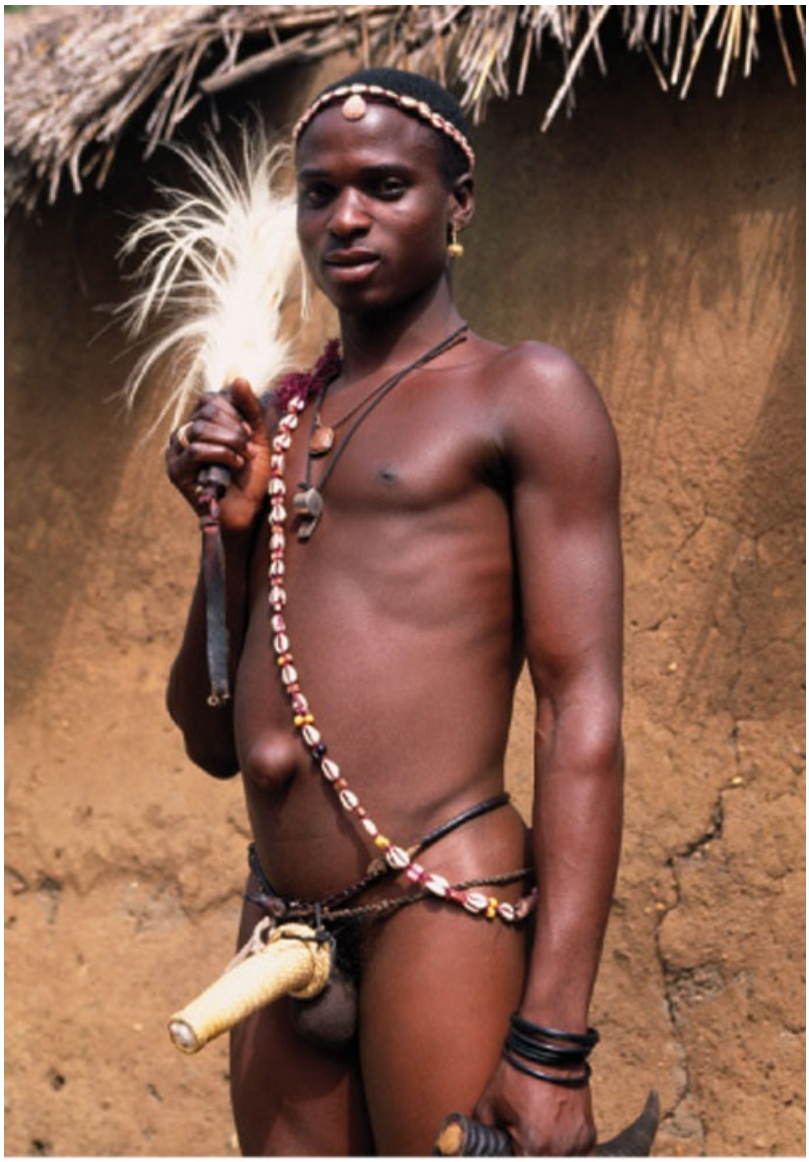
1.1.2 Sexual Behaviors and Attitudes

Kissing is a highly erotic and romanticized part of sexual relations in Western cultures. You will probably be surprised to learn, therefore, that this practice is not shared by many cultures, including the Japanese, Hindus of India, and many groups in Africa and South America (Ford & Beach, 1951; Gregor, 1985). "When the Thonga first saw Europeans kissing they laughed, expressing this sentiment: 'Look at them—they eat each other's saliva and dirt'" (Ford & Beach, 1951). Foreplay before intercourse is entirely unheard of in some cultures.

Anthropologists believe that the most sexually permissive group of people in the world are the Mangaians, who live on the Cook Islands in the South Pacific (Marshall, 1971). Mangaian boys and girls play together until the age of 3 or 4, but after that they separate into age groups according to sex during the day. When the boys approach adolescence, the arrival of manhood is recognized by superincision of the penis (cutting the skin of the penis lengthwise on top). As the wound heals, the boy is instructed in all aspects of sex, including how to bring a girl to orgasm, which is considered important. Girls receive similar instructions from older women. The boy is then given to an experienced woman, who removes the superincision scab during intercourse and teaches the boy an array of sexual techniques. After that, the boy actively seeks out girls at night, having sex an average of 18 to 20 times a week. Mangaian adolescents are encouraged to have sex with many partners and engage in all types of sexual activities. Once they reach adulthood, Mangaian men and women become monogamous.

Many other societies in the South Pacific, including Samoa and Pohnpei, similarly encourage their teenage children to enjoy sexual relations (Ward, 1989). In some of these cultures, the boys go into the huts where teenage girls live and have sex with them while the girls' parents are present. The parents ignore them and act as if the children are invisible. In all of these societies, the physical pleasure of both sexes is emphasized and emotional attachments come later. They regard our custom of emphasizing love before sex as very strange.

Figure 1–2



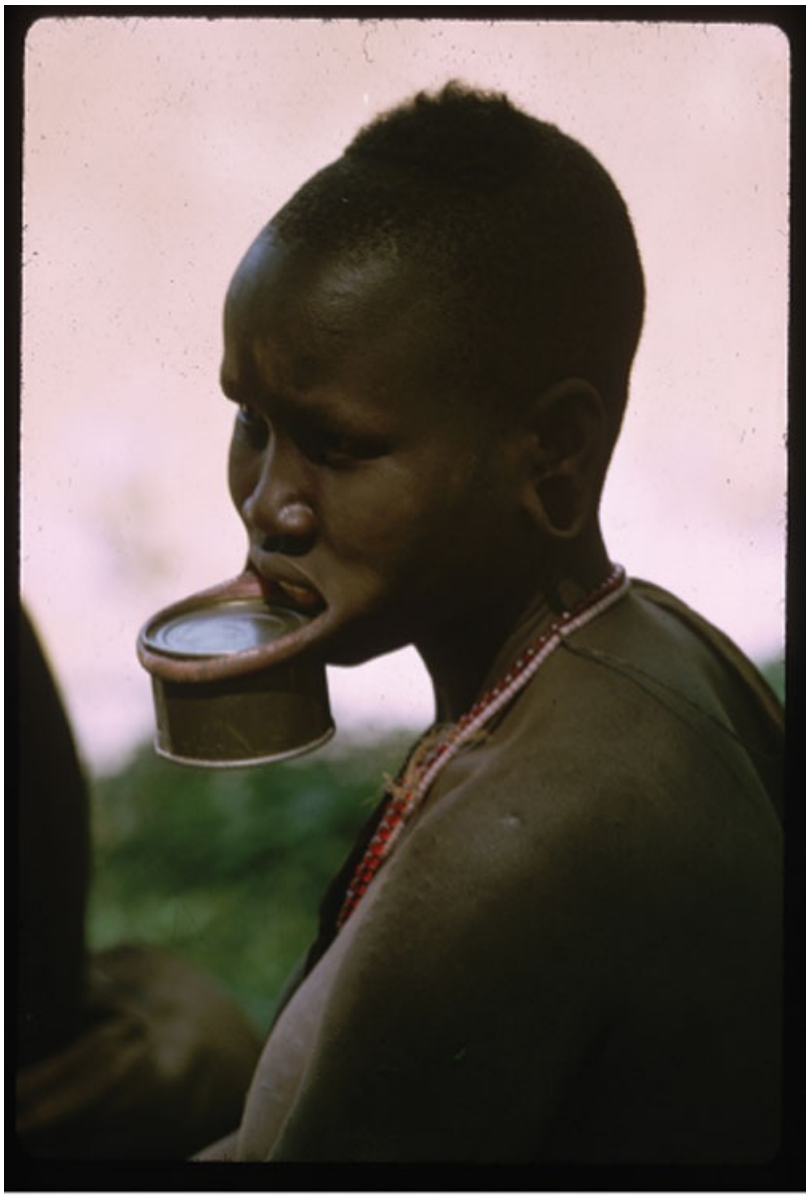
(a)

(b)

(c)

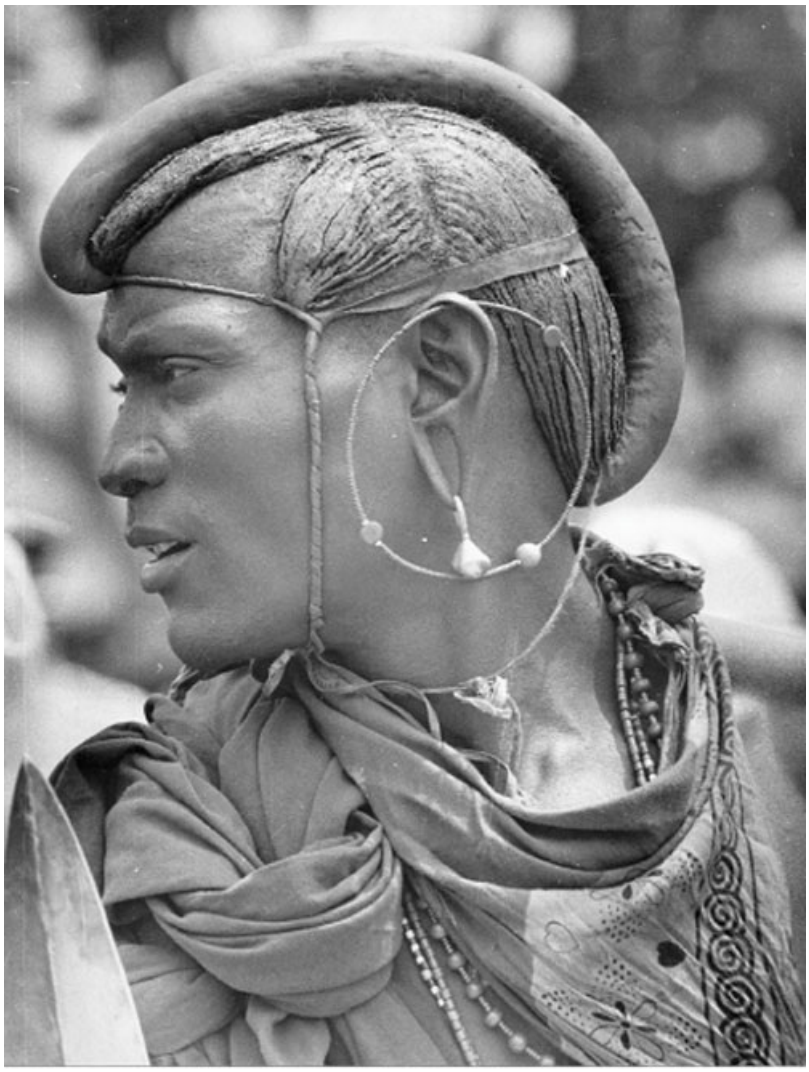
(d)

(e)



(f)

(g)



(h)

Cultures differ widely with regards to what they find to be attractive. In New Guinea, many men wear only a bamboo penis sheath (a), while in Borneo men have penis pins (b). Body scarification is common among Kuba (now Zaire) women (c). In contrast to these customs of nearly complete nudity, Islamic women must keep their faces covered while in public (d). In Samoa, men regard heavy women to be most attractive (e). Along the Ono River in Ethiopia, women use cans as lip ornaments (f), whereas among the Karen in Thailand an elongated neck is considered beautiful (g). Elaborate headdress and ear piercing are attractive among men in Tanganyika (h).

Source: (a) Atlantide Phototravel/Corbis Documentary/Getty Images; (b) Peabody Museum of Archeology and Ethnology; (c) Eric Baccega/age fotostock/Alamy Stock Photo; (d) Pakistan Images/Alamy Stock Photo; (e) Douglas Peebles Photography/Alamy Stock Photo; (f) Jonathan Blair/Corbis Documentary/Getty Images; (g) Kevin R. Morris/Corbis/VCG/Getty Images; (h) Haywood Magee/Hulton Archive/Getty Images

The most sexually repressed society in the world is believed to be the Inis Baeg, a fictitious name (coined by anthropologists to preserve anonymity) for a group of people who live on an island off the coast of Ireland (Messenger, 1971). Any mention of sex is taboo, so that children are never told about things like menstruation and pregnancy, which are greatly feared. Nudity is strictly forbidden. Even married adults do not see each other completely naked—they do not bathe together, and they wear smocks during sexual intercourse. Sexual relations are not regarded as something positive by either sex. Foreplay is unheard of, and intercourse, which is always done in the missionary position, is completed as quickly as possible because men consider it to be dangerous to their health (and, unlike Mangaian women, Inis Baeg women almost never achieve orgasm).

Between the two extremes of the Mangaians and the Inis Baeg is a large range of sexual attitudes and behaviors. You will find that many cultures are more restrictive (or repressed) than our own. For example, until very recently it was taboo to openly discuss sex in China, Japan, Russia, and many African cultures (Ecker, 1994; Kitazawa, 1994; Rivkin-Fish, 1999). Oral-genital sex is common in Western cultures, but most African cultures consider it disgusting. In many Islamic countries, women's sexuality is suppressed by genital mutilation during childhood (see Box 4–A).

On the other hand, many cultures are more permissive (or tolerant) than our own. In Chapter 9, for example, you will read about the Sambian culture where homosexual relations are expected among young boys and teenaged boys (Box 9–A). Sex with minors is a crime in Western culture, but in the Tiwi culture (Melville Island) girls are married to an adult man at age 7 and begin having sexual intercourse shortly afterward (Goodall, 1971). Incest is also a taboo in Western culture, but marriage between cousins or between uncles and nieces is often expected in other cultures

(Box 15–C). Similarly, monogamy is the standard in Western cultures, while in many others polygamy is practiced (Box 12–B). Even the overall approach to sex can differ among cultures. For example, sex in Western cultures tends to focus on genital stimulation, orgasm, and physical gratification, whereas Eastern Tantric cultures emphasize spiritual union during sex (Box 13–A).

1.1.3 Cultural Diversity Within the United States

To this point, we have referred to Western culture as if it were composed of a homogenous group of people. North America may originally have been settled primarily by Caucasian Christians of European descent, but the population today is much more diverse. A sizable proportion of the U.S. population is made up of African Americans, Latinos, and Asian Americans. However, even within these ethnic groups, there are often distinct subgroups. Among Asian Americans, for example, there are people whose ancestors came from Japan, China, Vietnam, Thailand, Korea, the Philippines, and South Pacific islands. Within each subculture there are several factors that can influence sexual attitudes and behaviors. These include religion, level of education, and socioeconomic status. In short, it is sometimes difficult to make generalizations even about cultural subgroups. With these cautions in mind, what generalizations can we make?

One example of changing cultural differences in sexual behavior in the United States is found when we examine oral-genital sexual relations. This has been a very common behavior among white middle-class (especially college-educated) Americans for at least 60 years (Kinsey et al., 1948, 1953). However, until recently it was practiced by only a minority of African Americans (Laumann et al., 1994). The small proportion of African Americans engaging in this behavior could be explained in part by their African ancestry and also by the socioeconomic status of many black Americans. Oral-genital sex is less common among all low-educated, low-income groups, regardless of ethnic background. Today, with the greater assimilation of African Americans into the middle class, these cultural differences are disappearing and the percentage of blacks engaging in oral-genital sex is close to that for whites (Dodge et al., 2010).

On the other hand, African Americans tend to begin sexual intercourse earlier than Caucasians (Cavazos-Rehg et al., 2009). Asian Americans are generally the least permissive in their sexual attitudes and behaviors (Ahrold & Meston, 2010; Okazaki, 2002). This is partly a reflection of restrictive attitudes about sex in Asian countries but also results from the strong emphasis that people from many Asian countries place on family and social conformity. Asian Americans tend to have very low rates for both premarital intercourse and multiple sexual partners. On the other hand, they have the highest rate (among the subcultures discussed) for abortions. This is not only a reflection of non-Western religious beliefs (that do not question the morality of abortion) but, often, also a result of having immigrated from overpopulated countries where the prevailing attitude is that it is best for the general good to limit the number of children one has.

Another factor that can influence sexual attitudes and behaviors is the number of generations that have passed since one's ancestors immigrated to the United States. As people from other countries become more assimilated to American culture, their attitudes and behavior come to resemble those of mainstream Americans (e.g., Ahrold & Meston, 2010; Okazaki, 2002). Much of what you will read in the chapters ahead is true for nearly all subcultures in the United States. However, when there are major differences, you will read about them also.

Personal Reflections

Has your own cultural heritage affected your attitudes about sex? If so, how?

Historical Perspectives

1. 1.2 Explain the historical influence of Judaism, Christianity, the Victorian Era, and the sexual revolution on contemporary attitudes about sexuality.

If the Mangaians and Inis Baeg represent the two extremes, where does American culture fall on this continuum? In many ways our behavior is permissive—we live during the so-called sexual revolution—but our attitudes about sex are often less than positive (evidenced, for example, by the fact that parents and children rarely talk about it together). The constant emphasis on sex on TV, in movies, in magazines, and on the radio gives children one type of message—sex is fun, sex is exciting, sex is great. At the same time, these same children get another type of message from their parents, school, and church—sex is not for you! Is it any wonder that many Americans are confused about sex? Sex is something good on the one hand yet bad on the other. We fall somewhere between the Mangaians and Inis Baeg. We are permissive yet repressed. To see how we arrived at this point in the 21st century, we must examine the history of sexual attitudes in our own culture.

1.2.1 Judaism

Life for the biblical Jews was harsh, and they considered it a great advantage to have many children. The Jews were directed to do so in the first chapter of the first book of the Old Testament:

> And God blessed them, and God said to them, "Be fruitful and multiply, and fill the earth and subdue it."

(**genesis** 1:28, Revised Standard Version)

Having many children ensured the survival of the Jewish people and was viewed as an obligation. Thus, the Hebrews recognized that the primary purpose of sex was for *procreation* (to have children). Celibacy was looked upon as neglect of one's obligations and was regarded as sinful.

Sons were especially valued because of their dual roles as providers and defenders. In the strongly patriarchal Hebrew society, daughters and wives were regarded as property (of fathers or husbands), and there were many rules to guarantee that material property was passed on to legitimate offspring. Thus the Hebrews were very concerned with the social consequences of sex. Sex outside of marriage, for example, was severely condemned and punished. A Jewish woman caught committing adultery was stoned to death, but a man who committed adultery was considered only to have violated another man's property rights. Rape, too, was considered to be a violation of property rights. The punishment for homosexuality and bestiality was death (Leviticus 18:22–29).

In contrast to those harsh views, the Old Testament presents a positive view of sex within a marriage. A good example of this can be found in the Song of Solomon (Song of Songs):

How graceful are your feet in sandals,
O queenly maiden!
Your rounded thighs are like jewels,
the work of a master hand.
Your navel is a rounded bowl
that never lacks mixed wine. . . .
Your two breasts are like two fawns,
twins of a gazelle. . . .
You are stately as a palm tree,
and your breasts are like its clusters.
I say I will climb the palm tree
and lay hold of its branches.

(**song of solomon** 7:1–8, Revised Standard Version)

The human body, including the genitals, was not considered to be obscene, for God had created Adam and Eve in his own image. Mutual sexual pleasure was very important to Hebrew couples. In fact, sex between husband and wife was cause for rejoicing, a.pngt from God. A married couple could engage in any sexual activity, with only one restriction—the husband had to ejaculate within his wife's vagina (not doing so was considered "spilling of seed" because it could not lead to having children).

Personal Reflections

The Hebrews of biblical times believed that humans were created in the image of God, and therefore they were not ashamed of any part of their bodies, including their genitals. What do you think about this? How do you feel about your own body? (Do not just respond "good" or "bad," but explain in some detail.)

1.2.2 The Greeks and Romans

The ancient Greeks and Romans, like the Jews, placed a strong emphasis on marriage and the family. Although procreation was viewed as the primary purpose of marital sex, a couple had children for the state, not God. Unlike the biblical Jews, Greek and Roman men were allowed considerable sexual freedom outside marriage. In Greece, sexual relations between men and adolescent boys in a teacher–student relationship not

only were tolerated but were encouraged as part of the boy's intellectual, emotional, and moral development.

The Greeks idealized the human body and physical beauty (as is evident in their art), but in the latter part of the Greek era there was a strong emphasis on spiritual development and a denial of physical pleasures. The basis for this change was dualism, the belief that body and soul are separate (and antagonistic). Dualism gave rise to an *ascetic philosophy*, which taught that from wisdom came virtue and that these could only be achieved by avoiding strong passions. Plato, for example, believed that a person could achieve immortality by avoiding sexual desire and striving for intellectual and spiritual love (thus the term *platonic* for sexless love). As you will see next, dualism was a major influence on early Christian leaders.

1.2.3 Christianity

Like the theology of the latter-period Greeks, Christian theology separated physical love from spiritual love. The period of decline of the Roman Empire, which coincided with the rise of Christianity, was marked by sexual excess and debauchery. The views of the early Christians regarding sex were partly the result of an attempt to keep order.

It is written in the Gospel of Matthew that Jesus said, "Everyone who looks at a woman lustfully has already committed adultery with her in his heart" (Matthew 5:27, Revised Standard Version). Thus, it was not enough for a Christian to conform behaviorally; there was to be purity of inner thoughts as well.

The teachings of the early Christian writers reflect their own personal struggles with sexual temptation. One of the most influential was Saint Paul (about a.d. 5–67):

> For I know that nothing good dwells within me, that is, in my flesh. I can will what is right, but I cannot do it. For I do not do the good I want, but the evil I do not want is what I do.

(**romans** 7:18–19, Revised Standard Version)

Saint Paul blamed Eve for the expulsion from the Garden of Eden and preached that a celibate lifestyle was the way to heaven. Marriage was only for the weak willed:

> To the unmarried and the widows I say that it is well for them to remain single as I do. But if they cannot exercise self-control, they should marry. For it is better to marry than to be aflame with passion. . . if you marry, you do not sin.

(**corinthians** 7:8–9, 7:28, Revised Standard Version)

Some have interpreted these ambiguous passages to mean that Paul believed that sex within marriage was sinful. Scholars now say that Paul did not believe that marital sex was a sin but that he was concerned that married couples who sexually desired one another would become too involved in worldly (physical) concerns (Deming, 1995; Poirier & Frankovic, 1996). Paul's argument was that celibacy was spiritually superior to marriage. Thus, Paul regarded marriage as a compromise (and a rather poor one at that) for dealing with the problems of the flesh.

Saint Jerome (about a.d. 340–420) said that a man who loved his wife too passionately was guilty of adultery:

> A wise man ought to love his wife with judgment not with passion. . . . He who too ardently loves his own wife is an adulterer.

(Hunt, 1959, p. 115)

Pope John Paul II created some controversy within the Catholic Church when he appeared to echo the beliefs of Saint Jerome:

> Adultery in the heart is committed not only because a man looks in a certain way at a woman who is not his wife. . .Even if he were to look that way at his wife, he would be committing adultery.

(*Sermon. St. Peter's Square, October 8, 1980.*)

The major influence on Christian beliefs was Saint Augustine (a.d. 354–430) (Figure 1–3). As a teenager and young adult he led a promiscuous lifestyle, which included a mistress and son born out of wedlock (Boswell, 1980). He is reported to have prayed, "Give me chastity and continence, but do not give it yet" (*The Confessions*, Book VIII, chap. 7). After reading the works of Saint Paul, he converted to Christianity and thereafter led an ascetic life.

Figure 1–3

Saint Augustine (a.d. 354–430) was the major influence on Christian attitudes about sex. He believed that all sexual acts were driven by lust and were therefore evil, including sex within marriage.

Source: PAINTING/Alamy Stock Photo

It was Augustine, more than anyone else, who solidified the Church's antisexual attitude. Augustine believed that all sexual intercourse was sinful and thus all children were born from the sin of their parents. As a result of the downfall of Adam and Eve, he argued, sex was shameful and equated with guilt. Augustine recognized that married couples had to engage in sexual intercourse for procreation but denounced sex between a husband and wife for the purpose of pleasure (see Soble, 2009). He even considered marital sex for the purpose of procreation to be an

unpleasant necessity:

> They who marry. . . if the means could be given them of having children without intercourse with their wives, would they not with joy unspeakable embrace so great a blessing? Would they not with great delight accept it?

(Cited in Goergen, 1975)

Augustine not only departed from the Hebrews in denying the pleasures of (marital) sex but in the process also differed from them by showing complete disgust for the human body: "Between feces and urine we are born." Augustine's views on sexual intercourse were shared by nearly all early Christian leaders:

> Arnobius called it filthy and degrading, Methodius unseemly, Jerome unclean, Tertullian shameful, Ambrose a defilement. In fact there was an unstated consensus that God ought to have invented a better way of dealing with the problem of procreation.

(Tannahill, 1980, p. 141)

The Catholic Church's view that the only reason married couples should engage in sex is for procreation was confirmed by Pope John Paul II as recently as 1993 ("Veritatis Splendor") and 1995 ("Evangelium Vitae"). Although not all Christians today are of the same denomination, they all share the same early history, and thus they all have been influenced by the beliefs of Saint Augustine.

"I grew up being told my body was a filthy thing, sex was a sin, and I would burn in hell if I paid any attention to it. Everybody shoved the word 'sin' down my throat and showed disgust at the slightest infraction, real or imagined, of 'God's rules.' The result is that I had an extremely low self-esteem during adolescence, as well as an inner struggle between Mother Nature and the expectations of 'God,' which about drove me nuts."

(from the authors' files)

Personal Reflections

Christian views about sex were strongly influenced by Saint Augustine, who believed that the only legitimate reason to engage in sex was to have children. How do you feel about engaging in sex for pleasure? How do you feel about masturbation? With regard to sexual behavior, how has your religious upbringing affected your opinions about what is right or wrong?

1.2.4 The Victorian Era

The 19th century is often referred to as the Victorian era, after Queen Victoria (1819–1901), who reigned in England for most of the century. It was an era of public prudery and purity. All pleasurable aspects of sex were denied. Influenced by conservative reform ideals of the British Evangelicals in the late 1700s and early 1800s, the Victorians came to view women (who just a few centuries before had been considered sexual temptresses) as asexual (i.e., having no interest in sex) and as innocent as children (Cott, 2002). Men were the ones who were viewed as responsible for lust. According to Victorian moralists, a woman's place was in the home, and wives engaged in sex only to perform their "wifely duties." Women's dresses covered the neck, back, and ankles, and the prudery was carried to such an extreme that even piano legs were covered. At the dinner table, it was considered improper to ask for a "breast" of chicken.

Source: Archival material from Playboy magazine. Copyright © 1993 by Playboy. Reprinted with permission. All rights reserved.

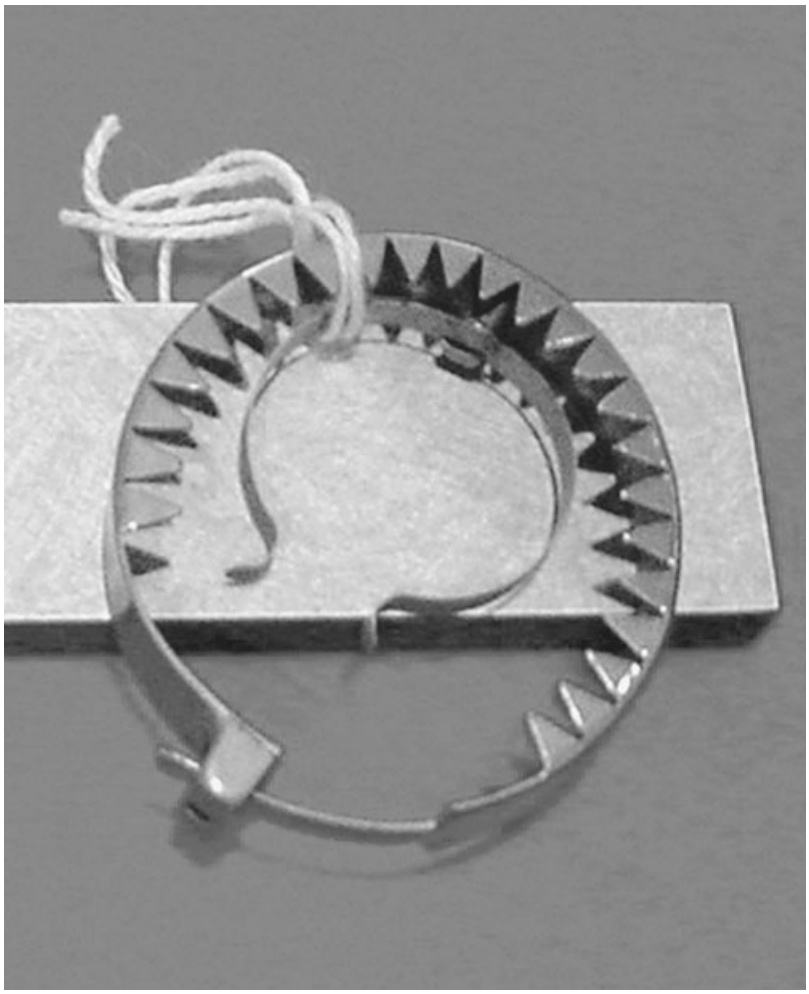
The medical views of the 19th century generally supported the antisexuality of the era. A prominent Swiss physician named Tissot had published a book in 1741 in which he claimed that masturbation could lead to blindness, consumption, other physical disorders, and insanity. As early as 1727, Daniel Defoe had written that excess sex leads to "Palsies and Epilepsies, Falling-Sickness, trembling of the Joints, pale dejected Aspects, Leanness, and at last Rottenness, and other Filthy and loathsome Distempers. . . ." (p. 91). Victorian physicians believed that loss of semen was as detrimental to a man's health as loss of blood, a belief that had originated with the Greek physician Hippocrates (Haller & Haller, 1977). Even the thought of sex was believed to be harmful to a man's health:

> If the thought is permitted to center upon the sexual relation the blood will be diverted from the brain and the muscles and the entire man will suffer because of the depletion. . . .

(Dr. Sylvannus Stall, 1897)

As a result of these beliefs, parents often went to ridiculous lengths to prevent masturbation (Hall, 1992) and nocturnal emissions ("wet dreams," or spermatorrhea, as it was called then), including having their boys circumcised or making them wear antimasturbation devices to bed at night (see Stephens, 2009). Between 1856 and 1932, the U.S. government awarded at least 33 patents for sexual restraint devices (Schwartz, 1973); even more were awarded in England. Three such inventions are shown in Figure 1–4.

Figure 1–4



Three antisex devices invented and patented during the Victorian era: (left) a spermatorrhea ring to prevent nocturnal emission; (middle) a female chastity belt; (right) a male chastity belt.

Source: (left) Courtesy of American Urological Association's Didusch Center for Urologic History, www.urologichistory.museum; (middle and right) Maison Faurie Antiquities

Adults were supposed to show restraint in their desires for sexual intercourse as well, even within marriage. Here is an example of the attitudes that prevailed during that time:

> At this point, dear reader, let me concede one shocking truth. Some young women actually anticipate the wedding night ordeal with curiosity and pleasure! Beware such an attitude! One cardinal rule of marriage should never be forgotten: give little, give seldom, and above all give grudgingly.

(**ruth smythers**, *Instruction and Advice for the Young Bride,* 1894)

The amount of misinformation that was distributed by the medical community during the Victorian era is really quite appalling. For example, a group of British doctors claimed to have evidence that touching a menstruating woman could spoil hams (*British Medical Journal*, 1878). Consider also a book titled *Perfect Womanhood* by Mary Melendy, "M.D., Ph.D.," published in 1903. It was a book of advice for women, and in addition to the usual warnings about masturbation and excessive sex, it contained the following advice about when it was safest to have intercourse (to avoid pregnancy):

> It is a law of nature—to which there may be some exceptions—that conception must take place at about the time of the menstrual flow. . . . It may be said with certainty, however, that from ten days after the cessation of the menstrual flow until three days preceding its return, there is little chance of conception, while the converse is equally true. . . .

As you will learn in Chapter 3, this is not true.

The private lives of most Victorians may not have been as repressed and prudish as the image conveyed by the moralists of that era. A questionnaire given to 45 married women in a study conducted by Dr. Clelia Mosher in 1892 reveals that most of the women desired and enjoyed sex (Jacob, 1981). There was also a great deal of hypocrisy during this era. Prostitution and pornography flourished, and extramarital affairs were common (Trudgill, 1976).

Although Queen Victoria died in 1901, the Victorian era of repressed sexuality continued well into the 20th century. For example, some television shows in the 1950s would show Elvis Presley only from the waist up. During this same time period, television hosts and actors were not even allowed to use the word "pregnant" ("with child" was considered to be the proper term). When Lucy of the *I Love Lucy* show first said "pregnant" on television, it caused a public outrage. With this degree of negativity and repressiveness regarding sex, how did Western culture enter into the sexual revolution?

1.2.5 The Sexual Revolution

It was not unusual for our great-great-grandfathers, whether they worked on the farm or in the city, to put in 12- to 16-hour days, often 6 days a week. Child labor was common, so that many children were also working these hours. In addition to puritanical Victorian ideals, the lack of leisure time limited opportunities for sexual relations.

The industrial revolution slowly changed all this. Mechanization and more efficient means of production eventually led to shorter workweeks, freeing people to engage in leisure activities. The invention of the automobile allowed young people to get away from the watchful eyes of their parents and neighbors. The Great Depression of the 1930s and then World War II in the 1940s again prevented most people from having much

leisure time. The 1950s saw the first peacetime generation of American teens whose families were affluent enough to provide them with an automobile. For the first time, Americans had two things necessary to engage in leisure sex: time and mobility.

The growing women's rights movement eventually resulted in more equality for women, and they began to take an active role in sexual matters (they were not the passive, asexual creatures portrayed by Victorian moralists). With the introduction of penicillin in 1943, people worried less about deadly syphilis and other sexually transmitted infections (Francis, 2013). If they got these diseases, they could now be cured.

In 1960, the birth control pill and the IUD became available, so that having sexual intercourse could be spontaneous and people did not have to worry about unwanted pregnancies. The major impact of this was that the pleasurable aspects of sex could be completely separated from the reproductive aspects. It did not take long before people began to think that one had nothing to do with the other.

As a result of these several factors, we entered the so-called sexual revolution. From the 1940s to the 1980s there was a marked decrease in the average age at which Americans first engaged in sexual intercourse and a dramatic increase in the number of lifetime sexual partners (Liu et al., 2015). This trend continued from the 1980s to the early 2000s (Twenge et al., 2015). The newest generation of Americans to come of age was under pressure not to abstain from premarital sex but to engage in it.

The 1980s saw the emergence of HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) as a worldwide life-threatening infection. However, when the large majority of new cases in the United States were diagnosed in gay men and intravenous drug users, Americans were slow to respond. By the mid-1990s more and more people were becoming aware that the virus leading to AIDS could be spread during heterosexual intercourse, and researchers began to see evidence of what may be a more conservative attitude about sex. Between 1991 and 2015, there was a decline in the number of teenagers who had had sexual intercourse (Kann et al., 2016). As a result, there was also a decline in teenage pregnancies, births, and abortions (Finer & Zolna, 2013). However, the U.S. teenage pregnancy rate is still higher than for any other developed country.

We do not yet know whether these recent trends signal an end to, or a change in, the sexual revolution. Compared to past generations, behaviorally, our society is still permissive, but many people still do not have a positive attitude about their own sexuality. Many of the negative attitudes of the early Christian church and the Victorian era are still with us. Even at the height of the sexual revolution, most parents could not bring themselves to have meaningful discussions with their children about sex. It is no wonder that so many people still have so many questions, doubts, and anxieties about sex.

Personal Reflections

Did Saint Augustine's and the Victorians' views about sex seem strange or silly to you? Do you think people 100 years from now will think what we presently consider as "normal" to be strange?

What Influences Our Attitudes About Sex Today?

1. 1.3 Explain the process of socialization and explain how one socializing agent, the media, has become an omnipresent influence on sexual socialization.

Socialization refers to the manner in which a society shapes individual behaviors and expectations of behaviors (norms). The social influences that shape behaviors are often referred to as socializing agents. These include parents, peers, school, religion, and the media. You have just learned that for centuries religion was the primary socializing agent for sexual attitudes in Western culture. For some teens, this is still true:

"The media has always shown that everyone is having sex, no matter what type or what age. I have never followed the example of the media and that is mainly because of my religious beliefs. I don't believe that sex is wrong. I have just been taught that you wait until marriage."

"I was raised in a Catholic home and I have been taught to wait until marriage, etc. Just because I see something on TV or in a magazine does not want to make me go out and try something."

(All examples are from the authors' files.)

Teens who identify themselves as religious tend to have conservative attitudes about sex, often resulting in waiting until an older age to initiate intercourse (typically with a fiancé or new spouse) (Hull et al., 2011; Pedersen, 2014). Although learning about sex from parents and one's church leaders tends to delay initiation of sex, learning from friends and the media increases the likelihood of engaging in sexual intercourse (Bleakley et al., 2009). In the beginning of the chapter, you learned that the major sources of sexual information for most teens today are friends and the media, and your friends probably got most of their information from the media (American Academy of Pediatrics, 2010; Sprecher et al., 2008).

1.3.1 The Media as a Socializing Agent

Would it surprise you to learn that the average American child spends more than 7 hours a day watching, listening to, or reading some form of the media (Rideout et al., 2010)? When considered together, the sexually related messages received by young people from different branches of the media—television, movies, radio, music, magazines, and tabloids—are omnipresent and pervasive and generally overwhelm the input received from all other sources combined (American Academy of Pediatrics, 2010).

"I would see on television and movies that everyone had sex. That's when I would say I used television to overcome my fear of sleeping with other people."

"To me it's never a question of when to become sexually active. It's always how to become sexually active. What I really mean is that when you are watching television you see some love scenes and they make you want to try the same thing."

"From a young age seeing sexual references and acts on TV clued me in on sex being a lot of fun and highly enjoyable. So sex was something I greatly anticipated. I watched women on shows or movies who were considered sexy and I wanted to be like them."

"I had a very negative attitude towards sex and my body. I was raised with everything being a taboo. Now since I am so into television and movies and magazines, my whole sexual attitude has changed. I have dropped all of the negative attitudes that I was taught and I try a lot of the things that I see in the media."

(All examples are from the authors' files.)

Magazines

You do not have to go to XXX bookstores to find magazines that use sex to make sales. *Penthouse, Hustler*, and other magazines for men are openly sold in drugstores and newsstands. And sell they do, with (double-digit) millions sold every month. Even more mainstream magazines sometimes increase their sexual content to boost sales. *Sports Illustrated* normally sells over 2 million copies a week, but its annual swimsuit issue sells over 5 million.

Many magazines for women also emphasize sex. Nearly all the articles in *Cosmopolitan* are about sex. As an example, the cover of one issue emphasized articles on multiple orgasms ("Yes! Yes! Yes! Cosmo's Come-Again Guide to Help You Climax Over and Over. Read This, Grab Him, and Head to Bed"). Even magazines that target young teen and preteen girls, such as *YM*, often have sexually related articles ("Look Summer Sexy").

Personal Reflections

What effect has the sexual content in magazines and magazine advertisements had on your attitudes about physical attractiveness? Masculinity? Femininity? Sex and what is sexually normal?

Music

In today's music world, it is common for groups and performers to release songs and albums with sexually explicit lyrics. In fact, over one third of the lyrics have sexual (often degrading) references (Primack et al., 2008). Much of this is not even played on the radio because it is so explicit, but it is readily available to teens at retail stores, online, and via YouTube and other video-sharing sites. A survey of undergraduates on a college

campus found that students spent an average of 36 hours a month watching music videos (Ward, 2002). Most music videos contain sexual imagery. What effect do you suppose it has on teens when they watch their favorite rock and pop stars accompanied by sexual imagery?

Personal Reflections

What effect has sexual content in music (and music videos) had on your attitudes about sex? Have you ever wanted to be a rock star? Are rock stars sexier than other people? Why?

Films, Radio, and Television

Since 1980, every R-rated movie directed at teens has included nudity and, frequently, sexual intercourse (Strasburger et al., 2009). The movie industry continues to push the limits of what is considered acceptable. Hollywood did not show women's breasts until the mid-1960s, but by the 1990s films showing women in full frontal nudity were commonplace. Sharon Stone's leg-crossing scene in 1992's *Basic Instinct* caused quite a stir, but since then films with male genitals have become common as well. Heavy sexual content is now commonplace in today's mainstream movies. Are the sex scenes always an integral part of the story, or are they included for gratuitous reasons, to arouse and titillate? Well, according to people who were present when *Basic Instinct* was being filmed, director Paul Verhoeven arrived on the set one day and loudly asked, "How can we put more tits and p— into this movie?" (Zevin, 1992).

> Life does not imitate art; it only imitates bad television.

(from Woody Allen's 1992 movie, *Husbands and Wives)*

The average American child watches television for several hours a day. One expert on communication has described television as "the most powerful storyteller in American culture, one that continually repeats the myths and ideologies, the facts and patterns of relationships that define and legitimize the social order" (J. D. Brown, 2002, p. 44). And what is the primary message that television presents about sex?

Over three fourths of the programs shown at evening prime time have sexual content (70% of the shows that teens rate as their top-20 favorites and almost half of these involve sexual behaviors), with an average of 5.9 scenes per hour (Eyal et al., 2007; Kaiser Family Foundation, 2005; Kunkel et al., 2007). Mostly it is talk about sex, but about 10% of prime-time shows have scenes in which sexual intercourse is depicted or strongly implied. In all, a typical teenager sees 15,000 references about sex each year on television (Strasburger, 2012).

Only about 11% of television shows with sexually related content make any reference to sexual health or responsibility (e.g., unintended pregnancies, birth control, sexually transmitted infections) or risks (Kunkel et al., 2007). It is obvious that television studios find it easier to show pleasure and passion than responsibility and problems. As stated by researcher Jane Brown, "Content analyses suggest that media audiences are most likely to learn that sex is consequence-free, rarely planned, and more a matter of lust than love" (2002, p. 45).

Personal Reflections

How many of the movies and TV shows that you see contain sexual content (behaviors and talk about sex)? How many references a year do you think you see? What effect do you think this has had on your own sexual attitudes and behaviors?

Advertising

Did you know that the average American child sees about 40,000 commercials each year (Robinson et al., 2001)? And that is just on television alone. Many of these advertisements use sexual appeals to sell their products.

Figure 1–5

Rock and pop stars such as Lady Gaga and Miley Cyrus commonly use sex in music videos and on stage to promote themselves. Publishers of popular magazines similarly use sex appeal on the covers to sell their products.

Source: (left) JGM/PacificCoastNews/Newscom; (right) Frank Micelotta/Invision/AP Images; (bottom right) Roberto Herrett/Loop Images Ltd/Alamy Stock Photo

Sex certainly sells, or at least manufacturers of perfumes and colognes, liquor and beer, cigarettes, and clothing think so. People find ads that use sexual appeal to be more attention-getting, more likable, and more persuasive than ads that do not use sexual appeal (Reichert, 2003). People remember sexual ads better as well (Furnham & Mainaud, 2011). As a result, sexual explicitness in ads has risen sharply since 1990 (Reichert, 2003).

Figure 1–7

Many advertisers use sex (in a process called identification) rather than product information to sell their product.

Source: Henry Diltz/Corbis Documentary/Getty Images

The aim of sexy or romantic themes in advertisements is identification, not product information. The message of using young attractive models in sexy or romantic poses is that if you use this product, you too can be sexy and have exciting and romantic interactions. Advertisers argue that the use of models in ads merely reflects the present cultural attitudes.

Most children now have access to the Internet within their own home. Already today the most commonly used search term is *sex*. Over half of American teens have visited a sexually explicit website (Braun-Courville & Rojas, 2009; Brown & L'Engle, 2009; Tsitsika et al., 2009). This material is readily available, and try as they might, many parents have difficulties preventing their children from obtaining it.

1.3.2 Sexual Socialization: Cause and Effect?

What specific evidence is there to support the idea that the media play a major role in sexual socialization? Half of American teens actively seek sexual content in the media (Bleakley et al., 2011). Many studies have found that teens who watch television shows, music videos, or movies with a lot of sexual content are more likely to begin having sexual intercourse earlier than other children (see American Academy of Pediatrics, 2010, for a review). This is true even when other characteristics of individuals are controlled (Collins et al., 2004). A national survey of teens conducted over 3 years found that the teens who watched the most sexual content on TV were twice as likely (12% to 5%) as others to get pregnant or get someone pregnant (again, the experimenters controlled for other known variables) (Chandra et al., 2008).

Figure 1–6

Many radio and TV personalities appeal to young people's interest in sex. Howard Stern (left) emphasizes the crude and vulgar aspects of sex, whereas Dr. Drew Pinsky (right) teaches sexual responsibility.

Source: Mitchell Gerber/Corbis/VCG/Getty Images; Damian Dovarganes/AP Images

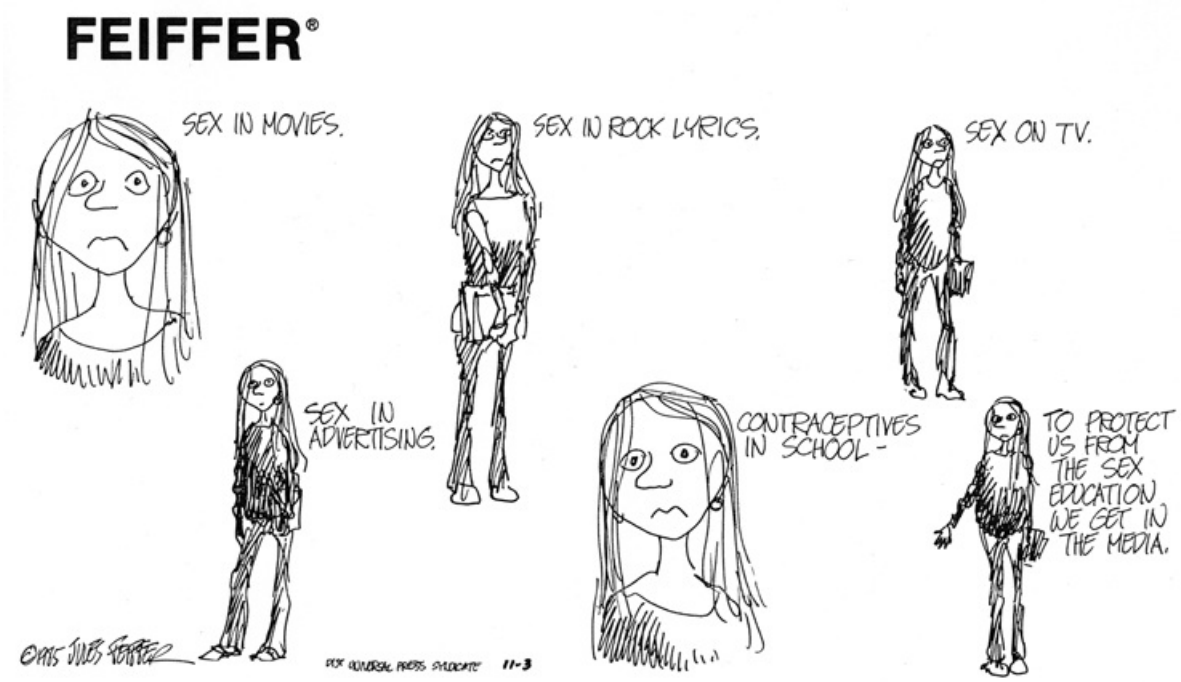
The problem with correlational studies is that we do not know which came first—maybe teens who have a greater interest in sex are drawn to TV shows with sexual content. However, in controlled experiments, teenagers who had just watched television shows with a lot of sexual content gave more positive ratings to casual sex than teenagers who had not been shown the programs (Bryant & Rockwell, 1994) and showed a greater acceptance of sexual stereotypes as well (Ward & Friedman, 2006). As for the question of cause or effect, it probably works in both directions. One study of 14- to 16-year-old teens (that again controlled for other variables) found that sexually active teens were more likely to access sexual content in the media, and that this exposure made it more likely that their sexual activity would increase (Bleakley et al., 2008).

In a review of many studies, Greenberg and Hofschire (2000) concluded that frequent sexual content on television has four major effects on viewers: (1) overestimation of the prevalence of certain sexual activities in the general public; (2) disinhibition—a more liberal attitude about sex; (3) increased interest in sexual issues; and (4) learning about sexual topics.

It is not uncommon for a publisher of a magazine or a producer of a particular television show to deny that his or her product could possibly, by itself, influence the attitudes and behaviors of large numbers of people. They are probably correct, yet at the same time they are missing the point. Kunkel et al. (1999) have summed up the process of socialization very nicely:

> As with most aspects of media influence, the effect of viewing sexual content. . . . is not thought to be direct and powerful, with a single exposure to a particular program [movie, or magazine] leading a viewer to think or act in any given way. Rather, the effects of messages about sex are conceptualized more as the product of a slow and cumulative process. Because such influence tends to be gradual in nature, it is the overall pattern of messages across the [media] landscape that is of primary interest for explaining the effects of long-term exposure. (p. 235)

In other words, the *cumulative effect* is that children take what they see and hear in the media to learn social norms (Brown et al., 1990). One group of communication experts described the mass media as "a kind of sexual super peer" (Brown et al., 2005). The early exposure to media and the huge quantity of information that children receive from the media simply overwhelm the input from other socializing agents. As recently concluded by two experts: "A strong case can be made that in the United States, the media are…the de facto sex educators" (Strasburger & Brown, 2014).



Source: © Jules Feiffer

1.3-3 Full Alternative Text

Personal Reflections

In the three previous Personal Reflections, you were asked about the effects of specific branches of the media on your sexual attitudes and behaviors. You may have denied or minimized the effect of any one branch. Now consider them all together and the fact that you have been bombarded with messages about sex since early childhood. Do you suppose your attitudes about sex would be any different if you had been raised in a culture with no radio, movies, or television or if the media presented a negative portrayal of sex?

Sex as a Science

1. 1.4 Explain the contributions of Sigmund Freud, Henry Havelock Ellis, Alfred Kinsey, and Masters and Johnson to the field of sexuality.

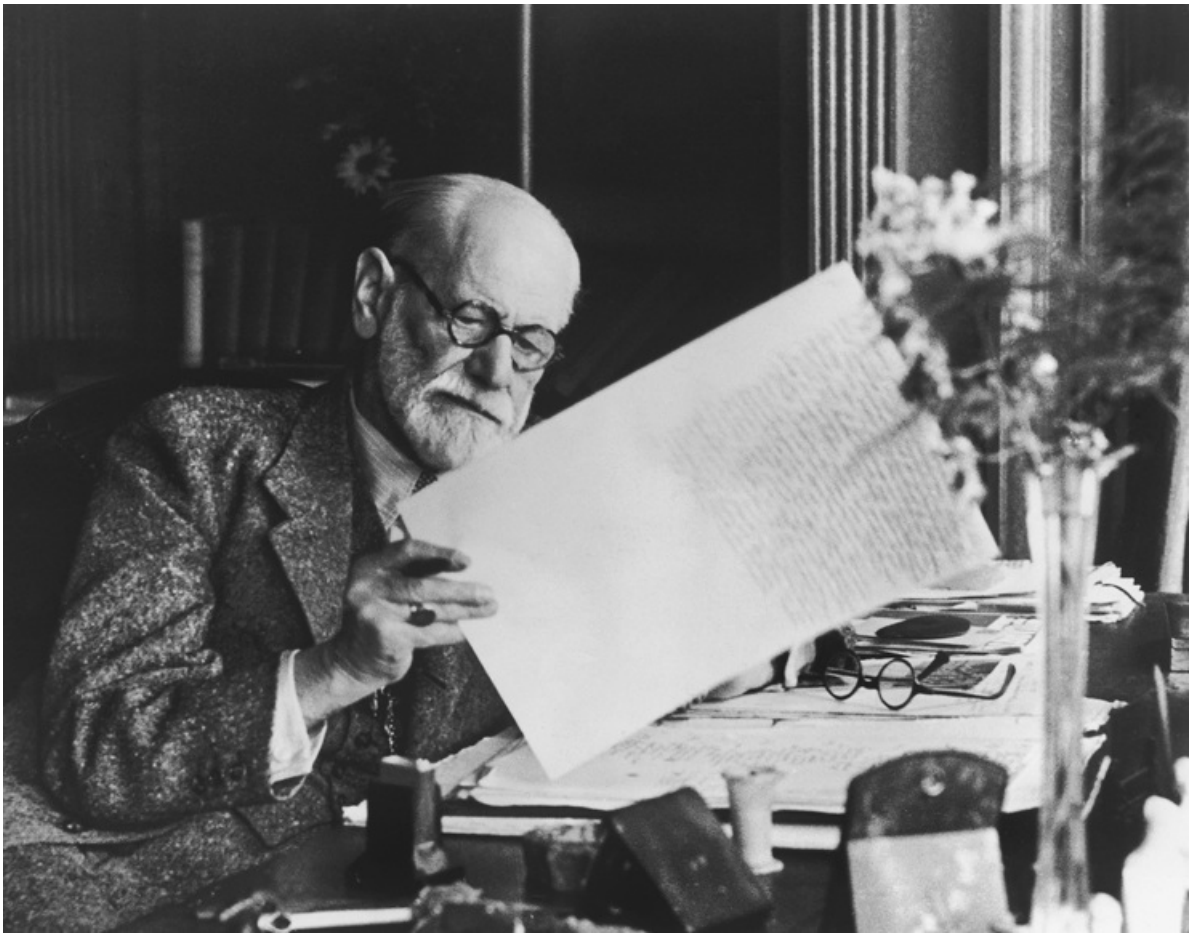
Until the past few centuries, religion was the primary influence in intellectual endeavors. The rise of science was slow and was met with much resistance. Galileo (1564–1642), for example, was forced to publicly recant his support for Copernicus' theory that the earth moved around the sun—and not vice versa, as stated in church doctrine—or face excommunication. People's desire for facts and knowledge could not be stifled, however, and the following centuries saw great advances in the biological and physical sciences. Science slowly replaced religion as the authority on most subjects.

Unfortunately, sexual behavior as a subject for scientific investigation met with more resistance than most others. It was not until the mid-1900s that researchers interested in studying sexual behavior were able to apply the two tools necessary for scientific inquiry: observation and measurement. Let us take a brief look at a few individuals who were responsible for making sexual behavior a serious, objective field of study. Further details of their work will be discussed in later chapters.

1.4.1 Sigmund Freud (1856–1939)

Sigmund Freud, perhaps more than anyone else, is responsible for demonstrating the influence of sexuality in human life (Figure 1–8). It is all the more remarkable that he did so during the antisexual atmosphere of the Victorian era. In actuality, Freud was not a sex researcher. Rather, he merely discussed sexuality as a primary motivation for behavior. Sexual energy—or *libido,* as Freud called it—was said to be channeled into particular areas of the body at different ages. Freud developed psychoanalysis as a means for evaluating and treating unconscious sexual motivations.

Figure 1–8



Sigmund Freud lived during the Victorian era, a period often described as being indiscriminately antisexual. He is given the major credit for showing the importance of sexuality in human behavior and motivations.

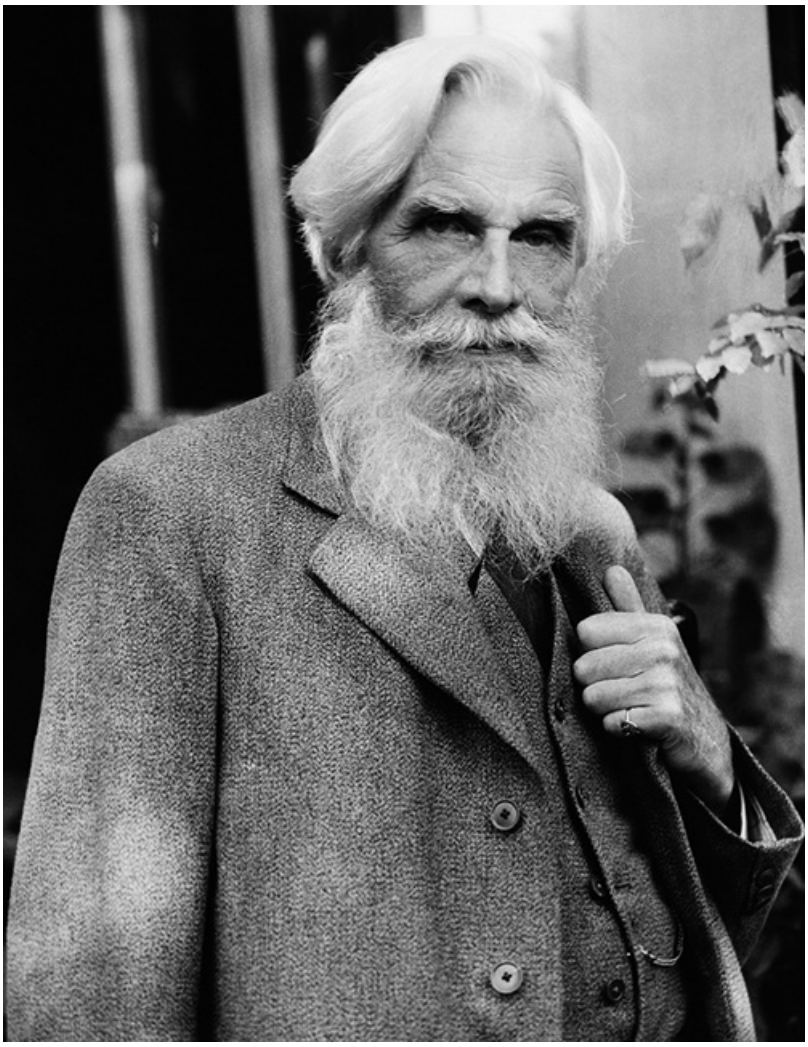
Source: akg-images/The Image Works

Although many people disagree with Freud's theory today (see, for example, Gray, 1993), he remains important for his ideas on sexual motivation and sexuality in infants and children. However, like other Victorian doctors, Freud had many incorrect beliefs about sex, including the belief that loss of semen was as detrimental to a man's health as was loss of blood.

1.4.2 Henry Havelock Ellis (1859–1939)

When he was a young man in the 1800s, Henry Havelock Ellis (Figure 1–9) had frequent nocturnal emissions (wet dreams), which at the time was called spermatorrhea because Victorian physicians believed it was caused by the same thing that caused gonorrhea. The end result, Ellis was told, would be blindness, insanity, and eventual death. He wanted to commit suicide but was too fearful, so instead he kept a diary to document his death by this dreaded "disease." When his eyesight and reasoning did not deteriorate over the passing months, Ellis concluded that loss of semen did not really lead to death, and he became angry about the misconceptions held by the medical profession. He devoted the remainder of his life to sexual research.

Figure 1–9



Henry Havelock Ellis.

Source: Bettmann/Getty Images

As a physician practicing in Victorian England, Ellis collected a large amount of information about people's sexual behaviors from case histories and cross-cultural studies. He eventually published six volumes of a series titled *Studies in the Psychology of Sex* between 1896 and 1910 and a seventh in 1928. He argued that women were not asexual and that men's and women's orgasms were very similar. Ellis was particularly important for his emphasis on the wide range of human sexual behaviors and for his belief that behaviors such as masturbation and homosexuality should be considered normal. His tolerant view of sexuality was in marked contrast to that of the Victorian moralists and was a major influence on researchers for several generations.

1.4.2 Alfred C. Kinsey (1894–1956)

The modern era of sex research did not begin until the publication of Alfred Kinsey's studies (1948, 1953) 20 years after Ellis' last volume. Similar to Ellis' boyhood fears of nocturnal emissions, as a boy Kinsey was greatly afraid he would go insane because he masturbated. Later in life he told a friend, "I decided I didn't want any young people going through the nonsense I went through" (Ericksen, 2000). When asked to teach a course on marriage at Indiana University in 1938, Alfred C. Kinsey was amazed to find how little objective data there were on sexual behavior. He started collecting his own data by giving questionnaires to his students, but he soon decided that personal interviews resulted in a greater amount of more detailed data. He was joined by Wardell Pomeroy, Clyde Martin, and Paul Gebhard, and their work was supported by the Rockefeller Foundation (see Figure 1–10). The final samples had a total of 5,300 men and 5,940 women.

Figure 1–10

Alfred C. Kinsey and colleagues. From left to right: Clyde Martin, Paul Gebhard, Kinsey, Wardell Pomeroy.

Source: Topham/The Image Works

Kinsey's work opened the door to a whole new field of research, but this did not come without a price. His findings that most people masturbated, that many people engaged in oral-genital sex, that women could have multiple orgasms, and that many men had had a same-sex sexual experience shocked many people. He was accused of being antifamily and amoral. One Columbia University professor stated that "there should be a law against doing research dealing exclusively with sex" (*New York Times*, April 1, 1948). Some researchers believe that Kinsey was the major influence in changing 20th-century attitudes about sex (Bullough, 2004). The Kinsey Institute for Research in Sex, Gender, and Reproduction at Indiana University continues to be a major center for the study of human sexuality.

1.4.4 Masters and Johnson

Kinsey paved the way for scientific studies of sexual behavior, but functional anatomy and physiological studies of sex were still limited to experiments with laboratory animals. William Masters (1915–2001), a physician, and Virginia Johnson (1925–2013) (Figure 1–11) did not believe that experiments with rats could tell us a great deal about sexual behavior in people. Therefore, in 1954, Masters and Johnson started to directly observe and record the physiological responses in humans engaged in sexual activity under laboratory conditions. Their results, which were based on over 10,000 episodes of sexual activity of 312 men and 382 women, were not published until 1966 (*Human Sexual Response*). Although some people were shocked at Masters and Johnson's observational approach, calling them "scientific peeping Toms," most people in the medical community appreciated the importance of their findings.

Figure 1–11

William Masters and Virginia Johnson.

Source: Globe Photos/ZUMA Press, Inc./Alamy Stock Photo

As in all other areas of medical science, the understanding of anatomy and physiology led to methods for treating clinical problems and abnormalities. Masters and Johnson developed the first methods for treating sexual problems and opened a sexual therapy clinic in 1965. Their techniques were described in their 1970 book *Human Sexual Inadequacy*. The behavioral approach to treating sexual disorders, based on Masters and Johnson's work, has helped thousands of people to overcome sexual problems.

1.4.5 Edward O. Laumann and the National Health and Social Life Surveys

In 1989, a panel of the National Academy of Science's National Research Council asked federal agencies to fund new surveys of sexual behavior in order to help with AIDS prevention. In the same year, the U.S. Department of Health and Human Services initially approved $15 million for a large survey of 20,000 Americans that would be led by sociologist Edward Laumann. However, U.S. Senator Jesse Helms of North Carolina introduced an amendment in the Senate to eliminate funding for surveys of sexual behavior, and the White House Office of Management and Budget eventually blocked attempts to fund the survey.

Despite the new political obstacles, Laumann and his colleagues Robert Michael, John Gagnon, and Stuart Michaels (see Figure 1–12) eventually received $1.7 million from private foundations, and after scaling down their project, in 1992 they interviewed 3,432 adults (Laumann et al., 1994). Their random sample had a 79% participation rate (very high for this type of survey) and was a good representation of all English-speaking adults aged 18 to 59 living in the United States. In short, the National Health and Social Life Survey was the most comprehensive nationally representative survey to date, as in-depth as the Kinsey surveys but with scientifically sound sampling techniques. Since their initial work, Laumann and colleagues have continued to publish results of their surveys (e.g., Laumann et al., 1997, 1999, 2006, 2009).

Figure 1–12

Robert T. Michael, John H. Gagnon, Stuart Michaels, and Edward O. Laumann. They headed the first sexual survey for which the sample was representative of the U.S. population.

Source: Bruce Powell Photography

1.4.6 The 2010 National Survey of Sexual Health and Behavior

In 2010, the first nationally representative sample of sexual behavior since the 1994 Laumann et al. study was published. The study was conducted by the Center for Sexual Health Promotion, led by Michael Reece, at Indiana University's School of Health, Physical Education, and Recreation. It was a comprehensive study of 5,865 people aged 14 to 94. Unlike previous surveys, much of the data were collected via the Internet. The participation rate was a respectable 52.6% for adults but only 38.2% for adolescents. One of the most important findings was that Americans engage in a wide variety of sexual behaviors. You will see many references to this study in the chapters ahead (see Reece et al., 2010 a, b, c, e).

Personal Reflections

How do you feel about sex as a subject for scientific study? Do you think researchers should ask people about their sexual behaviors? What about physiological studies in which researchers measure bodily responses while people actually engage in various sexual acts?

Scientific Methodology

1. 1.5 Explain the uses and limitations of scientific methodology.

Scientific methodology such as surveys, correlational studies, direct observations, case studies, and experimental research can be used effectively to study human sexual behavior. In this section, we discuss the uses and limitations of each of these methods.

1.5.1 Surveys and Samples

Throughout this book you will see statistics about sexual behaviors (e.g., percentages of people, frequencies of behavior). In order to know such things, it was necessary for someone like Kinsey, for example, to ask people about their sexual attitudes and behaviors. This involves taking a survey. A survey is a study of people's attitudes, opinions, or behaviors. The researcher generally asks a standard set of questions, either in a face-to-face interview or on a paper-and-pencil questionnaire.

The researcher begins by specifying the population—the complete set of observations about which he or she wishes to draw conclusions. The population of interest may be quite large (e.g., all adults living in the United States), or it can be small (e.g., all adults living in a town). If the population of interest is large, it may not be possible to obtain responses from everyone. In this case, the researcher must take a sample (subset) from the population. There have been many surveys of sexual behavior, including surveys done by *Redbook, Cosmopolitan*, and other magazines. Sometimes the results of these surveys agree, but in other cases they disagree, sometimes considerably. Which ones should we trust to be true? Are any of them accurate?

It might seem to make sense to some of you that the accuracy of a survey would depend on the size of the sample (i.e., the number of people surveyed). Although sample size is important, there are other factors that, if not considered, can negate any advantage obtained by using a large sample. One of the most important questions is whether the sample is representative of the entire population. For this to occur, the sample must be taken randomly.

What is random sampling? Does it mean blindly picking names from a phone book or stopping people on the street? No, because these types of samples might have a built-in bias. A random sample is one in which observations are drawn so that all possible samples of the same size have an equal chance of being selected (see King et al., 2011). A special type of random sample is a stratified random sample, sometimes called a *representative sample* because it quite accurately represents the target population. This is the type used by the Gallup and Harris polls to predict the outcome of presidential elections. Before they take their surveys, these polls break the entire country down by sex, race, education, income, geographic location, and many other factors. They know, for example, exactly what percentage of the population is white, Protestant, college-educated, and living in the Northeast. Their sample survey includes this percentage of people with these characteristics. As a result, the Gallup and Harris surveys are rarely off by more than a few percentage points. Yet both polls survey only about 2,500 people out of an estimated 110 million voters.

Kinsey's two studies were quite large, but his samples were not randomly drawn from the U.S. population. They were what is known as *convenience samples*—samples made up of whatever group is available (such as students in a course). Kinsey's samples overrepresented midwestern, white, college-educated people and also included a disproportionately large number of inmates from local prisons. Surveys conducted by magazines are also generally quite large, sometimes with over 100,000 respondents, but are they representative of the country as a whole? One third of the respondents to a 1982 *Playboy* magazine questionnaire said that they had engaged in group sex. Do you really believe this is true for the entire country?

There are more problems in taking a survey of people's sexual behavior than making sure it is representative of the population. Ask yourself the following questions:

1. How often do you masturbate?
2. How many sexual partners have you had in your lifetime?
3. Do you have sexual intercourse in different positions?
4. Do you engage in oral-genital sex?
5. Have you ever had a homosexual experience?
6. Have you ever had an extramarital affair?

Answering some of these questions may have made you feel uncomfortable, for these are very personal questions. How would we know that the people we are surveying are telling the truth? Some people might try to make themselves look good by lying when answering questions about their personal life, so some questionnaires contain "truth items," that is, questions such as "Have you ever told a lie?" It is assumed that everyone has told a lie in his or her life (maybe just a little one), so someone responding negatively to this item would be assumed to be not telling the truth.

Incorrect answers are not necessarily the result of intentional deceit but can also be due to faulty recall. How well do you remember all the events of your childhood, for example? If couples are surveyed, what does the interviewer do if there are discrepancies in the answers given by the two people? How can the interviewer decide who is telling the truth, or is it the case that they both recall events differently?

Some people may exaggerate their sexual experiences. Surveys often find, for example, that the number of female sexual partners reported by men

is greater than the number of male partners reported by women (see Wiederman, 1997). Problems like these can sometimes be minimized if the survey is done by questionnaire rather than by interview and the questions can be answered anonymously; that is, the respondent is assured that no one (including the person doing the survey) will ever know who he or she is (Durant & Carey, 2000).

What do we do when people refuse to participate? In a survey by Morton Hunt (1974), which was an attempt to update Kinsey's data (1948, 1953), only 20% of the people contacted agreed to participate. From a scientific point of view, it is necessary that everyone randomly selected to be in a survey participate in it, but it probably would not surprise you to learn that many people refuse to answer questions like those you just read. We cannot force people to do so. This is the problem of volunteer bias.

In recent years, many researchers have used the Internet to ask people to participate in sex surveys. Are there differences between people who agree to participate in a sex survey and those who do not (McCallum & Peterson, 2012)? In fact, studies have found several differences between people who volunteer to participate in sexual studies and those who refuse. Volunteers had more sexual experiences, were more interested in variety, had a more positive attitude about sex, and had less sexual guilt (Bogaert, 1996; Strassberg & Lowe, 1995). What this means is that the greater the number of people in a survey who refuse to participate, the more cautious we should be in making generalizations about the entire population.

1.5.2 An Example of Problems in Survey Studies: What Do "Sex," "Had Sex," and "Sexual Relations" Mean?

In 1998, when President Clinton appeared on national television to address accusations that he had had sexual relations with Monica Lewinsky, a White House intern, he claimed, "I did not have sexual relations with that woman." Many people assumed that he had lied when it was later discovered that the president and Ms. Lewinsky had engaged in oral-genital relations. But did he really lie?

In a study conducted by the Kinsey Institute, researchers asked students at a midwestern state university, "Would you say you 'had sex' with someone if the most intimate behavior you engaged in was. . . a person had oral (mouth) contact with your genitals?" or ". . . you had oral (mouth) contact with a person's genitals?" (Sanders & Reinisch, 1999). Only 40% of the college students responded that they would say that they had "had sex." Interestingly, 20% of the respondents did not regard penile-anal intercourse as having "had sex." Today, many college students still do not regard oral sex as having sex (Byers et al., 2009; Hans et al., 2010), although they are more likely to regard it as having sex if they are considering their partner's behavior outside the relationship (Sewell & Strassberg, 2015).

". . . about a year into the relationship, after engaging in oral sex, we came very close to actually having sexual intercourse. I stopped because I didn't want to have sex until marriage. . ."

(from the authors' files)

The Kinsey Institute's study makes it very clear that sex researchers must be specific when they use terms such as "sex" or "had sex." Unless otherwise specified (e.g., vaginal intercourse, anal intercourse, oral-genital sex), in this book we will use the terms "*sex*" and "*had sex*" in the way defined by the National Health and Social Life Survey (Laumann et al., 1994):

> . . . By "sex" or "sexual activity," we mean any mutually voluntary activity with another person that involves genital contact and sexual excitement or arousal, that is, feeling really turned on, even if intercourse or orgasm did not occur.

Personal Reflections

Would you tell the truth on a survey about sexual behavior? What if you could answer anonymously? Why or why not?

1.5.3 Correlation

You are probably aware that there is a relationship between performance on certain standardized tests (the SAT or ACT, for example) and freshman-year grades. Correlation is a mathematical measure of the degree of relationship between two variables. Correlations can be either *positive* (increases in one variable are associated with increases in the other) or *negative* (increases in one variable are associated with decreases in the other).

The relationship between two variables is rarely perfect. We all know students who had mediocre scores on their SAT or ACT test but who did very well in college (perhaps because they were exceptionally motivated and worked hard). On the other hand, a few students who do very well on their entrance tests do rather poorly in college (perhaps because they were not motivated). Generally, however, the association is good enough so that colleges and universities can use the test scores to predict performance in school. The greater the correlation between two variables, the more accurately we can predict the standing in one from the standing in another.

Correlations are also found in studies of human sexuality. For example, in their nationally representative survey, Laumann and his colleagues (1994) found that the more sex a married person has, the more likely he or she is to masturbate (a positive correlation). This may be interesting, but there is a major limitation to the correlational method—correlation never proves causation. In the case of the relationship between sex and masturbation, we cannot tell whether frequent intercourse leads to (causes) frequent masturbation or frequent masturbation leads to frequent intercourse. Or maybe there is a third variable that similarly affects both frequency of intercourse and frequency of masturbation. Laumann's group, for example, believed that frequency of intercourse and masturbation was a reflection of a person's overall sex drive. Although we must use caution in drawing conclusions from correlations, they are often very useful in pointing the way to more systematic research.

1.5.4 Direct Observation

You have just learned that one of the main problems with conducting a survey is ascertaining the truthfulness of responses. One way around this problem is to make direct observations of people's behavior. Anthropologists do this when they study the behavior of people of other cultures in their natural settings. This is the type of study that Marshall (1971) did of the Mangaians and Messenger (1971) did of the Inis Baeg. Of course, people may not behave normally if they know that they are being observed (the *observer effect*), so it is necessary for the observer to take great care to interfere as little as possible.

Direct observation studies can also be done in the lab. The classic example is the work of Masters and Johnson, who, you recall, observed over 10,000 episodes of sexual activity in their laboratory in St. Louis (Masters & Johnson, 1966). For Masters and Johnson, the advantage of observing behavior in the lab was that they could make close observations and also take measurements with electrophysiological recording equipment. However, the same limitations apply here as with the previous methods. Were the people Masters and Johnson studied affected by the fact that they knew they were being observed (observer effect)? Are people who would volunteer to have sex under these conditions different from the general population (volunteer bias)? Masters and Johnson were interested in physiological responses, which are probably the same for most people, but we still must be cautious when making generalizations about the entire population.

1.5.5 Case Studies

Clinical psychologists and psychiatrists commonly do in-depth studies of individuals, called case studies. They may gather information from questionnaires, interviews with other persons, and even public records, but most of what they learn usually comes from face-to-face interviews conducted over a long period of time. The goal of a case study is to understand a person's behavior and motivations as much as possible. Some of Freud's case studies—such as the case of Little Hans, a 5-year-old boy who had a great fear of horses—are still read today. Freud eventually concluded that Hans' fear of powerful animals grew out of his masturbatory behavior and was actually a disguise for his fear that his father might cut his penis off.

One potential problem with case studies is that the therapist's observations and conclusions might be biased by his or her own beliefs and values (observer bias). During the Victorian era, for example, Freud and other physicians believed that masturbation was dangerous and would eventually lead to neurosis (Groenendijk, 1997). In today's world, self-exploration is regarded as normal for young children. Do you suppose that a therapist today would attach great importance to Hans' masturbation?

1.5.6 Experimental Research

The biggest limitation of the research methods you have just read about is that none of them can be used to demonstrate cause-and-effect relationships between two variables. To do so, we must use the experimental method. With this approach, the researcher systematically manipulates some variable, called an *independent variable*, while keeping all other variables the same. The variable that is measured is called the *dependent variable*. Typically, the researcher compares two groups (sometimes more). One group receives the experimental treatment and the other (called a control group) does not. If there is any difference between groups in the dependent variable, we can conclude that it was caused by manipulating the independent variable.

While experimental research has advantages over the other methods, it, too, often has limitations. Often, the two groups studied are convenience samples, so we must be cautious about generalizing the results. Moreover, researchers simply cannot use experimental designs to address some questions. We may believe, for example, that an infant's hormone levels shortly after birth strongly influence future sexual orientation, but we cannot purposely manipulate hormones in children in order to prove our hypothesis.

In the chapters ahead you will see references to hundreds of studies. Although each study has its limitations, it is often the case that a particular topic has been studied in numerous investigations using a variety of methods. The more agreement there is among the results of different studies, the safer we can feel about making general conclusions.

Sexuality Education

1. 1.6 Summarize the history of sexuality education.

According to historian Phillippe Ariès (1962), "in medieval society the idea of childhood did not exist." Young children were treated as miniature adults and expected to start working in the fields shortly after they learned to walk. The idea of a separate category called childhood, different from adults, did not arise until the mid-1700s. Although other scholars disagree with Ariès, they agree that the concept of childhood was different than the way we view it in Western culture today. In England during the 1600s, for example, children were believed to be carriers of original sin, prone to evil impulses, and thus childhood was the time of life in which parents and society had to instill control. During the 1700s, this view gave way to the modern view of children as vulnerable and needing protection (Hockey & James, 1993). However, at that time children were considered asexual. Just a century later Freud argued that even young children between the ages of 3 and 5 were sexual. Children now had to be protected from their own sexuality.

The biological immaturity of children is an irrefutable fact, but "childhood is a concept, and it is determined by how a society interprets that biological fact, and by the meanings it attaches to it" (Parsons, 2000). Children of the 1600s, 1700s, and 1800s were understood differently because the concept of childhood was different for each of those time periods. We can see verification of this by examining how other cultures interpret childhood. In the section on cross-cultural comparisons you read about both the Sambian culture in the South Pacific where young boys (starting at age 7) are expected to perform oral-genital sex on adolescent boys (Herdt, 1993) and the Tiwi culture (Melville Island, north of Australia), where girls are married and begin having intercourse at age 7 (Goodall, 1971). Boys of the Batek tribe in northern Sumatra are introduced into sex by masturbating with an older man (Geertz, 1960). Among the Azande of Sudan, boys perform the role of wives to adult warriors (Ford & Beach, 1951). In the Hausa culture of Nigeria, childhood for girls ends abruptly at age 10 when they are married (James et al., 1998). In other cultures (e.g., Chewoy in Malaysia) girls are not regarded as women until they give birth. In our own culture, a person is generally not recognized as an adult until he or she turns 18. Obviously, different cultures attach different meanings to childhood and being a child.

Most of us assume that sex educators teach factual information. But as you have just learned, what is believed to be factual about children's sexuality depends on the culture and the era. What do you suppose sex educators (parents, others) in Mangaia, the most sexually permissive culture in the world, teach children about sexuality? How do you suppose this would differ from what the sex educators among the Inis Baeg, the most sexually repressed culture in the world, teach children?

1.6.1 The History of Sex Education in the United States

In the United States, sex education in schools originated as part of a social hygiene movement to prevent rising levels of sexually transmitted infections (Imber, 1994). The first printed matter for sex education appeared in the early 1900s (see Fitz-Gerald & Fitz-Gerald, 1998). The "education" (lectures and printed matter) was in actuality moralistic and anti-sex, designed to repress sexual behavior (Kyman, 1998). Why? In addition to sexually transmitted infections, recall that the medical profession of that era also believed that loss of semen was harmful to men's health (Stephens, 2009). Masturbation, for example, was called "self-abuse," and physicians believed it to be the cause of insanity. Thus, for sex educators the prevailing philosophy of the day was prophylactics—protection from "distorted knowledge" by teaching restraint (Penland, 1981). Girls, in particular, were to be protected because of their delicate and asexual (pure) nature. The teaching of sexual physiology and hygiene was reserved for boys.

By 1940, the focus of sex education in the United States was changing from prophylactics to personal relationships and long-term adjustment. The curriculum now included a biological component, but the basic approach was still moralistic, focusing on sex within marriage and family life (Penland, 1981). Normal, healthy sexuality was supposed to be expressed only in marriage. As was the case earlier in the century, the basic message was still "Just Say No" (Moran, 2000). Girls were now allowed to take sex education, but classes were almost always segregated by sex (Fine, 1988).

Another generation later the sexual revolution was in full swing. By the mid-1960s, the first scientific surveys and studies had been conducted (e.g., Kinsey and colleagues and Masters and Johnson). The philosophy that emerged among sex educators was a comprehensive sex education presented in a nonjudgmental, impartial manner with open discussion (Kyman, 1998). Girls were now included in the same classes as boys. In addition to sexual anatomy and sexual health, a variety of behaviors were presented as normal (e.g., masturbation, oral-genital sex), so that people could now engage in them without guilt or shame.

It should be obvious from this brief history that what is taught in sex education reflects the prevailing concept of child sexuality of the time. However, sex education is also a powerful socializing agent for children and adolescents; thus, today sexuality education has become a battleground among groups with different moral and political ideologies. Even if sex educators do not openly talk about values, sex education cannot be value-free (Reiss, 1995), and conflict about values is probably inevitable in democratic societies in which there is a diversity of ethnic, religious, and sexual groups.

1.6.2 Debates Over the Curriculum

On one side of the debate are those who wish to guide their children toward their own view of the world and who regard sexuality education as the exclusive right of the family (thus protecting the children from other points of view). This group is guided by the belief that there has been a decline in morals within our society and that only a narrow set of sexual behaviors is normal and moral. They tend to view sexual diversity as part of the problem of moral decline, and their ideology with regard to sex education is to restrict the curriculum.

On the other side are those who favor what is called comprehensive sexuality education. They believe that children should be exposed to a wide

variety of beliefs so that they can make their own choices as to what is best for them.

Nowhere is the battle over curriculum more heated than with regard to the subject of how to prevent teenage pregnancy and sexually transmitted infections. At the heart of this debate is the central issue of the purpose or goal of sexuality education. Those favoring comprehensive education argue that students should be taught about birth control methods and the use of condoms in the interest of public health. Those favoring a restrictive curriculum, on the other hand, see schools as agents of socialization that shape the moral and sexual norms of future generations, and they want sexuality education to promote family values and abstinence.

Nationally, only a small minority of Americans favors abstinence-only education, but politically they have a strong voice (see Constantine, 2008). Abstinence-only programs often have young teens make a formal virginity pledge. Some studies claim that they work (e.g., Bersamin et al., 2005; Martino et al., 2008), but many well-conducted studies have found that any behavioral changes made by abstinence-only programs are only short term and that those who take abstinence-only education and/or virginity pledges are more likely to engage in oral-genital sex (Brückner & Bearman, 2005), less likely to use protection (Lindberg & Maddow-Zimet, 2012), and more likely to get pregnant (Kohler et al., 2008). In 2007, a national study authorized by Congress reported that abstinence-only programs had no effect on whether teenagers engaged in sex (Trenholm et al., 2007).

The National Institutes of Health's (NIH) Consensus Panel on AIDS concluded that "abstinence-plus" programs (programs that teach abstinence, contraception, and the prevention of sexually transmitted infections) are more effective than "abstinence-only" programs (National Institutes of Health Consensus, 1997). Other reviews came to the same conclusion (Kirby, 2008; Stranger-Hall & Hall, 2011).

The American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Nurses Association, and the American Public Health Association have all endorsed comprehensive sex education.

> Telling teenagers, "Wait until you're older to begin having sex, but if you can't wait, use birth control" is a double message. But, it is a double message that every teenager in America can understand and benefit from, and it is consistent with normal adolescent psychology, because it acknowledges that adolescents do not always listen to their elders.

—**american** ACADEMY OF PEDIATRICS, 2010.

Among teens aged 15 to 17, there was a marked drop in pregnancy risk behaviors between 1995 and 2002, and over 75% of the decline was found to be due to improved contraceptive use (Santelli et al., 2007). Nevertheless, between 1998 and 2009, the federal government spent over $1.3 billion on abstinence-only sex education programs (Jayson, 2009b). In most states, this effectively ended teaching about other types of birth control. In 2009, President Obama's administration attempted to stop funding abstinence-only in favor of more comprehensive programs, but funding from Congress has continued and actually increased in 2016 (Hall et al., 2016). As of August 2016, only 24 states required sex education in high schools, and only 13 of those required that it be medically accurate. As a result, the percentage of teens receiving school-based instruction about birth control decreased between 2006 and 2013 (Lindberg et al., 2016).

Source: Paul Fell Cartoons

1.6-4 Full Alternative Text

Many northern European countries introduce sexuality education to schoolchildren as early as elementary school, and these countries have much lower rates of teenage pregnancies than the United States (Sedgh et al., 2015). In these countries teenage sexuality is regarded not as a political or religious issue but instead as a health issue (Kelly & McGee, 1999).

> Adolescent sexual health in these countries is based on values of rights, responsibility, and respect. Government and the general society consider it not only a duty to provide accurate information and confidential contraceptive services to the young, but also that provision of such services and information to adolescents is part of their rights. There is no attempt to motivate behavior of teenagers through a collective effort to demand abstinence. Thus, the goal is not to prevent adolescents from having sex but to educate and thereby empower them to make responsible decisions. By respecting the independence and privacy of adolescents the expectation is that, in return, the majority will act responsibly to try to avoid pregnancy and sexually transmitted infections.

(Lottes, 2002, pp. 80–81)

Often left out of the debate are the opinions of young people themselves. Most teens want to receive sexual health education in school. Here are some opinions of students in our own course:

"I believe human sexuality should be taught in public schools. The media exposes young people to every imaginable kind of sexual topics already."

"I think that sex education should be included in public high schools. . . . I knew girls that actually thought urinating after sex or bathing after sex prevented pregnancy. I think it is vital that teens know the real truth about a very important issue."

"Yes, because it gives students, especially at that age, the ability to learn about sex without feeling stupid because their friends know more than they do."

"Ignoring the fact that teens have sex will never help them to be responsible. By giving them knowledge of the consequences and responsibilities that go along with having sex, they are more inclined to make a better decision."

(All examples are from the authors' files.)

Today, young people have their own culture—they interact electronically. Without opportunities for formal sex education, many young people are turning to the Internet and social media. Although not all Internet sites provide good information, there are many excellent online sites (see Resources at the end of the chapter), and most teens are able to evaluate the sources well (Simon & Daneback, 2013). When used properly, Internet-based interventions can be effective in promoting sexual health knowledge and behavior change (Guse et al., 2012; Jones et al., 2014; Simon & Daneback, 2013; Swanton et al., 2015).

As a student at a college or university, you were probably not required to take this course. When you enrolled, you exercised your freedom of choice. In this text, we will provide accurate information and attempt to make you aware of the diversity in sexual behavior and values. We do not advocate one lifestyle over another or one set of values over another. Our goal for you is that, upon completion of this course, you will feel more comfortable with your own sexuality and at the same time find a tolerance and respect for the beliefs of others.

Personal Reflections

Do you believe that sexuality education should be taught in school? If not, why not? If so, beginning at what level? Why?

Study Guide

Key Terms

- Alfred C. Kinsey
- case study
- correlation
- direct observation
- dualism
- ethnocentric
- experimental method
- Henry Havelock Ellis
- identification
- Masters and Johnson
- missionary position
- observer bias
- population
- procreation
- random sample
- Saint Augustine
- sample
- sex, "had sex"
- sexuality
- sexual revolution
- Sigmund Freud
- socialization
- socializing agent
- stratified random sample
- survey
- Victorian era
- volunteer bias

Interactive Review

Answers can be found on p. 468.

1. Some people feel that sexuality education should be the responsibility of parents, yet fewer than one third of college students report ever having a meaningful discussion with their parents about sex. Most young people turn to (1) _____ and (2) _____ for information about sex, but much of what they learn is incorrect. The best alternative would be for children to receive factual information in school. Surveys indicate that more than (3) _____ % of Americans favor sexuality education in school.

   Sex is only a part of (4) _____, which encompasses all of the sexual attitudes, feelings, and behaviors associated with being human. Sexual behaviors and attitudes (such as what is considered to be sexually attractive) vary from culture to culture and can even change within a culture over time. American sexual attitudes are both permissive and repressed, and as a result many people in the United States have

ambivalent feelings about sex.

The idea that the primary purpose of sex is for procreation (to have children) originally came from (5) , who also had a very positive attitude about their bodies and sexual pleasure between husbands and wives. The early (6) affirmed the procreational purpose of sex but completely denied its pleasurable aspects. Sexual desire, even within marriage, was now associated with guilt. The biggest proponent of this view within Christianity was (7) . In Western culture, negative attitudes about sex reached their zenith during the reign of (8) of England. During this time, the medical profession contributed many incorrect negative beliefs about engaging in sex, including the belief that excess sex, particularly masturbation, could lead to serious medical problems and eventually to insanity.

The industrial revolution slowly changed Americans' lives, including their sex lives. With shorter workdays and workweeks and greater mobility (e.g., automobiles) than in past generations, people now had more free time to spend together. With the availability of (9) during World War II and the marketing of (10) in 1960, the United States entered the sexual revolution.

The manner in which society shapes behaviors and attitudes is called (11) . There is probably no other socializing agent with as much of an impact on young people's sexual attitudes and behaviors as (12) , especially television. Many advertisements, whether on television, in magazines, or online, provide little product information but instead use sex to sell their products in a process called (13) Sexual socialization does not occur as a result of a single exposure but instead is a slow and cumulative process. The sexual content in the media is omnipresent, but the manner in which sex is portrayed may be just as important as the quantity.

Because of the antisexual attitudes of the Victorian era, scientific study of human sexuality was slow to develop. (14) , who emphasized the sexuality of all people, including children, and (15) who published seven volumes about the psychology of sex, were two researchers of the Victorian era who attempted to counter antisexual attitudes. However, it has only been within the past 60 years that the scientific and medical communities have accepted sex as a subject for serious discussion and research. The first large-scale surveys were done by (16) in the 1940s and early 1950s. (17) published their physiological investigations of human sexual behavior in 1966.

Sexuality education is a socializing agent, and thus today it is mired in controversy, with those who favor abstinence-plus education opposed by those who favor abstinence-only education.

Self-Test

Answers can be found on p. 468.

A. True or False

- **T F** 18. The Old Testament presents a positive view of sex within marriage.
- **T F** 19. American sexual behaviors are considered to be the norm by the rest of the world.
- **T F** 20. Because of AIDS, all states now require that public schools offer education about sexually transmitted infections.
- **T F** 21. The larger the number of people in a survey, the more accurate it always is.
- **T F** 22. All cultures consider women's breasts to be highly erotic.
- **T F** 23. Kissing is one sexual behavior that is done worldwide.
- **T F** 24. One good method of obtaining a random sample is to randomly pick names from a phone book.
- **T F** 25. Half of all Americans will get at least one sexually transmitted infection in their lifetime.
- **T F** 26. Over half of all American teenagers have had sexual intercourse by the time they graduate from high school.
- **T F** 27. The era of permissiveness known as the "sexual revolution" started during the Victorian era.
- **T F** 28. Kinsey's surveys are a good example of the use of random sampling techniques.
- **T F** 29. A strong positive correlation between two variables is evidence of a cause-and-effect relationship.
- **T F** 30. Starting in the 1990s, there has been a decline in the percentage of teenagers engaging in sexual intercourse and in teenage pregnancies.
- **T F** 31. According to historian Phillippe Ariès, the idea of childhood did not exist in medieval society.
- **T F** 32. The biological immaturity of children is an irrefutable fact, but childhood is a social concept.
- **T F** 33. In some cultures girls are expected to marry and begin having intercourse before puberty.

- **T F** 34. Children who watch a lot of television shows with sexual content are no more likely than others to have begun sexual intercourse.
- **T F** 35. In a controlled experiment, teenagers who had just watched television shows with a lot of sexual content gave more negative ratings to casual sex than teens who had not watched the programs.

B. Matching

- 36. A Victorian-era physician who emphasized the sexuality of children and adults
- 37. He viewed sex for procreation as an unpleasant necessity and equated guilt with sexual desire
- 38. Conducted the first large-scale physiological study of human sexual behavior
- 39. They believed that the purpose of sex was for procreation, but had a very positive attitude about sexual relations between a husband and wife
- 40. They believed in an ascetic philosophy: Wisdom and virtue come from denying physical pleasures
- 41. He conducted the first large-scale survey of American sexual attitudes and behaviors
- 42. A Victorian-era sex researcher with a tolerant attitude about sexuality
- 43. They held antisexual attitudes that were reinforced by the mistaken medical beliefs of that time
- 44. He headed the first survey of a nationally representative sample of adults living in households

1. Henry Havelock Ellis
2. Edwardians
3. ancient Greeks
4. Jesus
5. Sigmund Freud
6. Masters and Johnson
7. biblical Hebrews
8. Puritans
9. Victorians
10. Saint John
11. Saint Thomas Aquinas
12. Alfred Kinsey
13. Saint Augustine
14. Edward Laumann

C. Fill in the Blanks

- 45. Anthropologists believe the most sexually repressed society in the world to be the .
- 46. Four important influences that led to the sexual revolution were (a) , (b) , (c) , and (d) .
- 47. A random sample is properly defined as a sample drawn from a population in a manner so that has an equal chance of being selected.
- 48. A major influence on early Christian thought was the Greek philosophy of dualism, which separated and .
- 49. Victorian physicians called nocturnal emissions because they believed they were caused by the same thing that causes gonorrhea.
- 50. In the National Health and Social Life Survey (Laumann et al., 1994), "sex" or "had sex" was defined as .
- 51. has been called "the most powerful storyteller in American culture, one that continually repeats the myths and ideologies, the facts and patterns of relationships that define our world and legitimize the social order" (Brown, 2002).

Suggested Readings and Resources can be found on p. 459.

Chapter 2 Our Sexual and Reproductive Anatomy

> When most people think of body image, they think about aspects of physical appearance, attractiveness, and beauty. But body image is so much more. It's our mental representation of ourselves; it's what allows us to contemplate ourselves. Body image isn't simply influenced by feelings, and it actively influences much of our behavior, self-esteem, and psychopathology…. Indeed, our body is our personal billboard.

—David Garner, Psychology Today

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 2.1 Describe each part of the external female anatomy—mons veneris, labia majora, labia minora, clitoris, and vaginal and urethral openings—and explain its function(s).
2. 2.2 Explain why early detection of breast cancer can save lives and describe how to perform a breast self-examination.
3. 2.3 Describe each of the female internal anatomical structures—vagina, uterus, Fallopian tubes, and ovaries—and explain its function(s).
4. 2.4 Explain the importance of pelvic examinations and Pap smears for women's health.
5. 2.5 Describe each of the structures of the external male anatomy—penis and scrotum—and explain its function(s).
6. 2.6 Discuss the advantages and disadvantages of circumcision of the penis.
7. 2.7 Describe each of the male internal anatomical structures–testicles, epididymis, vas deferens, ejaculatory ducts, urethra, prostate gland, seminal vesicles, and Cowper's glands—and explain its function(s).
8. 2.8 Describe how to perform a testicular self-examination.
9. 2.9 Identify the early signs of prostate problems and understand the importance of regular prostate examinations for men's health.
10. 2.10 Explain why having a positive body image is important to sexual health.

Many of the first words that we learn are anatomical terms. Parents often spend hours teaching their young children to point to and name different parts of the body, such as the mouth, eyes, ears, and nose. Unfortunately, when naming body parts, many parents simply skip from arms, chest, and "tummy" to legs, knees, and feet, completely omitting any mention of the genitals and anus. Other parents teach their children the correct anatomical words for all other parts of the body but substitute such "cute" words as "weeney," "booty," "peanut," and "talleywacker" for the genitals (see Martin et al., 2011). As for the functions of this mysterious body area, many of us are simply taught during toilet training to make "pee-pees" and "poo-poos."

As we grow older, we learn new words from our peers that describe our sexual anatomy and behavior, but quite often these are slang terms. Men are more likely than women to use slang terms when referring to genitalia (and generally use a greater number of terms) (Braun & Kitzinger, 2001; Fischer, 1989). Many of the slang terms have negative connotations. Interestingly, both men and women are likely to have a negative opinion of those who use sexually degrading terms for female genitals (Murnen, 2000).

Slang terms can also result in misinformation about sexual anatomy and behavior. In response to an item on a questionnaire given on the first day of our class, many students indicated that they believed that an erection in men occurs when a bone protrudes from the base of the penis. This belief should not be surprising, for after all, why else would an erection be called a "boner?" Slang terms such as "cherry," "nuts," and "pussy" can be misleading.

There is perhaps no better example of the distorted negative attitudes that some people have toward sex than the common use of the word "fuck" instead of intercourse. It is frequently used to express displeasure ("What the fuck is going on here?"), trouble ("I got fucked over at work"), or aggression ("Fuck you!"). At many other times we think of sexual intercourse as a pleasurable experience. The word "fuck" probably originated from the Middle English word "fucken." At one time its use was not considered improper, but the word acquired negative connotations in the mid-1600s.

It is not our intent to teach "dirty" words or slang terminology. In fact, people who take courses in human sexuality often end up using the proper terms more frequently (Fischer, 1989). We must acknowledge the fact, however, that many of us come to class with a sexual vocabulary that consists almost entirely of slang words. The question that many students have, of course, is "What good will it do to learn the correct anatomical terms, which are almost always Latin or Greek?" The lack of such knowledge obviously does not hinder most people from becoming sexually experienced. Learning correct anatomical terms may result in our becoming less inhibited about our own bodies and those of our partners. Many people are so ashamed of their genitals that they do not consider their genitals to be a positive part of their anatomy. This is more often true of women than men (Herbenick, 2009; Reinholtz & Muehlenhard, 1995). Here are a few comments that we have received from students:

"As for the illustrations in Chapter 2, I thought they were good and very well illustrated, but they were rather embarrassing to look at."

"Figure 2–3 made me feel uncomfortable. I felt as if everyone could see me."

"The pictures in this chapter were quite graphic. I wish they were on another separate page so that we wouldn't have to look at them the entire time we read a particular page. Even just reading this by myself was a little embarrassing."

"I had difficulties looking at the pictures without embarrassment and shame. I should be able to look without any bad feelings."

(All examples are from the authors' files.)

No one should feel embarrassed or ashamed about any part of his or her own body, including the genitals. If you have never done so, we encourage you to examine yourself during this part of the course.

Personal Reflections

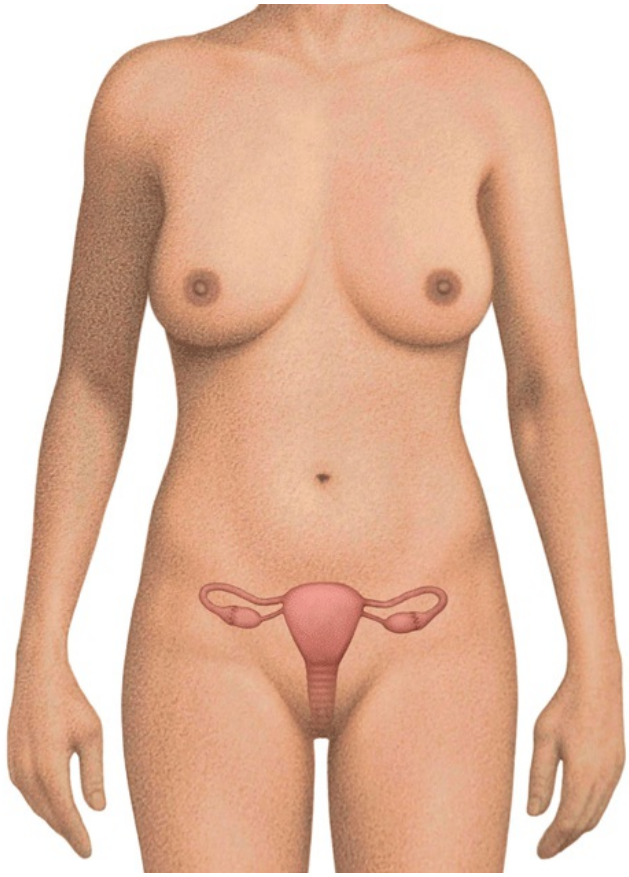
Do you use sexual slang terms (a) to refer to your genitalia or (b) when you are upset? Why? If you do, list the terms you use, and then write down the correct word next to each. Say each correct term out loud a few times. Are you comfortable or uncomfortable doing this? Could you use these terms in normal conversation without being embarrassed or uncomfortable? If you cannot, why not? After all, you probably use the slang terms.

External Female Anatomy

1. 2.1 Describe each part of the external female anatomy—mons veneris, labia majora, labia minora, clitoris, and vaginal and urethral openings—and explain its function(s).

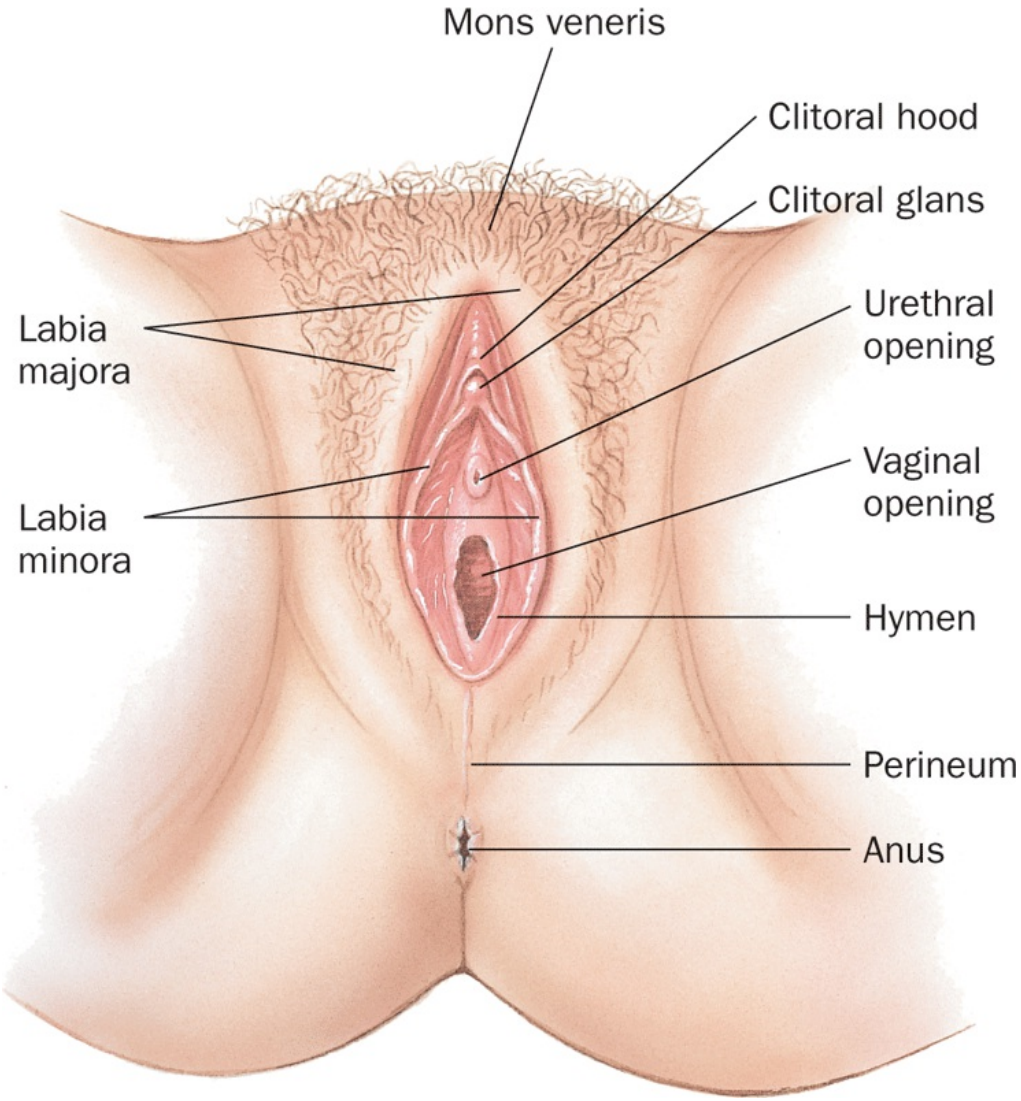
You can see the location of the female reproductive system in Figure 2–1. A picture of the external female genitalia, collectively known as the vulva (Latin for "covering"), is shown in Figure 2–2. The vulva consists of the mons veneris, the labia majora, the labia minora, the clitoris, and the vaginal and urethral openings. When examining herself (which requires use of a hand mirror), a woman should not consider herself to be abnormal if she does not look identical to the drawing in Figure 2–2. As with all other parts of the body, women's genitalia vary in appearance from person to person, differing in size, shape, and color (see Figure 2–3). The positive or negative feelings that a woman has toward her genitalia are directly related to her participation in and enjoyment of sexual activity (Reinholtz & Muehlenhard, 1995).

Figure 2–1



Anatomical location of the female reproductive system.

Figure 2–2



The female genitalia (vulva), with the labia parted to show the vaginal and urethral openings.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Figure 2–3

Some variations in the appearance of female genitalia.

Source: John R. Foster/Science Source; Daniel Sambraus/Science Source; Medicshots/Alamy Stock Photo

2.1.1 The Mons Veneris

Translated from Latin, mons veneris means "mount of Venus." The term refers to the soft layer of fatty tissue overlaying the area where the pubic bones come together. Venus, of course, was the Roman goddess of love, and the mons area is considered to be very erotic after puberty, when it becomes covered with hair.

Our sensitivity to touch is dependent on the density of nerve endings in a particular area of skin. Areas such as the lips and fingertips have a high density of nerve endings and thus are very sensitive to touch, while areas such as the back have a much lower density of nerve endings and are much less sensitive to touch. Because of numerous nerve endings in the mons area, many women find gentle stimulation of the mons pleasurable.

The soft layer of fatty tissue cushions the pubic region during intercourse, but one can only speculate as to what is the purpose of *pubic hair*. Some researchers believe that this pocket of hair on an otherwise mostly hairless body is meant to be sexually attractive.

Until the 1970s, it was uncommon for women to shave their pubic area. This changed as bikini bottoms and panties became smaller. At first, women just trimmed their pubic hair or got bikini waxes, but today it is common for young women to shave or wax most or all of their hair (Herbenick et al., 2010b; Smolak & Murnen, 2011). The most common reasons given are cleanliness and sexual attractiveness (Butler et al., 2015). Unfortunately, this has led many people to have negative attitudes about women who do not shave, and many women now feel pressured to do so. Here are some representative attitudes from students in our course.

Men:

"I don't have any preference when it comes to women's pubic hair. Sometimes shaved can be more attractive, but both are equally acceptable."

"Personally, I like hair. To me it looks more appealing with hair on the vagina. But too much hair is a turn off. I like hair to be trimmed."

"I do not like women's pubic hair at all. It is much more attractive to see a girl with none. Pubic hair can sometimes be a turn off."

“I feel that female pubic hair is gross. I can’t imagine playing in a jungle, so I feel that it’s common courtesy for a woman to at least trim.”

“My girlfriend doesn’t shave and I’m glad. I’ve been with a woman who did, and it seemed weird—she was like a little girl down there. I prefer a woman who looks like a woman.”

Women:

“I am a very neat person when it comes to my appearance. Since women shave their underarms and legs, why not shave other body parts too? Being smooth and hairless makes me feel sexy.”

“I shave pubic hair because it is gross and annoying. I do not see why it is any different than shaving your legs. Plus pubic hair gets in the way during menstruation.”

“I don’t shave at all. I like my body the way it is—and that includes my vaginal area. It’s never been an issue for any of my partners, either.”

“I shave my bikini area, but not completely. If a man doesn’t like it, he can get over it.”

“Anytime a girl becomes sexually active, they become very insecure about what their partner will think of their body, especially pubic hair. Shaving is painful, time consuming, and just a nuisance. Most girls assume guys like shaven because that’s how most women in the media are portrayed. Models wearing next to nothing; it’s obvious they shave, but most women aren’t models and don’t need to be hairless for a photo shoot. Pubic hair is part of a woman’s body and should be embraced, not something to be ashamed of.”

(All examples are from the authors’ files.)

Personal Reflections

What do you think have been the major socializing agents leading to the change in attitude about women’s pubic hair during the past 3–4 decades? Is this change in attitude good? Should women be made to feel self-conscious or ashamed about yet another part of their bodies?

2.1.2 The Labia

The labia consist of two outer (labia majora, or major lips) and two inner (labia minora, or minor lips) elongated folds of skin, which, in the sexually unstimulated state, cover (and thus protect) the vaginal and urethral openings. The labia majora extend from the mons to the hairless bit of skin between the vaginal opening and the anus, called the perineum. The outer surfaces of the labia majora become covered with hair at the time of puberty. After childbirth it is not uncommon for the labia majora to remain separated to some extent in the unstimulated state.

The pinkish and hairless labia minora are located between, and sometimes protrude beyond, the labia majora. Among some African groups, elongation of the labia minora is considered to be highly erotic, and girls are taught to pull on them from early childhood (Pérez et al., 2015).

The labia minora, which meet at the top to form the clitoral hood (or *prepuce*), are very sensitive to touch. They have numerous blood vessels that become engorged with blood during sexual stimulation, causing them to swell and turn bright red or wine colored.

Located at the base of the labia minora are the Bartholin’s glands, which, during prolonged stimulation, contribute a few drops of an alkaline fluid to the inner surfaces via ducts. The small amount of fluid does not make a significant contribution to vaginal lubrication during sexual intercourse, but it does help to counteract the normal acidity of the outer vagina (sperm cannot live in an acidic environment).

Piercing of the labia and clitoral hood has become increasingly popular in recent years. However, the practice is associated with a significant number of problems (Meltzer, 2005). Unfortunately, today some women are having genital plastic surgery (“designer vagina”—but actually called labiaplasty) because they have such negative attitudes about the appearance of their genitals (Deans et al., 2011).

2.1.3 The Clitoris

The clitoris (from a Greek word meaning “hill” or “slope”) develops from the same embryonic tissue as the penis but has twice as many nerve endings as the much larger penis, making it extremely sensitive to touch. In fact, it is the only structure in either men or women with no known function other than to focus sexual sensations (Masters & Johnson, 1970). The only visible portion is the *glans,* which in a sexually unaroused woman looks like a small, shiny button located just below the hood of skin formed where the two labia minora meet.

The body, or *shaft,* of the clitoris is located beneath the clitoral hood. It is about 1 inch long and one-quarter inch in diameter. The clitoris contains two parallel cylinders of spongy tissue called *corpora cavernosa,* which, toward the rear, form much larger structures called *crura* (Latin for “legs”) that fan out and attach to the pubic bone (O’Connell & DeLancey, 2005). The spongy tissues of the clitoris become engorged with blood during sexual arousal. This causes the clitoris to increase in size, but because of the way it is attached to the pubic bone, the clitoris does not actually become erect like the penis. If sexual stimulation continues, the clitoris pulls back against the pubic bone and disappears from view beneath the clitoral hood.

Experts have long believed that women’s sexual pleasure is not related to the size of the clitoris or other anatomical features that allow for direct stimulation by a penis (such as a shorter distance between the clitoral glans and the vaginal opening) (Money, 1970). Although one recent study suggests that such features may play at least some role in women’s sexual pleasure (see Oakley et al., 2014), the reality is that the penis usually does not come into direct contact with the clitoris during (heterosexual) sexual intercourse.

Surgical removal of the clitoris was sometimes performed in the United States and Europe during Victorian times in order to prevent girls from masturbating and growing up “oversexed.” *Clitoridectomy* is no longer legally performed in America, but it is very common in Northern African countries and parts of the Middle East, Malaysia, and Indonesia (see Box 4–A).

Thick secretions called *smegma* can accumulate beneath the clitoral hood and result in discomfort during sexual intercourse by causing the glans to stick to the clitoral hood. The secretions can generally be washed off, however, by bathing thoroughly.

2.1.4 The Vaginal Opening

The vaginal and urethral openings are visible only if the labia minora are parted. The area between the two labia minora is sometimes referred to as the vestibular area (Latin for “entrance hall”) and the vaginal opening as the *introitus* (Latin for “entrance”). The vaginal opening has lots of nerve endings and thus is very sensitive to stimulation. It is surrounded by the bulbocavernosus muscle, a ring of sphincter muscles similar to the sphincter muscles surrounding the anus. Sexually experienced women can learn to

voluntarily contract or relax these muscles during intercourse. In sexually inexperienced women, on the other hand, these muscles may involuntarily contract as a result of extreme nervousness, making penetration very difficult. The vestibular bulbs, which are located underneath the sphincter muscles on both sides of the vaginal opening, also help the vagina grip the penis by swelling with blood during sexual arousal.

In sexually inexperienced women, a thin membrane called the hymen (named after the Greek god of marriage) may partially cover the opening to the vagina. This membrane is found only in human females. Until shortly before birth, the hymen separates the vagina from the urinary system. It ruptures after birth but in humans remains as a fold of membrane around the vaginal opening. It is found in all normal newborn girls (Berenson, 1993). The hymen has one or more openings that allow for passage of menstrual flow. In the rare instance that the hymen has no opening, a simple surgical incision can be made at the time of first menstruation.

The hymen has no known physiological function, but the presence of the hymen has been used by men throughout history as proof of virginity (Blank, 2007). In the time of the biblical Hebrews, a newlywed woman who did not bleed during first intercourse was sometimes stoned to death:

> But if the thing is true, that the tokens of virginity were not found in the young woman, then they shall bring out the young woman to the door of her father's house, and the men of her city shall stone her to death with stones, because she has wrought folly in Israel by playing the harlot in her father's house....

(deuteronomy 22:20–21, Revised Standard Version)

Even today, in many parts of the world a newlywed wife can be divorced or exiled if her husband believes her to be unchaste. Many Muslims, Chinese, and Moroccans display a bloodstained sheet on the wedding night as proof of a new bride's chastity. In other cultures, girls are ritually "deflowered" with stone phalluses or horns. Although these extreme customs are not found in Western culture, many American men nevertheless expect their female partners to bleed during first intercourse, so much so that some sexually experienced women elect to have a hymen surgically reconstructed before marriage (Goodman, 2011).

"When my girlfriend and I first had intercourse it was just understood by listening to my peers that she was supposed to bleed and I should see some kind of skin hanging (hymen). This didn't happen and for years it bothered me because I thought she lied to me when she told me that I was her first. It wasn't until after taking this course that I realized how ignorant my friends and I were."

"Being very athletic came natural for me and by the time I was 12, I had won four athletic trophies and many certificates. My mother took me to a doctor right after I turned 14 and he told her that I was not a virgin because my hymen was not in place. I cried for 2 weeks. It was not true. My life was very traumatic for the next 6 months. Now at 40 years old, I am still angry."

(All examples are from the authors' files.)

In actuality, there is often very little bleeding or discomfort during first sexual intercourse. The hymen sometimes ruptures during insertion of a tampon, and in some women the opening in the hymen only stretches rather than tears during first intercourse (thus there would be no bleeding). Untold millions of women throughout history have probably suffered much grief (and even death) for failing to display what many men wrongly believe is the appropriate response to first intercourse.

2.1.5 The Urethral Opening

Urine passes from the bladder through a small tube called the urethra and out the urethral opening, which is located below the clitoris and above the vaginal opening. A man's urethra serves for the passage of sperm as well as urine, but a woman's urinary system is not related to her reproductive system. Women are more susceptible to urinary tract infections than men. Many factors increase the risk, including recent sexual intercourse and rectal bacteria (see Chapter 5).

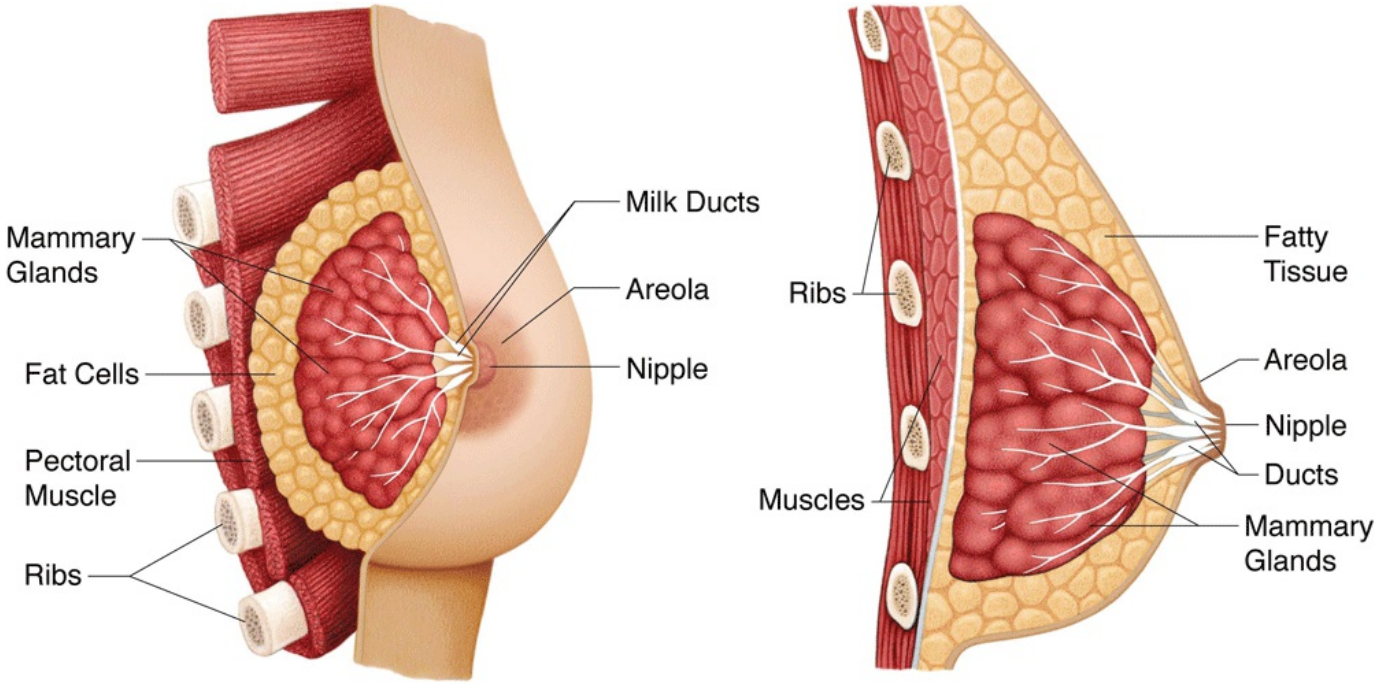
2.1.6 The Breasts

Although breasts are not part of a woman's reproductive system, they are considered to be highly erotic by most men in Western societies, and therefore we must consider them part of a woman's sexual anatomy. Recall from Chapter 1, however, that women's breasts have no erotic significance in many cultures around the world.

Breasts develop at puberty as a result of increasing levels of the hormone *estrogen*, which is produced by the ovaries. Thus, the breasts are really a secondary sex characteristic, just as pubic hair is. Interestingly, it is common for one breast (usually the left) to be slightly larger than the other.

Each adult breast consists of 15 to 20 mammary (milk-producing) glands (see Figure 2–4). A separate duct connects each gland to the *nipple,* which is made up of smooth muscle fibers and also has lots of nerve fibers (making the nipples sensitive to touch). When a woman becomes sexually aroused, the smooth muscle fibers contract and the nipples become erect. The darkened area around the nipple, called the *areola,* becomes even darker during pregnancy. The small bumps on the areola are glands that secrete oil to keep the nipples lubricated during breast-feeding.

Figure 2–4



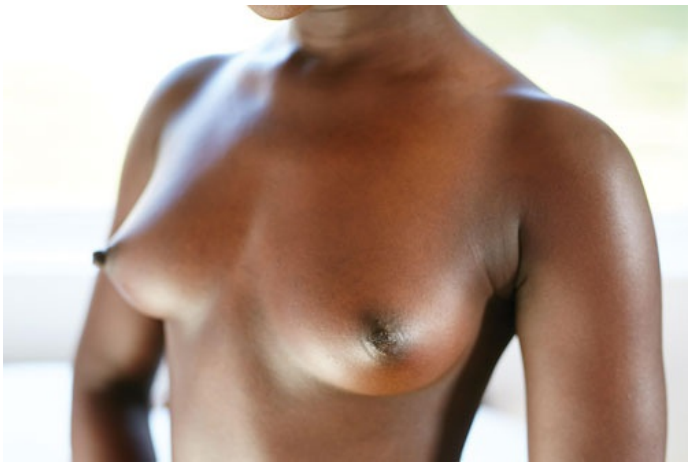
Anatomy of the female breast.

Figure 2–4 Full Alternative Text

In the late stage of pregnancy, a hormone called *prolactin* from the pituitary gland (at the base of the brain) causes the mammary glands to start producing milk (called *lactation*). A baby's sucking on the nipple causes the pituitary to produce the hormone *oxytocin,* which results in the ejection of milk. There can also be secretions from the breasts at other times (a condition known as *galactorrhea*) as a result of certain drugs, birth control pills, stress, or rough fabrics rubbing against the breasts. Some people, including men, have inverted nipples or an extra nipple, but this generally does not pose a health problem.

Breasts vary in size from woman to woman (see Figure 2–5). Breast size is not determined by the number of mammary glands, which is about the same for all women, but by the amount of fatty (adipose) tissue packed between the glands. This is determined primarily by heredity. There is no relation between breast size and sensitivity to touch (Masters & Johnson, 1966). Large breasts do not have a greater number of nerve endings than small breasts. Nevertheless, because of the attention that many men give to breast size, many women are not satisfied with the appearance of their breasts (Ålgars et al., 2011) and wish they were larger.

Figure 2–5



Some variations in the appearance of female breasts.

Source: Chris Rout/Alamy Stock Photo; David J. Green - studio/Alamy Stock Photo; Chris Rout/Alamy Stock Photo

Breast augmentation exercises and the lotions and mechanical devices advertised in women's magazines do not work (remember, breast size is determined by the amount of fatty tissue). In the 1960s, plastic surgeons began implanting soft pouches filled with silicone to increase the size of breasts. About 260,000 American women have their breasts enlarged in this manner each year, 80% of them for cosmetic purposes. However, complications are common (in fact, about 35,000 women a year have their implants removed). Sooner or later, most implants begin to leak. This initially raised concerns about the possibility of cancer and autoimmune disease, but the Institute of Medicine concluded that there was no evidence that silicone implants caused cancer or connective tissue disease (see S. L. Brown, 2002).

Box 2–ASexuality and Health

Breast Cancer and Examination

1. 2.2 Explain why early detection of breast cancer can save lives and describe how to perform a breast self-examination.

Apart from skin cancer, cancer of the breast is the most common type of cancer (and the second leading cause of cancer death) in women, with about 246,660 new invasive cases and about 40,450 deaths per year (American Cancer Society, 2016). One in eight American women will develop breast cancer in her lifetime. A fact that is less well known is that men can get breast cancer too and the number of cases has been increasing (about 2,600 men will be diagnosed this year and about 440 will die).

Some of the factors that put a woman at high risk include a family history of breast cancer (about 5% of new cases are caused by an inherited gene mutation BRCA1), extensive dense breast tissue, being older than 50 years (most women with breast cancer are postmenopausal), never having given birth or having the first child after age 30, starting menstruation before age 12, or undergoing menopause after age 55 (American Cancer Society, 2016).

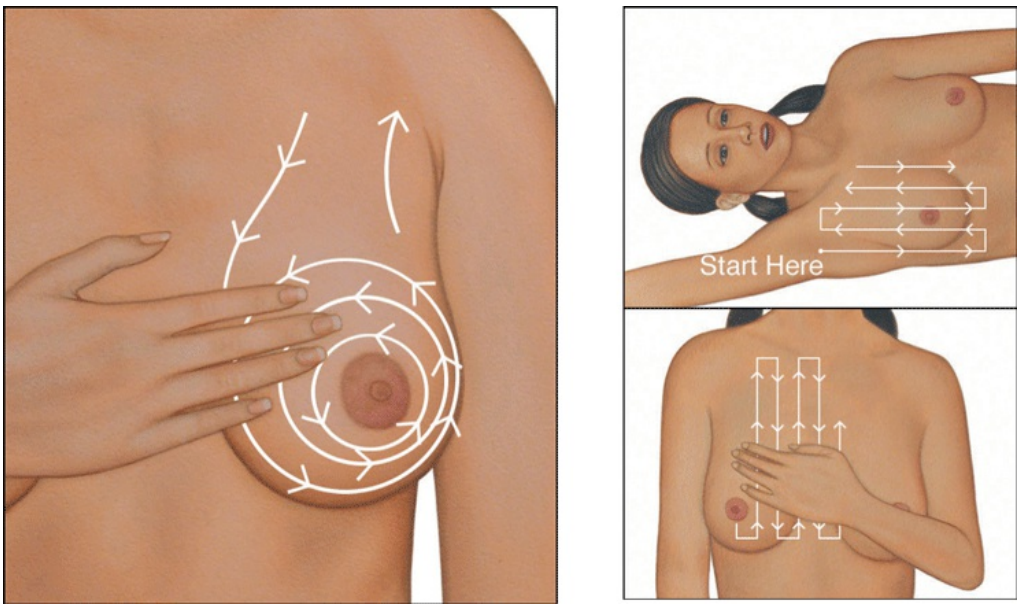
A majority of breast cancers (especially in postmenopausal women) are fueled by the female hormone estrogen. Most birth control pills contain estrogen, but the current consensus is that today's low-dosage birth control pill does not increase the risk (e.g., Marchbanks et al., 2012; Nelson & Cwiak, 2011). On the other hand, there is evidence that long-term hormone replacement therapy for postmenopausal women increases the risk of breast cancer (see Chapter 10).

With early detection, there is a 99% survival rate (American Cancer Society, 2016). However, about half of all cases of breast cancer have spread beyond the breast before they are discovered. Unfortunately, there is currently a big controversy about what women should do to detect breast cancer early. The American Cancer Society (2016) recommends that women at average risk should examine their breasts on a monthly basis starting at age 20 and have a mammogram (breast X-ray) every year starting at age 45 and screenings every other year starting at age 55 (Oeffinger et al., 2015). Mammograms have reduced deaths by about 20% (Myers et al., 2015). On the other hand, the U.S. Preventive Services Task Force recommended in 2015 against self-exams and routine mammograms before the age of 50, claiming that the procedures resulted in too many false positives and unnecessary biopsies and saved very few lives. So, what should you do? If you are at average risk, consult with your doctor and decide with him or her what is best for you.

If you wish to conduct self-exams, the best time is immediately after menstruation ends, when estrogen levels are low and the breasts are not tender or swollen. First look at yourself in front of a mirror. Do this with your hands at your sides, then with your hands on your hips, and finally with your hands raised above your head. Look for any bulging, flattening, dimpling, or redness. The symptoms are usually painless. In each position, examine one breast with the opposite hand. With fingers flat, press gently in

small circular motions, starting at the top, and check the outermost part of the entire breast in clockwise fashion (see Figure 2–6). It is normal to have a ridge of firm tissue in the lower curve of each breast. After you have completed the circle, move your fingers an inch closer to the nipple and make another complete check around the breast. At least three to four complete circles around the breast will be required. Be sure to examine under your arms as well because this is one of the most common areas for cancer to occur. In addition, examine the nipple by squeezing it and noting any discharge. Repeat the same procedure on the other breast. An alternative method of examining the breasts in which you examine yourself with vertical strips has been gaining in popularity (Barton et al., 1999).

Figure 2–6



Breast self-examination: the traditional method (left) and the new alternative method (right).

Whichever method you use, report any suspected abnormality to your doctor immediately.

"I am a 33-year-old nurse that has instructed many other women about self-examination, but unfortunately, did not practice what I preached. After one of your lectures I did examine my breasts and was horrified to find a small lump."

(from the authors' files)

Eight out of 10 lumps that are discovered are benign (non-cancerous) cysts (fluid-filled sacs) or fibroadenomas (solid tumors). They are known as *fibrocystic disease* and (because they are rare after menopause) are believed to be caused by hormones. Therefore, do not panic if you find a lump in your breast, as the chances are good that it is not malignant.

Should you have a lump and it is diagnosed as cancerous, a number of surgical procedures might be performed: (1) radical *mastectomy*, in which the entire breast, underlying muscle, and lymph nodes are removed; (2) simple mastectomy, in which only the breast is removed; and (3) *lumpectomy*, in which only the lump and a small bit of surrounding tissue are removed. Chemotherapy, radiation therapy, and hormonal therapy (tamoxifen) are also used. Treatment will depend on how early the cancer is detected and the type of tumor. Genetic tests are used to identify three types of tumors. As a result of the new targeted treatments, the 10-year survival rate has more than doubled since the 1960s (Grayson, 2012).

Whatever the therapy, it is not uncommon for women with breast cancer to experience sexual problems and the need to make adjustments (Meyerowitz et al., 1999; Moyer, 1997). The reaction of a woman's partner is important. For example, a woman who has had a breast removed needs to be reassured that she is not going to be desired or loved less than before. Would you expect your partner to love you less if you lost a toe, foot, leg, finger, hand, or arm? Of course not. So why should it be any different if she loses a breast? This may seem obvious to you, but your partner will probably want to hear you say it.

"I came from a family consisting of five daughters and no one had ever been diagnosed with breast cancer. I had never given it a thought that I would be the one to have a lump in my breast.... I had a modified radical mastectomy of my left breast.... When my doctor told my husband and me my husband was wonderful about it. All you need to get over the shock is an understanding and supportive husband and family. Emotionally I was able to get over the surgery because he never made me feel like 'half' a woman."

(from the authors' files)

Personal Reflections (women)

Do you regularly examine your breasts for abnormal lumps? If the answer is no, why not? The Centers for Disease Control and Prevention report that nearly 81.1% of women aged 50 or older have had a mammogram (Richardson et al., 2010). If you are in this age group and have not had one, why not?

One study found that in nearly 15% of women who receive breast implants a painful fibrous capsule forms around the implant (called capsular contracture), making the breast hard, tight, and unnatural in appearance and often requiring additional surgery (Hvilsom et al., 2009). Another study found that the number of these complications was 25% (S. L. Brown, 2002). Breast implants may also decrease the survival rate for women diagnosed with breast cancer (Lavigne et al., 2013).

Talk-show host Jenny Jones has had six operations because of the damage her implants did to her breasts. She was quoted in *People* magazine as saying, "I hate my body a thousand times more now than I ever did before.... I would sell everything I own to be able to have the body back that I gave up." Students in our class have relayed similar experiences:

"My mom had a breast augmentation job done about 2 years ago and has had nothing but problems. She started growing too much scar tissue and lumps in her breasts, and now, after all the pain and money and aggravation she went through, she's having them removed this summer. I know she did it for my dad, but she can never tell me enough times how sorry she is she ever did it."

(from the authors' files)

Many naturally large-breasted women would like to be smaller. One common reason is that many very large-breasted women suffer from bad back pain:

"I currently wear a DD cup.... My chest has become a large nuisance. It is hard for me to dance, jog, or do any kind of activity that involves moving around a lot. Finding clothes is very hard.... I just recently talked to a friend of mine who had a breast reduction. I really want to have this operation. It would make me feel better about myself."

(from the authors' files)

Personal Reflections (women)

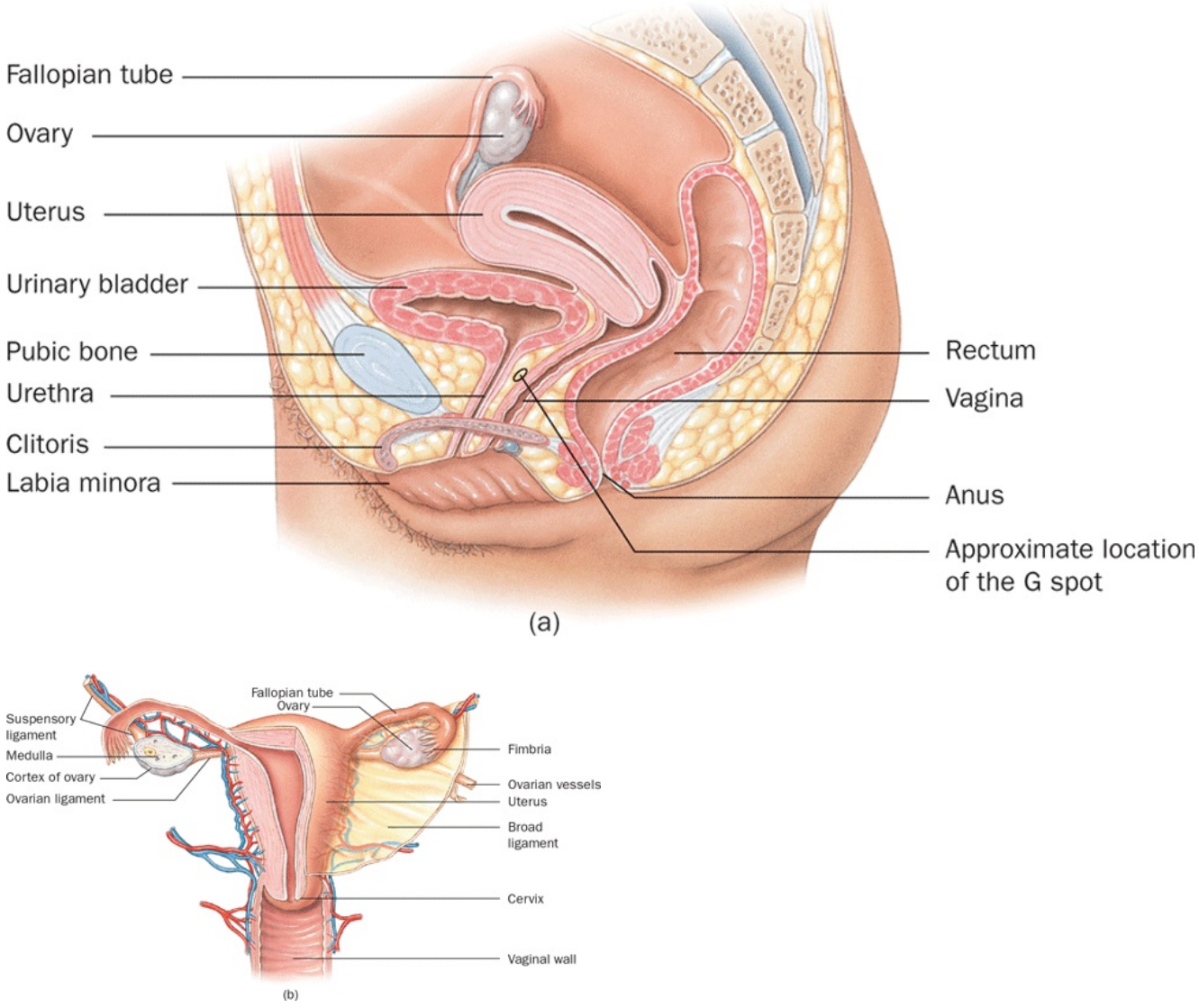
Do you wish you had different-sized or different-shaped breasts? How would you like to be different? Why? Should a woman's breast size be an important factor in sexually pleasing a partner?

Internal Female Anatomy

1. 2.3 Describe each of the female internal anatomical structures—vagina, uterus, Fallopian tubes, and ovaries—and explain its function(s).

The vagina, uterus, Fallopian tubes, and ovaries are often referred to as a woman's reproductive system (see Figure 2–7). The vagina serves as a depository for the man's sperm. Eggs are produced by the ovaries. During a woman's reproductive years, one or more eggs will mature on a monthly basis and will be released from an ovary and picked up by one of the Fallopian tubes. It is in the Fallopian tube that an egg and a sperm unite to start a new living being. The fertilized egg then travels through the tube and implants itself within the uterus (see Chapter 7).

Figure 2–7



(a) The internal female reproductive system, viewed from the side. (b) A frontal view of the internal female reproductive system.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

2.3.1 The Vagina

We have already discussed the vaginal opening as part of the genitalia or external anatomy, but the vagina (Latin for "sheath") is really an internal structure located behind the bladder and in front of the rectum. It serves not only as a depository for sperm during sexual intercourse but also as the birth canal and thus is capable of expanding to about 4 inches in diameter. Many of the derogatory slang terms that men use to describe female genitals imply that it is "simply a hole to be filled" (Braun & Kitzinger, 2001). However, the vagina is not an open orifice always ready to accommodate the insertion of a penis. In the unstimulated state, it is about 3 to 5 inches long and its walls are collapsed. It is not until a woman becomes sexually aroused that the walls of the inner two thirds of the vagina begin to expand to accommodate a penis. The vaginal opening actually narrows during sexual arousal (see Chapter 4).

The vaginal walls have three layers. The inner layer has a soft mucosal surface similar to that of the inside of the mouth. Before puberty, the walls of the vagina are thin and relatively inelastic. The rising levels of female hormones at puberty cause the vaginal walls to thicken and become more elastic and highly vascularized (i.e., having lots of blood vessels). Vaginal lubrication during sexual arousal results from the walls of the vagina becoming filled with blood, with the resulting pressure causing fluid (super- filtered blood plasma) to be secreted from the mucosal lining. At menopause (the time in life when a woman's reproductive capacity ends) the ovaries atrophy, and the consequent loss of hormones causes the walls of the vagina to again become thin and inelastic, similar to their condition before puberty. There is also a decrease in the blood supply to the vaginal walls after menopause, resulting in decreased vaginal lubrication, and thus many older women may require a lubricant during sexual intercourse.

The vagina is a self-cleansing organ. Many potentially harmful bacteria from the outside environment are destroyed by other bacteria that are found naturally within the vagina. In addition, the walls of the vagina continually secrete fluids that help to maintain an acidic environment. A healthy vagina has a musky odor. Vaginal odors act as a sexual stimulant to the males in most mammalian species, and in laboratory studies most men do not find musky vaginal odors offensive (Hassett, 1978). However, if a person hears enough dirty jokes and stories about vaginal odors before becoming sexually experienced, he or she will come to believe this, even though it is not true. How did these stories get started?

Probably because most women will occasionally get a vaginal infection that can be accompanied by an unpleasant odor (you will read about vaginal infections in Chapter 5). These infections can be easily and quickly cured. In order to sell their products, however, advertisers of feminine hygiene sprays and douches imply that vaginal odors are always offensive and must be masked with a perfumed substance. The fact is that these products do not cure vaginal infections; in fact, they often make them worse by further changing the chemical environment of the vagina.

"A year ago I started using a feminine hygiene deodorant spray. I had used this spray for an average of 5 months before I realized that my discharge was abnormal. After talking with my doctor I found that I had a yeast infection. All of this could have been avoided if I had only stayed away from feminine deodorant sprays."

(from the authors' files)

Studies have found that regular douching increases the risk of bacterial vaginosis and ectopic pregnancy (Klebanoff et al., 2010; Zhang et al., 1997). Women should avoid using douches unless told to do so by a physician.

Personal Reflections

Women, do you have any anxieties or insecurities about whether your vaginal odors may be offensive? Do you use feminine hygiene products or douche regularly? If so, why? If you answered "yes," how did you acquire these negative feelings about the female body? Men, have you ever told a joke, or laughed at a joke, about offensive vaginal odors? If so, how would you feel (and how would it affect feelings about your own sexuality) if women commonly told jokes about offensive penis odors?

Although the vaginal opening is very sensitive to touch, the walls of the inner two thirds of the vagina are relatively insensitive to touch as a result of having few nerve endings. It has been demonstrated that some women cannot even tell when their inner vaginal walls are being touched by a probe (Kinsey et al., 1953). Does this mean that the presence of a penis in the vagina does not contribute to a woman's subjective feelings of pleasure during sexual intercourse? Not necessarily. Although the vaginal walls are sparse in nerve endings, the vagina is surrounded by a large muscle, the pubococcygeus (PC) muscle, which is more richly innervated with nerves. It has been found that women who have little vaginal sensation during intercourse (some report that they cannot even feel the penis) have a weak pubococcygeus muscle (Kegel, 1952). As a result, some sex therapists have advocated daily exercises to strengthen this muscle in order to enhance pleasure during sexual intercourse (Barbach, 1976; Graber, 1982; Perry & Whipple, 1981). These exercises, called Kegel exercises, are the same ones that many physicians instruct women with urinary incontinence to do to regain urinary control (Price et al., 2010). The pubococcygeus muscle controls urine flow, but it becomes stretched and weak during pregnancy, causing many women to suffer from urinary incontinence.

Here are the steps for doing Kegel exercises: (1) Learn what it feels like to contract the PC muscle by stopping yourself in the middle of urinating with your legs apart; (2) after you know what it feels like to contract the PC muscle, insert a finger into your vagina and bear down until you can feel the muscle squeeze your finger; and (3) once you can do this, start doing daily Kegels without a finger inserted. Physicians and therapists suggest practicing 10 contractions of 3 seconds each three times a day. The best thing about Kegel exercises is that they can be done anytime and anywhere, and no one else knows what you are doing.

There is an exception to the general statement that the vaginal walls are relatively insensitive to touch. The second one fifth of the front wall has a richer supply of nerves than the rest of the vagina (Song et al., 2009). In fact, some women have a small, very sensitive spot in this area (at about the level of the top of the pubic bone) (see Figure 2–7a). This has been named the

Grafenberg (G) spot, after the German doctor who first reported it in 1950 (Perry & Whipple, 1981). Stimulation of the G spot often leads to an orgasm that some women say feels different from an orgasm caused by clitoral stimulation (see Chapter 4). Originally it was claimed that all women had a G spot, but later studies suggested that only 10% or fewer women have this area of heightened sensitivity (Alzate & Londono, 1984).

One in every 4,000 to 5,000 girls is born without a vagina (Harnish, 1988). When this occurs, physicians are usually able to surgically construct one.

2.3.2 The Uterus

It is within the uterus, or womb, that a fertilized egg will attach itself and become an embryo and then a fetus. Resembling a small inverted pear, the uterus in women who have not had children measures only about 3 inches long and 3 inches across at its broadest portion, but it is capable of tremendous expansion. The *cervix,* the narrow end of the uterus, projects into the back of the vagina and can be easily felt (as a slippery bump) by inserting a finger into the back of the vagina. The broad part of the uterus is called the *fundus.* Ligaments hold the uterus in the pelvic cavity at about a 90-degree angle to the vagina, although in some women it may tilt slightly forward or backward.

The uterus has three layers: the innermost endometrium, where the fertilized egg implants; a strong middle layer of muscles called the *myometrium*, which contracts during labor; and an external cover called the *perimetrium.* The endometrium thickens and becomes rich in blood vessels after ovulation, but if fertilization does not occur it is sloughed off and discharged from the woman's body during menstruation. The cervical opening, or *os* (Latin for "mouth"), is normally no wider than the diameter of a matchstick, but it dilates to 10 centimeters (about 4 inches) at childbirth to allow delivery of the baby.

Unfortunately, the cervix is the site of one of the most common types of cancer in women. It is extremely important, therefore, that all sexually experienced women go to a physician for regular examinations and Pap smears (see Box 2–B).

2.3.3 The Fallopian Tubes

Extending 4 inches laterally from both sides of the uterus are the Fallopian tubes, or oviducts, as they are sometimes called. There is no direct physical connection between the Fallopian tubes and the ovaries, but the finger-like projections at the end of the tubes (called *fimbria*) brush against the ovaries. After an egg is expelled from an ovary into the abdominal cavity at ovulation, it is picked up by one of the fimbria. If a sperm fertilizes the egg, it will usually do so within the tube. The fertilized egg then continues its 3- to 4-day trip through the tube and normally implants itself in the endometrium of the uterus.

2.3.4 The Ovaries

The ovaries are the female gonads and develop from the same embryonic tissue as the male gonads, the testicles. They are suspended by ligaments on both sides of the uterus. The ovaries have two functions: to produce eggs, or *ova (singular ovum*), and to produce female hormones (*estrogen* and *progesterone*). At birth, a girl has all the immature eggs that she will ever have, about 300,000 to 400,000 in each ovary. Each egg is surrounded by some other cells and contained within a thin capsule to form what is called a primary follicle. At puberty, one or more of the follicles is stimulated to mature on about a monthly basis (the menstrual cycle). When mature, the follicle is called a *Graafian follicle.* This process ends at menopause, and thus only about 400 of the several hundred thousand ova in a woman's ovaries will ever mature during her lifetime. In contrast, a man's testicles produce millions of new sperm every day.

Box 2–B Sexuality and Health

Cancer of the Female Reproductive System

1. 2.4 Explain the importance of pelvic examinations and Pap smears for women's health.

Cancer of the Cervix

The cervix is a common site for cancer in women. Each year up to 2 million American women are diagnosed with precancerous conditions of the cervix called *cervical dysplasia.* About 12,990 American women are diagnosed with invasive cervical cancer (spread beyond the surface of the cervix) (American Cancer Society, 2016). It results in about 4,120 deaths a year.

Women can have this cancer at almost any age. Women at high risk include those who began having sexual intercourse at an early age or who have had numerous sexual partners and those whose partners have had numerous sexual partners. Cancer of the cervix is rare among celibate women. *It is not sex itself that is the cause of cervical cancer but certain types of human papillomaviruses (HPV), a virus that is spread during sexual activity* (Policar, 2011; see Chapter 5). Vaccines have been developed that are very effective for the major types of HPV that cause cervical dysplasia (see Chapter 5). Regular use of condoms also reduces the risk of getting cervical cancer.

A *pelvic exam* and Pap smear test (named after Dr. George Papanicolaou, who developed the test) are a necessary part of female health care. Regular Pap smears prevent over 70% of cancers of the cervix (Policar, 2011). Cervical cancer is most commonly found in women who do not get regular Pap tests (Volerman & Cifu, 2014).

Many women are nevertheless reluctant to get a Pap smear because of embarrassment. The first step, therefore, is to find a doctor with whom you are comfortable and who shows concern for his or her patients (as by warming instruments to body temperature before using them). In the examination room, the woman lies flat on her back with her legs apart and her feet in footrests called stirrups (Figure 2–8). An instrument called a speculum, which is shaped like a duck's bill, is inserted into the vagina and gently opened so that the vaginal walls and cervix may be inspected. A cotton swab or thin wooden stick is used to gently skim the surface of the cervix in order to collect cells, which are then examined under a microscope for abnormalities. During the exam, the doctor will also check the vaginal walls and vulva for possible infections. Some doctors may include a rectal exam at this time. The entire process generally takes only a few minutes, and although some women may experience discomfort, it is generally not painful.

Figure 2–8

The pelvic examination.

"Human sexuality class has made me more educated about my body, and I became more aware. Before I entered this class I was very scared of going to the gynecologist for a visit (age 20). Recently I went for my first visit and found my fears were ridiculous. It was not bad at all and I even felt better to find out I was OK."

"At the beginning of the semester you mentioned UNO's Health Services and I decided to check them out. When the results of my Pap smear came in, I had tested positive. I had stage II dysplasia. I had cryotherapy.... If it had not been for this class, I don't know how long I would have waited to get a Pap smear or what the results would have been."

(All examples are from the authors' files.)

Any detected abnormalities of cells are treated according to severity. In the precancerous stage, the localized abnormal cells are often destroyed by extreme cold (cryotherapy) or intense heat (electrocoagulation). Precancerous abnormalities in cells often take as long as 8 years before they start to invade other tissues. If cancer of the cervix is found, a woman may have to have a *hysterectomy* (surgical removal of the uterus).

The American College of Obstetricians and Gynecologists advises women that annual checkups should begin at age 21 (Volerman & Cifu, 2014). The test should include a test for HPV starting at age 30. Because cervical cancer is "slow growing," they recommend that otherwise healthy women aged 21 to 65 get Pap smears every 3 years.

Many women mistakenly believe that the Pap smear test also screens for sexually transmitted infections, but it does not (Hawkins et al., 2011). If you have had multiple sexual partners (and are thus at high risk to get a sexually transmitted infection), you should consider these additional tests at this time.

Cancer of the Endometrium and Ovaries

Cancer of the endometrium is also very common, with an estimated 60,050 new cases and 10,470 deaths per year in the United States (American Cancer Society, 2016). Typically, the first symptom is abnormal vaginal bleeding, so if you should experience this, go to a physician immediately. He or she will make a diagnosis by dilation and curettage (D&C). Should cancer be found, your doctor will probably recommend a hysterectomy.

Ovarian cancer occurs in about 22,280 American women each year. It causes the death of more American women each year (approximately 14,240) than either cervical or endometrial cancer (American Cancer Society, 2016). Most cases are found in postmenopausal women or women approaching menopause (between 50 and 59 years old). It is more common in women who have never been pregnant and less so in women who use oral contraceptives. However, the highest risk factor is a family history of ovarian cancer. There is a blood test for women at high risk (it tests for CA-125, a protein produced by cancerous ovarian cells). Treatment usually involves removal of the ovaries and radiation.

For any of these types of gynecological cancers, recovery of sexual well-being is important to many women. A woman's relationship context will be very important in this process (Gilbert et al., 2011).

Personal Reflections (women)

About 90% of American women aged 25 to 64 have had a Pap smear (or equivalent) test in the past 3 years (Nelson et al., 2009). Have you had one within the past 3 years? If not, why not?

External Male Anatomy

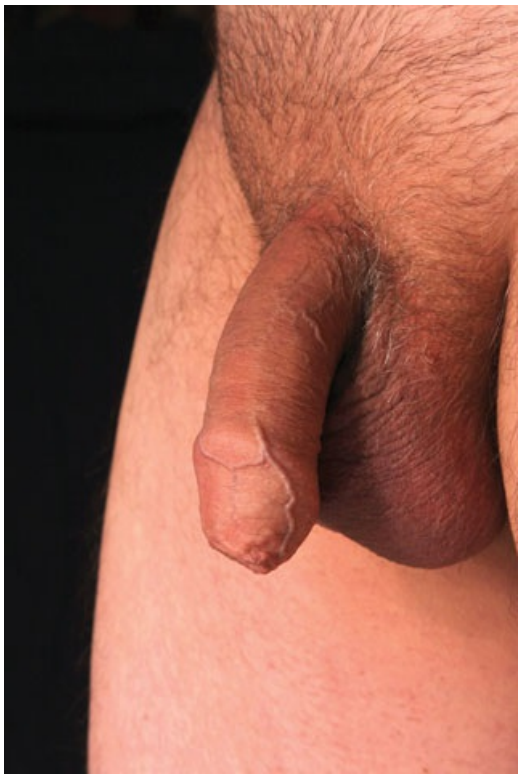
1. 2.5 Describe each of the structures of the external male anatomy—penis and scrotum—and explain its function(s).

Generally speaking, men have a better idea than women of what their genitals look like. Not only is a man's genitalia more visible to him than a woman's genitalia is to her, but boys are taught at a very young age to hold the penis while urinating and thus may be less inhibited than girls about touching and examining themselves. Although they differ in appearance, many of the male structures develop from the same embryonic tissue as female structures (the penis and clitoris, for example). The male reproductive system and genitalia are shown in Figure 2–9 and Figure 2–10. Penises differ in appearance just like any other part of the body, and men should not consider themselves abnormal if they do not look identical to Figure 2–10. Similar to women, many young men today are developing negative attitudes about pubic hair and shaving (Butler et al., 2015; Smolak & Murnen, 2011).

Figure 2–9

Anatomical location of the male reproductive system.

Figure 2–10



A circumcised (left) and uncircumcised (right) penis.

Source: John Henderson/Alamy Stock Photo

“My girlfriend shaves and she likes it when I shave. It feels a lot cleaner down there.”

“I shave because I tried it once and enjoyed the feeling. I think girls like how it looks.”

(from the authors’ files)

Personal Reflections

What were your feelings when you first looked at Figures 2–3 and 2–10? If you experienced any discomfort or anxiety, why? As part of this chapter, we have suggested that you examine your own genitals. Were you able to do this without feelings of guilt or anxiety? If not, why do you think you have negative feelings about looking at this part of your body?

2.5.1 The Penis: Outer Appearance

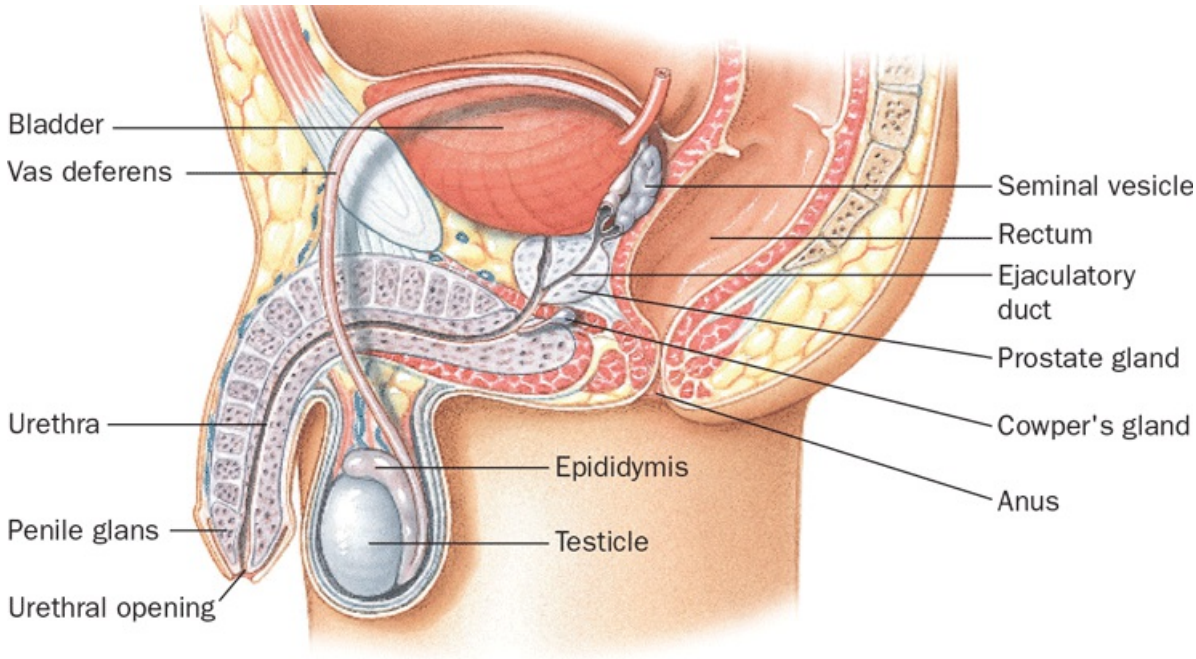
The penis (Latin for "tail") has both a reproductive and a urinary function. It serves to deposit sperm in a woman's vagina and also to eliminate urine from the bladder. When a man is unaroused, the penis is soft and hangs between the legs. It hardens and becomes erect during sexual stimulation, thus enabling penetration of the vagina. The average size of the penis in the unstimulated (flaccid) condition is 3.75 inches in length and 1.2 inches in diameter; it is about 4.5 to 5.75 inches in length and 1.5 inches in diameter when erect (see Chapter 4). Some penises are curved to the left or right, and others are curved up or down. In a rare condition called micropenis, the penis never develops to more than 1 inch in length (see Callens et al., 2013). In Chapter 4, we will consider whether penis size relates to sexual satisfaction in women.

The skin of the penis is very loose to allow for expansion during erection. At birth the *foreskin* folds over the glans, the smooth rounded end of the penis, but many men have had their foreskin cut off in a surgical procedure known as circumcision (see Figure 2–10). If you should have an uncircumcised son, be sure to teach him that good hygiene includes cleaning under the foreskin (see Box 2–C). However, when bathing a newborn, do not pull back forcibly on the foreskin for the first several months because it is often partially adhered to the penis during this time. In some boys it is still adhered at 3 years of age (Williams et al., 1993).

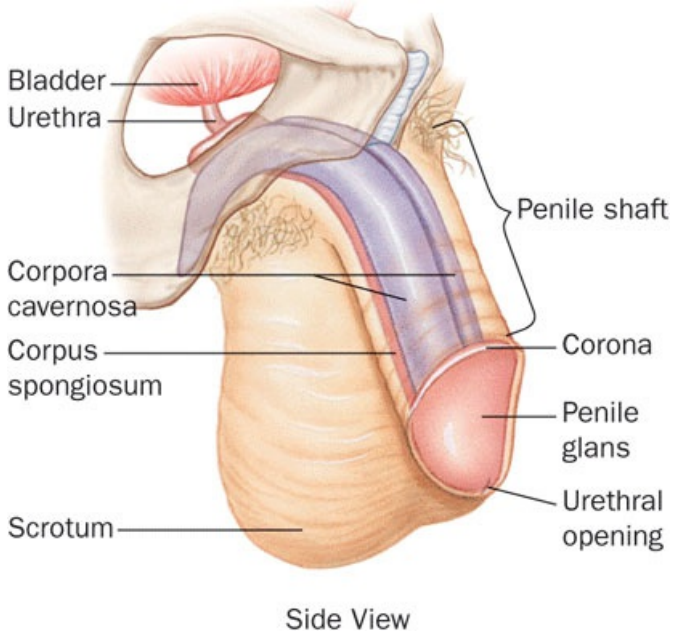
2.5.2 The Penis: Internal Structure

The penis has three parts: the body or shaft, the glans, and the root. Only the first two parts are visible (see Figure 2–12). In cross section, the *shaft* of the penis can be seen to consist of three parallel cylinders of spongy tissue, two *corpora cavernosa* (or "cavernous bodies") on top and a *corpus spongiosum* (or "spongy body") on the bottom. Each is contained in its own fibrous sheath. The corpora cavernosa do not extend the full length of the penis. Instead, the spongy body expands greatly in front to form the round, smooth *glans*. The raised rim at the border of the shaft and glans is called the *corona* (and is the most sensitive to touch of any part of the penis). The *urethra*, which serves as the passageway for urine and sperm, runs through the corpus spongiosum, and thus the urethral opening (or meatus) is normally located at the tip of the glans. Occasionally it is located to one side of the glans, and although this usually poses no major problem, it can cause a man to have a negative perception of his own genitals. For reasons not yet determined, this condition (called *hypospadias*) has nearly doubled in frequency of occurrence since 1970, but it can be corrected by surgery (Paulozzi et al., 1997).

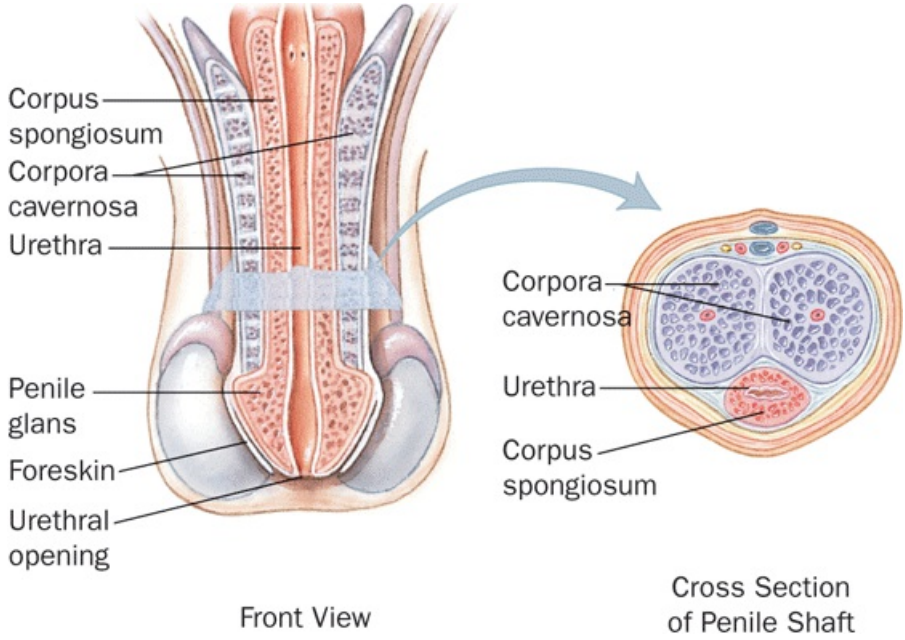
Figure 2–12



2.3-1 Full Alternative Text



2.3-1 Full Alternative Text



2.3-1 Full Alternative Text

The internal male reproductive system: (top) from a side view; (bottom) from a frontal view and cross section of the penis.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Figure 2–11

The penis bone (baculum or oosik) of a walrus. Men do not have this bone but instead become erect by the penis filling with blood.

Source: Vladimir Melnik/Shutterstock

The *root* of the penis consists of the expanded ends of the cavernous bodies, which fan out to form *crura* and attach to the pubic bone (note the similarity in structure to the clitoris) and the expanded end of the spongy body (called the *bulb*). The root is surrounded by two muscles (the

bulbocavernosus and the ischiocavernosus) that aid in urination and ejaculation.

In many species, an erection occurs in part due to a bone, called a baculum or oosik, that protrudes into the penis (see Figure 2–11). This is true of gorillas, chimpanzees, bears, cats, dogs, rodents, walruses, and seals. This bone is absent in elephants, whales, dolphins, and humans. In humans, when a man becomes sexually aroused, the arteries going to the penis dilate and the many cavities of the cavernous and spongy bodies fill with blood. Valves in the veins that drain the penis simultaneously close. Expansion of the sinuses (cavities) and contraction of the muscles at the base of the penis may further aid this process by pressing against the veins and partially cutting off the drainage. In brief, an erection results from the spongy tissues of the penis becoming engorged (filled) with blood. *Detumescence*, or loss of erection, is not as well understood but probably occurs as a result of the arteries beginning to constrict, thus removing pressure from the veins and allowing drainage.

Some men have a severe curvature of the penis, called *Peyronie's Disease*. This is sometimes due to developmental abnormalities, but it is often due to injury to the fibrous sheath (elastic tissue) that holds the three parallel cylinders of spongy tissue. If the fibrous sheath is injured at any spot, the elastic tissue is replaced by scar tissue that does not expand during erection, thus causing curvature of the penis. If the curvature is too extreme, it can cause pain during intercourse. Peyronie's Disease can be corrected (Chung et al., 2016). In some positions of sexual intercourse, men can place too much pressure or weight on their penis, and this can result in a "fracture" (rupturing of fibrous sheaths surrounding the cavernous bodies), which may require surgery (Kramer, 2011).

2.5.3 The Scrotum

The sac located beneath the penis is called the scrotum. It holds the testicles outside of the body cavity. Sperm are produced in the testicles, but they can only be produced in an environment several degrees lower than the normal body temperature of 98.6 degrees Fahrenheit. Scrotal temperature is typically about 93 degrees Fahrenheit. The skin of the scrotum is sparsely covered with hair and has many sweat glands that aid in temperature regulation. The scrotum also has small muscle fibers that contract when it is cold to help draw the testicles closer to the body cavity for warmth. When it is hot, the muscle fibers relax and the testicles are suspended farther away from the body cavity.

In tropical areas of the world, it is not uncommon for men to suffer from elephantiasis of the scrotum (caused by a parasite), a condition in which the scrotum can get as large as a basketball.

Box 2–c Cross-Cultural Perspectives/Sexuality and Health Male Circumcision

1. 2.6 Discuss the advantages and disadvantages of circumcision of the penis.

Circumcision has been performed on boys since at least 4000 b.c. Egyptian mummies dating from this period give evidence of it, and the Greek historians and geographers Herodotus and Strabo later wrote about observing it in their travels (Glick, 2005). The ancient Egyptians and Ethiopians performed circumcisions for cleanliness (Herodotus), and the practice was borrowed by the Hebrews at about the time of Abraham (the custom later fell into disuse but was revived by Moses). Today, Jewish boys are circumcised on the 8th day of life to symbolize the covenant with God made by Abraham (Genesis 17:9–14). Muslim boys are also circumcised as part of a religious ceremony, often at 13 years of age.

In many cultures today, the operation is performed as a puberty rite, and sometimes it involves more than the cutting away of the foreskin. The Mangaians and other South Pacific islanders cut lengthwise along the top of the penis (superincision) all the way to the abdomen (Marshall, 1971). Primitive tribes in central Australia make a slit to the depth of the urethra along the entire length of the lower side of the penis (subincision) so that men urinate at the base of the penis, requiring that they sit like women (Gregersen, 1982). Still other cultures insert rods with gemstones, feathers, or bristles attached to the end (D. Brown, 1990; see Figure 1–2 in this text). Many anthropologists believe that these customs are performed as symbolic pledges of loyalty to the group.

In the United States and England, circumcision became popular during the 19th century because Victorian physicians believed that circumcised penises were less sensitive and that the operation would therefore prevent masturbation and hypersexuality. Circumcision reached its height in popularity between World Wars I and II but then fell out of favor in most English-speaking countries. Fewer than one quarter of boys are routinely circumcised in countries such as England, Canada, New Zealand, and Australia. Today, about 58% of boys born in the United States are circumcised in the hospital (Zhang et al., 2011), but more are done outside, for a total of about 80.5% of American boys (Introcaso et al., 2013).

Today, the reason for circumcision most commonly given by American physicians is to ensure proper hygiene. Glands located beneath the foreskin secrete an oily substance that gets mixed with dead cells to form a cheesy substance called smegma. Without proper hygiene, the smegma serves as a possible breeding ground for bacteria. The rate of urinary tract infections in uncircumcised infants is at least 4 times greater than in circumcised infants. Numerous studies have also found that circumcised men have a much lower chance of getting HIV (the virus that causes AIDS), human papillomavirus infections, and some other sexually transmitted infections if they have unprotected vaginal intercourse with infected partners (see Albero et al., 2012; Gray, 2012). Research has shown that circumcision does not reduce penile sensitivity or cause sexual problems (Morris & Krieger, 2013).

The American Academy of Pediatrics opposed the *routine* circumcision of newborns in 1999 but reversed its position in 2012, concluding that "the health benefits of newborn male circumcision outweigh the risks" (Task Force on Circumcision, 2012). The academy also advised doctors to use a topical cream anesthetic when circumcision is performed.

Personal Reflections

If you should have a son, do you plan to have him circumcised? Why or why not?

Note: You will read about circumcision of the clitoris in Box 4–A.

Internal Male Anatomy

1. 2.7 Describe each of the male internal anatomical structures—testicles, epididymis, vas deferens, ejaculatory ducts, urethra, prostate gland, seminal vesicles, and Cowper's glands—and explain its function(s).

The male internal reproductive system consists of the testicles, a duct system to transport sperm out of the body, the prostate gland and seminal vesicles that produce the fluid in which the sperm are mixed, and the Cowper's glands (see Figure 2–12).

2.7.1 The Testicles

The testicles (the male gonads, or *testes*) develop from the same embryonic tissue as the ovaries (the female gonads). Like the ovaries, the testicles have two functions: to produce *sperm* and to produce male hormones. Millions of new sperm start to be produced each day in several hundred *seminiferous tubules* (the entire process takes about 70 days). Each tubule is 1 to 3 feet in length, and if they were laid together, end to end, they would measure over one-quarter mile in length. In between the seminiferous tubules are cells called *interstitial cells of Leydig,* which produce male hormones. Male (or masculinizing) hormones are called *androgens.* The most important is *testosterone* (you will find many references to this hormone in later chapters). Another hormone produced in the testicles (by Sertoli cells) is called *inhibin*, discussed in Chapter 3.

The testicles are in the abdominal cavity for most of fetal development, but about 2 months before birth they descend through the inguinal canal into the scrotum. They fail to descend in about 2% to 5% of male births, a condition known as cryptorchidism (Kollin et al., 2006). This usually corrects itself (only 1% to 2% have failed to descend by 3 months), but if it persists, it can result in sterility and increased risk of hernia and cancer of the testicles.

Each testicle is suspended in the scrotum by the *spermatic cord,* a tube-like structure that contains blood vessels, nerves, the vas deferens, and a muscle that helps to raise and lower the testicles in response to changes in environmental temperature and level of sexual arousal (the testicles are drawn closer to the body during sexual arousal). Each testicle is enclosed in a tight fibrous sheath.

In right-handed men it is normal for the left testicle to hang lower than the right one, and vice versa in left-handed men (the reason is unknown). Both testicles, however, should be about the same size. The testicles are very sensitive to pressure, and men differ as to whether they like to have them touched during sexual relations.

Men should be aware of health problems associated with the testicles. The virus that is responsible for mumps, for example, causes the testicles to swell painfully, and the pressure against the fibrous sheath can crush the seminiferous tubules, resulting in sterility if mumps occurs after puberty. The testicles are also the site of a form of cancer (see Box 2–D).

The word *testes*, by the way, is derived from a Latin word for *witness* ("to testify"). People shake hands when completing a deal or sealing a promise today, but in biblical times a man held the testicles of the man to whom he gave an oath. The idea was that if he broke his oath, the children of the other man had the right to take revenge.

2.7.2 The Duct System

After sperm are produced in the seminiferous tubules, they pass through a four-part duct system before being expelled from the penis during an ejaculation. The seminiferous tubules converge to form the epididymis, coiled tubes (about 20 feet long if uncoiled) that can be felt on the top and back of each testicle. Sperm mature (become more fertile and achieve greater motility) as they travel through the epididymis, which takes up to 6 weeks (Orgebin-Crist, 1998). From here the sperm pass into the paired 14- to 16-inch vas deferens. The vas begin in the scrotum and then travel through the spermatic cord and enter the abdominal cavity through the inguinal canal. From there, they go up and over the bladder toward the prostate gland. Many sperm are stored in the expanded end of the vas, called the *ampulla*, prior to ejaculation.

During orgasm, rhythmic muscular contractions force the sperm into the ejaculatory ducts, short (about 1 inch long) paired tubes that run through the prostate gland, where they are mixed with fluids from the prostate and seminal vesicles to form *semen.* The two ejaculatory ducts open into the urethra, which passes through the spongy body of the penis. Sphincter muscles surround the part of the urethra coming from the bladder. These involuntarily contract during an erection so that urine does not get mixed with semen.

2.7.3 The Prostate Gland and Seminal Vesicles

Although an average ejaculation contains about 200 million to 300 million sperm, they make up very little of the total volume. Most of the volume is seminal fluid from the seminal vesicles (accounting for about 70% of the fluid) and the prostate gland (about 30%). Among other substances, the seminal vesicles (misnamed because anatomists once thought that was where sperm were stored prior to ejaculation) secrete fructose, prostaglandins, and bases. Fructose (a sugar) activates the sperm and makes them mobile, while prostaglandins cause contractions of the uterus, aiding movement through that structure. Bases neutralize the normal acidity of the vagina so that sperm will not be destroyed on their way to the more favorable alkaline environment of the uterus. The prostate gland secretes all of these substances and another substance (fibrinogenase) that causes semen to temporarily coagulate after ejaculation, thus helping to prevent spillage from the vagina. The prostate also secretes an antibiotic, possibly to protect the male and female reproductive systems from infection. The prostate is the site of the second most common type of cancer found in men and should be checked annually when men reach middle age (see Box 2–E).

2.7.4 The Cowper's Glands

The Cowper's, or bulbourethral, glands are two pea-sized structures located beneath the prostate. They secrete a few drops of an alkaline fluid (a base) that may appear at the tip of the penis prior to orgasm. The fluid neutralizes the normal acidity of the urethra, and thus sperm are not destroyed when passing through the penis during ejaculation.

Box 2–DSexuality and Health

Testicular Cancer and Self-Examination

1. 2.8 Describe how to perform a testicular self-examination.

Cancer of the testicles is not very common. About 8,720 new cases occur in the United States each year, with 380 deaths (American Cancer Society, 2016). One half of cases occur in men aged 20 to 34. White men are four to five times more likely to develop it than other ethnicities. This type of cancer received much attention when bicyclist Lance Armstrong, comedian Tom Green, and Olympic Gold Medal–winning skater Scott Hamilton were diagnosed with it. Men at highest risk are those whose testicles did not descend into the scrotum before the age of 10, those who had an early puberty, and those with inguinal hernias. Cancer of the testicles is not related to masturbation, frequent sex, or sexually transmitted infections.

The most common symptom of testicular cancer is a small lump or a testicle that is slightly enlarged. In the first stages of testicular cancer, the tumors are painless; thus it is important that all men (particularly those in a high-risk group) examine themselves regularly— once a month is advised. Examine yourself after a warm bath or shower. This causes the testicles to descend and the skin of the scrotum to relax. Examine your testicles one at a time by placing both thumbs on top and the middle and index fingers on bottom (see Figure 2–13). Gently roll your testicle between the thumbs and fingers. When doing so, you will also feel your epididymis, which feels like a spongy rope on the top and back of each testicle.

Figure 2–13

Testicular self-examination.

Not all abnormal lumps are cancerous, but if a lump should be, treatment usually involves surgical removal of the affected testicle and chemotherapy. The cancer rarely spreads to the other testicle. With proper care, 95% of men can be cured (Hanna & Einhorn, 2014). Sexual functioning is usually normal (Jonker-Pool et al., 2001). The unaffected testicle can produce enough sperm to father a child. Synthetic implants can be inserted into the scrotum to give the man's genitals a normal appearance.

Personal Reflections (men)

Do you regularly examine your testicles for abnormal lumps? If not, why not? The self-exam takes only about 3 minutes.

Box 2–E Sexuality and Health

Prostate Problems and Examination

1. 2.9 Identify the early signs of prostate problems and understand the importance of regular prostate examinations for men's health.

Cancer of the prostate is the most common nonskin cancer among men in the United States, with approximately 180,890 new cases and 26,120 deaths each year (American Cancer Society, 2016). About two thirds of newly diagnosed cases are in men 65 and older. The highest risk factors are a family history of prostate cancer, high testosterone levels, and dietary fat. The rates are considerably higher among African American men than among white men.

The good news is that cancer of the prostate is usually a very slow-growing type of cancer. Many men show no symptoms in the early stages. Later, symptoms may include difficulty in urination or a frequent need to urinate (especially at night), blood in the urine, and continuing pain in the lower back or pelvic region. Once the cancer spreads to the lymph nodes, there is only a 30% chance that it is curable.

Prostate cancer was traditionally treated either by radical prostatectomy (surgical removal of the prostate, seminal vesicles, and other tissues), laparoscopic surgery, and/or radiation. However, side effects of these treatments frequently include impotence and urinary incontinence (inability to control the bladder), and many men feel that the cures are worse than the disease (Sanda et al., 2008). Because localized early-stage prostate cancer is often slow to develop, many doctors have advised that the best treatment is "watchful waiting"—doing nothing except regular monitoring until there is a threat that the cancer will spread to surrounding tissue (Wilt et al., 2012). Men aged 65 and older who are diagnosed with early-stage prostate cancer generally die of other causes before the cancer spreads.

The traditional method for diagnosing prostate cancer has been the rectal examination, in which a physician feels the prostate for any abnormalities. There is also a blood test for detecting prostate-specific antigen (PSA), a substance produced by prostate cells. PSA levels are usually higher in men with prostate cancer. However, the U.S. Preventive Services Task Force recommended against routine screening for all men by the PSA test because it often leads to unnecessary anxieties and surgeries, i.e., "the harms outweigh the benefits" (Eggener et al., 2015). Each patient should be considered individually, depending on risk factors (Sohn, 2015). The American Cancer Society (2016) still recommends that men be checked regularly starting about age 50.

Cancer is not the only problem a man can have with his prostate. Inflammatory infections (e.g., prostatitis), sometimes resulting from untreated sexually transmitted infections, can occur. In addition, as men grow older it is common for the prostate to enlarge as a result of overgrowth of normal prostate tissue. This condition, called *benign prostatic hyperplasia* (often called BPH), affects about 50% of men over the age of 60 (Davidson & Chutka, 2008). The overgrowth pinches off the urethra, causing increase in frequency of or difficulty in urination. The traditional treatment has been transurethral prostatectomy, in which the prostate tissue is removed by an instrument inserted through the urethra. However, about 10% to 15% of men who have had this operation suffer complications, including impotence (although some cases of impotence may be psychological in origin). Drugs are available to shrink the prostate, but the most promising new treatments are devices that use microwaves or radio waves to kill the excess tissue. Many physicians believe that unless the urethra is completely blocked or there are other bothersome symptoms (such as urinary difficulties), the best approach, again, is watchful waiting.

Personal Reflections (men)

If you are over 50 years old (or 45 if you are African American), have you been to a doctor for a prostate examination? If not, why?

Our Sexual Bodies

1. 2.10 Explain why having a positive body image is important to sexual health.

Would it surprise you to learn that most Americans are unhappy with their bodies (Garner, 1997)? Why? Body concerns are more common among women than men (Sanchez & Kiefer, 2007). A recent study found that most young women have received negative comments about multiple parts of their bodies and from multiple sources (Allen et al., 2016).

In the United States, cultural standards continue to emphasize extreme stereotypes as the most admired physiques. Over the years, *Playboy* magazine centerfolds became thinner and more Barbie doll-like (Schick et al., 2010), while *Playgirl* magazine's male centerfolds have become heavier and more muscular (Leit et al., 2001). We are taught to desire these extreme physiques beginning in childhood. Girls are told that the nearly physically impossible, busty, thin-waisted Barbie doll is the feminine ideal, while over the years the GI Joe action figures have become more and more muscular to the point of human impossibility. It is not surprising, therefore, that adult men desire a hypermuscular 6-pack-abs body for themselves (see Frederick et al., 2007; Hatoum & Belle, 2004)—as well as a smaller waist-to-hip ratio (e.g., Furnham et al., 2006; Singh, 1993) and longer leg-to-body ratio (Swami et al., 2006) in their female partners. Consequently, it is also not surprising that many men and women are dissatisfied with their bodies and have low self-esteem because they cannot achieve these stereotypical ideals (Blond, 2008; Hatoum & Belle, 2004).

A positive body image is strongly associated with better sexual functioning, whereas body shame is related to greater sexual problems (Lemer et al., 2013; Sanchez & Kiefer, 2007; Wiederman, 2012; Woertman & van den Brink, 2012). Many Americans have become obsessed about their bodies and have become so image conscious that they pay thousands of dollars for face-lifts, breast or penis enlargements, hair transplants, and even padding for their buttocks and legs. But is sex only for the very beautiful? Of course not. Physical appearance might make us sexually appealing to others at first, but a good healthy sexual life involves having *sensuality,* which encompasses all of our senses as well as who we are as a total person. A person's voice, feel, taste, smell, and personality can all be sensual and contribute to his or her sexuality. For example, an overweight person who appreciates the importance of touching and taking his or her time may be a much better sexual partner than one who physically may be a perfect "10."

Think how boring the world would be if we all looked the same, even if all our bodies were perfect. We each have different ideas and standards as to what we find sexually arousing. Some men are preoccupied with becoming bald, but many women find bald men sexy, so much that many young men shave their heads. We are all unique, and if we can appreciate that uniqueness and love ourselves, then we also have the capacity to truly care for others. Chances are that our partners have (or will have as they grow older) as many unique physical features as we do. So, find a partner who appreciates you for who you are and how you look, and vice versa, and learn to feel good about yourself. In the excitement of sexual relations with someone we truly enjoy and care for, a paunchy midline, a bald spot, or a small penis or small breasts are not important. We all have the capacity to be sensual beings, and we all have bodies that are sexual.

Personal Reflections

What body parts of others do you find to be most sexually arousing? Why? Do you think this is a learned response, or is it biologically determined? If the latter, how do you account for the fact that people in other cultures may not be aroused by parts of the body that you find to be arousing (see Chapter 1)?

Study Guide

Key Terms

- androgens
- areola
- Bartholin's glands
- breasts
- bulbocavernosus muscle
- cervix
- circumcision
- clitoral hood
- clitoris
- corona
- copora cavernosa
- corpus spongiosum
- Cowper's glands
- crura
- ejaculatory ducts
- endometrium
- epididymis
- Fallopian tubes
- fimbria
- foreskin
- fundus
- genitalia
- Grafenberg (G) spot
- hymen
- interstitial cells of Leydig, p. 45
- Kegel exercises
- labia majora
- labia minora
- mammary glands
- mammogram
- mons veneris
- nipple
- os
- ova (ovum)

- ovary
- oxytocin
- Pap smear
- penis
- perineum
- primary follicle
- prolactin
- prostate gland
- pubococcygeus (PC) muscle
- scrotum
- semen
- seminal vesicles
- smegma
- sperm
- spermatic cord
- testicles
- urethra
- uterus
- vagina
- vas deferens
- vestibular area
- vestibular bulbs
- vulva

Interactive Review

Answers can be found on p. 468

1. When referring to their genitals or breasts, many people feel more comfortable using slang terms than the correct anatomical names. The use of sexual slang often reflects ambivalent feelings about sex and may lead to misinformation.

   Women's genitalia are collectively known as the (1) . This includes the (2) , (3) , (4) , (5) , (6) , and (7) . The (8) and (9) become covered with hair at puberty. The (10) has no known function other than to focus pleasurable sensations. It is most similar in structure to a man's (11) . The (12) meet at the top to form the clitoral hood. The area between the labia minora is called the (13) . Sexually inexperienced women have a thin membrane, called the (14) , that partially covers the vaginal opening. A woman's breasts are not part of her reproductive anatomy, but in cultures where men consider them to be erotic, they are part of her sexual anatomy. One in (15) women will get breast cancer sometime in her lifetime.

   A woman's internal reproductive system includes the (16) , (17) , (18) , and (19) . The (20) is the depository for sperm, the birth canal, and the exit route for menstrual fluids. It is a self-cleansing organ, and its odor is generally not offensive. The walls of the inner two thirds of the (21) are relatively insensitive to touch, but about 10% of all women have an area of heightened sensitivity on the front wall called the (22) . When a mature ovum (egg) is released from a(n) (23) , it is picked up by a(n) (24) , which then transports it to the (25) . If fertilized by a sperm, the egg usually implants in the (26) of the uterus. Women should have regular pelvic exams and Pap smears to test for (27) .

   Men's external anatomy consists of the penis and the (28) , which contains the (29) . Erection of the penis occurs when the two (30) and the (31) become engorged with blood. The rounded end of the penis, called the (32) , is

covered by the (33) unless this excess skin has been surgically removed in an operation called (34) . The American Academy of Pediatrics favors routine circumcision of newborns.

Men's internal reproductive system includes the (35) , which produce sperm and the male hormone (36) , and a four-part duct system (starting from the testicles) consisting of the (37) , (38) , (39) , and (40) , which transports sperm out of the body. During an ejaculation, sperm are mixed with fluids from the (41) and (42) to form (43) . A small amount of fluid is released by the (44) before a man reaches orgasm. Cancer of the (45) is the most common type of cancer in men aged 20 to 34. The most common cancer (other than skin cancer) among all men in the United States is cancer of the (46) .

Self-Test

Answers can be found on p. 468.

A. True or False

- **T F** 47. The testicles in adult men normally produce millions of new sperm every day.
- **T F** 48. It is normal for one testicle to hang lower in the scrotum than the other.
- **T F** 49. Sperm can only be produced in an environment that is several degrees lower than normal body temperature.
- **T F** 50. Most doctors routinely check for sexually transmitted infections when they perform pelvic exams.
- **T F** 51. Most women have a G spot.
- **T F** 52. The American Cancer Society advises that women should have mammograms starting at age 45.
- **T F** 53. The ovaries produce hundreds of new eggs every month during a woman's reproductive years.
- **T F** 54. The American Academy of Pediatrics presently favors the routine circumcision of boys for health reasons.
- **T F** 55. The use of feminine hygiene sprays and douches is a recommended part of normal feminine hygiene.
- **T F** 56. There is no direct physical pathway between the ovaries and the Fallopian tubes.
- **T F** 57. The labia majora are hairless and meet at the top to form the clitoral hood.
- **T F** 58. Deep, pleasurable vaginal sensations during intercourse are due to sensitive vaginal walls.
- **T F** 59. Erections in men are due in part to a bone that protrudes into the penis.
- **T F** 60. If a woman does not bleed vaginally during intercourse it is a good indicator that she has previously had sexual intercourse.
- **T F** 61. A woman's sexual responsiveness is related to breast size.

B. Matching

- 62. areola
- 63. mons veneris
- 64. perineum
- 65. introitus
- 66. corpora cavernosa
- 67. bulbocavernosus muscle
- 68. corona
- 69. fimbria
- 70. glans
- 71. Bartholin's glands
- 72. smegma

- 73. pubococcygeus muscle
- 74. vestibular bulbs
- 75. spermatic cord

1. term used to refer to the vaginal opening
2. darkened area around the nipple
3. hairless area of skin between the vaginal opening and the anus
4. cheesy substance secreted by glands in the foreskin and clitoral hood
5. soft layer of fatty tissue overlaying the pubic bone
6. two spongy cylinders in the penis
7. large muscle that surrounds the vagina and the bladder
8. raised ridge where the glans and shaft of the penis meet
9. tiny finger-like endings of the Fallopian tubes
10. smooth rounded end of the penis and clitoris
11. two glands located at the base of the labia minora
12. ring of sphincter muscles that surround the vaginal opening and root of the penis
13. structures located on both sides of the vaginal opening that become engorged with blood during sexual arousal
14. tube-like structure that suspends the testicles in the scrotum

C. Fill in the Blanks

- 76. The American Cancer Society recommends that men over the age of 50 should have an annual examination to check for cancer of the .
- 77. In women, the two outer elongated folds of skin that extend from the mons to the perineum are called the .
- 78. The innermost layer of the uterus, which is sloughed off and discharged from the woman's body during menstruation, is called the .
- 79. In men, an erection results from the spongy tissues of the penis becoming engorged with .
- 80. When a man becomes sexually aroused, a few drops of a clear fluid produced by the may appear at the tip of the penis.
- 81. Breast size in women is determined by the .
- 82. The best time for most women to examine their breasts for abnormal lumps is .
- 83. After sperm travel through the vas deferens, they enter the paired .
- 84. Most of the fluid in an ejaculation comes from the .
- 85. The best time for a man to examine his testicles for abnormal lumps is .
- 86. Two glands that secrete small amounts of alkaline fluid into ducts at the base of the labia minora are called .
- 87. Sperm are produced in the of the testicles.
- 88. Both the penis and the have corpora cavernosa.
- 89. The muscle surrounding the vagina and bladder is called the muscle.
- 90. In women who have a G spot, it is located on the wall of the vagina.
- 91. The pituitary hormone that causes production of milk is .

Suggested Readings and Resources can be found on p. 459.

Chapter 3 Hormones and Sexuality

The menstrual cycle is often conceptualized in the biomedical literature as a unidimensional, biological, and pathological aspect of women's bodies and health…. Social science scholars recognize that the biological event…is experienced and perceived within a broader sociocultural context…it is associated with…girls' and women's gender identity, sexuality, body image, reproductive lives, and social status.

—Ingrid Johnston-Robledo & Margaret L. Stubbs, 2013

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 3.1 Identify and describe the hormones of the endocrine system that are involved in reproduction.
2. 3.2 Describe the four phases of the menstrual cycle and discuss the variability of cycle length.
3. 3.3 Discuss the relationships between the menstrual cycle, pheromones, and sexual desire.
4. 3.4 Explain the regulation of hormones in men.
5. 3.5 Summarize the historical and contemporary attitudes about menstruation.
6. 3.6 Define and explain menstrual problems such as amenorrhea, premenstrual syndrome (PMS), dysmenorrhea, endometriosis, and toxic shock syndrome (TSS).
7. 3.7 Discuss the pros and cons of menstrual suppression.
8. 3.8 Explain the relationship between hormones and sexual desire.
9. 3.9 Identify the dangerous effects of anabolic steroids.

What are hormones? Do you know what they do? Although most people have heard of hormones, very few are certain of their function. Here are some typical responses by students enrolled in our course. Many had no idea what hormones do:

"Before I was enrolled in this course I did not know what hormones were. All I knew was that they were part of our body and were there for some reason." (woman)

"I knew hormones made you grow and sweat. But I didn't know they had anything to do with menstruation. I didn't even know they had any purpose besides just being there." (woman)

"I thought hormones were the building blocks of our body, like DNA, except hormones were related to attitudes of an individual." (man)

Many thought that hormones controlled our moods:

"I thought that hormones controlled my moods. Whenever I'm happy, sad, mad, angry, or even 'in the mood' it was all hormones. Any unusual behavior was because of hormones." (woman)

"I believed that hormones were really only in women and they were only in use when a female was on her period. When women had cramps, I've always heard people say, 'She's on her period. Her hormones are acting up!'" (woman)

Others thought that hormones had only to do with sexual behavior:

"I thought hormones made guys horny and go after girls. The girls would always tell us 'The hormones must be flowing' whenever we would do anything to try to impress them. So I figured only guys had them." (man)

"I always thought hormones made a person horny. I always heard people say that when a person was interested in sex 'their hormones were going crazy.'" (woman)

"I always thought that hormones determined how feminine or masculine someone can be. I thought it was what made people gay or straight or in-between." (man)

(All examples are from the authors' files.)

Let us now see what role hormones really play in human sexuality.

The Endocrine System

1. 3.1 Identify and describe the hormones of the endocrine system that are involved in reproduction.

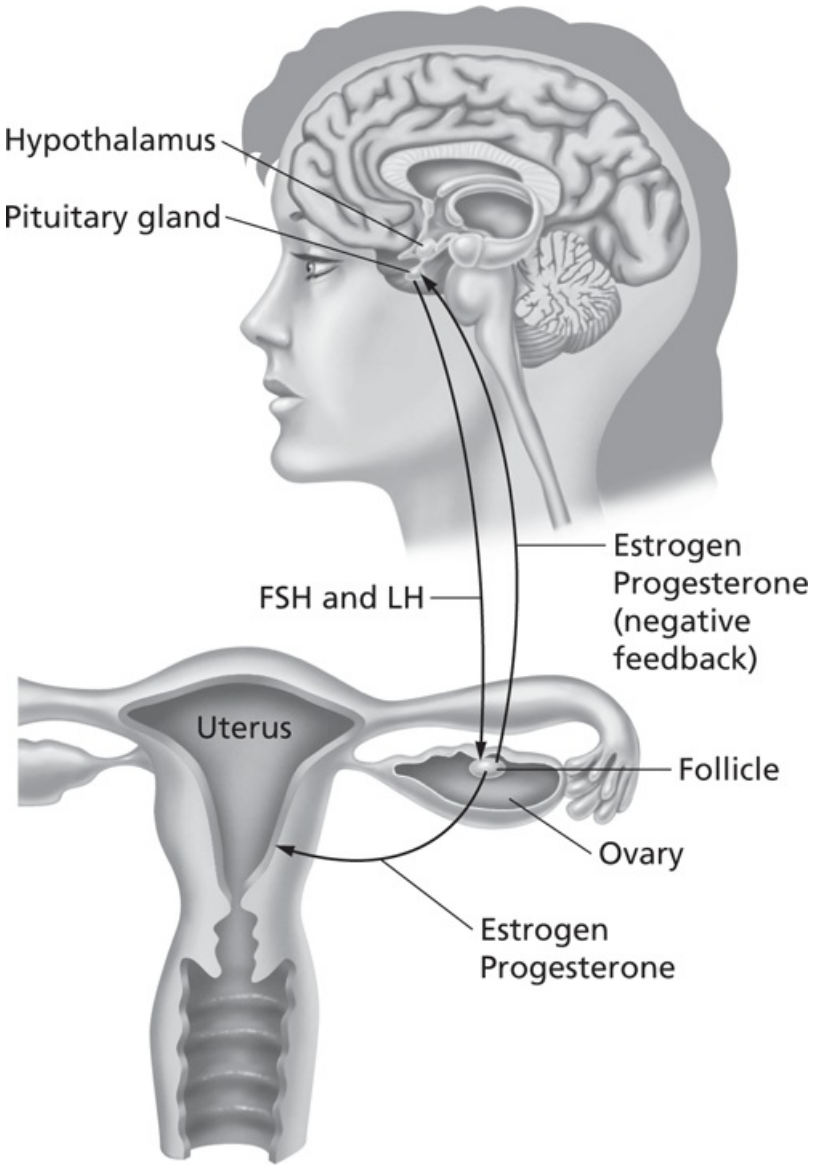
Hormones play a crucial role in both men and women. They are important for growth (growth hormone), metabolism (thyroid hormone), water retention (antidiuretic hormone), reaction to stress (cortisol), and many other functions. They are also important for the development and maintenance of our reproductive system, and they influence our sexual behavior.

Hormones are chemical substances that are released into our bloodstream by ductless glands. They are carried in the blood to other parts of the body, where they exert their effects. Hormones released by one gland often cause another gland to release its own hormones. This network of ductless glands is called the endocrine system.

Not all glands in the body are endocrine glands. Salivary glands and sweat glands, for example, are not endocrine glands. They secrete their products (saliva and sweat) through ducts to the surface. The testicles and ovaries, on the other hand, are part of the endocrine gland system. The *testicles* manufacture and release testosterone, which is often referred to as the "male hormone"; the *ovaries* produce the "female hormones" estrogen and progesterone. However, testosterone is also produced in small amounts by the ovaries, and estrogen in small amounts by the testicles. The *adrenal glands* (located near the kidneys) also produce small amounts of these hormones; thus, all three hormones are found in both men and women.

What causes the testicles and ovaries to secrete their hormones? The immediate answer is that it is the *pituitary gland,* which is located at the base of the brain (see Figure 3–1). The pituitary gland releases eight different hormones into the bloodstream. Two of these have their effect on the ovaries and testicles, and are thus called *gonadotropins* ("gonad-seeking"). In women, follicle-stimulating hormone (FSH) stimulates the maturation of a *follicle* (an immature egg) in one of the ovaries. This was its first known function, and thus how it received its name. However, FSH is also released by a man's pituitary to stimulate the production of sperm in the testicles.

Figure 3–1



The brain–pituitary–gonad feedback loop in women.

Figure 3–1 Full Alternative Text

A second pituitary gonadotropin hormone is called luteinizing hormone (LH). In women, LH triggers *ovulation* (release of an egg). In men, it stimulates the testicles to produce male hormones.

There are two other pituitary hormones that you will read about in later chapters. Prolactin and oxytocin are important for milk production and release during breast-feeding (Chapter 7). Oxytocin has also been implicated in contractions of the uterus during both labor and orgasm (Mah & Binik, 2001). Some researchers have called oxytocin the "love hormone" because blood levels increase during romantic attraction, touching, and cuddling (see Chapter 12).

The pituitary was once called the "master gland" of the body because many of its hormones (like FSH and LH) influence the activities of other glands (like the ovaries and testicles). We now know, however, that the brain controls the release of pituitary hormones, so maybe it is the brain that should be called the master gland. The release of gonadotropin hormones from the pituitary, for example, is under the control of another hormone, called gonadotropin-releasing hormone (GnRH), which is manufactured in the *hypothalamus,* a small area at the base of the brain (see Figure 3–1).

GnRH, the gonadotropins, and the gonadal hormones (testosterone, estrogen, and progesterone) are regulated by negative feedback loops. To better understand a negative feedback loop, think of how a thermostat works. When the room is cold, the thermostat triggers the furnace to go on. An increase in room temperature eventually causes the thermostat to turn the furnace off. Now look at Figure 3–1. In women, increases in blood levels of GnRH from the hypothalamus cause an increase in the release of FSH from the pituitary gland, which in turn results in increased blood levels of estrogen from the ovary. The increased estrogen levels then work to decrease the production of GnRH. There is a similar feedback loop among GnRH, LH, and progesterone.

These are just the basics. The complete story, of course, is more complicated. For example, another ovarian hormone, called inhibin, helps to regulate FSH production, and input from the brain affects release of GnRH. The feedback-loop model of hormonal regulation is made even more complicated by the fact that a woman's pituitary and gonadal hormones vary cyclically on about a monthly basis. This is known as the menstrual cycle, which we will now describe in more detail. We will consider the regulation of male hormones later.

Do not feel alone if you presently do not know much about the menstrual cycle. Surveys show that most teenage girls have only minimal knowledge about it (White, 2013). How much do you suppose most men know about it?

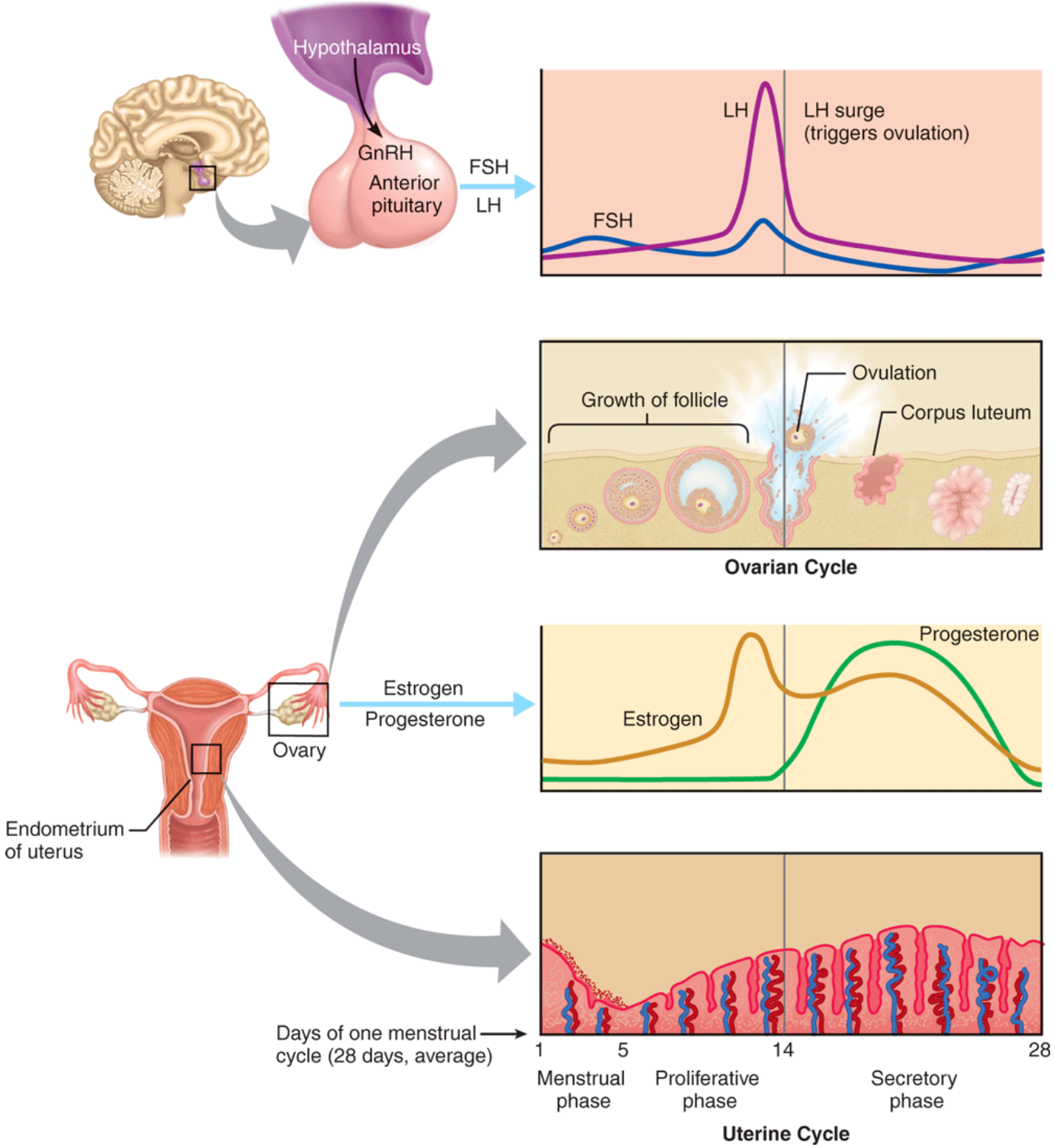
The Menstrual Cycle

1. 3.2 Describe the four phases of the menstrual cycle and discuss the variability of cycle length.

An ovum (egg), you recall, is surrounded by other cells within a thin capsule of tissue to form what is called a follicle. At birth, each ovary has about 300,000 to 400,000 immature (called primordial) follicles, and the ovaries do not produce any new follicles during a woman's lifetime (however, see White et al., 2015). Instead, after birth about 1,000 follicles begin to mature every month. The entire growth phase of a follicle proceeds through several stages (primordial, primary, secondary, antral, and Graafian) and takes at least 220 days (McGee & Hsueh, 2000). During the first several years of life the follicles never complete their development beyond the antral stage, and only about 200,000 primordial follicles remain in each ovary at the time of puberty. When a girl reaches puberty, follicle-stimulating hormone from her pituitary gland allows one or more antral follicles to enter the final stage of growth, which takes a little less than a month. During this phase of growth, called the menstrual cycle, the endometrium of the uterus thickens and becomes highly vascularized (supplied with lots of blood vessels) in preparation for implantation of a fertilized egg. If the egg is not fertilized by a sperm, endometrial tissues are discharged from the body, accompanied by bleeding (menstruation), and a new follicle then begins the final stage of maturation. This process will end at *menopause*, when the ovaries shrivel up to the point that no follicles can mature (usually around the age of 50), and thus an average woman will have about 400 menstrual cycles in her lifetime.

The average length of an adult human menstrual cycle is about 28 days. We will describe the hormonal events that occur in a 28-day cycle as consisting of four phases (Shulman, 2011). *In numbering the days, it is customary to refer to the start of menstruation as day 1*. This is because menstruation is the only event of the cycle that all women can recognize. *In actuality, however, menstruation is really the last of the four phases of the cycle*, so we will begin with the events that occur after menstruation, on about day 5 (see Figure 3–2). Try not to be confused by the system used for numbering days. As you will soon learn, consistent 28-day cycles are not very common, so the numbers of the days in parentheses will be different for shorter and longer cycles.

Figure 3–2



Hormonal, ovarian, and uterine changes during a 28-day menstrual cycle.

Source: Johnson, Michael, *Human Biology: Concepts and Current Issues,* 4th, © 2008. p. 379. Reprinted and electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

Figure 3–2 Full Alternative Text

3.2.1 Preovulatory Phase (Days 5 to 13)

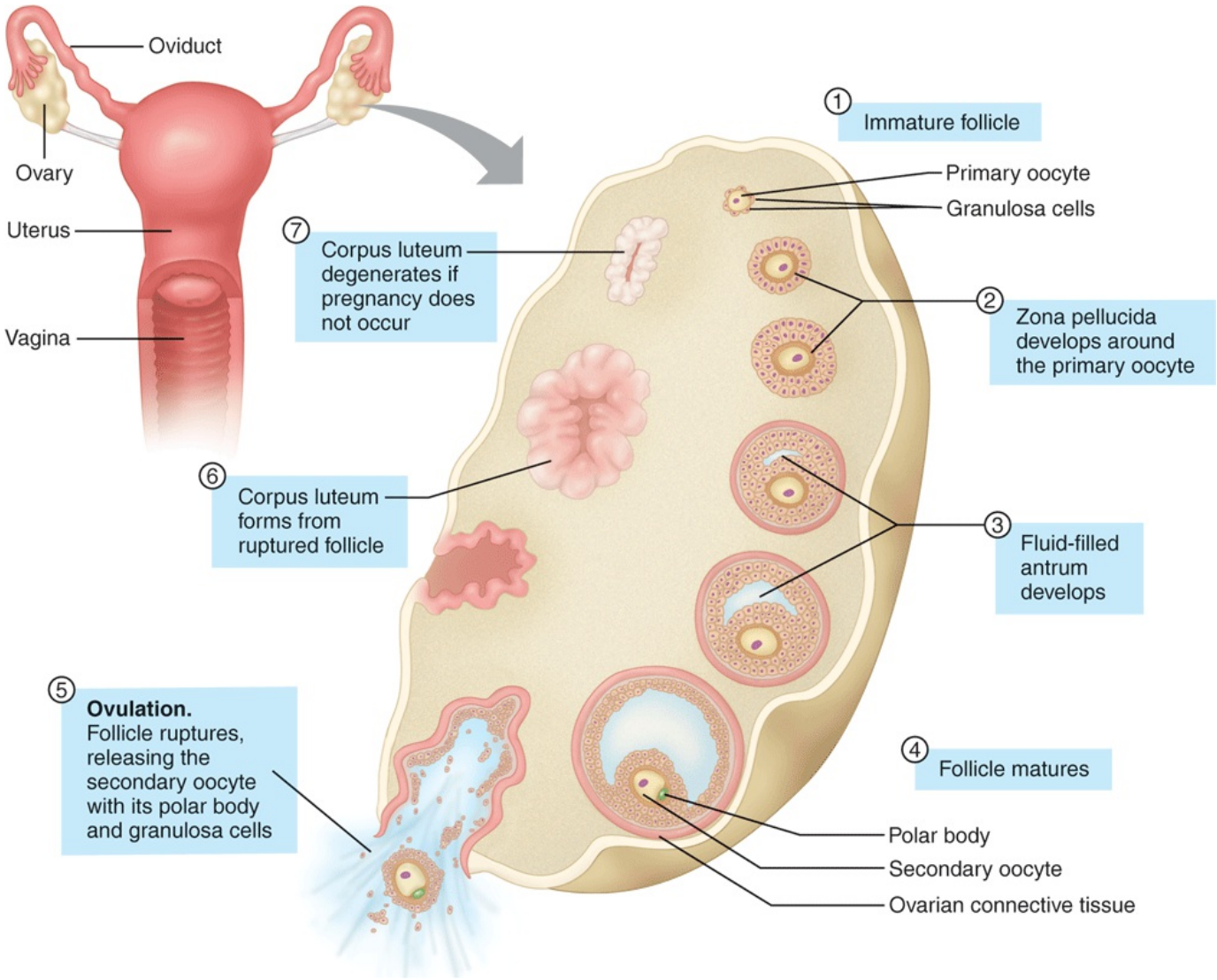
This phase is also referred to as the *follicular* or *proliferative phase*. The pituitary secretes relatively high levels of follicle-stimulating hormone (FSH), which, as the name indicates, stimulates the development of a follicle in the ovary. The growing follicle, in turn, becomes a temporary endocrine gland and secretes increasingly higher levels of estrogen. Estrogen is carried in the bloodstream back to the brain and pituitary, where it inhibits further release of FSH (see Figure 3–1). Estrogen also stimulates release of luteinizing hormone (LH) from the pituitary and promotes proliferation (growth) of the endometrium of the uterus. Near the end of this phase, estrogen levels reach their peak, which triggers a release of LH from the pituitary (called the LH surge).

3.2.2 Ovulation (Day 14)

The LH surge (along with a sharp increase in FSH) signals the onset of ovulation within 12 to 24 hours. By this time, the mature follicle (now called a *Graafian follicle*) has moved to the surface of the ovary (see Figure 3–3). At ovulation, the follicle ruptures and the ripe ovum is expelled into the abdominal cavity, where it will soon be picked up by a Fallopian tube. Only the ovum is expelled during ovulation. The cells that had surrounded it in the follicle remain in the ovary and now have a new name, the corpus luteum. In addition, the hormonal changes induce a change in the quantity and consistency of cervical mucus—from white and sticky to clear and slippery like an egg white

—to provide a more hospitable environment for sperm.

Figure 3–3



Changes that take place in the ovary during a menstrual cycle.

Source: Johnson, Michael, *Human Biology: Concepts and Current Issues,* 4th, © 2008, p. 381. Reprinted and electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

Figure 3–3 Full Alternative Text

Some women experience lower abdominal cramps for about a day during ovulation. This is sometimes referred to as *Mittelschmerz* (German for "middle pain"). It is more common among young women than older women.

For a woman to get pregnant, both an egg and sperm must be present. An egg remains ripe for only about 24 hours, but sperm can live in a Fallopian tube for up to 5 days (Wilcox et al, 1995). Thus, the fertile period for women is 5 days before ovulation to 1 day afterwards. You will read more about this in Chapter 6.

3.2.3 Postovulatory Phase (Days 15 to 28)

The postovulatory phase is also referred to as the *luteal* or *secretory phase*. The cells of the corpus luteum, which are already secreting estrogen, also begin to secrete large levels of progesterone after ovulation. Progesterone inhibits further release of LH from the pituitary and further prepares the thickened endometrium in case the egg is fertilized. The endometrium develops small blood vessels, and its glands secrete nourishing substances. If the egg is fertilized by a sperm, it continues its trip through the Fallopian tube and implants itself in the endometrium. The developing placenta produces the hormone *human chorionic gonadotropin (HCG)*, which ensures that the corpus luteum will continue to secrete estrogen and progesterone to maintain the endometrium (thus HCG serves the same role as the pituitary hormones).

But how often in a woman's reproductive lifetime will one of her eggs be fertilized and result in pregnancy? Not too often. Most of the time fertilization does not occur, and in the absence of implantation, the corpus luteum degenerates. When this happens, there is a sharp decline in estrogen and progesterone.

3.2.4 Menstruation (Days 1 to 4)

With the decline in levels of estrogen and progesterone, there is loss of the hormones that were responsible for the development and maintenance of the endometrium. The endometrium is sloughed off and shed over a 3- to 6-day period. Menstruation is the discharge of sloughed-off endometrial tissue, cervical mucus, and blood (about 4 to 6 tablespoons over the entire menstrual period). The loss of estrogen (which was inhibiting the release of FSH, you recall) also results in the pituitary gland once again secreting FSH, and a new cycle begins.

Personal Reflections

Do you regard menstruation as a normal bodily process that is experienced by all women in good health (between puberty and menopause)? If your answer is "yes" but you answer "no" to either one of the next two Personal Reflections, examine your feelings more carefully.

3.2.5 Length of the Menstrual Cycle

In the previous sections, you learned that the average length of a woman's menstrual cycle is 28 days. Actually, this is not true until women are full adults, often not until they are in their 30s (see Shulman, 2011). During adolescence, most girls' cycles average longer than 28 days. Even for adult women most cycles do not last exactly 28 days. There is considerable variability from woman to woman and from cycle to cycle in the same woman. One study found that half of women have cycles that vary in length by 7 days or more (Shulman, 2011). Another study reported that most women's cycles vary by 8 days or more (Harlow & Ephross, 1995). The variability in cycle length is greatest during the 2 to 5 years after a girl's first menstruation and before a woman's menopause. There is more variability in the preovulatory (follicular) phase than in the postovulatory (luteal) phase. Many things can affect the length of the menstrual cycle including stress, nutrition, illness, drugs, and—as you will see next—other women's cycles.

Relationships Between the Menstrual Cycle, Pheromones, and Sexual Desire

1. 3.3 Discuss the relationships between the menstrual cycle, pheromones, and sexual desire.

In a letter to advice columnist "Dear Abby," a man insisted that women's sexuality was just like that of female cats and dogs. There are some obvious differences between women and cats and dogs. Women, for example, do not walk on all fours or bark or meow. So why is it so difficult for some people to believe that sexual desire in women may be determined differently than in non-human species? Only women and females of a few other primate species (mostly apes) have menstrual cycles. The females of other mammalian species, including cats and dogs, have estrous cycles. Although owners of female cats and dogs may have noticed some periodic vaginal discharge, these animals do not have a menstrual period. The slight discharge (called spotting) occurs during ovulation, and it is only at this time that the female is sexually receptive ("in heat," or in estrus) to the male.

Numerous studies have investigated whether women's sexual interest changes with different stages of the menstrual cycle. The results of early studies were contradictory (see Regan, 1996, for a review). One problem is that results are influenced by which aspect of sexual activity is measured (e.g., interest, fantasy, dreams, physiological arousal, masturbation, or intercourse). Later studies have found that there is, indeed, an increase in women's sexual activity and fantasies in the days leading up to and including ovulation (Bullivant et al., 2004; Dawson et al., 2012; Hedricks, 1995; Wilcox et al., 2004). Not only do women report feeling more attractive and desirable (and try to look more attractive) near ovulation (Röder et al., 2009), but olfactory and visual perceptions also change around mid-cycle in a direction that might indicate increased sexual motivation—they become more attentive to "maleness" features (Macrae et al., 2002; Tarin & Gomez-Piquer, 2002; see Röder et al., 2009). For example, researchers have found that women prefer men with stereotypic rugged masculine features around the time of ovulation (Gangestad et al., 2007; Penton-Voak et al., 1999).

All of these increases were modest, and what is important to remember is that *women, unlike the females of most other mammalian species, can become sexually aroused at any time of the cycle*. In most other species fertility and sexual behavior are physiologically linked (by hormones and pheromones), but in women non-physiological influences (such as the social context and happiness within the relationship) become much more important for linking sexual behavior with the fertile period. The importance of this will become more obvious when you read about women's sexual desire in Chapter 4 and Chapter 13.

The sexual behavior of animals is also greatly influenced by their sense of smell. If you have ever owned a female cat or dog, you know about this. When your pet was "in heat," male animals from all over the neighborhood started showing up in your yard. They were attracted by natural body scents called *pheromones.* In the scientific literature, pheromones are defined as "a substance secreted by an animal to the outside of that individual which is then received by another individual . . . of the same species, which then elicits some behavioral or developmental response in the latter" (Karlson & Luscher, 1959). The excretion of pheromones has been well established for many non-human species (Rodriguez, 2004), and it has also been found that the receptor site is a structure called the vomeronasal organ, part of the olfactory (smell) system. In humans, pheromones are odorless. Many people use perfumes and colognes to enhance their sexual attractiveness, but is there any evidence that human sexuality is influenced by natural, odorless body secretions?

The answer might be yes. In a study of 135 college coeds, Martha McClintock (1971) found that roommates came to have similar menstrual cycles while living together over the course of a year. At the beginning of the year, their cycles were an average of 8.5 days apart, but by the end of the year their cycles were an average of only 4.9 days apart. Subsequent studies reported that mothers and daughters who lived together also displayed menstrual synchrony (Weller & Weller, 1993, 1997). McClintock suggested that some undetermined natural body odor synchronized women's cycles (see McClintock, 1999, for a review). Women who were regularly smeared under the nose with sweat collected from the underarms of other women began to have menstrual cycles that coincided with those of the sweat donors (Preti et al., 1986). A cautionary note: Many studies have not been able to find menstrual synchrony, so the phenomenon may not be as great as originally believed (see Schank, 2001, for a review).

Studies also suggest that male pheromones may affect women's menstrual cycles. Several studies, for example, found that women who had regular sexual experiences with a man had more regular menstrual cycles (e.g., Cutler et al., 1985). Women with abnormal menstrual cycles who were regularly smeared under the nose with underarm secretions collected from men began to show more normal cycles (Cutler et al., 1986).

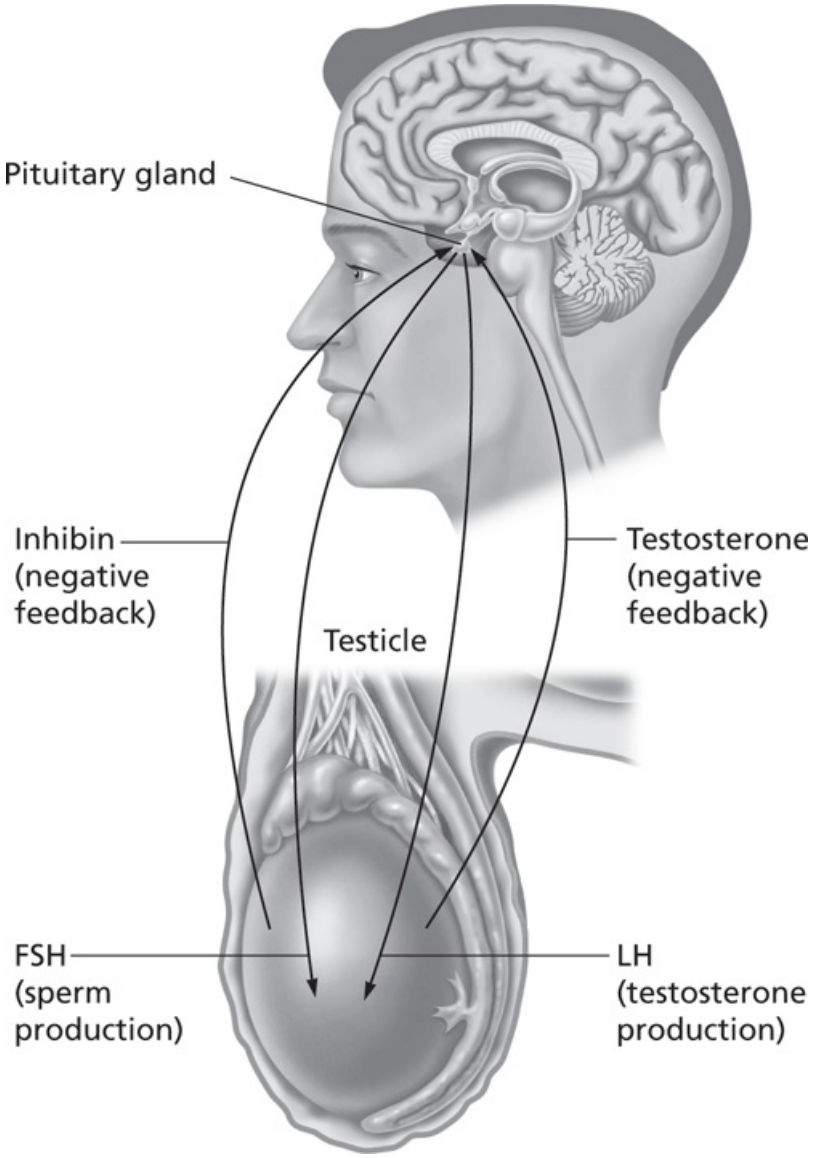
Many studies have found that men find women to be more attractive and are more attentive toward them during ovulation (Haselton et al., 2007; Puts et al., 2013; see Haselton & Gildersleeve, 2011, for a review). How would men know? Men find women's natural body scents to be more attractive around the time of ovulation (Gildersleeve et al., 2012). One study found that when men smelled T-shirts that had been worn by women, the scent of T-shirts that had been worn during ovulation caused an increase in testosterone levels. This response was not observed for T-shirts worn at other times of the menstrual cycle (Miller & Maner, 2010).

Regulation of Male Hormones

1. 3.4 Explain the regulation of hormones in men.

In men, the hypothalamus, pituitary gland, and testicles operate in a feedback loop (see Figure 3–4) much like the feedback loop in women. Let us first consider sperm production. Release of gonadotropin-releasing hormone (GnRH) from the hypothalamus causes release of follicle-stimulating hormone (FSH) from the pituitary. Increases in blood levels of FSH stimulate production of sperm in the seminiferous tubules of the testicles. FSH production is inhibited by increases in blood levels of inhibin, produced in men by Sertoli cells in the testicles.

Figure 3–4



The brain–pituitary–gonad feedback loop in men.

Figure 3–4 Full Alternative Text

Testosterone production increases when GnRH from the hypothalamus stimulates release of luteinizing hormone (LH) from the pituitary gland. Higher blood levels of testosterone (produced by the Leydig's cells in the testicles, you recall) then inhibit the production of GnRH.

You have just read how women's pituitary and gonadal hormones fluctuate (go through cycles) on about a monthly basis during their reproductive years. However, the levels of FSH, LH, and testosterone in men are relatively stable. There is a diurnal rhythm of testosterone production (higher levels during the day than at night), but testosterone levels do not change dramatically in a monthly cycle.

What accounts for the fact that women of reproductive age have monthly cycles of fluctuating hormone levels while men do not? Are women's pituitary glands different from men's pituitary glands? Research with animals has shown that when male pituitary glands are transplanted into females, these glands also begin to secrete FSH and LH cyclically. Thus, the difference is in the hypothalamus of the brain, not in the pituitaries. A woman's hypothalamus is, in fact, different in both structure and connections from a man's hypothalamus, and it is for this reason that women show cycles in FSH and LH (and consequently, the gonadal hormones) and men do not. We will have more to say about this later in the book.

Attitudes About Menstruation

1. 3.5 Summarize historical and contemporary attitudes about menstruation.

In her book *Outrageous Acts and Everyday Rebellions* (1983), feminist Gloria Steinem asked what our attitudes about this subject would be if men were the ones who menstruated:

> Clearly, menstruation would become an enviable, boast worthy, masculine event: Men would brag about how long and how much. Young boys would talk about it as the envied beginning of manhood..pngts, religious ceremonies, family dinners, and stag parties would mark the day. . . . Sanitary supplies would be federally funded and free. Of course, some men would still pay for the prestige of such commercial brands as Paul Newman Tampons, Muhammad Ali's Rope-a-Dope Pads, John Wayne Maxi-Pads—"For those Light Bachelor Days!"

(**STEINEM, G**. (1983). Outrageous acts and everyday rebellions. New York: Holt, Rinehart & Winston.)

There is nothing dirty or nasty about menstruation, and with a little knowledge, it is not even mysterious, but rather a basic, important biological function. The discharge, you recall, consists of nothing more than some sloughed-off endometrial tissue, mucus, and a small amount of blood. From a contraceptive perspective, menstruation is the safest phase of the cycle in which to have unprotected intercourse (although pregnancy is not impossible if a woman were to have a very short cycle). Nevertheless, many people do have a negative attitude about menstruation.

3.5.1 Historical Attitudes

The biblical Hebrews regarded a menstruating woman (*Niddah* in Hebrew) as "unclean" or "impure" and believed that she could transfer her condition of uncleanliness to a man during sexual intercourse:

> When a woman has a discharge of blood which is her regular discharge from her body, she shall be in her impurity for seven days, and whoever touches her shall be unclean until the evening. And everything upon which she lies during her impurity shall be unclean; everything also upon which she sits shall be unclean. . . . And if any man lies with her, and her impurity is on him, he shall be unclean seven days; and every bed on which he lies shall be unclean.

(leviticus 15:19–21, 24, Revised Standard Version)

Sexual intercourse was strictly forbidden for 7 days from the time a woman first noticed menstrual blood. If no blood was noticed on the 8th day, she immersed herself in a *mikvah* (ritual bath) and was again considered "pure." The menstrual taboo later was extended to all physical contact, and a *Niddah* was required to leave her home and stay in a special house called a house for uncleanliness. Orthodox Jews still adhere to a literal interpretation of the passages in Leviticus. (See also Box 3–A.)

Box 3–A Cross-Cultural Perspectives

Menstrual Taboos Versus Menstrual Celebrations

A taboo is defined as "forbidden and excluded persons, acts, words, thoughts, and things that supposedly threaten a group's welfare and survival and are, therefore, used to that group's advantage" (Voight, 1984). In many cultures, menstruation is a taboo in that menstruating women are portrayed as sick, impure, or filthy.

In our own culture, we have a long history of negative attitudes about menstruation. The Bible instructed that no one touch a woman while she was in her "impurity," and even today most of the world's major religions have menstrual taboos (Guterman et al., 2008). As recently as the Victorian era physicians advised that menstruating women be kept away from the kitchen or pantry so that they would not spoil hams (British Medical Journal, 1878).

Today, menstrual taboos persist in many cultures around the world, including such geographically diverse places as central Africa, Alaska, and the South Pacific. For example, the Havik Brahmins of southern India believe that if a woman touches her husband while she is menstruating, it will shorten his life (Ullrich, 1992). This is similar to the belief held by Sambian (Melanesian) men that menstrual blood endangers their health (Herdt, 1993).

"I am from the Sara-Kaba tribe in Chad. When a woman is menstruating, she is not supposed to go in the kitchen and cook. She has a special dish to drink from because the men believe if they drink from it, it could cause an accident and even death."

(from the authors' files)

The Lele of the Congo believe that if a menstruating woman enters the forest, it will ruin hunting for the men (Douglas, 1966), while the Thonga of South Africa believe that sex with a menstruating woman will cause the man to be weak in battle (Ford & Beach, 1965).

In order to ensure that a menstruating woman has no contact with men, many cultures require that she remain in a small menstrual hut for an entire week. Figure 3–5 shows a group of such huts in New Guinea (Ward, 1989). This practice is carried to an extreme among the Kolish Indians of Alaska, who lock young girls in a small hut for as long as a year after their first menstruation (Delaney et al., 1988). Women of the Dyak tribe (Southeast Asia) must live for a year in a white cabin while wearing white clothes and eating nothing but white foods. Other cultures do not use

special huts but do require that a woman sleep outside of the house while she is menstruating (Ullrich, 1992).

Figure 3–5

Menstrual huts in New Guinea where menstruating women are isolated for 7 days.

Source: Martha Ward

It is a common practice, in these cultures, to introduce menstrual taboos to young girls during initiation ceremonies held about the time of their first menstruation (Schlegel & Barry, 1980). These ceremonies are rites of passage into adulthood, signifying that the girls are ready for sexual activity or marriage. Anthropologists believe that the taboos serve to emphasize the low status and inferiority of women in these cultures, where the social organization (including division of labor) is based on sex (see Forbes et al., 2003). Formal menstrual taboos are most frequently observed in small food-gathering or horticultural societies (Schlegel & Barry, 1980), but researchers believe that even in our own country stigmatizing menstruation results in women's lower status compared to men (Johnston-Robledo & Chrisler, 2013).

Larger societies generally do not have formal adolescent initiation ceremonies, and there are some cultures in which people do not have negative attitudes about menstruation. In fact, some view it positively (Chrisler & Zittel, 1998). In Japan, for example, parents celebrate a daughter's first menstruation in a positive manner (Delaney et al., 1988.).

"Growing up, I was not told much about sex by my parents. As a result, I felt uncomfortable about beginning menstruation. My best friend's mom, on the other hand, who was from Japan, told her about menstruation early and openly. When she began menstruation, she felt comfortable telling her mom, and according to the custom of her native country, a celebration dinner was planned to celebrate her entrance into womanhood."

(from the authors' files)

Which girl do you suppose felt better about herself as a blossoming woman during adolescence?

Many Native American cultures also held celebrations at the time of a girl's first menstruation (and some still do) (Owen, 1993). The Mescalero Apaches, for example, had annual celebrations for all the girls who had passed from childhood to womanhood. During menstrual periods, the women of some Native American cultures were segregated together in "moon lodges." This was regarded as a positive experience, a time of bonding without any chores (Angier, 1999). However, cultures that view menstruation (or first menstruation) in positive terms are clearly in the minority. For most, it remains an event viewed with great negativity.

Attitudes about menstruation were even more negative during the time of the Roman Empire. Consider, for example, this passage from the Roman historian Pliny (a.d. 77) describing the possible effects of menstrual blood (Delaney et al., 1988):

> Contact with it turns new wine sour, crops touched by it become barren, grafts die, seeds in gardens are dried up, the fruit of trees falls off. . . the edge of steel and the gleam of ivory are dulled, hives of bees die, even bronze and iron are at once seized by rust, and a horrible smell fills the air, to taste it drives dogs mad and infects their bites with an incurable poison.

As you will see in the next section, many people in the United States still have very negative attitudes about menstruation today.

Personal Reflections

How was menstruation first described to you: as something positive (e.g., "becoming a woman"), as just a fact of life, or as something negative? What effect do you think these early experiences have had on your present attitudes about menstruation? Are you able to talk about menstruation in your family today? If not, why not?

3.5.2 Contemporary Attitudes

Although our country no longer has formal menstrual taboos, there are still many people who have negative attitudes about menstruation (see Johnston-Robledo & Chrisler, 2013, for a review). Both men and women tend to have negative feelings toward women when they are menstruating (e.g., less likable, less agreeable, less clean, more irritable) (Forbes et al., 2003; Roberts et al., 2002). Not surprisingly, in its 1997 Body Image Survey, *Psychology Today* magazine found that three fourths of women said that menstruation made them have negative feelings about themselves (Garner, 1997).

Many people believe menstrual myths—that is, incorrect beliefs, such as women should avoid bathing, swimming, and exercise during menstruation (White, 2013). Here are a few more provided by students in our class:

"When I was about 10, I was told that if a woman was on her menstrual cycle, she shouldn't visit friends who had infant boys because the baby would get a strain."

"My mother told me to tie a piece of black thread around my baby's foot when I went out in public. She claimed that women menstruating would give the baby colic."

"When you had your period not to cook or go around the stove while cooking red gravy because it would curdle."

"All my mother said was, 'Never wash your hair when you are on your period. It will give you cramps.' Not being able to wash my hair for almost a week was pure torture."

(All examples are from the authors' files.)

The majority of American men and women seldom initiate sex during menstruation (Barnhart et al., 1995; Hensel et al., 2004; see Hedricks, 1995, for a review). For women, this is often due not only to their own discomfort but to that of their partner as well (Fahs, 2011). Sex during menstruation is more common among better-educated young women, among people in committed relationships (Allen & Goldberg, 2009), and especially among women who are comfortable with their sexuality (Rempel & Baumgartner, 2003). When people can be persuaded to try sexual intercourse during menstruation, they are often surprised by their reaction:

"My girlfriend sometimes wanted to have sex while she was menstruating. However, I was always reluctant. After taking this course I decided to give it a shot. Much to my surprise, I didn't mind it at all. In fact, she enjoys herself more than normal."

"The first time my girlfriend and I had sex during menstruation I told her that she was going to have to remove the condom afterwards without me looking. The thought of it disgusted me. But as we started, we found that we enjoyed it much more because we did not have to worry about getting her pregnant, it relaxed her afterwards, and because of the added fluids, she was much more lubricated. Now we look forward to sex during menstruation."

"I enjoy making love to my boyfriend while I'm having my periods. It might be messy, but it gives me pleasure, and most important it makes my period light the next day. Anyone who hasn't tried making love this way is crazy. If their only excuse is that it's messy, haven't they ever heard of a shower?"

(All examples are from the authors' files.)

Advertisements for menstrual products emphasize negativity, e.g., secrecy and avoidance (Kissling, 2006). Most American men have such negative attitudes about menstruation that they are too embarrassed to buy tampons or sanitary napkins for their partners:

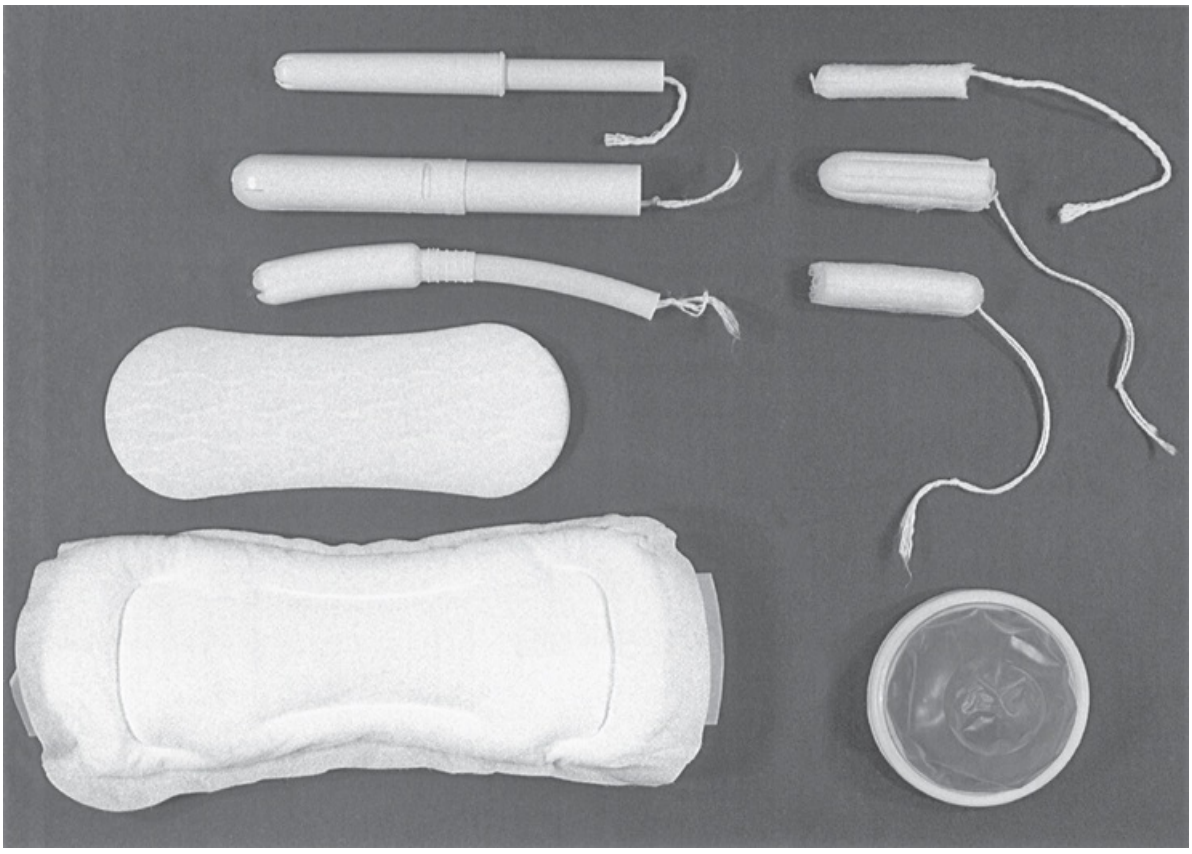
"One class session you asked how many men would buy tampons for their girlfriend. I don't think that is a fair question, because I wouldn't ask my girlfriend to buy condoms for me."

(from the authors' files)

When a person buys condoms, it is with the intent of having sex. Tampons, sanitary napkins, and products such as Instead (see Fig. 3–6) are not

used for sexual relations. In fact, menstruation has nothing to do with whether a woman is sexually experienced. Sexually inexperienced women menstruate. However, even many women are embarrassed about purchasing menstrual products:

Figure 3–6



Menstrual products. Top: examples of six types of tampons—three with applicators (left) and three without applicators (right). Bottom: examples of two types of menstrual pads—underpants liner for light flow and larger one for heavier flow (left) and a newer product (Instead), a soft disposable plastic cup that fits under the cervix, molds to a woman's body, and collects menstrual flow for up to 12 hours (right). Instead is left in during sexual intercourse (but it is not a contraceptive). Some companies now make reusable cotton menstrual pads (e.g., GladRags).

Source: Bruce King

"Before taking this class I didn't realize what effect attitudes in the U.S. had on me. When I went to the store to buy sanitary napkins I would try to hide them until I was getting ready to pay for them. I would not want a man to see me pay for them. I felt that they would think or say she's on her period."

(from the authors' files)

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If you would be uncomfortable about buying tampons or sanitary napkins, ask yourself why. No one feels uncomfortable about buying toilet paper at the store. The reason for this, of course, is that we all know that everyone has bowel movements. It is a normal physiological event for both men and women. Menstruation is a normal physiological occurrence for women.

Personal Reflections

What are your attitudes about menstruation? Do you regard it as a normal physiological event, or is it something about which you or your sexual partner feel ashamed or embarrassed? Test your attitude by answering one of the following two questions: (1) Women, would you feel comfortable asking your boyfriend or husband to buy you some tampons or sanitary napkins at the store? (2) Men, if your girlfriend or wife asked you to do so, would you feel comfortable buying her some tampons or sanitary napkins at the store? If not, why not?

Menstrual Problems

1. 3.6 Define and explain menstrual problems such as amenorrhea, premenstrual syndrome (PMS), dysmenorrhea, endometriosis, and toxic shock syndrome (TSS).

Many women experience problems that are associated in some manner with the menstrual cycle. The next sections will cover these problems and the conditions that are associated with them.

3.6.1 Amenorrhea

Amenorrhea refers to the *absence of menstruation for 3 months* or longer in women who previously had regular menstrual cycles (or, in younger girls, no menstrual periods by the age of 15) (Nelson & Baldwin, 2011). *Oligomenorrhea* is the absence of menstruation for shorter intervals or unevenly spaced menstrual periods. Amenorrhea is normal, of course, when a woman is pregnant, and it is not unusual during breast-feeding or in the first few months after a woman discontinues use of birth control pills. It is also common for menstrual cycles to be irregular during the first few years after menarche (a girl's first menstrual period). With the exception of these reasons, women should be having menstrual periods on about a monthly basis from their late teens until they approach menopause, at which time their cycles will again become irregular. However, about 3% of women in their reproductive years have amenorrhea, and oligomenorrhea is even more common (Nelson & Baldwin, 2011; Schachter & Shoham, 1994).

As you will learn in Chapter 7, a failure to ovulate (and menstruate) may be due to pituitary or ovarian problems (Crosignani et al., 1999). However, a woman's health can also affect her hormone levels. There is a relationship between body fat levels and age of menarche. Girls with high body fat levels generally start menstruating at a younger age than girls with low levels of body fat (Currie et al., 2012). Amenorrhea is common among female athletes (Odden & Fick, 1998). Women with the eating disorder anorexia nervosa are often considerably underweight and, as a result, rarely menstruate (Pinheiro et al., 2007). Adult women who are not menstruating regularly should not assume, however, that this is due to diet or abnormal body-fat levels.

While poor health can result in amenorrhea, amenorrhea can also affect a woman's health. For example, the low levels of estrogen usually associated with amenorrhea often result in long-term problems such as osteoporosis and cardiovascular disease (Schachter & Shoham, 1994). Thus, a premenopausal woman who is not menstruating regularly should consult a physician.

3.6.2 Premenstrual Syndrome (PMS)

In recent years, premenstrual syndrome (PMS) has received more attention than any other menstrual problem. PMS refers to a group of physical and/or emotional changes that many women experience in the *last 3 to 14 days before the start of their menstrual period* (i.e., during the postovulatory, or luteal, phase of the cycle). Physical symptoms may include bloating, breast tenderness, abdominal swelling, swollen hands and feet, weight gain, constipation, and headaches. Emotional changes may include depression, anxiety, tension, irritability, and an inability to concentrate. About 30% to 40% of women of reproductive age suffer from PMS (Ryu & Kim, 2015). For most of these women it is a long-lasting problem (Ju et al., 2014).

Numerous articles have claimed that marital conflicts, job absenteeism, accidents, suicide attempts, and criminal acts are more common in the last several days before the start of menstruation than at other times of the menstrual cycle (e.g., Dalton, 1960, 1980; Hylan et al., 1999). This has led to the commonly portrayed stereotype of the premenstrual woman as "a frenzied, raging beast. . . prone to rapid mood swings and crying spells,. . . out of control, and likely at any moment to turn violent" (see Chrisler et al., 2006). In fact, for the large majority of women the symptoms of PMS are mild (Chrisler et al., 2006).

In addition, some researchers say that the term *PMS* is widely overused—and misused (Chrisler & Caplan, 2003; Hardie, 1997). They claim that most women who perceive themselves as having PMS do not really have a recurrent pattern of premenstrual mood changes and mistakenly attribute high stress, poor health, and work problems to PMS. When asked to complete surveys about these problems, men score just as high as most women who perceive themselves as having PMS (Hardie, 1997). So what distinguishes PMS from other conditions with similar symptoms? In order to be classified as true PMS, the symptoms must regularly occur in a cyclic fashion before menstruation and *must end within a few days after the start of menstruation* (Ryu et al., 2015).

For some women, premenstrual mood changes are severe. In fact, the American Psychiatric Association (2013) decided to classify some of the more severe symptoms of PMS as **premenstrual dysphoric disorder,** or **PMDD** (*Diagnostic and Statistical Manual of Mental Disorders, 5th edition*). To be diagnosed with PMDD, a woman's symptoms must markedly interfere with social relations, work, or education and include at least one of the following symptoms: markedly depressed mood, marked anxiety or tension, persistent and marked irritability or anger, or "marked affective lability" (extreme changes in mood, such as sudden sadness). It is estimated that 3% to 8% of all women in their reproductive years have PMDD (Ryu et al., 2015).

"I am a 29-year-old female who is suffering with PMS. It starts exactly 2 weeks before my menstrual period. I can tell when my PMS starts because I start to get very frustrated for no reason at all. Little things that I can normally handle seem impossible at this time. I start to regret that I have children and I desire a divorce from my husband. It seems like the walls are closing in on me and I suddenly get the urge to run away. I can't make any sense out of myself at this time and a lot of times I think of suicide. I know that I am going through PMS but I have no control of my emotions and actions, and thinking. I hate myself at this time. As soon as a drop of blood is released from my body (menstruation) I feel like all my stress and anxieties are released with that blood. All of a sudden I feel like myself again."

(from the authors' files)

Women with PMS or PMDD generally have normal hormone levels and normal estrogen/progesterone ratios. The current consensus of opinion is that the ovarian hormones act in combination with a brain chemical called serotonin to produce the symptoms (Rapkin & Winer, 2008). Several studies have found that the antidepressant drug Prozac (fluoxetine) substantially reduces the tension and irritability in many women with PMDD. Prozac blocks the reuptake of serotonin into brain cells. Selective serotonin reuptake–inhibiting drugs such as sertraline have proven to be very effective in reducing PMDD symptoms.

Is there anything that women with mild symptoms of PMS (i.e., the majority of women) can do? Some of the symptoms can often be relieved by combination birth control pills and changes in diet. Diuretics ("water pills"), for example, can be prescribed to eliminate excess body fluid, which causes bloating and swelling; cutting down on salt intake can also achieve this. Caffeine (found in coffee, tea, many soft drinks, and chocolate) should be avoided because its stimulating effect will worsen problems like nervousness, irritability, and anxiety.

Although a hormonal basis for PMS is suspected, social and cultural factors can also play a role (see Chrisler & Caplan, 2003). PMS is not even known in many non-Western cultures. Several researchers have noted that PMS is greatest in women who have a very negative attitude about menstruation. With so many people still treating menstruation as taboo, is it any wonder that some women are depressed during the few days before it begins?

Personal Reflections

Do you or your partner suffer from premenstrual syndrome? If the answer is "yes," is it possible that any negativity that you or your partner have about menstruation may contribute to it? What do you do about PMS?

3.6.3 Dysmenorrhea

Many women experience *painful abdominal cramps during menstruation*, called dysmenorrhea. Symptoms can also include backaches, headaches, a feeling of being bloated, and nausea. About 60% to 70% of women of reproductive age have experienced menstrual pain, but only a small percentage do so continuously (Ju et al., 2014; Nelson & Baldwin, 2011). It is most common in young adult women 17 to 24 years old.

There are two types of dysmenorrhea—primary and secondary. In *primary dysmenorrhea*, the symptoms are not associated with any pelvic abnormalities; whereas in *secondary dysmenorrhea* there are pelvic abnormalities. Secondary dysmenorrhea is often caused by endometriosis (see next section), pelvic inflammatory disease (see Chapter 5), or ovarian cysts.

Primary dysmenorrhea is not a psychological condition, as was once believed. It is the result of an overproduction of *prostaglandins*, substances that cause contractions of the uterus. The symptoms may be severe enough to cause many women to occasionally miss work or school.

"My periods used to ruin 5 days out of the month. I could barely get out of bed with extreme cramps to the point of nausea. Nothing helped, not even over-the-counter medicine. I have been on birth control pills for almost a year. It is the best thing that ever happened. I haven't experienced any pain."

"The cramps kept me doubled over for days at a time, feeling like I was going to die. Only recently did I find out about drugs like Advil."

"Sex actually seems to relieve the severity of the cramps for a while."

(All examples are from the authors' files.)

All three of these personal experiences reflect common (and usually successful) ways of alleviating primary dysmenorrhea. Drugs like ibuprofen (trade names Motrin, Advil, and others) inhibit the production of prostaglandins. Many physicians prescribe birth control pills for women who suffer from dysmenorrhea. Finally, Masters and Johnson (1966) reported that orgasms relieve the symptoms, at least temporarily.

3.6.4 Heavy Bleeding (Menorrhagia)

About 9% to 14% of women experience heavy menstrual bleeding with every cycle (Nelson & Baldwin, 2011). This is called menorrhagia, and in about 5% of women it is severe enough that they seek medical help. It is most common in women approaching menopause, but it can occur at any age. Not only can this severely interfere with one's personal life, but medically it can cause anemia. Treatments include birth control pills, tranexamic acid, an intrauterine device containing progestin, and, in women who do not want more children, endometrial ablation or hysterectomy. Of these, the most effective is the levonorgestral-releasing IUD (Gupta et al., 2013; see Chapter 6).

3.6.5 Endometriosis

The endometrium of the uterus grows and thickens during each menstrual cycle and is then sloughed off and discharged during menstruation. Endometriosis refers to a condition in which the *endometrial tissue also grows outside the uterus*. It occurs in 5% to 10% of women of reproductive age (Bulun, 2009). Endometriosis may involve the Fallopian tubes, ovaries, external surface of the uterus, vagina, pelvic cavity, and other areas. Like endometrial tissue in the uterus, the out-of-place tissue grows and then breaks apart and bleeds during the menstrual cycle, but the blood cannot drain normally like the inner uterine lining. The abnormal bleeding becomes surrounded by inflammation, and scar tissue forms, in many cases causing adhesions (abnormal growth that binds organs together).

It is not fully understood how endometriosis develops, but those who have it suffer severe cramps and abdominal soreness, especially at menstruation, and often there is excessive menstrual bleeding. Some women experience deep pelvic pain during sexual intercourse as well:

"I have had problems with severe menstrual cramps since I was a junior in high school. The pain got worse and worse over the years. I would have to wear a tampon and two sanitary napkins just to catch the blood. It was awful. I remember missing many days of school because the pain was so severe I could not walk. Then it was discovered that I had endometriosis."

(from the authors' files)

For women who have painful symptoms, relief can often be achieved with hormone therapy that reduces estrogen levels (Bulun, 2009). The birth control pill is often helpful. However, in many cases a combination of hormones and surgery (removal of the abnormal abdominal tissue) is required (Brosens & Benagiano, 2011).

3.6.6 Toxic Shock Syndrome (TSS)

Men are not the only ones who take anabolic steroids. About 2.7% of high school girls have used nonprescription steroids at least once (Kann et al., 2016). Women who take steroids risk sterilization, masculinization of the fetus should pregnancy occur, and a much greater-than-normal chance of breast cancer. Anabolic steroids also have a marked masculinizing effect in women (e.g., causing facial hair growth, male pattern baldness, and deepening of the voice), which is not reversed by discontinuing use of the drugs.

Although anabolic steroids often boost energy and self-esteem, at least temporarily, other behavior changes may include anxiety, irritability, depression, impaired judgment, and paranoid delusions. Steroid use often increases aggressiveness and violent behavior (Beaver et al., 2008; Cunningham et al., 2013; Lumia & McGinnis, 2010).

"I work at a local hospital. . . . One evening a patient came in with flu-like symptoms. The woman got progressively sicker as time went by and her color was actually turning purple in tint. The doctor looked her over from head to toe and then stated that he had found an old tampon in the back of her vagina. He diagnosed her with TSS. The patient's symptoms were getting worse so we went ahead with an emergency transfer by helicopter. After she left, the clerk answered the phone and told us it was the helicopter. Our patient had died."

(from the authors' files)

Toxic shock syndrome (TSS) is caused by toxins produced by a bacterium *(Staphylococcus aureus)*. The symptoms, which are often mistaken for the flu, include a sudden high fever, vomiting, diarrhea, fainting or dizziness, low blood pressure, and a red rash that resembles a bad sunburn (Hanrahan, 1994). It sometimes results in death. Although children and men can get TSS, over 85% of all TSS cases are related to menstruation (Bryner, 1989).

There were over 300 cases of TSS in 1980, when the Centers for Disease Control released the first published report of the disease. Most of the cases were in women who had used extra-absorbent tampons (Vostral, 2011). The number of cases of TSS fell dramatically after highly absorbent tampons were removed from the market, but there are still close to 200 cases reported nationwide each year.

The *Staphylococcus* bacterium needs oxygen to multiply, and the air pockets in tampons contain oxygen. If the *Staphylococcus* bacterium is in the vagina and the person does not have antibodies to them (most people do by the time they are adults), the conditions are right for the development of toxic shock. Tampons do not cause toxic shock, but women who use tampons should change them three or four times a day and switch to sanitary napkins at night before going to bed. If any of the previously described symptoms should develop during menstruation, be sure to see a doctor immediately.

Menstrual Suppression: A Cure or More Negativity?

1. 3.7 Identify the pros and cons of menstrual suppression.

In 2003, the Food and Drug Administration approved *Seasonale*®, a birth control pill that could be taken for 84 days in order to suppress menstruation during that time. This was followed by a similar pill, *Seasonique*, and in 2007, the FDA approved *Lybrel*®, a birth control pill that allowed women to suppress their periods for a year or longer. Menstrual suppression caused by contraceptive products was not new. Progestin-only products (implants and the shot) and IUDs can also suppress menstruation (see Chapter 6). What was new was that these new birth control products were designed with the intent to suppress menstruation. Menstrual suppression was touted as a cure for menstrual disorders such as endometriosis and dysmenorrhea. It does, in fact, help with these problems. Menstrual suppression was also recommended for female athletes and military personnel. More recently, it has been advertised as a lifestyle choice (see Hicks & Rome, 2010).

In a recent survey, women who chose to suppress menstruation said that they did so for convenience and aesthetics and to manage their own bodies (Repta & Clarke, 2013). Women in our course give a variety of reasons why they take menstrual suppression pills:

". . . because I have always had long, heavy periods with a great deal of cramping and bloating."

". . . because I have endometriosis and the pills allow me to avoid painful cramps."

". . . I don't have to deal with tampons and a mess. It is easier, so why not?"

"It is a hassle to deal with periods. This is especially true when I have a lot of college work. It is just easier to skip the whole process altogether."

"I can count several occasions when women don't want to be on their period: formals, spring break, exams. I don't want to have to worry about scheduling my activities around my period."

(All examples are from the authors' files.)

Personal Reflections

Menstrual suppression is viewed more positively by women who consider menstruation to be shameful or bothersome (Johnston-Robledo et al., 2003). Many experts believe that advertisements for menstrual suppression products contribute to our culture's negativity about menstruation (Johnston-Robledo & Stubbs, 2013). "It perpetuates a lot of negative attitudes and taboos about menstruation, that it's something that's bothersome and dirty and debilitating and shameful" (Ingrid Johnston-Robledo, quoted by Stein, 2007). What do you think?

Hormones and Sexual Desire

1. 3.8 Explain the relationship between hormones and sexual desire.

Is the degree of our sexual desire related to our hormone levels? Do people with high sex drives have high levels of hormones while people with low sex drives have low levels? Do some hormones influence sexual desire more than others?

Research on sex and hormones relies heavily on two types of studies: those investigating the effects of administering hormones and those investigating the effects of a loss of hormones (usually after surgical removal of the ovaries or testicles). We will restrict our discussion to human studies because, as you have already learned in reading about menstrual versus estrous cycles, the differences between human sexual behavior and the sexual behavior of most non-human mammalian species is so great as to make generalizations from studies with laboratory animals very questionable.

In humans, there is considerable evidence for testosterone playing a role in sexual desire (see Regan, 1999, for a review). After puberty in boys, 6 to 8 milligrams of testosterone are produced every day (95% of it by the testicles and 5% by the adrenal glands), and among very young (12 to 14 years old) adolescent boys, sexual activity increases as testosterone levels increase (Halpern et al., 1998). There is a gradual decline in testosterone production as a man grows older, but men who are sexually active often have high testosterone levels. However, we do not know which came first (the old chicken-and-egg question).

Hypogonadal men (men who have abnormally low levels of testosterone) show very little interest in sex. Hormone replacement therapy generally restores sexual desire (Corona et al., 2014; Shah & Montoya, 2007). Some studies have found that administration of testosterone enhances sexual desire and activity, even in men with normal hormone levels (Alexander et al., 1997; R. A. Anderson et al., 1992; Bagatell et al., 1994).

In some parts of the world, men who were once used as harem attendants were forced to have their testicles removed (castration, or *orchiectomy*) so that they would not be interested in the women they were supposed to guard. In many cases this worked, especially if the men were not yet sexually experienced at the time of castration. However, there were also stories of some eunuchs (as they are called) having the time of their lives, like roosters guarding a henhouse. Modern studies of castrated men show, however, that sex drive and behavior are drastically or completely suppressed in a high percentage of cases. In most men, the decline is rapid, but castrated men may continue to show some interest in sex for years (Bancroft, 1984).

Which hormones are important for sexual desire in women? There is no evidence to support a role for progesterone or oxytocin (Worsley et al., 2016). In fact, progesterone negatively predicts sexual desire (Roney & Simmons, 2013).

Menopause, or surgical removal of the ovaries, does not reduce sexual desire in most women. In those postmenopausal and other women who do show a decrease, the International Society for Sexual Medicine Consensus is that estrogen replacement therapy alone generally has no effect (Santoro et al., 2016; but see Cappelletti & Wallen, 2016, for a dissenting opinion).

What about testosterone? Small amounts of testosterone (0.5 milligram) are normally produced daily by a woman's ovaries and adrenal glands. Several studies have found that testosterone levels in women are directly related to measures of sexual behavior and desire (Alexander & Sherwin, 1993; Guay, 2001; Sherwin, 1988; Wåhlin-Jacobsen et al., 2015). A deficiency in testosterone produces a marked decrease in sexual desire and responsiveness in women, and some studies have found that desire restored with testosterone replacement therapy (Davis et al., 2008; Shah & Montoya, 2007). In conclusion, a stronger case can be made for the influence of testosterone on sexual desire in women than for estrogen and progesterone (Bancroft & Graham, 2011; Davis et al., 2008).

The Food and Drug Administration has yet to approve testosterone therapy for sexual desire disorders in women. Why not? Because sexual desire in women is more complex than a simple relationship with testosterone and involves social and psychological factors as well (Santoro et al., 2016; van Anders, 2012). As you will learn in Chapters 4 and 13, women's sexual desire in particular is highly correlated with relationship and intimacy needs.

Box 3–B Sexuality and Health

Anabolic Steroids

1. 3.9 Identify the dangerous effects of anabolic steroids.

In their pursuit to be the best, athletes are always looking for an edge over their competitors. Megavitamins, painkillers, stimulants—all have been used in the desire to win. The most commonly used substances today are anabolic steroids (the more correct name is anabolic-androgenic steroids). These steroid hormones are derivatives of testosterone. They have masculinizing (androgenic) effects and also promote growth by enhancing protein uptake by the muscle cell (the anabolic effect) (see Wood & Stanton, 2012).

In recent years, there have been numerous scandals involving the misuse of steroids by athletes. In 2007 alone, Floyd Landis was stripped of his 2006 Tour de France title, Marion Jones admitted to having used steroids when she won five Olympic medals, and World Wrestling Entertainment wrestler Chris Benoit killed his family and himself while using heavy dosages of steroids.

When administered in proper dosages by a physician, anabolic steroids often have therapeutic value for people recovering from illness or surgery. However, in an attempt to gain weight and build muscle mass and strength, many athletes started taking many times (often 100 times) the normal dose. Unfortunately, steroid use is not restricted to professional athletes. Today, about 4.8% of 12th-grade high school boys have used illegal

steroids (Kann et al., 2016). Many do so just to achieve a better body image (Jampel et al., 2016).

The misuse of anabolic steroids can have serious harmful effects (Bonetti et al., 2007). These include high blood pressure and other serious cardiovascular diseases, tumors of the liver and prostate gland, decrease in size of the testicles and impaired reproductive function in men, and lumps in the breast tissue. Steroids can also stunt growth in boys who have not yet reached their full height. Taking anabolic steroids will not make a man's penis bigger, and steroids are likely to cause acne.

Figure 3–7

During the 2013 season, Major League Baseball announced major suspensions for 14 players for use of performance enhancing drugs. These included Alex Rodriguez (left) who was suspended for the 2014 season and former national league MVP Ryan Braun (right) who was suspended for 65 games.

Source: David Maxwell/epa european pressphoto agency b.v./Alamy Stock Photo; John Green/Cal Sport Media/Alamy Stock Photo

Many high school athletes and some college athletes probably take anabolic steroids without knowing much about their side effects, but many world-class athletes who know better continue to do so. Why? For most users, self-fulfillment is most important and they deny any harmful effects (Monaghan, 2002).

Here are some personal experiences related by students taking our course:

"My friends and I worked out in high school. It was a goal of mine to be bigger and stronger than the others. I decided to take anabolic steroids. Not sure how to do it, I had another inexperienced friend help me inject it into my buttocks. About 2 weeks later I noticed my testicles were getting smaller. In another week I started to get severe abdominal pains."

"I am 19 years old and started using steroids last summer. I wanted to bench press 500 pounds. I gained about 40 pounds. These steroids tended to make me irritable and edgy. I occasionally got bad acne on my back and my testicles shrunk."

(All examples are from the authors' files.)

Study Guide

Key Terms

- adrenal glands
- amenorrhea
- anabolic steroids
- corpus luteum
- dysmenorrhea
- endocrine system
- endometriosis
- estrogen
- estrous cycle
- follicle
- follicle-stimulating hormone (FSH)
- follicular (proliferative) phase
- gonadotropin-releasing hormone (GnRH)
- gonadotropins
- hormones
- inhibin
- luteal (secretory) phase
- luteinizing hormone (LH)
- menarche
- menorrhagia
- menopause
- menstrual cycle
- menstrual taboos
- menstruation
- Mittelschmerz
- orchiectomy
- ovaries
- ovulation
- oxytocin
- pheromones
- pituitary gland
- premenstrual dysphoric disorder (PMDD)
- premenstrual syndrome (PMS)
- progesterone

- prolactin
- prostaglandins
- testicles
- testosterone
- toxic shock syndrome (TSS)

Interactive Review

Answers can be found on p. 468.

1. Hormones are chemical substances that are released into the bloodstream by ductless (1) glands. The ovaries and testicles are part of this system. The testicles produce the "male hormone" (2) , and the ovaries produce the "female hormones" (3) and (4) . Hormones from the (5) cause the ovaries and testicles to produce their hormones.

   In adult women, an egg matures on an average of every (6) days. The pituitary hormone that starts the menstrual cycle is called (7) . This hormone stimulates the development of a(n) (8) in the ovary. During the preovulatory phase of the menstrual cycle (also called the (9) phase), estrogen from the follicle promotes growth of the (10) , inhibits release of (11) , and stimulates release of (12) . The (13) surge signals the onset of (14) , at which time the ovum is expelled into the (15) and is picked up by a(n) (16) . During the postovulatory phase of the cycle, also called the (17) phase, the (18) secretes progesterone in large amounts. If the egg is fertilized by a sperm, it normally implants in the (19) . If the egg is not fertilized, the corpus luteum degenerates and the (20) is sloughed off and discharged in a normal physiological process called (21) . Although the average length of the menstrual cycle is 28 days, at least half of women have cycles that vary in length by (22) . In most non-human mammalian species, the cycle of hormonal events is called the (23) cycle. Unlike human women, females of species with this type of cycle are sexually receptive to males only during (24) .

   In men, FSH stimulates (25) , while (26) stimulates the production of (27) in the Leydig's cells of the testicles.

   Some cultures have menstrual (28) that prohibit contact with a menstruating woman. Even in our own culture many women and their partners avoid sexual intercourse during menstruation, but this generally reflects inaccurate information and/or negative culturally learned responses. Menstrual discharge consists simply of (29) , (30) , and (31) .

   Some women experience menstrual-related problems. The absence of menstruation is called (32) . Emotional and/or physical changes taking place (33) days before the start of menstruation are referred to as (34) . What distinguishes this condition from other emotional states is that it ends (35) . The major cause of (36) , painful menstruation, is an overproduction of (37) . Endometriosis refers to a condition in which (38) . Women who use tampons but do not change them frequently risk getting a serious bacterial infection called (39) .

   In men, sexual desire appears to be related to circulating levels of (40) . Studies of women after menopause, or after surgical removal of the ovaries, suggest that women's sexual desire is not strongly affected by the hormones (41) or (42) . Other studies indicate that the hormone (43) does influence sexual desire in women.

   Misuse of anabolic steroids, derivatives of testosterone, can cause serious harmful effects such as (44) (name three effects).

Self-Test

Answers can be found on p. 469.

A. True or False

- **T F** 45. Hormones are important for women's sexual desire but not for men's.
- **T F** 46. Testosterone is found only in men, and estrogen is found only in women.
- **T F** 47. All female mammals have menstrual cycles.
- **T F** 48. Most women's menstrual cycles are 28 days in length.
- **T F** 49. It is medically safe for a man to have sexual intercourse with a menstruating woman.
- **T F** 50. Women who use tampons should change them three or four times a day, even if the tampons are advertised as long lasting.
- **T F** 51. Women show a dramatic increase in sexual desire around the time of ovulation.
- **T F** 52. Women's ovaries produce new eggs throughout their lifetimes.

- **T F** 53. Near the end of the postovulatory phase of the menstrual cycle, there is an LH surge.
- **T F** 54. There is some evidence suggesting that women's menstrual cycles can be altered by odorless body secretions.
- **T F** 55. Only women can get toxic shock syndrome.
- **T F** 56. Estrogen, according to most research, is the primary hormone responsible for sexual desire in women.

B. Matching

- 57. endocrine system
- 58. testosterone
- 59. luteinizing hormone
- 60. estrogen
- 61. FSH
- 62. follicular phase
- 63. corpus luteum
- 64. amenorrhea
- 65. luteal phase
- 66. dysmenorrhea
- 67. *Mittelschmerz*
- 68. inhibin
- 69. ovulation
- 70. prostaglandins
- 71. premenstrual syndrome
- 72. endometriosis

1. substances that cause contractions of the uterus
2. cells surrounding the ovum that are left behind at ovulation
3. emotional and/or physical changes that precede menstruation
4. "male" hormone produced in testicles, ovaries, and adrenal glands
5. cramps experienced for about a day during ovulation
6. postovulatory phase when the corpus luteum begins to secrete large amounts of progesterone
7. endometrial tissue growing outside the uterus
8. network of ductless glands
9. rupture of the mature ovum into the abdominal cavity
10. "female" hormone produced in ovaries, testicles, and adrenal glands
11. preovulatory phase when the pituitary secretes FSH and the follicle secretes estrogen
12. pituitary hormone that stimulates production of sperm and maturation of ova
13. absence of menstruation
14. pituitary hormone that triggers ovulation in women and the production of testosterone in men
15. painful cramps during menstruation

16. substance produced in the ovaries and testicles that inhibits production of FSH

C. Fill in the Blanks

- 73. The gland located at the base of the brain that secretes follicle-stimulating hormone and luteinizing hormone is the gland.
- 74. Natural body scents that can affect the behavior of other members of the same species are called .
- 75. Each immature ovum is surrounded by other cells within a thin capsule of tissue to form what is called a .
- 76. During ovulation, the cells that surround the ovum in the follicle remain in the ovary and are then referred to as the .
- 77. If you wish to avoid pregnancy, the safest phase of the menstrual cycle to have unprotected intercourse is .
- 78. If an egg is fertilized by a sperm and implantation occurs, the corpus luteum is maintained by a hormone from the developing placenta called .
- 79. The hypothalamic hormone that causes release of FSH and LH from the pituitary is called .
- 80. In the female hormone feedback loop, LH production is suppressed primarily by .
- 81. In the male hormone feedback loop, LH production is suppressed primarily by .
- 82. In the male hormone feedback loop, FSH production is suppressed by .
- 83. The pituitary hormone associated with milk release, labor and orgasmic contractions, and romantic attraction is called .
- 84. In a woman's menstrual cycle, the fertile period is day(s) before and day(s) after .
- 85. For numbering purposes, Day 1 of the menstrual cycle is .

Suggested Readings and Resources can be found on p. 459.

Chapter 4 Similarities and Differences in Our Sexual Responses

How can biologists, behaviorists, theologians, and educators insist in good conscience upon the continued existence of a massive state of ignorance of human sexual response, to the detriment of the well-being of millions of individuals?. . . Can that one facet of our lives, affecting more people in more ways than any other physiologic response other than those necessary to our very existence, be allowed to continue without benefit of objective, scientific analysis?

—Excerpt from *Human Sexual Response* by William Masters & Virginia Johnson, 1966, Boston: Little, Brown.

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 4.1 List the four broad categories of sexual response that men and women experience and describe how each response typically is measured.
2. 4.2 Discuss the three dimensions on which models of sexual response differ and compare and contrast the original Masters and Johnson model, the Kaplan model, and the circular Basson model. Discuss whether linear models of sexual response accurately explain men's and women's experiences.
3. 4.3 Describe the five phases of the contemporary linear model of male sexual response in order of their occurrence. Explain the process of penile erection (and other physiological and genital changes that occur during male sexual arousal).
4. 4.4 Describe the two contemporary (linear and circular) models of female sexual response. Explain the process of vaginal lubrication (and other physiological and genital changes that occur during female sexual arousal), and discuss why many women's subjective arousal is correlated poorly with their physiological arousal.
5. 4.5 Explain and discuss several ongoing questions and controversies about orgasm.
6. 4.6 Explain and discuss the practice of female genital mutilation/cutting.
7. 4.7 Discuss the role of penis size in sexual pleasuring.
8. 4.8 Discuss the validity of reputed aphrodisiacs.
9. 4.9 Explain and appreciate the fact that people with disabilities, like everyone else, are sexual human beings.

A great many events happen to our bodies and our minds during sexual excitement and sexual activity. Some of these events are external and easily observable by us (and others). Some are internal, hidden, and less readily apparent. Some events are psychological and others are physiological or behavioral. A given event may feed into or influence other events—for example, a sexual thought or feeling may trigger a genital or physiological reaction, and a physical reaction may produce a corresponding thought or feeling (or even another physical reaction). Human sexual response clearly is complex and multidimensional. In this chapter, we will consider the various sexual responses that men and women experience and express as well as the different models of human sexual response that have been proposed. We will also review current controversies about specific sexual responses as well as factors that may influence sexual experiences.

Sexual Responses: Types and Measurement

1. 4.1 List the four broad categories of sexual response that men and women experience and describe how each response typically is measured.

Men and women are capable of experiencing and expressing a wide array of sexual responses, including sexual desire or interest, sexual arousal or excitement, sexual activity, and sexual affect or cognition (see Table 4–1). Each of these responses is considered to be separate and distinct, although (as we will discuss throughout this chapter) they often co-occur.

Table 4–1 Sexual Responses and How They Are Measured

Table 4–1 Full Alternative Text

Sexual Response	What is it?	How is it measured?
Sexual desire	Motivational component of sexuality; sexual urge, wish, craving, or interest	Self-report
Sexual arousal	Genital component of sexuality; sexual excitement	
• Physiological-genital arousal	Physiological and genital sensations (such as vasocongestion, myotonia, and cardiopulmonary changes)	Observation
• Subjective sexual arousal	Subjective awareness of physiological and genital sensations	Self-report
Sexual activity	Overt sexual behaviors	Self-report
Sexual affect and cognitions	Feelings and thoughts about sexuality and sexual responses	Self-report

4.1.1 Sexual Desire

Sexual desire (also commonly referred to as *sexual interest, sexual attraction, passion, libido*, or *lust*) is the motivational component of human sexuality (Regan, 2016). People typically experience sexual desire as (1) an interest in sexual objects (such as one's partner) or sexual activities (such as intercourse or masturbation), (2) a physical sensation (such as genital sexual arousal), and (3) a wish, need, urge, or craving for sexual contact (Kaplan, 1979; Levin, 1984, 2003; Regan & Berscheid, 1999). Here is how students in our classes view sexual desire:

"The urge to have sex with a partner. It's a mental-physiological combination sexual with someone. My friends and I call it being horny." (man)

"Being turned on by a member of the opposite sex. It is the craving/drive to have some sort of sexual contact with a member of the opposite sex." (woman)

(All examples are from the authors' files.)

Some scientists believe that there are two types of sexual desire (see Basson, 2002b). *Spontaneous sexual desire* refers to desire that arises from an innate or internally generated cause, whereas *responsive sexual desire* is desire that is produced by an external event, cue, or situation.

"There are times when I have a lot of sexual desire. I don't know where this urge comes from. It's just there. I find myself thinking about sex and wanting to have sex. If I'm at home, I will usually masturbate to satisfy my urges." (woman, example of spontaneous sexual desire)

"When I see a sex scene on TV, especially if it's with an actress I think is hot, I get turned on. I imagine myself doing those things with her, and I feel desire and a strong need to have sex." (man, example of responsive sexual desire)

(All examples are from the authors' files.)

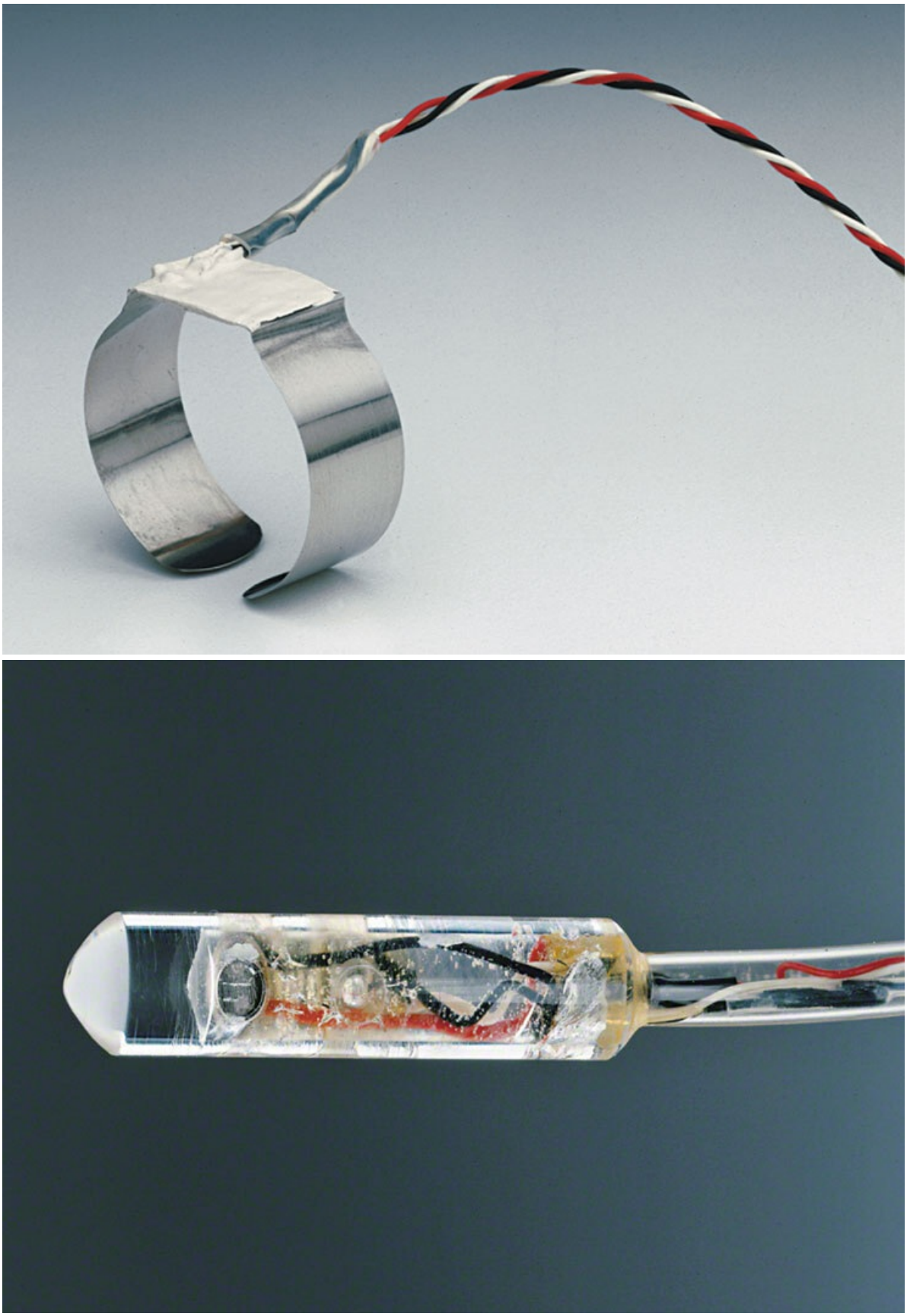
Because sexual desire is a subjective experience rather than an overt physical or behavioral event that can be directly observed, scientists rely on self-report methods to measure it. Examples include asking people to rate their level or amount of desire ("How much sexual desire do you experience?"), the frequency of their sexual urges ("How often do you experience sexual desire?"), or the intensity or degree of their sexual interest in their current partner ("How intensely do you desire sexually?," "How sexually attracted are you to ?"). In addition, two multi-item self-report measures of sexual desire exist (Spector et al.'s [1996] *Sexual Desire Inventory-2* and Goldhammer and McCabe's [2011b] *Female Sexual Desire Questionnaire*).

4.1.2 Sexual Arousal

Sexual arousal (also referred to as *sexual excitement*) is the genital component of human sexuality (Masters et al., 1994). Sexual arousal has both a physical component and a psychological, or subjective, component. The physical component, called *physiological-genital arousal*, is usually conceptualized as a state of activation of a complex system of reflexes that involve the sex organs and the nervous system (Masters & Johnson, 1966; Masters et al., 1994). As we will discuss in the next section, three basic processes are involved in physiological-genital arousal: (1) *vasocongestion*, which refers to engorgement of the organs and tissues of the body with blood; (2) *myotonia* or muscular tension; and (3) *cardiopulmonary changes*, or elevations and reductions in heart rate, blood pressure, and breathing. Masters and Johnson are the scientists who first explored and identified these physiological and genital reactions. You were introduced to their work in Chapter 1. How did they actually make their observations and do their recordings?

Masters and Johnson recruited their sample of 312 men and 382 women (aged 18 to 89) from the local community. The "laboratory" was a simple room containing a bed and recording equipment that measured physiological responses (such as heart rate, blood pressure, muscle tension, respiration, and brain activity). In addition, Masters and Johnson had special equipment made to record the volume of blood in the genitals. Two of these devices are shown in Figure 4–1. The *penile strain gauge* is a thin rubber tube filled with mercury that fits over the base of the penis and transmits a small electric current that can record even a slight change in the circumference of the penis. The *vaginal photoplethysmograph* fits like a tampon into the vagina and has a light and photocell to record blood volume in the vaginal walls (by measuring changes in the reflection of light).

Figure 4–1



An early model penile strain gauge (left, the Geer gauge) and vaginal photoplethysmograph (right, the Barlow gauge) used by Masters and Johnson to measure vasocongestion in the genitals.

Source: Behavioral Technology, Inc.

Figure 4–1 Full Alternative Text

This equipment was placed on (or in) the participants, who were then asked to engage in various sexual activities ranging from masturbation to penile-vaginal intercourse to oral-genital sex. (Participants were first allowed to engage in sexual activities with no one else present so that they would feel comfortable. After that initial episode, however, there was always at least one investigator present). Masters and Johnson used the devices to record over 10,000 sexual episodes leading to orgasm, and many participants were observed repeatedly in order to determine the

amount of variability in their genital and physiological responses. This work was instrumental in documenting the physical details of sexual arousal.

Nonetheless, like other physiologically oriented studies, those of Masters and Johnson received some criticism. The main criticism concerned the rather unnatural laboratory setting. Were participants unduly affected by the presence of observers or by the recording equipment? Furthermore, how "normal" or "average" were the participants themselves? Were they like other people, or were they somehow unique? Think about it. Would you volunteer to participate in a study like this? Some of you might respond to that question with an enthusiastic "yes," whereas others of you might give a resounding "no!" Whatever your (or anyone's) inclination, it is generally assumed in medical research that studies of normal physiological processes (digestion, for example) do not require a random or even a representative sample of participants because these processes will be more or less the same from person to person. So, although the volunteers in the Masters and Johnson studies perhaps were unusual, and the setting perhaps was unnatural, we can safely conclude that the processes recorded and identified do apply to us all. We will discuss these specific physiological-genital events in the next section of this chapter.

The psychological component of sexual arousal is called *subjective sexual arousal*, and it is the perception and awareness of the body's genital and physiological changes during arousal (Green & Mosher, 1985). In contrast to the physical component of arousal, subjective sexual arousal can only be assessed with self-report (as it requires the person to consciously report on his or her bodily responses). For example, a researcher might ask men and women to report on their perceptions of genital or physiological sensations (e.g., penile erection, vaginal lubrication, breast or nipple sensations, increased heart rate, perspiration); to rate their overall level, amount, or intensity of sexual arousal; or to respond to items related to sexual arousal (e.g., aroused, excited, turned on). As we will discuss in Chapter 13, researchers interested in identifying and treating sexual problems often ask people to provide this type of subjective information about sexual arousal (such as difficulties with vaginal lubrication, penile erection, or orgasm).

4.1.3 Sexual Activity

Sexual activity is another category of sexual response that consists of overt sexual behaviors, such as masturbation, kissing, anal sex, oral-genital sex, or penile-vaginal intercourse. Because much of this textbook is devoted to discussing these and other sexual behaviors in detail (see, for example, Chapter 11), we simply note that researchers typically rely on self-report methods to assess the occurrence and frequency of different sexual activities. Examples of large-scale, self-report studies measuring specific sexual behaviors are provided in Chapter 1 (and discussed throughout this book). These include the surveys conducted by Alfred Kinsey and his colleagues in the 1940s and early 1950s as well as more recent work by Laumann and his colleagues (Laumann et al., 1994) and the ongoing National Survey of Sexual Health and Behavior (NSSHB).

4.1.4 Sexual Affect and Cognitions

When people experience sexual desire, become physiologically and genitally aroused (and subjectively aware of their arousal), and engage in sexual activities, they also experience various emotions, feelings, evaluations, beliefs, and attitudes associated with these responses (e.g., pleasure, satisfaction, curiosity, shame, guilt, sadness, anxiety, beliefs about the appropriateness and quality of the sexual response, event, or episode). This conglomeration of feelings and thoughts related to sexuality and sexual responses is known as sexual affect and cognitions, and it represents an extremely important type of sexual response. Indeed, as we will discuss in Chapters 13 and 14, whether a person's sexuality—desire, arousal, preferences, or activity—is labeled "problematic" is almost entirely based on how that person (and, sometimes, his or her partner) feels and thinks about his or her sexuality. For example, a person who experiences very low (or very high) levels of sexual desire may or may not be considered "hypo" (or "hyper") sexual depending on his or her affective and cognitive reactions to that desire level. People's sexuality-related feelings and beliefs are measured with self-report. For example, a researcher might ask participants to consider their last episode of sexual intercourse and to rate it with respect to enjoyment, pleasure, and satisfaction.

Men and women obviously experience a wide array of sexual responses, ranging from the purely physical to the purely psychological. Researchers have been interested in whether and how these responses are related and over the years they have proposed different models of human sexual response. In the next section, we present and discuss these models.

Personal Reflections

Do you think it is important that we know the physiological responses that normally occur during sexual arousal? Is it important that physicians and therapists have this information? What do you think about studies, such as those by Masters and Johnson, that require observing and recording individuals engaged in sex? If your opinion is negative, how else could we learn about the normal physiological responses during sexual arousal?

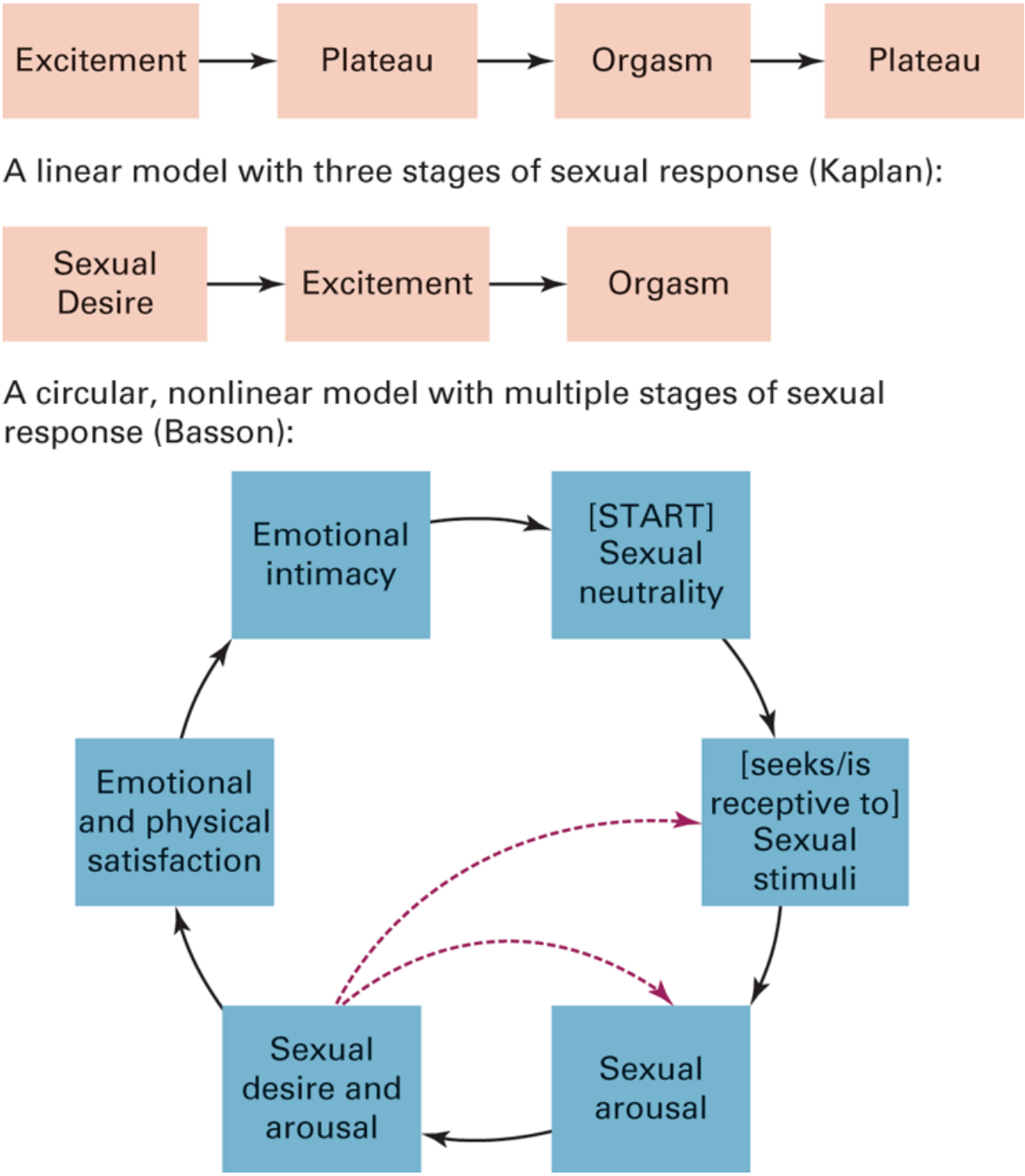
Models of Sexual Response

1. 4.2 Discuss the three dimensions on which models of sexual response differ and compare and contrast the original Masters and Johnson model, the Kaplan model, and the circular Basson model. Discuss whether linear models of sexual response accurately explain men's and women's experiences.

For the past half century, various models of human sexual responses have been proposed. These models differ in three basic ways. The first concerns which sexual responses are included in the model (e.g., sexual desire, physiological-genital sexual arousal, subjective sexual arousal, sexual affect and cognitions). The second concerns whether the model is linear (i.e., portrays sexual responses as occurring in a sequential pattern) or nonlinear (i.e., views sexual responses as occurring in a non-sequential or circular pattern). And the third concerns the number of phases or stages that the model includes.

For example, based on their observations of the physiological and genital processes involved in sexual arousal, Masters and Johnson (1966) proposed a linear or sequential model called the sexual response cycle. This model characterizes the physical changes that take place in men's and women's bodies as occurring in four phases: (1) excitement, (2) plateau, (3) orgasm, and (4) resolution (see Figure 4–2). Although this is a sequential model, Masters and Johnson did note that there is no hard and fast demarcation between the various phases and that both men and women may enter a later phase while their bodies are still experiencing the processes involved in an earlier one. Because of its focus on physical responses to sexual stimulation (as opposed to subjective or psychological responses), the Masters and Johnson model is best understood as a model of physiological-genital sexual arousal rather than as a general model of sexual response.

Figure 4–2 Three Models of Sexual Response



A linear model with four stages of sexual response (Masters & Johnson):

Figure 4–2 Full Alternative Text

A decade later, clinician and noted sex therapist Helen Singer Kaplan (1979) expanded the original Masters and Johnson sexual response cycle. Noting that people do not suddenly find themselves flushed, excited, and ready for sex, she argued for the importance of including an initial sexual desire phase. According to Kaplan's sequential model, the sexual response cycle consists of three physiologically related but discrete phases: (1) desire, (2) excitement (which encompassed Masters and Johnson's excitement and plateau phases), and (3) orgasm. Interestingly, based on Kaplan's work, Masters and Johnson subsequently altered their original four-phase model to include sexual desire, stating that "it is certainly true that sexual desire serves as a springboard for subsequent sexual arousal . . . Because of this, it is useful to view sexual desire as the first phase of the human sexual response cycle, as has been suggested by psychiatrist Helen Singer Kaplan" (1994, p. 46).

Some scientists believe that linear models such as those proposed by Masters and Johnson and Kaplan are better at capturing men's than women's sexual responses (e.g., Basson, 2000, 2001a, b; 2002a, b, c; Basson et al., 2003; Tiefer, 2001). These scholars argue that many women do not move progressively and sequentially through the phases included in those models.

Moreover, they note that the emphasis in these models on physiological and genital responses does not provide a place for nonphysical factors (including affect and cognition as well as the larger relational context in which sex occurs), which appear to play an important role in women's sexual responses. Consequently, some of them have proposed nonlinear or circular models that give greater primacy to emotional intimacy, sexual satisfaction, and other psychological and interpersonal processes (see, for example, Basson, 2001a,b,c; Whipple & Brash-McGreer, 1997). We will discuss these models in greater detail when we consider women's sexual response cycle.

So which model is correct? There is recent evidence in support of the view that the sexual response cycles of *some* men and women are different. For example, in one study, researchers asked a large sample of sexually active, partnered men and women to indicate which of the various sexual response cycle models most accurately reflected their own sexual experience (Giraldi et al., 2015). Most men (87%) endorsed a linear model (i.e., Masters and Johnson's model or Kaplan's model). Most women (62%) also stated that their sexual responses were most accurately captured by a linear model. However, a sizeable number of women (26%) endorsed a nonlinear, circular model of sexual response (i.e., Basson, 2001a). Only 5% of men endorsed a circular model. And a small group of participants (7% of men and 12% of women) felt that none of the existing models reflected their own sexual response pattern. Interestingly, men and women with sexual dysfunctions (see Chapter 13) were more likely to endorse a nonlinear, circular model of sexual response. This research suggests that linear models do indeed accurately reflect (most) men's sexuality but that women's sexuality is more varied (with roughly two thirds of women regularly experiencing a linear response pattern and about one quarter reporting a circular or nonlinear pattern). The researchers concluded that "no single model of sexual response could describe [both] men's and women's sexual responses" (Giraldi et al., 2015, p. 116).

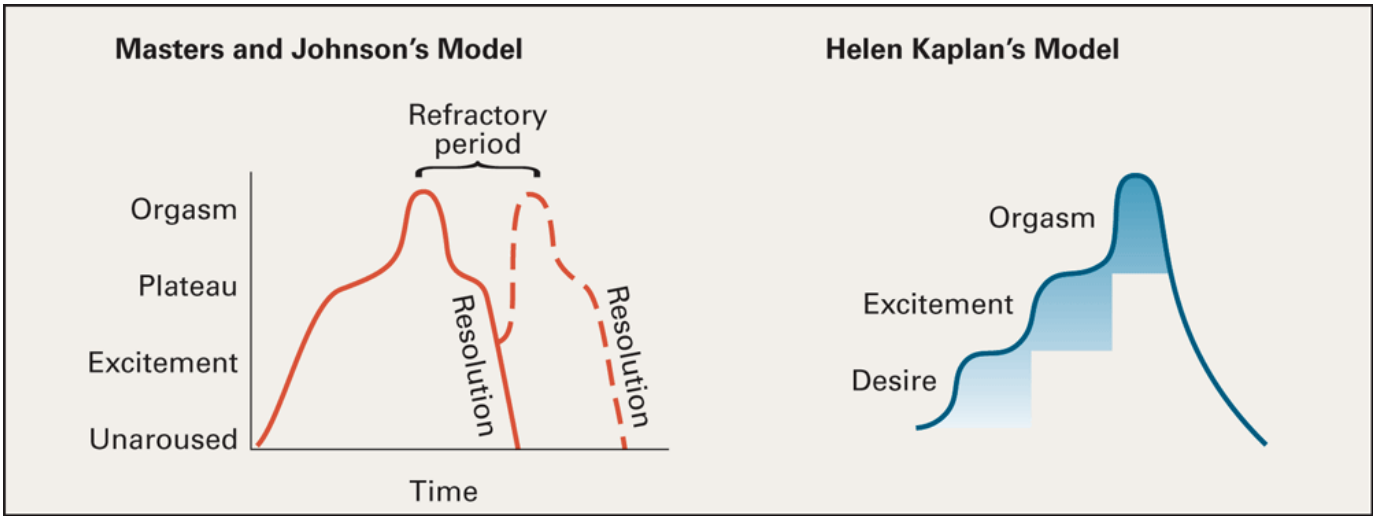
For this chapter, we have made the decision to discuss men's and women's sexual response cycles separately in order to highlight both differences and similarities in our sexual responses. We will begin with a description of men's sexual responses and then compare and contrast those with women's responses.

Men's Sexual Response: The Five-Phase Linear Model

1. 4.3 Describe the five phases of the contemporary linear model of male sexual response in order of their occurrence. Explain the process of penile erection (and other physiological and genital changes that occur during male sexual arousal).

Masters and Johnson (1966) and Kaplan (1979) proposed the very first models of male (and female) sexual response, illustrated in Figure 4–3. Today, scientists have combined these two models and thus generally view the male sexual response cycle as consisting of a relatively linear set of five phases: desire, excitement, plateau, orgasm, and resolution (see Figure 4–4). It is important to remember that although sexual affect and cognitions generally are not included in this five-phase model, men's responses before, during, and after sexual stimulation or activity are undoubtedly affected by their feelings, evaluations, emotions, thoughts, and beliefs. Indeed, as we will discuss in Chapter 13, a man who is anxious or worried about whether he will be able to get or maintain an erection may experience difficulties with sexual arousal (and other sexual responses). Perhaps future models will more carefully delineate the role played by these important aspects of sexuality in men's experiences.

Figure 4–3



Two early linear models of the male human sexual response cycle. The rise and fall in the pattern of the orange and blue lines correspond to changes in levels of physiological and genital arousal.

Figure 4–3 Full Alternative Text

Figure 4–4

Contemporary model of the male (and female) sexual response cycle, a cycle consisting of a relatively linear set of five phases.

Figure 4–4 Full Alternative Text

4.3.1 Sexual Desire

Recall that sexual desire can arise automatically as the result of some internal mechanism over which a person has little conscious control (spontaneous sexual desire) *or* it can be produced by an external stimulus (responsive sexual desire). Although men (and women) experience both forms of sexual desire, spontaneously generated sexual interest is the type of desire that men report most commonly experiencing (see Štulhofer et al., 2013). And they experience it quite frequently—one investigation found that college-aged men said that they spontaneously felt sexual desire an average of 37 times per week (Regan & Atkins, 2006).

Regardless of what piques his sexual interest—that is, whether he is internally or externally stimulated—once a man experiences desire he is likely to progress relatively rapidly and smoothly to the next phase of the sexual response cycle (sexual arousal or excitement). As we will see, the physiological and genital responses that occur during excitement and the remaining phases of arousal do not differ across individual men or as a result of different sexual stimuli or activities. The physical reactions are the same regardless of whether the source of arousal is another person (of the opposite sex or of the same sex) or oneself (fantasy and/or masturbation).

4.3.2 Excitement (Arousal)

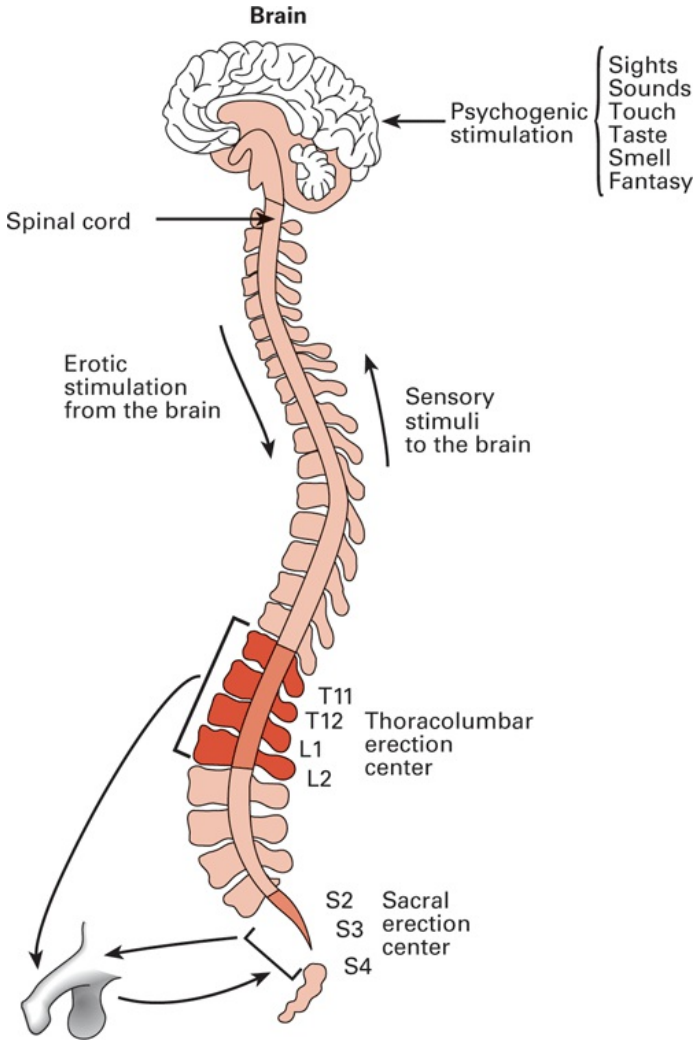
Recall that physiological-genital sexual arousal involves three fundamental physical processes. These are vasocongestion, or the filling of body tissue with blood; myotonia, or muscle tension in the body and genital area; and *cardiopulmonary changes* in heart rate, blood pressure, and breathing.

The first physical sign of arousal in men, of course, is *erection of the penis* resulting from the spongy tissues of the corpora cavernosa and the corpus spongiosum becoming engorged with blood (see Figure 4–6). This vasocongestive response starts within 3 to 8 seconds after stimulation begins but usually does not result in a full erection right away. Many men, however, worry if they do not have a "steel-hard" erection immediately upon stimulation. Remember, the excitement phase is just the initial phase of arousal, and it is not unusual for men to be easily distracted at first by either mental or external stimuli, resulting in fluctuation in the firmness of the erection. This is perfectly normal.

Vasocongestion of the penis results from nerve impulses causing dilation of the arteries that carry blood to the penis. To better understand this, look at Figure 4–5. There are two centers in the spinal cord responsible for erection. The more important of the two is located in the lowest (sacral) part of the spinal cord. Nerve impulses caused by stimulation of the penis travel to this center, which then sends nerve impulses back to the penis in a reflex action. Many men with spinal cords cut above the sacral erection center can still get erections in this reflexive manner, although they cannot feel stimulation of the penis. This is true for quadriplegics as well as paraplegics (C. J. Alexander et

al., 1993). In men with intact spinal cords, nerve impulses from the brain (generated by such things as sights, sounds, and fantasies) are carried to the erection center and result in vasocongestion. A second erection center, located higher in the spinal cord (thoracolumbar), also receives impulses originating in the brain, and thus it too contributes to psychologically caused erections. Although vasocongestion of the penis sounds like a mechanically easy process, a number of things can interfere with it, including physical or emotional stress and/or fatigue (see Chapter 13).

Figure 4–5

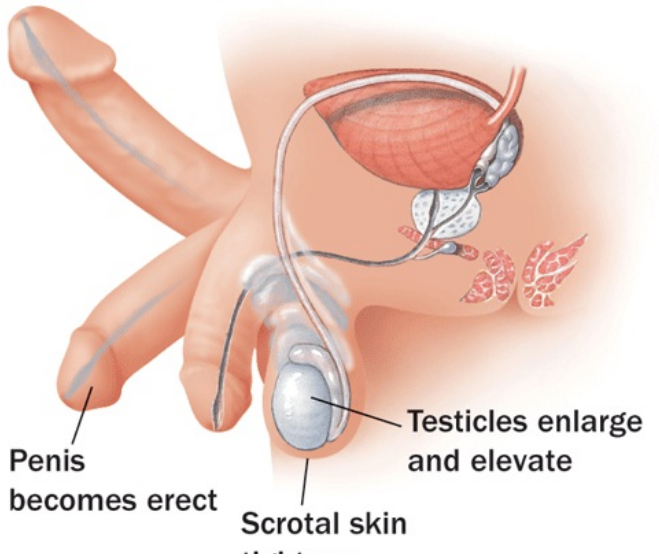


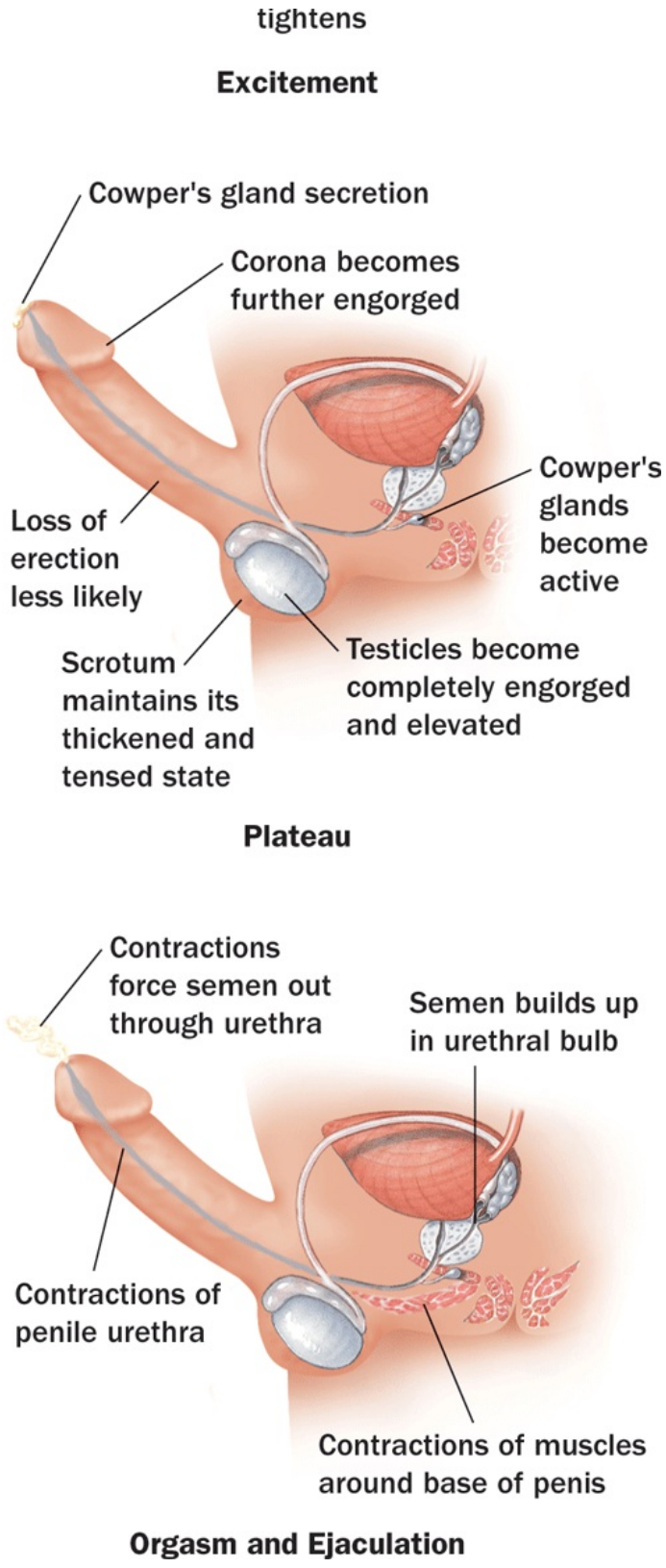
Neural mechanisms involved in an erection.

Figure 4–5 Full Alternative Text

Vasocongestion of the penis is not the only response that happens in men during the excitement phase. Increases in heart rate, blood pressure, and muscle tension also occur. Specifically, the scrotum thickens (the muscle layer contracts) and the spermatic cord shortens, thus elevating the testicles toward the body. Late in the excitement phase, the testicles also start to become engorged with blood and enlarge (see Figure 4–6). In addition, nipple erection occurs in some men, a reaction that is not related to a man's masculinity or femininity.

Figure 4–6





Men's physiological-genital sexual responses: excitement, plateau, and orgasm and ejaculation.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Figure 4–6 Full Alternative Text

4.3.3 Plateau

The plateau phase is a period of high sexual arousal that potentially sets the stage for orgasm. For some men this phase may be quite short; for others it may last a long time. In this phase, the diameter of the penis further increases, especially near the corona. In addition, the testicles become fully engorged with blood (increasing in size by 50% to 100%) and continue to elevate and rotate until their back surfaces touch the perineum, an indication that orgasm is near (see Figure 4–6). The Cowper's glands secrete a few drops of clear fluid that may appear at the tip of the penis. About 25% of men also experience a *sex-tension flush* (also called a *sex flush*) on various areas of their body; this resembles a measles-like rash and is due to the skin undergoing a vasocongestive response.

4.3.4 Orgasm

The Essence of Orgasm

With continued and effective stimulation, men experience intense physical sensations lasting a few seconds that are referred to collectively as orgasm (climax, or "coming"). Masters and Johnson define orgasm as a sudden discharge, through rhythmic muscular contractions, of the accumulated sexual tension that people experience in the plateau phase. Specifically, using their electrophysiological recording equipment, they were able to identify rhythmic muscular contractions in specific parts of the body that initially occurred every 0.8 seconds but then diminished in intensity and regularity. Others have reported that the first contractions are only 0.6 second apart (Bohlen et al., 1980), but regardless of their timing, orgasm clearly involves physiological responses that occur in specific tissues.

But does this definition describe the real essence of orgasm? If a Martian were to land on earth and ask you what an orgasm is, how would you describe it? Here are some responses male students in our classes gave when we asked them to describe their orgasms for someone who had never had one:

". . . like a bomb but feels great. When you reach your max, you feel like you are going to burst open. Then you feel like you are floating in the sky."

". . . like a roller coaster. At first you feel excited, your whole body feels tingly. My heart feels like it's falling in my chest. Then my stomach and leg muscles tighten up, and all tension is then released in a moment."

"Like a bolt of lightning strikes you in the back of your spine. You get stiff, curling your toes and making ludicrous faces."

". . .like you have been drinking 10–15 beers on a road trip and the person driving won't pull over for you to relieve yourself. The feeling is like when they finally do pull over, and the first few seconds of relief."

"It's more than just a physical sensation or experience. My body does go stiff and tight, and I'm straining and tensed up. But it's also mental because I also have a sense of urgency and need, and then when it happens I get this enormous sense of release and pleasure. It's a total mind-body experience."

(All examples are from the authors' files.)

The variety of our students' responses begs the question, is an orgasm nothing more than rhythmic muscular contractions in a few genital tissues, or is it something else entirely, something perceptual and subjective? In other words, did Masters and Johnson record what an orgasm actually is or merely what it looks like? Later studies were unable to find a relationship between a person's perception of orgasm and the muscular contractions. Contractions often begin before a person's perception of orgasm begins and end before the person reports orgasm to be over. Moreover, strong contractions are sometimes seen with "mild" orgasms, whereas weak contractions are sometimes associated with orgasms that are perceived as intensely pleasurable (Bohlen et al., 1980, 1982; Levin & Wagner, 1985). In short, researchers can measure the contractions, but they cannot measure the pleasure. The perception of the orgasm can be assessed only by the individual person who is experiencing it. Subjectively, people report a feeling of pleasure focused initially in the genitals and then spreading throughout the entire body. This has led some experts to conclude that the essence of orgasm lies not in the genitals but in the brain (see Mah & Binik, 2005).

The fact that some paraplegics and quadriplegics, people whose spinal cord has been transected, report having orgasms, lends support to the idea that there is a subjective, psychological component to the experience of orgasm (C. J. Alexander et al., 1993; Komisaruk & Whipple, 2011).

In summary, scientists now understand orgasm to be primarily a perceptual or subjective experience (i.e., generated in the brain), though it is associated with and felt as a response to physiological and genital reactions.

The Two Stages of Men's Orgasms

In men, the physical reactions associated with orgasm occur in two stages. In the first stage, called *emission,* rhythmic muscular contractions in the vas deferens, prostate gland, and seminal vesicles force the sperm and the prostate and seminal fluids into the ejaculatory ducts, thus forming *semen*. Sphincter muscles (circular bands of muscle fibers) contract and close off the part of the urethra that goes through the prostate, and the semen causes it to swell to two to three times its normal size (called the urethral bulb). These initial contractions give men a feeling of ejaculatory inevitability (the famous "I'm coming")—the feeling that orgasm is about to happen and cannot be put off.

In the second stage, called *expulsion*, these contractions are joined by contractions in the urethra and muscles at the base of the penis to force the semen from the penis—ejaculation. During this stage, the sphincter muscles surrounding the part of the urethra coming from the bladder are tightly contracted so that urine is not mixed with semen. A few men have a medical problem known as *retrograde ejaculation* in which the sphincter muscle that allows passage of semen through the penile urethra closes (instead of opening) and the sphincter muscle surrounding the part of the urethra from the bladder opens (instead of closing), thus forcing semen into the bladder instead of out of the body.

Although ejaculation occurs at about the same time as orgasm in men, *they are really two different events*. Orgasm refers to the subjective pleasurable sensations associated with emission and expulsion, while ejaculation refers to the physical release of semen from the body. The passage of semen through the penis has nothing to do with the sensation of orgasm or the intensity of orgasm. Think about it: If the passage of fluid through the urethra were the cause of the pleasurable sensations, at which other times during the day would men have a very intense orgasm (but do not)? Orgasm and ejaculation, in fact, do not always occur together. Before puberty, for example, boys can have orgasms but do not ejaculate (the prostate and seminal vesicles do not enlarge until puberty). Ejaculation in the absence of orgasm has also been reported in adult men with some types of illness and/or who are taking certain medications.

4.3.5 Resolution

Resolution is defined as a return to the unaroused state. In men, this involves a loss of erection, a decrease in testicle size, movement of the testicles away from the body cavity, and disappearance of the sex flush in those men who experience this. Loss of erection (detumescence) is due to the return of normal blood flow to the penis. Some of the excess blood is pumped out by the orgasmic contractions, and normal blood flow then returns as the arteries begin to constrict and the veins open. The testicles had become swollen with blood during the plateau phase, and if orgasm is delayed or not achieved, men may now experience testicular aching (what is sometimes known as "blue balls"). The discomfort is only temporary and is not dangerous—and the testicles and scrotum do not, in fact, turn blue.

Research indicates that some men are capable of reaching orgasm two or more times during a single sexual encounter—though not immediately (see Wibowo & Wassersug, 2016). If emotional and/or physical stimulation continues after an orgasm, a man's physiological responses may not fall all the way back to pre-excitement phase levels, but they will drop below plateau level for some period of time. Partial or full erection may be possible, but the man will be unable to have another orgasm until his responses build up to plateau level again. (Remember, it is not possible to have an orgasm until one's responses have reached the heightened state of arousal called plateau.) The period of time after an orgasm in which it is physiologically impossible for a man to achieve another orgasm is called the refractory period (see Figure 4–3). It is not a fixed amount of time; the refractory period differs from individual to individual. It tends to grow longer as men age and also after each successive orgasm (should a man have two or more orgasms). One of the most important factors is the amount of stimulation a man receives. For example, the refractory period may be very short if a man is having sex with a new partner. This is known as the "Coolidge effect," named after former U.S. President Calvin Coolidge. According to a well-known fable, President and Mrs. Coolidge were taking separate tours of a government farm. When Mrs. Coolidge reached the henhouse, she asked the farmer whether the continuous and vigorous sexual activity of the hens was really the work of just one rooster. After the farmer acknowledged that it was, Mrs. Coolidge responded, "You might point that out to Mr.

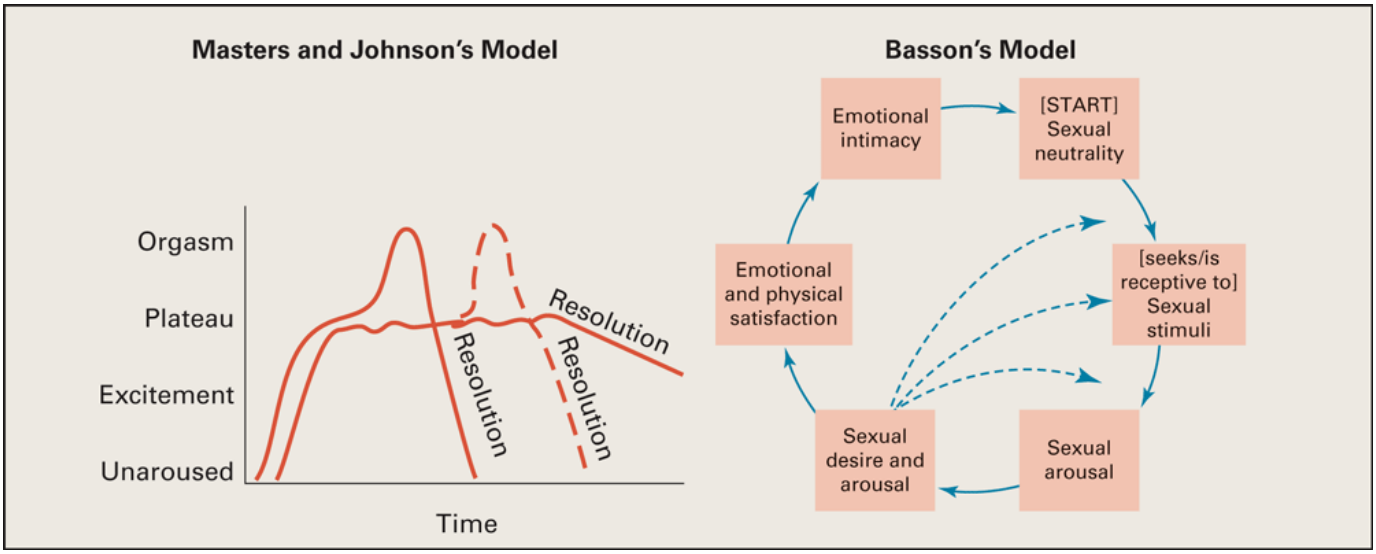
Coolidge." Her statement was relayed to the President, who then asked the farmer whether the rooster had sex with the same hen each time. When the farmer responded "Oh no, Mr. President, a different hen each time," Mr. Coolidge replied, "You might point that out to Mrs. Coolidge."

Women's Sexual Response Cycle

1. 4.4 Describe the two contemporary (linear and circular) models of female sexual response. Explain the process of vaginal lubrication (and other physiological and genital changes that occur during female sexual arousal), and discuss why many women's subjective arousal is correlated poorly with their physiological arousal.

The two primary models of women's sexual responses (linear and circular) were mentioned earlier in this chapter and are illustrated in Figure 4–7. As we discussed, there appears to be greater variation in women's sexual responses than is observed in men. In particular, although most women (more than 60%) experience desire, excitement, plateau, orgasm, and resolution in the linear manner originally outlined by Masters and Johnson and Kaplan and combined into a five-phase model we presented in Figure 4–4, a sizeable proportion do not (see Giraldi et al., 2015). For those women (about 25%), a circular model appears to more accurately capture the reality of their sexual responses.

Figure 4–7



Two models of the female sexual response cycle. Masters and Johnson's linear model for women resembles their model for men in its emphasis on sequential and physiological (largely genital) responses (do note that they added an initial sexual desire phase in the early 1990s that is not represented in this figure). Basson's circular model places a greater emphasis on emotional intimacy and cognitive interpretation of stimuli and acknowledges that responses may not follow a straightforward and linear path.

Figure 4–7 Full Alternative Text

Several circular or nonlinear models have been created; however, the most well-known and researched is that proposed by Rosemary Basson (2000, 2001ac, 2002a). This model emphasizes the importance of sexual affect and cognitions (including the role of emotional intimacy needs and cognitive interpretation of sexual stimuli) and the relational context (including the partner's actions) in women's sexual responsiveness. Notably, it also acknowledges that for some women desire does not always precede but may in fact follow or occur alongside sexual arousal (excitement). Specifically, Basson suggests that unlike most men (for whom desire generally arises spontaneously and then progresses to arousal and then to activity leading to orgasm), many women experience desire only after sexual excitement has begun to build and/or activity has commenced. This responsive desire, in turn, may produce positive feelings of satisfaction and pleasure and heighten existing arousal and sexual receptivity in a feedback loop. Because of its emphasis on the role of the partner, the relationship context, and sexuality-related affect and cognitions, this model may be particularly useful in explaining the experiences of women (and men) with various sexual dysfunctions (see Chapter 13). Indeed, research shows that women (and men) experiencing sexual difficulties are more likely to say that a circular model is more accurate at describing their sexual response cycle than a linear model (Giraldi et al., 2015).

4.4.1 Sexual Desire

There are some important differences between men's and women's sexual desire. First, women are more likely than men to conceptualize and experience sexual desire as a broader interpersonal need (as opposed to a specific sexual need). For example, when Regan and Berscheid (1996) asked college students the question "What is sexual desire?," their results indicated that more women than men viewed sexual desire as a need or desire for love, emotional intimacy, or romance—and not as a simple need or urge for sex.

Second, in line with scientific speculation (see Basson, 2002b; Baumeister, 2000; Regan, 2015), research reveals that the initial triggers of sexual desire differ for men and women. Specifically, whereas men's desire appears to often arise internally and spontaneously, women's desire often develops in response to external, contextual cues (see Goldhammer & McCabe, 2011a; Regan & Berscheid, 1995). Of course, it is important to note that, these differences aside, both men and women are capable of experiencing (and do experience) spontaneous and responsive desire. Indeed, one investigation (Regan & Atkins, 2006) found that college-aged women reported experiencing approximately nine episodes of spontaneously occurring sexual desire each week.

In addition to different triggers or causes, there is also evidence that some women do not subjectively experience sexual desire as a separate event that is distinct from other responses (such as sexual arousal) (see Beck et al., 1991). That is, they subjectively experience one process containing aspects of sexual interest or urges or motivations as well as aspects of physical and subjective arousal or excitation (see Basson, 2002c; Meana, 2010; Tiefer, 2001).

4.4.2 Excitement (Arousal)

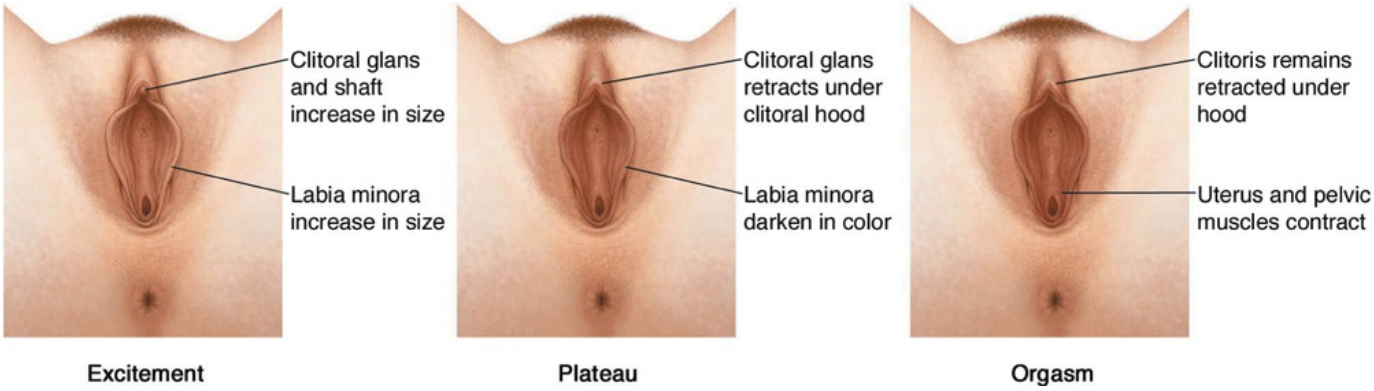
As with men, sexual arousal in women is characterized by changes in vasocongestion, myotonia, and cardiopulmonary function. Specifically, during the excitement phase, the first sign of sexual arousal in women is a vasocongestive response, and just as in men, it begins within seconds after the start of stimulation. The vaginal walls become engorged with blood, and the pressure soon causes the walls to secrete drops of fluid (superfiltered blood plasma) on the inner surfaces. This is called *vaginal lubrication.* However, while it is difficult for a man not to notice that his penis is getting firm, many women may not be aware that their vagina is lubricating (that is, that they are experiencing sexual excitement) until several minutes have passed.

In a heterosexual sexual encounter, many men mistake the presence of vaginal lubrication as a sign that their female partner is ready to begin intercourse. Although

lubrication makes vaginal penetration easier and prevents irritation during thrusting, remember that this is just the first physiological response experienced by a woman and does not mean that she is emotionally, or even physically, ready to begin sexual intercourse (a point to which we will return).

In addition to vaginal lubrication, the labia majora, which normally cover and protect the vaginal opening, flatten and begin to move apart. The walls of the vagina, which are collapsed in the unstimulated state, begin to balloon out, and the cervix and uterus pull up, thus getting the vagina ready to accommodate a penis or other object (see Figure 4–9). The clitoris, which is made up of two corpora cavernosa, becomes engorged with blood, resulting in an increase in diameter of the shaft (and length of the shaft in about 10% of women) as well as a slight increase in diameter of the glans. As a result, the clitoris is more prominent during the Excitement phase (women) than at any other time (see Figure 4–8).

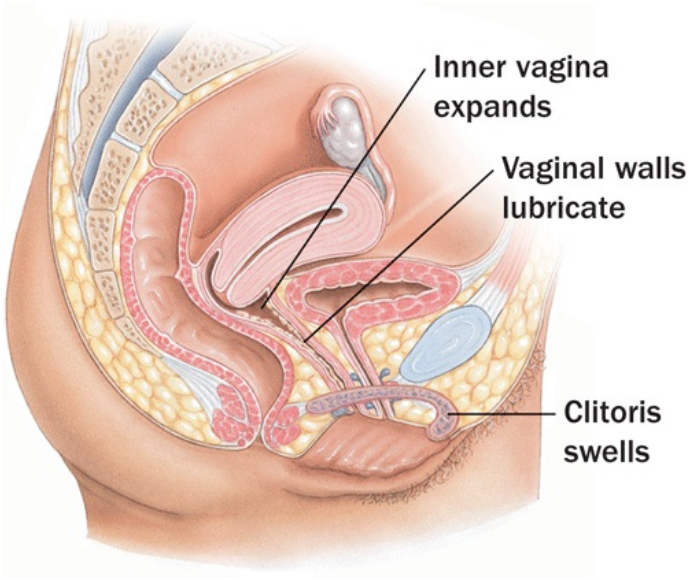
Figure 4–8



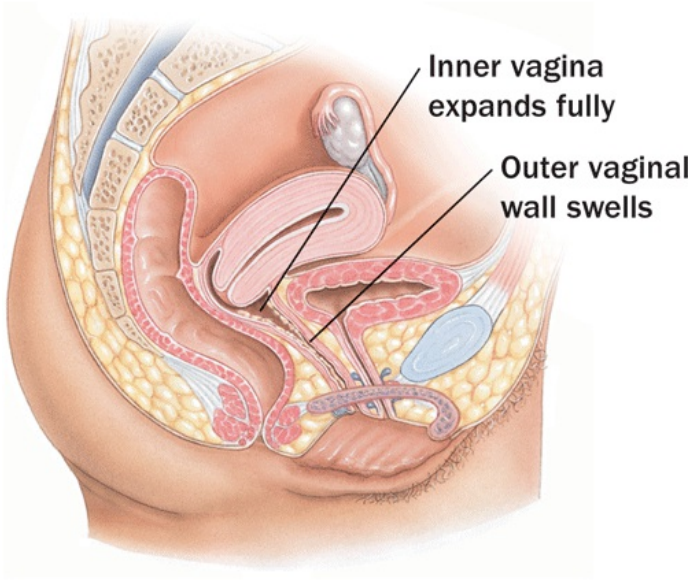
Changes in the clitoris and labia during sexual arousal.

Figure 4–8 Full Alternative Text

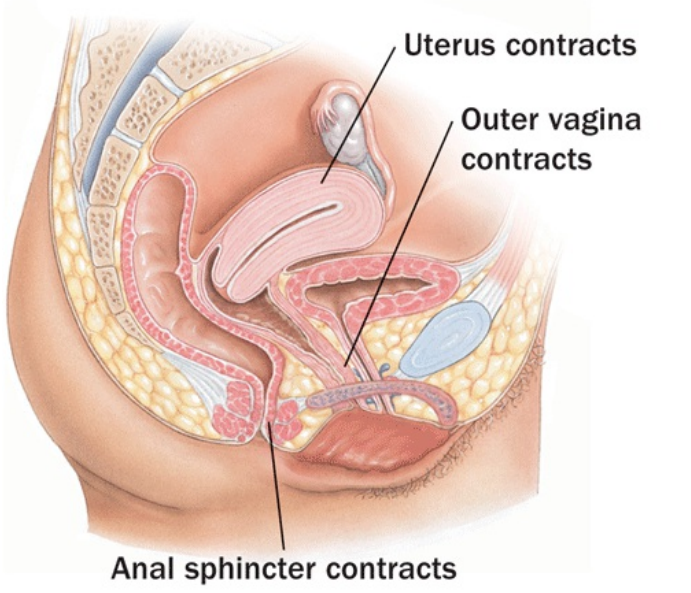
Figure 4–9



Excitement



Plateau



Orgasm

Women's physiological and genital sexual responses: excitement, plateau, and orgasm.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Figure 4–9 Full Alternative Text

The nipples also become erect during the excitement phase—a result of contraction of small muscle fibers, not vasocongestion. Vasocongestion of breast tissues is responsible, however, for a slight increase in breast size late in the excitement phase.

As we have discussed, Masters and Johnson were focused on describing the physiological and genital changes that occur in our bodies during arousal. Consequently, they were relatively silent on the subjective component of arousal (the psychological experience and subjective awareness of bodily changes). However, subsequent research has revealed that for men, the physical and psychological aspects of sexual arousal are strongly associated and generally co-occur. In other words, a man who is physically aroused is likely to also be subjectively aroused (and vice versa).

But is this true for women? Not necessarily (and perhaps not usually). Many of the physiological and genital changes that occur in a woman's body during the excitement phase are internal and relatively subtle, and thus they may not be consciously recognized when they first develop. There is nothing subtle about an erection, but how many women are immediately aware of vaginal lubrication? Unlike men, *for many women subjective arousal is very poorly correlated with measures of physiological and genital arousal* (such as vasocongestion) (Chivers et al., 2010). In fact, in many cases, women's autonomic nervous systems respond to "sexual" stimuli with genital vasocongestion, but the women do not interpret this response as sexual arousal, and some may even find it to be unpleasant (see Basson et al., 2003). This is why it is very important for a woman's partner to be sure that she is fully sexually stimulated—meaning mentally as well as physically aroused—before beginning sexual intercourse.

Personal Reflections

Do you know what factors influence your desire for sexual contact as well as your continued arousal as you go through the excitement, plateau, and orgasm phases of the sexual response cycle? Do you know which kinds of stimulation will give you the most pleasure? Do you know what pleases your partner most? Is it assumption or fact? Have you talked with your partner about how best to please each other? If not, why not?

4.4.3 Plateau

Assuming that sexual stimulation continues, women's bodies will reach the state of high physiological and genital arousal that marks the plateau phase (see Figure 4–9). While the inner two thirds of the vagina continue to expand like an inflated balloon and the uterus continues to elevate (creating a "tenting effect" in the vaginal walls), something quite different happens in the tissues of the outer third of the vagina. These tissues become greatly engorged with blood and swell, a reaction that Masters and Johnson called the *orgasmic platform.* The swelling of tissues results in a narrowing of the vaginal opening by 30% to 50%. Thus, the tissues of the outer third of the vagina grip the penis during this stage (negating the importance of penis size, according to Masters and Johnson).

Changes in blood flow also may cause a measles-like rash to appear on areas of the skin early in the plateau stage (or late in the excitement stage). This *sex-tension flush* (or *sex flush*) as it is called, occurs in 50% to 75% of all women and generally appears on the breasts, upper abdomen, and buttocks, although it can appear on any part of the body.

Three additional responses occur in women during the plateau phase that are sometimes misinterpreted by their partners to mean that the woman is no longer aroused, when in fact she is at a very heightened stage. First, the clitoris pulls back against the pubic bone and disappears beneath the clitoral hood (see Figure 4–8). Second, the breasts, and particularly the areola, become engorged with blood and swell, increasing in size by 20% to 25% in women who have not breast-fed a baby and to a lesser extent in those who have. This obscures the nipple erection that was readily apparent in the excitement phase. Third, the secretion of fluids from the vaginal walls may slow down if the plateau phase is prolonged (the Bartholin's glands secrete a few drops of fluid during this stage, but not enough to contribute to lubrication). Women's partners may worry about the disappearance of some of the responses that were so prominent during the initial excitement phase, but once again, these are the normal physiological responses when women become highly aroused. The glans of the clitoris, for example, is extremely sensitive to touch at this stage, and indirect stimulation is generally sufficient to maintain arousal. In fact, some women find direct stimulation of the clitoris during this phase to be too intense and less pleasurable than indirect stimulation.

The labia minora also become greatly engorged with blood during the plateau phase, resulting in a doubling or tripling in thickness and a vivid color change (from pink to wine color). The thickening of the labia minora helps to further push the labia majora apart and expose the vaginal opening. Masters and Johnson claimed that the color change in the labia minora means that a woman is very close to orgasm.

4.4.4 Orgasm

Incredible as it may seem to us today, until just a few decades ago many people (including many physicians and therapists) did not believe that women had orgasms. This mistaken belief was due in part to attitudes left over from the Victorian era. Women at that time were considered relatively nonsexual—they were not expected to enjoy sex and were believed to participate in it only to "fulfill their wifely duties" (and certainly not to satisfy any desire for sexual pleasure).

It was not until Masters and Johnson recorded electrophysiological responses from women that this assumption was challenged and ultimately rejected (at least in Western societies). Like men, women also demonstrated rhythmic muscular contractions in specific tissues that were initially 0.8 seconds apart. These tissues included the outer third of the vagina (the orgasmic platform), the uterus, and the anal sphincter muscles. In addition to the nearly identical recordings, men and women also describe orgasms similarly. Compare the following responses provided by our female students with those provided earlier in the section on men:

"It feels like all the tension that has been building and building is released with an explosion. It is the most pleasurable thing in the whole world."

"It is at first a force that feels as if you're on a roller coaster ride and are about to be propelled off. Then come the contractions that feel as if the roller coaster ride is hitting every bump on the track."

"A feeling that kind of feels like waves of electricity rushing through your whole entire body. It kind of ripples through and makes your toes and fingers curl."

". . . like when you have to urinate extremely bad and when you finally relieve yourself, you sometimes shake. Compare this at 100 times greater and it feels like an orgasm."

(All examples are from the authors' files.)

When physicians and psychologists were presented with descriptions of orgasm such as those just cited, they were unable to distinguish those that had been written by men from those written by women (Vance & Wagner, 1976; Wiest, 1977). Men's and women's ratings of adjectives describing their subjective experience of orgasm are also nearly identical (Mah & Binik, 2002).

The only real difference, in fact, between men and women concerns the physical responses that accompany orgasm. Women's muscular contractions occur in a single stage whereas men's occur in the two-stage sequence of emission and expulsion (women also are less likely to report the same sense of impending and rushing inevitability, of "coming," that men do and that is associated with ejaculation).

4.4.5 Resolution

A woman's physiological and genital responses, like those of men, generally drop below the plateau level after orgasm and return to the unaroused state, called *resolution* (see the first solid line in Masters and Johnson's model in Figure 4–7). Not every episode of arousal is guaranteed to lead to an orgasm, even for women who usually experience them (see the wavy line in Figure 4–7, which illustrates the responses of a woman who reaches the plateau stage of sexual arousal but then returns to her initial unaroused state without having had an orgasm). As many as 10% of sexually experienced women have never had an orgasm.

Some women, however, are capable of having true multiple orgasms—two, three, four, or more full orgasms in quick succession without dropping below the plateau level (see the dotted line in Figure 4–7). They must be capable, of course, of having the first orgasm, and additional orgasms are possible only with continued sexual desire/arousal and effective stimulation. Of women who experience orgasms, about 14% to 16% regularly have multiple orgasms (Kinsey et al., 1953), and perhaps as many as 40% experience multiple orgasms at least occasionally (Darling et al., 1991). Thus, the sexual response cycle is more variable in women than it is in men, and differs from woman to woman and from occasion to occasion (Basson, 2000; Tiefer, 1991).

Many women report that multiple orgasms are most easily experienced during masturbation, when they are not distracted by the partner and when sexual fantasy is maximal.

"Sometimes [I get] two or three orgasms right after each other. I can have multiple orgasms as much as eight times in a row, but this is only during masturbation."

"I have rarely had an orgasm with a partner. But I generally have one—usually more than one—when I masturbate, and this is true whether I use a vibrator or not."

(All examples are from the authors' files.)

Some women and men view multiple orgasms as an important—perhaps the most important—goal of sex, and they feel like sexual failures when the goal is not achieved. It is important to remember that multiple orgasms are an uncommon event for most of us, and physiologically speaking they are certainly not an "easy" thing to experience. Many individuals are completely satisfied by a single orgasm (and most men and women, including those who do not regularly experience orgasm, report being satisfied with their sex lives; see Regan, 2017). In keeping with our emphasis on becoming and being a sexually healthy person (see Chapter 11), we strongly believe that neither women nor men should put pressure on themselves or their partners with respect to orgasm (or any other part of the sexual response cycle). This "bigger, better, longer" sexual Olympics mentality can only detract from having a good, healthy, and sexually satisfying experience and may even contribute to the development of sexual problems (see Chapter 13).

At some point after a single orgasm or multiple orgasms, a woman's responses will start to fall below plateau level and return to normal. The blood drains from the breasts and the tissues of the outer third of the vagina, the sex flush disappears, the uterus comes down, and the vagina shortens in width and length. The clitoris returns to its normal position within seconds, but the glans may be extremely sensitive to touch for several minutes.

Personal Reflections

Do you judge your sexual experiences by your ability to reach orgasms or your frequency of orgasm? By your partner's orgasm? Why? Many women do not experience orgasm during sexual intercourse. How do you think they feel about it? How would you feel if it were you? Do you think that it is necessary to have an orgasm to enjoy sex?

Continuing Questions and Controversies About Orgasms

1. 4.5 Explain and discuss several ongoing questions and controversies about orgasm.

Of all the sexual responses that men and women experience, none has raised more questions, sparked more debate, or generated more controversy than the topic of orgasms. In the next section of this chapter, we present some of these interesting questions and discuss the answers that scientists have provided (or have failed to provide, as the case may be). We consider questions involving women's orgasms first and then turn to men's orgasms.

4.5.1 Are All Women Capable of Orgasm During (Heterosexual) Sexual Intercourse?

"I have had sex but never actually had an orgasm. If I have I did not know it. Sex feels good, but I think I never had one because of the way people say an orgasm feels."

"Unfortunately, I have yet to learn how to have an orgasm with a partner during intercourse, but I have no problem reaching orgasm during oral sex."

"I've had eight sex partners in my life, with five of these being long-term relationships. With only one of these men did I experience orgasm during the actual act of intercourse. I have them on my own during masturbation and also during mutual masturbation, but it is unusual for me to have them from intercourse. I don't worry about it. Men's and women's bodies don't always jibe, you know?"

(All examples are from the authors' files.)

In their nationally representative U.S. study, Laumann and colleagues (1994) found that 75% of married women and 62% of single women usually had an orgasm during sex. More recently, a large, nationally representative Australian study (Richters et al., 2006) revealed that 69% of women had an orgasm during their last sexual encounter (95% of men did); however, only 50% did so if the sex involved intercourse alone (with no manual stimulation of the clitoris or oral-genital sex). About 5% to 10% of American women have never had an orgasm during intercourse or any other sexual activity (Spector & Carey, 1990). Taken together, this research reveals that a sizeable minority of women do not regularly (or never) have an orgasm during vaginal intercourse.

Many factors play a role in women's ability to reach orgasm as a result of this particular sexual activity (Basson, 2000; Mah & Binik, 2005; Raboch & Raboch, 1992). Some of these factors are biological or developmental, including age. Younger women (in their teens) and older women (50 or older) are less likely to experience orgasm than are women in their 20s, 30s, and 40s (Richters et al., 2006). Some factors have to do with how a woman is stimulated during vaginal intercourse. For example, from years of experience in her own clinical practice, sex therapist Helen Singer Kaplan (1974) concluded that "there are millions of women who are sexually responsive, and often multiply orgasmic, but who cannot have an orgasm during [vaginal] intercourse unless they receive simultaneous clitoral stimulation." Of course, it is important to remember that orgasms are a subjective response—they are produced by more than mere physical mechanics. Many women who are perfectly capable of having orgasms during intercourse (or other activities) may not be able to actually do so as a result of psychological or interpersonal factors, including their feelings about their partner and the overall state of their relationship (Basson, 2000). We will return to this issue in Chapter 13.

Heterosexual men have become increasingly focused on whether their female partners experience an orgasm during intercourse. Indeed, a recent Google search conducted by the second author of this textbook using the phrase "How men can give a woman an orgasm" produced more than 33 million results. Given men's overwhelming interest in women's orgasms, you will probably not be surprised to learn that many women (about two thirds) resort to faking orgasms during vaginal intercourse (Muehlenhard & Shippee, 2010). Why do they lie? The usual reasons are to protect the partner (avoid hurting his feelings), bolster the partner's sexual self-esteem (make him feel good about his sexual prowess or skill), bolster their own sexual self-esteem (suppress feelings of inadequacy or abnormality), and strategically end the sexual encounter (Fahs, 2014; Muehlenhard & Shippee, 2010; Opperman et al., 2014).

"I have the most amazing husband. He loves me and wants to satisfy me sexually, and we are able to talk about sex pretty honestly with each other. But I have to admit that I sometimes lie about whether I've had an orgasm. There are times when for whatever reason I can't get into the sex enough to finish. He always asks if I've finished before he comes, and I really don't want him to feel bad so I'll lie."

"Of course I've faked it. Who hasn't? Sometimes the sex is good but I realize it's not going to happen for me, so I fake it because at some point it just needs to end."

"Yes, I have faked orgasm before. I do it to provide a way for the sex to end without my partner feeling bad or me having to go into some sort of protracted excuse or explanation for why I didn't come."

"Orgasm is not the only reason I have sex. But it's kind of become the only thing that matters. All women are expected to want one and to actually have one—a big one—every time they have sex. I call it the 'porno mentality.' It takes me awhile to have an orgasm, and sometimes I don't care if I have one, but I feel like I have to pretend. So I do."

"I haven't had an orgasm yet from intercourse. I think I should have had one by now, since I've been having sex with my boyfriend for almost a year. I don't want him to think there's something wrong with me, so I pretend to have one when we do it. Maybe there is something wrong with me."

(All examples are from the authors' files.)

Certainly no woman should feel pressured to have an orgasm from vaginal intercourse or that she is somehow less sexually capable if she does not have orgasms from this type of activity (or at all). No woman should feel compelled to lie about her orgasmic situation in order to protect her partner's ego, and her partner(s) should not feel bad if the woman does not have an orgasm in this way. As we will discuss in Chapter 13, a sexual response (or lack of response) becomes a problem only when the person views it as such. If having an orgasm during sex (in particular, during vaginal intercourse) is important to a woman and her partner, the two of them should openly and honestly communicate about this and be willing to work together to find ways to increase the likelihood of it happening (the Addendum at the end of Chapter 13 provides some helpful advice about sexual communication).

4.5.2 What Is the Purpose of the Female Orgasm?

For men, the subjective experience of orgasm usually goes hand in hand with the physical occurrence of ejaculation. Ejaculation, of course, is critical to reproduction—it provides sperm with an opportunity to reach and fertilize a woman's egg. Consequently, many evolutionary scientists view the male orgasm as having *functional significance*. This means that it would have been adaptive in the ancestral environment in which the human species developed—it would have provided some benefit to our early human ancestors in terms of survival or reproductive success (see Cosmides & Tooby, 1997; Regan, 2002). However, the functional significance of the female orgasm has been a topic of much debate among those same evolutionary scholars. Unlike men's orgasms, women's orgasms are not accompanied by any physiological process that is critical to reproduction (such as the release of an egg). What is the functional value, then, of the female orgasm? Why would this sexual response be part of our species' evolutionary heritage?

Evolutionary scientists have made several attempts to answer this question (for reviews, see Wheatley & Puts, 2015, and Zuk, 2006). Some argue that women's orgasms actually do have functional value. These researchers posit that female orgasm is an adaptive response that evolved through natural selection the way other human characteristics (including male orgasm) did—that is, by conferring survival or reproductive benefits in the ancestral environment in which our species developed. These scientists have proposed a number of specific hypotheses about the ways in which orgasms might have served an adaptive purpose. For example, perhaps orgasms increased the likelihood that our female ancestors remained lying down after intercourse (retaining sperm in the reproductive tract and thus increasing the chance of conception). Perhaps ancestral women were more likely to achieve orgasms with particularly desirable (as opposed to undesirable) mates—men with physical and psychological qualities (such as intelligence, loyalty, health, and strength) that would have contributed positively to the woman's chances of survival and helped her to produce "high quality" offspring. Similarly, perhaps having regular orgasms increased a woman's desire to form a lasting, committed pair-bond with the partner who helped her achieve those orgasms (such a pair-bond would also have increased her chances of survival and reproduction in the harsh ancestral environment from which our species emerged).

Other evolutionary scientists disagree with these "adaptationist" ideas, favoring an alternative perspective. According to the "by-product hypothesis" (Levin, 2011; Lloyd, 2005; Symons, 1979), there is nothing inherently adaptive about the female orgasm. Rather, women have orgasms simply because the tissue of the clitoris comes from the same embryonic source as that of the penis. These scholars argue that natural selection favored the development of the male orgasm (which, as we have discussed, has reproductive value due to its association with ejaculation), and they thus consider the female orgasm to be something of a "happy accident." This perspective, too, has been criticized (see Zuk, 2006).

Because we cannot travel back in time to the ancestral environment and observe the evolutionary development of our species, we will never know if having orgasms actually helped women solve adaptive problems (like selecting a "good" mate who would help her survive and reproduce) or was merely a "by-product" of the evolution of the male orgasm. We will also, for that matter, never truly know if having orgasms—which are a subjective experience, remember—actually increased the survival or reproductive success of ancestral men. Ejaculation, not orgasm, is the male response required for reproduction. Thus, we will never be able to determine if any of these explanations are correct. Perhaps none of them are. We leave you with a question. As individuals, do we really need to have an evolutionary reason for the occurrence of orgasm? Orgasms feel good for both men and women. Maybe that is reason enough for their existence.

4.5.3 How Many Types of Female Orgasm Are There?

Sigmund Freud, unlike many of his Victorian colleagues, not only believed that women had orgasms but started another controversy when he said that there were two types of female orgasms, one due to clitoral stimulation and one resulting from vaginal sensations. Unfortunately, he claimed that *clitoral orgasms* were infantile and a sign of psychosexual immaturity (because they were caused by non-coital acts), whereas *vaginal orgasms* were "authentic" and "mature" and a sign of normal psychosexual development (the result of stimulation by the penis). "The elimination of clitoral sexuality," he wrote, "is a necessary precondition for the development of femininity."

The inner two thirds of the vagina has few nerve endings. Kinsey and colleagues (1953), who doubted the authenticity of vaginal orgasms, had five gynecologists touch the vaginal walls of 879 women with a probe. Most women could not tell when their vagina was being stimulated but were very much aware when their clitoris was touched.

Masters and Johnson (1966) later reported that all women's orgasms were physiologically the same. No matter whether the source of stimulation was clitoral or vaginal, identical rhythmic muscular contractions were recorded in the same physical structures. The same contractions also were recorded in women who had reached orgasm from breast stimulation alone. Masters and Johnson concluded that an orgasm is an orgasm, regardless of the source of stimulation, and that they are all essentially clitoral.

On the other hand, several early studies found that some women subjectively distinguished between orgasms caused by clitoral stimulation during masturbation and orgasms during intercourse (which were described as "fuller, but not stronger," "more internal," and "deeper" [e.g., Bentler & Peeler, 1979; Butler, 1976]). Anecdotally, some women also say that they have never had an orgasm from clitoral stimulation—that their orgasms

always result from vaginal stimulation:

"I am a 30-year-old woman who has been sexually active since my late teens. I've always been very responsive sexually, resulting in multiple, intense orgasms during intercourse. The significant point is, I have orgasms during intercourse, but never during oral sex or direct clitoral stimulation. My orgasms are strictly vaginal, they are never clitoral. I'd always felt fine about this until I had a relationship with a man who said there was something wrong with me because I did not reach orgasm during oral sex. He made me feel so bad that I literally lost all of my self-esteem and self-confidence. I truly believed I was abnormal."

(from the authors' files)

If the walls of the inner two thirds of the vagina are so sparse in nerve endings, what could be the anatomical basis for vaginal orgasms? Recall from Chapter 2 that the muscle surrounding the vagina, the pubococcygeus (PC) muscle, has a richer supply of nerve endings than the vaginal walls and that women who report vaginal sensations during intercourse tend to have strong PC muscles (Kinsey et al., 1953). In 1982, Ladas, Whipple, and Perry suggested in their book, *The G Spot*, another possible basis for a vaginal orgasm. The Grafenberg (G) spot was first described by the German gynecologist Ernst Grafenberg in the 1940s (see Grafenberg, 1950). It was described as being a very sensitive area about the size of a dime located on the front wall of the vagina, about halfway between the back of the pubic bone and the front of the cervix (just under the bladder) (Song et al., 2009; see Figure 2–7). It swells when stimulated, and a woman's first reaction (lasting a few seconds) may be an urge to urinate. Media stories about the erogenous potential of the G spot abound, and surveys reveal that many women believe that the G spot exists (though they often cannot locate it on their own bodies). However, there is very little current anatomical evidence in support of its existence (see Kilchevsky et al., 2012). If the G spot does exist, studies suggest that fewer than 10% of women have it (Alzate & Londono, 1984). Thus, the G spot may—or may not—serve as the basis for vaginal orgasms.

Most researchers now agree that some women may experience vaginal orgasms, or a combination of clitoral and vaginal orgasms (Jannini et al., 2012).

"I believe I've had clitoral orgasms, vaginal orgasms, and the blended type. All of these feel different. . . . For me the best type of orgasm is the blended type because I feel it all over and when it is over my body trembles as if I had just stopped running."

(from the authors' files)

Women's experiences of orgasm can also differ with regard to the duration of the orgasm. For example, Basson (2000) found that for some women orgasm is not a short, intense release of sexual tension (as occurs in men and as shown by the peaks in the curve of the Masters and Johnson model in Figure 4–7) but can last for well over a minute.

Is all this just a question of semantics—that is, of people confusing the stimulus with the response? The most effective stimulus for erection in men is touching the glans of the penis (light pressure stimulates the pudendal nerve), but the orgasmic contractions come from the base of the penis and perineum (deep pressure stimulates the pelvic nerve). Yet no one argues over how many types of orgasm men experience or whether men have glans orgasms or perineal orgasms. Instead, men are viewed as having a total-body orgasm, with different ranges of intensity.

So do women have different types of orgasm, or do they experience different ranges of one basic type of orgasm that has both clitoral and vaginal components? There are three things that we can conclude with certainty. First, for both women and men, we know that "physiologically, an orgasm is an orgasm, though there are degrees of intensity" (William Masters, as quoted in Gallagher, 1986). Second, and again for women and men, the nature of the sexual activity (e.g., masturbation versus intercourse, the partner's actions) as well as sexual affect and cognitions (e.g., anticipation and enjoyment versus anxiety and guilt) can affect the subjective experience of orgasm. And third, one type of orgasm should not be viewed as infantile, immature, or less important and another type as mature, authentic, or more important. In short, a woman (and her partner) should not worry about what type of stimulation produces orgasm or the exact type of orgasm she has. As Barbara Seaman (1972) wrote, "The liberated orgasm is any orgasm a woman likes."

4.5.4 Do Women Ejaculate During Orgasm?

Adult men ejaculate during orgasm, but do women also ejaculate? The emission of a fluid by some women during orgasm was noted as early as 300 years ago by the Dutch embryologist Regnier de Graff, who described the fluid as coming from the small glands surrounding the urethral opening. This was confirmed in the modern scientific literature by Ernst Grafenberg (after whom the G spot was named) in 1950. The emission of fluid in some women was described as a dribble and in others as a gushing stream.

"I have always achieved vaginal orgasms with fluid. The fluid is clear and white. It has no odor and is not unpleasant. I thought all women have this type of orgasm."

"The first time I emitted a fluid, I thought I had urinated on myself and my boyfriend. I mean it was all over. My boyfriend kept looking at me real strange and I couldn't explain it. After the first time I kept making sure that I went to the bathroom before we had intercourse. When it happened after I knew I couldn't have that much fluid in my bladder. I got a little worried, but my boyfriend enjoyed watching me 'let loose' and got very excited."

"Sometimes I get so wet during intercourse, especially after I come, that the bed looks like I peed on it. The fluid doesn't smell like pee, though. This doesn't always happen, just occasionally. My boyfriend really likes it when it happens. He calls it the exuberance of my passion."

(All examples are from the authors' files.)

Prior to the 1980s, women who emitted a fluid during orgasm were almost always told by physicians that the fluid was urine and that they suffered from urinary incontinence (bladder control issues; in this case caused by muscle exertion or stress during sexual activity). In 1981, however, several articles on female ejaculation appeared in *The Journal of Sex Research*. These articles confirmed that the fluid was not emitted from the bladder (or from the vagina) but from the Skene's glands located in the urethra (Belzer, 1981; Perry & Whipple, 1981). These glands are thought to develop from the same embryonic tissue as men's prostate (Dietrich et al., 2011), and the fluid, which was said to differ in color (clear to milky white) and odor from urine, was found to contain prostatic acid phosphatase, an enzyme found in prostate secretions (Zaviacic & Ablin, 2000; Zaviacic et al., 1988).

How many women emit fluid (that is, ejaculate) during orgasm? Early research suggested that anywhere from 10% to 40% of women ejaculated on occasion (e.g., Perry & Whipple, 1981). Later studies have generally confirmed this estimate (for a review, see Pastor, 2013). However, while it can no longer be doubted that some women do ejaculate during orgasm, some question still remains as to the exact nature of the fluid. No doubt some women do suffer from stress-induced incontinence and emit urine during orgasm (Serati et al., 2011). Other women may simply experience such an extensive amount of vaginal lubrication during intercourse that it subsequently feels or looks as if they have had an "ejaculation." And some women actually may experience a true ejaculation of fluid during orgasm that is produced by Skene's glands.

4.5.5 Can Men Have Multiple Orgasms?

Based on their laboratory observations, Masters and Johnson (1966) concluded that only women could have true multiple orgasms—two or more orgasms within a short time without dropping below plateau. Whenever they recorded orgasm with ejaculation from men, it was always followed by a refractory period (hence their conclusion that only when a man's level of arousal built back up to the plateau level was it possible for him to have another orgasm). However, the results of one case study and two surveys published after Masters and Johnson reached their conclusion suggested that some men might, in fact, be capable of achieving a second (or third or fourth, etc.) orgasm during a single episode of sexual activity without requiring a refractory period. The case study (Whipple et al., 1998) was of a 35-year-old man who reported having had multiple ejaculatory orgasms since the age of 15. This man was observed by researchers in a laboratory and physiological measurements confirmed that he had six orgasms with ejaculation over the course of 36 minutes without entering a refractory period.

The first survey study (Robbins & Jensen, 1978) reported findings from 13 men who said that they were able to experience multiple dry "mini-orgasms" by withholding ejaculation before having a full "wet orgasm" (that is, an orgasm accompanied with ejaculation). According to the survey participants, the wet orgasm was always followed by a refractory period. In the second survey study (Dunn & Trost, 1989), 21 men reported experiencing different kinds of multiple orgasm. Some had one or more dry orgasms before ejaculating, while others had an orgasm with ejaculation followed by one or more dry orgasms. Anecdotally, a few of the male students in our classes also have reported multiple orgasms on occasion:

"In the 50 questions you had us answer, one of them said that most men cannot have multiple orgasms. I am a male that has this ability . . ."

"My boyfriend keeps his erection for hours and can continue to copulate continuously without stopping, even after ejaculating, and can ejaculate multiple times."

"Occasionally I will feel like I'm going to ejaculate and in order to prolong the sex I will consciously try to not ejaculate by thinking of other things. At the same time I'm doing this I experience what I can only describe as a small orgasm—it feels good but not as 'big' or 'explosive' as a regular orgasm. Then I will have a regular orgasm with ejaculation, and after that I need to wait before I can have sex again."

(All examples are from the authors' files.)

Very little recent research has been devoted to the question of men's orgasmic potential (multiple or otherwise). This may stem from the fact that men, compared with women, are generally orgasmic. That is, sexual activity of any type (e.g., masturbation, oral- genital sex, intercourse) tends to result in at least one orgasm for most men (unlike women, as we have discussed). Thus, orgasm issues in men may be of less pressing concern to scientists, clinicians, and other health professionals. Nevertheless, with respect to the male multiple orgasm, it is probably safe to conclude the following: (1) most men require a refractory period before they are physically capable of having additional ejaculations with accompanying orgasms, and (2) while certainly possible, the experience of multiple orgasms does not appear to be a common occurrence in men (see Wibowo & Wassersug, 2016).

Box 4–A Cross-Cultural Perspectives

Female Genital Mutilation or Cutting

1. 4.6 Explain and discuss the practice of female genital mutilation/cutting.

The term "female genital mutilation" or "female genital cutting" refers to any procedure involving partial removal of, total removal of, or deliberate injury to the female genitals for non-medical reasons (World Health Organization [WHO], 2008, 2016a). Cutting of girls' and women's genitals has been a common practice in many cultures since antiquity. The first record we have of it was reported by the Greek historian Herodotus in 450 b.c. in ancient Egypt (Joseph, 1996).

In the United States, it is illegal to perform genital mutilation on girls and young women under the age of 18, and it is also illegal to send girls out of the country to have the procedure performed (a practice commonly known as "vacation cutting"). These laws were passed after the Justice Department's Board of Immigration Appeals granted asylum in 1996 to a young woman named Fauziya Kassindja, who fled her homeland of Togo in order to escape being subjected to genital mutilation. Moreover, every U.S. state has general child protection laws that can be used to

prosecute genital mutilation of girls, and about half of the individual states have enacted laws specific to the practice of genital cutting (many of which apply regardless of the female's age).

Figure 4–10

Fauziya Kassindja was 19 when she fled a forced marriage and genital mutilation in her native country of Togo. She was detained for a year in a U.S. prison while her case made its way through the courts. Finally, in 1996, Kassindja was granted asylum. Her case set legal precedent—for the first time, genital mutilation was formally recognized by the U.S. government as a form of persecution and a basis for asylum. She is pictured here in 1996 with the student attorney (Layli Miller-Muro) who represented her before the immigration judge.

Source: JOYCE NALTCHAYAN/AFP/Getty Images

Nonetheless, female genital mutilation is still performed in secret in the United States, with recent prevalence figures suggesting that more than 500,000 girls or women have been cut or are at risk of undergoing cutting (Goldberg et al., 2016). Rates appear to be rising, a phenomenon that many scientists and health professionals believe is the result of increased immigration from countries that traditionally practice female genital mutilation (such as Ethiopia, Egypt, and Somalia) (see Akinsulure-Smith & Sicalides, 2016).

Indeed, female genital cutting is routinely performed in many parts of the world, despite ongoing efforts by a wide array of international and local human rights and social justice organizations to eradicate the practice. A recent UNICEF survey of 30 countries revealed that at least 200 million girls and women have been subjected to genital mutilation (UNICEF, 2016). The practice is most common among countries in Africa (e.g., Djibouti, Egypt, Guinea, Mali, Sierra Leone, Somalia, Sudan), the Middle East (e.g., Iraq, Yemen), and parts of Asia (e.g., Indonesia). In many African countries, more than 90% of girls and women have been genitally mutilated (WHO, 2008).

Four types of genital cutting have been identified (see Table 4–2). Type I, *clitoridectomy or circumcision*, refers to removal (excision) of the clitoral hood (Type Ia) or removal of the clitoral hood and the clitoris (Type Ib). Type II, called *excision*, involves three similar forms of mutilation —removal of the labia minora (Type IIa), removal of the labia minora and the clitoris (Type IIb), or removal of the labia minora and clitoris as well as the labia majora (Type IIc). These two forms of cutting (Type I and II) account for about 80% of all the cases worldwide (WHO, 2008). The most extreme form of genital mutilation, called *infibulation* (Type III), involves cutting away the labia (minora, majora, or both), often accompanied by excision of the clitoris, and then sewing together the raw sides of the vulva with only a small opening left for urine and menstrual flow to pass through. As noted by Akinsulure-Smith and Sicalides (2016), girls and women who survive the initial procedures involved in Type III mutilation may be subjected to a repeated cycle of *defibulation* (opening of the mutilated labia upon marriage to allow penetration for intercourse and subsequent childbirth) and *reinfibulation* (resewing together of the labia after childbirth). The last category of genital mutilation, Type IV, includes all other procedures that cause injury to female genitals for non-medical reasons (such as scraping, cauterizing, piercing, or incising the

clitoris and/or labia).

Table 4–2 Types of Female Genital Mutilation

Category	Label	Definition
Type I	Circumcision (Ia) or clitoridectomy (Ib)	Removal of clitoral hood (Ia) or removal of clitoral hood and clitoris (Ib)
Type II	Excision	Removal of labia minora (IIa), of clitoris and labia minora (IIb), or of clitoris, labia minora, and labia majora (IIc)
Type III	Infibulation	Narrowing of vaginal opening by (1) removal of labia (minora, majora, or both) and often clitoris and (2) sewing together remaining tissue on the sides of the vulva
Type IV		All other harmful procedures conducted on female genitals for non-medical reasons (such as scraping, incising, cauterizing)

Source: World Health Organization (2016), *Classification of female genital mutilation.*

Table 4–2 Full Alternative Text

Female genital cutting is usually performed by an older, respected village woman with a knife, razor, or other sharp object (scissors, glass shard, stone, even a finger nail) and without anesthesia, requiring that the girl be tied or held down during the procedure. It is usually done during early childhood but in some cases, it is carried out just prior to marriage.

> Once I was inside the hut, the women began to sing my praises, to which I turned a deaf ear, as I was overcome with terror. "Lie down there," the excisor suddenly said to me, pointing to a mat stretched out on the ground. No sooner had I laid down than I felt my thin frail legs tightly grasped by heavy hands and pulled wide apart. I lifted my head. Two women on each side of me pinned me to the ground. My arms were also immobilized. Suddenly, I felt some strange substance being spread over my genital organs. I would have given anything at that moment to be a thousand miles away: then a shooting pain brought me back to reality from my thoughts of flight. First I underwent the ablation of the labia minor and then of the clitoris. The operation seemed to go on forever. . . . I was in the throes of endless agony. . . . I felt wet. I was bleeding. The blood flowed in torrents. Then they applied a mixture of butter and medicinal herbs which stopped the bleeding. Never had I felt such excruciating pain!
>
> (Joseph, 1996, pp. 3–4)

Figure 4–11

Female genital mutilation is routinely practiced in many countries around the world.

Source: Louise Gubb/Corbis Historical/Getty Images

There are absolutely no health benefits to the practice of genital mutilation. However, there are multiple harmful consequences, including pain, blood loss, infection, shock, and even death. Girls and women who survive the process of infibulation suffer from chronic vaginal and pelvic infections, are at increased risk of miscarriage, experience difficult and painful labor, and are more likely to hemorrhage and die after giving birth (Adam et al., 2010; WHO, 2008, 2016a). Babies born to genitally mutilated women are also more likely to die during infancy (WHO, 2008).

Given the uniformly negative consequences of genital mutilation, why are girls and women in so many countries subjected to it? And why, in those countries in which it most commonly occurs, do *both* men and women support the practice? Some reasons have to do with deeply rooted sociocultural beliefs about female sexuality and gender roles (see Abdalla, 1982). For example, in many of these cultures genital mutilation is viewed as an effective method for reducing a woman's sexual interest (Akinsulure-Smith & Sicalides, 2016). It is the case that sexual intercourse is often painful for women whose genitals have been excised or cut, and most do not enjoy sexual activity as a result (Utz-Billing & Kentenich, 2009). In these cultures, the primary role for women is that of wife and mother, and genital mutilation is believed to free a woman from personal

sexual desires that might detract from her ability to fulfill that role.

Similarly, countries where genital mutilation is commonly practiced are strongly patriarchal, and there is great concern about guaranteeing the inheritance of property from fathers to legitimate sons. By reducing a woman's sexual desire (and, in cases of infibulation, eliminating her ability to have sex even if she wanted to do so), genital mutilation is viewed as a method for guaranteeing virginity before marriage and ensuring fidelity after marriage. This, so the argument goes, helps men in these societies know beyond a shadow of a doubt that any offspring they sire are indeed their own.

Cultural identity also may play a role in the occurrence of female genital mutilation. Some proponents of genital cutting argue that the practice serves as an important cultural rite that initiates a girl into womanhood and affirms her identity as a member of her tribe, society, or group. This may explain why girls who refuse to submit to the practice—and their families—are often harassed, targeted, and ostracized by members of their community (see Gruenbaum, 2006).

There is evidence that these cultural beliefs are changing, particularly among younger generations. Increasing numbers of young women are refusing to undergo the procedure, and increasing numbers of young men say that they do not want to marry women who have been genitally mutilated (for a review, see WHO, 2008).

The World Health Organization, all United Nations agencies, all African governments, and a wide array of other international, regional, and local agencies have banded together to end the practice of female genital mutilation. To some people, this may seem hypocritical. After all, male circumcision is both legal and widely practiced in many countries including the United States (see Box 2–C). Why should female circumcision be viewed or treated any differently? According to the World Health Organization and other agencies, the answer has to do in part with the different physical consequences of circumcision for males and females. Specifically, male circumcision is more likely than female circumcision to be conducted by medical professionals in hygienic conditions. It also typically involves less severe injury to genital tissues and is less likely to disrupt normal bodily functions and to result in harmful immediate and long-term health consequences (WHO, 2008). Unlike female genital mutilation, male circumcision also appears to confer some health benefits, including a reduced risk of urinary tract infections and acquiring HIV (see Box 2–C).

But what about the rights of different world cultures to practice their customs freely without interference from outsiders? Shouldn't cultural traditions be respected? This is a valid question. It is undoubtedly important to respect the traditions, customs, and norms of other cultures. But is "tradition" a sufficient reason for continuing a particular practice, particularly one that causes harm to the individual? The history of many countries is littered with cultural practices—like slavery and child labor—that at one time were widely accepted but later were abolished as a result of changes in people's understanding of social justice and civil rights. Indeed, the *Universal Declaration on Cultural Diversity* adopted in 2001 by UNESCO (United Nations Educational, Scientific and Cultural Organization) clearly states that "no one may invoke cultural diversity to infringe upon human rights." Based on this Universal Declaration, cultural tradition does not appear to provide sufficient reason for the continued practice of female genital mutilation.

> Female genital mutilation has been recognized as discrimination based on sex because it is rooted in gender inequalities and power imbalances between men and women and inhibits women's full and equal enjoyment of their human rights. It is a form of violence against girls and women, with physical and psychological consequences. Female genital mutilation deprives girls and women from making an independent decision about an intervention that has a lasting effect on their bodies and infringes on their autonomy and control over their lives . . . International law stipulates that freedom to manifest one's religion or beliefs [is] subject to limitations necessary to protect the fundamental rights and freedoms of others. Therefore, social and cultural claims cannot be evoked to justify female genital mutilation.

(WHO, 2008, p. 10)

Personal Reflections

What was your reaction to reading about the practice of female genital mutilation? What is your view about male circumcision in the United States? We do not allow circumcision or excision of women's genitals in this country because to do so would deny them control over their bodies and sexuality. But do we deny women's (and men's) sexuality in other ways? How?

Penis Size: Does It Matter?

1. 4.7 Discuss the role of penis size in sexual pleasuring.

In an article written for *Cosmopolitan* magazine in 1984, reporter Michael Barson stated that "for a man, the one emotion more disquieting than his own sense of not being big enough is the terror of finding himself in bed with a woman who shares his opinion." It should come as no surprise that many men wonder about the size of their genital "equipment" because large penises have received a great deal of positive attention in contemporary Western society.

4.7.1 Historical Perceptions

Historically, this was not always—or even usually—the case. In the world of ancient Greece, for example, a large penis signified barbarism and social inferiority, whereas a small, delicate penis was a sign of nobility and mind–body harmony and balance (see McNiven, 1995). Consequently, Greek art typically depicts manual laborers, slaves, and other marginalized male members of society with an oversized phallus, whereas gods, heroes, athletes, and noblemen are shown with a more modest organ (see Figure 4–12). This practice continued across many centuries. Sculptors and painters during the Renaissance period of Western civilization maintained the aesthetics of the ancient Greeks, portraying male athletes, gods, and Biblical figures with smaller, rather than larger, penises. Michelangelo's *David* (1501–1504) is an example of Renaissance sculpture fashioned in this manner.

Figure 4–12

Historians believe that the smaller penises given to gods, noblemen, and athletes by artists in ancient Greece were meant to signify nobility of mind and body. Conversely, larger penises conveyed barbarism and social inferiority, and thus were included in depictions of manual laborers, slaves, and other marginalized members of society. This style was later mimicked by artists during the Renaissance period spanning the 14th to 17th centuries.

The *Artemisian Bronze* (National Archaeological Museum of Athens), a 5th-century BC sculpture depicting Zeus hurling a (missing)

thunderbolt.

Source: Erin Babnik/Alamy Stock Photo

A painted clay tablet from ancient Corinth (6th century BC) depicting a slave at work in a mining excavation. Note the exaggerated penis.

Source: Johannes Laurentius/Art Resource, NY

Michelangelo's *David*, a famous Renaissance statue depicting the Biblical hero (created 1501–1504, housed in the Galleria dell'Accademia, Florence).

Source: Kris Legg/Alamy Stock Photo

4.7.2 Contemporary Attitudes

Modern Western society, however, appears to have split from its ancient roots, at least with respect to penis size and what penis size signifies. Modern literary classics (e.g., *Lady Chatterley's Lover*), contemporary pulp fiction and romance novels, and erotic and pornographic media routinely present the penis in exaggerated terms that equate generous size with manliness and sexual prowess. As noted by sex therapist Bernie Zilbergeld (1978), "penises in fantasyland come in only three sizes—large, gigantic, and so big you can barely get through the front door." All of this tends to leave the impression that the size of a man's penis is directly related to his degree of masculinity and sex appeal as well as his ability to please a partner in bed. It makes perfect sense, then, that so many men worry about the size of their penises (Johnston et al., 2014; Veale et al., 2016) and often wish that their penises were larger (Lever et al., 2006).

"I wish I were bigger. I think that my penis is probably too small."

"I worry sometimes that my penis is not as big as it should be."

"I've never seen anyone else's penis aside from brief glances in the gym. From what I'd seen there I thought I was pretty small. I was glad to learn from the book that I'm actually in the normal range."

"I have an inferiority complex about my penis size. Even though my penis is larger than normal (about 7 inches) . . . no matter how many women tell me that my penis is large, I still have that complex."

"I know other guys measure their penises, but I'm afraid to because I think it's below normal in size. I guess I'd rather not know than know for sure and then have to live with the knowledge that I'm not adequate."

(All examples are from the authors' files.)

For most heterosexual men the only opportunity to compare themselves with other men is in the locker room, where they may get a false impression both of what is "average" and of how their penis measures up, so to speak, with the penises of other men. This is because there is a lot

of variation in penis size in the flaccid condition. For example, studies in which men's penises were measured (across the top) while flaccid reveal a wide range of sizes (anywhere from 1.4 to 4.7 inches long), with most men falling between 2.6 to 4.3 inches in length and between 1.0 to 1.2 inches in diameter (see Masters & Johnson, 1966; Mondaini et al., 2002). Interestingly, penises that are smaller when flaccid display a proportionately greater increase in size upon erection than do larger penises (Jamison & Gebhard, 1988). For example, Masters and Johnson (1966) identified the men in their studies with the largest and smallest (flaccid) penises. Upon achieving full erection, each man's penis was measured again. Although all penises increased in size during the arousal process, small penises increased proportionately more than did larger penises. Full erection "essentially doubled the smaller organs in length over flaccid-size standards" but did not do the same for larger organs (p. 192). However, since most heterosexual men (and non-partnered homosexual men) do not have an opportunity to personally see a lot of other erect penises, they may erroneously assume that their (flaccid) penis is undersized when comparing it to those of other men. Indeed, one study found that almost two thirds (63%) of men who were concerned about their penis size reported that their anxieties began in childhood or adolescence when they first saw other boys' penises (Mondaini et al., 2002).

4.7.3 Comparisons of Size When Fully Erect

This is not to say that all penises are the same size when fully erect. Early studies that relied on men's self-measurement reported that the average size of an erect penis (measured along the top) was about 6.2 inches in length and about 1.5 inches in diameter (Bogaert & Hershberger, 1999; Jamison & Gebhard, 1988; Richters et al., 1995; A. M. A. Smith et al., 1998). However, self-measurement techniques have proven unreliable (Harding & Golombok, 2002). Studies using objective measurements (in which penis size is measured by trained health professionals) have found the length of an erect penis to range anywhere from 3.4 inches to 6.4 inches, with an average length of about 5 inches and with the penises of most men falling in the 4.2- to 5.7-inch range (Da Ros et al., 1994; Habous et al., 2015; Sparling, 1997; Wessells et al., 1996). Thus, variation in size is normal in both flaccid and erect penises.

Frequent intercourse or masturbation does not cause a penis to get larger. Also, contrary to some popular stories, penis size is not related to a man's height, weight, or build; the size of his hands; his shoe size; or the like. There is also no support for the myth that African American men have larger penises or that Asian men have smaller penises than other men. In fact, no study has found a substantial difference in penis size among men from different ethnic groups, although the topic continues to be widely discussed on social media and seemingly accepted by many members of the general public (for discussion, see Tizon, 2014 and Johnson, 2015).

4.7.4 Enhancement Techniques

Despite what many men and women believe (see Johnston et al., 2014), there also is no evidence that changes in diet or exercise, or a course of the penis-enlarging pills so frequently advertised on television and the Internet, actually work (Nugteren et al., 2010b). Today, some men (including average-sized men) are paying thousands of dollars to have their penises made larger (by cutting ligaments that hold part of the penis inside the body and injecting fat from other parts of the body into the penis). However, the International Society for Sexual Medicine has issued a warning about the safety of this procedure (Ghanem et al., 2013), and many men are unhappy with the results (see Nugteren et al., 2010a). Before any man considers undergoing these painful and costly procedures, let us examine whether the size of a man's penis really is important in pleasing a partner during sexual intercourse. Keep in mind that most of this research uses heterosexual participants and thus may not generalize to non-heterosexual populations.

In order to answer this question (at least for heterosexual men), let us first reexamine some basic facts about female anatomy. In the unaroused state, the vagina measures about 2.8 to 3.2 inches in length and its walls are collapsed (Masters & Johnson, 1966). When a woman becomes sexually aroused, the walls of the inner two thirds of the vagina expand and its depth averages between 4 and 5 inches, which—perhaps not coincidentally—is about the same length as the average erect penis (isn't nature wonderful?). In its capacity to physically stimulate the vagina, therefore, there is no real advantage to having a penis that is larger than average, for there is no place for it to go. And do not forget that the walls of the inner two thirds of the vagina are relatively sparse in nerve endings anyway. Most important, remember that the focus of physical sensations in most women is not the vagina but the clitoris, which usually does not come into direct physical contact with the penis during intercourse. Thrusting of the penis stimulates the clitoris only indirectly by causing the clitoral hood to rub back and forth over the clitoral glans. Thus, with respect to the workings of the female body, penis size does not appear terribly important.

4.7.5 Do Women Really Care?

But what about the female mind? Do women really care about the size of a man's penis? In one recent investigation (Prause et al., 2015), women were asked to respond to the following question: "How much do you think you care about penis size compared to other women?" The majority (85%) reported caring about penis size the same as or less than other women, 15% said they cared "a little more" than other women, and none said they cared about it "a lot more" than others. In another study, several hundred women were asked what was most important to them during sexual intercourse. Not one mentioned penis size (Zilbergeld, 1978). And in yet another study, when asked to list the characteristics that made a man sexually desirable, heterosexual women mentioned a number of physical attributes (e.g., attractive face, broad shoulders, muscular build)—but none of them had to do with the size of his penis (Regan & Berscheid, 1995). In fact, in the informal surveys we conduct in our classes, only once has a woman expressed a definite preference for large penises. For the large majority of women (numbering in the thousands at this point in time), penis size was not important. Here are some typical responses:

"Penis size—of course it doesn't matter!"

"And about penis size, we don't care!"

"Also, penis size doesn't mean anything, especially to women."

“It’s not what you have that’s so important, but how you use it.”

“The only people who care about the size of men’s penises are men. Seriously, get over it. It’s what you do with it that matters.”

“It is not the size of the ship that matters, but the motion of the ocean.”

“I am so tired of this issue. Every single guy I know is worried about it, and no woman I know gives a damn. You are more than your penis! I don’t go out with a penis, I go out with a PERSON. And I don’t have sex with a penis, I have sex with a PERSON.”

(All examples are from the authors’ files.)

Not only do most women report not caring very much about the size of a man’s penis in general, but they do not seem to overwhelmingly prefer a larger penis to a smaller one (even though many men seem to think they do; Johnston et al., 2014). In fact, Fisher et al. (1983) found that depictions of large penises produced no more sexual arousal in women than depictions of smaller ones.

Why is penis size relatively unimportant to most women? Read again the sections on women’s sexual response cycle. For many women, desire and excitement are related more to what a partner does to stimulate them and to how well their relationship and intimacy needs are met than to any specific physical attribute that a partner possesses.

Aphrodisiacs: Do They Affect Sexual Response?

1. 4.8 Discuss the validity of reputed aphrodisiacs.

"Many of my older friends believe that if you eat raw oysters before you have sex you can last for hours."

"As one of my friends ordered oysters, he commented on how it was such a good aphrodisiac. . . . He explained that every time he goes to a seafood restaurant and eats oysters he is 10 times better in bed."

"I heard that chocolate is a natural aphrodisiac for women."

"I read in *Cosmopolitan* that eating bananas will give you super-intense orgasms because of all the potassium they have."

(All examples are from the authors' files.)

People have searched for aphrodisiacs—substances that enhance sexual desire or prolong sexual performance (named after the Greek goddess of love, Aphrodite)—for centuries. At one time or another, over 500 naturally occurring substances have been believed to be aphrodisiacs, including a host of herbs (e.g., rosemary), spices (e.g., cinnamon, saffron), plant roots (e.g., ginseng), tree bark extracts (e.g., yohimbine), animal products (e.g., bull's testicles, powdered rhinoceros horn, elephant sperm, turtle eggs), and a wide variety of fruits and vegetables (e.g., avocados, bananas, celery stalks, asparagus spears, figs, peaches, tomatoes, and radishes) (see Castleman, 1997; Connell, 1965; Rätsch & Müller-Ebeling, 2013). Some people maintain that oysters are an aphrodisiac. Many of these foods gained their reputation as aphrodisiacs during the Middle Ages when it was commonly thought that plants and foods announced their usefulness by the way they looked. Thus, phallic-looking items such as carrots, bananas, asparagus spears, and the horns of animals or soft moist foods that resembled women's genitals (such as oysters, peaches, figs, and apricots) became popular. However, the fact is that none of these substances has any physiological effect on sexual responsivity (Shamloul, 2010). Any temporary change or improvement in sexual functioning that people experience is purely a psychological effect (believing that something will work can be arousing), and the effect will wear off shortly.

Spanish fly, made from powdered beetles that are found in Spain, is perhaps the most famous reputed aphrodisiac. Taken orally, the active substance (cantharides) causes inflammation and irritation of the urinary and genital tracts, which some may interpret as lust. Spanish fly can also cause a painful, persistent erection (priapism), even when there is no desire for sex—as well as ulcers of the digestive and urinary tracts, diarrhea, and severe pain.

4.8.1 Alcohol

Alcohol is commonly believed to enhance sexual desire and responsivity. One of its initial effects is dilation of blood vessels in the skin, which gives a feeling of warmth and well-being. A drink or two depresses certain areas of your brain, making you less inhibited about engaging in sex or other behaviors that you might not ordinarily do. However, anything more than a single drink can impair the nervous system responses needed for engaging in sex. As Shakespeare says of drink in *Macbeth*, "It provokes the desire, but it takes away the performance." Alcohol, in fact, is an anaphrodisiac, a suppressant of sexual functioning in both men and women (McKay, 2005).

4.8.2 Drug Use

Some illegal drugs also have reputations as sexual stimulants. Cocaine was popularized in the Western world by Sigmund Freud, who wrote of its properties as both a general stimulant and an aphrodisiac. It indeed is a central nervous system stimulant, and thus may give the user a temporary burst of energy and a feeling of self-confidence, but the drug's effects are often equally due to heightened expectations and the social situation in which it is used (i.e., like alcohol, drugs give people an excuse that they can use afterward to justify the fact that they had sex). The use of cocaine, however, can often result in erectile failures and difficulties reaching orgasm for both men and women (Cocores et al., 1986; Henderson et al., 1995).

Amphetamines ("speed" or "uppers") are also stimulants, and in low doses they may increase sexual desire and provide the user with a burst of energy (sometimes used for marathon sexual encounters). However, researchers generally conclude that high single doses or chronic use of amphetamines impairs sexual functioning (see Buffum et al., 1981; Regan & Berscheid, 1999). Chronic use can also result in severe paranoia and other harmful consequences.

Marijuana decreases desire, lowers arousal, and inhibits orgasm in both men and women (Shamloul, 2010). Additionally, men who use marijuana chronically may experience erectile problems, lowered testosterone levels, and decreased sperm production (Shamloul & Bella, 2011).

Among young people, Ecstasy (3, 4- methylenedioxymethamphetamine, or MDMA) has become popular as an aphrodisiac. The drug causes release of the brain chemical serotonin and is related to hallucinogens and stimulants. It gives users a feeling of euphoria and heightened sensual experiences (Kennedy et al., 2010). Recently, it has become popular with some men to take it with Viagra—the combination is often called "sextasy" (Breslau, 2002). However, the combination often causes pounding headaches and prolonged painful erections. Research has shown that even a single dose of Ecstasy can cause permanent brain damage in animals and that moderate use in humans leads to memory loss (Walters et al., 2002).

4.8.3 Natural Products

A growing number of "nutraceuticals" are also available to men and women hoping to improve sexual functioning and enhance sexual performance.

These legal, nonprescription supplements usually contain a mix of vitamins and minerals as well as pharmacological agents that affect central nervous system neurotransmitters—the chemical substances that allow brain cells to "talk" to one another. One of these substances, derived from the sap of an African tree, is yohimbine hydrochloride. There is some evidence that yohimbine may have a positive effect on erectile function in men with psychologically caused impotence (Ernst & Pittler, 1998; Porst et al., 2013). However, yohimbine appears to have little or no effect on men who do not have erectile problems. Red ginseng has also been reported to help with erectile difficulties, but the studies demonstrating this finding are so methodologically unsound that no definitive conclusion can be made (Shamloul, 2010).

There is no evidence that other natural products work as aphrodisiacs or have an effect on any aspect of sexual response. This includes ambrein, bufo toad, horny goat weed, muira prama, saw palmetto, chocolate, maca, and Ayurvedic herbs (Cui et al., 2015; Shamloul, 2010). Nonetheless, the sale of "herbal" or "natural" aphrodisiacs has become a big industry, and one that shows no sign of stopping.

4.8.4 Pheromones

You have also probably seen advertisements for pheromones or perfumes and colognes with pheromones added (e.g., *Pherómone, PherX, Magnetism, Pherazone, Max Attraction*) that promise increased sexual attention from others. Researchers from one company that markets synthetic pheromones reported that men who added a synthesized nonodorous pheromonal substance to their aftershave lotion showed increased levels of sexual intercourse with and "sleeping next to" a romantic partner compared to men in a control group who used regular aftershave (Cutler et al., 1998). Similar results have been reported for women (McCoy & Pitino, 2002). Although interesting, these results have not been replicated, and scientists have not been able to provide convincing evidence of a reliable link between pheromonal substances and sexual attraction (see Regan & Berscheid, 1999; Regan, 2017). This should not surprise any of us. Sexual attraction is a complex phenomenon that is sparked by much more than the ingestion of a particular food or drug or the spraying on of a particular chemical substance. These products are not magic elixirs that can guarantee you a sexual experience.

"When I was 18 years old, I read about this pheromone spray which allegedly would attract women and make them desire sex with me. The pamphlet I got in the mail had several alleged true stories of the success of this stuff. I thought it was a fantastic breakthrough and immediately sent off my $65.00. In return I received a very small (2 fluid oz.) bottle of this spray which I excitedly sprayed on before I hit the town. Did I get laid? Hell no. I didn't even get a nice conversation."

"There was this guy I liked in high school, and he didn't like me back. So I saved up and bought this super expensive perfume that was supposed to have stuff in it that would make guys attracted to you. I'm embarrassed to admit that at the time I really did believe it would work. Well, it didn't. I used it every day until the bottle ran out and he never even looked at me. Of course, now I know better than to think that a spritz of perfume could ever cause someone to truly want you—it's never that simple or easy."

(All examples are from the authors' files.)

Despite the lack of scientific evidence in support of a tried-and-true aphrodisiac, some people will probably continue to search for a problem-free drug or substance that enhances sexual performance. Their efforts would probably be better rewarded if they instead took the time to learn how to communicate and be intimate with their partners. We will discuss how to do this in later chapters.

Sexuality and People with Disabilities

1. 4.9 Explain and appreciate the fact that people with disabilities, like everyone else, are sexual human beings.

Is sexual pleasure reserved only for the young and beautiful? Judging by the number of jokes about the sexual behavior of the elderly, the skinny and obese, the physically awkward, and other people whom our society often labels as "unattractive," many people apparently think so. What about people who are blind, deaf, or spinal cord–damaged or who have other physical infirmities or disabilities? What about the mentally impaired? Do these groups of people have sexual desires and feelings? If so, should they be allowed to express those desires? Many people hold even more extreme negative attitudes when it comes to the sexuality of people with disabilities.

In this chapter we focused quite a bit on the physiological and genital events that occur during sexual arousal. Masters and Johnson's model places emphasis on sex as a physical act. But is sexuality just physical? Look again at the definition of sexuality at the beginning of Chapter 1. Here is another definition, one that was given by a group of women with complete spinal cord injury:

"It is a tremendous core of who I am. Everything else comes out of that. How I think and feel about my body, my physical body. How I would define myself as a woman. How I am in all my relationships, whether they are sexual or otherwise. How I decorate my house. It's everything that I am. I may not have another way . . . another component that is so strong that I could say sums up everything that I am. So it's the physical, it's spiritual, it's emotional, everything."

(from Richards et al., 1997)

4.9.1 Attitudes About Sex and Disability

Earlier in the chapter you learned about the effects of one kind of physical disability on sexual functioning: the effects of spinal cord damage on the ability to achieve erection and/or orgasm (C. J. Alexander et al., 1993; Whipple & Komisaruk, 2011). We discussed how some spinal cord–injured men are capable of erections, but many are not, and those who are not often experience psychological distress about their lack of normal sexual function (Barbonetti et al., 2012). However, as difficult as a person's physical disabilities may make it to engage in sex or to enter into a sexual relationship, an even greater barrier may be the attitudes of others (Sakellariou, 2006). For example, we received the following note from a spinal cord–damaged student:

"Recently my boyfriend's mother wanted him to explain to me that she wants grandchildren. I guess she assumed that because I'm in a wheelchair that I'm incapable of having children. Her ignorance amazed me. People who are in wheelchairs, whether they be paraplegics or quadriplegics, are no less sexually able. Sexuality is basically psychological, in terms of its influence upon a person's overall behavior. Thus, the fact that one is paralyzed from the neck down or from the hips down doesn't discount from one's sexual drive or fertility."

(All examples are from the authors' files.)

Many people treat adults with physical or mental disabilities as if they were asexual or childlike and think it ridiculous or unseemly that these individuals should even have any interest in sex (see Milligan & Neufeldt, 2001, for a review). Parents of children or teens with disabilities sometimes try to "protect" them by withholding sexual information, and friends and acquaintances of disabled adults often try to shield them by never discussing the subject in their presence. As a result, persons with disabilities often have low sexual esteem and seriously limit how they express themselves sexually (McCabe et al., 2003).

> "I know the feeling well—anxious to form relationships, but no one approaches you for a date; raised to expect that you will never marry; given little information on reproduction except that it should be avoided at all costs."

(from Nosek et al., 1997)

Even medical doctors and other health professionals tend to ignore sexuality during treatment of disabilities or when providing care for disabled men and women (Kedde et al., 2012; Schaafsma et al., 2014). The well-intended but often incorrect assumption of the professionals, family members, and friends who would protect people with disabilities by denying or ignoring their sexual needs is that they "have more important things to worry about."

"My younger sister has Down Syndrome. I know she has sexual feelings because she asks me questions about sex, boys and her body. But my mom refuses to believe this or even discuss it and when I tried to ask the nurse at my sister's school how to deal with this she shut me down. All she said was, 'let's focus on getting her through her classes, that's what's important for her now.' Well I think what's important is that my sister (and I) get information that is designed for people like her so she can be safe and doesn't get taken advantage of."

"I have a 17-year old cousin who is blind. He's a great guy, and he's also good looking and very popular with the ladies. I tell him all the time that it runs in the family! I've secretly given him the birds and bees talk because no one else will and he wants to start dating and doing normal guy-girl things. I've tried to talk with my aunt and uncle but my uncle just goes "Give him time, no need to rush into anything, he has other things to deal with" like he's still a little kid. But he's a man and he has a man's needs. I don't understand why they can't see this when it's so clear to me and everyone else around."

(All examples are from the authors' files.)

People with both lifelong and recent disabilities want to learn (or relearn) more than just how to be physically capable. They also want to know how to be sexual and how to love and be loved. Here is part of a letter from the husband of a woman who had undergone 3 years of surgeries and

rehabilitation for severe spinal cord damage suffered in an automobile accident:

Figure 4–13

We are all sexual beings.

Source: Rob Brimson/The Image Bank/Getty Images; Mikael Vaisanen/Getty Images

"In July 'Susan' felt well enough to try once more. Sex was very good that day . . . we took it slow and easy . . . . We compensated with lots of holding and touching, something that often had been lacking in our pre-accident relationship. Incredibly, just holding each other in bed became very satisfying, and it actually seemed to bring us closer together emotionally."

(All examples are from the authors' files.)

4.9.2 Dealing with Injuries and Impairments

People with spinal cord damage usually show an initial "shutting down" and "shutting out" of sexuality after the injury, followed by relationship disconnection (avoidance of sex with a partner) (Richards et al., 1997). The sexual desire of the partner can help overcome this. With proper support, spinal cord–damaged people eventually go through a phase of sexual exploration (both giving and receiving sexual pleasure) and sexual reaffirmation (becoming comfortable with their own sexuality). Spinal cord–injured individuals often have the same sexual needs and desires as others (Moin et al., 2009). They may show a decrease in sexual intercourse but often compensate for this with other sexual activities that are both satisfying and mutually pleasurable for the partner (Ostrander, 2009). There are, in fact, many ways to enjoy sexual relations besides intercourse.

What about people with traumatic brain injury or severe mental impairments? They display sexual behavior, including touching, kissing, and masturbation but are often unable to differentiate between appropriate times and places. This "inappropriate" (by society's standards) behavior results in many people, even special education teachers and health care staff, having negative views of sexual behaviors in men and women with brain injuries or developmental delays or impairments (e.g., Schaafsma et al., 2014; Scotti et al., 1996; Wolfe, 1997). However, denial of sexuality in (and for) the mentally impaired is not a realistic solution. "Regardless of their specific disabilities, persons with mental retardation are individuals with sexual feelings who develop physically at a rate comparable to that of normal young adults and respond to many of the same sexual stimuli and situations as do persons without mental retardation" (Scotti et al., 1996). A more realistic approach is to provide appropriate sexuality education to both persons with mental disabilities and to their service providers.

People with hearing or vision impairments, chronic diseases, or other physical disabilities (e.g., cerebral palsy) also have sexual desires and needs that should not be ignored by family, educators, and health care providers (Kedde et al., 2012; Linton et al., 2016). In fact, women and men with physical disabilities often are as interested in sex as their non-disabled counterparts (see Kelly & Kapperman, 2012; Nosek et al., 1997). Remember, regardless of what we look like or our physical or mental capabilities, we are all sexual beings. Everyone deserves to have access to accurate sexual and reproductive information and to create and achieve a sexually healthy lifestyle.

Personal Reflections

If you were to have an accident and become physically disabled, do you think you would still want to hug, hold, kiss, and share affection (and have sex, if possible) with your partner? How do you presently react when you see a person with disabilities engaging in these behaviors?

Study Guide

Key Terms

- anaphrodisiacs
- aphrodisiacs
- ejaculation
- erection (of the penis)
- excitement phase
- excitement phase (women)
- female genital mutilation
- Grafenberg (G) spot
- Helen Singer Kaplan
- Masters and Johnson
- multiple orgasms
- myotonia
- orgasm
- orgasmic platform
- plateau
- refractory period
- resolution
- retrograde ejaculation
- Rosemary Basson
- semen
- sex-tension flush
- sexual activity
- sexual affect and cognitions
- sexual arousal
- sexual desire
- sexuality
- sexual response cycle
- Skene's glands
- vasocongestion
- vaginal lubrication

Interactive Review

Answers can be found on p. 469.

1. (1) is the motivational component of sexuality, often referred to as sexual interest or lust. (2) is the genital component, whereas (3) is the term we use to refer to overt behaviors like intercourse or masturbation. All of the thoughts and feelings that people have about sexuality and that are associated with sexual responses collectively are known as (4) .

(5) observed and recorded physiological responses from hundreds of people engaged in sexual activity. They divided the physiological-genital responses that occur during sex into four phases: (6) , (7) , (8) , and (9) . This linear pattern of responses is often referred to as the (10) . Later, sex therapist (11) added a new first phase, (12) , which Masters and Johnson and subsequent researchers have also adopted. Other researchers, most notably (13) , have suggested that the sexual responses of women, in particular, may be better captured by a nonlinear or (14) model.

After experiencing sexual desire, the first physiological-genital response in the excitement phase for both men and women is (15) , which results in (16) in men and (17) in women. It is important to recognize that in women, unlike in men, physiological-genital arousal does not always correlate well with (18) . During the (19) phase in women, the tissues of the outer third of the vagina become swollen with blood, causing the vaginal opening to narrow. This response is referred to as the (20) . Also during this phase, the clitoris (21) . Early in the plateau phase, (22) % of all women and about 25% of all men experience a rash on the skin called the (23) .

At the time of orgasm, both men and women have (24) in specific tissues that initially occur every 0.8 seconds. However, recent studies indicate that the real essence of orgasm is not in the genitals, but in (25) . Men's and women's descriptions of orgasm are (26) . The physical reactions associated with men's orgasms occur in two stages, (27) and (28) . The expulsion of semen from the penis is called (29) . After men have an orgasm, their physiological responses generally dip below plateau, during which time they cannot have another ejaculation/orgasm. This period of time is called the (30) . Unlike most men, some women can have (31) , defined as two or more orgasms in quick succession without dropping below the plateau level. The return to the unaroused state is called (32) .

By most estimates, about (33) % of married women and about (34) % of single women regularly experience orgasm during sexual intercourse. Helen Singer Kaplan and other researchers believe that women are most likely to reach orgasm during vaginal intercourse if they receive simultaneous (35) stimulation.

Freud believed that there were two types of female orgasm, one caused by (36) stimulation and another by (37) sensations. Masters and Johnson originally claimed that all female orgasms were identical and essentially were focused in the (38) . However, some women report having experienced different types of orgasms, and work conducted in the 1980s revealed that many of these women had a sensitive area on the (39) wall of the vagina called the (40) . Stimulation of this area sometimes resulted in (41) during orgasm. In some women the fluid was identified as urine, but in others it contained an enzyme that is identical to an enzyme secreted from men's (42) . Most women say that the size of a partner's penis is (43) for their pleasure during intercourse. Many people have tried to enhance their sexual desire or performance by taking substances called (44) , but there is little evidence that such substances have any real effect.

People with disabilities may have special problems communicating or engaging in the physical act of sex, but sexuality is more than just the physical responses described by Masters and Johnson. It includes emotional and spiritual feelings and how we relate to others. We are all sexual human beings.

Self-Test

A. True or False

1. **T F** 45. Sexual desire is typically measured using self-report methods.
2. **T F** 46. Sexual arousal is a purely physiological response.
3. **T F** 47. The sexual responses of most men and women are accurately captured by a sequential, linear model.
4. **T F** 48. The first physiological signs of arousal in men occur within seconds, but take several minutes to begin in women.
5. **T F** 49. Some women do not experience sexual desire and sexual arousal (excitement) as separate, distinct events.
6. **T F** 50. Vaginal lubrication is actually superfiltered blood plasma.
7. **T F** 51. The presence of vaginal lubrication means that a woman is ready to begin sexual intercourse.
8. **T F** 52. Both men and women can experience nipple erection during the excitement phase.
9. **T F** 53. When the clitoris pulls back and disappears beneath the clitoral hood, it means that a woman is less sexually aroused than before.
10. **T F** 54. The secretion of fluids from the vaginal walls may slow down if the plateau phase is prolonged.
11. **T F** 55. Generally speaking, descriptions of orgasm written by women can be easily distinguished from those written by men.
12. **T F** 56. Orgasm and ejaculation occur at the same time in men and are actually the same event.
13. **T F** 57. The rhythmic muscular contractions during orgasm recorded by Masters and Johnson are not strongly related to a person's subjective sensations of pleasure.

14. **T F** 58. A full orgasm for men, with ejaculation, is almost always followed by a refractory period.
15. **T F** 59. Some people who have suffered severe spinal cord injuries can experience orgasm.
16. **T F** 60. The walls of the inner two thirds of the vagina are very sensitive to touch, thus making penis length an important factor during intercourse.
17. **T F** 61. There is more variation in penis length in the unaroused condition than in the erect state.
18. **T F** 62. A man's penis size is related to his height, weight, and race.
19. **T F** 63. Alcohol excites the central nervous system and enhances sexual performance.
20. **T F** 64. Use of marijuana generally improves sexual performance.
21. **T F** 65. Regular use of cocaine often leads to erectile problems and difficulties reaching orgasm.
22. **T F** 66. Scientists have found evidence of a reliable link between pheromonal substances and sexual attraction.
23. **T F** 67. It is illegal to circumcise a girl or woman under the age of 18 in the United States.
24. **T F** 68. Circumcision has known health benefits for both men and women.

Answers can be found on p. 469.

B. Matching

(some questions have multiple answers)

- 69. desire
- 70. excitement phase
- 71. plateau phase
- 72. orgasm phase
- 73. resolution phase
- 74. vasocongestive response

1. Cowper's glands secrete a few drops of clear fluid
2. penis starts to become erect
3. labia minora become engorged with blood
4. an awareness that one wants or wishes to attain a sexual goal
5. rhythmic muscular contractions occur in outer vagina, uterus, and anal sphincter muscles
6. clitoris pulls back against the pubic bone
7. vaginal lubrication begins
8. blood drains from breasts, outer third of the vagina, labia minora, and clitoris
9. sex-tension flush appears
10. nipples become erect
11. clitoris is most prominent at this time
12. scrotum thickens and helps pull the testicles toward the body
13. blood drains from penis and testicles
14. walls of the inner two thirds of the vagina begin to balloon out
15. return to the unaroused state

16. rhythmic muscular contractions in vas deferens, prostate gland, urethra, and anal sphincter muscles
17. outer third of the vagina becomes engorged with blood
18. nipples appear to be less erect
19. labia majora flatten and spread apart
20. testicles increase in size by 50% to 100%
21. in men, a fluid is emitted from the urethra

C. Fill in the Blanks

- 75. The three basic physiological processes involved in sexual arousal are .
- 76. Tissues becoming filled with blood during sexual arousal is called .
- 77. Some women emit a fluid during orgasm that comes from the .
- 78. Most women and many men get a skin rash called the when they become highly sexually aroused.
- 79. The engorgement and swelling of the outer third of the vagina was named the by Masters and Johnson.
- 80. After ejaculating, most men have a period of time called the during which it is impossible for them to have another ejaculation and orgasm.

Suggested Readings and Resources can be found on p. 460.

Chapter 5 Sexually Transmitted Infections and Sexually Related Diseases

> When a person has sex, they're not having it just with that partner. They're having it with everybody that partner has had it with for the past 10 years.

—Otis Bowen, former U.S. Secretary of Health and Human Services

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 5.1 Explain what causes sexually transmitted infections, how they are spread, and who can get them.
2. 5.2 Describe the symptoms, complications, and treatment of gonorrhea.
3. 5.3 Describe the symptoms, complications, and treatment of chlamydia.
4. 5.4 Explain the complications that can occur if gonorrhea and chlamydia are left untreated.
5. 5.5 Describe the symptoms, complications, and treatment of syphilis.
6. 5.6 Describe other, less-common bacterial STIs.
7. 5.7 Describe the symptoms (recognized and unrecognized), complications, and treatment of herpes.
8. 5.8 Describe the symptoms, complications, and treatment of hepatitis.
9. 5.9 Describe the symptoms, complications, and treatment of human papillomavirus infection.
10. 5.10 Describe other viral infections, such as molluscum contagiosum and the Zika virus.
11. 5.11 Discuss the causes, effects, and treatment of HIV infection and AIDS.
12. 5.12 Identify various parasitic infestations caused through sexual transmission.
13. 5.13 Describe vaginal and bladder infections that affect women.
14. 5.14 Discuss safer sex practices and positive sexuality.

Sexually transmitted infections (STIs) are at epidemic proportions. Worldwide, the number of annual cases of non-HIV STIs increased by 50% between 1995 and 2008 (Ortayli et al., 2014). This year approximately 19.7 million Americans will contract an STI (Centers for Disease Control and Prevention [CDC], 2016; Satterwhite et al., 2013; see Table 5–1). Including already existing infections, there are about 110 to 136 million cases of STIs in the United States.

Table 5–1 STIs in the United States

Type of Sexually Transmitted Infection	Estimated New Cases per Year	Estimated New and Existing Cases
Human papillomavirus infection (HPV)	14,100,000	79,100,000
Chlamydia	2,860,000	1,570,000
Trichomoniasis	1,090,000	3,710,000
Gonorrhea	820,000	270,000
Genital herpes	776,000	24,000,000–50,000,000
Syphilis	64,000	117,000
Human immunodeficiency virus (HIV)	44,000	1,200,000
Hepatitis B	19,000	422,000
Total:	19,773,000	110,389,000–136,289,000

Sources: CDC Fact Sheet, 2013, 2016.

Table 5–1 Full Alternative Text

One in 4 teenage girls has an STI (CDC, 2016), but it isn't just young people who get them. One of the groups in which STIs are showing the greatest increase is seniors aged 65 and older (Emanuel, 2014). Some researchers calculate that, in all, 1 in 2 Americans will contract at least one sexually transmitted infection in their lifetime (Satterwhite et al., 2013), and the likelihood may be even greater than that (Chesson et al., 2014). It is to everyone's advantage, therefore, that we educate ourselves about the causes, symptoms, modes of transmission, and treatments for these infections. If left untreated, some of these infections can cause sterility, blindness, and even death, not to mention ruined relationships.

What Are They, Who Gets Them, and Where Did They Come From?

1. 5.1 Explain what causes sexually transmitted infections, how they are spread, and who can get them.

Some people believe that only promiscuous persons get STIs. This belief is incorrect, for hundreds of thousands of loyal and faithful men and women have caught these infections from partners. A similar number of innocent newborns have contracted them from infected mothers.

"I got gonorrhea from my boyfriend. I, myself, thought that I was engaged in a monogamous relationship. However, it was not monogamous for him."

"Over the past 2 years, I have had one steady boyfriend. I have never slept around and I thought he was faithful to me. I would have put my life on the line to prove this. During these 2 years I have contracted chlamydia three times, PID, and trichomoniasis."

"My first time having sex was at 16. My only fear was getting pregnant. My boyfriend said he was infertile so I couldn't get pregnant. We had sex. Approximately 1 month later I found out I had gonorrhea. I had no idea I could be a victim of an STI."

"I am a 48-year-old woman who contracted a sexually transmitted infection from my husband. As a result, I had to have a total hysterectomy."

(All examples are from the authors' files.)

These people were not promiscuous, yet they still contracted sexually transmitted infections. What causes STIs? It is not sexual behavior itself; the behavior is merely the mode of transmission for bacteria, viruses, or parasites that must be present for the infections to be transmitted. *Sexually transmitted infections (STIs) are spread, for the most part, by sexual contact* (including vaginal and anal intercourse and oral-genital contact) *with someone who has the bacteria, viruses, or parasites that cause the infections*.

Bacteria are very small single-celled organisms. They lack a nuclear membrane but have all the genetic material (RNA and DNA) and metabolic machinery to reproduce themselves. Viruses are just a protein shell around a nucleic acid core and cannot reproduce themselves. They invade host cells that provide the material to manufacture new virus particles. The bacteria and viruses responsible for STIs live outside the body for only a short period of time. The common belief that you can catch these infections from a toilet seat is greatly exaggerated.

Some people believe (or at least would like to believe) that sexually transmitted infections occur only in or primarily in poor, uneducated, and minority groups. Sexually transmitted infections, however, are non-discriminating. The bacteria or viruses that cause these infections do not care about your skin color; whether you are on welfare or a millionaire; whether you bathe every day or only once a week; or whether you are a grade school dropout or college-educated. In fact, at least two of these infections (chlamydia and human papillomavirus infection) are at epidemic proportions among college students today. The point, here and in the previous case histories, is that anyone having sex is at some risk for contracting a sexually transmitted infection.

Some of these infections were once called *venereal diseases* (after the Roman goddess of love, Venus), but this term generally referred to infections that are spread almost exclusively by sexual contact (gonorrhea, syphilis, and three other lesser known diseases). Most of you have heard these and other infections referred to as *sexually transmitted diseases (STDs)*. Today, however, health professionals prefer the term sexually transmitted infections (STIs) to emphasize that they are *infectious* diseases (other diseases, such as heart disease, are not). The term refers to the original venereal diseases plus other infectious diseases that can be, but are not always, transmitted by sexual contact.

There are still other diseases of the sexual organs that are caused by overgrowths of yeast or fungal organisms found naturally in the body, and these too can sometimes be passed on during sex. We will refer to these as sexually related diseases. A few other sexually transmitted infections are not really infections at all but rather infestations of parasites (pubic lice and scabies) that are transmitted from person to person during sexual contact.

Personal Reflections

How would you feel if you found out you had a sexually transmitted infection (or, if you have been infected, how did you feel)? Would you feel differently than you would if you had contracted the flu? Why? How would you tell your partners of their possible infection?

Some people believe that humans first contracted sexually transmitted infections by having sex with animals. In fact, later you will learn that the virus that causes AIDS originated in non-human primates, but it was probably first transmitted to humans by contact with blood, not by sex. On the other hand, no other animal species is known to have gonorrhea (Dixson, 2015).

Although where and how STIs originated remain unknown, some of these sexually transmitted infections have been around for at least a few thousand years, as many famous Greeks, Romans, and Egyptians (including Cleopatra) were described as having the symptoms. In fact, public kissing was banned by emperor Tiberius in Roman times because of an epidemic of a disease that was described as being identical to what we now know as herpes. An epidemic of syphilis also swept through Europe in the early 1500s, and it is still hotly debated whether Columbus and his sailors brought it back from the New World, or vice versa (Maatouk & Moutran, 2014). In fact, Columbus died of advanced syphilis.

It does not really matter where or how STIs originated; they are here and we must deal with them. Surveys of teenagers indicate that most know very little about sexually transmitted infections, although they believe themselves to be well informed (Lim et al., 2012; Moore & Smith, 2012). Many people are unaware, for example, that they can have an STI but show no symptoms and still be contagious. As a result, they do not seek treatment as early as they should. We will discuss some precautionary measures that can help you avoid contracting sexually transmitted infections and will outline what to do in case you should get one. First, let us examine the symptoms and treatment for some of the most widely known

infections. We will begin with those STIs caused by bacteria. How common are they? Worldwide, there will be nearly 500 million new cases this year of gonorrhea, chlamydia, and syphilis (Ndowa et al., 2012).

Gonorrhea

1. 5.2 Describe the symptoms, complications, and treatment of gonorrhea.

Gonorrhea (from the Greek *gonos*, "seed," and *rhoia*, "flow"; also known as "the clap" or "the drip") is probably the oldest of the STIs. Its symptoms are described in Leviticus in the Old Testament, which dates back to about 1500 b.c., and were also described in detail by Greek physicians. Worldwide, there will be about 106 million new cases this year (Ndowa et al., 2012). The Centers for Disease Control and Prevention (2016) estimates that there will be 820,000 new cases in the United States, 570,000 among young people aged 15 to 24. However, about half of these go undiagnosed (and unreported). The rate of infection is considerably higher among African Americans than it is among Latinos or whites (e.g., Bradley & Satterwhite, 2012; CDC, 2016).

5.2.1 Symptoms and Complications

Gonorrhea is caused by a bacterium (*Neisseria gonorrhoeae*, often referred to as "the gonococcus") named after Albert Neisser, who discovered it in 1879. It lives on warm, moist mucous membranes in the urethra, vagina, rectum, mouth and throat, and eyes. A person gets gonorrhea by having his or her mucous membranes come into contact with another person's infected membranes. Because of the location of these membranes in the body, this normally occurs only during intimate contact. This includes, of course, vaginal intercourse, but the gonococcus can also infect the anus and rectum (during anal intercourse) and the throat (during oral-genital sex, particularly fellatio). The bacteria have been found to survive for a short time outside the body, but your chances of picking them up from non-sexual contact are extremely remote.

"When I woke up I had thick puss coming from my penis and stinging when I tried to pee. I had sex last weekend with a girl I met at a party. I had heard of gonorrhea but never thought it would happen to me."

(from the authors' files)

In men who become infected during sexual intercourse, the gonococcus bacteria invade and cause inflammation of the urethra (*gonococcal urethritis*). This usually results in a thick, pus-like white or yellowish discharge from the urethra ("the drip"), starting 2 to 10 days after infection (see Figure 5–1). There is generally an irritation or a burning sensation at the urethral opening, and urination is often frequent and painful. Because the symptoms are painful and obvious, most men seek treatment immediately. However, *about 10% to 35% of men show no symptoms* (are *asymptomatic*), while in others the early symptoms disappear (Ndowa et al., 2012). These asymptomatic men are still infected and can pass the gonococcus to new partners. If left untreated, gonorrhea can spread up the man's reproductive system and cause inflammation of the prostate and epididymis (10% to 30% of cases), which can result in infertility. By this time, he usually experiences severe pain and fever.

Figure 5–1

Urethral pus-like discharge of gonorrhea

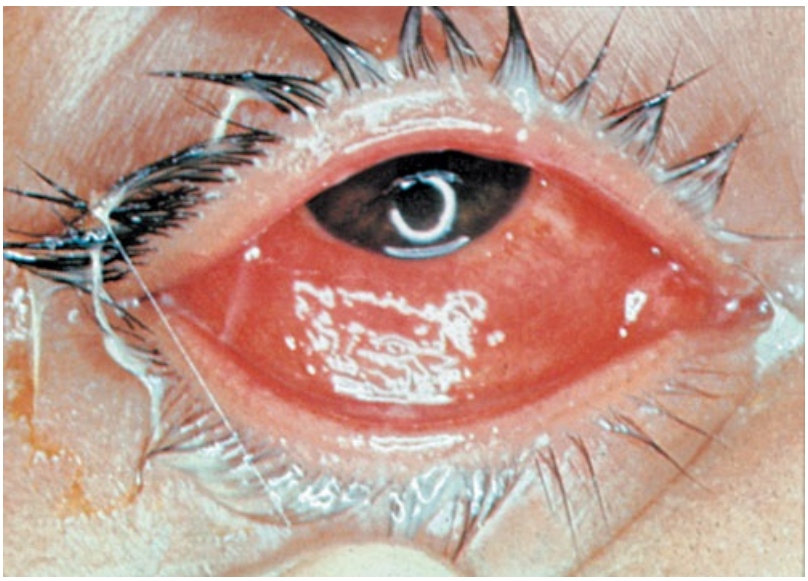
Urethral pus-like discharge of gonorrhea.

Source: Centers for Disease Control & Prevention

In women, the gonococcus initially invades the cervix, but unlike men, *most women show no symptoms during the early stages*. They are often unaware of their infection unless told about it by an infected male partner and thus can unknowingly pass gonorrhea on to new partners. In the 20% to 40% of women who show symptoms, there may be an abnormal vaginal discharge and irritation of the vulva and urethra, causing burning during urination. Because so many women are asymptomatic, they often go untreated, and the gonococcus spreads through the uterus into the Fallopian tubes. In up to 40% of untreated women, the tubes become swollen and inflamed, a condition known as pelvic inflammatory disease (PID), with symptoms of severe abdominal pain and fever (Brunham et al., 2015). Hospitalization may be necessary at this stage. PID can cause scarring of the Fallopian tubes, which blocks passage of the sperm and egg—a common cause of sterility and tubal pregnancies in women (see Chapter 7).

If a pregnant woman contracts gonorrhea, the fetus will usually not be infected because the gonococcus normally is not carried in the bloodstream (although joint and blood infections are possible). However, a baby's eyes can become infected at delivery as it passes through the infected cervix and vagina (a condition called *gonococcal opthalmia neonatorum*; see Figure 5–2). This can rapidly lead to blindness. Worldwide, 4,000 babies a year are blinded because of gonorrhea (Ndowa et al., 2012). Most states require that an antibiotic or silver nitrate drops be put into all babies' eyes at birth to prevent possible infections. Adults can also transmit the gonococcus to their eyes by a contaminated hand (see Guerrero et al., 2010).

Figure 5–2



Eye infection caused by gonorrhea.

Source: Centers for Disease Control & Prevention

5.2.2 Diagnosis and Treatment

Most individuals with symptoms of gonorrhea will seek treatment immediately. Remember, however, that many people—particularly women—have no early symptoms. Therefore, if you suspect that you have had sex with someone who has gonorrhea, see a doctor as soon as possible. Your doctor will probably test for gonorrhea by either a culture test or a molecular test (called nucleic acid amplification testing) (see CDC, 2016).

Now, some bad news: There are strains of the gonococcus that have become highly resistant to all medications (Kirkcaldy et al., 2015). It first became resistant to sulfur-based drugs, then penicillin, then tetracycline, and now the most recently used drugs called cephalosporins. The CDC is now recommending combination therapy (injection of ceftriaxone plus orally administered azithromycin or doxycycline) (CDC, 2016). This treatment combination has kept the cephalosporin-resistant cases to fewer than 1% (Kirkcaldy et al., 2015), but there is real concern at the CDC that gonorrhea may very soon be incurable. Because many people diagnosed with gonorrhea are also found to have chlamydia at the same time, the CDC is advising doctors to treat for both infections (CDC, 2016).

Should you ever be diagnosed with gonorrhea, be sure to tell all your recent partners that they may have gonorrhea so that they, too, can be treated. Gonorrhea is not like chicken pox, where you become immune after having had the infection. You can catch gonorrhea again if you have sex with someone infected with the gonococcus.

Chlamydia and Nongonococcal Urethritis

1. 5.3 Describe the symptoms, complications, and treatment of chlamydia.

Any inflammation of the urethra not caused by the gonococcus is called **nongonococcal (or nonspecific) urethritis (NGU)**. This term is often reserved for men with an inflamed urethra, but the organisms that cause it cause infection in women (*cervicitis*) as well. Several organisms can cause infection (including *Ureaplasma urealyticum* and *Trichomonas vaginalis*), but the one that is most frequently responsible today is *Chlamydia trachomatis*. The infection caused by this sexually transmitted bacterium is called chlamydia.

Chlamydia is much more common than gonorrhea, with about 2.86 million new cases in the United States this year (CDC, 2016), and nearly two thirds of the cases are in people aged 14 to 39 (Torrone et al., 2014). This includes 6.6% of women tested at college health centers (Habel et al., 2016). Because many students have never heard of chlamydia, they think that it cannot be all that bad. In fact, although its initial symptoms are usually milder than those of gonorrhea, if left untreated it is more likely than gonorrhea to cause damage to the reproductive organs.

5.3.1 Symptoms and Complications

Like the gonococcus, *Chlamydia trachomatis* lives only on mucous membranes. Chlamydia is spread when the infected membranes of one person come into contact with the membranes of another person.

If a person with chlamydia shows early symptoms, he or she will start doing so within 1 to 3 weeks after infection. The early symptoms are milder than, but similar to and sometimes mistaken for, those of gonorrhea: irritation and burning of the urethra (although usually not painful) and a discharge (usually thin and clear rather than pus-like). However, about 90% of women and a large proportion of men have no symptoms at all in the initial stage (Marrazzo & Cates, 2011).

"When I was attending LSU, I went to see the doctor for a regular gynecological exam. The nurse suggested that I consider some other tests for STIs because some of them had few or no symptoms. At first I declined, thinking that I had not slept with many people and, also, that if I had anything I would surely know from symptoms. But I changed my mind and was tested. When I called for results, I was shocked to find out that I was positive for chlamydia."

"After dating a guy for about a month, we broke it off. We had been sexually active throughout our relationship and had unprotected sex (without condoms) only one time. Right after breaking it off, I went in for my annual exam and, just by chance, opted to get an STI check. I even joked about it with my roommates saying 'better safe than sorry.' Two days later I got a call from Redfern saying I had tested positive for chlamydia."

(from the authors' files)

The Centers for Disease Control and Prevention recommends that *all sexually active women aged 25 and younger get routine annual screenings for chlamydia.* Why? Although about half of chlamydia cases resolve on their own within 1 year (Geisler, 2010), if left untreated, chlamydia spreads through the reproductive system, which in men can cause infection of the prostate and epididymis and possibly sterility. In women with symptoms, up to 18% develop pelvic inflammatory disease, which can leave the Fallopian tubes scarred and result in sterility or increased risk of tubal pregnancy (the percentage of women without symptoms for which this occurs is unknown) (Brunham et al., 2015). At this stage the infection can be quite painful and may require hospitalization. Research has shown that a *single attack of chlamydia is about 3 times more likely than gonorrhea to cause sterility in women*. Babies born to women who have chlamydia at the time of delivery can get eye infections (*chlamydia conjunctivitis*) and/or nose-throat infections (CDC, 2016).

In underdeveloped countries, the chlamydia bacterium often causes an eye infection called *trachoma*, which is spread to other people's eyes by flies. It is the leading cause of blindness in those areas. In tropical countries, certain subtypes of chlamydia are also responsible for a serious sexually transmitted infection called lymphogranuloma venereum (LGV) (rare in the United States). If left untreated, LGV causes the inguinal lymph nodes to swell, followed by swelling of the penis, labia, or clitoris (sometimes enormously so, resulting in elephantiasis of the external genitalia) (Brown et al., 1999). In the United States, there have been recent outbreaks among men who have sex with men (de Voux et al., 2016).

5.3.2 Diagnosis and Treatment

As with gonorrhea, the culture test for chlamydia infections *of the urethra* has been replaced with a noninvasive urine test (a nucleic acid amplification test). For other mucous membranes, a swab is taken followed by a culture test. If chlamydia is confirmed, it is usually treated with doxycycline or azithromycin (Marrazzo & Cates, 2011), but recent studies reveal that in some cases azithromycin is no longer effective (Kissinger et al., 2016). Remember, many people have no symptoms in the early stages, so if you think someone you have had sex with has chlamydia, seek treatment immediately.

Pelvic Inflammatory Disease (PID) in Women: A Likely Consequence of Untreated Chlamydia or Gonorrhea

1. 5.4 Explain the complications that can occur if gonorrhea and chlamydia are left untreated.

In the discussion of gonorrhea and chlamydia, we referred to pelvic inflammatory disease in women as a possible consequence if the infections went untreated. PID is a general term for an infection that travels from the lower genital tract (vagina and cervix) to the Fallopian tubes and sometimes to surrounding structures such as the ovaries and pelvic cavity. It results from infection with a variety of organisms, but 45% of cases are caused by *Chlamydia trachomatis* and perhaps half as many more cases are caused by *Neisseria gonorrhoeae* (Price et al., 2012).

There may be up to 750,000 new cases this year, requiring about 180,000 hospitalizations (Brunham et al., 2015). Symptoms may include tenderness or pain in the lower abdomen (sometimes to the extent that standing up straight is impossible), high fever, and chills. However, 3 times as many women experience a persistent low-grade infection, either with no other symptoms or with intermittent abdominal cramps. In these "silent" infections (i.e., the women do not go to a physician for diagnosis), the long-term inflammation can result in pelvic adhesions and abscesses. The inside diameter of the pathway an egg takes through a Fallopian tube is less than that of a human hair; thus, even a small amount of scar tissue can result in an ectopic (tubal) pregnancy or in permanent sterility.

Syphilis

1. 5.5 Describe the symptoms, complications, diagnosis, and treatment of syphilis.

The consequences of untreated gonorrhea or chlamydia can be serious, but untreated syphilis is far worse, being responsible for the deaths of over 100 million people worldwide in the 20th century (Chiappa & Forish, 1976). Syphilis is caused by *Treponema pallidum*, a spiral-shaped bacterium (spirochete).

Worldwide, there are about 12 million cases of syphilis per year. Most cases are in Southeast Asia and Africa. The CDC (2016) says that there were 63,450 new cases reported in 2014. This is more than double since 2000 (Patton et al., 2014). About 83% are among men who have sex with men. It is found mainly in large urban areas and is 5 times more common among African Americans than whites (CDC, 2016).

5.5.1 Symptoms and Complications

Almost all cases of syphilis are transmitted by sexual contact. This includes oral sex. However, unlike the bacteria that cause gonorrhea and chlamydia, which require contact of mucous membranes for transmission, the spirochete that causes syphilis can also pass directly through any little cut or scrape of the skin into the bloodstream. This means that one could potentially get syphilis by merely touching the sores of another person.

The symptoms of syphilis generally occur in four (often overlapping) stages (Clement et al., 2014). The *primary stage* usually begins 2 to 4 weeks after exposure with the appearance of a very ugly ulcer-like (raised edges with a crater) sore called a **chancre** (see Figure 5–3) at the site where the spirochete entered the body (usually the penis, cervix, lips, tongue, or anus). The chancre is full of bacteria and highly infectious, but even though the chancre looks awful, it is usually painless, and thus some people do not seek treatment. Because the painless chancre generally appears on the cervix in women, they usually are unaware that they are infected during the initial stage unless they get a pelvic exam. Even if a person is not treated, the sore will usually disappear in 10–14 days. However, the spirochete continues to be carried in the person's bloodstream, and thus individuals remain infected *and* infectious even after the chancre disappears.

Figure 5–3

A primary-stage syphilis chancre on the penis (top) and labia (bottom).

Source: SPL/Science Source; Centers for Disease Control & Prevention

Figure 5–3 Full Alternative Text

Symptoms of the *secondary stage* of syphilis usually appear within 2 to 8 weeks after the chancre disappears, but sometimes symptoms do not appear for several months. The main symptom is an *itchless, painless rash* that appears all over the body, including the palms of the hands and the soles of the feet (see Figure 5–4). In the moist areas around the genitals, the rash appears as large sores called *condylomata lata*, which break and ooze a highly infectious fluid full of bacteria. Other symptoms can include a sore throat, a persistent low-grade fever, nausea, loss of appetite, aches and pains, and sometimes even hair loss. These symptoms are bothersome enough that many infected people will seek treatment, but many people mistake the symptoms for the measles, an allergic reaction, or some other disease. Syphilis is sometimes called "the great imitator." If treatment is not obtained, these symptoms, like the chancre of the primary stage, will also disappear (within several weeks to 1 year) and not return.

Figure 5–4

Secondary-stage syphilis rash on the palms and body.

Source: Centers for Disease Control & Prevention

Figure 5–4 Full Alternative Text

An infected person now enters the symptomless *latent stage* and after about a year is generally not contagious because the spirochete is no longer found on the mucous membrane surfaces. This stage may last for years with no noticeable signs, but all the while the bacteria are attacking the internal organs of the body, particularly the heart and blood vessels and the brain and spinal cord.

About 85% of the people with untreated syphilis will not experience any more problems with the disease, but 15% will develop serious complications as a result of the accumulated organ damage. They are now in the *late* (or *tertiary*) *stage* (U.S. Preventive Services Task Force, 2016). Large ulcers called *gummas* often appear on the skin and bones (see Figure 5–5). Damage to the heart and blood vessels frequently results in death, and by this time, cumulative damage to the central nervous system often results in dementia. In fact, syphilis can infect the central nervous system at any stage. Symptoms might include cognitive disorders as well as sensory and motor deficits.

Figure 5–5

Late-stage gumma on the nose.

Source: Centers for Disease Control & Prevention

Particularly heartbreaking is the fact that *an unborn baby can catch syphilis from an infected mother*. This happens because the spirochete travels from the pregnant woman's blood into the placental blood system. If it is not diagnosed and treated, the fetus will be aborted, stillborn, or born with a rather advanced stage of the infection called *congenital syphilis*. The number of cases in the United States rose to 458, reflecting the rise in adult cases of syphilis (Bowen et al., 2015). Complications of congenital syphilis can include deformation of the bones and teeth, blindness, deafness, and other abnormalities that can result in an early death. Blood tests for syphilis are done routinely during pregnancy tests, and if detected the infection can be treated.

5.5.2 Diagnosis and Treatment

The spirochete taken from a chancre or sore can be identified under a microscope, but blood tests are almost always done as well. The saddest thing about any suffering or death that occurs from syphilis is that the spirochetes are so easily eradicated with antibiotics. Penicillin G is very effective, with the amount and duration of treatment depending on the stage of infection (Clement et al., 2014). Although antibiotics can eradicate the bacteria at any stage, they cannot reverse any organ damage that may have already occurred if the infection was left untreated until the late stage. It is important, therefore, that people seek treatment as early as possible.

Other Bacterial STIs

1. 5.6 Describe other, less common bacterial STIs.

Less common bacterial STIs include mycoplasma genitalium, chancroid, granuloma inguinale, and shigellosis. These infections are less common in the United States. In some parts of the world, they are epidemic.

5.6.1 Mycoplasma Genitalium

Mycoplasma genitalium is a bacterium that was first discovered in the 1980s. We still do not know much about it, but it is frequently found in 15% to 20% of men with nongonococcal urethritis and women with urethritis and/or cervicitis who do not have gonorrhea or chlamydia (CDC, 2016). There is increasing evidence that it is a sexually transmitted infection. In a nationally representative sample of young adults, *Mycoplasma genitalium* was more prevalent than gonorrhea and was 22 times more common in people who were having sexual intercourse than in people who were not (see Manhart et al., 2011). The infection is already becoming resistant to some antibiotics.

5.6.2 Less Common Bacterial STIs

There are other types of bacterially caused STIs that are common in tropical climates but rare in the United States. We have already mentioned lymphogranuloma venereum (see the section on chlamydia); two additional examples are chancroid and granuloma inguinale. Chancroid is caused by *Hemophilus ducreyi* and is characterized by small bumps on the genitals or other sites that rupture into soft, crater-like sores (see Figure 5–6). The incubation period from the time of infection to the appearance of the first sores is only 3 to 14 days. Unlike the syphilis chancre, chancroid is painful. The lymph nodes in the groin area often become inflamed and swollen. There are several million cases of chancroid in the world annually, but it is rare in the United States (CDC, 2016). Chancroid can be treated with several different antibiotics (Marrazzo & Cates, 2011).

Figure 5–6

Two adjacent chancroid lesions on the penis.

Source: Centers for Disease Control & Prevention

Granuloma inguinale is also rare in the United States, with fewer than 50 cases per year, but is much more common in tropical areas of the world. The main symptom is slowly progressive ulcerative lesions that bleed when touched and that can permanently destroy tissue and cause death if not treated. It is usually treated with doxycycline (CDC, 2016).

Shigellosis is another uncommon sexually transmitted infection. It is contracted from exposure to feces infected with the *Shigella* bacterium (a result of behavior such as oral stimulation of the anus). Symptoms include acute diarrhea, fever, and pain. Thirty percent of the cases in the United States occur in male homosexuals. Shigellosis is treated with tetracycline or ampicillin.

Personal Reflections

How would you feel if your best friend told you that he or she had an STI? Your teenaged son told you that he had an STI? Your teenaged daughter told you that she had an STI? Your partner told you that he or she had an STI acquired from a previous relationship?

Herpes

1. 5.7 Describe the symptoms (recognized and unrecognized), complications, and treatment of herpes.

Herpes (from a Greek word meaning "to creep") is *spread by direct skin-to-skin contact* (from the infected site on one person to the site of contact on another person). Two different types (1 and 2) of the virus were identified in the mid-1960s. Both types are related to, but not the same as, the viruses that cause chicken pox, shingles, and infectious mononucleosis. They cause painful blisters (which often rupture to form ulcers). In the mid-1960s there was a 95% site specificity: Ninety-five percent of people with fever blisters or a cold sore around the mouth had *herpes simplex virus type 1* and 95% of people with blisters around the genitals had herpes *simplex virus type 2*. Thus, it was mistakenly believed that HSV type 1 was acquired only by kissing and HSV type 2 only by sexual intercourse.

Today, there is no longer strong site specificity, particularly in young people. Among sexually active adults, genital herpes caused by the type 1 virus is increasing (CDC, 2016; Xu et al., 2006). *Both the type 1 and type 2 viruses can be transferred from mouth to genitals, and vice versa*. Nevertheless, many people persist in their mistaken belief that oral herpes can only be caught by kissing and genital herpes only through intercourse. Perhaps this letter to Ann Landers will be more persuasive:

Dear Ann Landers:

I got genital herpes from my boyfriend of two years from an innocent fever blister on his lip. I could not believe a woman could get a venereal disease from indulging in oral sex with someone who had a simple cold sore. My doctor cultured it and sure enough it came back Herpes Simplex Type I (the oral kind). But now I have genital herpes.

I developed a high fever after being exposed to the virus on his lip. That virus caused two fever blisters on my genitals. They reappear every two months and are quite painful.

My boyfriend dumped me when he learned I was infected. He remains "pure" and does not come down with a sexually transmitted infection, while I am alone and scared. There is no justice! Please, Ann Landers, inform the public at once. Tell them what can happen if a person has contact with those innocent-looking sores near the mouth.

Sign Me Dumb and Angry

Dear Angry: I have printed this information in my column more than once. Several readers wrote to say I was ill-informed, stupid, and just plain nuts. Thanks for your testimony.

(*Dear Ann Landers* and Reply Sign Me Dumb and Angry. By permission of Esther P. Lederer Trust and Creators Syndicate, Inc.)

We will refer to herpes blisters or ulcerations on the mouth as oral herpes and blisters or ulcerations on the genitals as genital herpes, without worrying whether the blisters were caused by the type 1 or type 2 virus (see Figure 5–7). Genital herpes is almost always contracted by intimate sexual contact (genital-to-genital, mouth-to-genital, genital-to-anal). Most cases of oral herpes are not transmitted by intimate sexual contact, and many cases are contracted during childhood (Xu et al., 2006). The virus can be easily spread by even a quick, casual kiss, and thus *it should not be assumed that a person suffering an attack of oral herpes was recently involved in sexual activity*. By the way, not all mouth ulcers are caused by the herpes virus. Canker sores, for example, are not caused by the herpes virus. However, "fever blisters" and most cold sores are herpes.

Figure 5–7

Herpes blisters on the mouth (left) and penis (center). Photo (right) shows ulcerated herpes lesions on the penis.

Source: Centers for Disease Control & Prevention; CDC/Dr. N. J. Flumara.; Dr. Gavin Hart; Dr. M. A. Ansary/Science Source

Figure 5–7 Full Alternative Text

5.7.1 Prevalence

The type 1 virus is much more common than type 2. By testing for antibodies to the viruses, the CDC estimates that 16.2% of Americans aged 14 to 49 are infected with HSV-2 (CDC, 2016). Over 50% are infected with HSV-1 (Xu et al., 2006). There will be about 776,000 new HSV-2 infections this year, and with existing infections that makes about 24 to 50 million Americans infected with this virus.

5.7.2 Symptoms—Primary Attack

Symptoms occur in three stages. In stage one, the *prodromal stage,* the person feels a tingling, burning, itching, or anesthetic-like sensation on the skin surface where he or she came into contact with the virus. Sometimes the symptoms are more diffuse; in the case of genital herpes, for example, the infected person may feel pain running down the buttocks and thighs. These initial signs indicate the beginning of viral *replication and shedding* (i.e., viruses traveling from the source, free to incorporate themselves into other cells). Therefore, the individual should immediately cease all intimate contact involving the infected area.

Within a few hours the skin surface will break into fluid-filled *blisters* called *vesicles* (see Figure 5–7). These can be excruciatingly painful. After a while, the vesicles break open, resembling pustules and then ulcerated running sores. Although herpes lesions generally resemble blisters, many people have sores that are more ulcerative in appearance (see Figure 5–7). These symptoms mark the second, or *vesicle stage*, which can last from 2 to 3 weeks. The first, or primary, herpes attack includes more than just painful blisters, however. The person often has flu-like symptoms, suffering muscle aches and pains, headache, fever, and swollen lymph glands. Urination can be quite painful for those with genital herpes (catheterization is sometimes required), and even walking or sitting can be extremely painful sometimes.

The sores begin to develop scales and form scabs, and the lesions eventually heal without leaving scars. This is the third, or *crusting-over stage.* Viruses are still being shed during the crusting-over stage; thus, intimate contact with the infected area should be avoided until all the sores are fully

healed. The average duration of a primary attack is about 16 days. The primary attack is severe because the person has not yet built up antibodies to the virus.

5.7.3 Recurrent Attacks

During the primary herpes attack, some of the virus migrates up sensory nerves from the infected site to the nerve's ganglion (the nerve cell center). The virus becomes dormant (inactive) when it reaches the ganglion. A recurrent attack occurs as a result of the virus reactivating and traveling down the sensory nerve to or near the same area as the initial sores. In the genital region, people with HSV-2 generally suffer many more recurrent attacks compared with those with type HSV-1. Recurrent attacks are often less severe than the primary attack (because the individual now produces antibodies).

What causes recurrent attacks? Stress to the immune system, either of a physical or emotional nature, seems to be the major cause. A recurrent attack can be brought on by illness, fatigue, menstruation, too much sunlight, and/or anxiety.

5.7.4 Asymptomatic and Unrecognized Infections

The herpes viruses are easily spread when sores (blisters or ulcerations) are present. The sores are an obvious sign of viral shedding, and infected persons should take measures to prevent the spread of the virus to other persons at this time. However, in many people the symptoms are mild, while still other individuals are asymptomatic shedders of the virus. In fact, as many as 90% of people infected with herpes in the genital region are unaware that they are infected (American Sexual Health Association, 2016). Experts now believe that most transmission of genital herpes occurs during periods when there are no recognizable symptoms.

"The guy I had been dating for two years told me that he had 'jock itch' and showed me a sore at the base of his penis. I didn't know what jock itch even looked like, much less herpes, so I believed him. His sore went away. About a month later another sore came up, so he went to the doctor . . . [who] told him he had herpes. Two days later I had a sore on my labia. . . . The doctor diagnosed the sore as herpes."

(from the authors' files)

5.7.5 Serious Complications

We generally think of herpes blisters as occurring only on the mouth and the genitals or anal area, but *the blisters may appear on any part of the body*. The virus can be spread to the eyes (by touching blisters that appear elsewhere on the body and then rubbing the eyes or by using saliva to insert contact lenses), resulting in *herpes keratitis*, or ocular herpes. This is *the leading cause of blindness resulting from infection in the United States today* (see Figure 5–8). Lesions on the eyeball result in scarring as they heal. It is the scars that eventually cause blindness. So if you have herpes, be sure to wash your hands if you touch the sores.

Figure 5–8

Herpes infection on the eyelid (left) and in the eye itself (right).

Source: Centers for Disease Control & Prevention

Figure 5–8 Full Alternative Text

Occasionally, dormant oral or facial herpes migrates to the brain rather than to the face, resulting in *herpes encephalitis*, a rare but often fatal condition. Primary attacks of herpes sometimes include inflammation of the membranes covering the brain and spinal cord (*herpes meningitis*), but full recovery usually follows.

Neonatal herpes is devastating. The greatest risk to a baby is with women who have a primary attack near the time of labor (30% to 50% chance) (CDC, 2016). Many babies who get herpes at birth (at least several hundred cases each year) suffer permanent and severe heart or neurological problems or die (Ambroggio et al., 2009; Donoval et al., 2006). The disease is so virulent in newborns because they have no defenses to fight off the infection. It is for these reasons that most doctors prefer to deliver babies by cesarean section to women with genital herpes. An active case of oral herpes is not a risk factor at the time of delivery, but parents (or anyone else) with an active case of oral herpes should avoid kissing or fondling a baby.

5.7.6 Diagnosis and Treatment

First, the bad news: There is no cure for herpes. Nothing you can do or take will rid your body of the herpes virus. The virus lies dormant in the ganglion cells between active outbreaks, and the potential for another attack is always there. Herpes sufferers nevertheless remain persistent in their attempts to find a home cure. None of these (including diet) has proven effective in scientific tests, and some of these home remedies (e.g., ether) have proven to make matters even worse in some cases.

Now, the good news: Although there is no known cure for herpes, three antiviral drugs are available that relieve symptoms and speed up the healing process during attacks—*acyclovir* (marketed under the name Zovirax), *valacyclovir* (Valtrex), and *famciclovir* (Famvir). Topical application of cream medication helps only a little. People with frequent attacks of genital herpes are advised to take the medication in pill form daily to suppress recurrent attacks. These drugs decrease viral shedding and herpes outbreaks by 70% to 80% (CDC, 2016). However, the drugs are not a cure, and recurrent attacks will return once they are discontinued. There has been considerable research to find a herpes vaccine, but none has proven to be highly effective (see Belshe et al., 2012).

5.7.7 The Personal Side of Herpes

Besides the physical symptoms, individuals suffering with genital herpes almost always have some psychological difficulties adjusting to their infection. They often pass through several stages: shock, emotional numbing, isolation and loneliness, and sometimes severe depression. The reactions of others may make them feel like "social lepers." In short, they often feel stigmatized (Merin, 2011).

So how should you deal with personal relationships if you have genital herpes? Counseling to learn accurate information about your infection is critical (CDC, 2016). Accept the fact that although there is no cure, you do not have the plague. *The use of condoms will reduce the chances of infecting a partner* (in case there is viral shedding without symptoms). If you have frequent or long-lasting attacks, talk to your doctor about taking one of the antiviral drugs. Contact the American Sexual Health Association. They will provide you with current information on herpes research, therapy, and care.

Personal Reflections

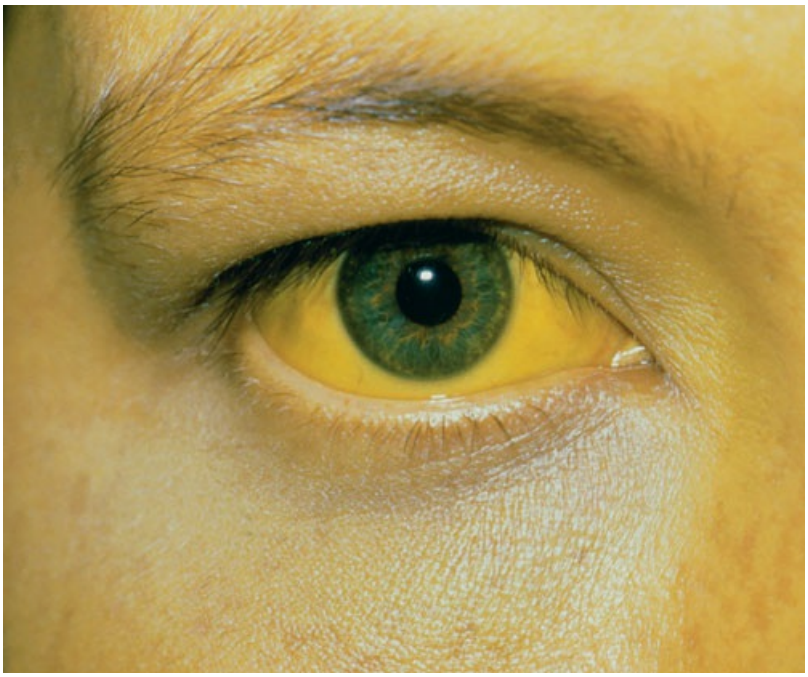
Many babies are born with sexually transmitted infections as a result of their mothers being infected during pregnancy. Is having an STI an indication of immorality, irresponsibility, both, or neither? Explain (you may wish to reconsider your answers to the first two Personal Reflections at this point).

Hepatitis

1. 5.8 Describe the symptoms, complications, and treatment of hepatitis.

Hepatitis is an inflammation of the liver that can have many causes. We will address three types caused by viruses. The symptoms can range from mild (poor appetite, diarrhea) to severe (fever; vomiting; pain; fatigue; jaundiced, or yellow-tinged, skin and eyes; dark urine). See Figure 5–9.

Figure 5–9



A typical symptom of hepatitis is jaundice: yellow-tinged eyes and skin.

Source: Garry Watson/Science Source

5.8.1 Hepatitis A

Hepatitis A (infectious hepatitis) is caused by a small virus (HAV) that is spread by direct or indirect oral contact with contaminated feces (see CDC, 2016; Marrazzo & Cates, 2011). The infection can be spread sexually (by oral-anal contact with an infected person during sex) and has a much higher incidence in male homosexuals than in other groups. However, it is most often contracted through nonsexual means, such as eating food handled by infected individuals or shellfish taken from contaminated waters. Symptoms generally begin to show 15 to 50 days after the person becomes infected. Unlike some other types of hepatitis, the infection does not result in chronic liver disease. A highly effective hepatitis A vaccine has greatly reduced the number of cases in the United States.

5.8.2 Hepatitis B

Hepatitis B (serum hepatitis) is caused by a different, larger virus (HBV) and is transmitted by infected blood or body fluids such as saliva, semen, and vaginal secretions. Symptoms begin 6 weeks to 6 months after exposure (CDC, 2016). It can cause a number of liver diseases, including cancer and cirrhosis. As many as 2 billion people worldwide have been infected with this virus, and about 378 million are chronic carriers, resulting in 1 million deaths each year (Ioannou, 2011). About 4.6% of Americans have been infected with hepatitis B at some time in their lives. There are still over 400,000 Americans who are chronically infected. Another 1.8 million foreign-born immigrants who were never vaccinated may have chronic hepatitis B (Kowdley et al., 2012). Over 50% of the new cases are spread during heterosexual intercourse (Marrazzo & Cates, 2011), and over two thirds of all pregnant women infected with hepatitis B pass the infection to their babies. A variety of antiviral drugs are used to treat the infection. Co-infection with HIV is not uncommon, making treatment more difficult (Kourtis et al., 2012).

5.8.3 Hepatitis C

Alert: *More Americans now die of the complications of hepatitis C each year (more than 15,000) than from HIV/AIDS* (Ly et al., 2012). Worldwide, there are 185 million chronic cases, with 2.7 million Americans with chronic infections (Denniston et al., 2014).

Hepatitis C is most commonly spread through contact with contaminated blood (blood-to-blood contact), and thus it is frequently found in people who inject illicit drugs and share needles. About 50% to 90% of injection drug users have hepatitis C (Aceijas & Rhodes, 2007). It is believed that the virus is only rarely spread during sex (Marrazzo & Cates, 2011), but there is evidence that it has become an STI in HIV-infected men who have sex with men (van de Laar et al., 2010). There is no vaccine available for protection against hepatitis C. However, there are now direct-acting antiviral drugs that can quickly cure hepatitis C infections (sofosbuvir plus ledipasvir; Kowdley et al., 2014).

Personal Reflections

The Centers for Disease Control and Prevention recommends that all children be vaccinated for hepatitis A and B and that all Americans born between 1945 and 1965 have a hepatitis C test. Because of these efforts, the number of acute (new) cases has dropped dramatically (Kievens et al., 2014). Will you have your children vaccinated?

Genital Human Papillomavirus Infection

1. 5.9 Describe the symptoms, complications, and treatment of human papillomavirus infection.

Have you ever heard of genital human papillomavirus (HPV) infection? Many college students have not, yet this is the most common sexually transmitted infection in the United States (CDC, 2016; see also Table 5-1). It is estimated that 79 million Americans are infected with HPV and that there are 14 million new cases every year (CDC, 2016). This is so common that *the lifetime probability of acquiring HPV for those who have had at least one opposite-sex partner is 84.6% for women and 91.3% for men* (Chesson et al., 2014). The large majority of infections (about 90%) disappear on their own within 2 years (Crow, 2012). However, there are very serious consequences in cases that persist.

Human papillomaviruses (HPV) infect epithelial cells (the covering of internal and external surfaces of the body). Over 100 different types have been identified, of which about 40 can be transmitted during sex (CDC, 2016). HPV infections are called *clinical infections* if there are symptoms visible to the naked eye and *subclinical infections* if there are no visible symptoms. Subclinical HPV infections are at least 10 times more common than clinical infections.

5.9.1 Genital Warts

We can separate clinical HPV cases into three broad categories: (1) those that cause a rare skin condition (epidermodysplasia verruciformis) that appears as reddish plaques, (2) those that cause nongenital warts (including common, plantar, and flat warts), and (3) those that cause warts in the genital and anal area (although these can also cause problems in the mouth, pharynx, and larynx). There are about 25 different human papillomaviruses that can cause anogenital warts (Figure 5–10), but 90% of genital warts are caused by HPV types 6 and 11 (CDC, 2016).

Figure 5–10

Early-stage (left) and late-stage (right) genital warts on the penis caused by human papillomavirus.

Source: Dr. P. Marazzi/Science Source; Centers for Disease Control & Prevention

Figure 5–10 Full Alternative Text

For those people who develop genital (venereal) warts, the first symptoms generally appear anywhere from 3 weeks to 8 months after contact with an infected person. The warts can cause itching, irritation, or bleeding. In men, the warts generally appear on the penis, scrotum, and/or anus, but they can also grow within the urethra. In women, the warts can appear on the cervix and walls of the vagina as well as the vulva and anus, and thus the virus can be transmitted to a baby during vaginal delivery. Genital warts can substantially decrease one's quality of life (Drolet, 2011).

"I contracted venereal warts from a married woman I frequently slept with. I then gave them to my girlfriend. I did not know I had the affliction until she was diagnosed during a semi-annual exam with her gynecologist. The removal procedure for me as a man was rather simple as opposed to her treatment. Her first treatment involved cryogenically freezing her cervix. After that unsuccessful attempt they resorted to laser surgery. She is still not cured."

"When I was 17 years old I went to the doctor for a Pap smear. He found warts on my cervix. My doctor performed laser surgery to get rid of the warts. A year and a half later I had another outbreak, had surgery, and within seven weeks after the surgery they came back. These last two times they weren't just on the cervix, they spread all the way to the vulva. . . . I have abstained from sex since the beginning of the second outbreak.

(All examples are from the authors' files.)

For individuals who have anogenital warts, various treatments are available, but none is ideal for all patients (Marrazzo & Cates, 2011). If the warts are small and you wish to treat yourself, you can apply a solution of podophyilox, imiquimod, or sinecatechin ointment, which causes them to dry up. Doctors can remove larger warts by liquid nitrogen or minor surgery. Internal warts are often removed by laser surgery. However, none of these methods attacks the virus directly, so recurrences of the warts are common (see previous case histories).

5.9.2 Cancer

Women with HPV infections have a greatly increased risk of developing cervical and/or vulvar cancer. In fact, nearly all women with cervical cancer are found to have HPV infections. The latency period between infection with HPV and detection of cancer is 5 to 25 years. About 15 kinds of human papillomaviruses are found in cervical cancers, most commonly HPV 16 and 18 (70% of cases), 31, 33, and 45. However, these HPVs don't just cause cervical cancer. HPV is also a leading cause of vaginal, penile, anal and rectal, and mouth and throat cancers (Viens et al., 2016). In fact, oral HPV infection now leads smoking and alcohol as the leading cause of mouth/throat cancer (Scudellari, 2013). About 10.1% of American men and 3.6% of American women now have oral HPV infections (Gillison et al., 2012).

Note that the types of HPV that cause cervical, oral, anal, and penile cancer are different from the two types that cause most genital warts (types 6 and 11). What this means is that *most people who are at risk of developing cervical cancer will have no visible symptoms*. Each year, for example, nearly 2 million American women are diagnosed with mild cervical dysplasia. Remember, most infections disappear on their own. Only women with persistent infections will develop cervical cancer—about 12,990 a year in the United States, resulting in over 4,100 deaths (American Cancer Society, 2016). Worldwide, there are 500,000 new cases each year and over 250,000 deaths.

A regular pelvic exam and Pap smear are an essential part of female health care. Women who test positive for HPV should have Pap smears at least every 6 months. There are now HPV DNA tests that can be done to identify the highest-risk types of HPV for cervical cancer (CDC, 2016). However, regular pelvic exams and Pap smear tests are still an essential part of female health care (see Box 2–B). For HPV infections of the cervix, cryotherapy (freezing) is the preferred therapy.

5.9.3 Vaccination as a Preventative Measure

Because millions of Americans infected with HPV have no symptoms, they are unaware that they can infect others. The best way to eliminate the infection would be to vaccinate people before they are exposed to the virus. Highly effective vaccines are now available. Gardasil protects against HPV types 16 and 18 (accounting for 70% of cervical cancers) and 6 and 11 (accounting for 90% of genital warts). A newer vaccine, Gardasil 9, protects against these four types and five others, making it 90% effective against cervical cancer (Petrosky et al., 2015). The vaccines work for both women and men and protect against anal and oral cancer as well. Three injections are required for full protective vaccination. The vaccines also reduce the risk of recurrent problems in women who already have had cervical HPV-caused disease (Joura et al., 2012). A CDC advisory panel *recommended that all girls and boys be routinely vaccinated at ages 11 or 12 (and as early as age 9) and that all others up through age 26 be vaccinated as well.*

Has the vaccination helped to decrease the prevalence of HPV? Australia began a national vaccination program in 2007, and by 2011 genital warts had nearly disappeared in teenaged girls (Korostil et al., 2013). In the United States, as of 2013, only a little more than half of girls aged 13 to 17 and only about one third of boys had received at least one of the three injections (see Rubin, 2015). Even with this modest vaccination rate, the number of new diagnoses of genital warts has dramatically declined (Calo & Brewer, 2015).

With this solid record, why aren't more parents having their teenaged children vaccinated? Besides unfounded concerns about vaccinations in general, because HPV is sexually transmitted some parents worry that vaccination will lead to sexual activity (Rubin, 2015). Look again at the lifetime probability of getting an HPV infection. Make the wise choice.

Personal Reflections

Have you ever engaged in sex with a new partner while under the influence of alcohol? If your answer is "yes," did your use of alcohol result in your engaging in unprotected sex? If it did, what will you do in the future to prevent this?

Other Viral Infections: Molluscum Contagiosum and Zika

1. 5.10 Describe other viral infections, such as molluscum contagiosum and the Zika virus.

Other viral infections, such as molluscum contagiosum and the Zika virus, are discussed in the following sections.

Molluscum Contagiosum

Molluscum contagiosum is a painless growth that is caused by a pox virus. The virus is easily spread by direct skin-to-skin contact, but the large majority of cases are not spread during sex (Marrazzo & Cates, 2011). Infected individuals can easily spread it to other parts of their bodies. The virus incubates for 2 weeks to 6 months and then erupts into dome-shaped growths that are usually 1 to 5 mm in diameter and look like small pimples filled with kernels of corn. Molluscum contagiosum is easily diagnosed by the appearance of the growths and is usually treated by removing the growths. However, they usually disappear on their own within 6 to 9 months.

5.10.2 Zika Virus

Now we have another sexually transmitted viral infection to worry about: Zika virus. The virus is easily spread by mosquitoes, but once infected, a man can spread it during sex (Oster et al., 2016). What this means is that even within a monogamous relationship a person infected by a mosquito could spread it to his partner. Zika virus infections in pregnant women can cause microcephaly (a small head and brain). Several cases of sexual transmission have now been confirmed in the United States. Unfortunately, at this time we still know little about this infection and its potential spread in the United States.

HIV Infection and AIDS

1. 5.11 Discuss the causes, effects, and treatment of HIV infection and AIDS.

In the early 1980s, doctors in California were puzzled when five men were diagnosed with *Pneumocystis carinii pneumonia*, a rare respiratory infection usually seen only in people with depressed immune systems. Several young men in Miami were simultaneously diagnosed as having *Kaposi's sarcoma*, a rare cancer of the capillary system that appears as purple blotches on the skin (see Figure 5–12). It, too, is a sign of a depressed immune system. More and more cases of depressed immune systems began to appear, but it was not until 1982 that the new infection was given a name: **acquired immunodeficiency syndrome,** or **AIDS**. It was not until 1984 that the cause of AIDS was identified as a virus, named **human immunodeficiency virus,** or **HIV**.

Figure 5–11

All of the STIs covered in this chapter can be transmitted during anal intercourse. This individual has genital warts (caused by human papillomavirus) heavily in the anal region and also on the labia.

Source: Biophoto Associates/Science Source

Figure 5–12

Kaposi's sarcoma lesions on a patient with AIDS.

Source: © Chuck Nacke/Alamy

In technical terms, HIV is a Lentivirus, a subfamily of retroviruses. Retroviruses reverse the normal pattern of reproduction in cells. There are two major types of HIV: HIV-1, which is the most common type worldwide; and HIV-2, found mainly in West Africa. HIV displays considerable genetic variability (Killian & Levy, 2011). There are four major genetic groups of HIV-1 (M, N O, P) with nine subtypes of group M. HIV-2 has two major groups (A and B). In the United States, the large majority of cases are HIV-1. However, different subtypes can be found in different people living in the same area, and HIV "superinfections" (an individual infected with multiple subtypes) are becoming more common (Redd et al., 2012).

5.11.1 HIV and the Body's Immune System

The immune system is that part of your body that defends against bacteria, viruses, fungi, and cancerous cells. White blood cells, or *lymphocytes*, are the main line of defense in this system. There are several types. One type, called *CD4+ lymphocytes* (also called *helper T cells* and *T4 lymphocytes*), has the job of recognizing the disease-causing agents and then signaling another type of white blood cell (*B cells*) to produce antibodies. The antibodies bind to the recognized agents so that they can be identified by yet another type of white blood cell, the *killer T cells* (T is for the thymus gland, where the cells develop). The CD4+ cells then signal the killer T cells to destroy the identified disease-causing agents. In addition to CD4+ cells, there are also *suppressor T cells* that suppress the activity of the B cells and killer T cells. A person normally has twice as many CD4+ (helper) cells as suppressor T cells.

Recall now that viruses must invade and live in normal body cells (called host cells) in order to replicate themselves. The human immunodeficiency virus infects CD4+ cells and reproduces itself, causing death of the cell in about 112 days and the release of more of the virus. The replicated virus then invades other CD4+ cells. Thus, HIV destroys the cells that ordinarily would work to fight it off. The body tries to replace the dead cells, but the number of CD4+ cells begins to decline early in the course of HIV infection. The victim eventually has fewer helper (CD4+) T cells than suppressor T cells, leaving the body defenseless against viruses, bacteria, and other infection-causing agents.

CD4+ white blood cells are not the only body cells invaded by HIV. The virus has also been found in cells of the brain, gastrointestinal tract, kidney, lungs, cerebrospinal fluid, and other blood and plasma cells. However, it is the destruction of CD4+ cells that leads to the condition we call AIDS.

5.11.2 Progression of HIV Infection

After invading the body, HIV reproduces unchecked at first, reaching enormous levels in the bloodstream. The amount of HIV in early infection depends, in part, on the amount of HIV that was in the donor. Between 50% and 75% of newly infected persons experience flu-like symptoms (e.g., fever, headache, diarrhea, tiredness, skin rash) starting 13 to 15 days after infection. This is called primary HIV infection and can last for several weeks (D'Souza et al., 2010). The body's immune system then launches a huge counterattack that kills the virus by the billions, reducing it to very low levels. In time, however, the virus regains the upper hand by slowly killing off the CD4+ cells.

A normal, healthy person has between 1,000 and 1,200 CD4+ cells per cubic millimeter of blood. Although CD4+ cell counts decline with time,

people with HIV show no visible symptoms in the first stage of the chronic infection, called asymptomatic HIV infection. This stage often lasts for years.

Infected persons generally start to show symptoms of a weakened immune system when their CD4+ cell count falls below 500 per cubic millimeter of blood. Symptoms may include fatigue, persistent headaches, loss of appetite, recurrent diarrhea, loss of body weight, low-grade fever (often accompanied by "night sweats"), swollen lymph nodes, and "colds," "flus," and yeast infections that linger on and on. At this point, the infection is called symptomatic HIV infection.

HIV infection is not called AIDS *until it has become life-threatening*. As the CD4+ cell count approaches 200 per cubic millimeter of blood, infected persons' immune systems have become so weakened that they fall prey to what are referred to as *opportunistic infections*—diseases such as lymphomas, Kaposi's sarcoma (see Figure 5–12), *Pneumocystis carinii* pneumonia, recurrent bacterial pneumonia, pulmonary tuberculosis, cryptococcal meningitis, and invasive cervical cancer (CDC, 2016). These are often accompanied by a severe decline in mental ability, referred to as HIV-associated dementia. In 1993, the Centers for Disease Control and Prevention expanded the definition of AIDS to include a *CD4+ cell count below 200*, regardless of whether the person had yet fallen victim to an opportunistic disease. AIDS patients die as a result of the opportunistic infections (not as a direct result of HIV).

Once an individual is infected with HIV, how long does it take to develop a full-blown case of AIDS? Without medication, about 40% to 45% of HIV-infected individuals will have reached the symptomatic stage within 2 years (Morgan et al., 2002). About 5% will develop AIDS within the first 3 years after infection with HIV-1, about 20% within 5 years, and 50% in 11 years (CDC, 2016).

There are some very interesting exceptions. A few HIV-infected individuals are called *long-term nonprogressors*. Despite their infection, they maintain high CD4+ levels and have not developed symptoms after 8 years (Hunt, 2009; Migueles & Connors, 2010). Some, called *elite controllers*, continue beyond 10 years with no symptoms (Grabar et al., 2009). Of particular interest are some high-risk individuals (e.g., sex workers, injection drug users) who have never become infected, though they have been exposed to HIV many times. This suggests that they have some sort of immunologic or genetic protection and that study of them might be useful in designing a vaccine (Shearer & Clerici, 2010).

What accounts for the fact that some HIV-infected people progress to AIDS in just a few years while others take many years? The type of HIV may be one factor. For example, persons infected with HIV-2 take much longer to develop AIDS than those infected with HIV-1 (many of whom are long-term nonprogressors). People who already have a weakened immune system (as a result of age or illness, for example) have a more rapid progression to AIDS. Individuals who experience acute primary HIV infection (flu-like symptoms or worse upon initial exposure) are more likely to develop AIDS earlier than people who are asymptomatic upon initial infection.

Several studies have shown that the best single predictor for progression to AIDS is not an individual's CD4+ cell count but his or her plasma HIV RNA levels, which show the amount of virus in the blood (Mellors et al., 1996; O'Brien et al., 1996). This is called the *viral load*. The higher the viral load, the sooner the person will develop AIDS.

How long can an HIV-infected person expect to live after being diagnosed with AIDS? Without medication, the survival time is only about 1 year. However, new drug therapies have allowed many HIV and AIDS patients to live longer, productive lives (see section on treatment).

5.11.3 Where and When Did Human Immunodeficiency Virus Originate?

There is no question that HIV-1 and HIV-2 are new to the human species, but where did they come from? "Conspiracy" theories are popular. At one time, the Soviets blamed HIV/AIDS on U.S. biological experiments gone awry. Others have claimed that the virus was injected into people with various vaccines. Many African Americans continue to believe that AIDS is man-made (Heller, 2015).

Scientific studies of the origins of HIV do not support conspiracy theories. There is a diverse genetic pool of non-human *simian* (primate) *immunodeficiency viruses (SIV)*. The viruses are found in rhesus monkeys, sooty mangabeys, African green monkeys, and chimpanzees. SIV normally does not cause illness in these non-human hosts. The SIV in sooty mangabeys has been clearly identified as the origin of HIV-2 (Chen et al., 1997; Gao et al., 1992). In other words, humans acquired HIV-2 through cross-species transmission, i.e., the virus is a "simian immunodeficiency virus residing in and adapting to a human host" (Myers et al., 1992).

What about HIV-1? Studies have definitely established that this virus was transmitted to humans from chimpanzees (Gao et al., 1999; Keele et al., 2006). Most evidence indicates that this first occurred in colonial French Equatorial Africa in the 1920s and 1930s (Faria et al., 2014).

Tests of stored blood samples show that HIV-1 was definitely starting to spread by 1959 (Zhu et al., 1998), and by the 1970s high rates of Kaposi's sarcoma were being reported in central Africa. The rest is history (see Ndung'U & Weiss, 2012, for a review).

5.11.4 How Is HIV Spread?

Can you get AIDS by casual contact with an HIV-infected person? The answer is *no*! If HIV could be contracted from casual contact, you would expect that family members living with AIDS patients would be at great risk. However, no family member of an AIDS patient has ever become infected by sharing household facilities and items, and no child has ever become infected by just playing with or living with an AIDS-infected brother or sister. HIV has sometimes been found in body fluids such as tears and saliva, but not in high enough concentrations to pose a threat.

In the final stages of AIDS, patients cannot hold food down, often have uncontrollable diarrhea, and generally sweat profusely. Yet except for a few people who accidentally stuck themselves with a contaminated needle and a few others whose skin was exposed to a large amount of contaminated blood (which may have entered the body through a small cut), none of the doctors, nurses, or other medical personnel who have

cared for the most seriously ill AIDS patients on a daily basis has ever developed an HIV infection.

Malaria and some other diseases are spread by mosquitoes, but it is certain that HIV is not spread in this manner (Castro et al., 1988). If it were, we would be seeing a much larger number of children and elderly people with AIDS.

So, how is HIV transmitted? There are three main ways: (1) sexual contact with an *infected* person, (2) exposure to infected blood (mainly needle sharing among intravenous drug users), and (3) mother-to-infant transmission. Thus, HIV is transmitted almost exclusively by intimate sexual contact and contaminated blood. Let us examine each of these means of transmission.

You cannot get HIV by having sex (of any type) with an uninfected partner. To get HIV during sex, the sexual partner must be infected with HIV. The risk of transmission of HIV during sex is directly related to the infected person's viral load (Attia et al., 2009; Quinn et al., 2000). Remember, the concentrations of HIV are greatest at the very beginning of the infection (primary stage), then decrease dramatically, and then increase again as the infection progresses toward the AIDS stage.

A major factor is whether HIV is transmitted onto an uninfected person's mucous membranes or directly into his or her blood. Any sexual activity in which bleeding occurs would greatly increase the risk. Because of this, anal intercourse is one of the easiest ways to spread HIV from an infected person to another. Many male homosexuals engage in anal intercourse, but it is also common among heterosexual couples (see Chapter 11).

Studies show that during vaginal intercourse HIV is at least twice as easy to transmit from an infected man to a female partner than vice versa (see Vernazza et al., 1999). Sores on the genitals caused by other sexually transmitted infections such as syphilis, chancroid, or herpes also greatly increase the risk of HIV transmission (see Vernazza et al., 1999).

Most experts believe that HIV can be transmitted during oral-genital sex but that the risk is much smaller than for anal or vaginal intercourse (Baggaley et al., 2008; Hasselrot et al., 2010). This is because of inhibiting substances found in saliva.

As previously mentioned, a second major way in which HIV is transmitted is by exposure to contaminated blood. Needle-sharing drug users are at especially high risk. But what about our chances of getting HIV from a blood transfusion? At one time this was a major concern. Today, because all blood is tested, only 1 of every 1.5 million units is likely to be infected with HIV (CDC, 2010a). In the United States, you will not get HIV from donating blood!

The third major way that HIV is transmitted is from an infected mother to her infant. Without antiretroviral drug therapy, the transmission rate is about 20% to 25% (Lindegren et al., 1999). The infections can occur either very late in pregnancy, during delivery, or by breast-feeding (Chasela et al., 2010; European Collaborative Study, 1992). The risk is greatest in women who have high levels of the virus in their blood (Landesman et al., 1996; Mofenson et al., 1999). The frequency of transmission of HIV-1 by breast-feeding is about 35% (Liang et al., 2009). This is so high that the United Nations recommended that women with HIV not breast-feed their babies.

5.11.5 Who Has HIV/AIDS?

HIV infection is a true pandemic. Currently, worldwide, there are about 37 million people currently living with HIV, with only 17 million of them receiving antiretroviral therapy (UNAIDS, 2016). There are over 2 million new cases each year (Cohen, 2016; UNAIDS, 2016). About 1.1 million people die of AIDS every year, and about 35 million people have died from AIDS since the epidemic began (UNAIDS, 2016).

At present, 90% of persons infected with HIV live in developing countries (UNAIDS, 2016). Over two thirds of the world's cases are in sub-Saharan Africa, where HIV originated (see Box 5–A). HIV may have originated in Africa, but today some of the greatest increases are in Eastern Europe/Central Asia and parts of Southeast Asia (Cohen, 2016; UNAIDS, 2016).

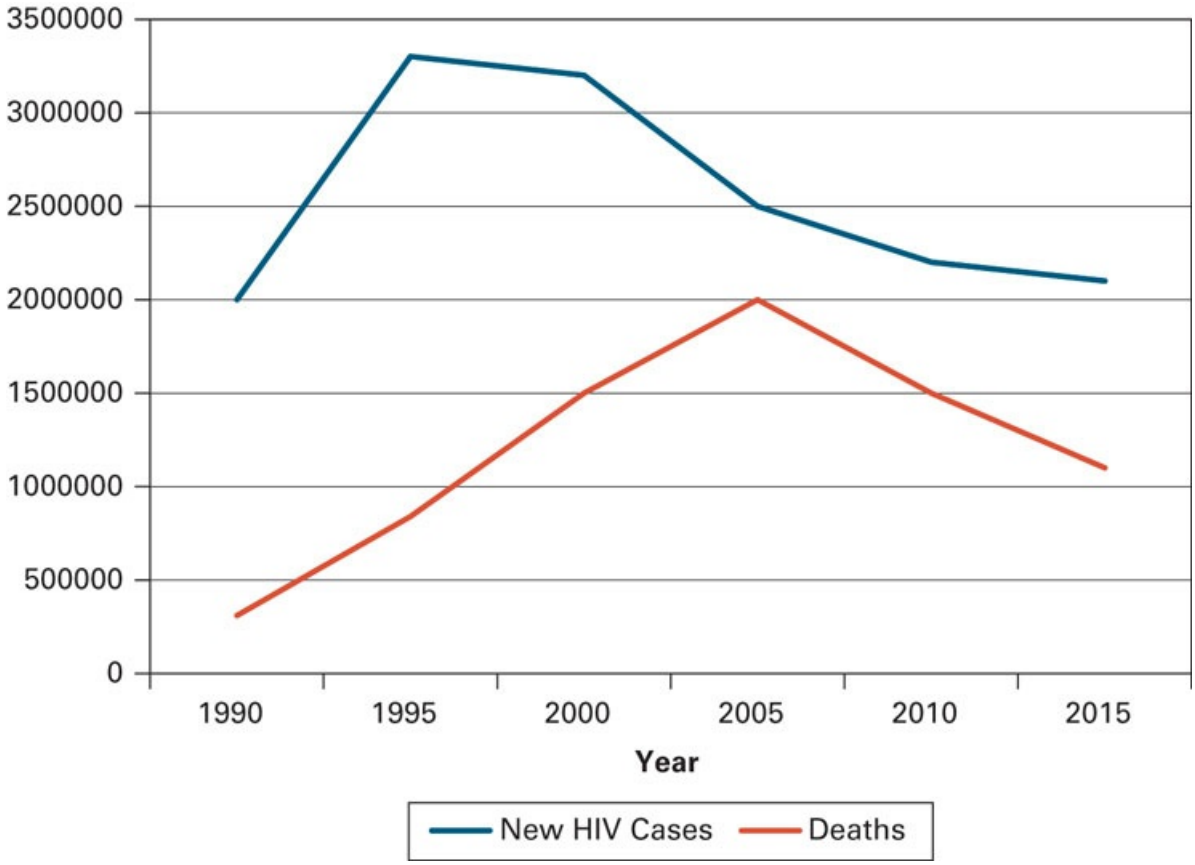
Worldwide, the largest proportion of HIV infections were acquired by heterosexual transmission. In sub-Saharan Africa, for example, over half of the millions of people infected with HIV are women. However, among men who have sex with men, the percentage infected with HIV is high, particularly among young men (Beyrer et al., 2013), and many are unaware that they are infected (Ferrer et al., 2015).

What about the United States? The Centers for Disease Control and Prevention reported that there were over 1.2 million Americans living with HIV/AIDS in 2016 (CDC, 2016). About 13% of these were undiagnosed. Of the 44,073 new HIV cases reported to the CDC in 2014, 81% were in men and 19% were in women (CDC, 2016). About 40% of new cases were diagnosed in young people aged 13 to 29. This is not surprising as 44% of young people are not aware of their infection. A disproportionate number of the new HIV cases occurred among African Americans (44%) and Latinos (about 23%), particularly those in low-income groups.

Nearly one quarter of new infections were the result of heterosexual contact. This was true for 87% of infected women. However, overall, gay and bisexual men accounted for 67% of the new diagnoses. One contributing factor is that unprotected anal intercourse among men who have sex with men has increased by nearly 20% since 2005 (Paz-Bailey et al., 2013). It should be noted that 26.4% of men who have had sex with men also have had sex with women (Singh et al., 2014). About 6% of new cases are attributed to intravenous drug use (sharing needles).

Here is some good news: Because of increased testing, earlier treatment, pre-exposure medications, and needle exchange programs, there has been a marked decline in both new HIV diagnoses and deaths due to AIDS (see Figure 5–13).

Figure 5–13



HIV worldwide 1990–2015: New cases and deaths.

Source: UNAIDS.org

Figure 5–13 Full Alternative Text

5.11.6 The Human Side of AIDS

With each passing year, more and more of us do not have to read a newspaper to get a firsthand experience with AIDS. About 28% of Americans know someone who is HIV-positive or who has died of AIDS (Firth et al., 2016). About 56% of gay or bisexual men do. AIDS is more than a disease; it is a personal tragedy, not only for the patient but for the patient's family and loved ones as well. Some students in our course have asked us to share their experiences. Here are a few:

Box 5–A Cross-Cultural Perspectives/Sexuality and Health

AIDS in Africa

In 2000, *Newsweek* magazine said that to take a trip to sub-Saharan Africa is to "peer through the portals of hell and glimpse the holocaust to come" (Bartholet et al., 2000). Sub-Saharan Africa accounts for over two thirds of all HIV cases globally (UNAIDS, 2016). This includes 80% of women infected globally. In South Africa, 6.6 million people are infected (over 5 times greater than in all of the United States); 3 million people in Nigeria are infected (Murray et al., 2014). AIDS is the leading cause of death in Eastern, Central, and Southern Africa (Ortblad et al., 2013). In the United States, life expectancy increased by 30 years during the 1900s. In many parts of Africa, it dropped from 59 years of age in 1990 to 34 to 37 years of age in 2008 (UNAIDS, 2016). The devastation caused by HIV in Africa rivals that caused by the Black Death in Europe during the Middle Ages, when one fourth of the population was lost.

What about the children? Have you ever read *Lord of the Flies*? About 90% of HIV-infected children live in sub-Saharan Africa. What's more, because of the AIDS-related deaths of their parents, at the end of 2010 there were 18.4 million AIDS orphans in sub-Saharan Africa, over 1.4 million in South Africa alone. An undeterminable number roam the streets, malnourished and often infected themselves.

The HIV epidemic has affected the prevalence of other infectious diseases as well. People with HIV have an increased susceptibility to tuberculosis and malaria, which results in increased transmission rates for these diseases (Murray et al., 2014). Economies are collapsing under the weight of the epidemic. There is widespread famine because so many farm workers have died of AIDS.

As bad as it is, in recent years there has been cause for optimism. The United States President's Emergency Plan for AIDS Relief began in 2002 (Goosby et al., 2012). This led to international cooperation to expand HIV services. By offering circumcision to men, expanded distribution of antiretroviral drugs, and pre-exposure prophylaxis, new cases of HIV were reduced by more than half (since 2001) in many African countries (Cohen, 2011; UNAIDS, 2016). Nevertheless, there are still many problems. Several studies have found that many infected individuals who begin antiretroviral therapy do not come back for a follow-up and over half do not adhere to regularly taking their medication (Marrazzo et al., 2015;

Ellman, 2016). This can very possibly result in drug-resistant strains of HIV and even more infections. Homophobia is widespread, and new anti-gay laws are making it difficult to reach many (Nordling, 2014).

Since the time you woke up yesterday morning, more than 3,000 African men, women, and children have died of AIDS. HIV spread through Africa many years before it appeared in the United States. If we do not take the necessary precautions, could the same fate that has befallen Africa happen here? Perhaps Dr. Ward Cates of the Centers for Disease Control and Prevention put it best: "Anyone who has the least ability to look into the future can already see the potential for this disease being much worse than anything mankind has seen before."

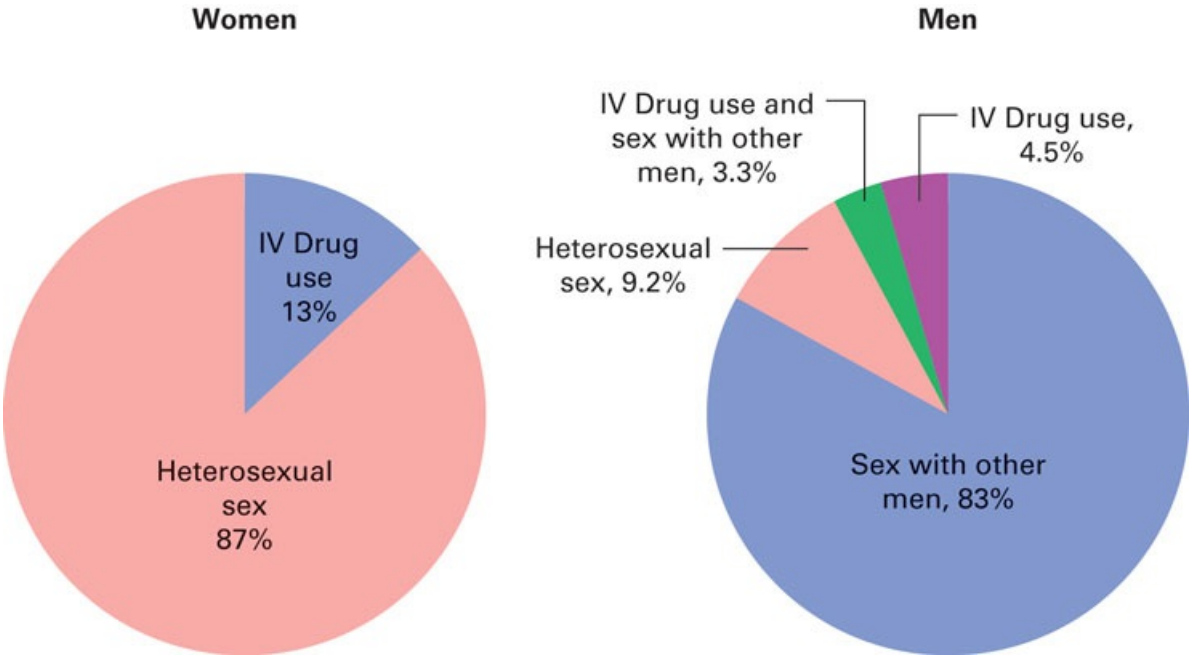
"My reaction to a low T-cell test was devastating. It was like a bomb exploding inside or a knife through the heart. My time is near and each day is a.pngt to cherish. . . . Finding out I was HIV positive was not as shocking as finding out that what I have changed to improve the quality of my life makes little difference in my life expectancy."

"My father has AIDS. You really don't know the severity of a problem until you're faced with it. Watching my father die has been extremely painful and stressful."

"I still believe that most students don't think that AIDS can happen to them. I have seen AIDS happen firsthand. I learned in one of the most painful ways I can imagine. Two years ago my older brother died of AIDS. I was only 19, he was 24. It had been said that everyone's lives would be touched by AIDS, and when I was younger I didn't believe it. Now I do."

(All examples are from the authors' files)

Figure 5–14



Sources of HIV infection among American men and women first diagnosed with AIDS in 2014.

Source: CDC, 2016.

Figure 5–14 Full Alternative Text

Many people have led productive lives for years after being diagnosed with AIDS. It is important, therefore, that HIV-infected individuals not give up hope and that they receive as much positive support as possible.

5.11.7 Testing for HIV

There are tests that can detect a single HIV-infected white blood cell among 100,000 healthy ones. However, the tests are very expensive. The standard tests for HIV do not test for the virus directly but instead detect antibodies to the virus that are produced by an infected person's immune system (see CDC, 2016). Blood is first checked with the EIA (enzyme immunoassay) test. However, the test can result in "false positives" (i.e., uninfected blood testing positive). If there is a positive indication, the blood is tested again with either the Western Blot, IFA (immunofluorescent assay), or virologic tests. A negative test result means only that a person *probably* has not been infected with HIV. Remember, it often takes several months for an infected person's body to start producing antibodies to the virus; a person who has just recently been infected will not test positive.

Until recently, HIV tests were invasive (blood had to be drawn). New tests are now available that measure the presence of antibodies to HIV in saliva or with a finger stick (a single drop of blood). These include home, self-administered tests (thus ensuring confidentiality) (Pai et al., 2013). It must be noted, however, that tests using saliva are not as accurate as blood tests.

Remember, of the 1.2 million Americans living with HIV, about 13% do not know that they are infected, including 44% of infected young people (CDC, 2016). Only 53% of adults have been tested for HIV (Firth et al., 2016). In 2006, the Centers for Disease Control and Prevention recommended that *testing for HIV should be a routine part of medical care for all Americans between 15 and 65 years of age* (see also McNulty et al., 2016).

5.11.8 Treatment for HIV/AIDS: Hope and Limitations

The first antiviral drug used to treat HIV was zidovudine (AZT), approved in 1987. Today, there are numerous antiretroviral drugs being used to fight the progression of HIV infection. Among adults with HIV, the virus quickly becomes resistant to any antiviral drugs used alone. Thus, in the 1990s health professionals began using several drugs (three or more, each attacking HIV in a different manner) in combination. This is commonly called *highly active antiretroviral therapy* (HAART). In many patients, this approach initially knocks blood HIV levels down to undetectable levels, raises CD4+ cell counts, and partially restores immune responses. Until recently, HAART was not used until people were in the late symptomatic or AIDS stage of HIV infection, but studies showed that HAART works best when it is started early in the infection (Günthard et al., 2016; Mayer & Krakower, 2016). This increases life expectancy by more than 30 years. HAART also reduces the chance of transmission from an infected person to an uninfected partner by nearly 100% (Rodger et al., 2016).

The results of HAART have been dramatic, substantially reducing the number of new AIDS diagnoses. However, the antiretroviral drug therapy is not a cure. Although HAART generally lowers HIV to extremely low (often undetectable) levels, HIV can still exist in places where the drugs do not affect it. If patients decide to stop the drug therapy, HIV levels generally increase dramatically within a short time (Cohen, 2016).

Many patients cannot tolerate the side effects. For example, long-term use often results in giant accumulations of body fat and insulin resistance or, conversely, extreme loss of body fat (Alam et al., 2012). The real Achilles heel of HAART has been adherence to the medication schedule. Many HIV-positive individuals who begin HAART do not stay on the medications (Malta et al., 2010). When people do not adhere to HAART, it can also result in HIV becoming resistant to the drugs (see Pham, 2009).

5.11.9 Prevention of HIV Infection

Health experts agree that the use of antiretroviral drugs alone will not bring an end to the HIV pandemic. In developing countries (e.g., sub-Saharan Africa), circumcision of young men has significantly reduced the transmission of HIV in heterosexual men (Gray et al., 2012; Mehta et al., 2013). Syringe exchange programs have reduced the spread of HIV among injection drug users—a 63% reduction since 2005 in the United States (CDC, 2016).

The most promising advance to help combat the spread of HIV is antiretroviral drugs prescribed to HIV-negative individuals as a *preexposure prophylaxis*—i.e., as a drug to prevent HIV being spread to them. They are for people in high-risk groups. Correct use of the drug will reduce transmission by about 75% (see Cohen, 2015). Again, however, the big question will be how many HIV-negative high-risk individuals will adhere to the drug regimen.

The first trials of an HIV vaccine began in 1987, but unfortunately, there are some major problems. First, it will be difficult to develop a vaccine that is effective against all the different genetic subtypes of HIV. Second, because the virus continues to mutate, a vaccine developed today may become ineffective over time. One promising approach is to stimulate the immune system to make broadly neutralizing antibodies (Mascola, 2016). Nevertheless, we are still years away from an effective vaccine.

In the meantime, the best way to minimize your own chance of ever contracting HIV is by your own behavior. That means not having multiple sexual partners (both yourself and your partner) and/or always using condoms and not using intravenous drugs (both yourself and your partner). See the section on "Practicing Safer Sex."

5.11.10 Public Reactions to AIDS

HIV-positive individuals have to deal with more than the fact that they have a deadly infection. They must also deal with the stigma of having HIV/AIDS (Piot et al., 2009).

How should we as a society deal with the HIV epidemic? First of all, it is important to educate the public that the virus is not spread by any type of casual contact, and thus there is no medical basis for avoiding nonsexual interactions with infected individuals. Most states now have laws that protect HIV-infected persons against discrimination in the workplace and in housing. Ensuring the privacy and equal treatment of persons with HIV infection is essential to the success of testing, treatment, and outreach programs. Public health officials will not gain the confidence and cooperation of infected individuals if these persons are not legally protected from stigma and irrational prejudice. As former President Ronald Reagan said, "It is the disease that is frightening, not the people who have it."

Personal Reflections

What do you do to protect yourself from sexually transmitted infections? Now that you have learned more about STIs, what changes in your sexual lifestyle do you plan to make to better protect yourself?

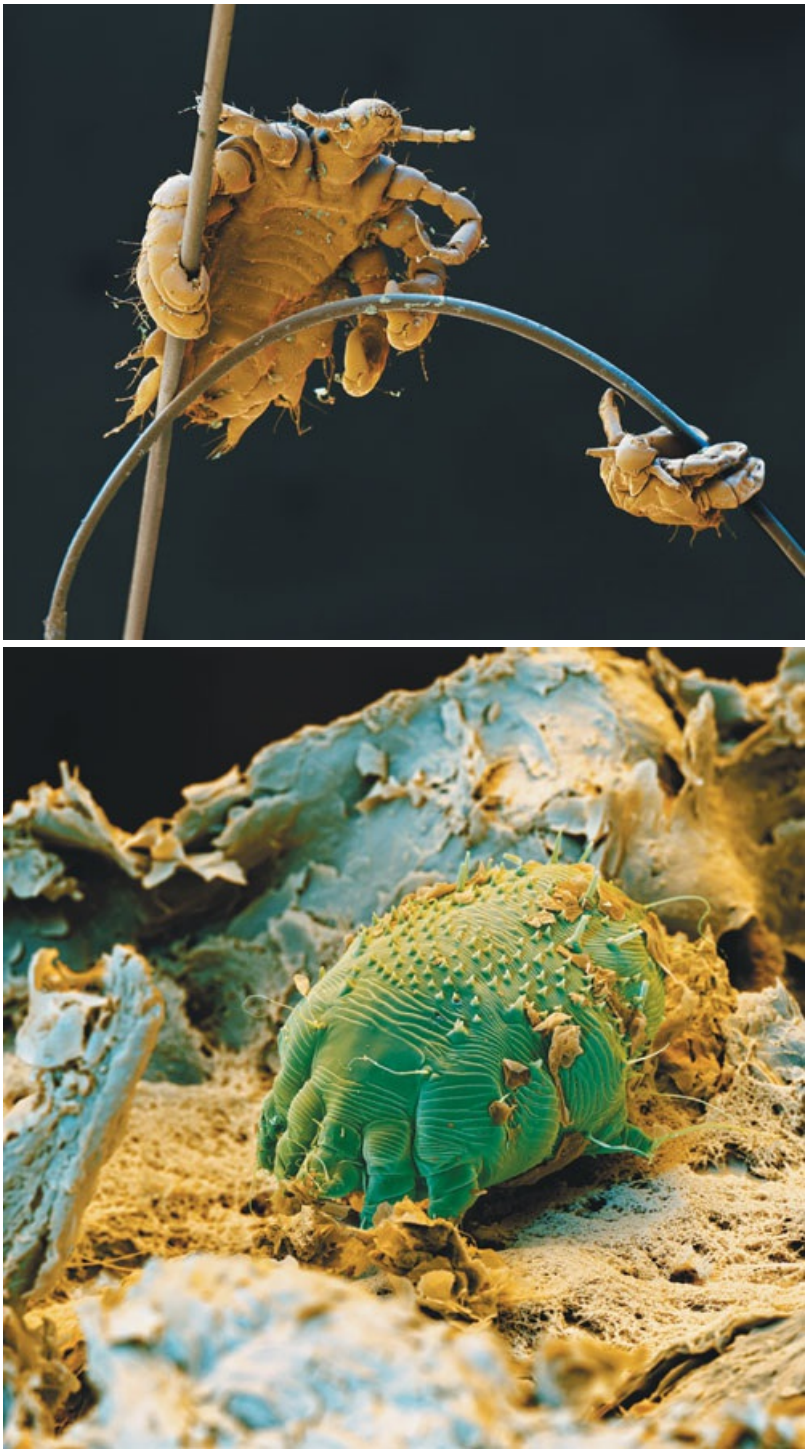
Parasitic Infestations

1. 5.12 Identify various parasitic infestations caused through sexual transmission.

Viral and bacterial infections are not the only things that can be transmitted from one person to another during sex. It is also possible to pick up parasites from an infested person. Condoms will do little good in preventing these types of infestations.

Worldwide, about 2% of people are infested with pubic lice (Dholakia et al., 2014). Pubic lice (*Phthirus pubis*, the crab louse, or "crabs") are 1- to 2-mm long, grayish (or dusky red after a meal of blood), six-legged parasites that attach themselves to pubic hair and feed on human blood (see Figure 5–15). *They are not the same as head lice.* Infestation with pubic lice is technically called *pediculosis pubis*. The lice travel very slowly, so they are almost always transmitted by skin-to-skin contact. Your chance of getting them during sex with an infested partner is about 95% (Brown et al., 1999). The lice cause intense itching.

Figure 5–15



Top: *Phthirus pubis* (crab lice). Bottom: *Sarcoptes scabiei* (gravid female mite).

Source: Eye of Science/Photo Researchers, Inc.; Eye of Science/Science Source

Figure 5–15 Full Alternative Text

"I was a senior in high school and I was sleeping with a guy who I had been involved with for a year. For about 2 weeks I had been itching in the pubic area. The longer it went on, the more irritating it got. Finally, I examined my pubic hair and found little crab-looking things. I was shocked and disgusted."

"I noticed an itching down in my pubic area. It got extensively annoying so I took a look to see what was happening down there. I almost started to scream when I noticed little flat insects crawling around that area."

(All examples are from the authors' files.)

The lice typically do not live for more than 24 hours away from the human body, but any eggs that fall off can survive and hatch up to 10 days later (Meinking & Taplin, 1996). You could, therefore, pick them up from the sheets, towels, or clothing of an infested person. Normal bathing will not wash the lice off, but you can eliminate them by applying 1% permethrin cream rinse to the infested area *and all other hairy body areas*. Repeat the treatment in 7 to 10 days. Resistance to permethrin is increasing, so use of a medication called malathion may be necessary. To avoid reinfestation, be sure to use very hot water to clean all clothing, sheets, and towels that might be infested.

Note: The recent practice of shaving pubic hair (see Chapter 2) has greatly reduced the number of infestations (Dholakia et al., 2014).

Scabies is a contagious infestation of 0.3- to 0.4-mm long, pearly white, parasitic itch mites (*Sarcoptes scabiei*; see Figure 5–15). The eight-legged mites burrow under the skin to lay their eggs, resulting at first in extremely itchy, red, pimple-like bumps when the eggs hatch. Large patches of scaling skin result if the mites are not immediately destroyed. Secondary bacterial infection is common.

"In between my junior and senior year of high school I got scabies. It itched so horribly that I would claw my skin off in my sleep and even while I was awake. It was absolutely awful."

(from the authors' files)

The itch mite is acquired by close contact with infested persons (the mites survive 24 to 36 hours off the body) and thus is most common in people living and sleeping in crowded conditions. Sexual contact is not necessary, but sexual transmission is common among adults (Brown et al., 1999). The mite "is notorious for its lack of respect for person, age, sex or race, whether it be in the epidermis of an emperor or a slave, a centurion or a nursling, it makes itself perfectly at home with undiscriminating impudence and equal obnoxiousness" (Friedman, 1947). Scabies is usually treated with permethrin 5% cream, but a single oral dose of ivermectin is also highly effective. Should you ever get scabies, be sure that you also wash all your sheets, towels, and clothing to avoid reinfestation.

Pinworms (*Enterobius vermicularis*) live in the large intestine and are generally gotten through non-sexual contact with the eggs. The female pinworms leave the rectum at night and lay their eggs around the anus, which causes intense itching (see Weber, 1993). Pinworms are common in children, who pass them from one to another by hand-to-mouth contact while playing. Pinworms can also be transmitted sexually in adults by manual or oral contact with the anus of an infected person. This mode of transmission occurs most commonly among homosexual men. Such sexual practices can also result in the transmission of a one-celled organism (*Entamoeba histolytica*) that causes intestinal amebiasis, or amebic dysentery (Petri & Singh, 1999).

Vaginal and Bladder Infections

1. 5.13 Describe vaginal and bladder infections that affect women.

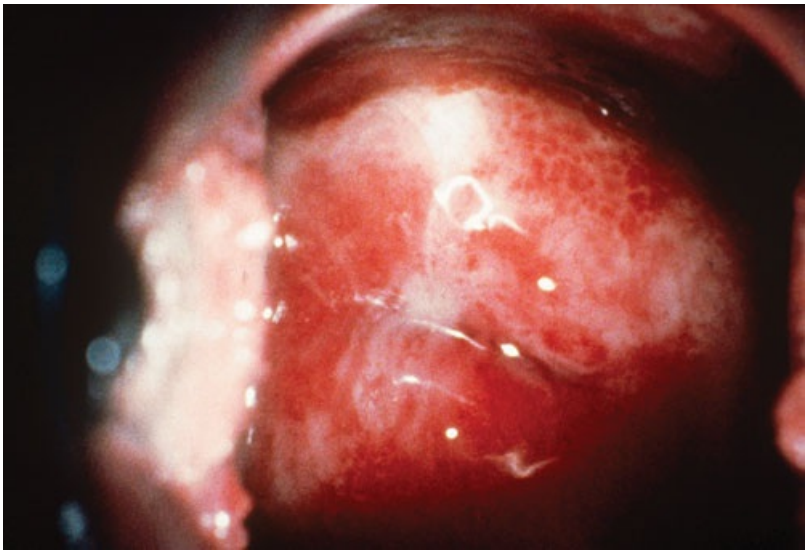
It is rare that a woman does not experience a vaginal infection at least once in her lifetime (CDC, 2010d). Symptoms generally include discomfort or pain during urination, itching, and a vaginal discharge that often has a disagreeable odor. Here are some common causes.

5.13.1 Trichomoniasis (Trichomonas Vaginalis Infection)

Only one type of vaginitis, trichomoniasis, is usually contracted by sexual contact. It is the most common non-viral STI in the United States, with about 1.1 million new cases of "trich" this year and 3.7 million total cases (CDC, 2016). Trich is most common in women, especially black women, but men often have trichomoniasis infections as well (see Marrazzo & Cates, 2011).

Trichomoniasis is caused by a one-cell protozoan named *Trichomonas vaginalis* that lives in the vagina and urethra. Symptoms in women generally appear from 4 days to 1 month after exposure and include a copious, frothy, whitish-green discharge with a foul odor accompanied by severe vaginal itching (see Figure 5–16). However, 70% to 85% of infected women have no symptoms (Meites et al., 2013). Most men infected with trich also show no symptoms (Marrazzo & Cates, 2011) and thus *act as asymptomatic carriers*, spreading it to new female partners—just the opposite of what we often see in the early stages of gonorrhea, chlamydia, and syphilis.

Figure 5–16



(a) The whitish-green discharge in trichomoniasis is usually copious and frothy; (b) Vaginal discharge in a patient with monilial (yeast) infection showing a white curdy appearance.

Source: BSIP SA/Alamy Stock Photo. / Aubert/Science Source

"About 2 weeks after becoming sexually involved with my boyfriend, I began to have severe pain during intercourse. Soon I noticed a discharge, itching, and an extremely foul odor. After many weeks of shame I finally went to the infirmary with my roommate, who was having urinary problems. Imagine how surprised we were to find out that we both had trichomoniasis. How could we catch such a thing? The only person she had sex with was her boyfriend and the only person I had sex with was my boyfriend! In the end we found out that our boyfriends went out together one night and had unprotected sex with a girl that they had known less than 6 hours!"

(from the authors' files)

Trichomoniasis can lead to premature labor in pregnant women, facilitates transmission of HIV from an infected partner, and greatly increases the risk of pelvic inflammatory disease (CDC, 2016).

Now the good news: Trichomoniasis is very curable (Schwebke et al., 2013). The diagnosis of "trich" is made by examining any discharge but more reliably by antigen or nucleic acid amplification tests (Meites et al., 2013). If trichomoniasis is suspected, both the infected woman *and her partner* should be treated. Otherwise, he will just reinfect her when intercourse resumes. Trich is easily eradicated by a drug called metronidazole (its trade name is Flagyl).

Box 5–B Sexuality and Health

Vaginal Health Care

For women, vaginal infections are probably second in frequency only to the common cold. Here are some hygiene tips to help minimize your chances of getting vaginitis:

- Bathe regularly, avoiding deodorant soaps and bubble baths, and do not share washcloths and towels.
- Dry the vulva thoroughly and wear cotton panties (synthetic fabrics retain heat and moisture, conditions in which bacteria thrive).

"I used to get yeast infections several times a year. Every time I would visit or call my doctor. . . . I finally figured it out on my own with a little help from one of the hottest days in June. I would always wear silk or polyester blend underpants and nylon hosiery. Do any of these materials allow absorption? Of course not. I ran out and bought cotton underpants and hosiery with garter belts. Five years have passed and not one yeast infection yet."

(from the authors' files)

- Never wear synthetic underpants to bed.
- Avoid feminine hygiene products.
- After a bowel movement, wipe the anus from front to back, not back to front, as this can spread rectal bacteria to the vagina.
- Allow time for adequate vaginal lubrication during intercourse, and if you use a lubricant, use a water-soluble one such as K-Y jelly (petroleum-based lubricants not only harbor bacteria but disintegrate condoms as well).
- If you and your partner engage in any type of anal stimulation during sex, be sure to wash the hands or penis before touching the vaginal area again.
- If your partner has sexual relationships with people other than yourself, make sure he uses a condom during intercourse.
- If you have frequent yeast infections, ask your doctor about douching with a mild acidic solution.
- Keep stress to a minimum, eat well, and get adequate sleep.
- See a doctor as soon as you notice any of the previously mentioned symptoms. Remember, vaginal infections are very common and nothing to be ashamed of. They can be treated very easily.

5.13.2 Moniliasis (or Candidiasis)

Moniliasis is caused by an overgrowth of a microorganism that is normally found in the vagina (*Candida albicans* in 80% of cases and other *Candida* species in 20%). It is a fungus or yeast infection that is very common in women. Three fourths of all women will experience it at least once in their lifetimes, and 40% to 45% will experience it at least twice (CDC, 2016). About 10% to 20% of women have what is called *recurrent candidiasis*—four or more episodes a year.

Symptoms include a thick, white, curdy discharge accompanied by intense itching (see Figure 5–16). Unfortunately, many women do not realize how common normal yeast infections are and feel alone or dirty when it happens to them.

"The first time I got a yeast infection I was terrified. I didn't know what it was. All I knew was that the itching was intolerable and I had this discharge that wasn't normal."

"The first time I had it was when I was 16. I started to have an uneasy itchy feeling. I took a shower and thought it would go away. It not only continued, but it became worse. I felt very dirty."

(All examples are from the authors' files.)

Yeast infections are sometimes transmitted sexually, but the vast majority of cases are *not* contracted in this manner. Thus, monilial infections are not really considered a sexually transmitted infection, such as trichomoniasis, but are a sexually related disease. The microbe can also invade the mouth (where it is called thrush), anus, and skin as well as internal organs. Thrush is often caused by high blood sugar, a weakened immune system, or use of steroids.

Anything that changes the normal chemical environment of the vagina can result in an overgrowth. This includes hormone changes, diabetes, heavy use of antibiotics (which kill off the "friendly" bacteria in the vagina that keep the yeast in check), and even overly zealous hygiene (e.g., the use of perfumed feminine hygiene products). Many women first experience a monilial infection during pregnancy, for example, or when they first start taking oral contraceptives.

"Once when I had an infected tooth, my dentist prescribed an antibiotic. About the third day I developed a yeast infection. No one had ever told me I could get a yeast infection from an antibiotic. When I told some of my friends, they told me this had happened to at least two of them before."

"I had my first yeast infection when I was pregnant with my first child. I was so embarrassed about having this terrible itch in the genital area that I couldn't tell anyone. Finally it was time for my regular prenatal checkup, and when the doctor examined me and saw that I had scratched myself raw he wanted to know why I had not called him. I was just too embarrassed to say I had an itch in the genital area."

(All examples are from the authors' files.)

Women with immune deficiencies (e.g., HIV infection and AIDS) are particularly susceptible to yeast infections.

Yeast infections are often treated with antifungal creams or suppositories. There are over-the-counter vaginal drugs that you can purchase in the drugstore (e.g., miconazole vaginal suppository, clotrimazole cream, butoconazole cream) and drugs that you take by mouth (Fluconazole) (Marrazzo & Cates, 2011). However, if the symptoms do not go away within a few days, see your doctor immediately, for you might have one of the other types of vaginitis.

5.13.3 Bacterial Vaginosis

In women aged 15 to 44, bacterial vaginosis is the most common vaginal infection, with about 21 million new cases per year. It is caused by several vaginal bacteria (particularly *Gardnerella vaginalis*) replacing other normal hydrogen peroxide–producing vaginal bacteria (CDC, 2016; Marrazzo & Cates, 2011). It is most common among African American women and women who have sex with women (Gorgos & Marrazzo, 2011). Bacterial vaginosis is presently not considered a sexually transmitted infection, but it is "sexually associated" (Marrazzo & Cates, 2011). The use of condoms decreases the prevalence. Vaginal douching increases the likelihood of getting bacterial vaginosis, suggesting that the infection can also be acquired by non-sexual means.

The main complaint of patients is a vaginal odor (sometimes described as fishy), but there is also an abnormal discharge (grayish and non-clumpy). We now know that this type of infection can lead to serious upper reproductive tract infection (Marrazzo & Cates, 2011). The antibiotics of choice are metronidazole or clindamycin, but the recurrence rate is very high.

5.13.4 Cystitis

Cystitis refers to a bacterial infection of the bladder, often called a urinary tract infection. As many as 20% of women will experience this sometime in their lifetime. Because a woman's urethra is considerably shorter than a man's (and thus bacteria have a shorter distance to travel) cystitis is much more common in women than men. It is especially common in sexually active young women and is strongly associated with recent intercourse. However, many cases are unrelated to sexual activity (Mayo Clinic Staff, 2013). The bacterium *Escherichia coli*, for example, is often transmitted from the rectum to the urethral opening by wiping forward from the anus after a bowel movement. Women should always wipe themselves from front to back.

Symptoms may include a frequent urge to urinate, painful urination, blood in the urine, and lower abdominal pains. Cystitis is usually treated with antibiotics (Mayo Clinic Staff, 2013). Vigorous intercourse, especially in women first becoming sexually active, can also result in urinary tract infection (hence the term *honeymoon cystitis*) by causing inward friction on the urethra, allowing non-sexually transmitted bacteria to ascend.

Some women suffer from chronic inflammation (and pain) of the bladder, a condition called *interstitial cystitis*. Researchers are not sure what causes it, but it is not caused by the bacteria that cause other types of cystitis. Because it may have multiple causes, treatment will depend on the individual (Hsieh et al., 2012).

Practicing Safer Sex

1. 5.14 Discuss safer sex practices and positive sexuality.

Add them up: 14.1 million new cases of HPV infection, 2.86 million new cases of chlamydia, 1.09 million new cases of trichomoniasis, 820,000 new cases of gonorrhea, 776,000 new cases of genital herpes, plus others (see Table 5–1). There will be over 19 million new cases of sexually transmitted infections this year—over 54,000 new cases every day—with most cases occurring within your age group (late teens through 40). Of course, some people who are sexually active will be infected with the same STI two or more times in a single year or even get two or more different STIs at once. Yes, having one does not prevent you from getting others, so it is possible to hit the jackpot and have more than one at once.

What are you doing to avoid sexually transmitted infections? It appears that many college students are doing little or nothing. In fact, many continue to engage in high-risk behaviors. There is a strong association between number of sexual partners and having or having already had a sexually transmitted infection (Joffe et al., 1992); yet, according to surveys, many young people have had multiple lifetime sexual partners (Kann et al., 2016).

Why do so many people continue to engage in high-risk sexual behaviors (see Box 5–C)? Many young men and women who have had multiple sexual partners believe "it won't happen to me" (Kusseling et al., 1996). Recall, however, that it *will* happen to 1 in 2 Americans in their lifetimes (CDC, 2016; Satterwhite et al., 2013). So let's get serious and consider how you can minimize the chances of it ever happening to you.

Box 5–C Sexuality And Health

Impediments to Practicing Safer Sex

In a national survey of men aged 18 to 24, it was found that only 46.9% had used a condom during intercourse with their most recent casual-sex partner (Reece et al., 2010c). During the 1980s, it was hoped that educating people about AIDS and the transmission of HIV would lead them to practice safer sex. Most young people today are, in fact, knowledgeable about HIV and AIDS. However, researchers find that there is no relationship at all between people's knowledge of AIDS and their sexual behavior (Lou & Chen, 2009). This has led many researchers to conclude that, by itself, knowledge is "not sufficient for compliance to safer-sex guidelines" (Helwig- Larsen & Collins, 1997; Sheeran et al., 1999; Tate et al., 2002).

If it is not lack of knowledge that prevents many people from practicing safer sex, what is it? Actually, there are many reasons. We will consider a few of the most important.

One of the most common reasons that men give for not using condoms is that one was not available when they were in the mood to have sex (Carter et al., 1999). Many men are embarrassed about buying condoms (Murphy & Boggess, 1998). Young people are also less likely to use condoms if they use alcohol or drugs prior to sex (Cooper, 2002; Walsh et al., 2014). Couples are also less likely to use condoms if one or the other person believes it reduces their sexual pleasure (Fennell, 2014; Higgins et al., 2015).

People are more likely to have a condom available if they have used them in the past, especially if they are with a partner with whom they have agreed to use condoms. The major problem here is that to have come to an agreement, a couple has to have talked about using condoms, and most people, including those who are college-educated, do not know how to initiate and engage in conversation about condoms (Sheeran et al., 1999). "The ability to negotiate condom use is a skill. . . ." (Noar et al., 2002). Practicing safer sex means that you must be able to talk with partners about using condoms, as well as about their sexual history, and that you must be able to put a stop to sexual activity if your partner will not use one. This requires some degree of assertiveness. Young people who have these behavioral skills are much more likely to practice safer sex (Noar et al., 2006; Widman et al., 2006; Wingood & DiClemente, 1998; Zamboni et al., 2000). For women, assertive strategies work best—a direct request to use condoms or withholding sex until the partner complies (French & Holland, 2013).

One factor that prevents some women from acting in their own best interest is the perceived power difference between men and women. Many women do not believe that they even have the right to make decisions about contraception (Rickert et al., 2002). Some men use coercive tactics to resist using condoms (Davis et al., 2014). If a woman's predominant experience of relations between men and women is of men exerting power over women and always getting their way, she is not likely to insist that a man use a condom if he does not want to (Browne & Minichiello, 1996; Seal, 1996).

Figure 5–17

A giant condom displayed at the Fifth International AIDS Conference in Montreal.

Source: Black Star

Even when there is little or no power difference, communication between a man and a woman about safer sex is often hindered by cultural double standards and sexual "scripts" (Ehrhardt, 1992; Metts & Fitzpatrick, 1992). In American culture, men are given more sexual freedom than are women. Thus, a woman may be viewed negatively by a partner and by others if she openly expresses a desire for sex or if she carries condoms (Hillier et al., 1998), and she may be considered respectable only if she refuses a partner's sexual advances. Women who believe that their partners endorse this standard are not likely to provide a condom or suggest that their partner use one. On the other hand, women often underestimate how often men want to use condoms (Edwards & Barber, 2010).

Another problem is that sexual scripts often work against the use of condoms when one starts dating a "respectable" and "safe" partner where the goal is the formation of a relationship (Afifi, 1999; Fortenberry et al., 2002; Hynie et al., 1998). There is a negative relational significance associated with condoms: if they are not being used for birth control, their only other use is for the prevention of STIs with an "unsafe" partner. When the focus of "getting to know you" is on the other person's suitability as a relational partner, the subject of condoms may be viewed negatively, suggesting promiscuity and possible infection (by oneself or the other) and increasing the likelihood of rejection (see Choi et al., 1994). In fact, some people purposely do not use condoms "as a strategy to find and maintain a primary relationship, establish trust and increase intimacy" (Corbett et al., 2009).

Even when condoms are used during early sexual episodes, they are likely to be abandoned once the two individuals perceive themselves as starting a relationship (He et al., 2016). But without previous, explicit, honest discussion about prior sexual experiences, you cannot be certain. Or, put another way, "You know if you're using a condom or you're not. You don't know if you're picking the right partner" (Heterosexual AIDS, 1988).

The only way to completely avoid any chance of ever getting an STI is never to have sex, but few of us wish to live the life of a Tibetan monk. There is no such thing as safe sex with another person; anyone having sex is at some risk. We can, however, practice "safer sex"—behaviors that minimize the chances of contracting an STI.

One safer sex solution is to *restrict your sexual activity to a mutually faithful, long-term, monogamous relationship*. If neither you nor your partner has an STI at the start of the relationship and neither of you has other partners, you do not have to worry about STIs. However, there are problems with this approach. First, while many of us limit our sexual behavior to monogamous relationships, most monogamous relationships do

not last forever. Many of us have lifestyles of what is commonly called *serial monogamy*. We break up and eventually enter into another monogamous relationship. You may have been having sex with only one person for a certain period of your life, but how many monogamous relationships have you had in your lifetime? If just one of those partners had an STI, he or she could have transmitted it to you. When we have new sexual partners, we can rarely be sure of their sexual history. Many people are unaware of their partners' current high-risk behaviors (other sexual partners, past injection drug use) (Witte et al., 2010). In addition, a great many people have lied to new partners about their past sexual experiences (Cochran & Mays, 1990).

"A friend of mine was going out with a guy from . They had a sexual relationship and used condoms most of the time. He only recently mentioned that he had tested positive for the AIDS virus in the past. My friend is under tremendous psychological distress."

(from the authors' files)

A second problem is that few of us can be 100% certain that our partner will remain monogamous. Many couples cannot even agree whether they are in a monogamous relationship (Warren et al., 2012). Read again the personal case histories at the beginning of the chapter.

A second solution is to *always use condoms*. A study of 124 heterosexual couples in which one partner was infected with HIV found that for those couples who used condoms consistently, none of the noninfected partners became infected during a total of 15,000 episodes of intercourse (De Vincenzi et al., 1994). It is certainly best to use condoms if you are going to engage in "casual" sex. For women whose partners refuse to wear condoms, there are some birth control techniques that reduce the risk of HIV (or other STI) infection (see Box 6–A in Chapter 6).

There are problems with condoms (as STI prevention) as well. Even if you and your partner or partners use them consistently and properly, they sometimes tear (see Chapter 6). Even microscopic tears are large enough to allow the passage of viruses. In other words, as is the case with practicing monogamy, condoms cannot guarantee that you will never get a sexually transmitted infection.

Which method is better? In a study that used probability modeling to test the amount of risk reduction, the authors concluded that "consistent and careful condom use is a far more effective method of reducing HIV infection than is reducing the number of sexual partners" (Reiss & Leik, 1989). Whichever behavioral strategy you use—condoms or the practice of monogamy (in a *long-term* relationship)—you will greatly reduce your chances of ever getting a sexually transmitted infection.

Personal Reflections

Do you and your new partner(s) discuss safer sex? Why or why not? Be sure to read Box 5–C.

5.14.1 What to Do and Where to Go If You Think You May Have an STI

You would think it would be obvious to people what to do if they thought they might have, or thought they were at risk for, a sexually transmitted infection—go to a doctor! However, many people hesitate to do this because of denial that they are at risk or worries about confidentiality. Among sexually experienced people aged 15 to 25, only 16.6% of females and 6.1% of males have been tested in the past year (Cuffe et al., 2016). Now that you know the consequences of untreated STIs, we hope that this will not include you. If you think you have an STI (or if you have put yourself at high risk of getting one):

1. See a physician immediately. Many primary care physicians lack the knowledge and experience to diagnose and treat sexually transmitted infections (Wiesenfeld et al., 2005). So, if possible, see a doctor who *specializes in treating infectious diseases*.
2. If he or she diagnoses you as having an STI, abstain from having sex until you are cured (or use condoms if there is no cure).
3. If you have an STI, tell your partner or partners so that they, too, can be treated and not infect others or yourself again.

There are two other reasons that someone might not go to a doctor immediately. Some (e.g., poor college students) may not be able to afford the doctor's charges and lab test costs, and others might not know where to go even if they had the money (they might not have a doctor, or they may wish to avoid the family doctor). Fortunately, the U.S. Public Health Service provides clinics for the diagnosis and treatment of sexually transmitted infections—often free of charge. The government is committed to eradicating STIs. So there is no excuse not to be treated. Contact the Public Health Service clinic in your area.

5.14.2 Positive Sexuality in the Era of AIDS

AIDS, human papillomavirus infections, herpes—the attention being given to these and other sexually transmitted infections is making many people afraid of sex. Our intent in this chapter has been to educate you about some of the *possible* consequences of sexual behavior, not to scare you so badly that you will want to avoid ever having sexual relations.

There are many activities human beings engage in that involve risk. Take skiing, for example. No one has to tell us that going down a snow-and-ice-covered mountain on a pair of skis is a dangerous activity. If trees, boulders, and other skiers are not avoided, the result can be terrible injury, yet this does not detract from the tremendous enjoyment many people derive from this winter sport. Those who ski learn that there are limitations to how they seek that pleasure. Skiing out of control has its consequences.

The same is true of driving an automobile. Many people own sports cars, and many others would like to. They get a certain thrill by accelerating quickly and driving fast. But, again, there are limitations. Taking a corner at too high a speed can be fatal. At high speeds, we must be able to react to unanticipated events (e.g., another car cutting in front of us) in a fraction of a second. Driving while having impaired judgment and motor

coordination due to alcohol consumption is certainly an often fatal high-risk behavior. The fact that each year thousands of people are injured or killed because they foolishly take that risk does not detract from the pleasure that the rest of us often get from driving our cars.

Source:

Glasbergen Cartoons

AIDS is not the first sexually transmitted infection, only the most recent. Syphilis was greatly feared before the discovery of antibiotics (Francis, 2013). Many millions more have died of syphilis than of AIDS, yet this has not stopped people from enjoying sex. Why? *Because sex, by itself, does not cause any of these infections*. Like driving an automobile, if we avoid foolish, high-risk behaviors, we can still enjoy the pleasures of sexual relations. The few seconds it takes to put on a seat belt does not detract from you enjoying your automobile. Similarly, the few seconds it would take you or your partner to put on a condom will not detract from the enjoyment of sex. Like drinking and driving, making sexual decisions while under the influence of alcohol is also foolish.

AIDS does not strike randomly—it only affects those who are exposed to the virus. If you make just a few adjustments to reduce the risk of exposure, sex can be as pleasurable and exciting as always.

Study Guide

Key Terms

- acquired immunodeficiency syndrome (AIDS)
- amebiasis
- asymptomatic HIV infection
- bacteria
- bacterial vaginosis
- chancroid
- chlamydia
- cystitis
- genital herpes
- genital (venereal) warts
- gonorrhea
- granuloma inguinale
- HAART
- hepatitis A
- hepatitis B
- hepatitis C
- human immunodeficiency virus (HIV)
- human papillomavirus (HPV)
- immune system
- lymphogranuloma venereum (LGV)
- molluscum contagiosum
- moniliasis
- nongonococcal (nonspecific) urethritis (NGU)
- oral herpes
- pelvic inflammatory disease (PID)
- pinworms
- primary HIV infection
- pubic lice
- safer sex
- scabies
- sexually related diseases
- sexually transmitted infections (STIs)
- shigellosis
- symptomatic HIV infection

- syphilis
- trichomoniasis
- virus
- Zika virus

Interactive Review

Answers can be found on p. 469.

1. There are about 19.7 million new cases of sexually transmitted infections in the United States every year. One in (1) Americans will have at least one STI sometime in their life.

   Sexual behavior does not cause STIs. The behavior is merely the mode of transmission for (2) , (3) , and/or (4) , that must be present for the infections to be transmitted. These causative agents are nondiscriminating—anyone having sex with an infected partner can get a sexually transmitted infection.

   The three most common STIs (in the United States) caused by bacteria are (5) , (6) , and (7) . In the early stages of (8) and (9) , most women and many men show no symptoms. If they are not treated, the bacteria that cause these two STIs can invade the upper reproductive tract and cause prostatitis and epididymitis in men and (10) in women. (11) passes through several stages, and if left untreated can cause organ damage and death. These types of STIs can usually be cured with (12) .

   Sexually transmitted infections caused by viruses are generally incurable because the viruses live inside normal body cells. Herpes has been around since biblical times and is spread by direct (13) -to- contact. Genital herpes is almost always transmitted by genital-to-genital or mouth-to-genital contact; oral herpes is usually spread by more casual contact. After the primary attack, many herpes sufferers experience (14) attacks when the virus replicates and sheds. The virus is most easily transmitted during active attacks, but can be transmitted at other times.

   Hepatitis is an inflammation of the (15) that can be caused by contact with contaminated (16) (hepatitis A) or infected (17) (hepatitis B). Over one half of all cases of hepatitis B are sexually transmitted. More Americans die from the complications of hepatitis C each year than from AIDS.

   Warts in the genital and anal areas are caused by a few types of the (18) virus. Other types of the virus are associated with cancer of the cervix, mouth/throat, and penis. Physicians can attempt to remove the warts or abnormal cervical cells, but they cannot attack the viruses directly; thus, in many cases, the condition reappears.

   AIDS is caused by the (19) . HIV invades and destroys (20) (also called helper T) cells, white blood cells that are a critical part of the body's (21) system. Most people infected with HIV remain asymptomatic for several years. HIV infection is not called AIDS until the immune system is so weakened that the individual's life is threatened. People with AIDS eventually die from a variety of (22) infections. Without medication, about half of all individuals who become infected with HIV will develop AIDS within (23) years. HIV originated in Africa from simian (non-human primate) immunodeficiency viruses. It is transmitted by (24) and exposure to infected (25) . It is not spread by (26) . HIV infection is a true pandemic, with at least 37 million people currently infected worldwide. Worldwide, most cases are spread by sexual activity between (27) . Presently, there is no cure, but there are several antiretroviral drugs that slow the progression of the infection.

   Pubic lice and scabies are not really infections, but (28) . Pubic lice attach themselves to pubic hair and feed on blood. Scabies is caused by a mite that burrows under the skin to lay its eggs.

   There are three general types of vaginal infections. (29) is caused by a one-celled protozoan that is transmitted during sexual intercourse. (30) vaginitis is a fungus or yeast infection that is very common in women. Anything that changes the chemical environment of the vagina can cause a yeast infection. (31) is caused by several vaginal bacteria that replace normal hydrogen peroxide-producing bacteria. Vaginal infections are very common and are nothing to be ashamed of.

   STIs do not strike randomly—they only affect those who are exposed to the bacteria or viruses. You can greatly reduce your chances of ever contracting a sexually transmitted infection by practicing safer sex. This means making one of two choices: (1) using condoms properly and consistently, or (2) abstaining from sexual relations until you are reasonably confident that you are in a long-term monogamous relationship.

   Answers can be found on p. 469.

Self-Test

A. True or False

- **T F** 32. People who have had a sexually transmitted infection in the past are immune to getting that type of STI again.

- **T F** 33. Cold sores and fever blisters are symptoms of herpes.
- **T F** 34. Homosexuality is one of the causes of AIDS.
- **T F** 35. If left untreated, gonorrhea can turn into syphilis.
- **T F** 36. Yeast infections (monilial vaginitis) can usually be prevented by using feminine hygiene products.
- **T F** 37. A person with a cold sore on the mouth can give his or her partner genital herpes during oral-genital sex.
- **T F** 38. Gonorrhea, chlamydia, and syphilis are often contracted by people who use toilet seats previously used by infected individuals.
- **T F** 39. Chlamydia is more common than gonorrhea.
- **T F** 40. It is possible to contract HIV by hugging, touching, or being close to an infected person.
- **T F** 41. The large majority of women do not show any symptoms in the early stages of gonorrhea or chlamydia.
- **T F** 42. Herpes can sometimes be cured with antibiotics.
- **T F** 43. A person can have only one type of sexually transmitted infection at a time.
- **T F** 44. HIV, the virus that causes AIDS, is sometimes spread by mosquitoes.
- **T F** 45. Pelvic inflammatory disease can be caused by infections that were not contracted during sex.
- **T F** 46. Condoms are generally ineffective against the human immunodeficiency virus.
- **T F** 47. The eggs of pubic lice can survive for days on towels or sheets.
- **T F** 48. A person who has no symptoms does not have to worry about having gonorrhea, chlamydia, or syphilis.
- **T F** 49. Only women can contract trichomoniasis and monilial infections.
- **T F** 50. Herpes can be cured with a drug called acyclovir.
- **T F** 51. The human papillomaviruses that cause cervical cancer are the same as those that cause genital warts.
- **T F** 52. The Zika virus can be spread during sexual intercourse.
- **T F** 53. Recurrent herpes attacks are generally more painful, and last longer, than the first (primary) attack.
- **T F** 54. Herpes is the leading infectious cause of blindness in the United States.
- **T F** 55. Hepatitis A is most often spread by nonsexual means.
- **T F** 56. Worldwide, most cases of HIV infection (infection with the virus that causes AIDS) are contracted by sex between heterosexuals.
- **T F** 57. Generally speaking, people who get AIDS this year are those who became infected with HIV 5 to 15 years ago.
- **T F** 58. To minimize their chance of a vaginal infection, women should wear panties made of synthetic fabrics.
- **T F** 59. People who get HIV are extremely contagious in the first 60 days after exposure.
- **T F** 60. HIV/AIDS can be considered cured when drug therapy reduces HIV to non-detectable levels.

B. Matching

Symptoms

- 61. painful, crater-like sores
- 62. itchless, painless rash all over the body
- 63. pus-like discharge and/or burning during urination
- 64. intense itching caused by grayish, six-legged parasites
- 65. thick, white, curdy vaginal discharge and intense itching
- 66. loss of appetite, fatigue, slow recovery from colds and flus, continual yeast infections, purple blotches on skin, pneumonia

- 67. cauliflower-like growths
- 68. severe abdominal pain and fever
- 69. scaling skin caused by pearly mites
- 70. large, ulcer-like, painless sore
- 71. fluid-filled blisters
- 72. copious, foamy, whitish-green vaginal discharge with foul odor
- 73. wart-like growths that look like small pimples filled with kernels of corn
- 74. thin, clear discharge and irritation of the urethra
- 75. jaundiced or yellow tinge of skin and eyes
- 76. large ulcers (gummas) on the skin and bones; damage to the heart and nervous system
- 77. inflammation of the bladder

Infection (or Infestation)

1. chancroid
2. chlamydia
3. gonorrhea
4. hepatitis
5. herpes
6. HIV infection (AIDS)
7. molluscum contagiosum
8. moniliasis (yeast infection)
9. PID
10. primary-stage syphilis
11. cystitis
12. secondary-stage syphilis
13. scabies
14. trichomoniasis
15. human papillomavirus infection
16. late-stage syphilis
17. pubic lice

C. Fill in the Blanks

- 78. Trichomoniasis, pubic lice, and scabies are all caused by .
- 79. In women, untreated gonorrhea or chlamydia can lead to .
- 80. A woman who has had is at high risk of getting cancer of the cervix.
- 81. The sexually transmitted infection that impairs the immune system is called .
- 82. Trichomoniasis, moniliasis, and bacterial vaginosis are all .
- 83. A viral liver infection that can be sexually transmitted is .

- 84. Two serious possible consequences of PID are and .
- 85. Three sexually transmitted infections that can be passed from an infected pregnan**T F**emale to the fetus are , , and .
- 86. is the most common thing that brings on recurrent herpes attacks.
- 87. The bacteria that cause gonorrhea and chlamydia live on .
- 88. Any inflammation of the urethra not caused by the gonococcus is called .
- 89. Antibiotics commonly lead to infections.
- 90. live in the large intestine and can be transmitted during sex, but are generally acquired by children through nonsexual means.
- 91. Many people diagnosed with gonorrhea are also found to have .
- 92. HIV attacks immune system cells called .
- 93. People with HIV are most contagious (when) .
- 94. The most common AIDS test tests for .
- 95. Gonorrhea, chlamydia, syphilis, herpes, HPV infection, HIV infection, trichomoniasis—for which of these infections do women usually not have visible symptoms in the initial stage?
- 96. For which of the infections listed in the previous question do men usually not show symptoms in the initial stage?
- 97. The best ways to avoid sexually transmitted infections are and .
- 98. The most common sexually transmitted infection in the United States is .

Suggested Readings and Resources can be found on p. 461.

Chapter 6 Birth Control

> The United States is the only Western nation that still subscribes to the dangerous myth that giving teenagers access to birth control . . . will make them sexually active at a younger age. Other countries advertise birth control products widely and have a much lower rate of teen pregnancy.

—American Academy of Pediatrics, 2010, p. 578

Learning Objectives

When you have finished studying this chapter, you should be able to:

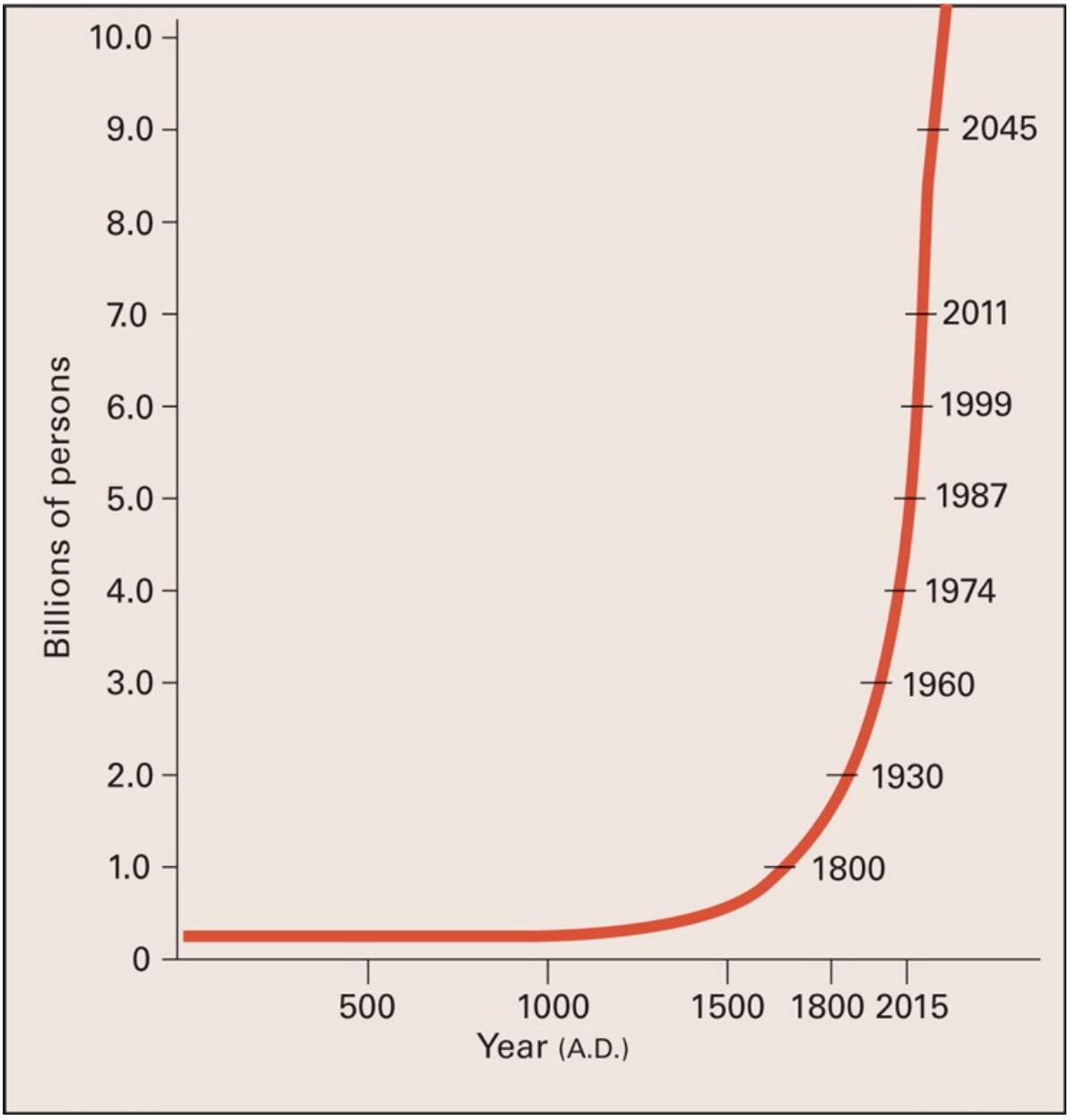
1. 6.1 Discuss the teenage pregnancy problem in the United States and understand the worldwide need for effective contraceptive techniques.
2. 6.2 Explain how the various fertility awareness methods of contraception work.
3. 6.3 Compare and contrast the various barrier methods of birth control and their effectiveness.
4. 6.4 Describe the various short-term hormonal methods of contraception (the pill, patch, and vaginal ring), how they work, and their potential side effects.
5. 6.5 Explain how emergency contraception works.
6. 6.6 Discuss the advantages of long-acting reversible contraception (the IUD and implants).
7. 6.7 Describe the various sterilization procedures and explain their advantages and disadvantages.
8. 6.8 Discuss the contraceptive methods that also help to prevent sexually transmitted infections.
9. 6.9 Delineate the methods used and arguments for and against abortion.
10. 6.10 Determine which contraceptive method is right for you.

World Population

Imagine two shipwrecked couples on a small South Pacific island in the year 1700. The island has a small supply of fresh water, some animal life but no predators, edible vegetation, and a small amount of land suitable for farming. For these four people, the island is Utopia—it has more than they will ever need. Each couple is fertile and has four children (probably an underestimate without birth control), and the children in turn pair off in their late teens to form four couples, each of which has four more children. Thus, in each generation there would be twice as many people as in the previous generation. If there were no accidental deaths and the people lived until age 65, there would be at least 224 people living on the island by the year 1800. For those people, the island is no longer Utopia. The animals have all been killed, the edible plant life is consumed within days of becoming ripe, and there is not nearly enough farmland to support a population of this size. What is worse, even the water supply must be rationed, and the population continues to increase. Soon there will be large-scale death from starvation and dehydration.

Wildlife experts are used to seeing this happen to populations of deer in areas where there are no predators, but is this scenario too far-fetched for humans? Consider that the world is really just an island. We have a limited amount of natural resources, including water. Should these resources become exhausted, we would find ourselves in the same situation as the inhabitants of our hypothetical island. The world population has been increasing at an alarming rate (see Figure 6–1), and it is now more than 25 times greater than in the year a.d. 1. It was about 1 billion in 1804 and reached 5 billion in 1987, 6 billion at the end of 1999, and 7 billion in 2011. The United Nations estimates that the world population could be 11.2 billion in 2100.

Figure 6–1



World population growth. Notice how rapidly the world population has increased since the beginning of the 20th century.

Figure 6–1 Full Alternative Text

Many experts predict that unless this world population explosion is substantially slowed, the end result will be widespread starvation, poverty, and political instability. Already, half the children born today are at poverty levels. Here is a warning by Paul and Anne Ehrlich, authors of *The*

Population Explosion (1990):

> We should not delude ourselves: The population explosion will come to an end before very long. The only remaining question is whether it will be halted through the humane method of birth control, or by nature wiping out the surplus.

In some parts of the world, mass starvation is no longer hypothetical but already a reality. It is happening in Ethiopia, Somalia, and many other parts of Africa and in Asia. In India, infanticide (the killing of children, especially newborn girls) is not uncommon (Cohen, 2000). Because of huge overpopulation and the threat of mass starvation, in 1980 the Chinese government ordered that couples not have more than one child. As a result of this policy, China's fertility rate fell dramatically from about six children per woman in 1970 to about 1.8 children. The one-child policy was partially ended in 2013 (Hesketh et al., 2015).

Worldwide, there are about 200 million pregnancies each year, of which 41% are unintended. Many of these unintended pregnancies occur because in developing countries women do not have access to modern contraception (Darroch, 2013; Singh et al., 2010). On the other hand, today, worldwide (each year), "Family planning programs prevent an estimated 187 million unintended pregnancies, including 60 million unplanned births and 105 million abortions, and avert an estimated 2.7 million infant deaths and 215,000 pregnancy related deaths" (Amy & Tripathi, 2009, p. 563). Accessible birth control in developing countries could avoid another 54 million unintended pregnancies every year (Darroch, 2013).

U.S. Births and Use of Birth Control

1. 6.1 Discuss the teenage pregnancy problem in the United States and understand the worldwide need for effective contraceptive techniques.

During the "baby boom" years (following the end of World War II through 1960), there was an average of 3.5 babies born to each American couple (Gibbs, 2010). If that rate had continued, the population of the United States today would be well over 500 million.

What prevented the United States from having this population explosion? Quite simply, it was the use of birth control, which has made it possible for people to limit the number of children they have. Nearly 100% of women of reproductive age having sexual intercourse use some type of birth control (for at least some period) (Daniels et al., 2013a). The birth rate started to fall in the early 1960s, and by 1970 the average American woman had 2.0 births in her lifetime. The U.S. birth rate had decreased further to 1.9 in 2012 (National Center for Health Statistics, 2013).

6.1.1 Teenage Pregnancy Rate

Over 75% of American married women use contraception, and as a result, the average age at which American women have their first baby is 23 (National Center for Health Statistics, 2013). Unfortunately, consistent use of contraception is apparently not as common among teens. The teenage pregnancy rate in the United States is the highest of any developed country in the world (Sedgh et al., 2015; see Table 6–1).

Table 6–1 Teenaged (15 to 19 Years Old) Pregnancy and Birth Rates (per 1,000 Women) in Developed Nations

	Pregnancies	Births
United States	57	34
New Zealand	51	26
Russian Federation	49	26
England and Wales	47	21
Sweden	29	6
Canada	28	13
Spain	26	10
France	25	7
Finland	23	8
Norway	23	7
Israel	22	13
Denmark	21	5
Czech Republic	20	11
Netherland	14	5
Japan	13	4
Germany	9	5

Source: Data from G. Sedgh et al., (2015). Adolescent Pregnancy, Birth, and Abortion Rates across Countries: Levels and Recent Trends. *Journal of Adolescent Health,* 56, 223–230.

Table 6–1 Full Alternative Text

The high teenage pregnancy rate in the United States comes in spite of significant improvements since the early 1990s. The percentage of high school students (all grades) who had ever engaged in sexual intercourse decreased from 54.1% in 1991 to 41.2% in 2015 (Kann et al., 2016). The U.S. teenage pregnancy rate also began to decline after 1991, and by 2013 it was only half (550,000 teenage pregnancies) of what it was in 1991 (Kost & Maddow-Zimet, 2016). As a result, the teenage birth rate has declined 41% since just 2006 (Romero et al., 2016) and abortions to teens have also declined dramatically (Kost & Maddow-Zimet, 2016). There are ethnic differences: the pregnancy and birth rates for African American and Hispanic teens is about twice as great as for white teens. This is related to social and economic status (Harden et al., 2009; Kearney & Levine, 2012). Teenage pregnancies are much more likely to occur among those with low income or low levels of education. Thus, the teenaged girls most likely to have babies are generally the ones least prepared to take care of them—teens who are already living in poverty and with low educational aspirations. Being an unwed teenaged mother does not guarantee that a woman will be locked into poverty with no job skills and little education, but most will experience long periods of hardship because of early childbearing.

About 45% of all pregnancies in the United States are unintended—down from 51% in 2008 (Finer & Zolne, 2016). Over one third of women who have had an unintended pregnancy have another unintended pregnancy (Wildsmith et al., 2010), and over 18% of births to teens are to girls who already have at least one child (Jayson, 2013).

What is responsible for the decline in teenage pregnancies in the past decade? Studies have shown that 86% of the decline is due to increased use of contraception and only 14% is the result of increased abstinence (Santelli et al., 2007). Among sexually active teens, about 52% of girls and 61.5% of boys reported that condoms were used during their last sexual intercourse, and 18.2% reported that birth control pills were used (Kann et al., 2016).

Why do some people have sex without using contraception? Some of the most common reasons are thinking that you cannot get pregnant and method-related difficulties and side effects (Mosher et al., 2015). If teens have already taken a chance without having it result in pregnancy, they are likely to take the chance again. Eventually, they begin to feel that they cannot get pregnant—that it will not happen to them.

"I have been having sex since I was 16. I have had different partners and unprotected sex with all of them. I always believed that I couldn't get pregnant. It only happens to bad girls and people who wanted it to happen. There were a couple of late periods and worrying, but it never made me want to try birth control. . . . I found out I was 2 months pregnant. I was completely shocked."

(from the authors' files)

Among teens and young adults, ignorance about contraception is also common (Frost et al., 2012).

"As a paramedic I've delivered more babies than I can count. Once I responded to a person with 'rectal bleeding.' To my surprise, a young girl greeted me saying that 'she has something coming out her rectum and she is bleeding all over.' The 15-year-old was scared to death, still clothed in underwear, bleeding, with a large mass between her legs, inside the underwear. I gained information from the family that no one had any inclination that this 15-year-old was even pregnant. What an education for a 15-year-old. Is this really what we want for our children, or do we want to provide the availability of more classes such as Human Sexuality? I vote for the latter."

(from the authors' files)

6.1.2 Prevailing Attitudes Toward Birth Control

Perhaps the most unfortunate part of all this is that the high rate of births to teens and young adults continues to occur in a day and age when highly effective means of birth control are available. This was not always the case. The prevailing attitude toward sex during Victorian times, you recall, was that it was for procreation only, and thus birth control was opposed. In many states it was against the law to sell or distribute contraceptive devices (see Prescott, 2016, for a history). As a result, women generally had several children, and many poor women who worried that they could not feed another child died during crude and often self-attempted abortions. It was as a result of watching one of these poor tenement women die from a self-induced abortion attempt in 1912 that Margaret Sanger (see Figure 6–2) gave up a nursing career and founded the Birth Control League (later changed to Planned Parenthood). The work of reformers and the changing attitude about the role of women in general gradually had an effect. The last of the state laws prohibiting the sale of contraceptive devices to married couples was finally repealed in 1965 (by a U.S. Supreme Court decision in the case of *Griswold v. Connecticut*), and laws preventing the sale to unmarried persons were struck down in 1972 (*Eisenstadt v. Baird*). By then, 81% of the public approved of the availability of birth control information.

Figure 6–2

Margaret Sanger, a founder of the birth control movement, was forbidden to talk about birth control, so in 1929 she voluntarily had her mouth taped and wrote about the subject on a blackboard.

Source: Bettmann/CORBIS

In recent decades, family planning programs have helped many young women. For example, California's public-private family planning partnership has greatly reduced teen pregnancies and saved the state billions of dollars (Darney, 2011). By providing free long-term reversible contraception (IUDs and implants) to women, St. Louis has had similar results (Peipert et al., 2012).

Personal Reflections

Are you prepared at the present time to assume the responsibilities of being a parent? Why or why not? How would your life change if you or your partner were pregnant (consider your relationship, finances, career goals, etc.)?

6.1.3 Evaluating Birth Control Methods

If all fertile couples practiced unprotected sexual intercourse (no pills, condoms, diaphragms, etc.) and did not abstain from having sex at any time of the month (no fertility awareness methods), about 85% of them would conceive within a year (Trussell, 2011). In judging the effectiveness of the various birth control techniques, we need to know how many couples using a particular contraceptive method would conceive in a year's time.

There are actually two figures here that are important: the perfect-use pregnancy rate and the typical-use pregnancy rate.

For a particular contraceptive technique, the perfect-use pregnancy rate is the percentage of couples who would conceive if all couples who were using the technique used it consistently and properly. The typical-use pregnancy rate is usually higher than the perfect-use rate because not all people use a method consistently or properly. The birth control pill, for example, was designed to be taken every day, but not all women remember to do so, and this results in some pregnancies. Although all the birth control techniques that you will learn about are better than using nothing at all, some are more effective than others. Ideally, a couple wishing to postpone or prevent pregnancy would like their birth control technique to be 100% effective (zero pregnancies in a year's time). Some contraceptive methods approach this, but others do not.

Pregnancy rates are almost always stated in terms of the number of pregnancies that occur *in the first year of use* for every 100 couples using the technique (see Table 6–2). Although we will follow that tradition, most people want to use birth control for a much longer period. In fact, for women who want to have only two children in their lifetime, they will have to use some type of contraception for about 30 years or more.

Table 6–2 Number of Pregnancies per 100 Women During the First Year of Continuous Use

Method	Perfect Use	Typical Use	Percentage Continuing Use at 1 Year
Male sterilization	0.1	0.15	100
Female sterilization	0.5	0.5	100
Nexplanon	0.05	0.05	84
Depo-Provera (3-month shot)	0.2	6	56
Combination birth control pill	0.3	9	67
Progestin-only (mini) pill	0.3	9	67
OrthoEvra (patch)	0.3	9	67
NuvaRing (vaginal ring)	0.3	9	67
IUD (Paragard)	0.6	0.8	85
IUD (Mirena)	0.2	0.2	85
Male condom (without spermicide)	2	18	45
Lactational amenorrhea method (6 months)	2		
Female condom	5	21	41
Diaphragm (with spermicide)	6	12	57
Cervical cap (for women who have not given birth)	9	16	
Contraceptive sponge (for women who have not given birth)	9	12	
Spermicides alone	18	28	42
Withdrawal	4	22	46
Fertility awareness:			
Calendar	9	24	
Standard Days	5	12	47
Billings	3	24	
Symptothermal	0.4	13–20	
Emergency contraception			
Plan B		50	
Ella		35	
Copper IUD		0.1	
No method	85	85	

Source: From Trussell, J. "Contraceptive Efficacy." In Hatcher, R. A., J. Trussell, A. L. Nelson, W. Cates, D. Kowal, and M. S. Policar. *Contraceptive Technology,* 20th Revised Edition. Copyright © 2011 Ardent Media. Reprinted with permission.

Table 6–2 Full Alternative Text

If a couple's chosen contraceptive technique has a pregnancy rate of 5% in the first year of use, what are the chances of an unplanned pregnancy if they continue to use the technique over a much longer time period? The 10-year pregnancy rate is between 23% (this assumes that the risk will have declined to zero by the end of that time span) and 40% (this assumes that the risk remains constant) (Ross, 1989). For a contraceptive technique with a first-year pregnancy rate of 10%, the 10-year pregnancy rate is between 40% and 66%. Some of the contraceptive techniques that we will consider have a first-year pregnancy rate of 20%. Over a 10-year time period, the chance of having an unplanned pregnancy while using these techniques is between 67% and 90%. Thus, while contraceptive methods reduce the number of unplanned pregnancies, most are far from being 100% effective over a long period of time.

In evaluating birth control techniques, we must look at more than just their effectiveness. Some techniques are more suitable for certain subgroups of the population than others. The birth control pill is highly effective, but it is not recommended for women with cardiovascular problems, for example. Some people only wish to postpone pregnancy and therefore require a reversible technique (i.e., one that can be discontinued at any time), while others wish to totally prevent any more pregnancies and require a long-acting technique. Factors such as spontaneity and aesthetics sometimes play a role, and some people may be looking for simultaneous protection against sexually transmitted infections. In many cases, religious beliefs must be considered. We will provide as much information about each of the techniques as possible, pro and con, so that when you decide to use birth control, you will be able to decide which method is best for you.

Personal Reflections

If you are having sexual relations, what do you do about contraception?

Contraceptive Myths and Relatively Ineffective Methods

The following sections describe several contraceptive myths as well as relatively ineffective methods of birth control.

Contraceptive Myths

"In high school I heard that if a male drinks Mountain Dew or Surge cold drinks they would have a low sperm count and could have sex and not get the girl pregnant."

"I heard a while back that the soft drink Surge made men sterile, so if he drank one before sex, his sperm count would be near zero."

(All examples are from the authors' files.)

Teens are often given a great deal of misinformation about contraception by friends and potential partners. Some of the information is so incorrect that it can be considered myth. For example, some of you may have heard that if a man drinks Mountain Dew before sex it reduces his sperm count or that if a woman douches with Coca-Cola or ice water afterward she cannot get pregnant. How many of you were told, "You can't get pregnant the first time you have sex" or "You can't get pregnant if you don't kiss"? Well, these stories are just not true. A girl is capable of reproduction as soon as she starts having menstrual cycles (recall that in the United States, the first menstrual period occurs at an average age of 12 1/2). This is evidence that she is ovulating, i.e., producing eggs. Some of you may have been told that a woman cannot get pregnant if she is on top or if she has sex while standing up (because of gravity), but these statements are also untrue. It is also not true that a woman must have an orgasm during sex in order to get pregnant. No doubt there are other stories that you have heard, but unless they are included in the remainder of the chapter (i.e., they have a basis in fact), chances are they just are not true.

Relatively Ineffective Methods

One of the most popular ways in which young people try to prevent pregnancy is withdrawal (coitus interruptus), where the man withdraws his penis just before reaching orgasm and ejaculates outside his partner's vagina. Well over half of sexually active women have used withdrawal on at least one occasion (Daniels et al., 2013a) for a variety of reasons (Arteaga & Gomez, 2016). It sounds logical, for if the man does not ejaculate in the woman's vagina, there should be no sperm there. The Cowper's glands, you recall, secrete a few drops of fluid before a man reaches orgasm. The fluid contains very little, if any, sperm (Kowal, 2011), and in fact, the perfect-use pregnancy rate is 4% in the first year. The real problem is that many men do not always withdraw before ejaculating. Thus, studies find that about 22 out of every 100 women using the withdrawal method conceive within the first year of use.

"An ex-boyfriend of mine thought if he pulled out before 'he came,' then a girl wouldn't get pregnant. He was shocked when he found out his current girlfriend was pregnant. He claimed he couldn't be the father because he didn't 'come.'"

(from the authors' files)

Withdrawal is better than nothing, but it is relatively ineffective compared with most types of contraception.

Some women believe that douching is an effective method of birth control.

"I was told that douching and/or using the bathroom right after sex would get rid of the sperm and you would not get pregnant."

(from the authors' files)

Again, it sounds logical. If you wash out the contents of the vagina, there should be no sperm. The problem is that no matter how quickly a woman douches after intercourse, some sperm will have already made it into the cervix. In fact, the pressure caused by douching can actually force sperm into the cervical opening. Over 40 out of every 100 couples who use douching as their only means of birth control will conceive in a year's time.

Abstinence-Only Sex Education

The most effective way to avoid an unwanted pregnancy is to abstain from sexual intercourse. Abstinence works well when it is a personal choice. Individuals who make this decision can be 100% worry free about getting pregnant or getting someone pregnant.

What about sex education programs that teach abstinence-only as birth control? From 1998 to 2016, the U.S. government provided over $1.6 billion to states to teach abstinence-only programs. As a result, the percentage of teens receiving formal education about birth control declined significantly (Lindberg et al., 2016). The abstinence-only approach is popular with those who believe that unplanned pregnancies are a big problem and that a decline in moral standards has contributed to the problem. But how effective are these programs? Studies find that any behavioral changes are usually just short term (Brückner & Bearman, 2005). A study authorized by Congress found that abstinence-only programs had no long-term effect (Trenholm et al., 2007; see Chapter 1). In fact, teens who take abstinence-only courses are less likely to use condoms when they do have sex and are more likely to get (or get someone) pregnant (Kohler et al., 2008; Lindberg & Maddow-Zimet, 2012; Stranger-Hall & Hall, 2011). In summary, abstinence-only as a public policy has not succeeded.

"Abstinence-plus" programs that teach abstinence *and* contraception, on the other hand, have often proved to be very effective in reducing teenage pregnancy rates (e.g., National Institutes of Health, 1997; see Chapter 1). Some comparisons with other countries might be helpful here. Denmark, for example, has comprehensive sexuality education in its schools. Danish teenagers become sexually active at as young an age as American teens (half by age 17), but the vast majority use contraception, and the teenage birth rate in Denmark is among the lowest in the world (see Table 6–1).

Lactational Amenorrhea Method

Breast-feeding has been called "nature's contraceptive." There is some truth to this. In fact, breast-feeding as a temporary method of birth control after childbirth has come to be known as the lactational amenorrhea method. The sucking response of the baby on the mother's nipple inhibits the release of FSH and LH from the pituitary, thus preventing normal menstrual cycles and ovulation. Before modern contraceptive techniques were introduced, breast-feeding was the major factor that determined the length of the interval between pregnancies and still is in many countries. If a mother is fully breast-feeding (no bottles) *and is not menstruating*, the chance of pregnancy during the first 6 months is less than 2% (Amy & Tripathi, 2009; Kennedy & Trussell, 2011). *The risk of ovulation rises quickly if a woman continues breast-feeding beyond 6 months*. Thus, the lactational amenorrhea method is not really a birth control method but a method to briefly postpone pregnancy.

Fertility Awareness: Abstaining from Sex During Ovulation

1. 6.2 Explain how the various fertility awareness methods of contraception work.

The fertility awareness method (also called the *rhythm method* or *natural family planning*) may be the only method acceptable to many of you because of your religious beliefs. For example, these are the only birth control methods that are not opposed by the Catholic Church and some evangelical Protestant denominations. *Fertility awareness is based on predicting when ovulation occurs*. There are several variations to this method, and we will present four of them.

A woman can only get pregnant when sperm are present during the first 24 hours or so after ovulation. After that, the egg is overly ripe and a sperm cannot fertilize it. Fertility awareness methods involve the identification of "safe days" in a woman's menstrual cycle and the abstinence of sex during the "unsafe days." Which days are "safe"?

Sperm can live in a Fallopian tube for several days. Although most do not live for more than 3 days, some can live for as long as 5 days. Wilcox, Weinberg, and Baird (1995) calculated the following probabilities of conception (in relation to the day of ovulation):

Day	Probability
−5	0.10
−4	0.16
−3	0.14
−2	0.27
−1	0.31
0 (ovulation)	0.33

In a woman with perfect 28-day cycles, ovulation would be at midcycle. The problem is that few women have cycles of the same length month after month. It is normal for a woman's cycle to differ in length over time by several days. At least half of women have cycles that vary in length by 7 days or more (Harlow & Ephross, 1995; Shulman, 2011). About 1.5% of women have cycles shorter than 21 days or longer than 35 days. All of the fertility awareness methods must take this variability into account. Many young women have 10 or fewer menstrual cycles a year. *It would be almost impossible for a woman who is not having regular menstrual cycles to use the following techniques.*

6.2.1 Calendar Method and Standard Days Method

The first thing a woman must do to use this method is to keep track of the length of her menstrual cycles for a minimum of six cycles (more would be better). Let us take a hypothetical example of a woman who has kept track of 10 cycles and found that although her average cycle length was 28 days, she had one that was only 24 days and another that lasted 32 days. The calendar method uses a formula to calculate the unsafe period. Subtract 18 from the length of the shortest cycle (24 – 18 = 6) and 11 from the length of the longest cycle (32 – 11 = 21). The unsafe period would thus be from days 6 through 21 (by the numbering system explained in Chapter 3, which says that day 1 is the start of menstruation). This is a period of over 2 weeks that the woman and her partner must abstain from having sexual intercourse. If the woman had had a cycle shorter than 24 days or longer than 32 days, the period of abstinence would have been even longer.

The calendar method has proven to be unreliable, with most studies reporting a typical-use failure rate of about 13% to 24% per year (Jennings & Burke, 2011). However, the perfect-use pregnancy rate is much lower and lower yet for women who *typically* have menstrual cycles of 26 to 32 days. If your cycles are almost always within these limits, then avoiding unprotected intercourse during days 8 through 19 reduces the pregnancy rate to 5% (although the typical-use pregnancy rate is 12%) (Jennings & Burke, 2011; Trussell, 2011). This is called the Standard Days Method. *Cyclebeads,* a string of 32 color-coded beads, help women using the Standard Days Method to keep track of their fertile days (see Figure 6–3). Women move a black rubber ring over one bead a day. Dark beads indicate a low risk of pregnancy and the 12 white beads a high risk. However, all it takes for the method to fail is just one cycle that is shorter or longer than previously observed.

Figure 6–3

Cyclebeads are used by women who typically have menstrual cycles of 26 to 32 days. The white beads indicate high-risk days.

Source: Photo Courtesy of Cycle Technologies, Inc.

There are two variations of the fertility awareness method that use biological markers to better identify the time of ovulation.

6.2.2 Billings Method (Cervical Mucus or Ovulation Method)

The fertility awareness method that is most widely used today is the Billings method, which attempts to pinpoint the time of ovulation by noting changes in the consistency of a woman's cervical mucus. It is named after two Australian doctors who developed it (Billings et al., 1974). Mucus is discharged from the cervix throughout a woman's menstrual cycle, and its appearance changes from white (or cloudy) and sticky to clear, slippery, and stretchy (like that of an egg white) a day or two before ovulation. Typically, a woman notes this change with a finger test, that is, placing a finger in the vagina and then examining the mucus. A couple is instructed to abstain from sexual intercourse from the end of menstruation until 4 days after the mucus has changed consistency.

Theoretically, the Billings method has only a 3% pregnancy rate, but the typical-use pregnancy rate is much higher. Most studies have found about 22 to 24 pregnancies per year for every 100 couples using this method (Jennings & Burke, 2011; Trussell, 2011).

6.2.3 Symptothermal Method

This method combines the Billings cervical mucus method with measurements of *basal (resting) body temperature (BBT)*. A woman's BBT rises by at least 0.4 degrees Fahrenheit about the time of ovulation and stays there for at least 10 days (Jennings & Burke, 2011). The BBT should be taken at the same time every day, preferably first thing in the morning. Once her BBT rises and remains high for 3 days, a woman can conclude that ovulation has occurred and that she is again infertile. Thus the Billings method (cervical secretions) is used to tell when ovulation begins, and the BBT method is used to tell when the fertile timespan is over. With perfect use, the pregnancy rate is 0.4%, but typical use is 13% to 20% (Jennings & Burke, 2011; Trussell, 2011).

6.2.4 Conclusions

Why are the typical-use pregnancy rates for the various fertility awareness methods so high when the perfect-use rates are much lower? Probably

because the techniques require a great deal of training and a high level of motivation to abstain during the fertile period (the average period of abstinence for all of the fertility awareness methods is 12 to 17 days per cycle). Most of the pregnancies do, in fact, result from conscious deviations from the rules. However, another problem with any method based on changes in cervical mucus is that perhaps as many as one third of young women and women approaching menopause do not have the typical mucus pattern. Not surprisingly, only about 18% of reproductive-aged American women had used fertility awareness for birth control at any time from 2006 to 2010, and fewer than 1% currently do (Daniels et al., 2013a, 2015).

Barrier Methods: Preventing Sperm from Meeting the Egg

1. 6.3 Compare and contrast the various barrier methods of birth control and their effectiveness.

Barrier (blockade) methods of birth control are designed to prevent pregnancy by placing a blockade between the penis and vagina/cervix so that sperm cannot reach the egg if ovulation has occurred. Thus, these methods do not require you to abstain from sexual intercourse, but they may interfere with the spontaneity of sexual relations by requiring you to stop and put something on or put something in.

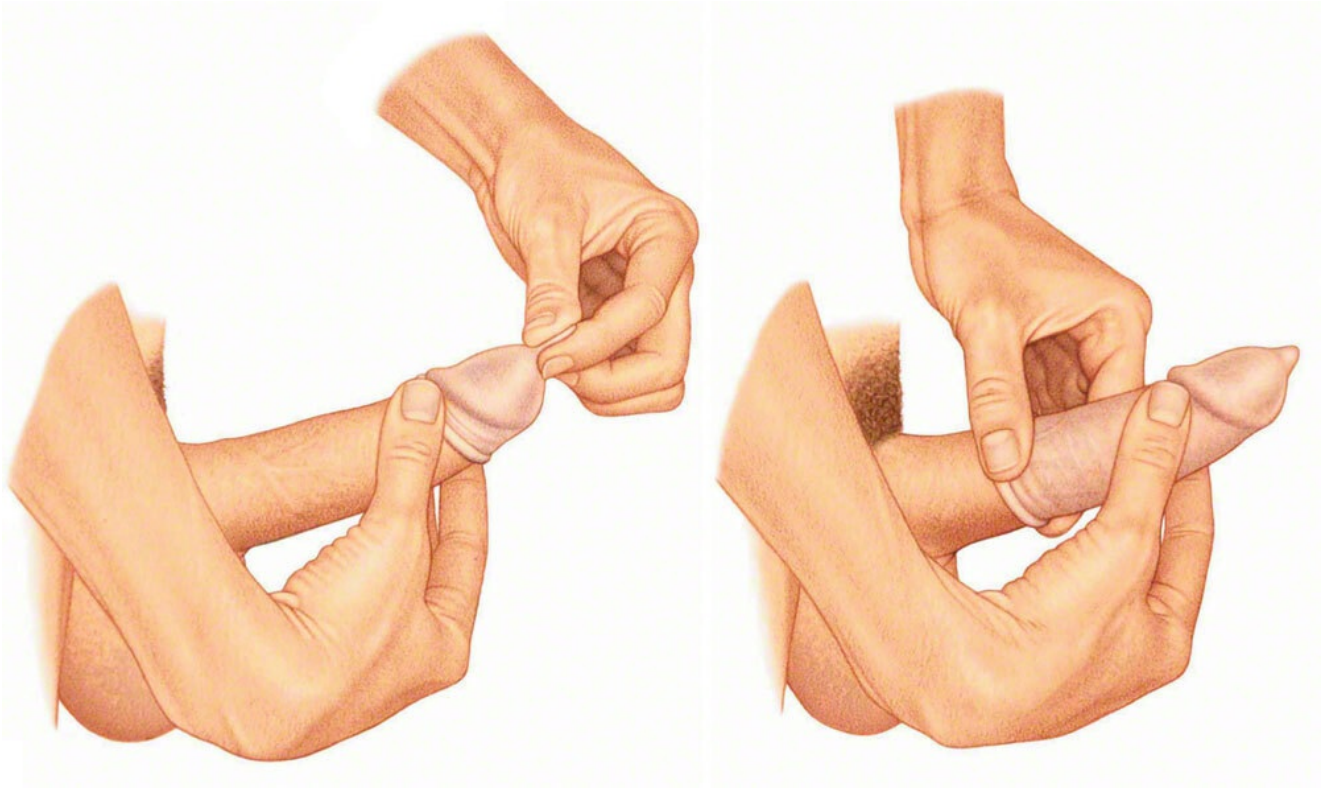
6.3.1 Male Condoms

Condoms ("rubbers," "safes," or prophylactics) are thin sheaths made of latex rubber, lamb intestine, polyurethane, or synthetic elastomers that fit over the penis and thus trap the sperm. Over 80% of the condoms sold in the United States are made of rubber. Because they also serve as a barrier between the man's membranes and his partner's membranes, rubber condoms *are also highly effective in preventing the spread of many sexually transmitted infections, including HIV and HPV* (National Institutes of Health Consensus Report and Centers for Disease Control and Prevention Fact Sheet—see Cates, 2003; Warner & Steiner, 2011). (Lamb intestine condoms do not prevent the spread of viruses.) In fact, condoms were originally invented for this purpose in the 1500s. A French writer in 1761 described condoms as "armor against love, gossamer against infection."

Today's condoms come rolled up, dry or lubricated, and in a variety of sizes, shapes, and colors. They present no major health hazards and are available without a prescription. There are only a few simple rules to remember:

1. Put the condom on before you start having intercourse. This is important to protect yourself from sexually transmitted infections. *Unroll it on the penis; do not try to yank it on like a sock* (see Figure 6–4). If the condom does not have a nipple tip, leave a little extra space at the tip of the penis to catch the ejaculate.

Figure 6–4



Use of the condom.

2. Hold on to the base of the condom when you are finished and withdraw. Otherwise, you might leave it and its contents in the woman's vagina.
3. Use a condom only once. If you have intercourse more than one time while having sex, use a new condom each time. If you try to reuse a condom it will eventually tear.
4. Check the expiration date. Do not store rubber condoms for long periods of time in a warm place (such as your wallet) or where they are exposed to light. This will eventually deteriorate them. Store them someplace cool, dark, and dry. Also, *do not use rubber condoms in combination with mineral oil, baby oil, vegetable oil, hand lotions, Vaseline, or other petroleum jellies*, for these, too, can damage them.

"During a recent sexual experience, my partner and I used oil from one of those fancy 'bath and body stores' for lubrication in conjunction with a condom. During intercourse, the condom disintegrated."

(from the authors' files)

If a lubricant is needed, use a water-based one like K-Y Jelly. Do not confuse "water-based" with "water-soluble." (The polyurethane condoms can be used with oil-based lubricants.) Some condoms are sold with spermicide, but the amount of spermicide is so small that they are no more effective (but are more expensive) than other lubricated condoms (Warner & Steiner, 2011).

If these very simple instructions are followed, the perfect-use pregnancy rate is only about 2%. However, the typical-use rate is about 18 pregnancies per 100 couples per year (Warner & Steiner, 2011). Make sure that you use condoms that fit; otherwise, it can cause breakage or slippage (Crosby et al., 2010). Several studies have found that during human use, the breakage rate is about 2% during vaginal intercourse but may be higher during anal intercourse. Slippage of condoms occurs in another 2% of cases (Warner & Steiner, 2011). However, the biggest problem is inconsistent use.

Condom use has increased dramatically in recent years. In fact, more American women of reproductive age have at some point relied on condoms (93%) than have used the birth

control pill (82%) (Daniels et al., 2013a). However, only about 15% of women aged 15 to 44 currently using contraception rely on condoms (Daniels et al., 2015). Studies have found that many unmarried men do not use condoms (Fortenberry et al., 2010; Reece et al., 2010c). If condoms are so effective for preventing pregnancy and sexually transmitted infections, why aren't all sexually active men using them consistently? Here are some lines that women in our class have told us that men commonly use to keep from using a condom (Oncale & King, 2001):

"I promise I will not come in you."

"I will pull out before I nut."

"It doesn't feel the same."

"I can't feel anything with it on."

"I don't have a disease."

"If you're not having sex with anybody else, why should I use it? If you trust me, you wouldn't make me use it."

Before they have ever tried one, most men have heard many times that condoms will reduce sensitivity and sexual pleasure. Many men actually lose their arousal because of their negative attitudes about condoms (and other safer-sex products) (Warner & Steiner, 2011). Their preconceived notions probably exaggerate the problem. Condoms will reduce a man's sensitivity, but only slightly. In fact, a nationally representative survey found that men who use condoms rate their sexual experience just as positively as men who do not use them (Herbenick et al., 2013). *Consumer Reports* (1989) found that many men find the reduced sensitivity to be something positive because it makes sex last longer.

Others complain that they are allergic to rubber. About 1% to 3% of men and women are allergic, but again, some condoms are made of natural animal membranes or polyurethane. Still others complain about the loss of spontaneity, that it is a nuisance to stop and put a condom on in the middle of having sex. How long does it take to put on a condom? The answer is only a few seconds. These reasons for not wearing condoms are in many cases simply excuses. The real reason many men will not use condoms is that they are too embarrassed to go into a store and purchase them (Bell, 2009).

"During high school, I was actually embarrassed to buy condoms. I only would get them in those bathroom machines. Perhaps if they were discreetly available, then more teens would buy them."

(from the authors' files)

A few women in our classes have said that they have talked a partner out of using a condom, but the large majority have to talk partners into using them. Here are some lines that women say they have used successfully to get a male partner to use a condom (Oncale & King, 2001):

"No condom, no sex."

"If you choose not to use a condom, you're choosing not to have sex with me."

"If you don't use one, you won't get none."

"It's not that I don't trust you; I don't trust who you've been with."

"There will be no action in the ballpark until the player with the bat puts his glove on."

Remember, condoms are used for reasons other than to prevent pregnancy. If you are sexually active and have multiple partners over time or if your partner has had multiple partners or is an intravenous drug user, you are in a high-risk category for contracting a sexually transmitted infection and should be using rubber condoms (see Box 6–A for additional information).

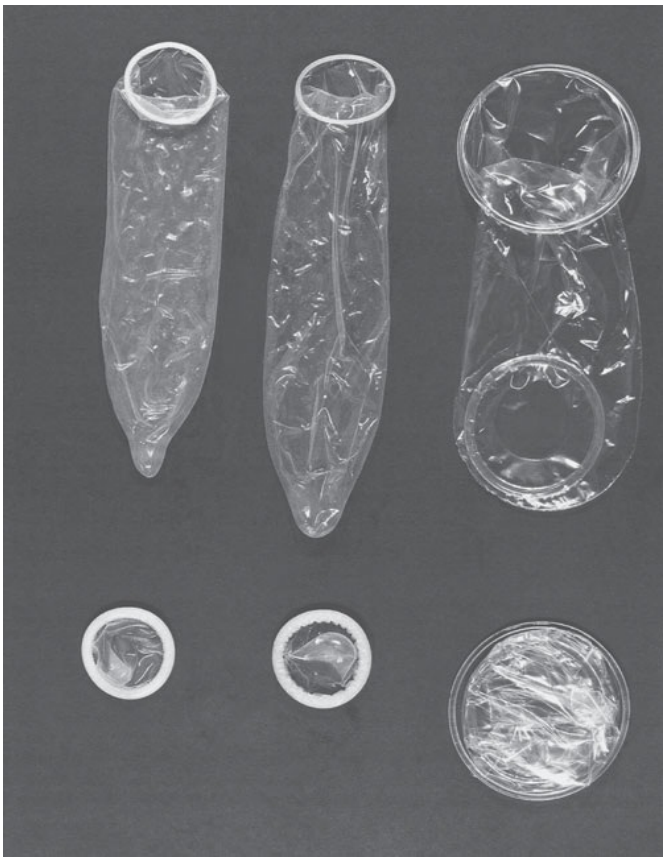
Personal Reflections

Whose responsibility is it for birth control—your responsibility or your partner's? Why? If you answered that it is your partner's responsibility, do you think that you share any of the responsibility for the consequences of engaging in sexual intercourse?

6.3.2 The Female Condom

The female condom, as it is called, is actually an intravaginal pouch—a 7-inch-long bag that is held in place in the vagina by two flexible rings (see Figure 6–5). A woman inserts it with her fingers by pushing the closed-ended ring against the cervix, as she would a diaphragm. It is held in place by the outer ring, which fits on the outside of the vagina, partially covering the labia (see Figure 6–6). In 2009, the original polyurethane condom (FC1) was replaced by a synthetic nitrile rubber latex female condom. The FC2 is softer, more flexible, and less expensive than the original. The female condoms raise no major health concerns and do not have adverse effects on the vaginal wall. Moreover, they offer protection against the bacteria and viruses that cause sexually transmitted infections (Cates & Harwood, 2011). Thus, for those women whose partners refuse to wear a male condom, the female condom provides them with the opportunity to protect their own health. Many people are put off by the appearance of the female condom, but many of those who try it say that it feels more like unprotected intercourse than sex with male condoms.

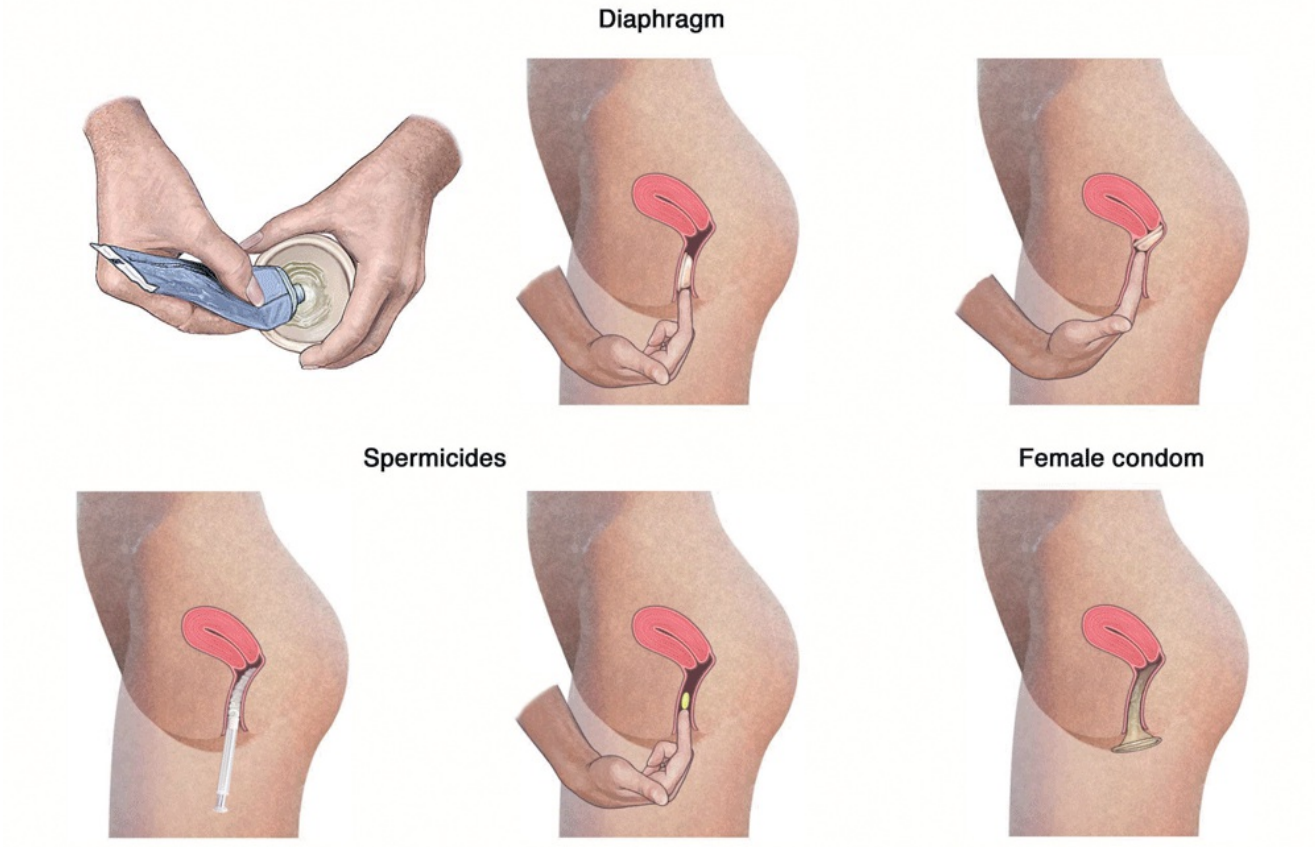
Figure 6–5



Male condoms (left and middle) are sold rolled and in different sizes. Female condoms (right) are intravaginal pouches that are held in place by two flexible rings.

Source: Bruce King

Figure 6–6



Use of the diaphragm (with spermicide), spermicides (foam and suppository), and female condom.

"I have never liked male condoms. Even when I would use extra lubricant the friction was very irritative. Then one day a friend suggested that I try using female condoms. I haven't used anything else since. Even my man says it feels like we aren't using anything at all."

(from the authors' files)

The main complaint that women have about the female condom is the noise it makes during intercourse, but this can be eliminated by using additional lubricant.

Studies have found that the pregnancy rate during typical use is about 21% (Cates & Harwood, 2011; Trussell, 2011). Some of the failures are due to slippage, often the result of women failing to learn how to insert female condoms properly. For those who use the female condom correctly, the first-year pregnancy rate is about 5%.

6.3.3 The Diaphragm

A diaphragm is a large, dome-shaped rubber cup with a flexible rim that fits over the cervix. It works by preventing the passage of sperm into the uterus. The ancient Greeks used empty pomegranate halves to block sperm from getting into the uterus, and in biblical times, women sometimes inserted camel or crocodile dung into the back of the vagina to prevent the sperms' passage. Fortunately for today's women, the rubber cup was invented in 1882 in Germany. By the 1930s, the diaphragm was being used by one third of all couples who practiced birth control. With the introduction of the birth control pill in 1960, the use of the diaphragm became almost nonexistent.

A woman has to be fitted for a diaphragm by a physician or health care worker (the distance between her cervix and pubic bone is measured). She will then be given a prescription for a diaphragm that fits her. You may have to be refitted if your body undergoes any major changes (e.g., pregnancy or weight changes of 10 pounds or more). A woman getting her first diaphragm is also going to need instructions and coaching on how to insert it properly and quickly (see Figure 6–6).

After you have learned to insert your diaphragm properly, there are only a few simple rules to remember:

1. Most doctors still recommend that diaphragms be used with a spermicidal jelly because it improves the pregnancy rate a bit (Cates & Harwood, 2011). Spread spermicidal jelly on the inside part of the diaphragm (the part in contact with the cervix) and rim before insertion. (See Figure 6–7.)

Figure 6–7

The diaphragm.

Source: Dorling Kindersley/Getty Images

2. Insert the diaphragm no more than 3 hours in advance of starting intercourse. Otherwise, the spermicide dissipates and adds little additional protection. For maximal effectiveness, the diaphragm should be put in immediately prior to intercourse, although this may interfere with spontaneity.
3. Leave the diaphragm in for 6 to 8 hours after intercourse to make sure that there are no more live sperm. If you have intercourse more than once while having sex, place more spermicide in the vagina before each time. Do not remove the diaphragm to do this (sperm may get into the cervix while the diaphragm is removed), but instead use a plunger or some other means of application. Do not leave a diaphragm in for more than 12 hours.

When used in combination with a spermicide, the perfect-use pregnancy rate for the diaphragm is usually stated as about 6% per year (Trussell, 2011). The typical-use pregnancy rate is about 12% per year. About half of these pregnancies, particularly among young women, are due to either inconsistent or improper use.

Very few American women today use a diaphragm (Daniels et al., 2013a, 2015). The most common complaint about the diaphragm is aesthetics. Some complain that insertion is a nuisance, interfering with spontaneity, and that spermicides can be messy and detract from such sexual behaviors as oral-genital sexual relations. These complaints are not heard as often, however, in women who are sexually experienced and in a monogamous relationship.

"For years I used a diaphragm. My partners always said that they could not feel it in me and that it did not take away from their pleasure."

(from the authors' files)

The most important thing to consider is that the diaphragm offers an inexpensive, safe, and relatively effective means of birth control when used consistently and properly.

6.3.4 The Cervical Cap and FemCap

Like the diaphragm, the two contraceptive devices discussed here are barrier devices that are designed to prevent passage of sperm from the vagina into the uterus. Made of latex rubber, the cervical cap is smaller and more compact than a diaphragm and resembles a large rubber thimble (see Figure 6–8). *It is used with a small amount of spermicide* (for added effectiveness) and fits over the cervix by suction. Like with the diaphragm, women must be fitted by a doctor or healthcare worker. Insertion and removal of the cap are more difficult than for the diaphragm, but once in place it is more comfortable than the diaphragm and can be left in for 24 hours. Women should check each time after having sexual intercourse to make sure that the cap has not been dislodged.

Figure 6–8

The cervical cap (left) and FemCap.

Source: Cervical Barrier Advancement Society and Ibis Reproductive Health

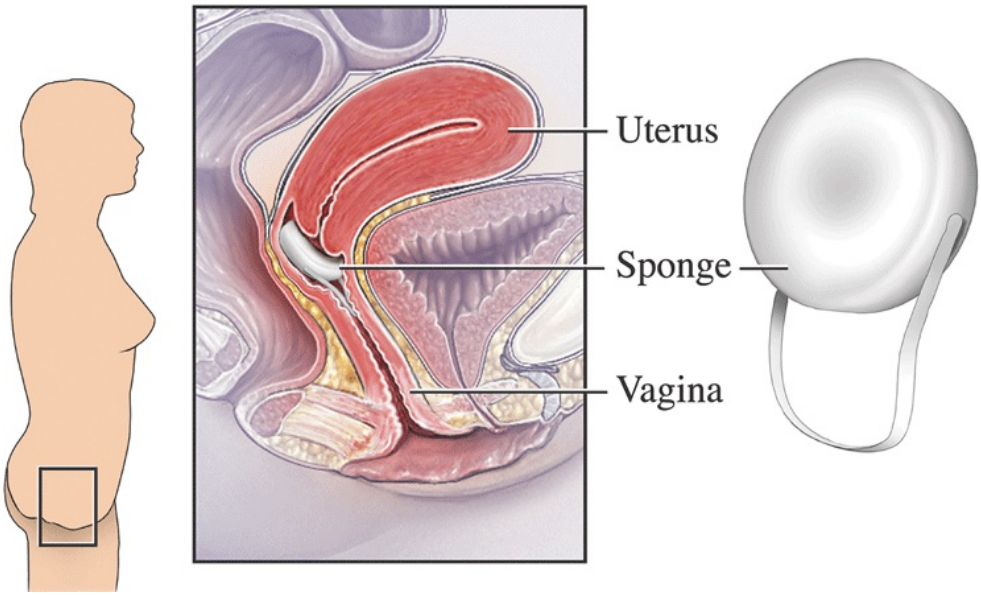
Although the cervical cap is popular in parts of Europe, you may have trouble finding it in the United States. However, there is a version of the cap called FemCap that is more readily available. Made of silicone (which is more comfortable than latex rubber), it has a concave side that fits over the cervix. Spermicide can be applied to both the inside and outside surfaces. Once inserted, it can be left in place for as long as 48 hours (Cates & Harwood, 2011). *FemCap* comes in three sizes, and a woman must be fitted to find the one that best suits her.

Both of these cervical barrier devices require a prescription. One major advantage is that they can be placed in the vagina 6 to 8 hours before having intercourse. *FemCap* must be replaced with a new one after a year; diaphragms are good for several years. The first-year typical-use failure rate in women who have not had children is about 16% but is only about 9.5% when used correctly. The pregnancy rate is higher for women who have given birth (Cates & Harwood, 2011).

6.3.5 The Contraceptive Sponge

The polyurethane Today contraceptive sponge is 2 inches in diameter and 1 inch thick and contains spermicide (nonoxynol-9). It works by blocking the cervical opening and killing sperm (see Figure 6–9). In addition to the Today sponge, there is also a Canadian sponge called Protectaid that is available online.

Figure 6–9



The contraceptive sponge.

Source: Nucleus Medical Art, Inc./Alamy

The sponge has several advantages over the diaphragm. First, it does not require a pelvic exam. It is sold in one size without a prescription. Second, users report that it is very easy to insert. A woman simply moistens it with tap water and inserts it deep in the vagina. One side has a concave dimple that fits over the cervix to decrease the chance of it being dislodged. Last, but not least, it can be left in for 24 hours, during which period the woman may have intercourse as many times as she wishes without having to add more spermicide. The sponge has a small loop on one side for removal and is thrown away when the woman is done.

Studies of the effectiveness of the sponge show a typical-use pregnancy rate of about 12% for women who have not had children but only 9% with perfect use. However, the pregnancy rates are much higher (24% and 20%, respectively) for women who have given birth (Trussell, 2011).

6.3.6 Spermicides: Substances That Kill Sperm

Spermicides contain chemicals that kill sperm (*nonoxynol-9*). They are sold in a variety of forms. Spermicidal foams, jellies, creams, and film (VCF, or *vaginal contraceptive film*, is a square of film that is placed over the cervix) help hold the sperm-killing chemicals in the vagina against the cervix and simultaneously act as a barrier to sperm. Suppositories and tablets are also available. Specific instructions differ for each type of spermicide, but all of them must be placed in the back of the vagina shortly before sexual intercourse begins. They lose their effectiveness over time, so new spermicide must be inserted shortly before each time a woman has intercourse.

Surveys have found the typical-use rate to be about 28 pregnancies per 100 couples per year (Cates & Harwood, 2011; Trussell, 2011). In fact, when used alone, the perfect-use pregnancy rate is only 18%. One review concluded that spermicides "are not reliable if used alone" (Amy & Tripathi, 2009). Thus, *spermicides are generally viewed as a method to be used in combination with barrier methods of contraception.*

Initial studies suggested that in addition to their contraceptive benefit, spermicides reduced the risk of contracting sexually transmitted infections, including HIV. However, later studies have found that spermicides *do not protect women* against gonorrhea, chlamydia, or HIV, and frequent use may even increase the risk of HIV sexual transmission (by irritating the vaginal lining) (Cates & Harwood, 2011).

Most college women rate spermicides as one of their least preferred types of contraception. The most common complaint is that, like the condom and the diaphragm, inserting the spermicidal material just before intercourse interferes with the spontaneity of sexual relations and detracts from the mood. Others complain that spermicides are messy or detract from oral-genital sex. However, as a backup to barrier techniques, spermicides have advantages that for many women may outweigh the disadvantages.

6.3.7 Barrier Methods and Spontaneity

All of us, we suppose, would like our sexual relations to be passionate and spontaneous, with no interruptions. Putting on a condom or inserting a diaphragm, contraceptive sponge, or spermicide does not take very long for many sexually experienced people. Some individuals even integrate the use of barrier methods (e.g., putting on a condom) as part of foreplay. But some couples occasionally take chances and have unprotected intercourse because they do not want to stop and possibly ruin the mood. This is one of the most common causes of failure for barrier methods. The contraceptive techniques that we will cover next get around this problem by not requiring anything be done at the time when you want to have sex (except getting your partner in the mood, of course).

The Pill, Patch, Ring, and Shot

1. 6.4 Describe the various short-term hormonal methods of contraception (the pill, patch, and vaginal ring), how they work, and their potential side effects.

The following sections discuss various short-term hormonal methods of contraception, such as the birth control pill, the patch, and vaginal ring. You will learn about how they work and their potential side effects.

6.4.1 Oral Contraception (the Birth Control Pill)

The birth control pill is one of the two most popular reversible methods of contraception. Worldwide, it is used by more than 100 million women (United Nations Population Division, 2001), and it is used by over 10 million American women. In fact, 25.9% of U.S. women of reproductive age currently using contraception are using the pill (Daniels et al., 2015), and 82% have used it for some period of time (Daniels et al., 2015).

The perfect-use pregnancy rate is close to zero (only 3 in 1,000 during the first year of use). If a woman consistently follows just one simple rule, she really does not need to worry about getting pregnant. What is the rule? Take the pill every day at the same time. However, the typical-use pregnancy rate is 9 pregnancies per year for every 100 couples using the pill (Nelson & Cwiak, 2011; Trussell, 2011). Most of the pregnancies that do occur are due to user, not method, failures. Studies show that 20% to 50% of pill users do not take their pills every day (see Smith & Oakley, 2005). If you forget to take the pill for even 1 day, you should use a backup method of birth control for a week (but continue to take your pills) (Nelson & Cwiak, 2011). Women, as well as their doctors, should also be aware that *the pill is rendered less effective by simultaneous use of many types of antibiotics, barbiturates, analgesics, and tranquilizers*.

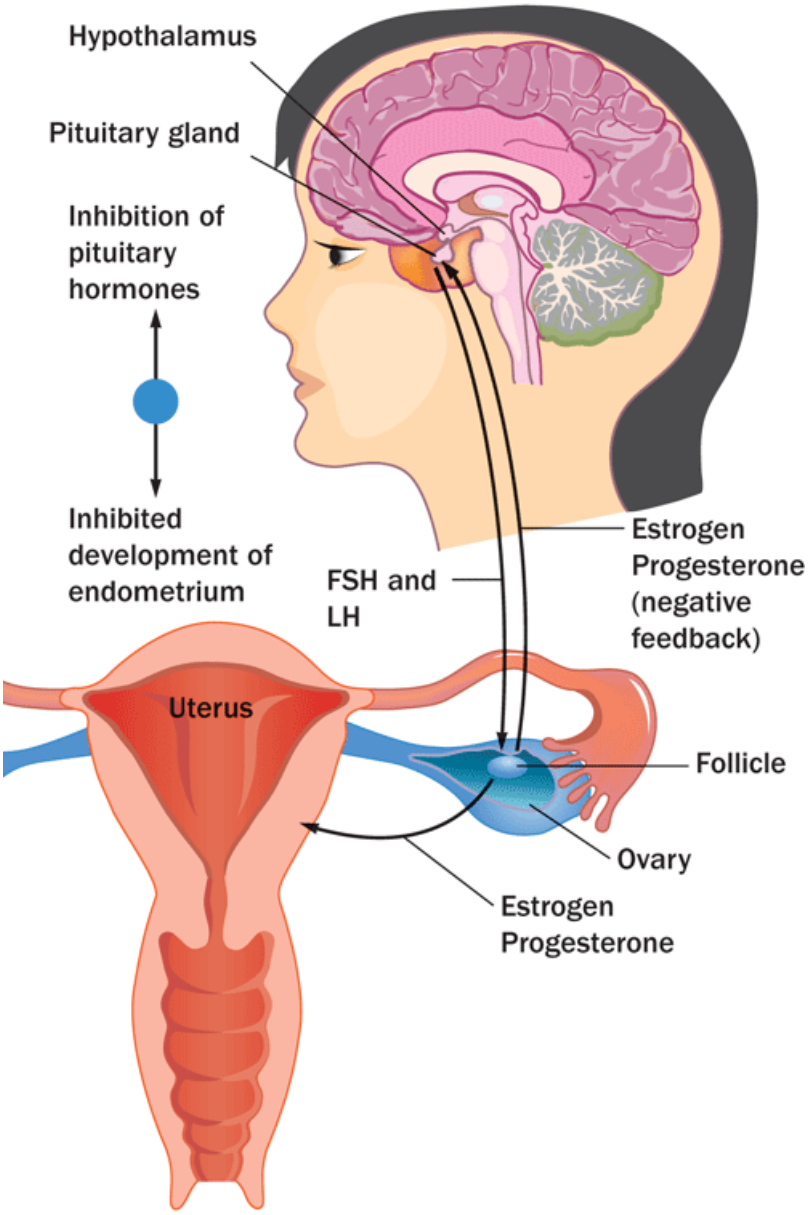
"During our senior year in high school, my cousin came to me because she was afraid that she was pregnant. She was on the pill, and she was taking them correctly. We could not figure out what went wrong. . . . About a month before she became pregnant, she went to the doctor for a bad cold. It turned out that the medicine which was prescribed for the cold made the birth control less effective."

(from the authors' files)

There is really not just one pill but several different types. In fact, there are nearly 100 brands marketed in the United States. The most widely used and most effective are the combination pills, which contain synthetic *estrogen* and synthetic progesterone (*progestins*). Most contain a fixed amount of the two hormones in each capsule, but there are also combination pills (called *multiphasic* pills) that adjust the levels of progestins weekly in an attempt to mimic the natural hormonal phases of the menstrual cycle. Regardless of the type, most brands of the pill are taken for 21 days and then discontinued for 7 days to permit menstrual bleeding (and for a shorter, lighter period, some brands offer a pill with 24 days of hormones and 4 days off). Most companies package the 21 pills containing hormones with 7 additional pills that contain no hormones (placebos) so that women will not get out of the habit of taking a pill every day. New "extended cycle" pills are designed to reduce the number of menstrual periods. *Seasonale* is taken for 84 days in a row followed by 7 placebos, and thus women will have only four periods a year. Another pill (named *Lybrel*) suppresses monthly periods for an entire year. These extended cycle pills are just as safe as other combination birth control pills (Teichmann et al., 2009).

The combination pill works primarily by (a) thickening cervical mucus, which prevents sperm from traveling, and (b) preventing ovulation. The hormones in the pill prevent the pituitary from releasing FSH and LH (see Figure 6–10). Without an egg present, it is impossible to get pregnant. When women decide to stop using the pill, the pregnancy rate in the first year afterward is just as high as for nonusers (Mansour et al., 2011).

Figure 6–10



How oral contraceptives work.

Figure 6–10 Full Alternative Text

There is also a progestin-only pill (also called the *minipill*) that contains only progestins. It works primarily by keeping cervical mucus thick, impairing the passage of sperm. Ovulation is often inhibited as well (Raymond, 2011b). This pill is for women who are breast-feeding (estrogen inhibits milk production) or who cannot tolerate the side effects of the estrogen-containing pill (only 0.4% of reproductive-aged women use it). It is only slightly less effective than the combination pill, but just as safe, if not safer. However, in some women these pills may cause menstrual bleeding irregularities.

There was a decline in the use of the combination pill during the 1970s and early 1980s when discoveries of serious health risks were reported. However, these studies were conducted with the first-generation, high-dosage pill. Today's "third and fourth generation" pills contain only a small fraction of the estrogen and progestins that the first-generation pills had (and, in fact, the entire 21-day package of today's pills contain less progestin than a single first-generation pill) (Nelson & Cwiak, 2011). The combination pill also has some significant health benefits. Surveys indicate that many women are incorrectly informed about the pill's risks and know nothing about the health benefits. Let us examine the risks and benefits in detail.

Negative Side Effects and Health Risks: Facts and Myths

An early study claimed that some women showed a decreased sex drive after they began to take the combination pill, and this was repeated in many women's magazines. However, a review of many studies found no evidence that this is true (Burrows et al., 2012; see also Mark et al., 2016). While a few women do show decreased sex drive, some show an increase, and the large majority are unaffected.

Some women do not use the birth control pill because they have heard that they might gain weight, but numerous clinical trials have demonstrated that this, too, is not true for the combination pill (Nelson & Cwiak, 2011).

It is not uncommon for women who are first starting to take the pill to experience some symptoms that mimic those of early pregnancy. These may include nausea, cramping, breast tenderness, and a bloated feeling. If these symptoms do not diminish within a few months, one good alternative is the "extended cycle" pills. As a result of the lowered dose of hormones in today's pill, breakthrough bleeding (i.e., bleeding during the 21 days of hormone use) sometimes occurs, but it usually disappears during the first 4 months of use. Despite these problems, the large majority of women who use the pill have a very favorable opinion of it as a contraceptive technique.

A (very) few women experience hypertension as a result of the combination pill. They can switch to the progestin-only pill. The new low-dose combination pills do not cause diabetes. The incidence of headaches is no greater for women on the pill than it is for other women. However, the pill is not recommended for women who have migraine headaches with aura. Birth control pills also *do not increase the risks of birth defects* (in those women who take the pill when they do not know that they are pregnant) (see Nelson & Cwiak, 2011).

The first-generation, high-dosage oral contraceptives were associated with serious cardiovascular problems (blood clots, heart attacks, and strokes). What about today's low-dose pills? Pill users who are younger than 35, *do not smoke,* and do not have high blood pressure or diabetes have very little risk of stroke or heart attack (Nelson & Cwiak, 2011). The newest pills slightly increase the risk of a blood clot, but overall this is a rare event. Oral contraceptive users over the age of 30 who smoke still have an unacceptably high risk of heart attack and stroke and should not use the combination pill.

Many studies, including one by the Centers for Disease Control and Prevention, have found that users of today's low-dosage pills are at no greater risk for breast cancer than nonusers (e.g., see Marchbanks et al., 2012; Nelson & Cwiak, 2011; Vessey & Yeates, 2013).

Health Benefits

It must be emphasized that birth control pills *do not protect against sexually transmitted infections*. However, *women who take the birth control pill are at less risk for several major health problems* compared to nonusers. The major benefits include a substantial decreased risk of cancer of the endometrium and cancer of the ovaries, a substantial decrease in the number of benign breast tumors, and reduced rates of ovarian cysts, endometriosis, and pelvic inflammatory disease (Collaborative Group, 2015; Nelson & Cwiak, 2011).

The birth control pill is also known to reduce menstrual-related problems. This includes premenstrual syndrome, dysmenorrhea, and bleeding (anemia is only two thirds as likely). In fact, some doctors prescribe the pill to women primarily to reduce menstrual problems and only secondarily as a contraceptive technique.

"I am now on the birth control pill. . . . My cramps were minimized a great deal and so was the length and heaviness of my period."

(from the authors' files)

For older women who do not smoke, are not obese, and do not have hypertension or cardiovascular problems, today's low-dosage pills are also being prescribed to regulate menstrual cycle disturbances that are common before menopause (Nelson & Cwiak, 2011).

Conclusions About Safety of the Pill

When considering the health risks associated with use of the pill, you should put things into proper perspective and compare the risks to what would happen if nobody used the pill. For women who do not smoke, *the health risks (including deaths) are significantly less than those caused by pregnancy and childbirth* (Nelson & Cwiak, 2011). The American College of Obstetricians and Gynecologists believe the pill to be so safe (with many medical benefits) that in 2012 it recommended that the pill be sold in stores without a prescription.

6.4.2 The Patch and the Ring

For women who want a highly effective hormonal contraceptive but do not want to worry about remembering to take a pill every day, there are now alternatives. OrthoEvra is *a 20-square-cm patch* that you apply to the skin (on the abdomen, buttocks, upper torso, or upper arm) like a Band-Aid (see Figure 6–11). It stays in place for 1 week, even during exercise and bathing, and slowly releases estrogen and progestin (the same hormones as in the combination pill) into the bloodstream. Three patches (3 weeks) are followed by a patch-free week (menstruation). Studies show that more women remember to change their patches regularly than take their pills. The side effects are the same as low-dosage oral contraceptives (some women also experience skin reactions at the patch site). The patch also exposes women to higher levels of estrogen than the pill, thus the chance of a stroke is higher for the patch (but rare in both cases and less common than stroke caused by pregnancy) (Nanda, 2011). Talk to your doctor first to make sure you are at low risk.

Figure 6–11

Two alternatives to oral contraceptives are the NuvaRing (left) and the contraceptive patch OrthoEvra (right).

Source: vario images GmbH & Co.KG/Alamy Stock Photo; Gusto/ Science Source

NuvaRing is a clear, flexible ring that is inserted into the vagina and worn for 3 weeks (see Figure 6–11). It, too, slowly releases estrogen and progestin and after 3 weeks is removed for a ring-free week (menstruation) before another one is inserted. *Progering* is a 3-month progesterone-only ring for use in women who are breast-feeding. Both rings may also be removed for a short time during sexual intercourse. The rings actually release fewer hormones than the pill and thus are regarded as very safe (Brache et al., 2013; Nanda, 2011). The side effects are similar to the pill (some women may experience vaginal irritation and discharge), but like the patch, compliance rates are higher than for the pill.

NuvaRing

A flexible ring containing the same hormones as the combination birth control pill that is inserted into the vagina and is effective for 3 weeks.

The perfect-use pregnancy rate is about 0.3% for both the patch and the ring. Typical use is about 9% (Nanda, 2011; Trussell, 2011). *Neither one protects against sexually transmitted infections*.

6.4.3 Injectable Contraception (“the Shot”)

If you are one of the 20% to 50% of women who cannot remember to take your oral contraceptive regularly, you might consider “the shot.” Depo-Provera (or its new form called *Depo-subQ provera 104*) is an injectable drug containing a progestin (medroxyprogesterone acetate, or DMPA, a synthetic form of progesterone). All you have to remember is to return to the doctor every 3 months to get another shot. (A self-administered DMPA shot may soon be available.) It works by preventing ovulation, thickening cervical mucus, and preventing buildup of the endometrium. After a woman stops injections, it often takes 9 to 10 months for fertility to return. The perfect-use pregnancy rate is only 0.2%, but the typical-use rate is 6% (because some women do not remember to get their shots on time) (Bartz & Goldberg, 2011). The shot *does not protect against sexually transmitted infections*.

Depo-Provera

Market name for medroxyprogesterone acetate, a chemical that when injected suppresses ovulation for 3 months.

Depo-Provera is a safe alternative for women who should not take estrogen (because of a history of stroke, for example) (Kaunitz et al., 2014). However, there are some side effects that cause nearly 50% of women to discontinue this method within 1 year (Daniels et al., 2013a). These include irregularities in menstrual bleeding and weight gain. Most women experience prolonged bleeding at first but eventually little or no bleeding (although some women regard this as a positive effect) (CDC, 2013c).

Emergency Contraception

1. 6.5 Explain how emergency contraception works.

What options does a woman have if she has unprotected intercourse (resulting, for example, from unplanned intercourse, a condom tearing, forgetting to take her birth control pills, or rape)? If she acts within a few days, there is emergency contraception.

Emergency contraception

> Methods that prevent conception when used in the first few days after sexual intercourse.

Plan B One-Step (or its generic version, Next Choice) is a progestin-only (levonorgestrel) emergency contraception product that is available over the counter without a prescription. One pill is 50% effective if taken within 3 days. Another type of emergency contraception pill—ulipristal acetate, marketed as *Ella*—is about 65% effective for up to 5 days after unprotected intercourse (Glasier, 2013; Trussell & Schwarz, 2011). These products may cause non-serious side effects such as nausea, headache, and breast tenderness in up to 29% of women. However, experts regard these as safe products (Jatlaou et al., 2016). Their use does not interfere with future fertility (Trussell & Schwarz, 2011).

The most effective method of emergency contraception is implantation of a copper IUD (within 5 days after intercourse), with a failure rate less than 1 in 1,000 (Raymond & Cleland, 2015).

Emergency contraception is not an abortion! It is not the same as the abortion pill (RU 486). Emergency contraception works by preventing ovulation and fertilization. If implantation of a fertilized egg has already occurred, emergency contraception is not effective—and will not harm the embryo (Gemzell-Danielsson et al., 2013; Trussell & Schwarz, 2011).

Now that emergency contraception is easily available, it could prevent numerous unintended pregnancies each year and greatly reduce the number of abortions. About 14% of 15–19-year-old teens and 23% of 20–24-year-old women have used emergency contraception (Daniels et al., 2013b).

Long-Acting Reversible Contraception

1. 6.6 Discuss the advantages of long-acting reversible contraception (the IUD and implants).

All of the previous contraceptive techniques required taking action over a short period of time. Fertility awareness methods require daily monitoring of bodily changes. Barrier methods require that the device be put on/in shortly before sexual intercourse begins. The pill, patch, ring, and shot require that a woman remember to take/change the technique on a regular basis. Thus, many people are looking for a highly effective, long-acting contraceptive technique that does not require regularly remembering to do something but at the same time is reversible (can be removed) should they wish to conceive. We present two choices in this section.

6.6.1 The IUD

Can you guess what the most commonly used reversible contraceptive in the world is? No, it is not the birth control pill. It is the IUD (intrauterine device), used by many more women worldwide than even the pill (Wu & Pickle, 2014). In parts of Asia, over 40% of contraceptive users use IUDs (Buhling et al., 2014). Among American women of reproductive age who are currently using contraception, about 10.3% use an IUD, up from 0.8% in 1995 (Daniels et al., 2015).

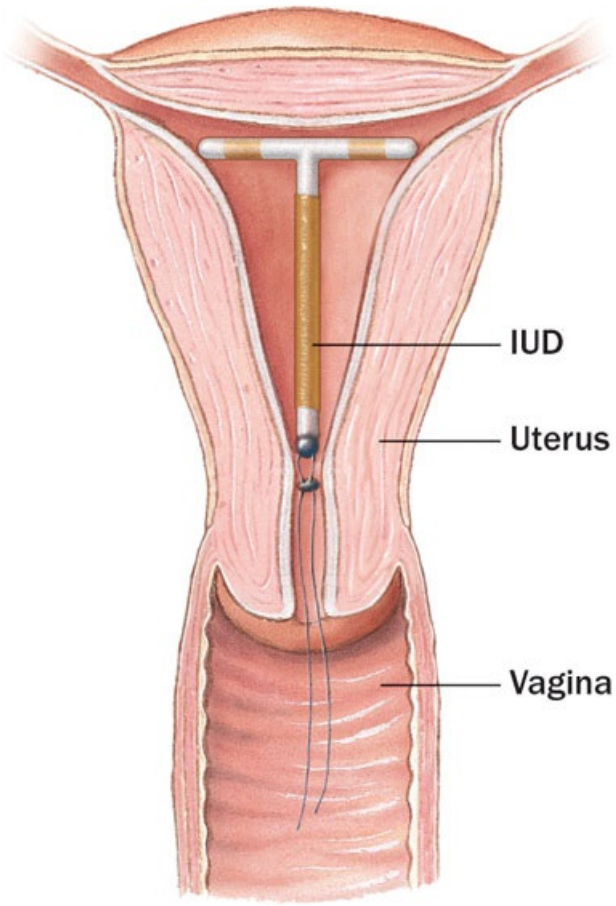
Intrauterine device (IUD)

> A birth control device, usually made of plastic with either a copper or progesterone coating, that is placed in the uterus to prevent conception and implantation.

The IUD is a small polyethylene device (of various shapes) that is placed into the uterus by a physician (see Figure 6–12). This is actually a very old idea—camel drivers used to insert a stone into a female camel's uterus to prevent pregnancy (don't ask us how they came up with this idea). IUDs work primarily by preventing fertilization, mostly by their effect on sperm transit through the uterus (Amy & Tripathi, 2009; Dean & Schwarz, 2011). Contrary to what you may have heard, they do not work by causing an abortion.

Figure 6–12

(a)



(b)

An IUD (intrauterine device), inserted (right).

Source: (left) Saturn Stills/Science Source; (right) Hock, *Human Sexuality,* © 2007 PrenticeHall, Inc. Reproduced by permission of Pearson Education, Inc.

There are two types of IUDs sold in the United States today: those with a copper coating (e.g., Copper-TCu380A) and those that release levonorgestrel (progesterone; e.g., Mirena). The Copper-TCu 380A (Paragard; see Figure 6–12) remains effective for 12 years (Wu & Pickle, 2014). The levonorgestrel-releasing IUDs remain effective for 5 to 7 years. It is the copper and progesterone that impair the passage of sperm. IUDs are highly effective, with typical-use pregnancy rates of much less than 1% per year, considerably better than the pill, patch, or ring (Dean & Schwarz, 2011). Compared to long-term use of other contraceptives, they are also relatively inexpensive.

Once the IUD is inserted, the woman's uterus sometimes attempts to expel the foreign object (2% to 10% of first-year users) (Dean & Schwarz, 2011). Because some women do not notice that their IUD has been expelled, manufacturers have added a polyethylene string to the IUD that protrudes from the cervix into the vagina so that women can check to see if their IUD is still in place. The copper IUD increases vaginal bleeding (which can be countered with drugs), whereas the Mirena IUD greatly reduces bleeding (a real advantage for women who normally have heavy menstruations). On the other hand, the progestin IUDs may cause weight gain, but the copper IUDs do not (Vickery et al., 2013).

The reputation of the IUD in the United States still suffers from the story of the Dalkon Shield, a very bad IUD that was removed from the market long ago (see Danvers et al., 2014, for a full history). Today's IUDs are not associated with an increased risk of pelvic inflammatory disease, ectopic pregnancy, breast cancer, or endometrial cancer. A woman becomes fertile again as soon as the IUD is removed (Dean & Schwarz, 2011; Mansour, 2012). Nevertheless, until recently, doctors have been cautious about prescribing IUDs to teenagers and young adults (because of the Dalkon Shield story). However, today's IUDs are regarded as so safe that both the American College of Obstetricians and Gynecologists and the World Health Organization now support use of the IUD by teens (see Turok, 2013). In the words of two experts:

> The contemporary copper intrauterine device (IUD) is one of the safest, most effective, and least expensive contraceptives available. It is a spectacularly effective, reversible contraceptive, rivaling female sterilization, injectables, and implants for pregnancy prevention. The IUD is convenient. Once inserted, it is nearly maintenance-free (except for monthly self-checks to locate the IUD string) for up to a decade.

(Rivera & Best, 2002, p. 385)

Of those women who use an IUD, the large majority have a favorable opinion about it. The continuation rate (85%), for example, is higher than for the birth control pill (Dean & Schwarz, 2011).

"After the birth of my second child, my doctor strongly advised no more children for a while. I was only 24 years old, so my doctor suggested an

IUD. It was very easily done in the doctor's office and my doctor advised me it was safe to have sex right away. It was a wonderful method of birth control."

(from the authors' files)

6.6.2 Hormone Implants

Nexplanon (formerly Implanon) is a single rod that contains progestin and remains active for 3 years (Figure 6–13). It works by thickening cervical mucus and preventing ovulation. It is inserted under the skin, usually on the inside of a woman's upper arm, and can be removed at any time. The pregnancy rate is no greater than 1 in 1,000 women (Raymond, 2011a). As with all progestin-only techniques, the major side effect is irregular vaginal bleeding, followed by little or no bleeding. The changes are not as great as observed in women using Depo-Provera (Hubacher et al., 2009), and many teens prefer an implant over the birth control pill (Lewis et al., 2010). Only 1.3% of American women using contraception rely on implants (Daniels et al., 2015), but among those who do, the 2-year continuation rate is higher than for either DMPA (the shot) or oral contraceptives (O'Neil-Callahan et al., 2013).

Figure 6–13

Nexplanon.

Source: By Ian Miles-Flashpoint Pictures/Alamy

There is also an implant called *Jadelle* with two progestin- releasing rods that is effective for 5 years. The Food and Drug Administration approved Jadelle in 1996, but it is not yet marketed in the United States. It is being used in several European countries.

6.6.3 Long-Term Versus Short-Acting Contraception

A group of researchers involved in a large-scale study recently concluded: "Given their effectiveness and high continuation rates, IUDs and implants should be first-line contraceptive options, and shorter-acting methods such as [oral contraceptives], patch, ring, and DMPA should be second tier" (O-Neil-Callahan et al., 2013, p. 1083).

Voluntary Sterilization

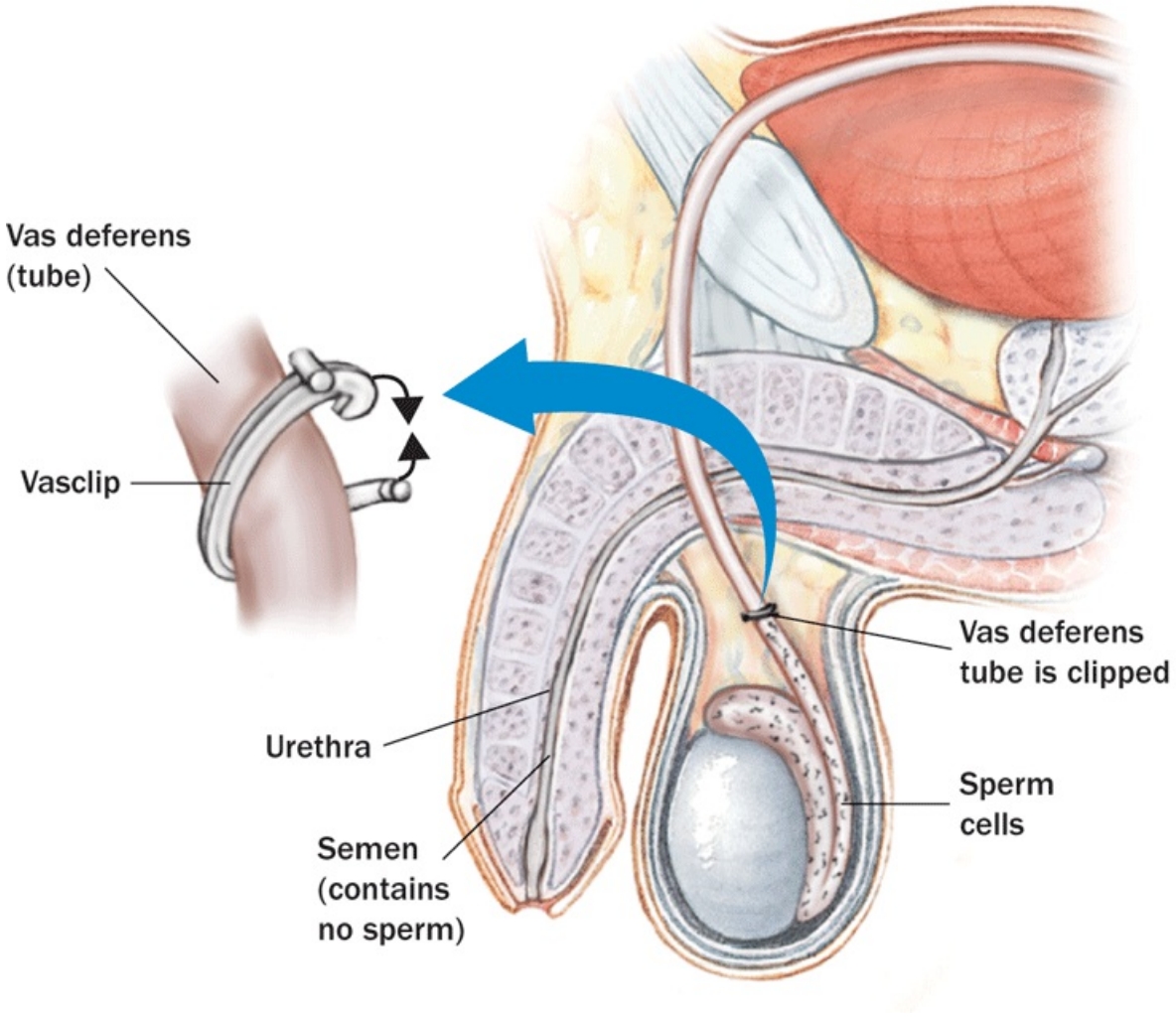
1. 6.7 Identify the various sterilization procedures and explain their advantages and disadvantages.

The most commonly used method of contraception worldwide is sterilization; 220 million couples rely on it. Would you be surprised to learn that more American couples also rely on sterilization for birth control than on any other birth control technique? For a couple to rely on this method, it is not necessary that they both be sterilized, so this figure is derived by adding male and female sterilizations. About 25.1% of American women who use contraceptives rely on female sterilization and another 8.2% on sterilization of their partner (Daniels et al., 2015).

6.7.1 Vasectomy

In men, the sterilization procedure is called vasectomy. In Western cultures, it has traditionally been done by making a small incision or two in the scrotum (under local anesthesia). As an alternative, a "no-scalpel" vasectomy has been introduced from China. With this technique, the skin of the scrotum is simply pierced with a sharp instrument. About half of all vasectomies performed in the United States are now done with this technique (Shih et al., 2011). Regardless of the initial penetration technique, the vas deferens is then tied off, cut, or cauterized. Another technique is called *Vasclip*, a plastic clamp no larger than a grain of rice that snaps onto the vas deferens to block sperm flow (see Figure 6–14). It causes less pain and fewer complications than traditional vasectomy. The entire procedure takes only 10 to 20 minutes.

Figure 6–14



A vasectomy can be performed by cutting the vas deferens or, as shown below by using a plastic clamp (Vasclip) to block the flow of sperm.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

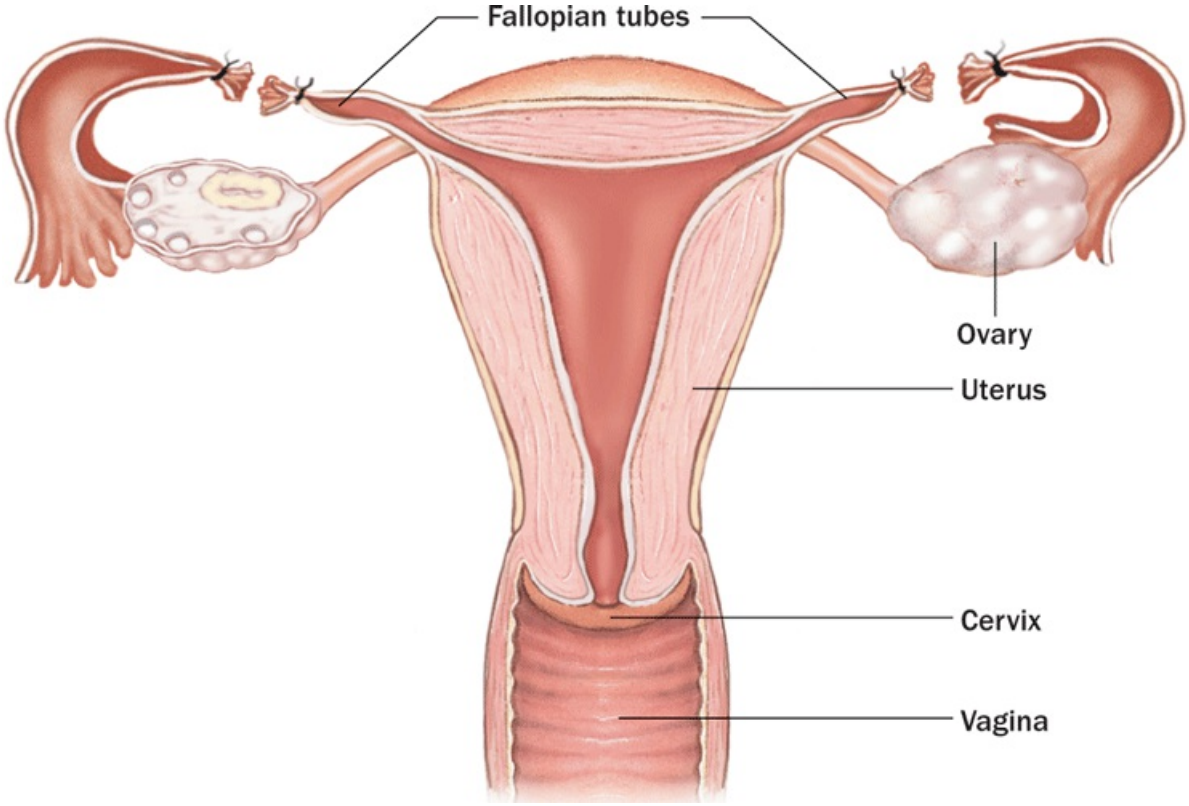
A vasectomy does not interfere with the production of hormones or sperm in the testicles. New sperm simply cannot get past the point where the vas have been tied and cut, and eventually they are destroyed by other cells called phagocytes. Sperm that are already past this point at the time of operation, however, must be eliminated before a man is "safe." Other means of contraception should be used for 3 months and until the man has had 20 ejaculations (Shih et al., 2011). Some men are reluctant to get a vasectomy because they think that they will no longer be able to ejaculate (obviously confusing ejaculation with orgasm), but recall from Chapter 2 that nearly all of the fluid (about 98%) in a man's ejaculation comes from the prostate gland and seminal vesicles, which are unaffected by the procedure. A man with a vasectomy will still ejaculate during orgasm, but his

ejaculation will contain no sperm, and the procedure has no effect on sexual desire or function (Guo et al., 2015).

6.7.2 Tubal Ligation

In women, the term *tubal ligation* is often used for a variety of techniques, but the more descriptive term is tubal sterilization. There are two basic techniques: transabdominal (incisions are made in the abdomen) and transcervical (see Roncari & Hou, 2011). See Figure 6–15. Both procedures are usually done with general anesthesia, but most women go home the same day. Unlike the male technique, a woman may safely engage in sexual intercourse as soon as she feels the desire to do so.

Figure 6–15



With a tubal sterilization, the Fallopian tubes are cut or blocked so that a sperm and egg cannot meet.

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

For transabdominal procedures, sterilization can be achieved in two different ways. In a *minilaparotomy*, 1-inch incisions are made in the abdomen, and the Fallopian tubes are pulled to the opening and cut, tied, or blocked with clips. A *laparoscopy* is a procedure in which a laparoscope, a long, tube-like instrument that transmits TV pictures, is inserted through a small incision in the navel. Once the tubes are located, surgical instruments are inserted through the laparoscope (or other tiny incisions) and the tubes are cut or cauterized.

In transcervical procedures, there are no incisions and general anesthesia is not required. One of two devices is placed into the Fallopian tubes. The Essure device irritates the lining of the tubes, resulting in scar tissue that plugs them up. The Adiana device emits a radio frequency that causes tubal lesions.

6.7.3 Complications

Surgical complications resulting from vasectomy are uncommon (less than 3%) and generally minor. Some sperm leak into the bloodstream, and as a result, at least half of the men who have had a vasectomy produce antibodies to their own sperm. However, several large studies have concluded that this has not resulted in any health problems (Roncari & Hou, 2011). A few studies raised concerns that vasectomy might increase men's risk of prostate cancer. However, after a scientific panel at the National Institutes of Health met to discuss these findings, they concluded that there was no evidence that vasectomy increased the risk of prostate cancer (see Cox et al., 2002).

Complications following tubal sterilization occur more frequently than after vasectomy but are still uncommon (Roncari & Hou, 2011). Menstrual abnormalities afterward rarely occur (Peterson et al., 2000). On the other hand, for reasons that are not yet known, women who have had tubal sterilization are more likely than other women to eventually have a hysterectomy (Roncari & Hou, 2011). Sterilization in women has a definite health benefit: It substantially decreases their risk of getting cancer of the ovaries (Roncari & Hou, 2011).

6.7.4 Can Sterilizations Be Reversed?

Sterilization procedures are highly effective, with failure rates of 0.15% for male sterilization and 0.5% for female sterilization (Trussell, 2011). Today, they should also be considered permanent. Few people who decide to be sterilized ever wish to have the procedure reversed. About 6% of men eventually regret the decision, as do 6% of women over the age of 30. About 20% of women under 30 regret the decision (Amy & Tripathi, 2009; Shih et al., 2011). For those who want a reversal, there is no guarantee of success. The problem is that the sewing together of the vas deferens or Fallopian tubes requires very skilled microsurgery techniques (the inside diameter of the passageway through a Fallopian tube, for example, is no greater than a human hair). The pregnancy rate after vasectomy reversal is between 40% and 60% (Shih et al., 2011). Success depends on the length of time since the vasectomy. This may be due to the increased levels of the man's antibodies to his own sperm. Successful reconstruction of the Fallopian tubes is very difficult because the slightest scarring can impair passage of the egg (and result in tubal pregnancy even if fertilization occurs). Success rates range from 43% to 88%, depending largely on the original type of sterilization. So, while there have been successful reversals in both men and women, the success rates are still far less than 100%. Therefore, only people who are quite sure that they do not want any more children should opt for these procedures.

If a couple decides that they do not want any more children (or any children at all), which person should agree to be sterilized? Perhaps this will help: A recent review concluded that vasectomy "is more efficacious, more cost effective, and has lower rates of complications" (Shih et al., 2011, p. 310).

Personal Reflections

Considering all factors (including your sexual lifestyle), which birth control technique is best for you? If you are not presently using it, how can you obtain it?

Box 6–A Sexuality and Health Contraceptive Methods That Help Prevent Sexually Transmitted Infections

1. 6.8 Discuss the contraceptive methods that also help to prevent sexually transmitted infections.

Sexually active individuals who are not in monogamous relationships must (and should) worry about sexually transmitted infections in addition to pregnancy. Unfortunately, contraceptive development has concentrated almost entirely on preventing pregnancy and has ignored STIs. What do we know about the effectiveness of currently available contraceptive devices in preventing STIs?

The contraceptive methods that are the most effective in preventing pregnancy (e.g., sterilization, implants, Depo-Provera, the IUD, and the birth control pill) offer no protection against STIs (Marrazzo & Cates, 2011). The same is true for fertility awareness methods.

The active ingredient in most spermicides, nonoxynol-9, does not protect against gonorrhea and chlamydia, and frequent use may actually increase an individual's risk of catching HIV from an infected partner by irritating the vaginal or rectal walls and making transmission of HIV easier (Cates & Harwood, 2011).

What about the barrier methods of contraception? Use of rubber condoms will reduce the risk of getting STIs that are spread by exchange of body fluids. "Skins" (condoms made of sheep intestine) have pores that are large enough for the passage of HIV and other viruses. Condoms also offer some protection against syphilis (Koss et al., 2009). Condoms break about 2% of the time during vaginal intercourse and more often during anal intercourse (Warner & Steiner, 2011).

Of course, if condoms were always used correctly and consistently, their effectiveness at STI prevention would be much greater. In one study of 124 serodiscordant couples (only one member was HIV positive) who used condoms consistently, none of the HIV-negative partners became infected during a total of 15,000 acts of intercourse (De Vincenzi et al., 1994). Both a National Institutes of Health Consensus Report and a Centers for Disease Control and Prevention Fact Sheet reached the same conclusion—condoms are effective in protecting against HIV and other sexually transmitted infections (see Cates, 2003).

What about women and barrier methods? At first glance, an obvious choice might be to have their partners always wear condoms, but this "may be unrealistic because traditional sex roles in most cultures do not encourage a woman to talk about sex or to initiate sexual practices or otherwise control an intimate heterosexual encounter" (Rosenberg & Gollub, 1992; see Box 5–C). Among women at high risk for getting an STI, the female condom would appear to be a good alternative (Cates & Harwood, 2011). However, while most women at high risk are willing to try it, only a minority like it well enough to use it consistently. Diaphragms offer no protection against STIs (Marrazzo & Cates, 2011). Thus, women who engage in high-risk sexual behavior (e.g., multiple partners) and rely on any technique other than condoms to prevent pregnancy should use dual-method contraception—primary method plus condoms. Unfortunately, few women adhere to dual-method contraceptive use (Tyler et al., 2014).

The real hope for the future lies in development of a microbicide, a bacteria-and-virus-killing cream or gel that a person can apply vaginally or rectally before intercourse. Many types are now undergoing testing, and at least one (with the antiretroviral drug tenofovir) has proven very promising in clinical trials (*Time*, 2010). When these become available, women will indeed be able to take measures to protect themselves. However, do not expect them to reach the market for several years (Schwartz & Gabelnick, 2011).

Future Technology

First the good news: Surveys indicate that at least 25% of men would be willing to use hormonal contraception (Glasier, 2010). Now the bad news: Research of a male pill that was found to be 96% effective was halted because some men experienced side effects commonly experienced by women on hormonal birth control methods (Behre et al., 2016). There will not be a male pill on the American market for many years. Trying to find a pill that inhibits sperm production without unwanted side effects has proven difficult (Kanakis & Goulis, 2015). In addition, both government and private funding has been minimal. Clinical trials continue with RISUG (reversible inhibition of sperm under guidance), a technique in which a polymer gel is injected into the vas deferens, with the polymer then destroying sperm for the next 10 years (Lohiya et al., 2014).

The most recent research is focusing on molecules in the testicles that are necessary for the production of sperm in the seminiferous tubules. For example, some researchers are targeting a molecule called retinoic acid (Nya-Ngatchou & Amory, 2013). The advantage of this is that it would stop sperm production without interfering with gonadal hormones.

Female-Controlled Barrier Methods

There has been considerable research and development of female-controlled barrier methods of contraception that will be easier to use and more comfortable than the diaphragm and female condom (Schwartz & Gabelnick, 2011). The silicone *SILCS intravaginal barrier* resembles a diaphragm but does not require fitting by a doctor (one size fits all) and is easier to insert and remove. A variety of new female condoms are also under development (Beksinska et al., 2011) as are new, safer estrogens and progesterones for use with hormonal contraception (Sitruk-Ware et al., 2013).

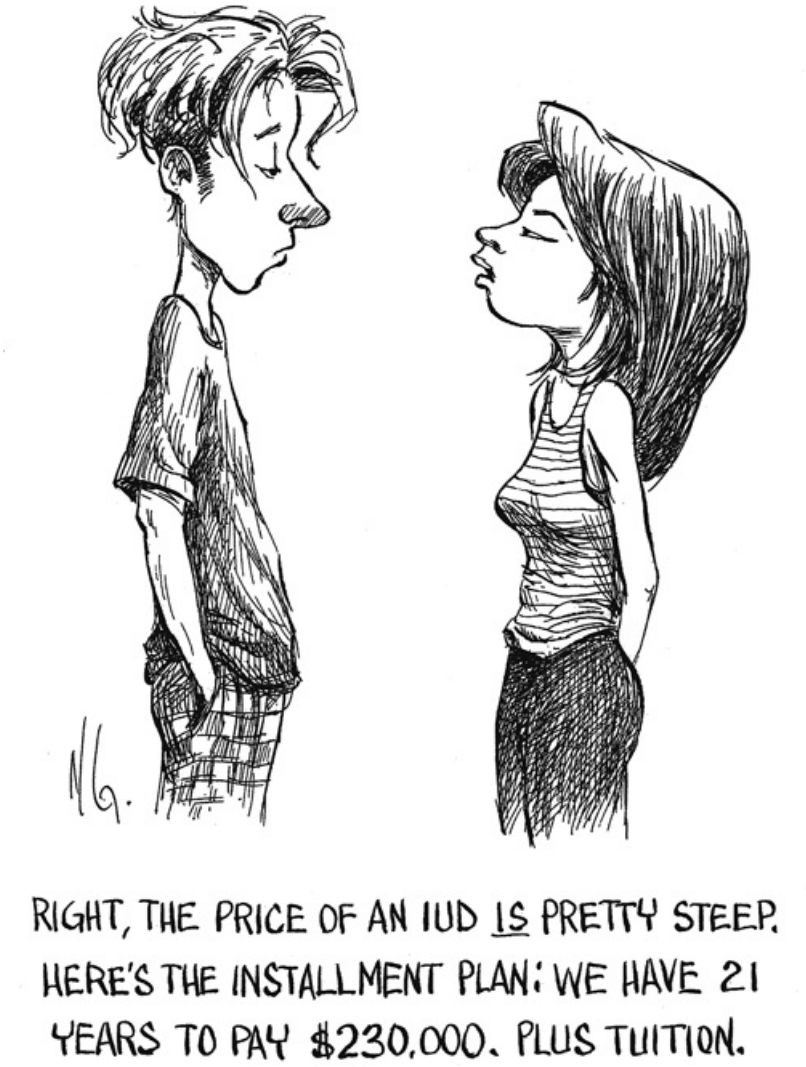
Vaccination

One promising future means of birth control is *vaccination* (Naz, 2011a). It might be possible to prevent pregnancy the same way you can the flu. Researchers are trying to develop vaccines that will cause the body to produce antibodies to proteins in either sperm or eggs. In the words of a leading researcher in this area, "For a contraceptive vaccine to be acceptable, it needs to be highly tissue-specific without any side effect and should provide close to full protection against pregnancy" (Naz, 2011b).

Contraceptive vaccine researchers are exploring three approaches: vaccines that target sperm or egg production, function, or outcome. For example, scientists in India are already clinically testing a vaccine that stimulates the production of antibodies to HCG (human chorionic gonadotropin), a hormone necessary to maintain pregnancy. With this vaccine, a fertilized egg could not implant and would be discharged during menstruation. The researchers are optimistic, but as with a male pill, we are many years away from anything available for human use.

Legal Concerns

The biggest deterrent to new contraceptive methods is not technology or lack of research but an insurance–product liability problem (see Danvers et al., 2014). American consumers are accepting of the fact that contraceptive methods sometimes fail to prevent pregnancy, but they are less forgiving about side effects. When a legal case involves an individual versus a large corporation, juries often award large settlements to the individual in the belief that the corporation can afford it. A jury awarded $5 million, for example, to a couple who claimed that their child's birth defects were caused by spermicides, even though the authors of the study that claimed to link spermicides with birth defects had repudiated their own results. A few more cases like this and we may see the end of spermicides, the contraceptive sponge, and all hormonal methods of contraception. In just the past few years we have seen Norplant and Lunelle (two types of implants used in many other parts of the world) taken off the market.



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Terminating Pregnancies: Abortion

1. 6.9 Delineate the methods used and arguments for and against abortion.

There is no reversible method of contraception that is 100% effective (although implants and the IUD come close); thus, unwanted pregnancies sometime occur even for couples who are using the most reliable forms of contraception. If an unwanted pregnancy should occur, a woman (or a couple) really has only three options: to continue with the pregnancy and keep the baby, to continue with the pregnancy and put the baby up for *adoption,* or to terminate the pregnancy (abortion). Of these three options, only abortion can be considered a method of birth control.

Over 40 million abortions are performed annually throughout the world, of which only about 60% are performed under safe conditions by trained providers (Sedgh et al., 2013). Worldwide, 7 million women a year in developing countries need medical treatment for complications from unsafe abortions (Singh & Maddow-Zimet, 2015). Unsafe abortions account for 15% of maternal deaths (Kassebaum et al., 2014). In the United States, about 1.1 million pregnancies end in abortion each year, down from 1.6 million in 1990 (Jones & Jerman, 2014). While the abortion rate is high among teens who get pregnant, about one third of women over 40 who get pregnant also choose to have an abortion (Nelson & Stewart, 2008).

Nearly 90% of all women who obtain abortions do so within 12 weeks of conception and 62% within 8 weeks (Paul & Stein, 2011). One of the most widely used arguments today by abortion opponents is that "abortion harms women." Well-conducted scientific studies do not support this (see Jordan & Wells, 2009). Death resulting from a legal abortion is very uncommon—less than 1 per 100,000 abortions—and, in fact, is much less common than deaths resulting from plastic surgery procedures (Raymond et al., 2014). Modern first-trimester abortions do not increase a woman's subsequent risk of infertility, miscarriage, ectopic pregnancy, having a low-birthweight baby, or breast cancer (see Paul & Stein, 2011).

What are some of the possible consequences of legalizing abortion? Of abolishing abortion? If abortion were made illegal in the United States, it would result in an increase of 440,000 births per year (Levine et al., 1999). In Romania, the abolishment of legalized abortion led to the highest maternal mortality rate in Europe and the abandonment of tens of thousands of children in institutions (Stephenson et al., 1992).

There are several methods used to terminate a pregnancy (see Paul & Stein, 2011):

1. *Medical (non-surgical) abortion* for early abortion: RU 486, or mifepristone, is a pill that can be used to chemically induce an abortion up to 8 weeks after a woman's last menstrual period. It is distributed under the name Mifeprex. It is about 92% effective when taken in combination with oral prostaglandins (misoprostol, which causes contractions of the uterus that expel the embryo) within the first 7 weeks after implantation. RU 486 works by blocking the body's use of progesterone, the hormone necessary for maintaining the endometrium of the uterus, thus causing shedding of the uterine lining. A woman takes the first drug at a doctor's office and the second drug at home 6 hours to 3 days later. The main side effects are nausea, cramping, and prolonged uterine bleeding, but major complications are rare (White et al., 2015). Medical abortion can be done completely at home in many countries (e.g., Australia), but the politics of abortion may never allow for this in the United States (Grossman & Goldstone, 2015).

2. Dilation and curettage (D&C): Once the standard procedure for unwanted pregnancies of 15 weeks or less, D&C procedures are now used less and less for purposes of abortion. Under general anesthesia, a woman's cervix is dilated, and the lining of the uterus is then scraped with a metal instrument called a curette. In addition to the risks associated with general anesthesia, this procedure results in more bleeding and discomfort than D&E procedures (next).

3. Dilation and evacuation (D&E): In this procedure, which does not require general anesthesia, a tube is inserted through the cervix and the fetal material is removed by suction. About 88% of all legal abortions in the United States are now performed by this method. Today, with use of a hand-held vacuum syringe, the procedure can be done 8 days after conception, and it takes only 5 minutes. D&E can be done without anesthesia in the first 4 to 6 weeks of pregnancy but requires local anesthesia and dilation of the cervix for pregnancies terminated during weeks 7 through 12. Later-stage abortions may require gentle scraping of the uterine walls in addition to suction.

4. Induced labor: This method is used exclusively for termination of pregnancies that have proceeded beyond 16 weeks (which accounts for less than 5% of all abortions). A solution of hypertonic saline or prostaglandins (hormones that cause smooth muscle contractions) is injected into the amniotic sac and induces labor within 12 to 36 hours. The fetus is born dead.

Some studies claim to have found that abortion is followed by an increase in mental health problems (see Coleman, 2011), but these studies have serious methodological flaws (see Steinberg et al., 2012). Large, well-conducted studies have found that women who have first-trimester abortions do not experience emotional or psychological problems afterward at a rate any greater than women who give birth to unwanted babies (e.g., Charles et al., 2008; Major et al., 2009; Munk-Olsen et al., 2011). In fact, 95% of women later say that it was the right decision (Rocca et al., 2015).

6.9.1 The Present Status and Future of Abortion in the United States

Abortion is a subject that has polarized people throughout the nation. Those opposed to abortion ("right-to-lifers") express concerns about protecting human life. "Pro-choicers," on the other hand, wish to retain the right of individuals to make decisions about something that will have a major impact on their own lives. In national surveys conducted by Gallup in 2016, 49% of people identified themselves as pro-choice and 44% as pro-life; 43% believed that abortion was morally acceptable, 47% said morally wrong, and 9% said it depended on the situation; 50% felt that it should be legal in some circumstances and another 29% said legal in all circumstances, while only 19% said that it should be illegal.

The laws regarding abortion have been in a state of transition for over 4 decades. Prior to 1973, each state could allow or prohibit abortion as it wished, but in that year a 7 to 2 Supreme Court decision (*Roe v. Wade*) prohibited the states from interfering with decisions made between a

woman and her doctor during the first 3 months of pregnancy. The ruling also prevented states from prohibiting abortion in the second trimester of pregnancy but did allow for more regulations designed to protect a woman's health (e.g., hospitalization). Antiabortion forces won a victory in 1977 when the Supreme Court upheld the Hyde Amendment, which disallowed the use of federal Medicaid money to pay for abortions. Without public funding, obtaining a legal abortion became difficult for women with limited incomes. The number of abortion providers also decreased substantially from 1990 to 2013 (Jones & Jerman, 2014). Although the decision in *Roe v. Wade* giving a woman the right to choose is still the law, subsequent court decisions have given states greater leeway in regulating abortion.

Religious beliefs regarding abortion have often changed as well. Within the Catholic Church, for example, even Thomas Aquinas believed that human life began in the second trimester, not at conception. The first pope to declare that abortion was murder was Sixtus V in 1588, but that was reversed just 3 years later by Pope Gregory XIV. For the next 300 years, abortion was allowed up to the time of what was termed "animation by a rational soul" (up to 40 days after conception in the case of a male embryo and for the first 80 days in the case of a female fetus; Connery, 1977; Grisez, 1970). In 1869, however, Pope Pius IX again declared that abortion was murder, and this has remained the belief of every pope since.

With the diversity of opinion regarding this subject, religious and legal beliefs about abortion will probably continue to change for many decades to come. In the meantime, both sides would probably benefit by supporting an increase in family planning services. Many studies have shown that "increasing the use of effective contraception leads to declines in induced abortion rates" (Shears, 2002a; see also Marston & Cleland, 2003).

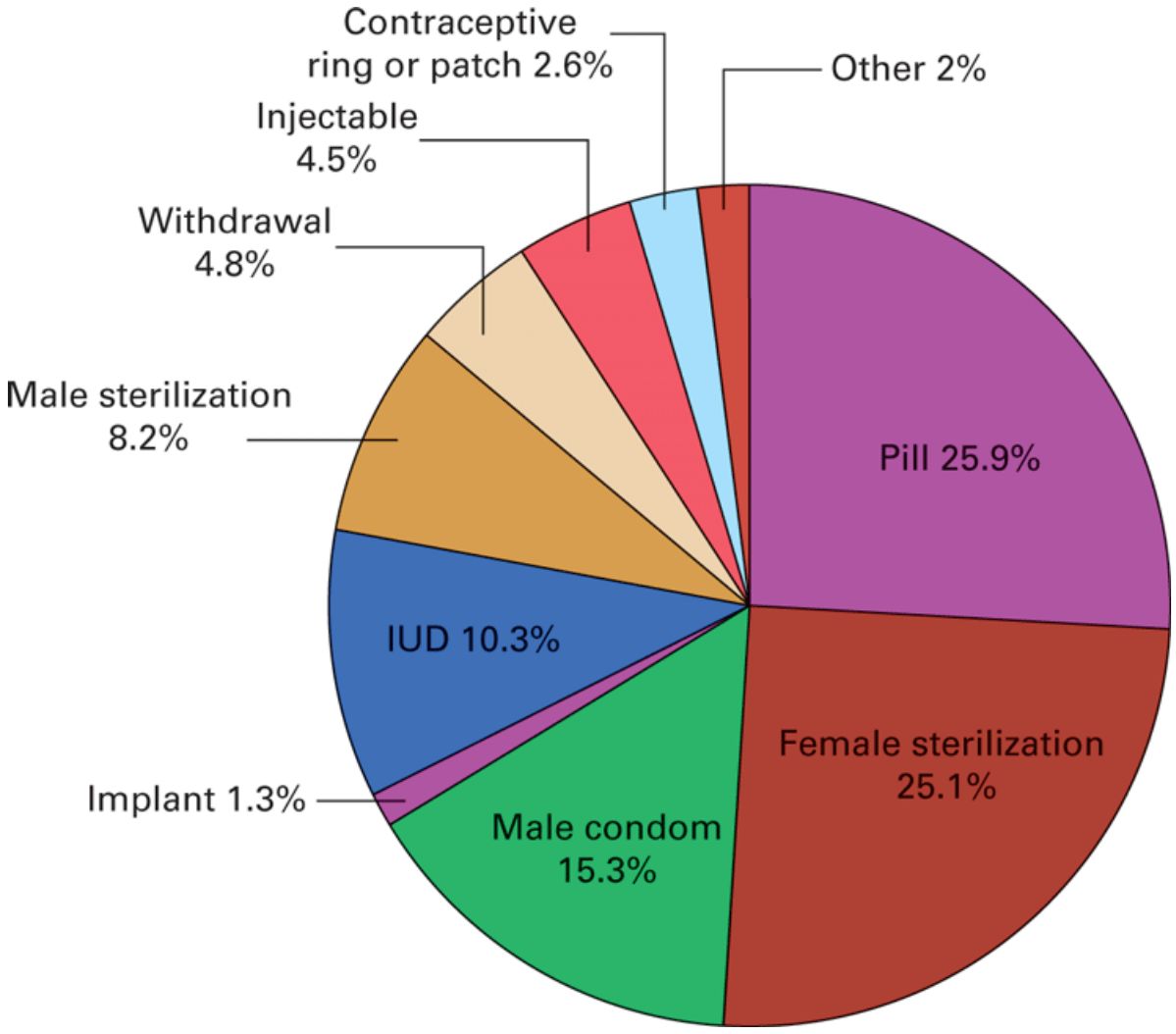
Choosing a Contraceptive Method

1. 6.10 Determine which contraceptive method is right for you.

It is important that men and women choose a method of birth control with which they and their partner are comfortable. A woman may like the diaphragm, but it will not be good if her partner resents her stopping in the middle of having sex to put it in. A man may prefer that his female partner take the pill, but it will not be good for the couple's relationship if she resents having to suffer possible side effects. A couple can work these kinds of problems out only by talking about the matter and communicating with each other on a regular basis.

Choosing a particular birth control method does not mean that you have to stick with it if you are unhappy about it for any reason. During 2006–2010, women used an average of three methods, and almost 30% used five or more (Daniels et al., 2013a). See Figure 6–16. Unfortunately, many of these women use no type of contraception at all for at least a month after stopping use of their first choice. If you do not presently wish to have children and are unhappy with the birth control method you use, decide on an alternative method *before* you stop using your present one.

Figure 6–16



Percent distribution of women aged 15 to 44 who are currently using contraception, by type of contraceptive method used: United States, 2011–2013.

Sources: CDC/HCHS, National Survey of Family Growth, 2011–2013, and Daniels et al. (2015). Current Contraceptive Use and Variation by Selected Characteristics among Women Aged 15–44: United States, 2011–2013. *National Health Statistics Report*, 86.

Figure 6–16 Full Alternative Text

When deciding which type of birth control to use, ask yourself the following questions; they were developed to help you decide whether the method you are considering is a good choice or a poor choice *for you*.

(Adaptation from *Contraceptive Technology,* 18th ed. (pp. 6-54), R. A. Hatcher et al., 2004, New York: Ardent Media. Adapted with permission.)

Most individuals will have a few "yes" answers. "Yes" answers mean that potential problems may lie in store. If you have more than four "yes" responses, you may want to talk to your physician, counselor, partner, or friend. Talking it over can help you to decide whether to use this method or how to use it so it will really be effective for you. In general, the more "yes" answers you have, the less likely you are to use this method

Answer "yes" or "no" to the following questions:	**Yes**	**No**
Length of time you used this method in the past.		

consistently and correctly.

1. Have I had problems using this method before?

This chapter has only introduced the various contraceptive methods. If additional information is desired, you are urged to contact your local Planned Parenthood organization or your state family planning clinic. The people who work there will be glad to help you.

2. Have I ever become pregnant while using this method?
   Sex is for people who are ready and willing to take a lifetime responsibility for the outcome of sex.

(Su, Fisher, Lasbury, L. Smith, 1993)

3. Am I afraid of using this method?

4. Would I really rather not use this method?

5. Will I have trouble remembering to use this method?

6. Will I have trouble using this method correctly?

7. Do I still have unanswered questions about this method?

8. Does this method make menstrual periods longer or more painful?

9. Does this method cost more than I can afford?

10. Could this method cause me to have serious complications?

11. Am I opposed to this method because of any religious or moral beliefs?

12. Is my partner opposed to this method?

13. Am I using this method without my partner's knowledge?

14. Will using this method embarrass my partner?

15. Will using this method embarrass me?

16. Will I enjoy intercourse less because of this method?

17. If this method interrupts lovemaking, will I avoid using it?

18. Has a nurse or doctor ever told me not to use this method?

19. Is there anything about my personality that could lead me to use this method incorrectly?

20. Am I at any risk of being exposed to HIV (the AIDS virus) or other sexually transmitted infections if I use this method?

Total Number of "Yes" Answers:

Study Guide

Key Terms

- abortion
- barrier (blockade) method
- Billings method
- calendar method
- cervical cap
- cervical mucus
- combination pill
- condom
- Contraception
- contraceptive sponge
- Depo-Provera
- diaphragm
- dilation and curettage (D&C)
- dilation and evacuation (D&E)
- douching
- emergency contraception
- female condom
- FemCap
- fertility awareness methods
- IUD (intrauterine device)
- lactational amenorrhea method (breast-feeding)
- microbicide
- Nexplanon
- NuvaRing
- OrthoEvra
- perfect-use pregnancy rate
- progestin-only pill
- spermicides
- Standard Days Method
- sterilization
- symptothermal method
- tubal sterilization
- typical-use pregnancy rate
- vasectomy

- withdrawal (coitus interruptus)

Interactive Review

Answers can be found on p. 470.

1. Worldwide, there is need for effective contraceptive technology. World population is expected to increase to over (1) billion by the middle of this century, yet already there are many parts of the world experiencing food shortages and mass starvation.

   The teen pregnancy rate in the United States is much higher than in most other developed countries. About (2) of pregnancies in the United States are unintended. Unfortunately, the teens most likely to have babies are those least prepared to take care of them.

   All the methods of birth control discussed in this chapter are better than using nothing, but some are more effective than others. The best way to avoid unintended pregnancy is (3) . Relatively ineffective methods include withdrawal and douching. Methods that require fertility awareness are called the (4) , (5) , and (6) methods. They rely on calculating when (7) will occur and abstaining from intercourse during that period. The typical-use pregnancy rates for these methods are higher than for most others. The (8) method works by breast-feeding inhibiting pituitary hormones. (9) work by killing sperm and are generally used in combination with a barrier method of contraception: (10) , (11) , (12) , or (13) . Barrier methods block sperm from getting into the (14) . Barrier methods often interfere with spontaneity, but for people who are not in a monogamous relationship, a major advantage of condoms (not offered by other methods) is that they (15) .

   The combination birth control pill contains synthetic (16) and (17) and works by preventing ovulation. The pills used today contain low dosages of estrogen and are safer than the high-dosage pills used in the past. Nevertheless, there are certain groups of women who, for medical reasons, should not take the pill. The (18) and (19) contain the same hormones as the combination pill, but do not require that a woman remember to use contraception every day. (20) (the shot that lasts 3 months) contains only progestin. These hormonal methods of contraception have theoretical failure rates of less than 1%. For women who have had unprotected intercourse, emergency contraception pills are often effective when taken within (21) days of intercourse, or even more effective, an IUD may be implanted within 5 days.

   Many people desire a long-acting reversible method of contraception. Two safe and highly reliable choices are (22) and (23) .

   If you consider male and female sterilization techniques together, more Americans rely on sterilization for birth control than any other method. In a vasectomy, the (24) is tied off and cut. Afterward, the man still ejaculates during orgasm, but his ejaculation contains no sperm. For a (25) , a woman's Fallopian tubes are cut, cauterized, or blocked by clips. The failure rate is close to zero.

   For women who have an unplanned or unwanted pregnancy, one option is abortion. Various techniques can be used to terminate pregnancy, including chemicals, scraping or suctioning away of the endometrium, and induced labor.

   It is important for you to choose an effective contraceptive technique before you have sexual intercourse. A questionnaire is provided at the end of the chapter that is designed to help you decide which method is best for you.

Self-Test

Answers can be found on p. 470.

A. True or False

- **T F** 26. The contraceptive sponge is effective for 24 hours.
- **T F** 27. Sweden and Denmark have substantially lower teenage birth rates than the United States.
- **T F** 28. The world population is expected to stabilize by the year 2020 because of increased use of birth control.
- **T F** 29. The U.S. fertility rate is presently about 1.9 births per woman.
- **T F** 30. If the perfect-use pregnancy rate for a contraceptive method is 20%, then for 100 couples who start using the method, about 20 of them will have conceived after 3 years.
- **T F** 31. In order for a woman to get pregnant, she must have an orgasm.
- **T F** 32. More couples rely on sterilization than on the birth control pill.
- **T F** 33. It is possible for a girl to get pregnant as soon as she starts having menstrual periods.
- **T F** 34. A relatively effective method of birth control for women is to wash out the contents of the vagina immediately after sexual intercourse.
- **T F** 35. The birth control pill reduces the risk of getting a sexually transmitted infection.

- **T F** 36. A vasectomy works as birth control by preventing ejaculation.
- **T F** 37. If carefully washed and dried, male condoms can be used safely on more than one occasion.
- **T F** 38. Most women gain weight when they start taking the birth control pill.
- **T F** 39. The contraceptive sponge is more effective than the diaphragm.
- **T F** 40. Taking antibiotics makes the birth control pill less effective.
- **T F** 41. Legal abortions do not increase a woman's later risk of infertility, miscarriage, breast cancer, or a low-birthweight baby.
- **T F** 42. Today's IUDs are effective and considered to be safe products.
- **T F** 43. The major difference between the cervical cap and the diaphragm is that the cervical cap does not need to be used with spermicide.
- **T F** 44. Emergency contraceptive techniques work by causing an abortion.
- **T F** 45. Breast-feeding a baby inhibits the release of follicle-stimulating hormone from a woman's pituitary gland.
- **T F** 46. The patch and vaginal ring are just as effective as the combination birth control pill.
- **T F** 47. Pregnancy and childbirth result in more maternal deaths than does the use of the birth control pill.
- **T F** 48. In the future, it will probably be possible to be vaccinated to prevent pregnancy (as is done for the flu).
- **T F** 49. Rubber condoms are more effective than "skin" condoms for prevention of STIs.
- **T F** 50. The female condom is actually an intravaginal pouch.
- **T F** 51. Most women who are over the age of 40 and do not smoke can continue to take the combination birth control pill.
- **T F** 52. The diaphragm offers women protection against gonorrhea and chlamydia.

B. Matching

(Some answers can be used more than once.)

Contraceptive Method

- 53. breast-feeding
- 54. calendar method
- 55. symptothermal method
- 56. Billings method
- 57. spermicides
- 58. male condom
- 59. female condom
- 60. diaphragm
- 61. cervical cap
- 62. contraceptive sponge
- 63. emergency contraception (Plan B)
- 64. the patch (OrthoEvra)
- 65. IUD
- 66. combination pill
- 67. Depo-Provera
- 68. vasectomy

- 69. tubal sterilization
- 70. vaginal ring (NuvaRing)
- 71. Nexplanon

1. prevents fertilization of an egg
2. active ingredient kills sperm
3. thickening cervical mucus
4. involves noting changes in cervical mucus in order to determine when to abstain from intercourse
5. prevents sperm deposited in the vagina from getting into the uterus
6. involves tying, cutting, or cauterizing Fallopian tubes, or blocking them by clips
7. contains enough spermicide to be effective for 24 hours
8. blocks sperm from getting into the vagina
9. uses a simple mathematical formula to determine when to abstain from intercourse
10. prevents ovulation
11. uses changes in resting temperature to determine when to abstain from intercourse
12. involves tying or cutting off vas deferens
13. prevents implantation
14. prevents release of FSH

C. Fill in the Blanks

- 72. Withdrawal is not a highly effective method of birth control because .
- 73. After a vasectomy, a man is not sterile until .
- 74. If a woman's shortest recorded menstrual cycle is 25 days and her longest is 31 days, by the calendar method she should abstain from intercourse from day to day .
- 75. Women's basal body temperature about the time of ovulation.
- 76. Women's cervical mucus becomes at the time of ovulation.
- 77. Rubber condoms should not be used in combination with lubricants.
- 78. Three non-prescription barrier types of contraception are the , , and the .
- 79. In cases of unprotected intercourse, pregnancy may be avoided within the first few days by .
- 80. Sperm can live in a Fallopian tube for as long as .
- 81. The best way to avoid an unwanted pregnancy is .

Suggested Readings and Resources can be found on p. 461.

Chapter 7 Pregnancy and Childbirth

> The sexes of a species are the classes of reproductively incomplete individuals. In order for a sex member to contribute to the physical foundations of its species, to reproduce part of itself into the next generation, it must remedy its incompleteness. The remedy is found in the union of incomplete parts from complementary complete organisms: eggs and sperm cells unite.

—Gordon Bermant & Julian Davidson, 1974

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 7.1 Explain the process of conception, trace the process of development from the zygote through implantation, and discuss some problems that sometimes occur with implantation.
2. 7.2 Describe what occurs in each trimester of pregnancy for both mother and embryo/fetus.
3. 7.3 Discuss recommendations concerning sexual intercourse during pregnancy.
4. 7.4 Summarize the possible effects of smoking, alcohol, drug use, and environmental hazards on the embryo and fetus.
5. 7.5 Discuss traditional and alternative birthing practices including Lamaze, Bradley, Leboyer, home births, and the use of midwives.
6. 7.6 Describe the three stages of labor and the events that occur in each.
7. 7.7 Identify and explain the problems that can occur during breech deliveries, cesareans, and preterm deliveries.
8. 7.8 Discuss issues following childbirth: the benefits of breast-feeding, postpartum depression, when to begin sexual intercourse, and spacing pregnancies.
9. 7.9 Compare and contrast the various methods for dealing with infertility.

Pregnancy and childbirth are intense experiences, remembered for a lifetime. The most potent human emotions—hope, fear, love, loneliness, depression, and joy—are often felt at their maximum levels. The first time that a woman feels a fetus move inside her, her first labor contractions, the first time that a child is viewed by its parents after birth—these are often the things that make life worth experiencing. Giving birth means assuming a great responsibility, for the newborn is totally dependent upon his or her parents. Relationships change with the addition of a new life and new responsibilities within a family. This requires that many adjustments in living be made. As you will see, it is important to begin making these adjustments before the baby is born—sometimes even before the baby is conceived.

Conception and Implantation

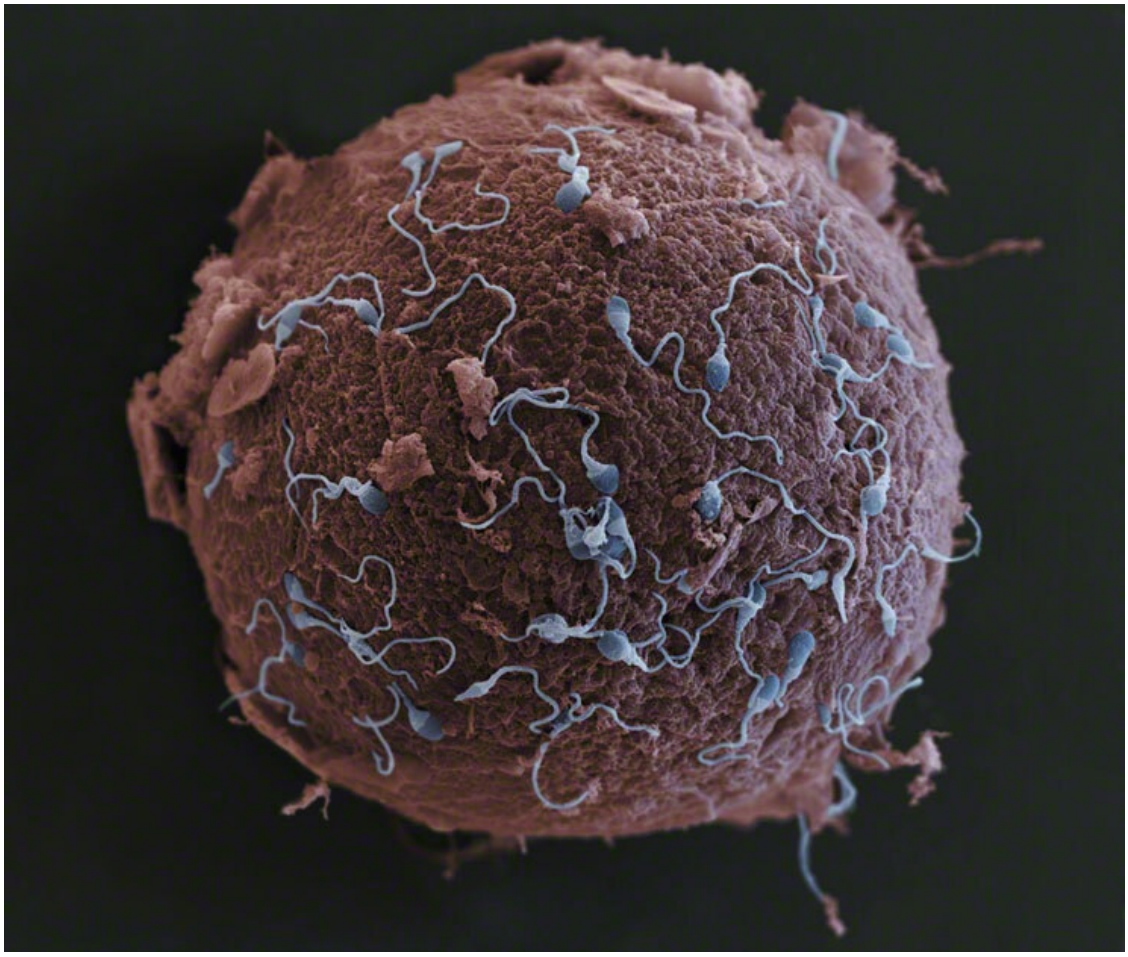
1. 7.1 Explain the process of conception, trace the process of development from the zygote through implantation, and discuss some problems that sometimes occur with implantation.

As you learned in Chapters 2 and 3, the ovaries store eggs (ova). Each egg is surrounded by a small sac, forming what is called a primary follicle. As a result of the release of follicle-stimulating hormone (FSH) from the pituitary gland, one (or more) of these primary follicles matures to become a Graafian follicle. About midway through a 28-day menstrual cycle, the Graafian follicle breaks open and the ovum is released into the abdominal cavity, where it is picked up by one of the Fallopian tubes. The ovum moves through the Fallopian tube to the uterus. It will take 3 to 7 days to reach the uterus, but *the ovum can only be fertilized during the first 24 hours after it leaves an ovary* (Moore et al., 2013). If a sperm does not penetrate the ovum during this time, the ovum becomes overly "ripe" and eventually disintegrates in the uterus, leaving the woman's body during her menstrual flow.

Sperm begin their development in the outer wall of a seminiferous tubule and migrate to the center of the tubule as they mature. A developing sperm goes through several stages: from spermatogonium, to spermatocyte, to spermatid, to a mature spermatozoon (which has a head and a "tail" called a flagellum). The entire process takes about 70 days.

At orgasm, during sexual intercourse, a man will ejaculate an average of 200 to 400 million sperm into the vagina. The sperm then attempt to pass through the cervix and uterus to the Fallopian tubes. This is not an easy journey. Some sperm are stopped by the force of gravity, some by the acidity of the woman's reproductive tract, some by clumping, and some simply by taking wrong turns (because usually only one egg is released, only one Fallopian tube will be the right path for the sperm to follow). Only a few thousand will live long enough to reach the Fallopian tubes, and fewer than 50 will reach the egg within the Fallopian tube (Moore et al., 2013). (See Figures 7–1 and 7–2.) Most sperm live for only 3 days inside a woman's reproductive tract, but a few may live for as long as 5 days (Wilcox et al., 1995). Thus, intercourse can result in conception only 6 days out of every 28-day menstrual cycle (*5 days before ovulation and the day of ovulation*). If you want to know the probability of conception on any one of these 6 days, go back to the section on fertility awareness methods in Chapter 6.

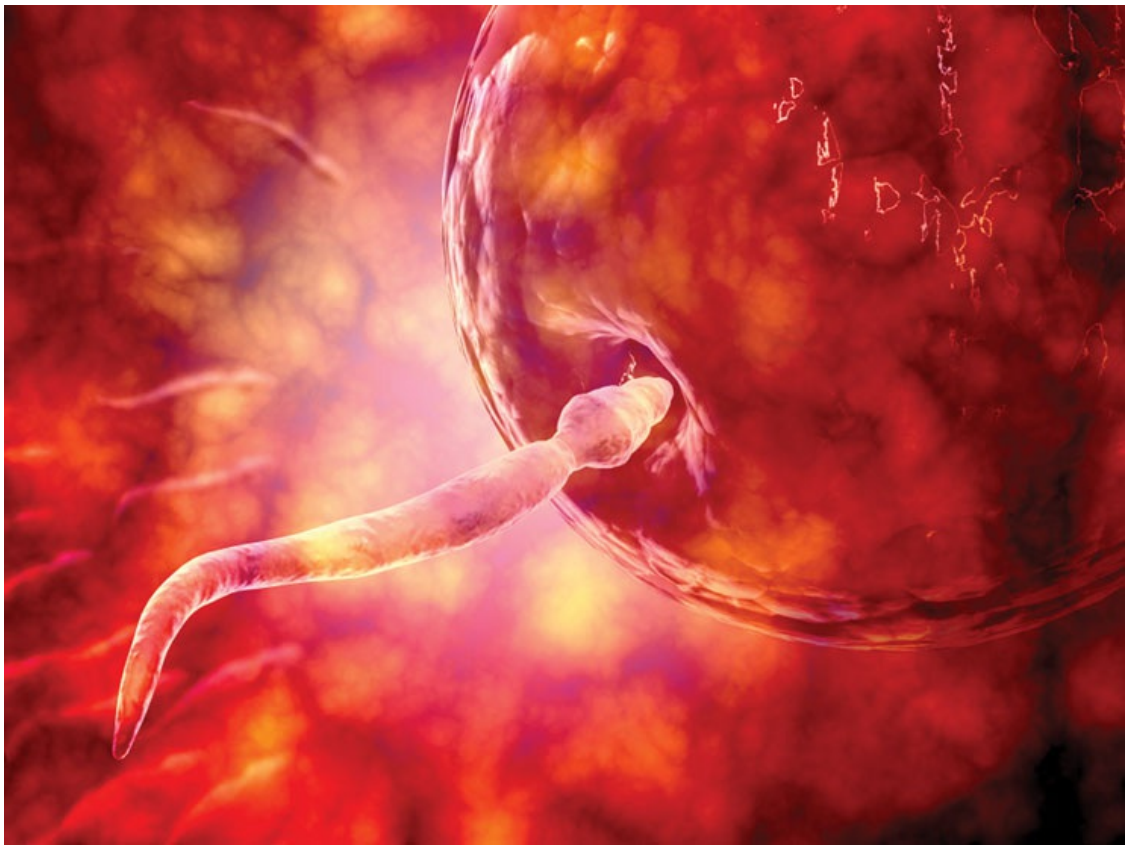
Figure 7–1



Many sperm attempting to penetrate the membrane of an ovum. Only one will be successful.

Source: Eye of Science/Science Source

Figure 7–2



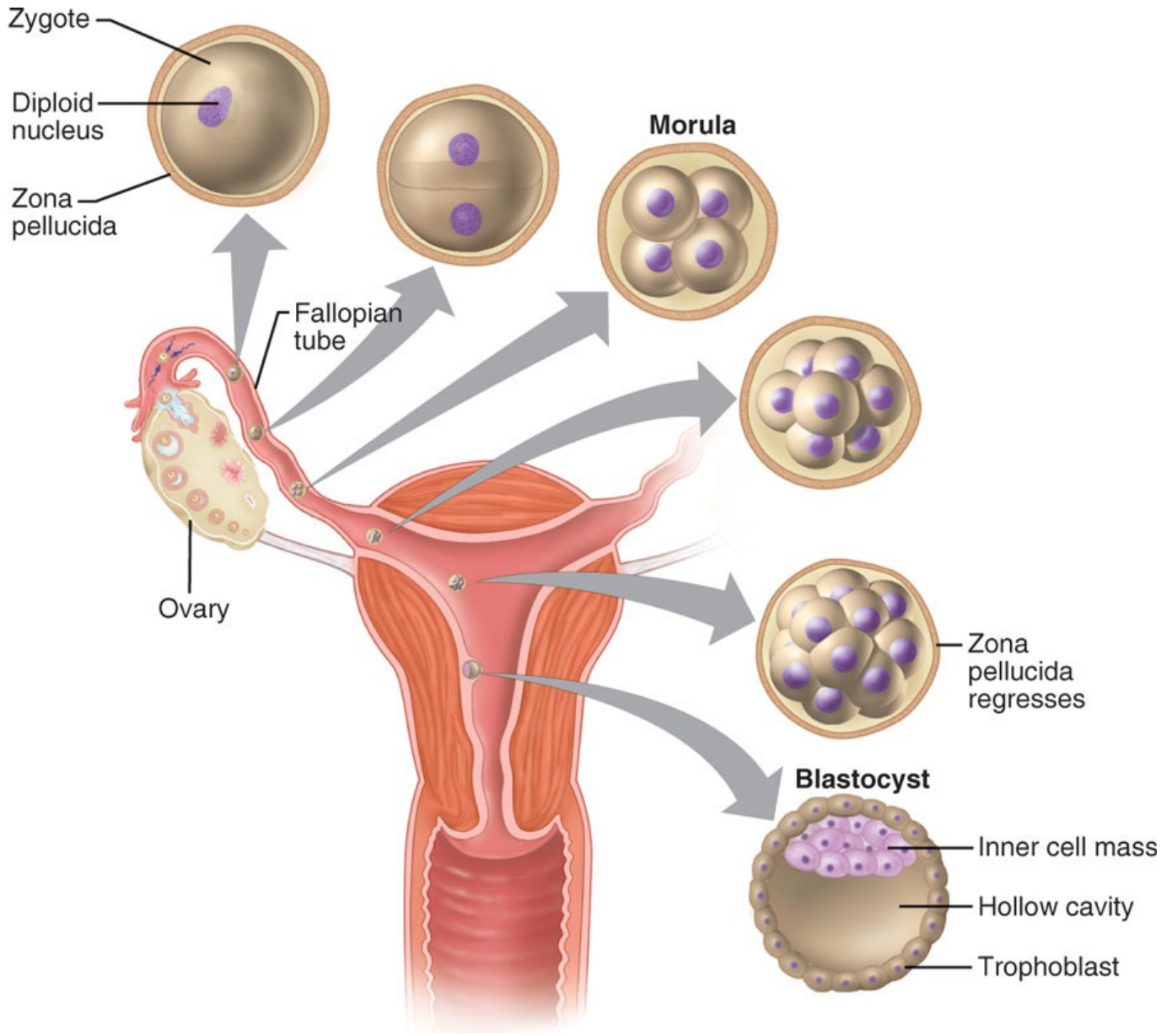
A close-up photo of sperm on the surface of an ovum.

Source: Stocktrek Images/Science Source

While the sperm are in the woman's reproductive tract, they undergo a process called capacitation in which their membranes become thin enough so that an enzyme (called hyaluronidase) can be released to soften the egg's outer layers. The egg sends out tiny projections and pulls one sperm to its surface, the *zona pellucida.* That sperm secretes the enzyme and penetrates the egg's surface, and conception takes place. An almost instantaneous chemical reaction within the ovum then prevents other sperm from penetrating the ovum. Within 24 to 30 hours, the nuclei of the sperm and the ovum fuse to form a one-celled organism called a zygote. This single cell contains the complete genetic code, or blueprint, for a new human being.

Shortly afterward, the zygote splits into two separate cells, then four, then eight, and so on (see Figure 7–3). As cell division occurs, each individual cell gets smaller. This collection of cells is called a morula. While cell division is rapidly taking place, the morula is slowly continuing its trip toward the uterus. When the conceptus has about 100 cells, it has developed a fluid-filled center and is then called a blastocyst. After the blastocyst reaches the uterus, it may float there for several days. At this point it is still smaller than the head of a pin.

Figure 7–3



Ovulation, fertilization, and implantation.

Source: Hock, *Human Sexuality*, © 2007 Prentice Hall, Inc. Reproduced by permission of Pearson Education, Inc.

Figure 7–3 Full Alternative Text

At about 8 to 11 days after ovulation, the blastocyst attaches itself to the endometrium via hair-like roots called *villi* (Wilcox et al., 1999). This is called implantation. By this time the endometrium has a large supply of blood that can serve as a source of nutrients and oxygen. The blastocyst is now called an embryo; it is called a fetus at about 8 weeks (see following section on pregnancy).

Personal Reflections

What qualities do you possess that will make you a good parent? Do you have any qualities that might not make you a good parent? What things can you do to prepare yourself to be a good parent? How well suited is your partner to be the mother or father of your child?

The outer cell layers of the embryo are called the trophoblast (from the Greek *trophe*, meaning "to nourish"). The trophoblast begins to grow rapidly and forms four protective layers or membranes, each with a special function. One produces blood cells for the embryo until it can produce its own. Another cell layer forms the umbilical cord—the major link between the developing embryo and its mother. The third membrane is called the amnion. It is a thick-skinned sac filled with water that surrounds the embryo. By surrounding the developing embryo with liquid, the amnion protects against bumps, sudden movements by the mother, and changes in temperature. The fourth membrane, called the chorion, will develop into the lining of the placenta. The placenta is an organ that serves as a connection or interface between the embryo's systems and those of the mother. The embryo is connected to the placenta by the umbilical cord. Through it, the embryo receives nourishment from its mother. It also receives antibodies for protection against infection. Wastes from the embryo's system travel from the umbilical cord to the placenta, and from there are taken up by the mother's excretory system.

Over 98% of term pregnancies result in the birth of a single baby. What causes twins (or other multiple births)? If two different ova are fertilized by two different sperm, the result is *dizygotic* (fraternal or non-identical) twins. *Monozygotic* (identical) twins result when a fertilized ovum subdivides before it implants in the uterus. The prevalence of twin births among American women has more than doubled since 1980, but most of this is due to an increased use of fertility therapies (National Center for Health Statistics, 2012; see later section). The chance of having multiple births increases with the age of the mother.

7.1.1 Problems with Implantation

It has been estimated that about three fourths of conceptions either fail to implant or are spontaneously aborted within the first 6 weeks (Wilcox et al., 1999). One in seven confirmed pregnancies ends in miscarriage (Fjerstad & Edelman, 2011). Failure to implant may be a means of "weeding out" or preventing the further development of blastocysts that are not completely healthy or normal.

One type of problem with implantation is called ectopic pregnancy (from the Greek *ektopos*, meaning "out of place"). In this case, conception is successful, but implantation takes place outside the uterus. In about 96% of these cases, implantation occurs in a Fallopian tube. In rarer cases, implantation can occur on an ovary, on the cervix, or in the abdomen. When implantation occurs in a Fallopian tube (often called a *tubal pregnancy*), there is simply not enough room for the embryo to grow. Unlike the uterus, the Fallopian tubes are not capable of much expansion. The embryo usually aborts on its own, but if it continues to grow after the 8th week, it may burst the tube. This is a serious complication of pregnancy, and it can be fatal. Although the mortality rate has been dropping due to earlier detection, ectopic pregnancies still account for about 6% of all pregnancy-related deaths.

Ectopic pregnancies account for about 1.5% to 2.0% of all pregnancies (Barnhart, 2009). They are more common in older women (Hoover et al., 2010). Ectopic pregnancies are caused by conditions that block or slow passage of the conceptus to the uterus. The most common cause is scarring of the Fallopian tubes due to pelvic inflammatory disease (often resulting from untreated chlamydia or gonorrhea) (Barnhart, 2009). Other factors include anatomical malformations, increasing age at time of conception, smoking, and douching. If a woman has an ectopic pregnancy, she has an increased risk of having more ectopic pregnancies in the future because many of the causes of the original problem, such as scarring, will still be present in later pregnancies.

"I got pregnant only to learn it was tubular. . . . One year later I got pregnant again, and again it was tubular. The specialist told me I needed surgery to remove scar tissue that was choking my Fallopian tube."

(from the authors' files)

In the past, women diagnosed with tubal pregnancy always had part of the affected tube surgically removed, which greatly reduced the chances of pregnancy in the future. Today, ectopic pregnancy is treated either by administering a drug (methotrexate) or by laparoscopic surgery (Hoover et al., 2010).

Pregnancy

1. 7.2 Describe what occurs in each trimester of pregnancy for both mother and embryo/fetus.

Pregnancy lasts an average of 260 to 270 days. "Due dates," the dates that physicians set as the "expected time of arrival" for babies, are rarely the dates of actual birth. This is because the exact date of conception is hard to measure with complete accuracy and because there is great variability among births, even with the same parents. Because pregnancy lasts about 9 months, this time is divided into 3-month periods, called trimesters, for descriptive purposes.

7.2.1 The First Trimester—The Mother

When a menstrual period is late, women often want quick and accurate information about whether they are actually pregnant. To get this information, they take a "pregnancy test." The test works by determining if a hormone secreted by the placenta (human chorionic gonadotropin, or HCG) is present in a woman's urine (see Fjerstad & Edelman, 2011). HCG prevents the corpus luteum from atrophying, thus keeping progesterone (the hormone maintaining the endometrium) levels high. A pregnancy test is most accurate (95% to 98%) 2 weeks or more after a missed period. Tests that measure HCG in blood can detect if a woman is pregnant even sooner than this.

The most common symptom of early pregnancy is nausea. It is called "morning sickness" (medically referred to as *nausea and vomiting of pregnancy*), though it often occurs at any time of the day. Fifty percent to 90% of pregnant women experience nausea and vomiting, with about one third having symptoms bad enough they need to see a doctor (Jarvis & Nelson-Piercy, 2011). Fewer than 1% of women experience a severe form called *hyperemesis gravidarum* (which will definitely require medical care).

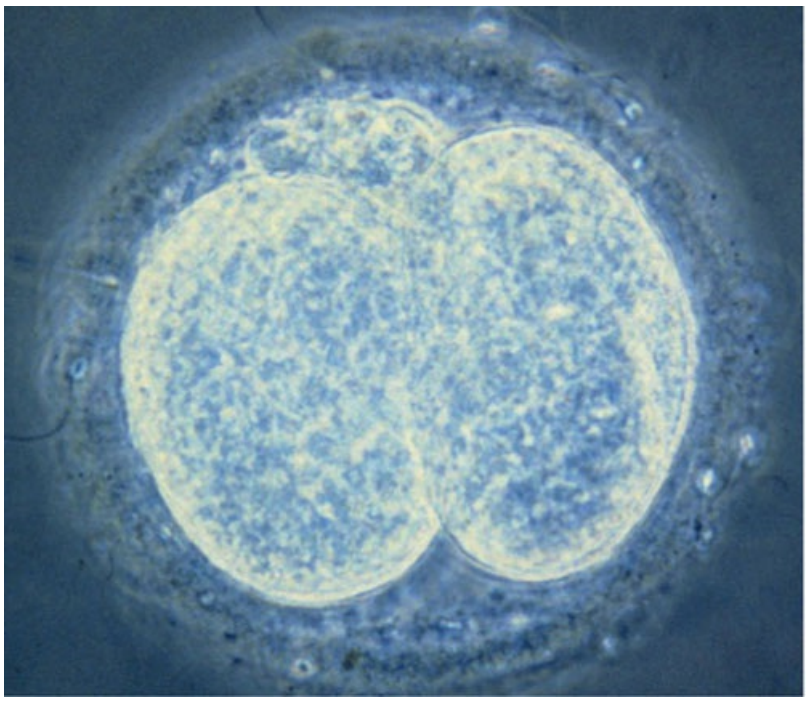
Morning sickness generally begins 6 to 8 weeks after conception, reaches its peak by 9 weeks, and then usually (although not always) spontaneously disappears by the 20th week. This corresponds to levels of HCG. Although there are a number of speculations as to its cause, nothing has been proven conclusively. Some women eat dry, bland foods (e.g., crackers), drink soda water, and try a variety of other home remedies to cope with morning sickness, but there is no known effective way of treating it. Many men experience some of the same symptoms of pregnancy as their partners. In the United States, this is sometimes called "sympathy pains," but the medical term for it is couvade syndrome (from a French term for the birthing process).

Other symptoms that women may exhibit during the first trimester include enlarged and tender breasts, prominent veins on the breasts, darkened areolas, enlarged nipples, increased frequency of urination, and irregular bowel movements. In addition, many women feel tired and run-down.

7.2.2 The First Trimester—The Embryo/Fetus

In the first trimester of pregnancy, a substantial amount of development takes place (see Figure 7–4). When the blastocyst implants, it is less than one third of an inch in diameter. After implantation, it is known as an embryo. Cell differentiation begins to take place now, and development occurs in orderly ways. Growth in the embryo occurs from the head downward and from the center (spine) outward. As mentioned earlier, the outer layers of the blastocyst form structures designed to nourish and protect it. In the embryo, three inner cell layers will form specific parts of the body: The *ectoderm* forms the nervous system, skin, and teeth. The *mesoderm* forms the muscles, skeleton, and blood vessels. The *endoderm* forms the internal organs (lungs, liver, digestive system, etc.).

Figure 7–4



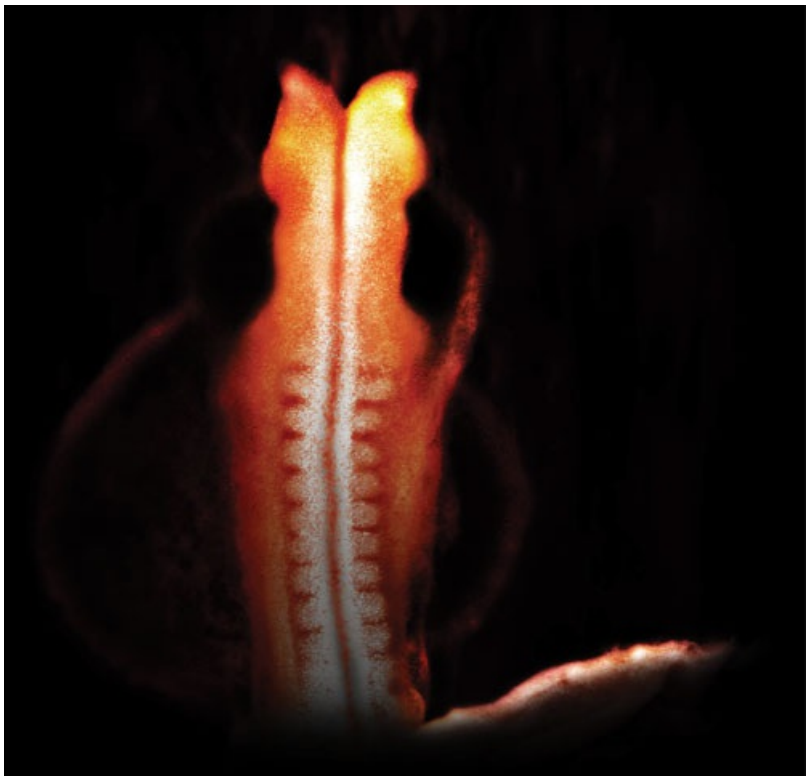
(a) 1 day (two cells)

(a) 1 day (two cells)

Source: Andy Walker, Midland Fertility Services/Science Source

(b) 3½ days

Source: Pascal Goetgheluck/Science Source



(c) 22 days (note the primitive spinal cord)

Source: Anatomical Travelogue/Science Source

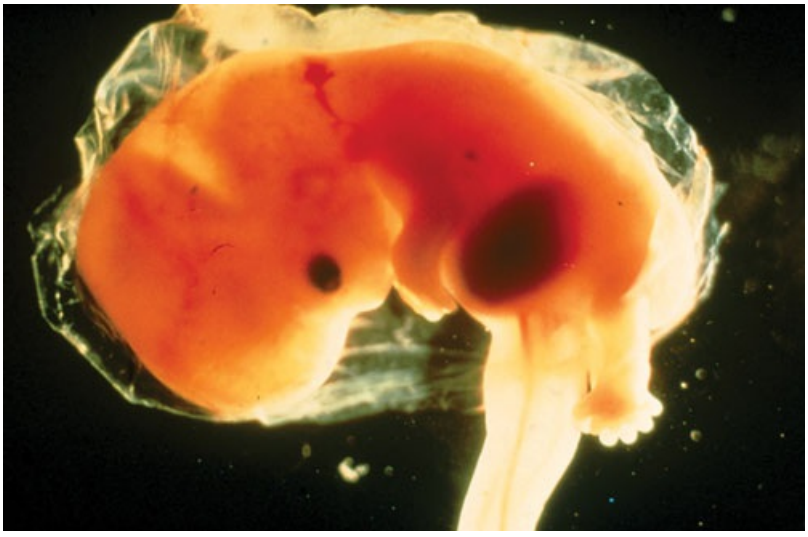
(d) 4 weeks

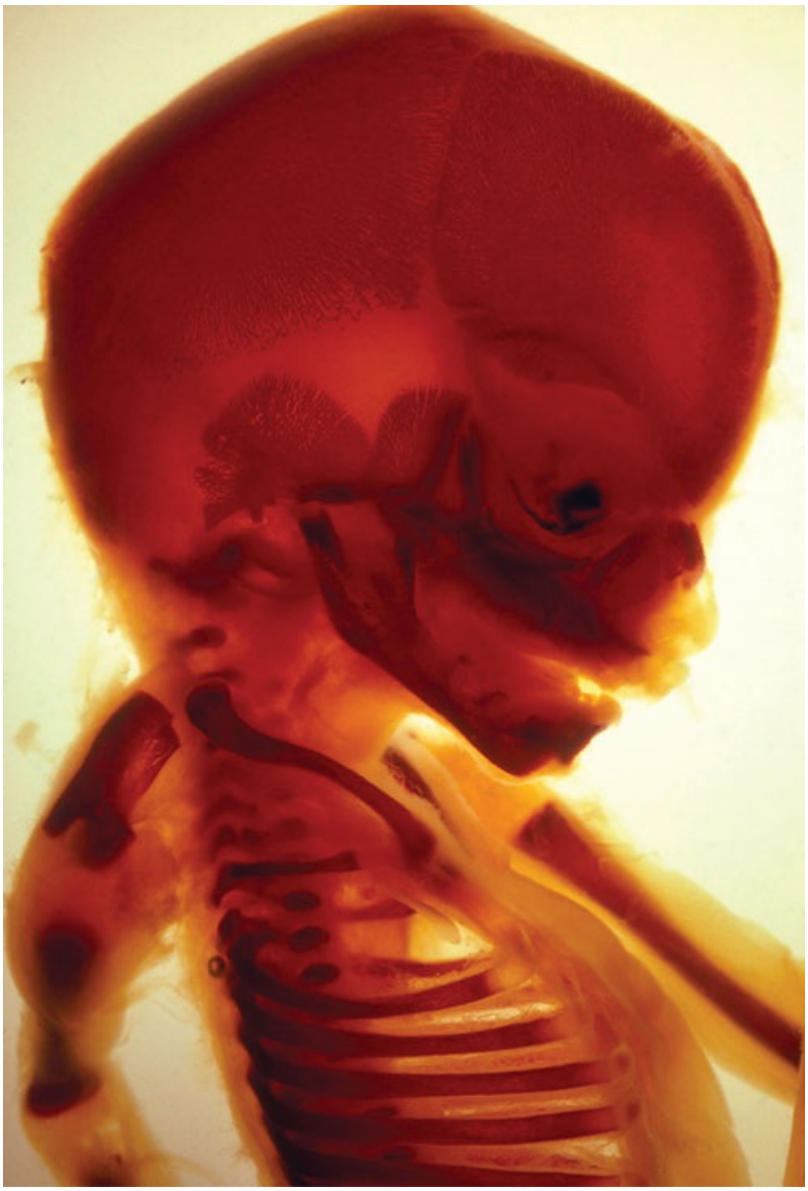
Source: Science Source

Stages of prenatal development. The heart and nervous system begin to function by the end of 4 weeks.

In the 3rd week of pregnancy, a central structure called a neural tube becomes a dominant feature. The neural tube will become the central nervous system. By the end of the 4th week, the umbilical cord, heart, and digestive system begin to form. At 6 weeks, the embryo has a "tail," which will become the tip of the spine. It also has structures that look like gills but are actually parts of the neck and face that have not yet fully developed. At 8 weeks, the embryo is about 1.125 inches long. All organs have begun to develop. The heart is pumping, and the stomach has begun to produce some digestive juices. The embryo, although small, is well on its way toward developing into a unique human being. After 8 weeks and until birth, the developing organism is called a fetus. (See Figure 7–5.)

Figure 7–5





Stages of prenatal development. Note the umbilical cord connection to the fetus in the photo taken at 8 weeks.

(a) 8 weeks SOURCE: Petit Format/Science Source (b) 12 weeks SOURCE: Scott Camazine/Science Source

7.2.3 The Second Trimester—The Mother

In the 4th or 5th month of pregnancy, the movements of the fetus can be felt by its mother. This first experience of movement is called quickening. Although a woman generally knows by this time that she is pregnant, this knowledge is usually an abstract or "intellectual" thing. Once a woman begins to feel a new life moving inside her, the fetus begins to be viewed as a person, and an emotional attachment to her unborn baby generally begins to form.

"During my 5th month of pregnancy, I felt the baby move for the first time. It almost felt like the rumbling a stomach makes when you're hungry. It could be described as a 'fluttering,' and it is very exciting. Unfortunately, it doesn't happen that often at first, so you have to 'catch it' if you want your partner to share in the experience."

(from the authors' files)

Women generally begin to get over their morning sickness in the second trimester. They also notice that their figures are changing, and they may worry about no longer being attractive to their partners. As her abdomen expands, red lines, or "stretch marks," may develop on a mother-to-be. The breasts begin to swell and may start to leak *colostrum*, a thick, sticky liquid that is produced before milk starts to flow. Water retention may cause edema (swelling) in the ankles, feet, and hands. Women may begin to develop varicose veins and/or hemorrhoids. The cessation of morning sickness often brings an increase in appetite.

7.2.4 The Second Trimester—The Fetus

At this time, the fetus begins to make sucking motions with its mouth. (Figure 7–6 shows a 16-week old fetus.) In the 5th month, the fetus has a detectable heartbeat. It will respond to sound, and it begins to show definite periods of sleep and wakefulness. If born at this time, the fetus has only a 1-in-10,000 chance of survival. In the 6th month, the fetus can open its eyes. It will suck its thumb and respond to light. At the end of the

second trimester, the fetus is about 1 foot long and weighs about 1 pound.

Figure 7–6

The fetus is recognizably human by 16 weeks.

Source: Nestle/Petit Format/Science Source

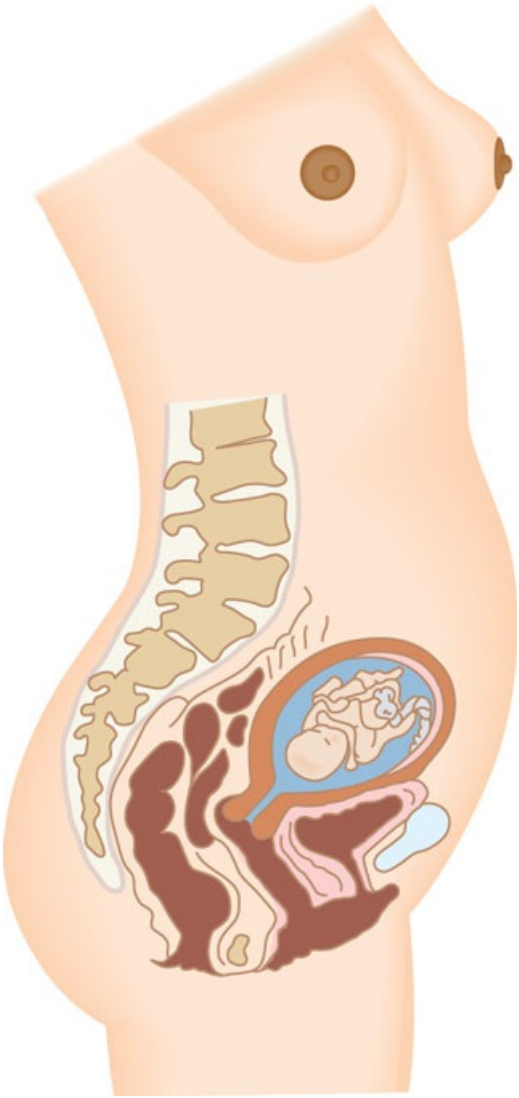
7.2.5 The Third Trimester—The Mother

For the expectant mother, walking, sitting, and rising become more difficult. Pregnant women often have to learn new ways to sit down and to get up out of a chair. Expectant mothers often experience back pain from carrying a new weight load in front of them, which shifts their center of gravity. The uterus, enlarging with the rapidly growing fetus, puts pressure on the bladder and stomach. As a result, urination becomes more frequent—a woman may have to urinate four or five times a night. Indigestion, heartburn, gas, and constipation are also common complaints. Leg cramps may occur, a condition sometimes treated by taking extra calcium. The woman's navel may push out. Often she experiences a low energy level.

7.2.6 The Third Trimester—The Fetus

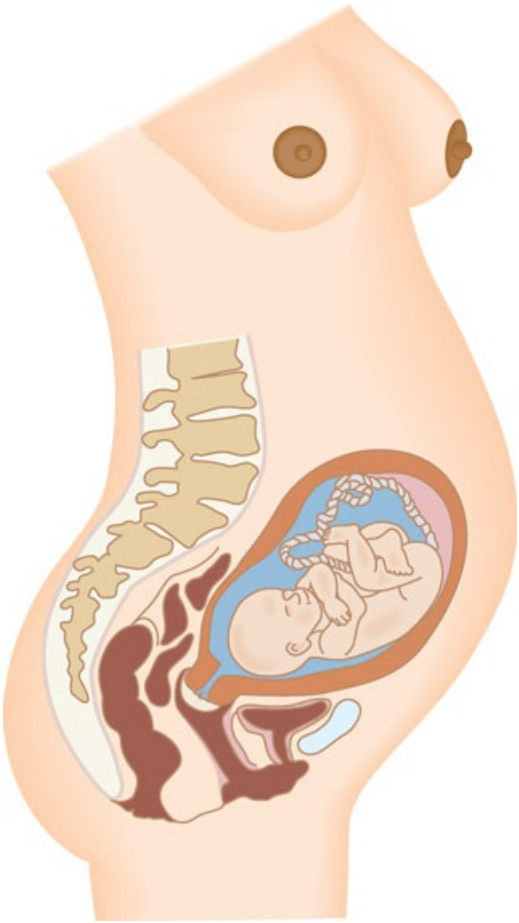
By the end of the 7th month of pregnancy, the fetus is about 15 inches long and weighs about 1½ pounds. Fatty tissues begin to develop under the skin. A lack of these tissues is what causes premature infants to look so skinny. In the 8th month, the fetus' weight begins to increase dramatically. At the end of the 8th month, it will weigh about 4 pounds and will be 16 to 17 inches long. From this point on, the fetus will gain about ½ pound per week. In the 9th month, the fetus will grow to about 20 inches in length and weigh an average of 7 to 7½ pounds. There is considerable variation in these measurements, however. (Figure 7–7 shows the development of the fetus at the 3rd, 5th, 7th, and 9th month.)

Figure 7–7(a)



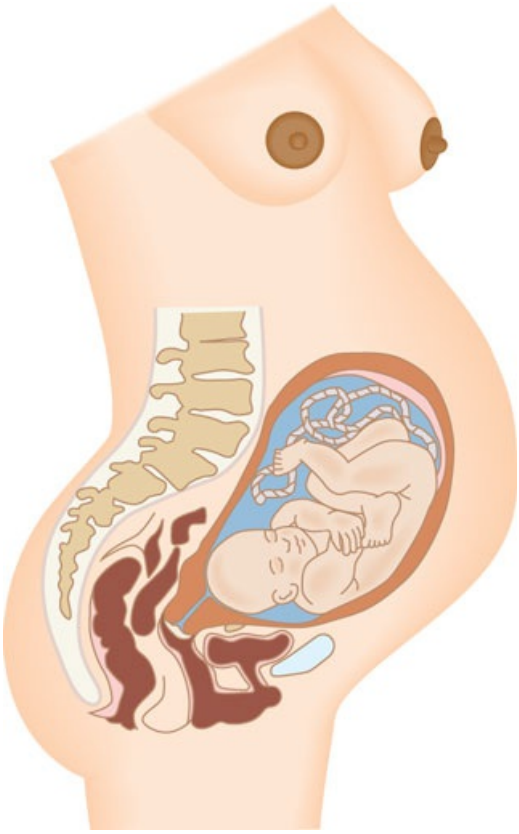
3rd Month. The fetus is now approximately 3 inches long and weighs about 1 ounce. It may continue to develop in the position shown, or it may turn or rotate frequently. The uterus begins to enlarge with the growing fetus and can now be felt extending about halfway up to the umbilicus.

Figure 7–7(b)



5th Month. The fetus measures approximately 10 to 12 inches long and weighs from ½ to 1 pound. It is still bright red. Its increased size now brings the dome of the uterus to the level of the umbilicus. The internal organs are maturing at astonishing speed; however, the lungs are insufficiently developed to cope with conditions outside of the uterus.

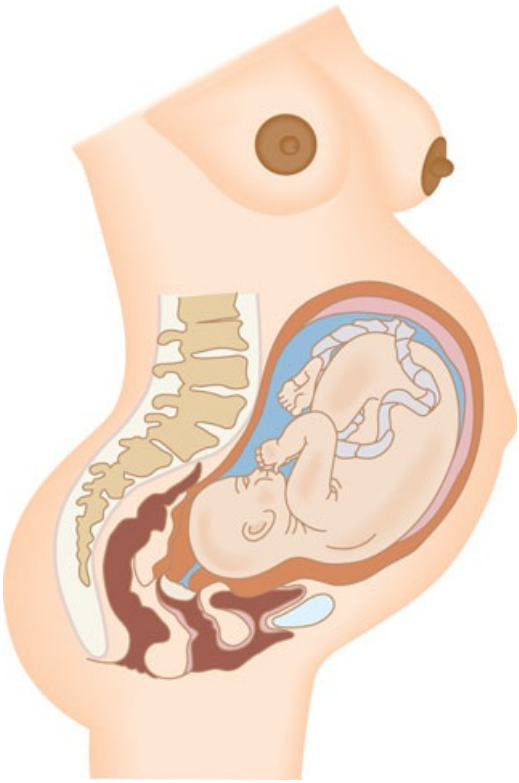
Figure 7–7(c)



7th Month. The fetus' weight has roughly doubled since last month, and it is about 3 inches longer. However, it still looks quite red and is covered with wrinkles that will eventually be erased by fat. At 7 months, the premature baby has a fair chance for survival in

nurseries if cared for by skilled physicians and nurses.

Figure 7–7(d)



9th Month. At birth or full term, the baby weighs about 7¼ pounds if a girl and 7½ if a boy, on average. Its length is approximately 20 inches. Its skin is covered with a creamy coating. The fine downy hair has largely disappeared. Fingernails may protrude beyond the ends of the fingers.

The fetus is covered with light hair (lanugo) and a waxy bluish substance (vernix caseosa). These will make the newborn look very interesting, but they serve as protective devices. Today, the vernix is often allowed to be absorbed into the skin after birth rather than being immediately washed off.

Sexual Intercourse During Pregnancy

1. 7.3 Discuss recommendations concerning sexual intercourse during pregnancy.

Two patterns of sexual activity have been observed during pregnancy. For the majority of women, there is a steady decline in sexual activity throughout pregnancy (Call et al., 1995; Regan et al., 2003). However, a large-scale study found that 90% of couples were still having intercourse in the 5th month of pregnancy (Hyde et al., 1996).

"The fact that it's impossible to get any more pregnant, it makes sex during pregnancy very exciting. My senses seemed much more heightened and both my husband and I found it to be extremely pleasurable."

(from the authors' files)

For a few women, there is an increase in sexual activity from the first to the second trimester (Regan et al., 2003). Freed of the worry about getting pregnant, some women begin to express their sexuality fully for the first time. This is followed by a decreased interest in sex during the third trimester (von Sydow, 1999).

Women (and men) give several reasons for a declining interest in sexual intercourse during pregnancy. One reason is physical discomfort. The traditional man-on-top position can be increasingly uncomfortable for the woman as pregnancy progresses. The woman-on-top position is probably most comfortable (Lee et al., 2010).

A second reason for decreased interest in sex is that women may feel that they no longer appear attractive (Radoš et al., 2014).

"We never had sexual intercourse after the first 5 months. I felt disgusted, embarrassed and upset with the way my body had changed."

(from the authors' files)

For many women, the primary motivation for sex during pregnancy is relationship concerns (Sagiv-Reiss et al., 2012). Bad communication and unhappiness with the relationship are major predictors of frequency of sex during pregnancy (Gałązka et al., 2014; Radoš et al., 2014).

Figure 7–8

Pregnancy is a time when a woman can still be proud of her body.

Source: Julie Dermansky/Science Source

Another reason is fear about the pregnancy or about the possibility of harming the fetus (Radoš et al., 2014).

"At about the middle of my pregnancy, my husband had a decrease of interest in sex while my interest had increased. I was already feeling fat and ugly, and this just made things worse. Many nights I stayed up crying because not only did I think I was fat and ugly, but I thought my husband did too. Then I realized his problem was that he was scared he was going to hurt me or the baby. I tried to convince him that he wouldn't, but I guess he just couldn't stop thinking about it while we were having sex."

(from the authors' files)

This leads to an important question: How far into pregnancy is it safe to engage in sexual intercourse? A review of 59 studies found that if there are no other risk factors, sexual intercourse during pregnancy does not harm the fetus (von Sydow, 1999). The consensus of opinion is summed up in the highly regarded *Williams Obstetrics*: "It has been generally accepted that in healthy pregnant women, sexual intercourse usually does no harm before the last four weeks or so of pregnancy" (Cunningham et al., 2010). What about the last 4 weeks? Here, there is some debate and you should consult with your doctor.

In any case, sexual behavior is not limited to intercourse, and in the latter stages of pregnancy alternative forms of sexual stimulation may be preferred. Hugging, touching, and other displays of affection are important ways of communicating attraction.

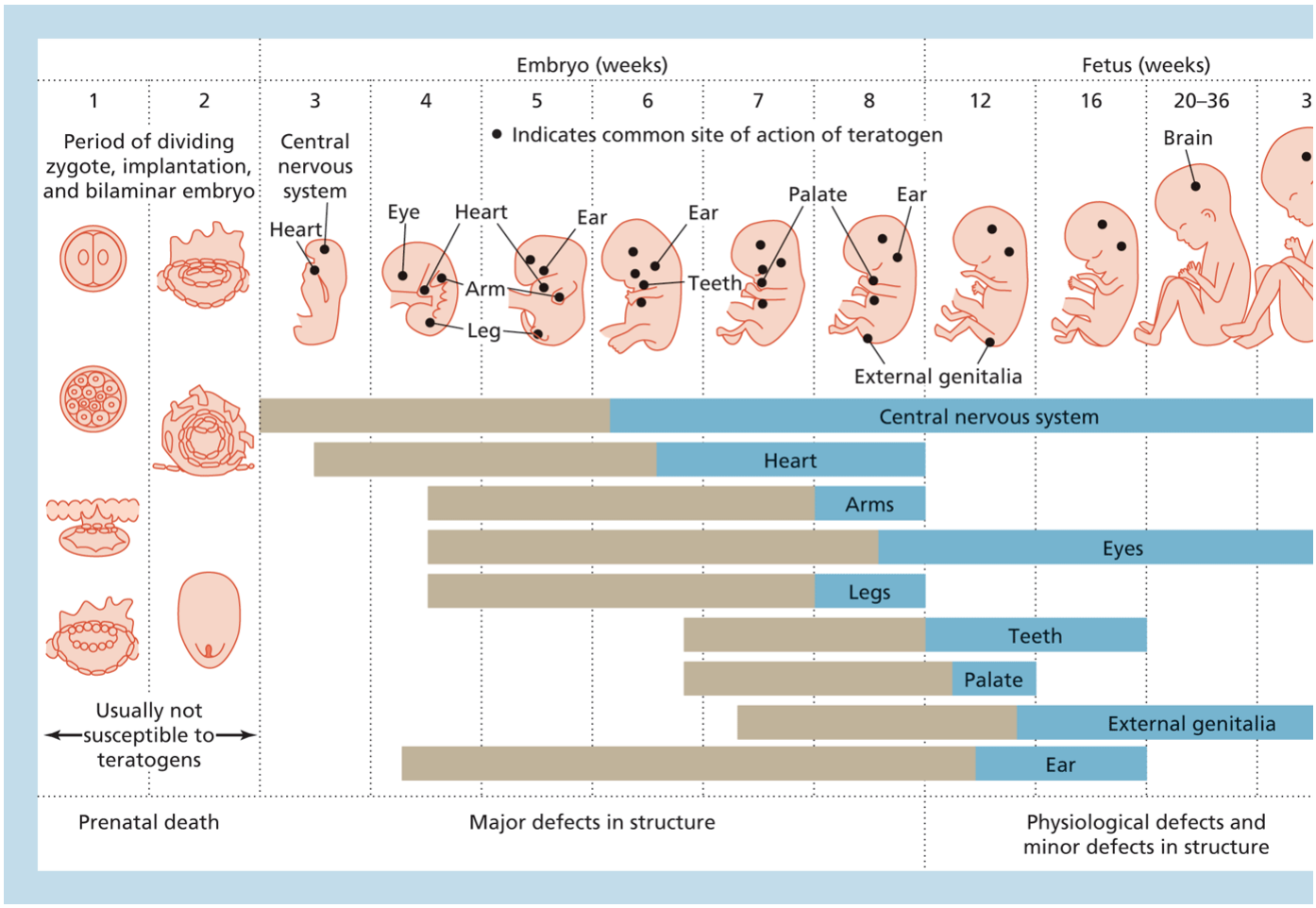
Complications of Pregnancy

1. 7.4 Summarize the possible effects of smoking, alcohol, drug use, and environmental hazards on the embryo and fetus.

About 97% of all births result in a healthy, normal infant. However, complications of pregnancy can occur. Many of these can be prevented if parents-to-be are aware of them.

Substances that can harm an embryo or fetus are called teratogens (from the Greek word *tera*, meaning "monster"). Until recently, the placenta was thought to be a perfect filter that kept out all harmful substances. Now we know of hundreds of teratogens that can cross the placental barrier. Three things determine the harm caused by teratogens—the amount of the teratogen, the duration (amount of time) of exposure to the teratogen, and the age of the embryo or fetus. Each part of the developing body has a time, called a critical period, when it is most susceptible to damage. These are the times when it is undergoing most of its formation. During critical periods, body parts are sensitive to "signals" or "messages" about how to develop. This sensitivity means that the developing embryo or fetus can be easily influenced by teratogens. Although teratogens should be avoided at all times, most body parts are maximally susceptible to damage during the first 8 weeks of development (see Figure 7–9).

Figure 7–9



Critical periods in prenatal development. The tan areas represent highly sensitive periods; the blue areas represent less sensitive periods.

Source: CICCARELLI, SAUNDRA K.; MEYER, GLENN E., PSYCHOLOGY, 1st Ed., © 2006; p. 258. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Figure 7–9 Full Alternative Text

Remember that in the first 8 weeks of pregnancy, many women will not be sure if they are pregnant. There is an important lesson to be learned from this. If a woman wants to change her behavior to improve the chances of having a healthy baby (e.g., stop drinking alcohol), it is better for her to do this when she is trying to become pregnant rather than after she finds out that she is pregnant. The woman's partner can encourage healthier habits by also changing his habits at the same time.

7.4.1 Smoking

About 13% of all pregnant women smoke (Martin et al., 2009). Cigarette smoking during pregnancy is a concern because it is associated with a substantial increase in the risk of having or causing a low-birth-weight baby, miscarriages, ectopic pregnancies, preterm births, and infant mortality. Mothers who smoke during pregnancy at least double the risk that their baby will die of sudden infant death syndrome ("crib death") (U.S. Office of the Surgeon General, 2004). The use of marijuana in combination with smoking tobacco further increases bad outcomes (Chabarria et al., 2016).

7.4.2 Alcohol

About 7.3% of U.S. women of reproductive age risk an alcohol-exposed pregnancy (Green et al., 2016). Drinking during pregnancy can have dire consequences, and binge drinking (five or more drinks) is especially bad for the fetus (Walling, 2005). Approximately 6 to 9 out of every 1,000 children born in the United States have physical deformities and/or mental impairments because of damage caused by the mother's use of alcohol during pregnancy (Fox et al., 2015). The condition is known as fetal alcohol syndrome (FAS), or *fetal alcohol spectrum disorders (FASD)* (CDC, 2016). In extreme cases, children born with FAS have facial deformities, abnormally spaced eyes, and small heads.

Recall that in the United States 45% of all pregnancies are unplanned (see Chapter 6), and women do not know they are pregnant until 4–6 weeks after conception. Alcohol probably has its maximum effect on the developing fetus in the 3rd week of pregnancy, but it can have negative effects throughout pregnancy. Even moderate alcohol consumption can result in children with emotional problems, learning disabilities, and inability to cope in school (Willford et al., 2006). These data indicate that *it is probably best to avoid alcohol entirely during pregnancy.* If you wouldn't give your newborn baby an alcoholic drink, why would you give it one before it is even born?

Many women who drink also smoke. The combined effect during pregnancy greatly increases the chances of having preterm labor and a low-birth-weight baby (Odendaal et al., 2009).

7.4.3 Narcotics (Including Pain Killers)

There has been a recent surge in the use of narcotics in the United States. This includes mothers addicted to prescription pain medications such as Oxycontin and Vicodin. The rates have tripled just since 2000 (Patrick et al., 2012), and the cost to taxpayers to treat addicted babies is $1.5 billion per year (Stempniak, 2016). The addicted infants must go through withdrawal after being born, showing symptoms such as fever, tremors, convulsions, and difficulty breathing.

The most widely reported effects of cocaine exposure during pregnancy are diminished growth and preterm birth (both resulting in low birth weight) and decreased head circumference and brain weight (Aghamohammadi & Zafari, 2016). "Crack babies" have a variety of sensory-motor and behavioral deficits including irritability and disorientation. There is also a real potential of later learning problems and behavioral disorders (see Singer et al., 2002, for a review).

7.4.4 Other Drugs

Many prescription drugs, such as antibiotics, are clearly harmful to the fetus. For some women, pregnancy can increase symptoms of depression, but antidepressants are also harmful (Clay, 2016). In addition, commonly used drugs such as antihistamines (in allergy medication and cough medicine) and megadoses of certain vitamins have proven to have harmful effects. Even aspirin can be harmful. The Food and Drug Administration has issued a warning against taking over-the-counter aspirin products during the last 3 months of pregnancy because they can affect fetal circulation and cause complications during delivery. Caffeine (found in coffee, tea, many soft drinks, and chocolate) has been found to result in reduced birth weights. Even too much vitamin A during pregnancy can cause birth defects (Rothman et al., 1995). The best advice, which is being given by increasingly large numbers of physicians, is not to take any drugs during pregnancy if at all possible.

Personal Reflections

Do you or your partner smoke, drink alcohol, or take drugs? Do you and your partner eat a well-balanced diet and get ample sleep? What decisions about health can you and your partner make to ensure the health of your baby during pregnancy and afterward?

7.4.5 Preeclampsia

A pregnant woman can have a disease called *toxemia of pregnancy.* In its early stages, this disease is called preeclampsia, and about 3% to 5% of pregnant women will experience it. Its symptoms include protein in the urine (which allows it to be detected by physicians), high blood pressure, weight gain, and swollen joints due to excessive water retention. In some cases, the disease advances to *eclampsia,* characterized by convulsions and coma. Worldwide, preeclampsia and eclampsia cause over 60,000 deaths each year.

"During my first pregnancy, they discovered that I had toxemia. I was immediately put on a low-sodium diet and had to stay in bed for the rest of my pregnancy. When she was born, my baby weighed only 4 lbs. 10 oz. and her weight then fell to 4 lbs. 1 oz. She had respiratory problems and severe jaundice. They kept her in an incubator for about 4 weeks. She was a very pretty baby, but took a long time to start crawling, walking, and talking. I didn't get toxemia in my second or third pregnancies."

(from the authors' files)

Preeclampsia occurs after the 20th week of pregnancy. It begins in the placenta and quickly results in widespread maternal endothelial disorders (Sibai, 2012). It is most likely to occur in younger women, especially if it is the first birth. Women who develop toxemia in their first pregnancy have an increased risk of developing it in later pregnancies. Also, women who used barrier contraceptives (e.g., condoms, diaphragms) prior to pregnancy have a much higher risk of preeclampsia. These results suggest that the disease is due to altered immune responses as a result of being exposed to semen (see Pipkin, 2001). Contrary to popular belief, large doses of vitamins do not prevent preeclampsia (Roberts et al., 2010). The only way to treat preeclampsia is to deliver the baby prematurely (Sibai, 2012), but of course this causes health risks for the baby.

7.4.6 Rh Incompatibility

There is a protein in the blood of a majority of people called the Rh factor. It got its name from the rhesus monkey, the species in which this blood protein was first discovered. If a person has the protein, he or she is "Rh positive." If not, the person is "Rh negative." Each person has two genes (one gene is received from each parent) that determine whether he or she has the protein. The Rh positive gene is dominant, which means that if a person has one Rh positive and one Rh negative gene, the blood will have this protein. A person can have Rh negative blood only when both genes are Rh negative.

In about 8% of all pregnancies in the United States, the mother will be Rh negative and the fetus will be Rh positive. When this occurs, there is an Rh compatibility problem. For the first birth, this situation usually is not dangerous. But during labor and delivery, blood of the fetus and the mother, kept separate in the placenta during pregnancy, may mix together. If this happens, the mother's blood treats the Rh factor in the baby's blood as if it were a dangerous foreign substance, forming antibodies that will attack and destroy the "invader" in the future. If the mother then has another Rh positive fetus, these antibodies can cross the placental barrier and attack the fetus' blood supply, causing a miscarriage, possible brain defects in the fetus, or even death.

Fortunately, there is an injection that can be given to the mother to prevent these antibodies from forming. The drug used for this is called *Rhogam.* It consists of Rh negative blood that already has these antibodies in it. Because Rhogam already has antibodies, the mother's system does not produce very many of its own. The antibodies in Rhogam eventually die off, leaving the mother capable of carrying another Rh positive fetus.

7.4.7 Detection of Problems in Pregnancy

There are several techniques for detecting problems in the fetus while it is inside the uterus. One is called chorionic villus sampling (see Brambati & Tulvi, 2005). As you learned earlier, the chorion surrounds the embryo and develops early in pregnancy. In chorionic sampling, a small tube is inserted through the vagina and cervix. Guided by ultrasound, the tube will remove some hair-like cells (villi) from the chorion by gentle vacuum suction. These cells can be examined to detect chromosomal problems or abnormalities in the fetus or to look for evidence of certain diseases. One of the major advantages of chorionic sampling is that it can be used to detect problems early in pregnancy (from the 10th to 12th week of pregnancy), but after 12 weeks of pregnancy all of the villi of the chorion are gone.

Another technique that provides similar information is amniocentesis (Brambati & Tulvi, 2005). In amniocentesis, a hollow needle is inserted through the abdomen and uterus of the mother, through the membrane of the amniotic sac, and into the amniotic fluid surrounding the fetus. Some of the amniotic fluid is then extracted, and fetal cells that have dropped off and have been floating in the fluid are examined for evidence of abnormalities. This procedure can only be used between the 14th and 18th weeks of pregnancy. For both chorionic villus sampling and amniocentesis, the chance of a miscarriage is only about 1 in 200 (Evans & Wapner, 2005).

Chorionic sampling and amniocentesis are called "invasive" techniques, meaning that they invade, or get inside of, the uterus and/or the fetus. A balance must be found between detecting potential problems and creating new problems when these procedures are used. Ultrasound is considered a "noninvasive" technique because it only bounces sound waves off the uterus and fetus (Fjerstad & Edelman, 2011). Ultrasound can be used to diagnose problems such as a malformation of the skeletal system. It cannot detect genetic defects like amniocentesis can.

Alpha-fetoprotein (AFP) screening involves testing a pregnant woman's blood between the 16th and 18th week of pregnancy. This test is used to detect abnormalities in neural development, including spina bifida.

7.4.8 Fetal Surgery

Another method in treating a problem pregnancy is fetal surgery—performing an operation on the fetus while it is still in the uterus of the mother. The technological advances in this field have been rapid. In 1989, physicians performed the first successful major surgery on a fetus, repairing a hernia of the diaphragm that if left untreated probably would have resulted in death shortly after birth (Harrison et al., 1990). Doctors have also corrected spina bifida on 23-week-old fetuses (Adzick et al., 1998).

7.4.9 Miscarriages (Spontaneous Abortions)

Earlier in this chapter you learned that about three fourths of all conceptions fail to survive beyond 6 weeks. Of the remaining quarter, about 15% fail to survive to term (Fjerstad & Edelman, 2011). There are many possible causes for miscarriage, including genetic, anatomic, and hormonal causes; infections; maternal autoimmune responses; and the smoking of cigarettes or use of cocaine (e.g., Speroff & Fritz, 2005). Usually, physicians will not attempt to diagnose causes of miscarriage until the woman has had three of them. *Recurrent miscarriages*, as these are called, occur in 0.5% to 1.0% of women and may have a variety of causes (see Bansal, 2010).

For many couples, a miscarriage can be a heavy emotional disappointment:

"I have been married for 14 years. I conceived seven times, and every time I had a miscarriage at about 4½ months. My doctor diagnosed that my uterus was too weak to carry the baby after 4 months and no matter what and how I tried I couldn't have a baby of my own. I get very depressed sometimes and cry. Lately I feel very uncomfortable around other people's babies."

"Some people may think only women are upset because of losing a baby due to miscarriage . . . but this hurt me in ways unimaginable. . . . First of all, I felt as if it was my fault for not being there. It hurt the most because a part of us had not yet had a chance to grow and mature into our baby. Our relationship is just now returning to normal."

(All examples are from the authors' files.)

At this point we would like to emphasize that hundreds of millions of babies are born without serious problems. A fetus is incredibly resistant to harm. It is important that you eat well, avoid toxic substances, get early and regular care from a physician, and prepare for the birth of your child through study and training (which we will describe shortly).

7.4.10 Nutrition and Exercise During Pregnancy

If you are pregnant, you are now eating for two. You will need to eat more *good-quality* foods than you usually do (see Boston Women's Health Book Collective, 2011). The U.S. Public Health Service recommends that pregnant women also *supplement their intake of folic acid* by taking a multivitamin. Your physician may make additional recommendations if you have certain conditions (such as adjusting salt intake to ease toxemia).

Some women have negative feelings about gaining weight during pregnancy Remember, this is not only normal but necessary. Never put yourself on a low-calorie diet during pregnancy. In 2009, the Institute of Medicine made the following recommendations for weight gain during pregnancy: 28–40 pounds for underweight women, 25–35 pounds for normal-weight women, 15–25 pounds for overweight women, and 11–20 pounds for obese women. Smaller than recommended weight gains increase the risk of toxemia, anemia, low birth weight, and infant death (Davis et al., 2014).

There has been some concern that vigorous exercise during pregnancy might cause premature labor and delivery. A large-scale study found not only no evidence to support this but also that regular exercisers who were in good condition had timely deliveries (reduced the chance of a preterm birth) (Hatch et al., 1998).

The conclusion: A good diet and exercise during pregnancy results in a better outcome for both the mother and her baby (Thangaratinam et al., 2012). Be sure to read the section "Problems with Childbirth."

Preparing for Childbirth

1. 7.5 Discuss traditional and alternative birthing practices including Lamaze, Bradley, Leboyer, home births, and the use of midwives.

In the United States, 74% of pregnant women have their initial prenatal examination in the first trimester (U.S. Department of Health and Human Services, 2013). However, that means that 26% of pregnant women either delay or never go for a prenatal exam. Prenatal exams are an essential part of health care during pregnancy. However, there is more to giving birth than ensuring the safety of the mother and baby. What about a woman's psychological well-being and emotional adjustment? Modern maternity care in developed countries is aided by many technological advances, but as Ulla Waldenström (1996) asked, "Does safety have to take the meaning out of birth?" In this section you will learn about several alternatives to the traditional medical model of birthing—methods that are concerned with safety but also try to make childbirth a meaningful experience.

The use of general anesthesia, labor rooms where women waited for hours, and delivery rooms were all instituted to make it easier for health professionals to deliver their services. Women were usually given very little education about what was to come, with only the expectation that it would be painful. For some of these women, labor and delivery were not positive experiences (Waldenström et al., 2004).

"At age 20 I prepared to give birth to my first child. 'Induced labor' was a convenient form of delivery for the physician, and widely practiced in the 70s. At my last visit to his office, he 'broke the water bag,' handed me five Kotex pads, and told me to walk across the street to hospital and admit myself. He said he would check on me later that evening. The delivery room nurse started a 'drip' to begin contractions. I now know why the old hospital had bars on the labor room windows. I cannot describe that intense pain, especially not having been prepared for natural childbirth. To jump would have been a blessing."

"My experience with childbirth was very traumatic. The pain I had to endure. . . . I remember reaching out to punch the nurse because the prepping solution she used on me was so cold. The next thing I knew, the gas mask covered my face and I was out cold."

(All examples are from the authors' files.)

Fathers were generally the forgotten person when a baby was born. They seldom were allowed to be with their wives during any part of labor or delivery.

"I went out of the room to get a candy bar while the nurse gave my wife an exam (neither I nor my wife had ever heard of Lamaze then). When I returned to her room, I saw my wife being taken away. The nurse explained that my wife was giving birth. I'd been awake for several nights with my wife, so I laid down on her bed to rest and fell asleep. Shortly after 6 p.m., the phone next to the bed rang and the nurse told me I was the father of a baby girl."

(from the authors' files)

In 1932, a British physician named Grantly Dick-Read wrote a book in which he advocated the practice of *natural childbirth* (Dick-Read, 1972). He became the founder of a movement away from "modern" techniques. Dick-Read concluded that modern birthing techniques, in which pregnant women were regarded as "patients," led to a fear–tension–pain cycle. He reasoned that women were being put into strange environments, not knowing what was going to happen next, and surrounded by strangers—and that this created fear. He believed that fear could cause physiological changes associated with tension, such as tightened muscles. These things were believed to increase substantially the sensation of pain felt by mothers during labor and delivery. Instead, he advocated educating mothers-to-be about pregnancy, labor, birth, and birth procedures to relieve fear of the unknown. He also advocated training in relaxation techniques to relieve the physiological effects of tension. Drugs were permissible if thought necessary but were to be avoided if possible. Today, people more properly refer to these techniques as prepared childbirth rather than natural childbirth.

7.5.1 The Lamaze Method

A French physician, Fernand Lamaze, traveled to the Soviet Union in 1951 to study birthing techniques in that country. Throughout the Soviet Union, Lamaze saw that women were giving birth without using anesthetics or experiencing great pain. The Soviets had extended the conditioning techniques of Ivan Pavlov into the area of labor and delivery. Women were conditioned to learn pleasant new associations for the sensations of labor and birth. They were also taught relaxation and breathing techniques to aid in making labor easier. Lamaze returned to France, modified the Soviet techniques slightly, and began using this new approach to childbirth in his practice (Lamaze, 1970). An American woman, Marjorie Karmel, used this approach under Lamaze's guidance and wrote about her experience in a best-selling 1959 book titled *Thank You, Dr. Lamaze.* Since then, the *Lamaze method* has become the most popular form of prepared childbirth in the United States. Compare the following childbirth experiences from two individuals who went through Lamaze training with the two case histories that were presented at the beginning of this section. Which persons do you think remember giving birth as a positive experience?

"I have gone through three different ways of giving birth—the first being totally drugged out. I didn't get to see my baby until the next morning. The next two deliveries were natural childbirth using a birthing room and I didn't have any restraints on me. You are given the freedom and dignity of childbirth. I used a birthing chair with my last baby. It was a more natural way of delivery and I found pushing to be less of an effort. The relaxation and breathing techniques taught with Lamaze training really kept me focused and prepared. You know what you want—this is the way you have chosen to give birth. . . . My husband was there the whole time encouraging me. It was such a joy to see what love had produced. The smile on my husband's face. We could hold the baby after its birth—there bonding begins."

"We had our children using Lamaze. The thing I remember most is how in control my wife was, even at the very end. She had drawn her own focal

point a few weeks before and concentrated on it every contraction while doing her breathing and effleurage. The absolutely best thing about the births was both of us being there to see our children the moment they were born. It was important to be there when my wife was giving birth, to be part of the experience. I cannot remember any other moment when I felt so connected to her and so alive."

(All examples are from the authors' files.)

The Lamaze approach tries to determine the specific causes of pain and provides methods for dealing with each cause. What are the causes of perceived pain in childbirth? Basically, these break down into (1) anxiety and fear; (2) muscle tension; (3) stretching of muscles; (4) too little oxygen getting to muscles; and (5) pressure on nerves. Here are some ways that Lamaze training deals with each of these causes (see Lothian & DeVries, 2005).

1. Anxiety and fear. Pain is a subjective experience. A football player may break an arm or leg and yet be unaware of it and continue to play until after the game is over (when the pain may suddenly become unbearable). Some people, on the other hand, wince and scream when they get a blood test before the needle even touches them. These examples illustrate two things that influence the experience of pain. The first is the anxiety and fear associated with the experience, and the second is the attention paid to the source of pain.

   In Lamaze training, fear and anxiety are first dealt with through education. The unknown is always frightening, and if a woman in labor does not know what to expect, her anxiety will increase her experience of pain. This is counteracted by teaching expectant mothers about pregnancy and childbirth. They learn about the different stages of labor and medical procedures associated with childbirth and take a tour of the maternity ward and birthing facilities. In this way, the expectant mother knows what to expect and is more familiar with the environment where labor and birth will take place.

   Another way that the subjective experience of pain is reduced is through learning to focus attention or concentration. During labor, the mother-to-be picks out something outside her body, such as a favorite knickknack or a piece of furniture, and learns to focus all of her attention on that thing or "focal point." By concentrating on the focal point, she is not concentrating on her pain, and so the perception or subjective experience of pain is reduced. Throughout their training, labor, and delivery expectant mothers are accompanied by a "*coach.*" The coach is often the father of the baby but can also be a friend. The coach helps the mother utilize her training, providing support, encouragement, and instruction. It is the coach's responsibility to keep the mother-to-be as comfortable as possible while at the same time keeping her concentration focused and her spirits up.

2. Muscle tension. When people are anxious or fearful, muscles tighten up. This is a natural reaction and can be adaptive because it allows quick movement in a "fight-or-flight" situation. However, keeping muscles tense over long time periods can cause them to ache and be used inefficiently. Labor is just such a situation. One of the first exercises in Lamaze training involves learning to know when muscles are tense and how to relax them.

3. Stretching of muscles. Like any set of muscles, the muscles used in labor will get tired and begin to ache if they are overworked, especially if they are out of condition. In Lamaze training, women are taught exercises so that these muscles can be toned up and strong when the baby decides to arrive.

4. Too little oxygen getting to muscles. Muscles use so much energy during vigorous exercise that they often cannot get enough oxygen, and so they begin to ache. The same is true in labor. In order to help deal with this, expectant mothers and coaches learn a variety of breathing techniques. These different types of breathing are generally used during contractions, while the woman's attention is fixed on her focal point.

5. Pressure on nerves. Pressure on nerves caused by the fetus moving through the birth canal is dealt with through the use of *effleurage*, or massage. One type of effleurage involves having the expectant mother lightly touch her abdomen with her fingertips, tracing large ovals on her skin during contractions. This light massage generally is a pleasant sensation, and by continually pairing the discomforts of contractions with a pleasant sensation, the subjective experience of pain is reduced.

Today, there are several other birthing techniques that couples can use in place of the traditional hospital–general anesthesia approach. Here are a few of them.

7.5.2 The Bradley Method

The second most popular type of prepared childbirth in the United States is based on the work of Robert Bradley in the 1940s. He, too, was inspired by Dick-Read and believed that pain during childbirth resulted from culturally learned fear. He argued against the "meddlesome interference with nature's instinctual conduct and plans" (Bradley, 1981). He emphasized childbirth without medication and had husbands play an even greater role than in Lamaze.

7.5.3 The Leboyer Method

Another French physician, Frederick Leboyer, wrote an influential book in 1975 called *Birth without Violence.* He felt that traditional techniques of delivery were traumatic for babies and instead advocated "gentle birth." In the *Leboyer method,* the baby is delivered and immediately placed on the mother's abdomen. The room is dimly lit to simulate the lighting inside the mother's body. The umbilical cord is not cut for several minutes, until it stops pulsating. The baby is then put in a warm bath (to simulate the amniotic fluid). The idea is to allow the transition of the baby from life inside the mother's body to life in the outside world to be as smooth as possible.

7.5.4 Home Birth, Birthing Rooms and Centers, Modern Midwifery, and Doulas

In 1870, fewer than 1% of women gave birth in hospitals (Tew, 1990). By 2000, only about 1% of women gave birth outside of a hospital. Today, in Europe and the United States, there is a growing movement back to having births in the home. The number of home births in the United States now totals about 35,000 a year, of which 75% are planned (Committee Opinion, 2016). This movement has been driven, in part, by economic considerations. Home births are much less expensive. There are also personal considerations. Many couples feel that having a baby in familiar surroundings is more natural than a hospital birth. Women who have delivered at home almost always say that it was a very positive experience (O'Brien et al., 2011). For healthy pregnant women who are at low risk for complications, many feel that home birth is a safe alternative to hospital delivery (de Jonge et al., 2013), but others find that although the risk of complications and death is very low, it is nevertheless twice as great as for hospital deliveries (Snowden et al., 2015).

To compete with this movement, many hospitals have "birthing rooms," which are designed to look like bedrooms rather than hospital rooms. Labor and delivery take place in the same bed, and often a crib is present so that the baby can sleep in the room with the mother after birth. In some areas, a closely related option is *birthing centers*, institutions that offer delivery in a home-like atmosphere with the assistance of skilled individuals such as midwives or physicians. They have proved to be just as safe for women as traditional hospital care (Waldenström & Nilsson, 1997), but this may be partly because birthing centers are really an option only to women with no foreseeable complications.

Whether the choice is to deliver at home, in a birthing center, or in a hospital, there is also a growing trend to use nurse-midwives rather than physicians. In many European countries, over two thirds of all babies are delivered by midwives. Nurse-midwives are generally registered nurses trained in obstetrical techniques who are well qualified for normal deliveries and minor emergencies. (It should be noted that other types of midwives may not have this type of formal education.) They are less expensive than physicians, and they provide personal care during the latter parts of pregnancy, labor, and delivery. Studies indicate that the outcome for babies (and mothers) is just as good when they are attended by nurse-midwives as when they are attended by physicians (Walsh & Downe, 2004).

A new and increasingly popular alternative (especially among poor populations) is use of a doula (Greek: female servant). This is a woman who serves as a female companion ("mother figure") during labor and childbirth. They lack the training of nurse-midwives, but emotional and physical outcomes are generally better than for women who go through labor and childbirth without a companion (see Hodnett et al., 2013; Odent, 2012).

7.5.5 Anesthetics or "Natural" Childbirth?

In the Book of Genesis, God punishes women for Eve's transgression (eating the forbidden fruit) by making childbirth painful:

> I will greatly multiply your pain in childbearing; In pain you shall bring forth children. *(Genesis 3:16, Revised Standard Version)*

When painkillers were first used for childbirth in the 1800s, the British clergy opposed it, arguing that it was against God's will. It was Queen Victoria who decisively argued in favor of painkillers.

Many people reading this book came into the world in a drugged state. This is because anesthetics were used during their mother's labor to relieve pain. Under general anesthesia, a woman is unable to push during contractions. As a result, the infant has to be pulled into the world with forceps, which resemble tongs. Anesthetics cross the placental barrier and enter the fetus. This is one reason why some infants have to be slapped in order to get them to cry and begin breathing. Babies born without the use of anesthetics generally come into the world with eyes open and ready to breathe without having to be slapped into consciousness.

Today, most births in which anesthetics are used do not involve general anesthetics. The mother-to-be can be given an *epidural*, a spinal anesthetic that deadens sensations from the waist down. Thus, it is possible to be anesthetized and still be conscious. However, epidurals are associated with some complications. Labor tends to last longer, the chance of fever is 5 times as great, and there is a much greater risk of hypotension (Leighton & Halpern, 2002).

The number of women choosing prepared childbirth courses in recent years has dropped dramatically (Childbirth Connection, 2016). More than 60% of American women who give birth receive an epidural or spinal anesthesia (Osterman & Martin, 2011). A little less than half are given opioids for labor pain relief. In fact, some women who do not have to are choosing to have a cesarean section (see later section).

So, which method should you choose? Do not start thinking of childbirth as a contest to see if you can get through with the least amount of medical help. This attitude can make the use of anesthetics or a C-section seem like a "failure." That should not be the case. Any birth that results in a healthy mother and baby is a good one, regardless of the technique used. That is always the goal of childbirth and should not be forgotten.

Personal Reflections

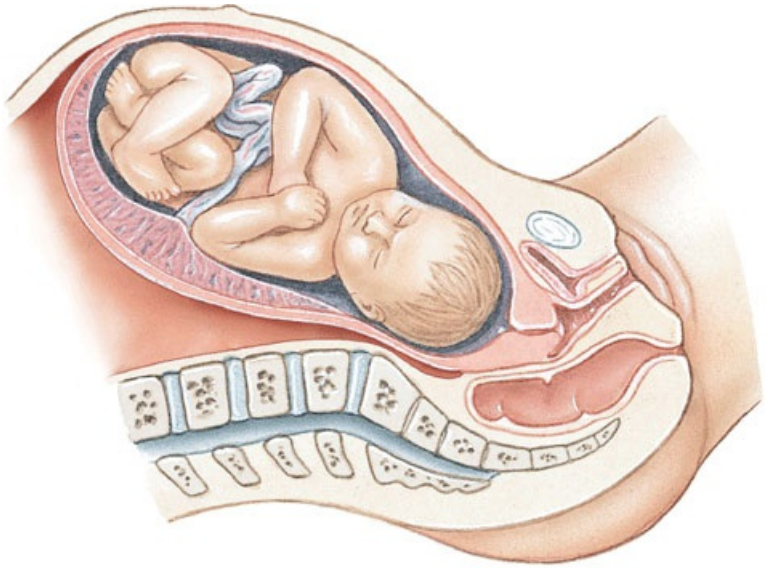
Make a list of all the words that come to your mind when you think of childbirth, labor, and delivery. Examine your list for negative stereotypical concepts. Are there alternatives?

Childbirth

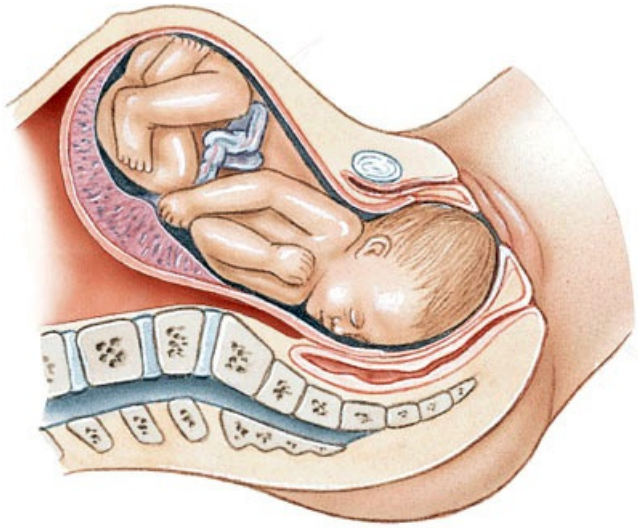
1. 7.6 Describe the three stages of labor and the events that occur in each.

Before birth, the fetus will generally rotate its position so that its head is downward. This can happen weeks or hours before birth and is what is meant when people say "the baby dropped." It is also called **"**lightening**"** because once the fetus' head (its largest part) has lowered in the uterus, pressure on the mother's abdomen and diaphragm is greatly reduced. Being able to breathe more easily makes a mother feel like the load that she has been carrying (the fetus) weighs less (is "lighter"). (See Figure 7–10.)

Figure 7–10

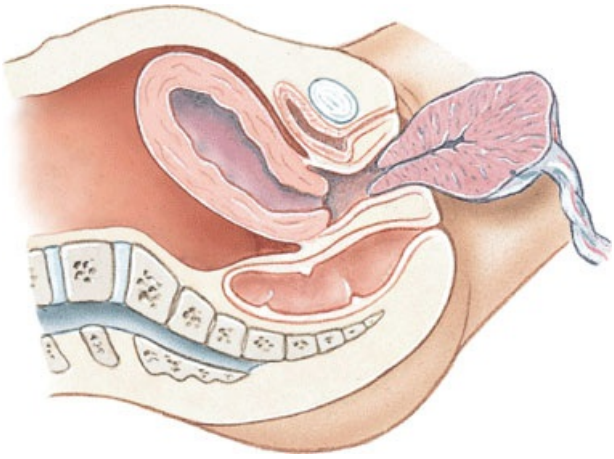


(a) Fully Developed Fetus Before Labor Begins



(b) Stage One Labor

(c) Stage Two Labor



(d) Stage Three Labor

Source: HOCK, ROGER R., HUMAN SEXUALITY, 1st Ed., © 2007. Reprinted and Electronically reproduced by permission of Pearson Education, Inc., New York, NY.

Shortly before a woman begins to give birth ("goes into labor"), she may experience a burst of energy. A woman may feel better than she has in months and may start to clean house or do some other type of work as a means of "burning off" this energy. It is probably a good idea to save some of this energy for later, when it certainly will be needed.

7.6.1 True Versus False Labor

Throughout the latter stages of pregnancy, the uterus will undergo contractions—tightenings and relaxations of the muscles. These are involuntary and for most of the pregnancy will go unnoticed. These contractions, called Braxton-Hicks contractions, are a type of natural "exercise program" for the uterus. Sometimes these contractions become so strong that they are noticed and mistaken for true labor. Parents-to-be sometimes worry and go to a hospital, only to be told that they have had a false labor and should return when the woman is in "real" labor. Here are some guidelines that help distinguish false labor from true labor.

One important sign of labor is the time between contractions. The uterus is basically a muscle in the shape of a bag. Its job is to push the fetus into the world. Like most muscles engaged in prolonged, heavy labor, it must repeatedly contract, or tighten. If contractions are coming 10 minutes apart on a regular basis, this is a good sign that labor has begun. False labor contractions are usually less regular. The duration of each contraction also should be measured. If contractions are 30 seconds long on a regular basis, this is a good sign that labor has begun. False labor contractions are usually shorter than contractions marking true labor.

Two important signs of the beginning of labor involve the cervix. The first sign is dilation. In the last month of pregnancy, the cervix will dilate to about 1 centimeter in diameter. When a woman goes into labor, the uterine contractions help cause the cervix to dilate more. It must eventually dilate to 10 centimeters (about 4 inches) in diameter before the baby can be born. In the first stage of labor, the cervix will dilate to about 2 or 3 centimeters. The second sign is effacement. The cervix must stretch until it is "thinned out," or "effaced," so that it won't block the baby's passage into the birth canal (vagina). A good sign of true labor is that the cervix is 70% or more effaced. At birth, it will be 100% effaced.

Stages of Labor

There is an abundance of evidence suggesting that it is the fetus that determines when labor begins, although the exact mechanism is still unknown (Norwitz et al., 1999). Once it begins, labor is divided into three stages. The initial stage of labor is a start-up stage and involves the woman's

body making preparations to expel the fetus from the uterus into the outside world. This stage usually lasts from 6 to 13 hours. At this time, uterine contractions begin to push the fetus downward toward the cervix. The cervix begins to dilate and efface. At first, contractions are far apart (one every 10 to 20 minutes) and do not last long (15 to 20 seconds), but eventually they begin to come closer together (1 to 2 minutes) and last longer (45 to 60 seconds or longer).

During pregnancy, the cervix becomes plugged up with a thick layer of mucus. This prevents the amniotic sac (bag of water) and the fetus from having direct contact with the outside environment (through the vagina). During labor, this mucous plug will come out. A discharge of mucus and blood (known as a "bloody show") is a sign of labor. However, for some women the mucus comes out a little at a time, so that this sign is not clearly seen. In other women, the plug literally pops out like the cork in a bottle of champagne.

For about 10% of pregnancies, the amniotic sac will break before labor begins. In some women, the break is a small tear and the fluid seeps out. In other women, the water gushes out. This is what happens when a woman's "*water breaks.*" Labor usually begins within a day after the amniotic sac breaks. If not, most physicians will induce labor with drugs. Physicians sometimes break the amniotic sac on purpose in order to speed up labor. It is even possible to give birth with the fetus enclosed in an unbroken amniotic sac. Physicians in this country do not allow this to happen and will break the sac first. However, in parts of Asia, children born in this manner are believed to be blessed with good fortune.

The last part of the first stage of labor is called the transition phase, so called because it marks the end of the initial stage of labor and the beginning of the next (birth) stage. This phase takes place when the cervix is almost fully dilated (8 to 10 cm). Contractions are severe, and the woman may start to think that there is no end to this process. Fortunately, transition usually lasts 40 minutes or less.

The second stage of labor begins when the cervix is fully dilated and the fetus begins moving through the birth canal. It ends with birth (see Figure 7–11). Contractions during this stage of labor are accompanied by an intense desire to push or "bear down." The contractions cause the opening of the vagina to expand, and expectant mothers often get a "second wind" because they now can see an end to their work. This stage lasts from 30 to 80 minutes on the average, depending on whether it is the first child or a later child.

Figure 7–11

Childbirth.

Source: Petit Format/Science Source

The first sign of the fetus is usually the sight of its head at the opening of the vagina. This is called crowning because ideally the crown of the head is leading the way. The person delivering the baby will tell the expectant mother when and how hard to push during contractions in order to get the baby into the world. The head is delivered first, with the physician reaching beneath the infant's chin to be sure that the umbilical cord is not wrapped around the baby's neck before the head is brought out. Once the head is delivered, suction is applied to the mouth and nose with a small rubber bulb so that the baby can breathe more easily. The head then turns, and the shoulders and rest of the body come out rather quickly. The mouth and nose are suctioned again.

The umbilical cord will be cut about 1½ inches from the baby's body. This stub will fall off in a few days, leaving the navel. (The navel is either an "inny" or an "outty," but the type of navel you have seems to depend on heredity, not on how the umbilical cord was cut.)

In the third stage of labor, the placenta detaches from the uterus and leaves the mother's body. This is what is called the afterbirth. This stage usually lasts only 10 to 12 minutes. The physician examines the afterbirth to make sure that it is in one piece; then it is discarded. If even small pieces of the placenta stay in the uterus, infection and bleeding can occur. When this takes place, physicians use a procedure called D&C (dilation and curettage), in which the cervix is dilated to allow access to the uterus, which is then scraped clean.

7.6.2 Episiotomy

An episiotomy is an incision made from the bottom of the vagina (through the perineum) toward the anus, thus enlarging the vaginal opening. An episiotomy is a useful procedure if the baby is in distress or if there is a risk of severe tearing (Practice Bulletin, 2016). Although the number of episiotomies has dropped substantially since 1980, many authorities still believe that most episiotomies are unnecessary and are done routinely only for the benefit of the physician (see Graham & Davies, 2005). See Practice Bulletin, 2016 (in the references), for the current guidelines.

Problems with Childbirth

1. 7.7 Identify and explain the problems that can occur during breech deliveries, cesareans, and preterm deliveries.

Pregnancy and childbirth do not always go as planned. Worldwide, nearly 350,000 women die each year as a result of childbirth (Hogan et al., 2010). This includes deaths within 1 year of childbirth caused by complications of pregnancy. The major causes of death are blood clots, hypertension, hemorrhage, and infections. The U.S. ranks only 26th in the world in infant mortality rate (582 deaths per 100,000 births), far behind most other developed countries (Jacob, 2016). Preterm birth-related complications account for over half of these deaths. The mortality rate is particularly high for babies born to African American mothers.

7.7.1 Stillbirths and Newborn Deaths

Stillbirth refers to the death of a fetus (while in the uterus) during the second half of pregnancy. Worldwide, the large majority of the annual 2.64 million stillbirths happen in low-income countries (Cousens et al., 2011). In the United States, about 1 in 160 pregnancies ends in stillbirth. The major causes, in order, are maternal overweight and obesity (and thus the mothers have or are prone to diabetes), maternal age, and maternal smoking (Flenady et al., 2011). The rates for black women are double those for white women.

According to the World Health Organization, about 3.3 million babies die each year before they are 1 month old. The United States ranks 41st (1 in 233 newborns dies), way behind countries like Japan (1 in 909) and France (1 in 455) (*USA Today*, 2011). Some of the leading causes are premature births, maternal obesity, maternal smoking, and maternal high blood pressure.

7.7.2 Breech Births

Babies, you recall, are generally born head first. This occurs in about 96% of all births, and ideally the back of the head, or crown, leads the way. Sometimes, a fetus will try to come through the birth canal feet or buttocks first. This is called a breech birth and occurs in 2% to 4% of all births. Sometimes during labor a woman will be asked to try lying in different positions, such as on her side, in the hope that this will cause the fetus to change to a head-first position. A physician can sometimes turn the fetus by grasping the mother's abdomen and manually changing the fetus' position.

Today, some physicians may try to perform a vaginal ("normal") delivery even if a breech birth is unpreventable. This will depend on the circumstances and the physician. If the physician feels that the risks of a vaginal delivery are too great, he or she may perform a cesarean section.

7.7.3 Placenta Previa

The blastocyst normally implants in the upper part of the uterus. However, for about 1 out of every 200 pregnant women, implantation occurs in the lower uterus. As the placenta grows, it often blocks the cervical opening, a condition called placenta previa. This does not affect the fetus, but it may prevent a vaginal delivery.

7.7.4 Cesarean Sections and Induced Labor

A **cesarean section** (also spelled *caesarean*), or **C-section**, is an incision through the abdominal and uterine walls to deliver a baby. Although the name is often attributed to the way in which Julius Caesar was born, in actuality it is derived from *lex cesarea*, a Roman law (715 b.c.) that allowed a fetus to be saved in the case of its mother's death.

There are many legitimate reasons for performing a cesarean section. These include some cases of breech birth or placenta previa, the baby's head being too big for the mother's pelvis, maternal illness or stress, and fetal stress. However, compared with vaginal births, cesarean sections are associated with a higher rate of post-delivery complications for both the baby and the mother. Recent studies indicate that, optimally, cesarean deliveries should not exceed 19% of all deliveries (see Molina et al., 2015), yet cesarean sections now account for nearly one third of all deliveries (Martin et al., 2015). Many individuals, including many health professionals, have begun to call for changes in the way physicians decide when to use this procedure (Resnik, 2006).

It used to be that once a woman had a C-section, all later pregnancies would have to end with C-section deliveries (because the cuts were made vertically through the horizontal abdominal muscles and through the contracting part of the uterus). Today, however, incisions are made horizontally through the abdomen and then through the noncontracting part of the uterus. In most cases, it is generally safe for a woman who has had a cesarean section to deliver vaginally (Crawford & Kaufman, 2006). Interestingly, about 15.6% of women worldwide (and an even greater number of American women) today say they would prefer a C-section over a vaginal delivery because they can choose when to deliver (e.g., Mazzoni et al., 2011). Because C-sections are so common, it is advisable for a pregnant woman to talk with her physician about his or her attitudes regarding their use before she goes into labor.

About 22% of births in the United States follow induced labor (Caughey et al., 2009). This is sometimes necessary because of complications to the mother or fetus but today is often chosen by women (called "elective" induction of labor) for non-medical reasons.

7.7.5 Preterm Infants

Traditionally, a "term" pregnancy has been considered as giving birth between 37 and 42 weeks after the start of the last menstrual period. However, the smallest number of bad outcomes occur between 39 and 41 weeks, and thus many medical groups now regard 2 weeks before this

period as "early term" and 2 weeks afterward as "late term" (Spong, 2013). Babies born to mothers pregnant for less than 37 weeks are called preterm infants. Preterm births account for about 12% of all U.S. births, up from 9.4% in 1981 (Born Too Soon, 2012). Conditions such as malnutrition and preeclampsia increase the risk of having a preterm birth; other risk factors include a previous preterm birth, age (the risk increases as women age) (Khoshnood et al., 2005), and obesity (Cnattingius et al., 2013).

Advances in neonatology (the care of newborn babies) have reduced the limit of viability to about 22 to 23 weeks after conception. One of the biggest problems facing a fetus born at this time is that it has great trouble breathing. Before the age of 23 weeks (around 5½ months), the fetus cannot produce a liquid called *surfactant*. Surfactant lets the lungs transmit oxygen from the atmosphere to the blood. After 4 months of age, the fetus can produce some surfactant, but it cannot maintain the liquid at the necessary levels until about 8 or 9 months of age. Newborns who cannot maintain proper levels of surfactant develop respiratory distress syndrome and die.

"When I was exactly 8 months pregnant my amniotic sac broke and labor was induced. When I saw my baby in the nursery, she was under oxygen, had all kinds of wires connected to her, an IV in her foot, and she had a lot of trouble breathing. I wasn't ready for this. However, I feel that if I was more informed about premature births I would have understood better."

(from the authors' files)

Most preterm births happen at 34 to 36 weeks, but over 1.6% occur at 33 weeks or earlier (March of Dimes, 2010). Before 1980, there was little hope of survival for babies born weighing less than 2 pounds. Today, infants born weighing less than 2 pounds are placed in *intensive care nurseries* (ICNs), where new techniques and equipment allow these extremely premature infants a chance of survival (see Stoll et al., 2015). Deaths due to respiratory distress have fallen 13.5% in recent years (Jacob, 2016). Nevertheless, premature infants run a high risk of having disabilities that can require treatment for many years. Babies born weighing 3 pounds or less are much more likely than others to have poor psychomotor skills, low IQ scores, and poor performance in school (Shenkin et al., 2004; Swamy et al., 2008).

After Childbirth

1. 7.8 Discuss issues following childbirth: the benefits of breast-feeding, postpartum depression, when to begin sexual intercourse, and spacing pregnancies.

In 1980, the average stay in a hospital room was 3.2 days for a vaginal delivery. This dropped to 1.7 days in the early 1990s, when most insurance companies refused to pay for more than 1 day. In a revolt against these "drive-by deliveries," many states passed laws in 1995–1996 requiring insurance companies to pay for at least 2 days. As a result, the average woman giving birth vaginally now stays 2.1 days (Weiss et al., 2004).

Figure 7–12

Mother's milk contains many infection-fighting proteins and is easier for a baby to digest than cow's milk.

Source: Gladskikh Tatiana/Shutterstock

7.8.1 Breast-Feeding the Baby

Milk production (lactation) begins about 3 days after a woman gives birth. Recall from Chapter 2 that two hormones produced by the pituitary gland are responsible for milk production. Prolactin stimulates the breasts to produce milk, while oxytocin causes the breasts to eject milk. When the baby sucks on the breasts, a milk-flow reflex is created. In fact, over time, merely hearing the baby cry can cause a mother's breasts to begin ejecting milk. At first, the breasts give out colostrum, which is high in protein and also helps immunize the infant against diseases. After about 3 days, milk begins to flow. The average amount of milk produced is 2½ to 3 cups per day, but there is a lot of variation among individuals.

About 79% of new American mothers breast-feed their babies during the first few weeks, but only about half are still doing so at 6 months (CDC, 2014). The American Academy of Pediatrics recommends that babies be exclusively breast-fed for the first year. Why? Mother's milk contains many infection-fighting proteins that protect the infant from gastrointestinal illnesses (e.g., diarrhea), respiratory infections, meningitis, skin diseases, and other problems (e.g., Raisler et al., 1999). Breast-feeding has benefits to mothers as well. When a mother begins nursing, a hormone is released that helps the uterus to contract and helps stop internal bleeding. Breast-feeding also reduces the mother's chance of developing breast cancer (Collaborative Group, 2002). However, recent studies find that there is no obvious benefit to long-term breast-feeding (Jenkins & Foster, 2014). Keep in mind, however, that drugs and pollutants can be transmitted to the infant through mother's milk. Before taking any medication (including birth control pills), therefore, it is important for nursing mothers to consult their physicians or pharmacists.

7.8.2 Postpartum Depression

The first 3 months after childbirth are called the *postpartum period.* Although most women look forward to having a baby, many experience a period of negative emotions during this time. In some cases their distress can be extreme:

"After I had my son I spent weeks and weeks sitting alone on the kitchen floor with him on my lap and crying and crying uncontrollably."

"I was so depressed after giving birth to a little girl. If somebody touched her, I screamed. When my baby was 3 days old I had a fight with my mother-in-law and husband. Actually, they tried to help me out, but I was so depressed that I always fought with them. Things got worse and I

thought I was going to get divorced. . . ."

"I can remember being depressed for a couple of months. . . . I felt so helpless. . . . Sometimes I resented my baby because I felt so bad and was so exhausted. I hated myself for having these feelings."

(All examples are from the authors' files.)

There is a range of negative emotions that women can experience after childbirth, and it is customary to distinguish three types of depression on the basis of severity (Miller, 2002). About half of women experience a letdown in the first week or two after delivery, called postpartum blues. Symptoms may include a depressed mood, confusion, anxiety, and crying, but the condition is mild and does not last long. However, about 10% to 15% of women experience postpartum depression, characterized by a deeper depression and anxiety, guilt, fatigue, and often obsessive-compulsiveness (Brummelte & Galea, 2016). The stricken mother may feel that she cannot face daily events, is overwhelmed by childcare, and feels ashamed and guilty about her inadequacy as a mother. About 1 in 1,000 women experiences postpartum psychosis, characterized by affective (mood) symptoms and hallucinations in what often resembles a manic depressive state. We will focus here on postpartum depression.

Biological factors, particularly hormone changes, may contribute to postpartum depression (Brummelte & Galea, 2016). The placenta secretes high levels of estrogen and progesterone during pregnancy, and there is a sudden drop in the levels of these hormones after birth. But social and psychological factors certainly play a major role. Stress factors include low socioeconomic status, unemployment and financial problems, and lack of social support. Marital unhappiness and lack of support by the spouse and family, for example, can contribute to the depression (Knudson-Martin & Silverstein, 2009; Miller, 2002).

Many studies indicate that if postpartum depression lasts several weeks, it can affect the infant's emotional, behavioral, and cognitive development (Brummelte & Galea, 2016). It is probably a mother's style of interacting with her child (brought on by the depression) that results in these negative consequences. Women with postpartum depression generally are treated in the same manner as other depressed patients (Miller, 2002).

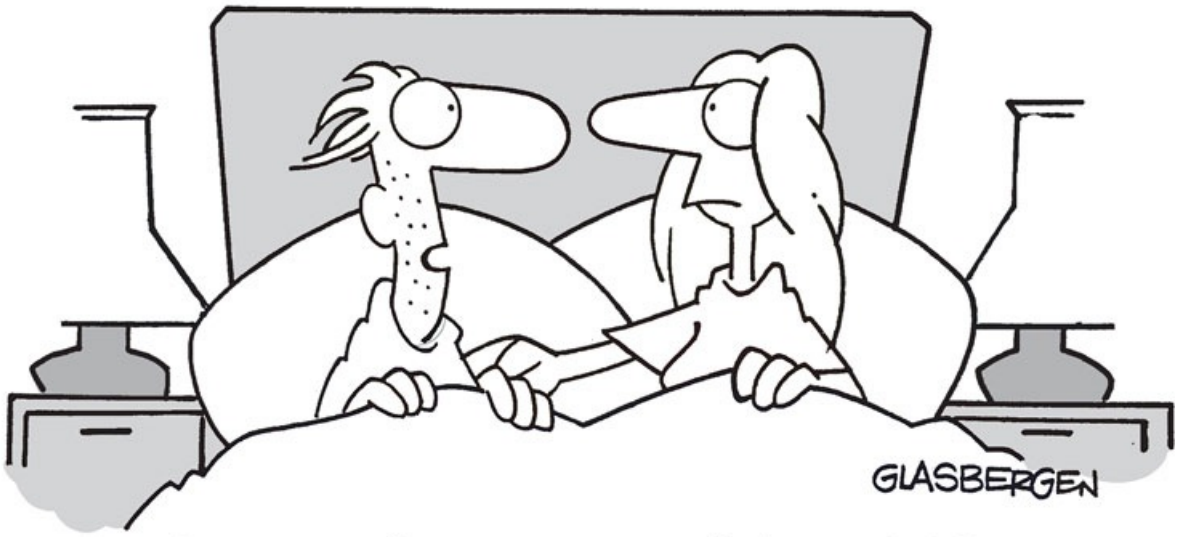
7.8.3 Sexual Intercourse After Childbirth

"We tried to make love again when our first baby was about 3½ weeks old. The pain from the episiotomy made this impossible and we both wound up very frustrated and wondering if our sex life would ever be back to normal. We finally did succeed at about 6 weeks but still it wasn't very comfortable."

(from the authors' files)

Labor often leaves a woman tired and sore for some time, and stitches from an episiotomy may leave her uncomfortable. Vaginal bleeding continues for 2 to 6 weeks in most women, and the loss of estrogen results in vaginal dryness and irritation during intercourse for some time (von Sydow, 1999). Most physicians advise that sexual intercourse not be resumed until 4 to 6 weeks after the birth. Despite these concerns, couples do resume sexual intercourse an average of 7 weeks after childbirth (Hyde et al., 1996).

Postpartum depression often results in reduced sexual relations after childbirth (Ahlborg et al., 2005; Chivers et al., 2011). Women also may worry about their sexuality because of decreased satisfaction with their bodies (e.g., stretch marks, extra weight left over from pregnancy, and "flabby" stomach muscles). The stretch marks soon become paler, and problems with weight and stomach muscles can be helped through exercise. Some women also worry that their vagina has become too large after birth, but the vaginal muscles generally become firm and tight again, especially if the woman continues to practice Kegel exercises (see Chapter 2).



Glasbergen Cartoons

The best time to resume sexual relations depends on many factors. In all cases, however, a man and a woman must learn to relate to each other both as sexual partners *and* as parents. Differences in sleep patterns with an infant who must be fed at night, demands on time and energy made on parents by children, and difficulty finding periods of privacy all force couples to make adjustments in their sexual behaviors. The stress of being a new parent (with all of the new responsibilities) often negatively affects a couple's sexual relations (Botros et al., 2006). For women, relationship satisfaction and fatigue are good predictors of a woman's sexual desire after childbirth (Ahlborg et al., 2005; Schlagintweit et al., 2016).

Personal Reflections

Will pregnancy affect your sexual relationship with your partner? How? Why? Will being parents affect your sexual relationship? How? Why? What steps can you and your partner take to ensure that as parents your sexual relationship will continue to be fulfilling?

7.8.4 Spacing Pregnancies

How much time in between pregnancies is best for producing a healthy, full-term baby? A large-scale study found that a woman should wait at least 11 months after giving birth before getting pregnant again, a 20-month interval between pregnancies (Grisaru-Granovsky et al., 2009). Getting pregnant sooner than this greatly increases the chance of a premature (and undersized) baby. Another study recommended waiting 18 to 23 months, a 27- to 32-month interval (Zhu et al., 1999). In fact, in the United States the average time between pregnancies is 34 months, but 35% are within 18 months and over half of these are unintended pregnancies (Gemmill & Lindberg, 2013).

Infertility and Impaired Fecundity

1. 7.9 Compare and contrast the various methods for dealing with infertility.

Infertility is defined as the inability of a couple to conceive. The ability of a couple to conceive within a certain period of time is called fecundity. For most studies, fecundity is measured over a year's time. Notice that these two terms have different meanings. A person can be fertile but not vey fecund. The causes of infertility are many and varied because so many organs of both sexes must function properly for conception to take place. About 40% of the problems involved with infertility are due to the man, with another 40% due to the woman. About 20% of the cases result from problems in both partners (Moore et al., 2013). As people age from their early 20s to their late 30s, most are still fertile, but they become less fecund.

Among married women aged 15 to 44, about 6% are infertile, and another 12% have impaired fecundity. About 9.4% of men in this age group are infertile (Chandra et al., 2013). Much of this is due to many people delaying childbearing (problems with fecundity due to an increase in age) (Oliwenstein, 2005).

Most people think of an infertile couple as a couple who have never been able to conceive, called *primary infertility.* However, the inability to conceive after having had one child, called *secondary infertility*, is about as common (Mosher & Pratt, 1991).

7.9.1 Infertility in Men

It has been known for a long time that fecundity in women decreases with age (Maheshwari et al., 2008). This is true for men as well (Ford et al., 2000). The probability that it would take longer than a year to conceive is only 8% for men under 25 years of age but nearly doubles to 15% for men over 35. This is due to declining numbers and quality of sperm (American Society for Reproductive Medicine, 2008).

As you may remember, only a very few of the millions of sperm cells released during ejaculation survive the trip to the egg. If a man's reproductive system cannot produce enough sperm and/or if the sperm he produces are too slow or too weak, the probability that fertilization can occur is substantially reduced. Low numbers of sperm are caused by a variety of factors, including endocrine problems (low levels of pituitary or gonadal hormones), drugs (including alcohol and many antibiotics), marijuana, radiation, and infections. If a man gets mumps after puberty, for example, it often spreads to the testicles and causes severe swelling that destroys the seminiferous tubules where sperm are produced. Other infections, including some sexually transmitted infections, can result in blockage of a man's duct system (just as some STIs can lead to blockage of the Fallopian tubes in women). Varicosity of the veins in the spermatic cord (*varicocele*) can also lead to a low sperm count. Because sperm can only be produced at a temperature several degrees lower than normal body temperature, sperm count is sensitive to temperature variations. See Kamischke and Nieschlag (1999) for a review of the many possible causes.

A review of 61 studies conducted worldwide in the 1990s concluded that the average sperm count per ejaculation had dropped by more than half in the previous 50 years (Carlsen et al., 1992). What could cause such a dramatic change? Neils Skakkeback, one of the authors of the paper, said, "It would have to be something in the environment or lifestyle. Changes that occur within a generation could hardly be due to a change in genetic background" (quoted by Epstein in AP release, September 1992). Further evidence is found in the fact that the rates for testicular cancer tripled during the same time period. Could industrial chemical pollutants have such effects? Boys born to (and breast-fed by) mothers exposed to high levels of pollutants can have testicular malformations and dramatically undersized penises, and the same is true for many species in the wild (see Begley & Glick, 1994). Many of the suspected pollutants resemble the female sex hormone estrogen in structure (see Joensen et al., 2009). A word of caution before we jump to conclusions—much of this work has been criticized for flawed procedures. A recent well-conducted study of Danish men found no change in semen quality over the past 15 years (Bonde et al., 2011).

Infertility is not just a physical problem; it also affects men emotionally:

"Several months ago we began trying to have kids unsuccessfully. When I was younger I had an . . . operation and my doctor said that because of this I would not be able to have children. My wife and I wanted children, and this situation has really put a strain on our marriage."

"Being sterile is not an easy thing to discuss. On top of diminishing dreams and goals, it has made finding the right girl to begin a lifelong relationship with very difficult. . . . My future wife and I will never be able to have children of our own. . . . I've always wanted to teach my son to play sports or take my daughter to dancing lessons. . . . Hopefully someday I will find the right woman and we can adopt."

(All examples are from the authors' files.)

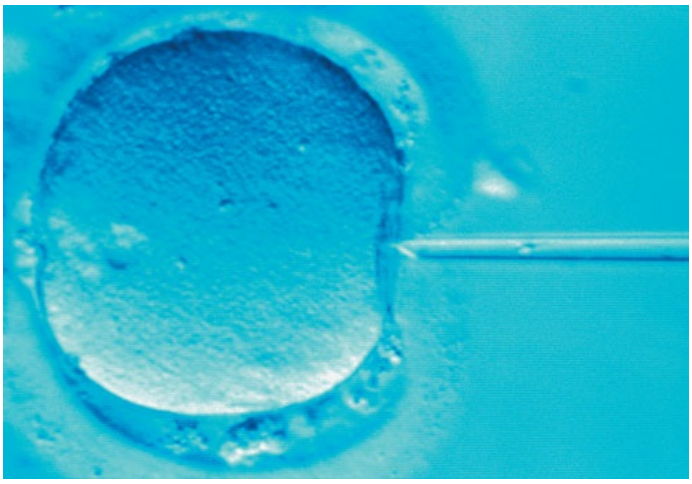
What are the medical treatments for male infertility? Infertility due to varicose veins in the spermatic cord (8% to 23% of cases) can often be corrected with surgery (Mishail et al., 2009). If the cause is hormonal, treatment with pituitary hormones (or brain hormones that cause release of pituitary hormones) or gonadal hormones (androgens) is often successful. A blocked duct system in men is much easier to correct through surgery than are blocked tubes in women.

When a man is found to have a low sperm count, a procedure called artificial insemination is often used. In this procedure, sperm are collected via masturbation and inserted into the female partner's uterus immediately after ovulation. Several ejaculations are usually collected and stored by freezing (frozen semen is just as effective as fresh). For example, if a man's average ejaculation were found to contain 50 million sperm, six to eight ejaculations (totaling 300 million to 400 million sperm) might be collected and frozen. When enough sperm have been collected, they are gathered together for a single insertion. The success rate is 10% to 15% per try (60% to 70% after six tries). Sperm can be safely preserved for more than 10 years, and some men make deposits in sperm banks before having a vasectomy, undergoing chemotherapy, working a hazardous job, or going off to war.

If a man's sperm count is so low that combining several ejaculations will not help, a couple can choose to use sperm from another, usually anonymous, man. In these cases, artificial insemination is often called *donor insemination.* About 70,000 babies are conceived in this manner every year in the United States.

The newest and most successful technique involves injecting a single sperm directly into an egg, called intracytoplasmic sperm injection (ICSI), and then the egg is placed in the uterus by in vitro fertilization (see next section). Nearly two thirds of all assisted reproductive procedures include ICSI (see Figure 7–13) (Centers for Disease Control and Prevention, 2007).

Figure 7–13



Intracytoplasmic sperm injection: Injecting a sperm into an egg.

Source: Mauro Fermariello/Science Source

7.9.2 Infertility in Women

The discovery that she is infertile can be emotionally stressful to a woman and her partner (Van der Merwe & Greeff, 2015):

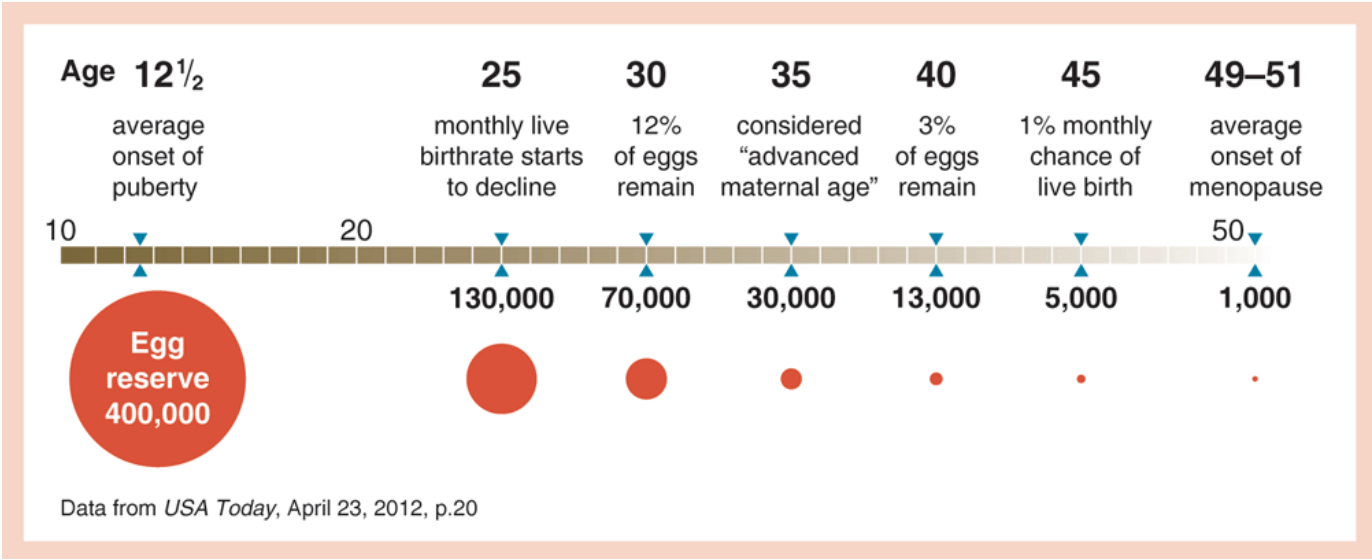
"My husband and I have been unsuccessful in our attempts to have children. My doctor gave me some fertility drugs and after about 4 months I got pregnant and miscarried. We tried the same drugs again with no success and finally threw in the towel. All of this took about 5 years."

"The experience is terribly isolating. People don't understand what you're upset about—after all, you didn't lose anything that they can see. All of our friends have had their kids. When we got together with our friends the main topics were breast-feeding and details about their pregnancy and delivery. It was heartbreaking not to be able to be happy for them because at the time we just happened to be in a lot of pain."

(from the authors' files)

For women of reproductive age, problems with fertilization generally come from two sources—structural problems in the Fallopian tubes or uterus and failure to release eggs (ova). Blockage of the Fallopian tubes accounts for about 25% to 35% of all cases (Honoré et al., 1999; Rebar, 2004). Blockage can be due to anatomical malformations, growths (e.g., polyps), endometriosis (discussion follows), infections, and scar tissue. Scar tissue from sexually transmitted infections, especially chlamydia and gonorrhea (resulting in pelvic inflammatory disease), accounts for at least half the cases of infertility from blocked tubes. Given the epidemic levels of these infections, this will continue to be a primary cause for both ectopic pregnancies and infertility in the near future (see Chapter 5).

Figure 7–14



Decrease in the number of eggs with age. The chances of giving birth decreases by 3% each year after age 30.

Figure 7–14 Full Alternative Text

The diameter of the passageway that an egg takes through the Fallopian tube is only about half that of a human hair. Sometimes surgeons are able to reopen these tiny structures, but the success rate for microsurgery is only about 50% (Honoré et al., 1999).

About 25% to 40% of infertile women have endometriosis to some degree (see Lessey, 2000, for a review). Endometriosis can cause infertility by the growth of endometrial tissue in the Fallopian tubes and/or around the ovaries. Many women today are postponing pregnancy, and endometriosis is known as the "career women's disease" because it is most common in women in their mid-20s and over, especially if they have postponed childbirth. Hormone treatment to control the growth of endometrial tissue or surgery to remove it has commonly been used (de Ziegler et al., 2010).

One of the major causes of infertility in women (accounting for about 20% of cases) is a failure to ovulate (Urman & Yakin, 2006). This becomes more common as women

age (Cabry et al., 2014). Some infertile women have too much of a hormone called prolactin, while others have too little or too much of what are called gonadotrophic hormones (hormones that stimulate the ovaries). Perhaps the most common cause of failure to ovulate is polycystic ovarian syndrome, in which eggs only partially develop within the ovary and there is an excess of male hormones. Obesity often causes ovulatory problems, and a good diet (e.g., slowly digested carbohydrates, no trans fats) can sometimes improve ovulation and chances of pregnancy (Brewer & Balen, 2010).

If a woman is having problems becoming pregnant because she is not having regular menstrual cycles, and thus eggs are not being released, her physician will try fertility drugs (see Crosignani et al., 1999). There are two major types. One type stimulates the pituitary gland to secrete FSH and LH, the hormones necessary to start the cycle (see Chapter 3). Clomiphene is an example of this type of drug. A second type stimulates the ovaries directly (HMG, or human menopausal gonadotropin, is an example). The success rate for fertility drugs is about 50% to 70% in cases where the problem is entirely hormonal.

Fertility drugs increase the chance of multiple births from 1% or 2% to 10% to 20% (Luke et al., 1994). As a result of increased use of fertility-enhancing techniques, twin births in the United States have doubled since 1980 (see National Center for Health Statistics, 2012). There was some concern that fertility drugs may increase the risk of ovarian cancer, but large studies have found no evidence for this (Jensen et al., 2009).

7.9.3 Assisted Reproductive Technology

The techniques for overcoming infertility entered a new era with the development of in vitro ("in glass") fertilization (IVF) in England in the 1970s. Here, eggs and sperm are combined in a Petri dish, and after fertilization takes place, one or more fertilized eggs (usually at about the four-cell stage) are placed into the woman's uterus. Each year in the United States, close to 50,000 women have babies as a result of IVF (Hammond et al., 2009). Children conceived with in vitro fertilization are often called "test-tube babies" by the press and others, but as you can see, the procedure does not even use test tubes.

The success rate is 65% to 83% for women under 35 years of age over an entire course of treatment of IVF/ICSI (several IVF cycles) (Malizia et al., 2009). The success can be improved by transferring two fertilized eggs (rather than one) to a woman's uterus, but this increases the chances of a multiple birth.

There are two variations: gamete intrafallopian transfer or.pngT (eggs and sperm are placed into a pipette and inserted directly into a Fallopian tube) and zygote intrafallopian transfer or ZIFT (fertilized eggs are placed directly into a Fallopian tube). Because.pngT and ZIFT require major surgery and the success rate is not much better, most physicians prefer the simpler, less invasive IVF procedure or even a newer modification called *in vitro maturation* (of oocytes) (Cabry et al., 2014; Seyhan et al., 2012). Here, rather than hyper-stimulate the ovaries to obtain eggs, eggs are collected early and allowed to mature in vitro.

The biggest obstacles to advancement in this field are social, political, and legal. Many people oppose these procedures to treat infertility. The Roman Catholic Church, for example, rejects both artificial insemination and in vitro fertilization, proclaiming that procreation must be "a physically embodied love act." The U.S. government has refused to fund research on IVF. Joseph Schulman, a former section director at the National Institutes of Health, said, "I can think of no other examples where for a decade and a half a whole area of investigation that has in fact proven itself to be of massive value to thousands and thousands of couples has been pigeonholed" (quoted in Baker, 1990).

Personal Reflections

Imagine that you and your partner have tried to conceive for 5 years. How do you feel? What would you do next? What options would you consider? What options would you never consider? Why or why not?

7.9.4 Surrogate Mothers

One of the most controversial fertility solutions is surrogate motherhood, sometimes resorted to when a woman cannot conceive or carry a fetus during pregnancy (see Ali & Kelley, 2008). In such a case, a couple may create a zygote through in vitro fertilization and then have the fertilized egg implanted in the uterus of another woman. In a second method, the surrogate mother is impregnated with the male partner's sperm, usually through artificial insemination. The surrogate mother gives birth, and the infant is raised by the infertile couple. The couple will generally pay for the surrogate mother's medical expenses along with necessary legal fees. They also will pay the surrogate mother a fee for providing this "service" (usually $20,000 to $25,000).

Surrogate mothers have been used since biblical times (see Genesis, Chapter 16). Today, some states have passed laws that allow surrogacy, while others have attempted to outlaw it. In cases where the surrogate mother has attempted to keep the baby, the courts have ruled in favor of the intended parents.

7.9.5 Delayed Childbearing and Assisted Reproductive Technology

In the past few decades, the average age at which women have their first baby has increased. However, you have just learned that as women grow older, their fecundity declines (Chandra et al., 2013). After age 30, the chances of having a healthy baby decrease by more than 3% each year. The problem is not with the uterus but with the decreased number and quality of eggs as women age (see Figure 7–14). At menopause, you recall, the ovaries stop working entirely and women are no longer capable of reproduction—or at least that was what was thought until recently.

As more and more women have entered careers and chosen to delay pregnancy, they have often been faced with fertility problems when they do decide they are ready for motherhood. Today, however, in vitro fertilization and the related procedures have allowed even some postmenopausal women to become pregnant and have children. Because the uterus remains healthy, eggs can be donated by a young woman (and thus are usually of high quality), and then in vitro fertilization is attempted to achieve fertilization and implantation (Forman et al., 2011).

More recently, postmenopausal women over the age of 50 have elected to have children by egg donation and in vitro fertilization. In 1994, a 62-year-old Italian woman gave birth after receiving donated eggs. In 2008, a 56-year-old Ohio woman gave birth to triplets. To date, the "record" is 70 years old. In the words of Marcia Angell, executive editor of the *New England Journal of Medicine*, "The limits on the childbearing years are now anyone's guess."

Many people, including many physicians, are debating the ethics and health-related issues of assisted delayed childbearing (Smajdor, 2011). The older a woman is during pregnancy, the greater the risk of a low-birth-weight baby. There are also risks to the woman herself—diabetes, high blood pressure, and increased likelihood of having to have a cesarean section. These problems might be minimized by careful screening, but what about the ethical considerations? For those who oppose assisted reproductive technology, proponents offer two arguments. First, there is often a double standard, with many people admiring older men who father children. Why shouldn't women have the same opportunity? Second, qualities like love, experience, and responsibility are more important than age in determining who will be a good mother. As the chairperson of the Council of the British Medical Association said, it is better to have "a fit, healthy 59-year-old than an unfit, unhealthy 19-year-old" mother. What qualities do you think make a good mother?

7.9.6 Superfertility

For some women, having children is, apparently, very easy. According to the *Guinness Book of World Records*, the most prolific mother alive is Leontina Albina of Chile, who gave birth to 59 children—always triplets or twins. She was one of three triplets sent to an orphanage, but while her two brothers were adopted, she was not. She

promised herself that if she ever had children, she would never give them away. Leontina married at age 12 and continued to have children into her 50s.

A word of caution: Studies show that women who have had six or more pregnancies are at higher risk for coronary heart disease and cardiovascular disease (Ness et al., 1993). Please take this into consideration if you are planning a large family.

Study Guide

Key Terms

- afterbirth
- alpha-fetoprotein (AFP) screening
- amniocentesis
- amnion
- artificial insemination
- blastocyst
- Braxton-Hicks contractions
- breech birth
- capacitation
- cesarean section (C-section)
- chorion
- chorionic villus sampling
- colostrum
- conception
- couvade syndrome
- critical period
- crowning
- dilation (cervix)
- doula
- ectopic pregnancy
- effacement (cervix)
- embryo
- episiotomy
- false labor
- fear–tension–pain cycle
- fecundity
- fertility drugs
- fetal alcohol syndrome (FAS)
- fetal surgery
- fetus
- Graafian follicle
- human chorionic gonadotropin (HCG)
- implantation
- infertility

- intracytoplasmic sperm injection (ICSI)
- in vitro fertilization (IVF)
- lanugo
- lightening
- miscarriage
- “morning sickness”
- morula
- nurse-midwife
- ovum (ova, pl.)
- oxytocin
- placenta
- placenta previa
- postpartum blues
- postpartum depression
- postpartum psychosis
- preeclampsia
- prenatal examination
- prepared childbirth
- preterm infant
- primary follicle
- prolactin
- quickening
- respiratory distress syndrome, p. 178
- Rh factor
- second stage of labor
- sperm
- start-up stage of labor
- surrogate mother
- teratogens
- third stage of labor
- transition phase
- trimesters
- trophoblast
- ultrasound
- umbilical cord
- vernix caseosa

- zygote

Interactive Review

Answers can be found on p. 470.

1. Sexual intercourse can result in conception on only about 6 days of the menstrual cycle (from about (1) days before (2) to about (3) day(s) afterwards. Fertilization usually occurs within a (4) , and implantation normally occurs in the (5) of the uterus. Implantation of a fertilized egg at any other location is called an (6) pregnancy, and the most common cause is scarring of the Fallopian tubes due to (7) . Pregnancy tests are positive if a woman's urine or blood contains a hormone secreted by the developing placenta called (8) .

   Pregnancy is divided into three 3-month intervals called (9) . After implantation, the conceptus is called an (10) for the first (11) months and then a (12) for the last (13) months of pregnancy. An expectant mother can first feel her unborn baby moving, an experience called (14) , during the (15) month of pregnancy. Sexual intercourse during pregnancy is generally thought not to be harmful to the fetus, although some health professionals recommend that a pregnant woman not engage in intercourse during the 9th month of pregnancy.

   There are many possible causes of complications of pregnancy. Substances that can cross the placental barrier and harm the unborn baby are called (16) . Examples include viruses, smoking, alcohol, cocaine, and other drugs. Fetal abnormalities can often be detected by ultrasound or by a variety of invasive techniques such as chorionic sampling, and (17) . Today, it is sometimes possible to perform surgery on a fetus while it is still in the uterus.

   Prepared childbirth courses (such as Lamaze) attempt to break the (18) cycle through education and preparation. Another choice is giving birth in the home (or in a home-like environment), usually with the aid of a nurse-(19) rather than a physician.

   The actual birthing experience is known as labor. Before giving birth, many women experience false labor. True labor is distinguished from false labor by the timing and length of (20) and by the (21) of the cervix. Labor proceeds in three stages. The initial or (22) stage usually lasts from 6 to 13 hours, although each stage of labor varies a great deal from woman to woman and even from birth to birth in the same woman. The (23) breaks (or is broken by the physician) just prior to or during this stage. The last part of the first stage of labor is called the (24) . It marks the beginning of the birth process. In the second stage of labor, the cervix is (25) and the fetus begins moving through the birth canal. The baby usually enters the world (26) first, and after delivery the (27) is cut. In the third stage of labor the (28) detaches from the uterus and leaves the mother's body. If complications develop during childbirth, the baby can be delivered surgically through the mother's abdomen by a (29) . Today, in most cases, it is considered safe for women who have previously had a C-section to deliver vaginally during subsequent deliveries.

   An increasing number of U.S. women are breast-feeding their babies. Mother's milk contains many infection-fighting (30) and is easier to digest than cow's milk. After giving birth, many women experience negative emotions, called (31) . Hormone changes, lack of sleep, and new demands can all contribute to this. Most physicians advise that women not resume sexual intercourse for (32) weeks after delivery.

   Infertility or impaired fecundity (failure to conceive within (33)) affects many couples in the United States. About (34) percent of these cases are due to problems with the man, (35) percent to problems with the woman, and about (36) percent to problems with both partners. In men, infertility is usually caused by either blockage of the duct system or (37) . For the latter, a procedure called (38) is often used. In women, infertility is usually the result of blocked (39) or a failure to (40) . Today, infertile couples can be helped by a variety of assisted reproductive procedures in which an egg is fertilized outside of a woman's body and then placed into her uterus (called (41)).

Self-Test

Answers can be found on p. 470.

A. True or False

- **T F** 42. At implantation, the one-celled organism is called a fetus.
- **T F** 43. About 75% of all conceptions either fail to implant or are spontaneously aborted within the first 6 weeks.
- **T F** 44. "Morning sickness" is most common during the last trimester of pregnancy.
- **T F** 45. An expectant mother cannot feel her unborn baby moving inside her ("quickening") until the second trimester.
- T F 46. Sexual intercourse during the 7th and 8th months of pregnancy is often harmful to the mother and/or fetus.
- **T F** 47. Drugs can adversely affect the fetus, but smoking, while hazardous to the mother, has little effect.
- **T F** 48. If a woman is Rh positive and her fetus is Rh negative, the condition is called Rh incompatibility.

- **T F** 49. One beer or one glass of wine a day is thought to be acceptable when a woman is pregnant.
- **T F** 50. One of the most common causes of scarring of the Fallopian tubes is untreated gonorrhea and chlamydia.
- **T F** 51. "Prepared childbirth" means having a baby without the use of anesthetics.
- **T F** 52. A baby is born during the third stage of labor.
- **T F** 53. If a woman has an ectopic pregnancy, there is an increased risk that her future pregnancies will also be ectopic.
- **T F** 54. The expression "test-tube babies" refers to the process whereby conception and embryonic development (i.e., the first 2 months) occur outside the mother's body.
- **T F** 55. Artificial insemination is the fertilization of an egg by synthetically manufactured sperm.
- **T F** 56. "Morning sickness" can be effectively treated with hormones.
- **T F** 57. True labor is marked by the onset of Braxton-Hicks contractions.

B. Matching

(Match the problem with the treatment or solution)

Treatment or solution

- 58. artificial insemination
- 59. cesarean section
- 60. chorionic villus sampling (or amniocentesis)
- 61. fertility drugs
- 62. fetal surgery
- 63. in vitro fertilization
- 64. laparoscopic surgery
- 65. surrogate mother
- 66. intracytoplasmic sperm injection

Problem

1. Susan has a tubal (ectopic) pregnancy.
2. Sherry andJohn cannot conceive because she is not having regular menstrual cycles.
3. Carol and David cannot conceive because he has a low sperm count.
4. Phyllis isnot yet fully dilated and her baby is in distress.
5. Diane cannot carry a fetus during pregnancy, but she and Frank want to have a baby that is biologically theirs.
6. Shelly andMark cannot conceive. Eggs taken from Shelly are fertilized by sperm from Mark and then placed into Shelly's uterus.
7. Linda and Walter's unborn baby has a life-threatening urinary tract infection.
8. Joan and Tom are worried that their unborn baby may have an abnormality.

C. Fill in the Blanks

- 67. Zygote, , , embryo, fetus.
- 68. The major link between the developing baby and the mother is the .
- 69. A pregnant woman who has gained excessive weight and has high blood pressure and swollen joints may have .
- 70. Before birth, the fetus' head drops lower in the uterus. This is called .

- 71. Three guidelines to determine if labor has begun are , , and .
- 72. The trimester is when a developing fetus is generally most susceptible to harmful substances.
- 73. The vast majority of ectopic pregnancies are pregnancies.
- 74. In 2009, the Institute of Medicine recommended that normal-weight women gain pounds during pregnancy.
- 75. By the time a fertilized egg has reached the uterus, it is a fluid-filled sphere called a .
- 76. The part of a baby that normally comes into the birth canal first is the .
- 77. An egg remains ripe only for about after ovulation.
- 78. The fetus is protected in a thick-skinned sac called the .
- 79. and are two procedures used by physicians during labor and childbirth that many experts feel are done far too routinely.
- 80. For a baby to have any chance of surviving, it must develop in the uterus for at least weeks.
- 81. The American Academy of Pediatrics recommends babies be breast-fed for the first .
- 82. To best ensure the chances of a healthy baby, a woman should wait months after giving birth before getting pregnant again.

Suggested Readings and Resources can be found on p. 461.

Chapter 8 Gender Identity and Gender Roles

Gender consists of the meanings ascribed to male and female social categories within a culture. When people incorporate these cultural meanings into their psyches, then gender becomes part of their identities.

—from Wendy Wood and Alice H. Eagly (2015), *Sex Roles*, 73, p. 461.

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 8.1 Distinguish between one's gender and one's sex and between gender identity and gender role.
2. 8.2 Explain various biological influences on sexual anatomy and gender identity.
3. 8.3 Describe the various types of genetic and hormonal disorders of sex development.
4. 8.4 Discuss gender incongruence in childhood and for adolescents and adults.
5. 8.5 Explain the Freudian, social learning, and cognitive-developmental theories of gender identity development.
6. 8.6 Explain and present evidence for the evolutionary and sociocultural theories of gender role differences and the concept of androgyny.
7. 8.7 Describe how gender roles have evolved in the United States.

What determines whether we are born with male or female anatomy? What does it mean to be "masculine" or "feminine"? If a father sees his son playing with a doll, what should the father do? Where do our ideas about "acting like a woman" or "acting like a man" come from? These are the types of questions that we will be addressing in this chapter. However, before we begin, let's look at the definitions of gender, gender identity, and gender roles.

Definitions of Gender, Gender Identity, and Gender Roles

1. 8.1 Distinguish between one's gender and one's sex and between gender identity and gender role.

When people hear the word *sex,* most think of biological features (genitalia, reproductive organs, chromosomes, etc.) or an act (lovemaking, having sex). But what is gender? Gender (from the Latin *genus* and the Old French *gendre,* meaning "kind" or "sort"), according to Joan Scott (1986),

> is a constitutive element of social relationships based on perceived differences between the sexes (p. 1067).

The American Psychological Association (2009) says that sex is biological and gender "is the term to use when referring to men and women as social groups." Sandra Harding (1986) added:

> In virtually every culture, gender difference is a pivotal way in which humans identify themselves as persons, organize social relations, and symbolize meaningful natural and social events and processes (p. 18).

In short, gender is the social construction of femininity and masculinity (Kessler & McKenna, 1978) and is used to differentiate social/cultural aspects of masculinity and femininity from biological aspects (see King, 2010).

Gender identity is your sense of self as a man (or boy) or a woman (or girl), while gender role includes everything you feel and think that conveys to yourself and others that you are, in fact, a man or a woman. In other words, gender role is the way you express your gender identity. Gender identity and gender role are not two different things, but rather two different aspects of the same thing. Gender identity is the inward experience of your gender role, and gender role is the outward expression of your gender identity.

In this chapter, you will learn about the forces that shape both gender identity and gender roles. These forces are biological and social, involving both genetics and learning. Most theorists agree that it is the interaction of such forces that ultimately determines gender identity and gender role. We will begin the chapter with a discussion of how gender identity is formed, focusing first on biological aspects of this process.

Biological Influences on Gender Identity

1. 8.2 Explain various biological influences on sexual anatomy and gender identity.

How do we end up as a boy or girl at birth? Genetics certainly plays an important role, but hormones are equally important.

The Role of Chromosomes

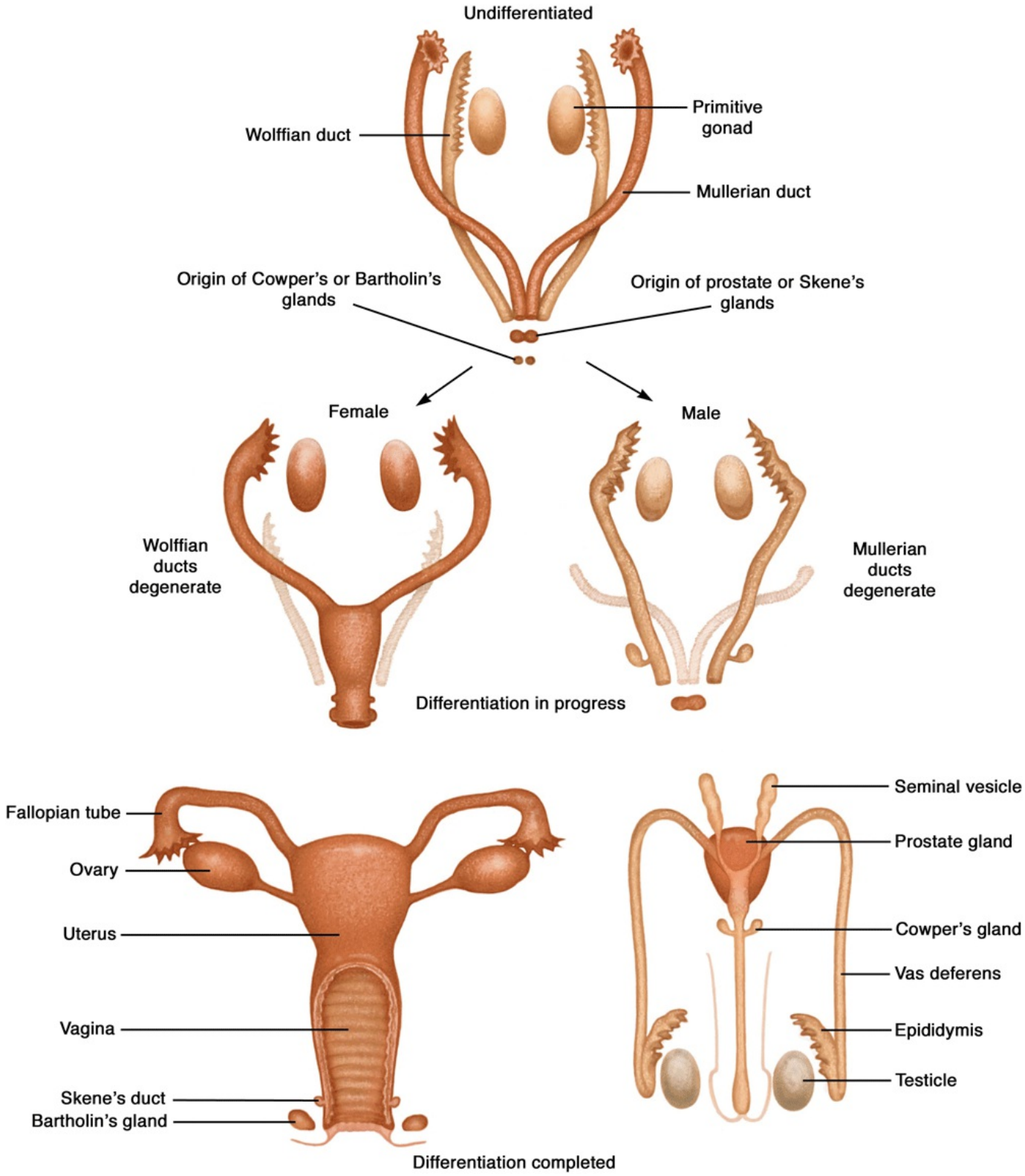
A human cell normally has 23 pairs of chromosomes, rod-shaped structures that determine a person's inherited characteristics. Eggs and sperm have only half the normal genetic material (one chromosome from each of the 23 pairs). Thus, when an egg and sperm unite (called *conception*), the resultant single cell will again have the normal 23 pairs. One of these pairs determines whether at birth the baby will be genetically a boy or a girl. *Girls usually have two X chromosomes (XX), while boys usually have one X and one Y chromosome (XY).* Thus, it is the sperm from the father that determines the genetic sex of the child, and this is determined at the moment of conception. However, sometimes individuals with an XX combination have male anatomy and other individuals with an XY combination have female anatomy. How is this possible? Researchers have determined that a smidgen of the Y chromosome—a gene called SRY (sex-determining region of the Y chromosome)—determines maleness (Wilhelm et al., 2007). This piece is missing from XY girls' Y, and it is present on XX boys' X. In addition, it has been found that one or more genes on the X chromosome may help determine femaleness (Vilain, 2001).

The Role of Hormones

As two researchers put it, "Nature's rule is, it would appear, that to masculinize, something must be added" (Money & Ehrhardt, 1972). That something is testosterone, which must be produced at a critical stage of embryonic development (i.e., during the first 2 months after conception) in order for an XY combination to result in a baby with male anatomy.

Embryos cannot be distinguished anatomically as either male or female for the first few weeks of development. A pair of primitive gonads develops during the 5th and 6th weeks that have the potential for developing into either ovaries or testes. At this stage, the embryo also has two duct systems: (1) the Wolffian duct system, which if allowed to develop will become male structures; and (2) the Mullerian duct system, which if allowed to develop will become female structures (see Figure 8–1). If the primitive gonads were removed at this stage of development, the baby would always be born anatomically a girl, even if it were genetically XY. Why?

Figure 8–1



Prenatal differentiation of the internal reproductive systems in men and women.

Figure 8–1 Full Alternative Text

Normally, the SRY gene on the Y chromosome triggers the transformation of the primitive gonads into testicles during the 7th week of gestation (Hiort & Holterhus, 2000). The newly developed testicles begin to secrete testosterone, which promotes the development of the Wolffian duct system into the male internal reproductive system. The masculinizing hormone is also responsible for the development of the external genitalia a few weeks later. What happens to the Mullerian duct system in these male embryos? The SRY gene activates the testicles to secrete an additional substance called Mullerian duct–inhibiting substance, which causes these ducts to shrink.

What happens to embryos with an XX combination (genetically female)? If there is no Y chromosome (and thus no chemical substance to convert the primitive gonads into testicles), the primitive gonads will eventually develop into ovaries. The absence of large levels of testosterone results in the shrinkage of the Wolffian duct system and the development of the Mullerian duct system into the female reproductive system.

In summary, it would appear that *unless there is a high level of testosterone at a critical stage (the 7th week) of prenatal development, nature has programmed everyone for female development.* In the vast majority of births, the baby's genetic and anatomical sex are matched. Occasionally, however, a different pattern of development may be seen.

Sexual Differentiation of the Brain

Are men's brains different from women's brains, and if so, could this account for differences in behavior? In the 1970s, it was discovered that parts of an area of the brain called the hypothalamus (see Chapter 3) were different in male and female rats (see Kelly et al., 1999, for a review). The difference is a result of differences in testosterone levels. Studies of humans show that men's and women's hypothalamuses (and other areas of the brain) also differ. We now know that this is the result of testosterone levels in the second half of pregnancy (Garcia-Falgueras & Swaab, 2010). Did you notice that this is a different time during pregnancy than for testosterone's role on the reproductive system?

Now for an important question: Is the purpose of chromosomes and embryonic and fetal hormones limited to determining the anatomical characteristics of men and women, or do they also contribute to an individual's gender identity and gender role? One way of examining this question is by looking at individuals whose chromosomes or embryonic/fetal hormone levels differed from the usual pattern.

Disorders of Sex Development

1. 8.3 Describe the various types of genetic and hormonal disorders of sex development.

Due to some disorders in prenatal development, some individuals are born with anatomical features not usually associated with being a boy or a girl. Often, but not always, this includes ambiguous genitals and can result from either chromosome or hormone disorders. Today, the preferred term (by both parents and health professionals) is disorders of sex development (see Davies et al., 2011; Marino, 2010). Older terms such as *intersexual, hermaphrodite*, and *pseudohermaphrodite* are controversial and disparaging.

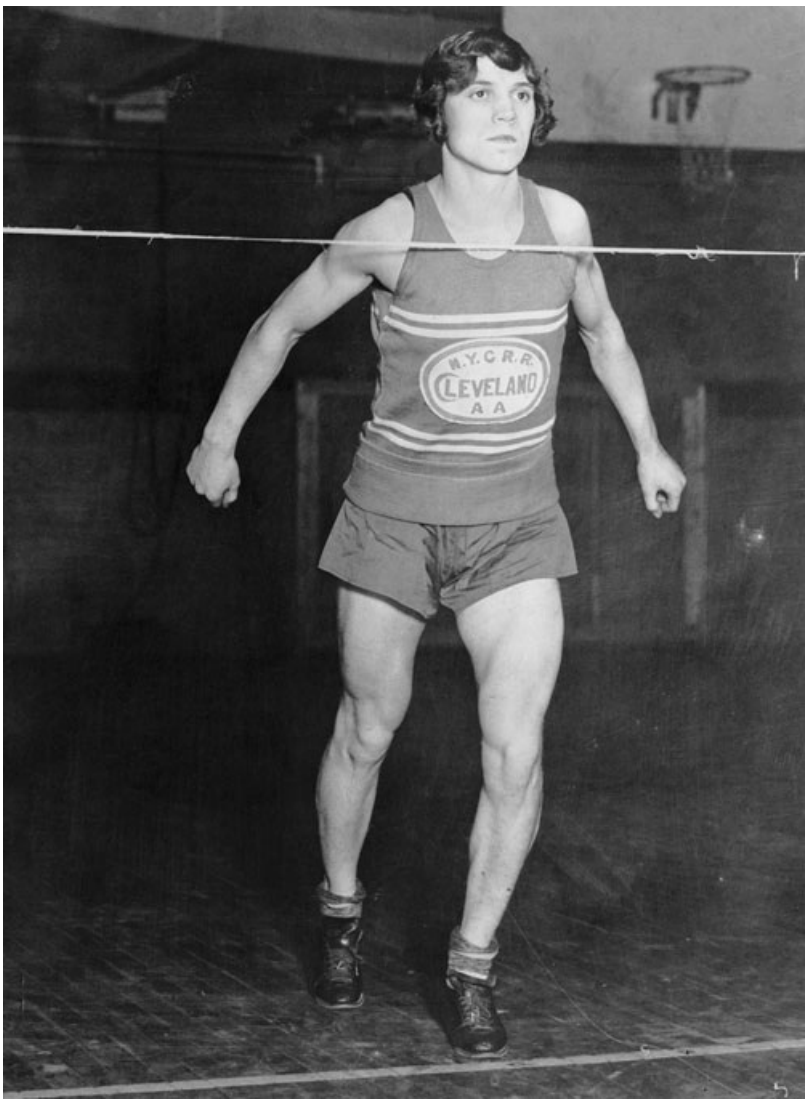
Chromosome Disorders

There are over 70 known disorders involving the sex chromosomes, and approximately 1 in every 426 people is born with unusual sex chromosome combinations (Nielson & Wohlert, 1991). For example, in 1 out of every 660 live male births, there is one or more extra X chromosomes (XXY or XXXY), a condition known as Klinefelter's syndrome (Aksglaede et al., 2011). These biological men have both masculine characteristics, because of the Y chromosome, and feminine characteristics, because of the XX chromosome combination. They tend to be tall with long arms and have poor muscular development, enlarged breasts and hips, a small penis with shrunken testicles, and low sexual desire. Some choose to live as boys and others as girls. One of the most famous cases is Caroline Cossey, who was raised as a boy but later chose to live as a woman and became a well-known model and "James Bond girl" (Cossey, 1991).

Turner's syndrome is a condition in which there is only one X chromosome (XO). It occurs in about 1 in every 2,000 to 3,000 live births. Because women with Turner's syndrome are missing a chromosome, the ovaries never develop properly; and in the absence of ovarian hormones, they also do not menstruate or develop breasts at puberty. They often report a decreased physical quality of life but generally do not have problems with gender identity (Kagan-Krieger, 1998; Ros et al., 2013).

One of the most interesting sex chromosome patterns involved Stella Walsh, an internationally renowned athlete who won an Olympic gold medal in the women's 100-meter dash in 1932 and a national pentathlon in 1954 (see Figure 8–2). After her death in 1980, it was found that some of the cells in her body were XX and others were XY. She had been raised and lived as a woman but had nonfunctional male sex organs.

Figure 8–2



Stella Walsh won an Olympic gold medal in the women's 100-meter dash in 1932. After her death, it was discovered that she had

both XX and XY cells.

Source: Bettmann/Getty Images

The vast majority of us are born with the correct combination of sex chromosomes. However, as you have learned, having an XY chromosome combination does not guarantee that a baby will be anatomically a boy at birth. Hormones are also critically important in the determination of one's sex.

Hormonal Disorders

Some children are born with both male and female reproductive systems as a result of the primitive gonads failing to differentiate properly during the embryonic stage (see Blyth & Duckett, 1991). They are usually genetic females, and even though a uterus is almost always present, they often have an ovary and Fallopian tube on one side and a testicle and a vas deferens and/or epididymis on the other (see Figure 8–3). The external genitalia are usually ambiguous in appearance, but because the phallus is often enlarged, nearly two thirds of these individuals are raised as boys, with complications arising at puberty when they begin to develop breasts and to menstruate. This is a rare condition, occurring in about only 1 in every 65,000 births.

Figure 8–3

This individual is genetically a woman (XX chromosomes), has one ovary and one testicle, and has always lived as a man.

Source: Dr. M. A. Ansary/Science Source

In a variation of this, a South African athlete, Caster Semenya, won the women's 800-meter race at the world championships in 2009 but later was allegedly found to have no uterus and ovaries but internal testicles. She had been raised as a girl and had the gender identity of a woman.

More common are disorders in which a person with an XX or XY chromosome pattern is born with the proper set of gonads (ovaries or testicles, respectively) but with external genitalia that are either ambiguous or that of the other sex. In women, the most common cause is congenital adrenal

hyperplasia (CAH), also known as *adrenogenital syndrome (AGS),* in which the adrenal glands secrete too much masculinizing hormone during fetal development (see Berenbaum et al., 2011). The internal organs are normal, but the genitals are masculinized (i.e., the clitoris and labia are enlarged), so that even physicians sometimes mistake these individuals for boys at birth (see Figure 8–4). This condition occurs in about 1 in 20,000 births.

Figure 8–4

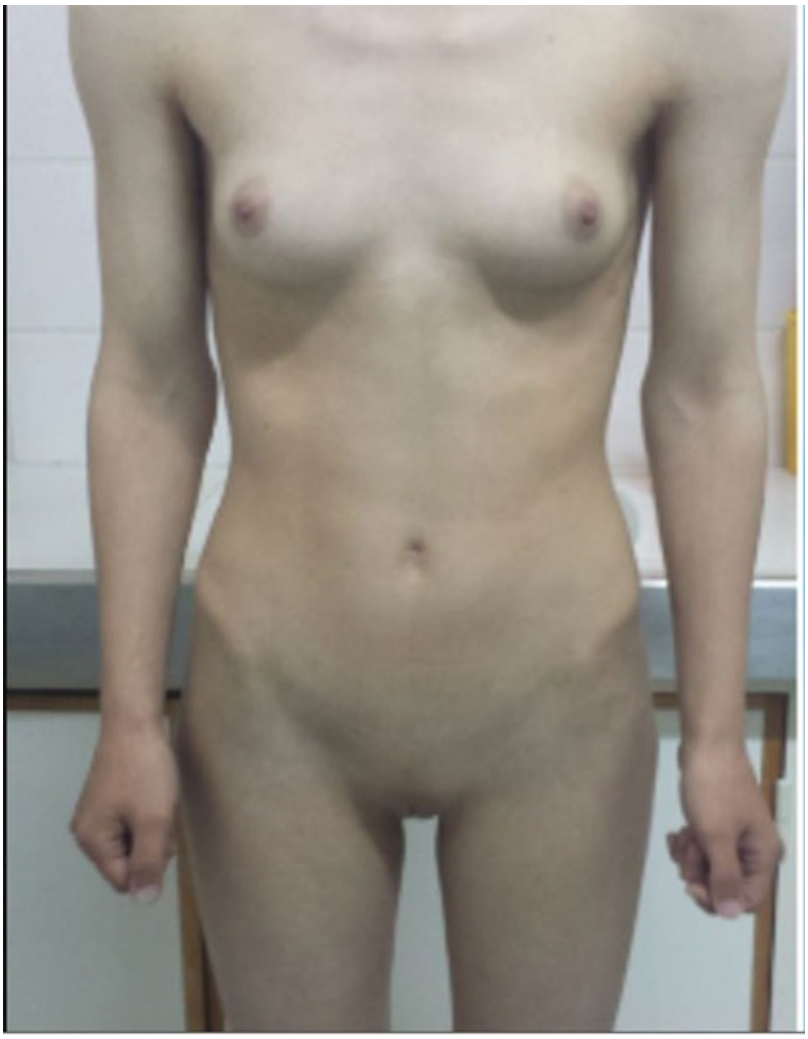
Congenital adrenal hyperplasia (CAH) in a pubertal girl.

Source: Matthew Tabaccos/Barcroft Media/ Getty Images

The large majority of CAH babies who are raised as girls show increased male-typical gender roles (Pasterski et al., 2007) but a female gender identity. Although there is an increased likelihood of bisexual or homosexual interests, most have a heterosexual orientation (Dessens et al., 2005; Hines, 2004b).

The most common hormonal disorder in men is known as androgen insensitivity syndrome (sometimes called testicular feminization syndrome), in which the testicles secrete normal amounts of testosterone but the body tissues do not respond to it (Kaplan & Owett, 1993). As a result, a clitoris, a short vagina, and labia develop, but the internal female structures fail to develop because the testicles still secrete Mullerian duct–inhibiting substance (see Figure 8–5). This happens in about 1 in 20,000 births. These individuals are generally raised as girls, and because of their insensitivity to testosterone, their estrogen causes them to develop breasts and hips at puberty. They can be very feminine in appearance. Individuals with androgen insensitivity generally have a female gender identity and gender roles, although there is some disagreement about how often they later choose to change their assigned gender (Hines et al., 2003; Mazur, 2005; Meyer-Bahlburg, 2005).

Figure 8–5



Androgen insensitivity syndrome in an individual who is genetically a man (XY chromosomes).

Source: U.S. National Library of Medicine

In 1974, 38 children in the Dominican Republic were discovered who had a type of androgen insensitivity syndrome. They had an XY chromosome combination and prenatally their testicles had produced testosterone and Mullerian duct–inhibiting substance, so that their internal structures were male. However, because of an inherited enzyme deficiency, the testosterone was not converted into dihydrotestosterone, which is necessary for proper formation of the external genitals (the condition is therefore called DHT deficiency syndrome). As a result, they had a very small penis that looked like a clitoris, an incomplete scrotum that looked like labia, undescended testicles, and a short, closed vaginal cavity.

Eighteen of these children were reared as girls, but at puberty, when their testicles started secreting large amounts of testosterone, their voices deepened, muscles developed, the testicles descended, and their "clitoris" grew to become a penis. Although the urethral opening was located on the perineum and not the tip of the penis, they were capable of ejaculating sperm.

How do you think you would feel if you were being raised as a girl but suddenly started growing a penis at puberty? The culture in these remote villages has a strong patriarchal "macho" bias. Girls are forced to stay home and do chores, while boys are given considerable freedom, including sexual freedom as adults. Parents of these children generally rejoiced when they discovered that they had an unexpected son. The villagers called them Guevedoces ("penis at twelve"). Under these circumstances, it is probably not surprising that 16 of these 18 children decided to become boys and subsequently developed a strong sexual interest in girls (Imperato-McGinley et al., 1979; see Davis, 2015).

How Many Sexes Are There?

Consider the following scenario and question:

> A person who does not start menstruating as expected during adolescence goes to a physician to find out why. The physician discovers that this person—whose outward appearance [including no penis] and sense of self are both female—has no uterus or ovaries, but instead has male (XY) chromosomes. Is this person female or male?

(MCKAIN, T. L. (1996). Acknowledging mixed-sex people. Journal of Sex & Marital Therapy, 22, 265–274.)

Did you hesitate to answer? Most people do. Why? Probably because being a boy or a girl is more complicated than having a single characteristic. More importantly, "Hesitation in answering the above question suggests how committed people are to the notion that everyone is either female or male, period. If people were not so wedded to this notion, they would simply respond that the person described above is female in some ways and

male in others" (McKain, 1996).

The important lesson from the first part of this chapter is that there is no direct relationship between sex and gender. You have been introduced to individuals with ambiguous genitalia. Some other cultures recognize three sexes (Herdt, 1990), and at least one scholar has argued that we should recognize at least five different sexes and that human sexuality is not a dichotomy but a continuum (Fausto-Sterling, 2000). Depending on how one defines normal or typical, 0.1% to 0.5% of all births have disorders of chromosomes, gonads, genitalia, or ducts (Ahmed et al., 2014).

Attempts to Reassign Sex in Infancy

Is gender identity determined mostly by biology or mostly by teaching the values of society (socialization) through child-rearing practices? Much debate has taken place over this question, but recent studies suggest that biology plays a much stronger role than previously believed. Consider, for example, the following case history.

Identical twin brothers were circumcised at 8 months of age, but due to a surgical mistake, one of the twins lost his penis. After considerable deliberation, and upon the recommendation of doctors, the boy's parents decided to raise the child as a girl. They were encouraged to do so because at that time it was believed that at birth people are psychosexually neutral and that normal psychosexual development depends on the appearance of one's genitals.

When the child was 1 ½ years old, his name was changed from Bruce to Brenda and surgical procedures were done to reconstruct the genitals in order to make them female (and he later was given female hormones). The child was dressed in girls' clothing and was encouraged to play with girls' toys and engage in girls' activities.

The published reports during this person's childhood concluded that the sex reassignment had been a success. According to Money (1975), Brenda readily achieved a female gender identity and gender role. The twin brother developed traditional masculine traits. Largely as a result of the "success" of this often cited case, thousands of children born with ambiguous genitals were given sex reassignment surgery (Colapinto, 2000).

Notice that up to this point the underlying assumption in the medical treatment for children with ambiguous genitals (whatever the cause) was that sex was dichotomous—an individual was either a boy or a girl. Furthermore, the standard practice was to define a person's sex on the appearance of his or her genitals. It was believed that in the case of babies with ambiguous genitals, all doctors had to do was surgically change them to be more male or female in appearance. The child could then be raised successfully as a boy or girl and would have a gender identity that corresponded to the surgically altered anatomy.

In the case of Brenda, later interviews revealed many problems. The psychiatrist following "her" development found that "she" had great difficulty in her attempt to become a woman. Brenda rejected girls' clothes and toys, preferring boys' clothes and toys. She imitated her father and was regarded as a tomboy. She frequently urinated (or tried to) while standing up. As Brenda entered adolescence, she became depressed and suicidal, which finally resulted in her parents telling her the truth—"she" was a boy. Brenda was happy and said, "for the first time, everything made sense and I understood who and what I was." Brenda changed his name to David (after the biblical figure who fought Goliath) and chose to have a mastectomy, receive male hormone shots, and undergo surgery to partially restore his penis. Afterward, he married and adopted his wife's children. When asked why he had rejected all the attempts to raise him as a girl, he said that being a girl "did not feel right" (see Figure 8–6) (Colapinto, 2000; Diamond, 1997). Unfortunately, David suffered from depression and later committed suicide.

Figure 8–6

David Reimer, whose penis was cut off at 8 months of age and who became the subject of an unsuccessful sex reassignment study.

Source: REUTERS/Alamy Stock Photo

Here is another example (Dittman, 1998). A baby boy was born with an extremely rare condition called penile agenesis, in which the testicles develop but the penis does not. He was castrated at age 3 and thereafter was raised as a girl and began hormone treatment to develop breasts at

age 14. In his late teens, he rejected these attempts at sex reassignment and had surgery to reconstruct a penis. He fully regarded himself as a man and later married.

These are not isolated cases (Rosenberg, 2007). Many individuals who underwent sex reassignment as infants because of ambiguous or injured genitals have rejected the socialization process (M. Diamond, 2004). Pediatric endocrinologist Bruce Wilson expressed what is becoming the prevailing view in medicine: "We have had to listen to what our former patients are saying. For a lot of us, it has become clear that current practices were causing problems, that we were doing more harm than good, and that we couldn't predict the outcome with any sort of accuracy" (cited in Palmer, 1999).

What can be concluded from these cases? According to M. Diamond (2004), they show that nature sets a predisposition for gender identity and that "one's sexual identity is not fixed by the gender of rearing." In other words, we cannot always define a person's sex (or make assumptions about his or her gender identity) simply on the basis of the appearance of the genitals. Obviously, biology (genetics and hormones) plays a major role. For example, in the cases of children with surgically altered genitals or children with DHT deficiency syndrome, it may very well be that although their genitals did not develop properly, fetal hormones altered the brain in the manner appropriate for their chromosomal pattern (Berenbaum & Beltz, 2011; Garcia-Falgueras & Swaab, 2010).

The accepted medical standards today are that decisions about surgery should not be made at birth based on anatomical appearance but that doctors and parents wait until the child is old enough to participate in the decision (Ahmed et al., 2014; Meyer-Bahlburg, 2011). Why? Because, as M. Diamond (1998) puts it, "One's sexual identity is prenatally organized as a function of the genetic-endocrine forces," regardless of the appearance of the genitals. In fact, more and more individuals with disorders of sex development are choosing not to have genital-altering surgery. Perhaps Carla Golden (2000) sums it up best: "The natural attitude would certainly be . . . knowing that there are women with penises, and men with vulvas" (p. 33).

Gender Incongruence

1. 8.4 Discuss gender incongruence in childhood and for adolescents and adults.

Are there ever cases in which children with normal genitals are not happy with their biological sex? The answer is yes. For some children, this feeling persists into adulthood.

Gender Identity Disorder in Children

Some children are "gender variant." They frequently engage in behaviors that are typical of the opposite sex. One study found that about 3% of 7-year-old boys and about 5% of girls showed cross-gender behavior (van Beijsterveldt et al., 2006). Sex atypical behavior as early as the age of 3 is highly predictive of sex atypical behavior at age 13, as children begin adolescence (Golombok et al., 2012). In some of these children, their gender identity also does not match their biological sex. They have normal anatomy, both internally and externally, and yet feel that they are actually a member of the opposite sex. Many feel extreme distress about their anatomy, a condition known as gender dysphoria ("a strong desire to be of the opposite gender or an insistence that he or she is the other gender" that is accompanied by "clinically significant distress" [American Psychiatric Association, DSM-V, 2013]). For example, boys may be disgusted with their penises and body hair, while the girls do not want to grow breasts, menstruate, or urinate in a sitting position. This feeling of a distressing mismatch between gender identity and anatomy often begins at a very early age.

> "Ever since I can remember anything at all I could never think of myself as a girl and I was in perpetual trouble, with this as the real reason. When I was 5 or 6 years old I began to say to myself that, whatever, anyone said, if I was not a boy at any rate I was not a girl. This has been my unchanged conviction all through my life."

("Miss D," from Henry Havelock, Ellis, 1918. Ellis, H. (1918). Studies in the psychology of sex, Vol. II. Sexual invention. Philadelphia: Davis.)

There are differing ideas about the cause(s) of gender dysphoria in children, and thus, considerable, often heated, debate about how to treat it (see Singal, 2016). Transgender activists want these children's gender identities to be recognized. However, researchers point out that the majority of gender incongruent children do not persist with gender dysphoria or display cross-gender behavior after puberty (see Steensma & Cohen-Kettenis, 2011; Wallien & Cohen-Kettenis, 2008).

For children with persistent gender dysphoria approaching puberty, the present accepted treatment is to give puberty-suppressing hormones (so that secondary sex characteristics do not develop) to buy time to allow the child to transition to his or her accepted gender (de Vries & Cohen-Kettenis, 2012; Drescher & Byne, 2012; Steensma & Cohen-Kettenis, 2011; Vrovenraets et al., 2015). Sex-reassignment surgery would only come later (Milrod, 2013).

Unfortunately, arguments over therapies have jumped ahead of what we actually know about causes of gender dysphoria. There is evidence for both biological factors and psychosocial factors, but little is actually known about how they interact (Steensma et al., 2013).

Gender Incongruence in Adults

As mentioned above, for some children, gender dysphoria persists into adulthood. Others do not develop gender dysphoria until puberty or afterward (often called "late onset") (see Johansson et al., 2010). Many of these individuals prefer to be described as transgender—someone having a gender identity and gender roles in a body opposite to society's expectations (e.g., Walch et al., 2012). There are about 700,000 transgender individuals living in the United States (Gates, 2011).

"My friend Kelly believes himself to be a male, when in fact he is really a female. Kelly has everyone call him a he. He's a girl, I know, but I call him a he and always have. He gets a lot of torment, so we try not to tell anyone the truth. He wants a sex change, but he doesn't have the money. He lives life as a guy. He has an auto mechanic job and a girlfriend, but I don't think he's gay. It was really weird at first, but I don't even notice it any more."

(from the authors' files)

Male-to-female transgender adults identify closely with women, and female-to-male transgender adults identify closely with men (Herman-Jeglinska et al., 2002; Lippa, 2001). Male-to-female transgender is twice as common as female-to-male transgender (Olsson & Möller, 2003). Relative to biological sex, transgender adults can have a homosexual sexual orientation (particularly common in female-to-male) or a non-homosexual sexual orientation (Bockting et al., 2009; Johansson et al., 2010). Many transgender adults self-identify as "genderqueer," an umbrella term for different gender identities and sexual orientations (Kuper et al., 2012). Studies have found that most transgender adults do not show signs of other psychopathology and are "normal" in the desired gender (Cohen-Kettenis & Gooren, 1999).

Almost all transgender adults cross-dress, but being transgender is not the same as transvestism (Zucker et al., 2012). A transvestite, as you will learn in Chapter 14, dresses in the clothing of the opposite sex in order to achieve sexual arousal. However, a transvestite does not want to change his or her biological sex and does not experience gender dysphoria. In contrast, transgender individuals cross-dress as a means of attempting to be more comfortable psychologically with their gender identity and appearance, not for sexual arousal.

The cause(s) of gender dysphoria has not been determined. Brain MRI and autopsy studies have revealed that the brains of transgender adults are different from those of heterosexual men and women (Cantor, 2011; Guillamon et al., 2016). Thus, it is likely (though unproven) that hormones in the second half of pregnancy may have had effects on later behavior and gender identity (see previous sections; see also Collaer & Hines, 1995).

Many adults with gender dysphoria desire to change their anatomical sex. This group is commonly referred to as transsexuals. Note that when transsexuals choose to "correct" their condition they change their body (their sex), not their gender identity.

The medical field offers sex "reassignment" surgery. The procedures always include extensive hormonal treatment as well (Spack, 2013). The male-to-female transformation can be done in one surgery (Raigosa et al., 2015). The penis and testicles are removed first. Next, a vagina is created using pelvic tissue. Sensory nerves in the skin of the penis are relocated to the inside of the new vagina. Breast augmentation and feminizing facial surgery are often part of the procedure.

In female-to-male surgery, the uterus, ovaries, and breasts are removed. Some individuals have no further changes made, while others decide to have an artificial penis created. The new penis is made using flaps of skin and muscle (from the groin, forearm, or other places) or by clitoral enlargement. It is incapable of normal erection, although artificial means of creating erections are possible, such as those used in treating erectile disorders. The surgical therapy generally includes mammoplasty as well.

Most studies have found that the vast majority of transsexuals achieve satisfactory results with the procedure, both sexually and in their overall quality of life. Today, as this has become more accepted, only about 5% or less express feelings of regret (Dhejne et al., 2014; Johansson et al., 2010; Wierckx et al., 2011). The vast majority report satisfaction with their sex reassignment, social relations, and overall well-being (Ruppin & Pfäfflin, 2015).

Most heterosexuals have a difficult time understanding transgender individuals. Many believe, for example, that male-to-female transgender individuals must not have been very "masculine" to begin with. Consider the following three cases. One of the most famous cases of sexual reassignment was that of an ophthalmologist named Richard Raskind (Richards & Ames, 1983). Raskind had attended college and medical school, become a highly ranked tennis player, and married. He hated his maleness and genitalia. "As a child . . . I would pray every night that I could be a girl. I knew then that I wanted Renee as my name. It means 'reborn'" (People magazine, 1976). He eventually decided to have sex reassignment surgery and become Renee Richards (Figure 8–7). A judge ruled that Renee could compete on the professional women's circuit. Chris Beck had been a U.S. Navy SEAL who earned a bronze star and purple heart in battle. In 2013, he came out as Kristin Beck, a trans woman, so that he could "be the real person that I always knew I was and always wished I could be" (Beck & Speckhard, 2013). Most recently, 1976 Olympic gold-medal winner in the decathlon (and proclaimed by everyone as the world's greatest athlete) Bruce Jenner told the world that she was a woman and renamed herself Caitlyn Jenner.

Figure 8–7

(upper left) Tennis player Renee Richards as she appeared after a sex reassignment operation; (upper right) Chaz Bono; (bottom left) Olympic gold medalist in the men's decathlon, Caitlyn Jenner; (bottom right) Former Navy SEAL Kristin Beck

Source: Focus On Sport/Getty Images Sports/Getty Images; PHIL MCCARTEN/REUTERS/Alamy Stock Photo; Billy Bennight/The Photo Access/Alamy Stock Photo; JIM URQUHART/REUTERS/Alamy Stock Photo;

Transgender individuals are "subject to stigma in a heteronormative culture with binary gender role norms" (Walch et al., 2012; see Glick, 2013). Negative attitudes toward them are generally greater than toward homosexuals (Norton & Herek, 2013). There are obvious examples of negative attitudes in athletics (Cooky & Dworkin, 2013; Robson, 2010). Just in recent years, a male-to-female transsexual had to sue (successfully) the Ladies Professional Golf Association to play on the women's golf tour, and runner Caster Semenya had to undergo "gender testing" after winning the women's 800 meters at the 2009 World Championships. The legal rights of transsexuals (including employment protection and civil status) are still uncertain in the United States (Green, 2010). In 2016, North Carolina passed a law requiring people to use public bathrooms based on their sexual anatomy at birth.

Psychological Theories of Gender Identity Development

1. 8.5 Explain the Freudian, social learning, and cognitive-developmental theories of gender identity development.

In the previous sections, you learned that biology plays the major role in establishing one's gender identity. This is not to say that the environment has no effect. The two interact. It is likely that "nature sets a predisposition for these sexual developments and within such limits the environment works" (Diamond, 1997). Parents are obviously an important part of a child's environment. Three major psychological theories of development claim that the parent is an important role model who influences the development of gender identity (see Gallahan, 2000, for an extensive review).

Freudian Theory

Sigmund Freud believed that psychological development was influenced primarily by sexual development. He called sexual energy *libido* and thought that the location of the libido (the area of the body responsible for sexual pleasure) changed over time. The part of the body where the libido is focused is called an "erogenous zone." The primary erogenous zone, according to Freud, depends on which *stage of psychosexual development* the individual has reached. In the first year of life, the mouth is the primary erogenous zone, so Freud called this the *oral stage.* Pleasure is derived from sucking and from exploring things with the mouth. The second stage is called the *anal stage,* which lasts from age 1½ to about age 3. According to Freud, the primary source of pleasure in this stage comes from holding in and expelling feces.

Box 8–A Cross-Cultural Perspectives

The Native American Two-Spirit and Samoan Fa'afafine

Before the influence of Western culture led to their disappearance, there existed among many North American Indian tribes individuals, known until recently as berdaches, who had special gender status. According to Callender and Kochems (1987), a berdache was "a person, usually male, who was anatomically normal but assumed the dress, occupations, and behavior of the other sex to effect a change in gender status." Accounts of berdaches date back to the 1500s (Katz, 1976), and they existed in at least 113 groups that extended from California to the Mississippi Valley and upper Great Lakes (list compiled by Callender & Kochems, 1987).

Early observations were heavily influenced by Western values and perceptions and focused primarily on the homosexuality or bisexuality of many of the berdaches. In fact, the word *berdache* is not an Indian term, but rather a medieval French term meaning "male homosexual" (and many Native Americans found the term to be ethnocentric and offensive). According to Callender and Kochems, homosexuality did not bestow the status of berdache on an individual, but many berdaches became homosexual. Translations of the Indian terms give "halfman-halfwoman" or "man-woman," with no insinuation about sexuality. Native Americans, as well as anthropologists, are presently urging that scholars use the term *two-spirit* or terms within native languages when referring to these individuals (see Jacobs & Thomas, 1994).

The two-spirits were held in awe and highly revered but were not chiefs or religious leaders (they were not shamans). Individuals became two-spirits by showing a strong interest in the work of the opposite sex during childhood and/or (and more commonly) by having a supernatural vision during adolescence that confirmed the change in gender status. In almost all groups, a male two-spirit dressed and fixed his hair like a woman and assumed a woman's occupations, at which he excelled—part of the reason he was admired. On certain occasions, he dressed like and assumed the role of a man. He was generally responsible for burial rituals, but because he could cross back and forth between genders, he was especially valued as a go-between for men and women. It was these exceptional gender-mixing abilities that led to his being greatly admired. But, as noted, Western values intervened. Lurie (1953), who studied the Winnebago Indians, reported, for example, that "most informants felt that the two-spirit was at one time a highly honored and respected person, but that the Winnebago had become ashamed of the custom because the white people thought it was amusing or evil."

Similar to the Native American two-spirit, in Samoa there is a group of cross-dressing men known as fa'afafine ("in the way of a woman") who play the same role in Samoan society as women (e.g., entertainers, teachers, caretakers) and who are well accepted by heterosexuals (Vasey & VanderLaan, 2010). They have sex with straight men but are not considered to be homosexual (homosexuality in Samoa is a strong taboo). In fact, sex between a Samoan man and a fa'afafine is regarded as a heterosexual interaction, and the first sexual experience of many young Samoan men is with a fa'afafine. In short, "a person's gender is based more on his or her role in the society than on actual anatomy" (Fraser, 2002). According to Dr. Vena Sele, Dean of Students at American Samoa Community College (and also a fa'afafine), "As long as you're playing the female role socially, and in sex, then you are as good as a woman" (Fraser, 2002, p. 74).

Figure 8–8

We'wha (left), a 19th-century two-spirit from the Zuni tribe, and (right) Samoan Fa'afafine.

Source: NAA INV 02440800 (National Anthropological Archives, Smithsonian Institution); Olivier CHOUCHANA/Gamma-Rapho/Getty Images

The third stage, called the *phallic stage,* lasts from about age 3 to 5. Freud believed that gender identity is learned at this time. It is during this stage, according to Freud, that boys begin to derive pleasure through masturbation, and as they do so, they begin to sexually desire their mothers and come to view their fathers as powerful rivals who might punish them for these desires by taking away their penises. This fear is called "castration anxiety" and is based on the fact that previous sources of pleasure have already been taken away through weaning and toilet training. Gender identity formation for boys takes place by resolving these conflicts, known as the *male Oedipus complex* (named after the principal character in the Greek play *Oedipus Rex*, in which a man kills the king of Thebes and then marries his queen, who turns out to be his own mother). Boys try to become like their fathers and adopt their fathers' gender identity. This process occurs unconsciously and is called identification. In this way, boys try to ensure that for the future, they, too, will be able to fulfill their sexual desires, just like their fathers.

Freud had a more complicated explanation for how gender identity is learned in girls. In the *female Oedipus complex,* according to Freud, when a girl realizes that she has no penis, she feels envious and angry, a state that he referred to as "penis envy." The girl blames her mother for this and wants to possess her father in order to replace the mother. Once she realizes that this cannot happen, she unconsciously identifies with her mother as a means of ensuring that she, too, will be able to fulfill her sexual desires in the future.

Most psychologists do not believe that Freud's theories are accurate descriptions of development. Many feel that his ideas are blatantly sexist and were the result of thinking founded on Victorian ideas of morality and sex roles (e.g., Lerman, 1986). Nevertheless, Freud was one of the first modern thinkers to discuss the possibility that children were sexual and to relate this to gender identity development.

Social Learning Theory

Social learning theory emphasizes the acquisition of new associations. An important type of learning that may be involved in acquiring gender roles is that of *operant conditioning,* which is based on the principle that an individual's behavior is modified by the consequences of the behavior. For example, a boy may be praised by a parent for "acting like a man" and not crying after he falls down, he may be yelled at or punished for putting on his mother's lipstick, or he may be allowed to stop doing his homework in order to help his father fix the car. In each of these three examples, the boy is being reinforced to behave in a "masculine manner." He is learning gender roles and will associate good things with "masculine behavior" and negative things (even punishment) with "feminine behavior." For a girl, encouragement and praise may follow the display of "feminine

behavior," while "boyish behavior" may result in being ignored or being shown disapproval by parents. Thus, behaviors that are reinforced will continue, and behaviors that are not reinforced will eventually stop.

According to social learning theorists, children often learn gender stereotyped behavior by imitating people of their own sex (Figure 8–9). For example, children love to imitate their parents and learn what "daddy" and "mommy" do simply by watching their parents. According to social learning theorists, gender identity is acquired in the process of learning gender roles.

Figure 8–9

Children often learn gender roles and a gender identity by observing and imitating their same-sex parents.

Source: f-stop/SuperStock

Cognitive-Developmental Theory

Cognitive theory views infants as "information seekers." Rather than talking about an "oral stage of psychosexual development" to explain why crawling infants put things into their mouths, cognitive theory claims that this is done because infants can "know" things and acquire information about the world this way. To a crawling infant without language, the world can be divided into things that can and cannot be put in the mouth. It can also be known in terms of things that taste good, taste bad, or have no taste. Gender is another category into which children can sort themselves.

This theory (Kohlberg, 1966) states that the concept of "male" is first learned by observing others. For example, a boy's father is a man, and because a boy is more like his father than his mother, he begins to think of himself and his father as males. Boys become motivated to seek out information about what boys and men should do and how he should behave, imitating a ready source of information about male conduct from their fathers. The mother becomes the prime source of information about what is appropriate "female behavior" for girls.

At this early age, children's idea of gender is "concrete," based on physical cues like hairstyle and dress. Cognitive theorists say that while most children have learned that they are a "boy" or a "girl" by the age of 3, they do not yet have an understanding of gender constancy. Gender constancy is the knowledge that one's gender is constant and will not change. For example, a 4-year-old boy may think that because girls have long hair, if he lets his hair grow long he will change into a girl. A 4-year-old girl may believe that when she wears jeans and a football helmet, she is a boy, but when she takes them off, she changes back into a girl again. Because they do not yet have an understanding of gender constancy, young boys may say that they will become mommies when they grow up and girls may say they will be daddies. This is a natural thing to believe until gender constancy has been acquired, which *usually happens by age 6 or 7.* According to cognitive developmentalists, once a child has acquired the concept of gender constancy, he or she actively seeks information about his or her own gender. "Gender identity develops as children realize that they belong to one gender group, and the consequences include increased motivation to be similar to other members of their group. . . . " (Martin & Ruble, 2004, p. 67).

Gender Role Theories

1. 8.6 Explain and present evidence for the evolutionary and sociocultural theories of gender role differences and the concept of androgyny.

There are two opposing theories about gender differences in human behavior. According to evolutionary (or sociobiological) theory (Buss, 1999; Geary, 1998), behavioral differences between men and women are due to the different reproductive pressures each faced over thousands of generations— and thus these differences are stable in today's world. Evolutionary psychologists argue that psychological sex differences are inherent and result from sexual selection pressures. The theory, as described by Wood and Eagly (2002) claims that:

> Women, as the sex that invested more in offspring (e.g., through gestation and nursing), became choosier about potential mates than men, the sex that invested less in offspring. As a result, ancestral men competed with other men for sexual access to women, and men's evolved dispositions came to favor aggression, competition, and risk taking. Ancestral women developed a proclivity to choose mates who could provide resources to support them and their children. Sexual selection in humans also emerged from women's competition with other women to attract marriage partners and men's selection of long-term mates for fecundity and faithfulness. Furthermore, because of females' internal fertilization, ancestral males could not be certain about the paternity of their offspring. To increase paternity certainty and gain fitness benefits from investing resources in their biological descendants, ancestral males developed a disposition to control women's sexuality . . .

Evolutionary psychology is not biological (genetic) determinism (see Confer et al., 2010). It does not take the position that genes determine behavior or psychology without influence from the environment. It does recognize environmental factors, particularly "the selection pressures that give rise to psychological adaptations'' (p. 120).

In sharp contrast to the evolutionary model, sociocultural theory (also called social constructionism or microstructural theory) says that the psychological differences between men and women are a social construction. The theory "begin(s) with the postulate that in humans, males and females are born neutral with respect to sex-dimorphic behavior predispositions" (Udry, 2000, p. 445). It is based on the notion that it is society's expectations of male and female behavior (the social structure) that predict how people will behave. The basis of this theory was stated as early as 1903 by psychologist Helen Bradford Thompson:

> The psychological differences of sex seem to be largely due, not to difference of average capacity, nor to difference in type of mental activity, but to differences in the social influences brought to bear on the developing individual from early infancy to adult years (p. 102).

Thus, rather than believing that masculinity or femininity is expressed because of inherent personality traits, sociocultural theory assumes that men and women would behave identically if society had identical expectations of them. Gender-role differences are therefore constructed by the way men and women interact within their environment and with each other.

Before we examine the evidence for these two theories of gender roles, let's look at the range of gender differences in behavior. Prior to the 1970s, masculinity and femininity were viewed as opposite ends of a unidimensional continuum (Hathaway & McKinley, 1943; Strong, 1936; Terman & Miles, 1936). In this bipolar model, a person who was high in masculinity would have to be low in femininity, and vice versa (see Spence & Helmreich, 1978).

This conceptualization of masculinity and femininity was revolutionized in 1973 by Anne Constantinople, who proposed that masculinity and femininity were independent constructs. According to Sandra Bem (1974), "Both historically and cross-culturally, masculinity and femininity seem to have represented two complementary domains of positive traits and behaviors, a cognitive focus on 'getting the job done' (a masculine or instrumental orientation) and 'an affective concern for the welfare of others' (a feminine or expressive orientation)."

Bem (1974) developed the Bem Sex-Role Inventory to measure the amount of masculinity and femininity within an individual's gender role. Individuals could be characterized as masculine or feminine if they scored high on one dimension and low on the other. For some individuals, this is extreme. Gender-role stereotypes are oversimplified, rigid beliefs that all members of a particular sex have distinct behavioral, psychological, and emotional characteristics. A person is considered stereotyped if he or she exhibits a relatively high number of characteristics associated with one gender and claims not to have or not to value the other type of characteristics.

A person having high scores on both dimensions of the Bem Sex-Role Inventory would be classified as androgynous. The term *androgyny* comes from the Greek words *andro*, for "male," and *gyn*, for "female." An androgynous person is capable of integrating both traditionally masculine characteristics and traditionally feminine characteristics into his or her gender role. He or she can be both assertive and compassionate, logical and emotional, depending on what is most appropriate for a particular situation.

Bem claimed that some people scored low on both dimensions. Such individuals would be labeled undifferentiated. These combinations of femininity and masculinity are summarized in Table 8–1.

Table 8–1 Bem's Sex-Role Classifications

	High Femininity	**Low Femininity**
High Masculinity	Androgynous	Masculine
Low Masculinity	Feminine	Undifferentiated

Table 8–1 Full Alternative Text

Androgynous individuals are viewed by these researchers as being socially desirable and healthy because of their flexibility, demonstrating instrumental or expressive orientations as the situation demands (Spence et al., 1974). They are described as being

> behaviorally flexible with respect to all manner of gender related phenomena. As such, they are willing and able to exhibit masculine behaviors, feminine behaviors, or both as situationally appropriate. Individuals with sex-typed personalities, on the other hand, will tend to avoid or exhibit lower levels of cross-sex-typed behaviors.

(Helmreich et al., 1979)

A later study found that while the items on the Bem Sex-Role Inventory did, in fact, measure two different personality characteristics, the two characteristics no longer had anything to do with masculinity and femininity—the authors of the study thus suggested the terms instrumental and expressive (Ballard-Reisch & Elton, 1992). One possibility is that people's perceptions of gender roles have changed over the past 50 years. We will examine this in the following sections.

Personal Reflections

In your opinion, what traits (other than physical characteristics) make a man masculine? What traits make a woman feminine? Why? Were there any traits shared by both men and women? Why or why not? Can a man be gentle, caring, affectionate, emotional, and nurturing to his children and still be masculine? Why or why not? Can a woman be assertive, independent, and ambitious in a career and still be feminine? Why or why not? Do you consider yourself to be stereotyped or androgynous? Why?

Gender-Role Development During Childhood

Evolutionary psychologists point out that the young of many mammalian species display sex differences in their play. One researcher found that young male vervet monkeys preferred "masculine" human toys (e.g., trucks) over "feminine" human toys (e.g., Barbie dolls) (Hines, 2004a). Eye-tracking studies in humans have shown that boys aged 3 to 12 months show a preference for toy trucks, while girls show a preference for dolls (Alexander et al., 2009; Jadva et al., 2010).

Recall that girls with congenital adrenal hyperplasia (exposed to high levels of androgens prenatally) display male-typical play behaviors. Administration of testosterone to very young nonhuman female mammals also increases male-typical play (Hines, 2004b), and it has also been found that male-typical play in boys and girls was related to their fetal testosterone levels (Auyeung et al., 2009).

What about sociocultural theory? Does society's expectations become a part of the individual's own set of attitudes and behaviors? The process of internalizing society's beliefs is called socialization. Cognitive theory, described earlier, shows that young children have difficulty understanding complex concepts. Their early learning often consists of dual categories, such as "good and bad" or "big and small." It is not surprising, then, that young children's ideas about gender roles reflect concrete, simple ideas, dividing behaviors or traits into either "masculine" or "feminine."

Sandra Bem (1981) has proposed that children cognitively organize the world according to gender. She calls this a gender schema—a set of ideas about gender roles that children create from their interactions with their environment. Objects in the environment are often treated as masculine or feminine. Why, for example, do we often regard dogs as masculine and cats as feminine? Languages such as French or Spanish classify all nouns as either masculine or feminine. Gender schemas can influence decisions about what activities to take part in or learn about.

Until recently, it was believed that children organize their world according to gender starting at age 2 or 3 (Hort et al., 1991). More recent studies indicate that children have gained this ability by 18 to 24 months of age (see Martin & Ruble, 2010). Young infants can distinguish between male and female faces and voices, and young children can distinguish gender groups. In fact, gender may be the first social category used by children (Kohlberg & Ullian, 1974).

The stereotype for the female gender role is that of a person who nurtures and cares for others; is passive, dependent, and cooperative; seeks social approval; and is expressive in showing her emotions. The male gender-role stereotype emphasizes independence, dominance, competition, aggression, success, achievement, and emotional repression. Most people believe that men and women differ in these ways (Doyle & Paludi, 1991).

Harvard psychologist Jerome Kagan said, "If I showed you a hundred kids aged 2, and you couldn't tell the sex by the haircuts, you couldn't tell if they were boys or girls" (quoted in Shapiro, 1990). If this is true, when does expression of gender roles start developing, and what (or who) is responsible?

Parents who assume "traditional" (stereotypic) gender roles behave differently toward their children (Ex & Janssens, 1998). In these families, mothers act as the caregivers, while the fathers act as playmates to their infants. Fathers, however, are much more likely than mothers to motivate their children, especially sons, to conform to stereotyped gender roles (Kane, 2006; Leve & Fagot, 1997). In one study, preschoolers were presented with stereotypic gender-role toys. In one condition, children were given toys that matched stereotypic toys for their own gender. However, in another condition boys were asked to play with dolls or kitchen sets the way girls would, while girls were asked to play with army war toys or cowboy outfits the way boys would. This was done while parents were out of the room. The experimenters were interested in studying how the parents would react when they entered the room and saw the types of toys the children were playing with. Mothers reacted similarly, regardless of whether the toys fit gender-role stereotypes, but fathers showed markedly more negative reactions when they found their children playing with toys that did not fit gender roles. This was especially true when boys were playing with "girls'" toys: the fathers often interfered with their sons' play and showed other signs of negative emotions in those situations (Langlois & Downs, 1980) (see Figure 8–10).

Figure 8–10

Do you think that playing with dolls can teach boys behaviors that will be useful when they become adults?

Source: MNStudio/Shutterstock

"My godson, Mikey, will definitely grow up with the idea that men are the head of the households and that women are 'under' them. My uncle encourages Mikey to play football and run around in the house, yet when he and his sister dance around it is not acceptable. Mikey is only allowed to play 'boy' games. He is not allowed to cook, because that is what a girl does."

"For as far back as I can remember my father only allowed us to do 'masculine' type things. Sports, cars, outdoor activities, etc. He never allowed us to play with girls. On one occasion I distinctly remember playing with two girl neighbors. My father came looking for me and found his son playing with dolls. For quite a while after that I was known as his 'faggot son.' I couldn't have been more than 10. I never became the 'faggot' son, but I did leave that day with a low self-esteem that I carried with me for quite some time."

(All examples are from the authors' files.)

Personal Reflections

How would you react if you found your young son playing with Barbie dolls? Why? How would you react if you found your young daughter playing with toy soldiers and footballs? Why**?**

Other adults treat boys and girls in different ways as well. In another study, individuals were shown an infant and asked to make observations about its appearance and behavior. The types of comments made were very different, depending on whether they were told the infant was a boy or a girl (Condry & Condry, 1977). The socialization process in gender-role development is seen everywhere in the child's environment. Children's toy catalogs often use pink pages to show toys for girls and bold colors for boys' toys (Auster & Mansbach, 2012). The toys available for boys are generally action-oriented (and often violent and competitive), while girls are given toys that emphasize physical attractiveness, nurturance, and domestic skills (Blakemore & Centers, 2005).

The socialization process begins at an early age. As early as 14 months of age, infants play with toys that are gender stereotyped more often than with other toys (O'Brien & Huston, 1985). In one study, it was found that boys aged 1 ½ believed that girls do not fight and that they like to clean house. Girls of the same age believed that boys do not cry and that they like to fight. Boys and girls aged 2 and 3 believed that boys like to help their dads, like to hit, and like to break the rules. They thought that girls liked to help their moms and did not hit (Kuhn et al., 1978). Thus, children show gender-stereotyped behavior even before they have a firm grasp of gender identity or gender constancy, and they begin developing gender-role stereotypes by the age of 3 (see Martin & Ruble, 2010).

In nearly all cultures, the large majority emphasize nurturant behavior in women and achievement and self-reliance in men. In a study of 24 culturally diverse countries, Williams and Best (1990) found that 5-year-old children from all countries believed that men were strong and aggressive and women were weak and softhearted. By the time they were 8, their beliefs were even more stereotyped. The conclusion: Belief in gender stereotypes not only increases with age in all countries, but the same stereotypes can be found in nearly all countries (though to different degrees) (see Gibbons, 2000, for a review).

Gender roles are usually learned first in the home, but when children reach school age, peers and teachers become powerful reinforcers of the

process of socialization and gender-role development (Fagot, 1995). The activities and chores that teachers assign to children in the classroom are often determined by stereotypic gender roles. Children quickly identify individuals who act "different." Boys or girls who do not display behaviors similar to the gender roles adopted by most of their peers may be singled out for teasing or ridicule. Interestingly, "tomboy" behavior in girls is usually far more tolerated by peers, teachers, and parents than "effeminate" behavior in boys, perhaps because they do not dislike or regret feminine activities but are just more inclusive of masculine activities (Martin & Dinella, 2012). It is much easier to carry the label of a "tomboy" than that of a "sissy." Children generally prefer playmates of the same sex (Powlishta et al., 1993), but if they have to choose, boys prefer girls with masculine play styles to boys with feminine play styles (Alexander & Hines, 1994). As boys and girls approach junior high school age, they tend to participate less in girl-dominated activities and more in boy-dominated activities (Sandberg & Meyer-Bahlburg, 1994). Single-sex schools have become increasingly popular in recent years, but "there is evidence that sex segregation increases gender stereotyping and legitimizes institutional sexism" (Halpern et al., 2011).

Textbooks and history books in particular have emphasized the central, dominant role of men and the supporting role of women, but there has been some change in recent years. In books, the ratio of male pronouns (*he, him, his*) to female pronouns (*she, her, hers*) has decreased from 4.5/1 in the 1960s to 2/1 by 2008 (Twenge et al., 2012). On the other hand, a recent study of young children's picture books found that there had been no change in the stereotypical portrayal of mothers and fathers during the 20th century (DeWitt et al., 2013).

Personal Reflections

How would you react if your teenage son wanted to take home economics instead of machine shop or auto mechanics? Why? How would you react if your teenage daughter wanted to take machine shop or auto mechanics instead of home economics? Why?

Here is a summary of what we know about the development of gender roles in childhood. There may be little noticeable difference between boys and girls before the age of 2, but there is no question that most children have embraced gender stereotypes by the age of 4. By the age of 3 or 4, children know sex stereotypes about clothing, toys, games, and work, and by the age of 4 or 5 most have stereotyped occupational goals. According to Yale psychiatrist Kyle Pruett, "There are rules about being feminine and there are rules about being masculine. You can argue until the cows come home about whether those are good or bad societal influences, but when you look at the children, they love to know the differences. It solidifies who they are" (quoted in Shapiro, 1990).

However, Pruett's own work shows that children do not necessarily have to develop strongly stereotyped views (see Shapiro, 1990, for a review). He followed the development of children in 16 families where the mothers worked full-time and the fathers were mostly responsible for caring for the children. The children had strong gender identities of being a boy or a girl but more relaxed views of gender roles than their friends. Pruett commented, "I saw the boys really enjoy their nurturing skills. They knew what to do with a baby, they didn't see that as a girl's job, they saw it as a human job. I saw the girls have very active images of the outside world and what their mothers were doing in the workplace" (quoted in Shapiro, 1990). Children raised in single-parent households or households with same-sex parents also tend to be less stereotyped in their attitudes and behaviors (Goldberg et al., 2012; Russell & Ellis, 1991).

Please note: Some people continue to believe that girls are more "emotional" than boys, but a review of many studies on the topic found that any differences between boys and girls are only small to modest from toddlerhood to middle school (Chaplin & Aldao, 2013).

Role of the Media

> All television is educational; the only question is: What is it teaching?

(Federal Communications Commissioner Nicholas Johnson)

Do the media contribute to gender-role stereotypes? Exposure to stereotypes on television begins in early childhood. For several decades television cartoons have portrayed boy characters as active, noisy, and aggressive and girl characters as concerned about their appearance, domestic, attracted to boys, and often in need of rescue. What's more, young children are aware of these differences and perceive the characters in stereotypical ways (Thompson & Zerbinos, 1997).

These same stereotypes are common in primetime television shows targeted for teenagers and adult audiences. Female roles on television typically emphasize romance more than work, and beauty more than intelligence, as the main thing by which women are valued.

Television advertisements frequently use stereotyped characters (Aronovsky & Furnham, 2008; Paek et al., 2011). Men are much more likely to be shown as the authoritative central figure (except for ads focusing on health or beauty), while women generally assume dependent, supportive roles. Magazines targeting teenage girls have increasingly used sexualizing characteristics during the past 5 decades (Graff et al., 2013), and young people are still exposed to extreme stereotypes (women as sex objects and subordinates) in music videos (Wallis, 2011).

Personal Reflections

Watch several television shows. Notice the gender roles that are presented for men and women. What do you feel should be changed, if anything?

What Causes Developmental Gender Differences?

Let us now return to the theories about gender role development. There is little question that boys and girls differ and that these developmental gender differences appear early in childhood. What causes these differences?

Recall that sociobiologists and evolutionary psychologists believe that behavioral differences have evolutionary value. Geary (1999) has proposed that gender differences in childhood also have adaptive value from an evolutionary perspective. He says, for example, that rough and tumble (and competitive) play among boys prepares them for male–male competition for women as adults. Girls, on the other hand, engage in play parenting and developing social skills, attributes that will aid them as adults. In other words, according to Geary the function of childhood is to develop competencies that will aid them in reproduction and survival as adults.

Sociocultural theorists, on the other hand, argue that it is the social structure that leads to psychological sex differences, beginning in childhood. Eagly and Wood (1999) proposed a "biosocial" theory that combines both explanations. They concluded that behavioral differences between boys and girls result from physical differences, which are then influenced by social factors (social structure, cultural beliefs, etc.) (see Wood & Eagly, 2002). There can be no denying that there are basic physical differences between men and women. This includes not only bone structure and muscle mass but hormonal differences as well. For example, men have much higher levels of testosterone than women, which is related to aggression and dominance (Mazur & Booth, 1998) and, as you have just learned, to gender-typical play during childhood as well (Auyeung et al., 2009).

Adult Gender Roles in the United States: Historic Overview

1. 8.7 Describe how gender roles have evolved in the United States.

Cancian (1989) and Kimmel (1989) examined the way in which adult gender roles have evolved in America. Cancian (1989) claimed that love became feminized during the 1800s, when the United States was becoming industrialized. Early American society did not have different gender roles for the expression of love, nurturance, or dependency. According to Cancian (1989), this was because the home was the center of the educational, economic, and social activities of the family, where both men and women shared in all aspects of family life.

With increased industrialization, men began to earn their livings away from home, and the economic activities of men and women began to split. Men were viewed as breadwinners who left the home to compete in a harsh outside world filled with competition and danger. Women continued to stay at home, and the home began to be viewed as a retreat for the husband after finishing his day's labors. Because the woman maintained the home, the qualities of nurturance, love, and devotion became associated with being feminine. The work that a wife did at home was not considered to be as important or meaningful as work done outside the home. Perhaps this was due to the fact that women failed to receive monetary compensation for their labors within the household. Independence, success, achievement, competition, and self-control came to be valued as masculine characteristics as the man pursued work outside the home. It should also be noted that the 1800s saw the opening of the American frontier, and this was seen as a man's job, calling for independence, self-reliance, and the ability to do without female influence.

Kimmel (1989) pointed out that the end of the 1800s saw a great deal of challenge to traditional masculine and feminine gender roles. Kimmel argued that social changes in the late 1800s gave rise to the "New Woman," who was single, economically independent, and highly educated and who did not believe that a woman should have to become dependent on a man in order to be feminine. The New Woman was part of a growing women's movement that attempted to challenge traditional gender roles and create a more equal distribution of power within American society. Kimmel noted that past definitions of masculinity and femininity helped produce power relationships between the sexes, and when those power relationships were challenged, gender roles were questioned as well and began to change. Women did not have property rights until the late 1800s. When England first considered it, the *London Times* wrote that it would destroy marriage, which it defined as "authority on the one side and subordination on the other" (Mundy, 2012).

We have similar forces at work in our society today. Women are seeking more control over job opportunities, the same amount of pay as men receive for comparable work, more freedom in the conduct of their personal affairs, and, in general, more equality between the sexes.

Adult Gender Roles Today

First, let's note the obvious—men and women are different. Studies show that this is true not only for anatomy but in other ways as well. A large-scale study (over 200,000 participants) across 53 nations found that men and women consistently differed in some personality traits (e.g., agreeableness, mental rotation) regardless of gender equality and economic development (Lippa, 2010; Lippa et al., 2010). The author concluded that this was evidence that biology was more important than cultural differences for some personality traits. However, many other differences between men and women are not the result of biology. In another large-scale study (82,905 participants) across 57 countries, it was found that gender equality was directly related to sexism. More developed countries have less sexism and greater levels of gender equality (Brandt, 2011). What is true about gender roles in the United States today?

As you have just learned, gender roles among U.S. adults have been in transition for over two centuries. In the past few decades, women not only have entered the work force in larger numbers but have gained entry into careers previously dominated by men. In 1960, fewer than 20% of all women with children under the age of 6 were employed outside the home. In the typical American family today, both adults are employed. In 2011, women made up 47% of the U.S. labor force, including 59% of college-educated people entering the work force (Spar, 2012). There are more women (57%) than men going to college, and 47% of new law degrees and 48% of new medical degrees go to women. Over one third of wives earn more than their husbands. As a result, attitudes about men and women and jobs/careers have become much more egalitarian, especially among younger generations. There are still major differences at the top. Women account for only a small percent of managers, department heads, CEOs, and political leaders (see Mundy, 2012; Spar, 2012). However, the idea that being a mother means not having a career is no longer true and is not influencing women to the extent it did in the past.

Figure 8–11

Week ending January 19 1957
Every Wednesday Fourpence
JOHN BULL
Beginning this week
WOMAN AT THE WHEEL
by SHEILA VAN DAMM
My unforgettable days with the heroes of Budapest
by NOEL BARBER

LEXINGTON

Gender roles for American women have undergone a dramatic change in recent decades. The illustration on the left is from a 1957 magazine, and the advice in the "good wife's guide" included such things as "Have dinner ready . . . on time for his return," "Prepare yourself and touch up your make-up," "Be happy to see him," "Listen to him," and "Make the evening his." Today, the majority of women contribute to their family's income, often in nontraditional roles such as soldiers and construction workers.

Source: (left) Image Courtesy of The Advertising Archives; (middle) Stringer/Getty Images News/Getty Images; (right) Blend Images/Shutterstock

Until recently, even if a woman worked outside the home, she generally assumed much more responsibility for housecleaning, meals, and childcare than did her male partner (Wall, 2007). Today, women continue to do most of the housework (Lachance-Grzela & Bouchard, 2010), but the gender gap is getting smaller. The amount of time women spend doing housework decreased from 1965 to 2010, while the amount of time men spent increased (but the ratio is still 1.6/1) (Bianchi et al., 2012). Trends like these are found in most countries that support gender equality (Treas & Tai, 2016). Among married couples with children, men also showed an increase in the number of hours spent caring for children (the ratio decreased from 4/1 in 1965 to 1.9/1 in 2010) (see also Jones & Mosher, 2013; Mundy, 2012). Young married couples tend to divide work and housework equally (Bianchi et al., 2012). When husbands do participate in domestic chores, women are happier with them (Baxter & Western, 1998).

These are just two examples of how men's and women's gender roles have become more egalitarian. Looking at a variety of traits (e.g., personality, cognitive, social), two large-scale studies have found that in 21st-century American culture gender differences are small to very small (Hyde, 2005; Zell et al., 2015).

Personal Reflections

Men:

Your wife has decided to resume postgraduate studies leading to a career. This will require that she be away from home more than before and that you assume more responsibilities for care of the house and children. Your reaction?

Women:

Your husband has decided to pass up a career opportunity (leading to higher rank and salary) to spend more time at home with the children. Your reaction?

Today, women must contend with conflicting sets of expectations from parents, friends, bosses, coworkers, and other people about what is appropriate feminine behavior. Is this good? Evolutionary theory would argue no—that mental health is likely to suffer the further one gets away from a person's "natural" role (e.g., reproduction and child-rearing for women). However, the evidence is in just the opposite direction. In a review, Barnett and Hyde (2001) concluded that multiple roles for women (and men) are beneficial for mental, physical, and relationship health. How? As evidence, they provided several factors, including: (a) a buffering effect—"the negative effects of stress or failure in one role can be buffered by successes and satisfactions in another role"; (b) added income; (c) increased opportunities for social support; (d) "multiple opportunities to experience successes and develop a sense of self-confidence"; (e) "a broader frame of reference . . . to get perspective on their ups and downs"; (f) increased self-complexity (resulting in less extreme swings in mood and self-appraisal); and (g) similarities of experiences between men and women (resulting in increased communication and relationship quality).

Figure 8–12

Husbands devote more time to domestic duties today than in the past, but they still do less than their wives (even when the wives are employed outside the home).

Source: B2M Productions/Photographer's Choice RF/Getty Images

Personal Reflections

Have you ever considered marriage? If so, what traits do you want in a husband or wife? Are these the same traits you will want in your partner after you become parents? Is your answer consistent with your answers to the previous questions?

An Example of Evolving Gender Roles: The Sexuality of Women

In Western culture, it was the early Christians who first viewed sex as sinful. Saint Augustine, the major influence on early Christian beliefs about sex, believed that lust was the original sin of Adam and Eve and, consequently, that sex was sinful (Saint Augustine, City of God, 4). He blamed Eve for the fall from grace, and in the two centuries that followed it was women who came to be viewed as temptresses.

> . . . she took of its fruit and ate; and she also gave some to her husband, and he ate. Then the eyes of both were opened, and they knew that they were naked;

(Genesis 3:6–7, Revised Standard Version)

Thus, in early Christianity, women were viewed as seducing men. Augustine believed that if Eve had not tempted Adam, there would have been no lust.

> The husband, exempt from all seductive goading of passion, could have come to rest on his wife's bosom with peace of mind undisturbed and pristine state of body intact.

(Saint Augustine, City of God)

The prevailing view of women's sexuality began to change at the time of the Crusades and the elevation of Mary in the Roman Catholic Church. The Virgin Mary was perceived as compassionate and pure, and thus a dichotomous view of women evolved: virgins as asexual and pure and sexually experienced women who expressed sexual desire as evil temptresses.

The general view during the Middle Ages was still that men were ruled by reason and had more control of their sexual impulses, while women were ruled by animal appetites (Murray, 1995, 1998). When men had anxieties about their bodies and sexual impulses, women were blamed for causing (often passively) their lust. Negative attitudes about women reached a fever pitch in the 1500s and 1600s, when tens of thousands of women were executed (generally burned at the stake to "purify" them) as witches.

With the rise of courtly love, which reached its peak in the 1600s, women (at least upper-class women) came to be admired and romanticized, but in a nonsexual way (Tannahill, 1980). During the Victorian era, we saw a complete turnabout in the way women were viewed (see Chapter 1). Rather than temptresses, the majority of Victorian moralists considered women to be asexual, and it was men who were now viewed as sexual aggressors who could not control their desires.

> Ordinarily the normal young girl has no undue sexual propensities, amorous thoughts or feelings. . . . Girls . . . should be aware of giving way to advances on the part of young men which have only one object in view: the gratification of their animal passion.

(Henry Stanton, 1922)

Figure 8–13

In Western culture, women's sexuality has been viewed differently at different times. Women were viewed as temptresses in early Christianity, but during the Victorian era marriageable women were regarded as asexual. Today, women in Western culture have achieved egalitarian roles.

Source: (left) Erich Lessing/Art Resource, NY; (middle) Photofrenetic/Alamy Stock Photo; (right) Stuart Jenner/Shutterstock

Women's gender roles were very stereotyped at this time, and they were expected to be subservient to men and fulfill their roles as wives and mothers. The noted psychologist G. Stanley Hall was of this opinion (Hall, 1904).

The sexual dichotomy of women was not completely abandoned in the Victorian era. With the rise of modern medicine, psychiatrists simply replaced the concept of whore with nymphomania (see Studd & Schwenkhagen, 2009). Women who did not restrict their sexual behavior to marriage could now be labeled with a medical diagnosis.

> Nymphomania may be defined as excessive venereal impulse in the female. . . . It is found in the most cultured, in the most modest, and in the most religious, almost to the same degree as in those less carefully educated . . . many of the nymphomaniacs are given to masturbation and . . . many of these cases end up as prostitutes.

(Max Huhner, M.D., 1916)

The 1900s witnessed the advancement of the feminist movement, greater autonomy for women, and finally, with the start of the sexual revolution (about 1960, see Chapter 1), sexual freedom and equality. In the time span from Saint Augustine to the present, the prevailing view of women had gone from temptresses, to asexual, to sexual equals.

Gender Differences in Sexuality

In a review of 177 studies that had been published between 1963 and 1990, Oliver and Hyde (1993) concluded that men had a higher level of sexual interest than women. The studies reported that men were more likely to engage in sexual intercourse, had intercourse more frequently, had a greater number of sex partners, masturbated much more frequently, and were more sexually permissive than women. A later study found that men

experience sexual desire an average of 37 times per week, compared to 9 times for women (Regan & Atkins, 2006). Studies also found that men were much more likely than women to engage in casual sex with someone they hardly know or do not know at all (Clark & Hatfield, 1989; Oliver & Hyde, 1993; Schmitt et al., 2003).

Have things changed in the past two decades? Researchers are beginning to question whether some of these gender differences in sexual interest and activity are as great as previously believed (e.g., Conley et al., 2011). For example, consider the often reported finding that men have had more sexual partners than women (e.g., Wiederman, 1997). This is true if you look at the mean for a set of numbers, but the mean is calculated by adding all the numbers (and then dividing by the total number of observations), and all it takes is a few men reporting extremely high numbers of partners to greatly increase the value of the mean. When one looks at the median (50th percentile, unaffected by extreme scores) number of sexual partners, the difference between men and women disappears. The frequently reported finding that men like casual sex more than women can be explained in large part by the social stigma directed at women for engaging in casual sex (Conley et al., 2011). A greater number of partners is viewed positively by most boys' peers and negatively by most girls' peers (Sakaluk & Milhausen, 2012).

In a follow-up to the 1993 Oliver and Hyde review, Petersen and Hyde (2011) looked at hundreds of studies conducted after 1993. As before, differences between men and women were found for frequency of intercourse and masturbation, premarital sex, and general sexual permissiveness. However, the differences were much smaller than reported 20 years earlier. There was next to no gender difference in the prevalence of oral and anal sex. (There was still a large gender difference for use of pornography.) Many of the gender differences also decreased with age (see Petersen & Hyde, 2010). Within heterosexual relationships, adherence to stereotypical sexual gender roles (male dominance and female submissiveness) was associated with a greater number of sexual problems for women (Sanchez et al., 2012).

Why the change? In a study of sexual desire, sociosexuality ("restricted versus unrestricted sexual attitudes and behaviors"), and height (a physical trait) across 53 nations (and 200,000 people), Lippa (2009) found sex differences for all three variables. For sexual desire, the variability in results was much greater for women than for men. Nevertheless, differences in sexual desire and height were rather consistent across nations, which supports a biological explanation for the differences. On the other hand, differences in sociosexuality across nations varied according to gender equality and economic development, in support of sociocultural explanations. Another study across 37 nations reported similar results: the more gender equality there is within a culture, the greater the tolerance/approval of premarital sex, casual sex, and younger age of first having sex (Baumeister & Mendoza, 2011).

In summary, the differences in behaviors and attitudes related to sexuality support evolutionary theory, but the differences are not as great as once thought. Across nations and ethnic groups, the magnitude of some of the differences depends on the degree of gender equity, in support of sociocultural theory.

Study Guide

Key Terms

- androgen insensitivity syndrome
- androgyny
- chromosomes
- congenital adrenal hyperplasia (CAH)
- DHT deficiency syndrome
- disorders of sex development
- evolutionary (sociobiological) theory
- expressive
- gender
- gender constancy
- gender dysphoria
- gender identity
- gender role
- gender-role stereotypes
- gender schemas
- identification
- instrumental
- Klinefelter's syndrome
- Mullerian duct–inhibiting substance
- Mullerian duct system
- socialization
- sociocultural (microstructural) theory
- transgender
- transsexual
- Turner's syndrome
- Wolffian duct system

Interactive Review

Answers can be found on p. 471.

1. (1) _____ is your subjective sense of being a man or a woman. (2) _____ are norms (what is considered appropriate) about the behaviors and attitudes of men and women. They vary from culture to culture and can change over time within the same culture.

   A person's genetic sex is determined at conception by the combination of an egg, which has an X chromosome for sex, and a sperm, which can have either an X or a Y chromosome. (3) _____ combinations usually result in girls, while (4) _____ combinations usually produce boys. There are over 70 known irregularities in chromosome combinations. These include men with one or more extra X chromosomes, (5) _____ syndrome, and women with only one X chromosome, (6) _____ syndrome.

   Hormones determine whether an embryo will develop anatomically to be a boy or girl. Unless there are high levels of (7) _____ at this critical stage of prenatal development, nature has programmed the body to develop into a (8) _____. Hormone disorders before birth

can result in a mismatch between genetic and anatomical sex, or a baby whose external genitalia are ambiguous in appearance. The most common condition in girls is called (9) . Some individuals feel that they are trapped inside a body of the wrong sex, a feeling called (10) . Persons whose gender identity does not match their biological sex are called (11) . They often elect to undergo sex reassignment surgery.

Studies with individuals with disorders of sex development or gender incongruences suggest that gender identity is determined, in large part, by biology. That is not to say that the environment does not play a role. (12) theory emphasizes unconscious identification with the parent of the same sex, while (13) theory emphasizes the role of reinforcement and imitation. Cognitive-developmental theory states that children do not acquire the concept of (14) until the age of (15) . (16) theory says that psychological sex differences between men and women are inherent and the result of different reproductive pressures each faced over thousands of generations. (17) theory emphasizes the role of the environment or social context in influencing the way gender roles develop over the life span. In either case, the development of gender roles begins before a child develops gender identity or gender constancy.

Masculinity and femininity were once viewed as opposite ends of a unidimensional continuum, but today they are generally viewed as (18) constructs. This has led to the theory of (19) , which says that a person can be both masculine and feminine and that this is the healthiest of all gender roles because of the flexibility it gives individuals in different situations.

Parents, teachers, the media, and peers are all powerful influences on the process of socialization and gender-role development. Gender is possibly the first social category learned by children. When children cognitively organize the world according to gender, they create gender (20) . As individuals become adults, they generally acquire more complex sets of gender roles, and for both sexes there is an integration of gender roles. Continued belief in stereotypic gender roles can adversely affect one's personal and sexual relations with a partner.

Traditional gender roles in our culture evolved over time in response to social forces. Those forces have been changing (an example has been the increased presence of women in the work force), and as a result, gender roles are in a state of transition. Recent studies have shown that some differences between men and women in sexual attitudes and behaviors are better explained by evolutionary theory (such as (21)) while others are better explained by sociocultural theory (such as (22)).

Self-Test

Answers can be found on p. 471.

A. True or False

- **T F** 23. Transgender and transsexual mean the same thing.
- **T F** 24. Hormone levels in the second half of pregnancy alter brain anatomy to be either "male" or "female."
- **T F** 25. By the age of 3, children know whether they are a boy or a girl, but do not understand that this cannot change.
- **T F** 26. In the absence of testosterone during embryonic development, we would all be born anatomically a girl.
- **T F** 27. Fathers tend to treat their children in more gender-stereotypic ways than do mothers.
- **T F** 28. Transsexual is a term for a type of homosexual.
- **T F** 29. According to social learning theory, imitation is a process by which children may learn gender identity and gender roles.
- **T F** 30. The rise of industrialization helped create the male gender role of being independent and unemotional.
- **T F** 31. Gender role is the way you express your gender identity.
- **T F** 32. The most common hormonal disorder of sex development in men is androgen insensitivity syndrome.
- **T F** 33. Men's and women's hypothalamuses are different.
- **T F** 34. A transsexual is someone who cross-dresses for sexual arousal.
- **T F** 35. Children do not show gender-stereotyped behavior until they have developed gender constancy.
- **T F** 36. In girls, male sex-play behavior is related to fetal testosterone levels.
- **T F** 37. There is little noticeable difference between the behavior of boys and the behavior of girls before the age of 2.

B. Matching

(Some questions have more than one answer.)

- 38. Tom believes he is a woman, but is anatomically a man and does not want sex reassignment surgery.

- 39. Bob is low in instrumental orientation ("getting the job done") and has great affective concern for the welfare of others.
- 40. Frank prefers men as sexual partners.
- 41. Susan cannot reproduce; she is short and infertile and has one X chromosome.
- 42. Joe is neither instrumental nor expressive, neither assertive nor emotional.
- 43. David's body did not respond to testosterone during prenatal development; he has female genitalia and undescended testes.
- 44. Sam was born with a very small penis that looked like a clitoris, an incomplete scrotum, and a short, closed vaginal cavity. At puberty his voice deepened, his testicles descended, and his "clitoris" grew to become a penis.
- 45. Wayne is both instrumental and expressive, assertive, and emotional.
- 46. Phillip believes he is a woman trapped in a male body and wishes to have sex reassignment surgery.
- 47. Carol has an enlarged clitoris and labia because of too much masculinizing hormone during her fetal development.
- 48. Mike believes that men should be assertive, aggressive, success-oriented, and unemotional and should play little role in housekeeping and childcare responsibilities.
- 49. Harold is tall with long arms; he has a small penis, shrunken testicles, low sexual desire, and an extra X chromosome.
- 50. Barbara is genetically a woman but has both male and female reproductive systems as a result of the failure of her primitive gonads to differentiate during the embryonic stage.

1. congenital adrenal hyperplasia
2. androgen insensitivity syndrome
3. androgynous individual
4. DHT-deficient individual
5. "feminine" on Bem Sex-Role Inventory
6. gender dysphoric
7. homosexual
8. disorder of sex development
9. Klinefelter's syndrome
10. stereotyped individual
11. transgender person
12. transsexual
13. Turner's syndrome
14. undifferentiated individual

C. Fill in the Blanks

- 51. A child's knowledge that his or her sex does not change is called in cognitive-developmental theory.
- 52. According to Cancian, gender roles for men and women did not start to differ until the .
- 53. According to theory, an individual's gender role results from society's expectations of male and female behavior.
- 54. According to Freud, children acquire the gender identity of the same-sex parent through the process of .
- 55. The process of internalizing society's beliefs is called .
- 56. Oversimplified, rigid beliefs that all members of a particular sex have distinct behavioral and emotional characteristics are called .
- 57. On Bem's Sex-Role Inventory, a person who scores low on both dimensions is called .

- 58. According to Freud, children acquire their gender identity in the stage of psychosexual development.
- 59. If an individual scores high on both the femininity dimension and the masculine dimension of the Bem Sex-Role Inventory, he or she would be called .
- 60. Money and Ehrhardt (1972) stated, "Nature's rule is, it would appear, that to masculinize, something must be added." That something is .
- 61. cross-dress for sexual arousal and gratification, whereas cross-dress because they truly believe they are members of the opposite sex.
- 62. In social learning explanations of gender identity development, when children watch their mothers and fathers and copy them, it is called .
- 63. Gender refers to .
- 64. According to Bem, masculine is to instrumental as feminine is to .
- 65. According to Kagan, boys' and girls' behaviors do not differ at the age of .
- 66. Some languages classify all nouns as either masculine or feminine. This is an example of .
- 67. The presence of shortly before and after birth changes the brain to male anatomy.
- 68. Among early North American Indian tribes, a was a highly respected man who cross-dressed and assumed the behaviors of a woman.

Suggested Readings and Resources can be found on p. 461.

Chapter 9 Sexual Orientation

> It doesn't really matter why people are gay or not gay. That's not the important question. What's really important is how they're treated. I haven't spent that much time thinking about where my sexuality comes from. I've spent a lot more time thinking about how I fit into this world I have to live in.

—David Barr, quoted by Angier, 1991

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 9.1 Define the terms *sexual orientation, heterosexual, homosexual*, and *bisexual.*
2. 9.2 Summarize what we know about the prevalence of homosexuality and bisexuality in the United States.
3. 9.3 Explain the difference between sexual orientation, gender iden tity, and gender roles.
4. 9.4 Discuss the origins of sexual orientation.
5. 9.5 Trace the history of attitudes about homosexuality in Western culture as well as the prevalence of sexual prejudice today.
6. 9.6 Compare our attitudes about homosexuality with those in other cultures.
7. 9.7 Describe what it involves for an individual to "come out."
8. 9.8 Discuss homosexual lifestyles and the ability of homosexuals to parent.
9. 9.9 Discuss whether therapists should attempt to change sexual orientation.

Are you sexually attracted to men? To women? To both men and women? These are questions about sexual orientation—one's sexual attraction to members of the opposite sex, the same sex, or both sexes.

Definitions

1. 9.1 Define the terms *sexual orientation, heterosexual, homosexual*, and *bisexual*.

Preferential attraction to members of the opposite sex is called heterosexuality while preferential attraction to same-sex individuals is called homosexuality. Bisexuality-refers to sexual attraction to people of either sex.

At one time it was believed that people were either one or the other: heterosexual or homosexual. Kinsey and his colleagues (1948) devised a 7-point rating scale to measure sexual orientation, with 0 representing people who are exclusively heterosexual and 6 representing people who are exclusively homosexual (see Table 9–1). Kinsey's group regarded anyone as bisexual who had a rating of 2, 3, or 4. A more recent study found support for five categories: heterosexual, mostly heterosexual, bisexual, mostly gay/lesbian, and gay/lesbian (Vrangalova & Savin-Williams, 2012). The important point is that today sexual orientation is viewed as a continuum (American Psychological Association, 2012).

Table 9–1

Kinsey and Colleagues' (1948) Rating Scale for Sexual Orientation

0	1	2	3	4	5	6
Exclusively heterosexual	Predominantly heterosexual; only incidentally homosexual	Predominantly heterosexual; more than incidentally homosexual	Equally heterosexual and homosexual	Predominantly homosexual; more than incidentally heterosexual	Predominantly homosexual; only incidentally heterosexual	Exclusively homosexual

Source: From *Sexual Behavior in the Human Male* (p. 147), by Kinsey et al., 1948, Philadelphia: Saunders. Copyright The Kinsey Institute. Courtesy of The Kinsey Institute for Research in Sex, Gender, and Reproduction.

Table 9–1 Full Alternative Text

Prevalence of Homosexuality and Bisexuality

1. 9.2 Summarize what we know about the prevalence of homosexuality and bisexuality in the United States.

The large-scale surveys by Kinsey and his associates discussed in Chapter 1 (Kinsey et al., 1948, 1953) were the first source of information about the prevalence of homosexuality in the United States. They found that 10% of their sample of white men had been exclusively homosexual for at least a 3-year period in their lives and that 1% to 3% of women were predominantly or exclusively homosexual.

Kinsey's survey used a convenience sample (see Chapter 1) that was not representative of the U.S. population. What do more recent nationally representative surveys indicate? In two nationally representative surveys conducted in 2013, 1.8 to 1.9% of adult men and 1.3 to 1.5% of women self-identified as homosexuals, with another 0.4 to 2.0% of men and 0.9 to 5.5% of women identifying as bisexual (Copen et al., 2016; Ward et al., 2014). In the 2010 National Survey of Sexual Health and Behavior, 4.2% of adult men and 0.9% of adult women identified themselves as homosexual, with another 2.6% of men and 3.6% of women self-identifying as bisexual (Herbenick et al., 2010c, d; Reece et al., 2010d). The percentages for blacks and Hispanics were similar (Dodge et al., 2010). In their lifetimes, about 5.4% self-identified heterosexual men had engaged in oral sex with another man, and 2.8% had engaged in receptive anal intercourse (Dodge et al., 2016). For adult women, fewer than 4% had given or received oral sex with another woman in the past year (Herbenick et al., 2010d).

Figure 9–1

Millions of American men and women are either homosexual or bisexual.

Source: Robert Dodge/Alamy Stock Photo

Earlier national surveys by the Williams Institute (2011) and Gallup (2012) found that while the prevalence of individuals who identify as gay, lesbian, or bisexual is 3.4 to 3.7% in the general population, it is higher among young adults, particularly women (8.3%), and includes all ethnic groups (blacks 4.6%, Asians 4.0%, Hispanics 4.0%, whites 3.2%).

Thus, *about 2.5% to 7% of American men and women self-identify as homosexual or bisexual.* Of these, more women identify as bisexual than men.

Defining Sexual Orientation: Another Look

1. 9.3 Explain the difference between sexual orientation, gender identity, and gender roles.

We must look at more than self-identity when characterizing people as heterosexual, homosexual, or bisexual. Behavior and sexual attraction to others are also important components, and they are not always consistent (Copen et al., 2016; Dodge et al., 2016; Fasula et al., 2016). About 17.4% of women and 6.2% to 10.0% of men report some type of same-sex sexual contact in their lifetime (Copen et al., 2016; Herbenick et al., 2010c). Similar results are found for sexual attraction (Copen et al., 2016).

How, then, shall we define **sexual orientation?** We will use a modification of the definition by Ellis and Ames (1987): *distinct preferences consistently made after adolescence in the presence of clear alternatives*. Preferences can be reflected in desire and/or behavior, and, as noted by Ellis and Ames, "isolated instances of sexual behavior may or may not reflect one's sexual orientation." In this chapter, we shall attempt to distinguish between *same-sex sexual behavior* and *same-sex sexual orientation*. Only the latter will be referred to as homosexuality.

The pathway to heterosexual self-identity may not always be as smooth as once believed (Morgan, 2012). Some reach their identity after passive exploration and others after active exploration. A smaller percentage of heterosexuals have unexplored commitment or identity diffusion.

The developmental pathway to homosexuality and bisexuality is much more diverse for women than for men (see Diamond, 2007; Diamond & Savin-Williams, 2000; Garnets & Peplau, 2001; Gartrell et al., 2012; McCabe et al., 2011; Rust, 2000). The large majority of homosexual and bisexual men became aware of their sexual orientation at a young age, before having had a same-sex experience (Bell et al., 1981; Calzo et al., 2011). However, it is very common for lesbian and bisexual women not to recognize their orientation until later (Savin-Williams & Diamond, 2000). At least 25% of lesbians have had a long period of heterosexual relations before identifying as lesbian (Kitzinger & Wilkinson, 1995; Larson, 2006).

Women are also more likely to move back and forth between heterosexual and homosexual relationships (Diamond, 2003, 2005). Among individuals who have had same-sex partners, women are more likely to identify as bisexual, whereas men are more likely to identify as homosexual (Rust, 2003; see Petersen & Hyde, 2011).

How stable are sexual orientation self-identities over time? Several studies have found that sexual self-identification as bisexual can change over time (Diamond, 2005; Kinnish et al., 2005; Savin-Williams & Ream, 2007). However, heterosexual self-identities tend to be stable, as are 100% homosexual identities (Mock & Eibach, 2012; Savin-Williams et al., 2012). Of those bisexuals who change, men can shift toward either homosexuality or heterosexuality, whereas bisexual women are much more likely to shift toward heterosexuality (Savin-Williams et al., 2012).

Is bisexuality a distinct identity in terms of sexual attraction to others? Recent studies have demonstrated that when shown same-sex, opposite-sex, and mixed (two women and a man) erotic stimuli, unlike heterosexuals and homosexuals, bisexuals displayed arousal to all stimuli (Cerny & Janssen, 2011; Lippa, 2013; Rosenthal et al., 2012). Bisexual men report equal degrees of arousal, sexual functioning, and pleasure with male and female partners (Dodge et al., 2013). A commonly used definition of bisexuality was suggested by MacDonald (1981, 1982):

> To be bisexual means that a person can enjoy and engage in sexual activity with members of both sexes, or recognizes a desire to do so. Also, although the strength and direction of preference may be constant for some bisexuals, it may vary considerably for others with respect to time of life and specific partners.

In conclusion, most researchers today agree that bisexuality is a legitimate classification of sexual orientation, distinct from both heterosexuality and homosexuality, but that bisexuals are much more fluid in their orientation than are heterosexuals or homosexuals.

Personal Reflections

How would you react if someone at work told you that he or she was homosexual? What if your best friend told you that he or she was homosexual? Your brother or sister? Your teenage son or daughter? Why?

9.3.1 Asexuality

Recently, researchers have begun to acknowledge that there may be another sexual orientation—asexuality, defined as a *lifelong* lack of sexual attraction to men or women (Bogaert, 2004). This would not include elderly people who had been sexually attracted to others when younger, or individuals who are no longer attracted to others because of declines in testosterone. Notice that this orientation is not even on Kinsey's scale. (Some argue that asexuality is not a distinct sexual orientation but a lack of orientation.)

On the basis of several studies, it is estimated that 1% of the population is asexual (Bogaert, 2015). However, studies have found that asexual individuals comprise a very diverse group (Carrigan, 2011; Chasin, 2011). Interestingly, asexual individuals do experience sexual arousal (both genital and subjective) to erotic stimuli (Brotto & Yule, 2011) and masturbate as frequently as others (Prause & Graham, 2007); they just lack sexual desire for other people (see Bogaert, 2015).

Sexual Orientation, Gender Identity, and Gender Roles

It has been our experience that many students are uncertain (or mistaken) about the relationship between a person's sexual orientation and his or her gender identity and gender roles. The *gender identity* of the vast majority of homosexuals and bisexuals is just as strong and consistent with their anatomical sex as is found among heterosexuals. Homosexuality and bisexuality are not the result of gender dysphoria.

The real misunderstanding concerns *sexual orientation* and *gender roles.* Many heterosexuals believe that they have the ability to tell whether a person is homosexual just by indirect cues (e.g., masculinity-femininity, facial features, walking style, clothing, gestures)—what is often called "gaydar" (Rieger et al., 2010; Valentova et al., 2011). Research shows that this is largely the result of using stereotypes to guess orientation (Cox et al., 2016). People are also much more likely to assume that a man is homosexual if he works as a nurse or secretary (Deaux & Lewis, 1983; Dunkle & Francis, 1990) and are quick to attribute feminine characteristics to a man they are told is homosexual (Madon, 1997).

Probably the major reason for beliefs like these is that for many people, masculinity and femininity are basic assumptions of heterosexuality: Men are masculine and attracted to women; women are feminine and attracted to men. If you believe this, then it follows that the less "masculine" a man is, the more likely that he will be perceived as homosexual; and if a man is homosexual, it is more likely that he will be perceived as "feminine." Many male homosexuals are more effeminate than heterosexual men, and many lesbians are more masculine than heterosexual women (Lippa, 2008), but whether a person conforms or does not conform to gender stereotypes does not always predict sexual orientation.

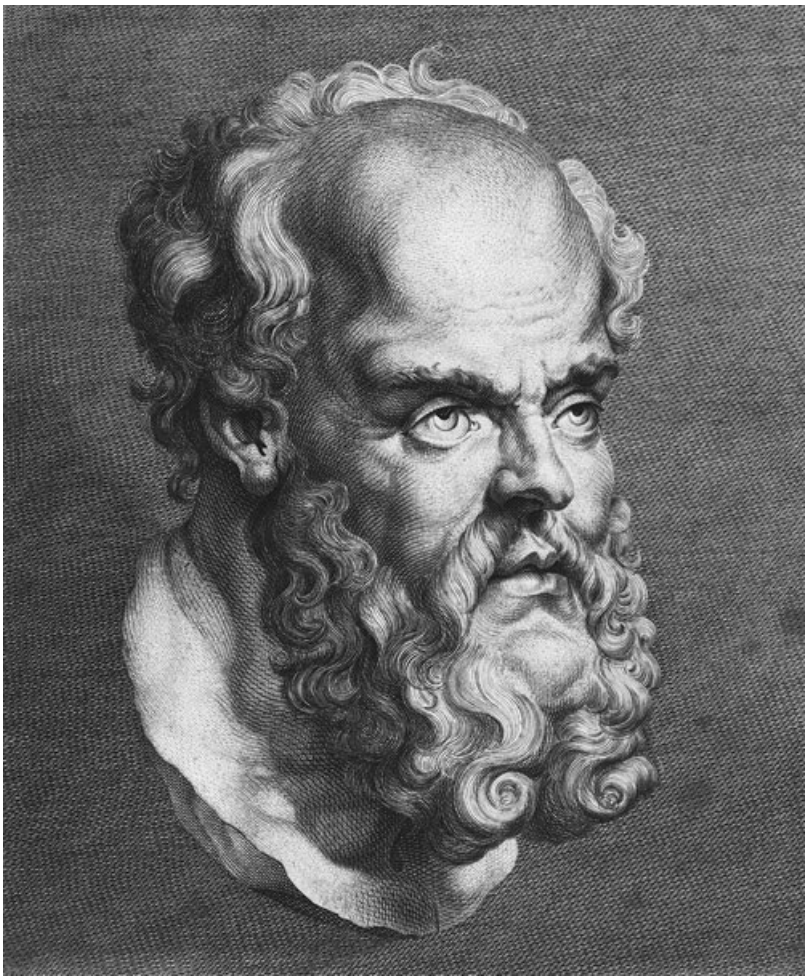
Gender (role) nonconformity during childhood is often associated later with a homosexual orientation. For example, several studies have found that for boys who persistently play with girls' dolls and display other stereotypically feminine traits, there is a much greater chance of their being homosexual as adults (Bailey & Zucker, 1995; Ellis et al., 2005; Phillips & Over, 1995; Strong et al., 2000).

However, gender nonconformity in childhood does not always predict adult sexual orientation. Green (1987) studied a small sample of extremely effeminate boys over a 15-year period. Most of the boys engaged in homosexual fantasizing and behavior as adolescents, but some later developed a clear heterosexual orientation.

Did you notice that the last two paragraphs focused on men? That is because the relation between childhood gender nonconformity and later homosexuality is greater for boys than it is for girls (see Garnets & Peplau, 2000). Many women report being tomboys as children, but only about 1.5% to 4.5% of adult women are homosexual or bisexual. Thus, "childhood gender nonconformity does not provide an adequate explanation for the development of sexual orientation in most women" (Garnets & Peplau, 2000).

In summary, there is no strong evidence that a homosexual or bisexual orientation must be associated with atypical gender roles. A great many homosexuals and bisexuals do not walk, talk, dress, or act any differently than anyone else (Kirk & Madsen, 1989).

Figure 9–2



Socrates. This Greek philosopher and teacher believed that any evil committed by human beings is done out of ignorance. He devoted his life completely to seeking truth and goodness.

Source: CHARLES PHELPS CUSHING/ClassicStock/Alamy Stock Photo

"I was born and raised in the south. During my early years I had not been exposed to anyone that was gay, or at least to my knowledge I hadn't. It was not a subject that was talked about. It was not until I got to college that I ever came into contact with someone who was openly gay. This lifestyle was all new for me and surprisingly I was okay with it.

For pretty much my whole life I was considered the 'All-American' type of girl. I had a loving family and I didn't drink or party like most kids do. I graduated with honors from high school. As for sports, I always made the region teams and time after time I won the MVP awards for all three sports. My senior year I received the miss congeniality award and to top it off I was voted prom queen. I was always someone who surrounded themselves with close friends and enjoyed being around others.

In the last 2 years I have come to grips with the fact that I am a girl attracted to other females. It's scary to think that even with all of my accomplishments and being considered such a wonderful person that it will possibly all come to an end. Nowadays, it seems that all that gets trumped by the fact that you have a different sexual orientation. I wonder how people can say that this lifestyle is a choice. Why would anyone choose to live a harder life than they have to?"

(from the authors' files)

The Origins of Sexual Orientation

1. 9.4 Discuss the origins of sexual orientation.

Why are some people heterosexual, others homosexual, and still others bisexual? Is sexual orientation biologically determined? Is it the result of the environment (family background, peers, etc.) shaping individuals? There are probably few topics in the study of human characteristics in which the nature-versus-nurture question has been so strongly debated. Let's examine the evidence.

9.4.1 Psychoanalytic Explanations: Do Parents Play a Role?

Sigmund Freud (1905) believed that male homosexuality resulted when a boy had a domineering, rejecting mother and turned to his father for love and later to men in general. Female homosexuality developed when a girl loved her mother and identified with her father and became fixated at this stage. Two early studies done with a small number of people who were in therapy claimed, in support of Freud, that homosexuals' parents differed from heterosexuals' parents in their social and parenting skills (Bieber et al., 1962; Wolff, 1971). A much larger study of better-adjusted persons failed to support their findings (Bell et al., 1981). Good parenting skills are found just as frequently in same-sex parents as in opposite-sex parents (Biblarz & Stacey, 2010). There is also no evidence that sexual orientation results from children identifying with a particular parent (Bell et al., 1981). In summary, psychoanalytic explanations have not proven very useful in explaining the origins of sexual orientation (Downey & Friedman, 1998).

9.4.2 The Effects of Environment

If sexual orientation were a learned behavior (a choice), homosexuals would be expected to have had good or rewarding experiences with same-sex individuals and bad experiences with members of the opposite sex in their early social experiences. What is the evidence in support of this explanation? Some people assume that homosexuals are people who are not attractive (or masculine or feminine) enough to "make it" with the opposite sex. However, the data do not support this. Most lesbians have had pleasurable sexual relations with men (Bell et al., 1981; Diamant et al., 1999). They simply prefer sexual relations with women. In Box 9–A, you will learn about some cultures in which it is the custom for boys to have sexual relations with men, but the percentage of adult men in these cultures who are homosexual is not greater than in cultures with a very negative attitude about homosexuality. Later in the chapter you will learn that children raised by openly homosexual parents are equally likely to grow up with a heterosexual orientation as children raised by heterosexual parents.

9.4.3 Biological Explanations

Genetic Factors

In 1952, Kallman found nearly 100% concordance for homosexual orientation in identical twins (here, concordance means matching, i.e., if one twin was homosexual, the other was too). The concordance for fraternal (nonidentical) twins was only about 10%. Similar results were found by a German researcher (Schlegel, 1962), and together these findings challenged the prevailing view that homosexuality was determined by social influences.

In the 1990s, several groups replicated these studies and verified a possible genetic basis for sexual orientation. Bailey and Pillard (1991) studied 167 pairs of brothers and found that 52% of the identical twin brothers of homosexual men in the study were also homosexual, compared with 22% of nonidentical twins and 11% of adoptive brothers. In another study of 143 pairs of sisters, they found that 48% of identical twins of homosexual women were also homosexual, compared to 16% of nonidentical twins and 6% of adoptive sisters (Bailey et al., 1993). Subsequent studies found similar results (Bailey et al., 2000; Kendler et al., 2000; Whitam et al., 1993).

These studies leave little doubt of a biological contribution to sexual orientation. But how much? Remember, not all of the identical twins were homosexual. A review concluded that 50% to 60% of sexual orientation is due to genetics (Rahman & Wilson, 2003). Even if the upper estimate is correct, that still leaves a lot of room for the influence of social and environmental factors.

Brain Anatomy

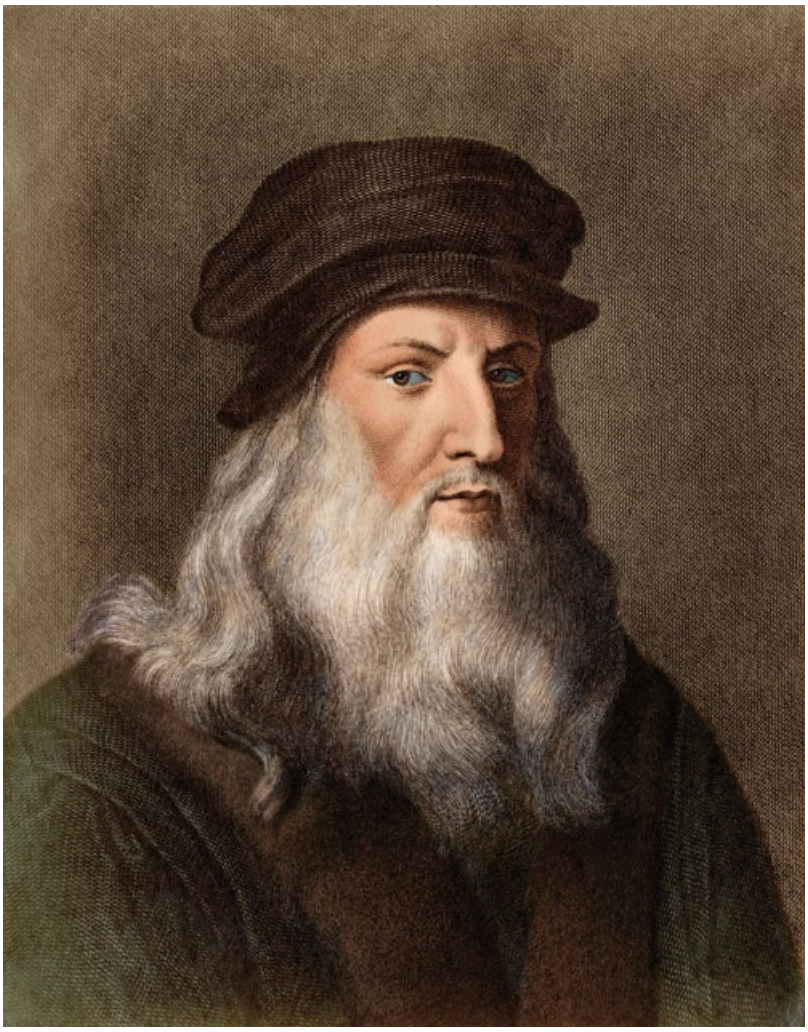
It has been known for quite some time that the brains of male and female rats differ anatomically (Gorski et al., 1978). Is there a difference between the brains of heterosexual and homosexual people? In one study, autopsies were performed on the brains of 19 homosexual men and 16 heterosexual men. It was found that a part of the hypothalamus (at the base of the brain) known to influence sexual behavior was more than twice as large in heterosexuals (LeVay, 1991). Others found that another part of the hypothalamus, the suprachiasmatic nucleus, had twice as many cells in homosexual men as in heterosexual men (Swaab & Hofman, 1990) and that a major fiber bundle that connects the two halves of the brain (the anterior commissure) was 34% larger in homosexual men than in heterosexual men (Allen & Gorski, 1992). Recent studies have found additional differences in cerebral dimorphism (see LeVay, 2011; Savic et al., 2010, for reviews). Dean Heimer of the National Institutes of Health concluded, "The simplest interpretation would be that there is a gene, or genes, that control the growth of [brain structures]. Both point to the same idea, that there is a biological component of sexual orientation" (cited by Maugh in the *Los Angeles Times*, 1991).

Birth Order (and the Prenatal Environment)

Many studies have found that, on average, homosexual men have more older brothers than heterosexual men (see Jannini et al., 2010, for a review). Each additional older biological brother (but not older sister) increases the probability that the younger brother will be homosexual by

about 33% (Blanchard, 2001; Cantor et al., 2002). (That does *not* mean that if you are male and have two older brothers that you will be homosexual; the probability is very small to start with.) No birth order effect is observed in homosexual women (Bogaert, 2000). Birth order effects are observed for many personality characteristics but not in families where children are adopted (Beer & Horn, 1999). This suggests that birth order effects in men are the result of biological influences; more specifically, a reaction of the mother's immune system (to the Y chromosome chemicals) triggered by the previous male fetuses (Jannini et al., 2010). This, they say, affects sexual differentiation of the brain (see Blanchard, 2001). What percentage of homosexual men owe their sexual orientation to this birth order effect? It has been calculated that it is about 1 in 7 (Cantor et al., 2002) and pertains only to extremely feminine homosexual men (Bogaert, 2005). The important implication of this research is that it points to prenatal factors in influencing sexual orientation in some men.

Figure 9–3



Leonardo da Vinci. This Italian Renaissance painter *(Mona Lisa, The Last Supper)*, anatomist, astronomer, and engineer was one of the most versatile geniuses in history.

Source: North Wind Picture Archives/Alamy Stock Photo

Hormones (and the Prenatal Environment)

What could account for the differences in brain anatomy between heterosexual and homosexual men? It is likely that the answer is hormones (see LeVay, 2011, for a review). Same-sex sexual behavior is observed in almost all species (Bailey & Zuk, 2009). Several studies with nonhuman species have shown that treatment with hormones prenatally (before birth) can result in same-sex sexual behaviors as adults (see Kelly et al., 1999, for a review).

In humans, the level of circulating male sex hormones (testosterone) in adult heterosexual and homosexual men does not differ (see Gladue, 1988). Furthermore, giving sex hormones to adult homosexuals (e.g., testosterone to homosexual men) does not change their sexual orientation. So, how and when do hormones exert their effect? Recall from Chapter 8 that women who were exposed to high levels of masculinizing hormones before birth (congenital adrenal hyperplasia) are much more likely than others to prefer boys' toys and activities as children and develop a homosexual or bisexual orientation as adults (Hines, 2004a, b; Pasterski et al., 2007).

Here is what we know about testosterone during prenatal and early development. Levels increase dramatically when the testicles develop in week 7 after conception (see Chapter 8), reach a peak between weeks 10–22, and then decline to the same levels as are found in baby girls (McFadden, 2008). In boys, testosterone levels then dramatically increase after birth for about 20 weeks and then decline again to the level of girls

until puberty. Therefore, any early differences in anatomy due to testosterone would have to occur during one of these two early testosterone surges (one prenatally and one shortly after birth) (McFadden, 2008).

For obvious reasons, it would be unethical to manipulate hormones in humans prenatally or shortly after birth. However, we now know that testosterone during these time periods affects the development of other anatomical structures, and researchers use these as measures when comparing adult heterosexuals and homosexuals. For example, male homosexuals tend to have finger-length ratios that are different from heterosexuals. They also tend to have an earlier onset of puberty (see Jannini et al., 2010, for a review).

9.4.4 Conclusions

Although there is a growing body of evidence for a biological contribution to sexual orientation (Jannini et al., 2010; LeVay, 2011), this does not mean that one's sexual orientation is destined by biology. The studies with identical twins point strongly to a biological factor, but the fact that about half the twins were discordant (in spite of the fact that they had identical genes) shows that environment also plays a role. The great fluidity with which an increasing number of teenaged and young adult women go in and out of opposite-sex and same-sex behaviors attests to the role of environmental factors for women (Gartrell et al., 2012; see Baumeister, 2000; Diamond, 2003).

Most researchers today agree that biological and social influences *both* contribute to the development of sexual orientation. The question is no longer nature versus nurture but to what extent each influences orientation. Several groups of researchers have recently reexamined large groups of identical twins (often thousands) to address this question. The results: genetic influences and the environment both contribute. In a population study of twins in Sweden, genetics accounted for .34–.39 of the variance in men and .18–.19 in women, shared environmental influences accounted for .00 in men and .16–.17 in women, whereas nonshared environmental factors accounted for .61–.66 in men and .64–.66 in women (Långström et al., 2010). A population study of Finnish twins found that when gender-role nonconformity in childhood and a homosexual orientation in adulthood occurred together, the genetic contribution was the strongest, with only a modest role for nonshared environmental effects (Alanko et al., 2010). A modest-to-strong contribution of both genetic influences and environmental influences to childhood gender-role nonconformity were similarly found for twins in England (Knafo et al., 2005), the Netherlands (van Beijsterveld et al., 2006), and Australia (Bailey et al., 2000). Daryl Bem (1996) and Simon LeVay (2011) have proposed an intriguing hypothesis—that genes do not code for sexual orientation per se, but for a "package" of characteristics and behaviors that steer individuals in the direction of a particular orientation.

Regardless to what extent biology plays a role in sexual orientation, research of this subject remains controversial. "Religious conservatives who believe that being gay is a choice argue that scientists are trying to legitimize it; gay activists worry that the research will lead to misguided attempts to 'cure' gay people" (Reardon, 2016).

Being Homosexual

1. 9.5 Trace the history of attitudes about homosexuality in Western culture as well as the prevalence of sexual prejudice today.

Homosexuality is a word derived from the Greek *homo*, meaning "same" (do not confuse this with the Latin *homo*, meaning "man"). The term was first used by a Hungarian physician in a pamphlet published in Germany in 1869 (Gregersen, 1982) and was popularized in the English language two decades later by Henry Havelock Ellis. The prefix *hetero*, by the way, is also derived from a Greek word and means "different." Homosexual behavior has been reported in nearly all cultures throughout the world (see Box 9–A).

Over the years there have been many derogatory terms used to describe homosexuals (e.g., "faggot," "fairy," "dyke"). Most homosexuals prefer the term gay for a male homosexual (although in some places the term is used for homosexuals of either sex) and lesbian for a female homosexual (derived from the name of the Greek island Lesbos where, in about 600 b.c., the poet Sappho led a circle of young female disciples). Heterosexuals are often referred to as **"**straights**."** The word "queer" was once regarded as derogatory, but in the past decade it has been increasingly used in the homosexual community as an umbrella term to refer to gays, lesbians, bisexuals, and transgendered individuals. Its use "attempts to negate the notion of sexual identity" (which "are created by society in order to repress individuals wishing to engage in behaviors that deviate from the heterosexual model") (Avila-Saavedra, 2009). Numerous LGBT and LGBTQ organizations now help lesbian, gay, bisexual, transgender, and queer individuals adjust in a too-often hostile environment.

Box 9–A Cross-Cultural Perspectives

Homosexuality in Other Cultures

1. 9.6 Compare our attitudes about homosexuality with those in other cultures.

Over the past three decades, the percentage of Americans who are understanding and accepting of homosexuality has steadily increased. We now have laws that guarantee same-sex marriage and protect against discrimination in the workplace. The same is true in most European nations. What about the rest of the world?

Two older studies of numerous cultures found that only about one third disapproved of homosexuality (Ford & Beach, 1965; Gregersen, 1982). In a more recent survey of 24 developed countries, 18 of them had more than 50% of their people regarding adult homosexual relations to be "always wrong" (Widmer et al., 1998). Homonegativity is especially prevalent in the Middle East, China, Russia, and many parts of Africa and South America (Jäckle & Wenzelburger, 2015). Russia banned homosexual athletes and tourists from attending the 2014 Winter Olympics (held in Russia). In Uganda, South Africa, and some other African nations, laws have recently been passed that make it a crime to be homosexual (Nature Editorial, 2015). These laws have made it difficult to prevent the spread of HIV.

One factor that affects attitudes is religious affiliation. Negative attitudes about homosexuality are the most prevalent in Islam, followed (in order) by Catholicism/Protestant Free Churches/Orthodox Christianity and European Protestant religions, with the least negativity found in cultures that are Hindu and (followed by) Buddhist/Tao /Confucian (Jäckle & Wenzelburger, 2015). In many Islamic countries, people are routinely killed if they are found to be homosexual.

Recall that in ancient Greece sexual relations between men and adolescent boys (called pederasty) was highly idealized (Plato's *Symposium*). It was believed that a boy could acquire knowledge by swallowing semen from an intellectual tutor. Pederasty is common in many cultures throughout the world. This includes at least 50 Melanesian (part of the South Pacific islands) societies and societies around the Mediterranean, the Middle East, Africa, Asia, and South America (Dykes, 2000; Gebhard, 1985; Herdt, 1993; Rind, 1998). In perhaps the most studied group, the Sambians (Baldwin & Baldwin, 1989; Herdt, 1993), boys are separated from their mothers at about the age of 7 and live only with other boys and men. They regularly perform oral sex on older (but not yet adult) boys; swallowing semen is a practice that the Sambians believe assures maleness (makes them strong, virile, and good warriors and hunters). The boys continue this for 6 to 8 years and then reverse roles, becoming semen donors to younger boys. At 16 years of age, a Sambian boy marries and for the next year or two is given oral sex by his new bride as well as by younger boys. Once his wife gives birth, however, the same-sex behavior stops, and the new Sambian adult is exclusively heterosexual (in desire as well as behavior) thereafter.

In another example of pederasty, male warriors of the Azande in Sudan take boys as "wives" because there is a shortage of women (S. Murray, 1992). The boys perform all the usual tasks of women and are passive partners in intercourse (performed between the thighs). When they grow older, the boys are free to marry women but may marry a boy if a woman is not available. In the Siwan culture in Africa, all boys are expected to be passive partners in anal intercourse with adult men. Married men loan their sons to one another and openly talk of their same-sex sexual relations with boys (Ford & Beach, 1951).

What about women? Female same-sex practices have not been studied as extensively as men's, but one study found examples of such behaviors in 95 native cultures (Blackwood, 2000). The types of behavior ranged from adolescent sex play to intimate friendships to erotic ritual practices.

Several important points can be learned from these cross-cultural studies. First, we must distinguish between same-sex sexual behaviors and a homosexual orientation. For example, although all Sambian men engage in same-sex practices during a specified time of their lives, Herdt (1987) estimates that fewer than 5% have a homosexual orientation as adults. In Mexico, Brazil, Turkey, Greece, and Morocco and other northern African countries, it is not uncommon for men to engage in anal intercourse, but only the passive partner is regarded as homosexual (Carrier, 1980). Thus, what is considered homosexuality is, in part, culturally defined.

The percentage of homosexuals across cultures that have been extensively studied is about the same: from 1% to 7%, regardless of whether the

culture has a negative or positive attitude about homosexuality (Diamond, 1993; Whitam, 1983). What do vary from culture to culture are attitudes about homosexuality. That is a learned response, and what is learned depends on the time and the place in which a person is raised.

9.5.1 Historical Attitudes About Homosexuality

Western attitudes about homosexuality have varied considerably throughout history. In ancient Greece, same-sex sexual behavior between adult men and boys (called pederasty) was widely accepted as an alternative to heterosexuality (Scanlon, 2005). Cantarella (1992) wrote that in ancient Greece pederasty had "become in practice an absolutely normal relationship, socially accepted, engaged in with total freedom, and celebrated by the poets." Plato praised homosexual relations in his *Symposium*. Homosexual relations between Greek scholars (e.g., Socrates, Plato) and their students were considered to be a natural part of the young boys' education. Marriage between individuals of the same sex was legal among the upper class during the time of the Roman Empire, but the most common type of same-sex behavior engaged in was also pederasty (see Rind, 1998).

Same-sex sexual activities were practiced—often as part of religious rituals—by many groups of Hebrews prior to the 7th century b.c. As part of a reformation movement designed to unify the many Hebrew groups, male homosexuality was thereafter condemned (along with other acts that had been part of older rituals) and was made punishable by death:

> If a man lies with a male as with a woman, both of them have committed an abomination; they shall be put to death, their blood is upon them.

(Leviticus 20:13, Revised Standard Version)

Female homosexuality was dealt with less harshly by the Jews because it did not involve "spillage of seed" or violation of male property rights (Locke, 2004).

European Christians, following the Roman tradition, initially were tolerant of same-sex sexual behaviors, especially pederasty (Boswell, 1980; Rind, 1998). It was not until the time of Saint Thomas Aquinas (a.d. 1225–1274), who emphasized the view of Saint Augustine that the only purpose of sex was procreation, that homosexuality came to be viewed as unnatural or "against the laws of nature." However, Boswell (1980) noted that while same-sex sexual behavior was considered a sin in the Middle Ages, people who committed the sin were not then viewed as a type of person who was different from others. This remained true during the 1600s and 1700s, when homosexual acts became a crime as well as a sin.

It was not until the late 1800s and the rise of modern medicine (particularly psychiatry) that people who engaged in homosexual acts came to be viewed as a particular class of people—people with a mental illness. Freud (1924) referred to homosexuals as "perverts" in his academic teaching. As a result, there has never been a period in Western culture with as much intolerance of homosexuality as there was in the 20th century. In 1953, President Eisenhower signed Executive Order 10450, which banned individuals engaged in "sexual perversion" from employment in the government. Thousands of gays and lesbians lost their jobs. In 1966, the editors of the highly respected *Time* magazine wrote a 2-page editorial on homosexuals, which concluded with the following statement:

> [Homosexuality is] a pathetic little second-rate substitute for reality, a pitiable flight from life. As such it deserves fairness, compassion, understanding and, when possible, treatment. But it deserves no encouragement, no glamorization, no rationalization, no fake status as minority martyrdom, no sophistry about simple differences in taste—and, above all, no pretense that it is anything but a pernicious sickness.

(Time Essay, 1966, p. 41)

Figure 9–4

While there is considerable evidence for a biological cause of sexual orientation, especially in men, recent research "recognizes the great diversity of women's erotic experiences and the many sociocultural factors that shape women's sexuality and sexual orientation

across the life span" (Garnets & Peplau, 2000, p. 181).

Source: Creatas Images/Thinkstock/Getty Images

Because homosexuals were viewed as mentally ill, the medical profession subjected them to frontal lobotomies, forced castrations or hysterectomies, electric shock treatments, hormone injections, and endless hours of psychotherapy (Katz, 1976). However, until the late 1950s, homosexuals had never been studied outside of a medical or prison setting. Then, in 1957, Evelyn Hooker published a paper showing that nonclinical heterosexual and homosexual men could not be distinguished by the best psychological tests (i.e., the homosexual men were as well adjusted as the heterosexual men). Even Freud had recognized this to be true:

> Often, though not always, they are men and women who otherwise have reached an irreproachably high standard of mental growth and development, intellectually and ethically, and are only afflicted with this one fateful peculiarity.

(Freud, 1924, p. 313)

Many people believe that the gay rights movement began in 1969 with a series of riots by gays and lesbians protesting against a raid by the New York City police on the Stonewall Inn, a gay bar (See Figure 9–5). The riots resulted in the formation of homosexual activist organizations. Finally, in 1973, the American Psychiatric Association decided to discontinue classifying homosexuality as a mental illness (see Herek, 2010, for a review of some of the events leading to this decision). The decision was not unanimously applauded; 37% of APA members were opposed to the change. Homosexuality remained as a mental disorder in the World Health Organization's *International Classification of Diseases* until 1992.

Figure 9–5

In 1969, police raided the Stonewall Inn in Greenwich Village of New York City. Many believe that the demonstrations that followed marked the beginning of the gay liberation movement in the United States.

Source: M. Stan Reaves/Alamy Stock Photo

The APA decision has had far-reaching implications. If homosexuality is no longer considered an illness, there is no need to cure it. However, attitudes often change slowly. Until the Supreme Court ruled against them in 2003, many states still had laws on the books that prohibited the sexual expression of homosexuality (see section on Sodomy Laws in Chapter 11). The U.S. military had always banned and discharged homosexuals, and it was not until 2011 that President Obama repealed the "don't ask, don't tell" policy (a compromise enacted by President Clinton) and allowed gays and lesbians to openly serve their country.

9.5.2 Sexual Prejudice Today

Sexual prejudice is often institutionalized. Many Christian churches continue to have a rejecting or punitive attitude toward homosexuality. They view homosexuals as desecrators of Christianity (Trevino et al., 2012). In an extreme example, the Westboro Baptist Church (based in Topeka, Kansas) holds anti-gay protests at military funerals (see Figure 9–6).

Figure 9–6

An anti-gay protest by members of a Christian church.

Source: George Sweeney/Alamy Stock Photo

Many people are prejudiced against others whom they perceive to be different. People discriminate on the basis of skin color, gender, and religion, but hostility toward gay, lesbian, and transgendered individuals has probably been more accepted among Americans than any other type of bias. Views by students in our class about homosexuality and homosexuals are greatly mixed:

"During my junior year in high school I made a new male friend. The more I got to know him, the more I began to suspect that he was gay. This scared me. As a result of my growing fears I discontinued our friendship."

"My feeling is that homosexuality is disgusting. . . . Just thinking about it gives me the creeps."

"A few of my closest friends are homosexuals. At first, I admit, it was a shock when they told me, but that never stopped me from being their friend. My boyfriend is definitely homophobic and it aggravates me every time he says something negative."

"To be really honest, if anyone is a homosexual, I don't care, as long as they are good people. . . . I believe that homosexuals should be legally accepted."

"I believe that homosexuality is morally wrong. While I try hard not to judge the feelings of others, I do not agree with acting out these feelings."

"When I was in high school I worked at a flower shop. I didn't realize the owner's son was gay until my junior year. He acted totally normal. . . . One afternoon I saw him driving somewhere with his boyfriend. Ever since that day I am kind of afraid and don't like to even have conversations with him. I don't know why I fear him so much because he has never done any harm to me."

(All examples are from the authors' files.)

Homosexuals are often victims of verbal abuse, harassment, bullying, and even hate crimes (e.g., Bontempo & D'Augelli, 2002). Hate crimes are defined by the FBI as "crime motivated by preformed, negative bias against persons, property, or organizations based solely on race, religion, ethnicity/national origin, sexual orientation, or disability" (U.S. Department of Justice, 1996). Over 50% of gay men have been verbally abused or threatened (Katz-Wise & Hyde, 2012). In 2009, President Obama signed the Hate Crimes Prevention Act, which made it a federal crime to assault anyone because of his or her sexual orientation, gender, or gender identity.

In such a harsh world, is it any wonder that homosexual and bisexual men and women have a higher prevalence of depression, mood, and/or stress disorders and suicide than heterosexuals (e.g., Haas et al., 2010; Koh & Ross, 2006; Operario et al., 2015)? Most of these mental health problems can be attributed to what has been called *minority stress*—the "stigma, prejudice, and discrimination [that] create a hostile and stressful social environment" (Eliason et al., 2012; see Hatzenbuehler, 2009).

The most widely used term to describe negative attitudes toward homosexuals is homophobia. However, homophobia generally implies that negative attitudes are the result of irrational fears that reflect individual psychopathology. Psychologist Gregory Herek (2000a, b) proposed that a better term is sexual prejudice. Sexual prejudice is socially reinforced and includes negative attitudes toward individuals, communities, and homosexual behaviors. Sexual prejudice is greater among men than it is among women, and prejudiced men generally have a much greater negative

attitude about gay men than they do lesbians (Herek, 2000b, 2002; Kite & Whitley, 1996). Besides religiosity and gender, other factors that affect attitudes about homosexuality are age (young people today are generally less prejudiced), education (people with low levels of education tend to be more prejudiced), and socioeconomic level (low-income people tend to be more negative) (Jäckle & Wenzelburger, 2015).

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Herek believes that anti-gay prejudice is an attempt to suppress any attraction to the same sex (see Herek, 1988), a way to "maintain a positive gender-related identity" (Falomir-Pichastor & Mugny, 2009). Homophobic epithets (e.g., "fag," "that's so gay") are often used to bolster heterosexual men's self-perception of masculinity and heterosexual identity (Carnaghi et al., 2011). Herek says, "The teens and early 20s [are] a time of identity consolidation, struggling with issues of manhood and masculinity, how one becomes a man. By attacking a gay man or a lesbian, these guys are trying symbolically to affirm their manhood" (Associated Press, July 1993). Interestingly, prejudice against very effeminate men is not uncommon even among gay men (Sánchez & Vilain, 2012).

Some of you may be rejecting this explanation of homophobia by men and attributing it instead to morality issues. If the basis of sexual prejudice by men were morality only, there would be no difference in heterosexual attitudes toward gays and lesbians. However, many sexually explicit male-oriented magazines and porn films show woman-on-woman sexual activity. Why? Publishers and producers of this material would not include it if they were not certain that a great many heterosexual men view female-on-female sexual activity as erotic and are aroused by it (Strager, 2003).

In recent years, attitudes toward gays and lesbians have become markedly less negative (see Keleher & Smith, 2012; Page, 2012). About 91% of gays and lesbians say that their community is more tolerant than in the past. Many studies have found that sexual prejudice lessens the more interactions one has with homosexuals (see Smith et al., 2009).

Personal Reflections

Sexual prejudice affects relations among heterosexuals as well. It prevents many same-sex family members (most commonly, fathers and sons) and friends from being affectionate with one another. Are you able to hug your same-sex parent? Good friends of the same sex? If not, examine which fears prevent you from doing so. Sexual prejudice hurts everyone, including those who display it.

Sexual Identity Development (the "Coming Out" Process)

1. 9.7 Describe what it involves for an individual to "come out."

With so many people in our society having negative attitudes about homosexuality, it should come as no surprise that acknowledging to oneself that one is homosexual, and then publicly declaring it, is often very difficult. The process of accepting and disclosing one's homosexuality or bisexuality is called sexual identity development or, more commonly, coming out. Today, this process is beginning at a younger age than in the past (Calzo et al., 2011). Several models have been offered to describe this process. We will follow the stages outlined by the Boston Women's Health Book Collective (2011).

9.7.1 Recognizing a Same-Sex Orientation

The first stage is *admitting to oneself that one has a homosexual or bisexual orientation*. Many gays and lesbians knew that they were "different" at a very young age. You will learn in Chapter 10 that sexual attraction (not to be confused with a desire to have sex) begins around the age of 10 for almost everyone (Herdt & McClintock, 2000; Pattatucci & Hamer, 1995). Attraction to individuals of the same sex frequently occurs at a young age and before sexual activity begins (Calzo et al., 2011).

"I discovered my sexuality at a surprising 6 years old. Naturally I didn't know at that young age that I was a lesbian, but I can remember having 'crushes' on my teachers and female upperclassmen."

"I think that the most important thing you lectured on was the predisposition of sexual orientation before birth. I, too, felt different as a child as early as by 10."

(All examples are from the authors' files.)

Recall that others (particularly women) do not recognize their sexual orientation until well into adolescence or even later (Diamond, 2003; Diamond & Savin-Williams, 2000; Garnets & Peplau, 2001; Kitzinger & Wilkinson, 1995). Because so many people have a negative opinion of it, recognizing that one is gay or lesbian is often a lonely and painful experience.

> "As a young gay person, you feel all of the things every other young person feels. You feel all of the normal doubts, uncertainties, questions and frustrations common to that time of life. And you also begin to have feelings and thoughts as precious and deep as any can be: of self, and worth, and love, and life, and purpose. But when you are young and gay, you also face a world of pain and isolation few people have to face.
>
> "We all know how vulnerable and fragile a life can be in those early years. And yet few people seem ready or willing to consider how it must feel to be young and gay. In a time when nurturing and affirmation are so important, the young gay person is told by his church that he is evil. Society says that they are misfits. The media displays freaks. And the world seems to say they are less than a whole person. And so, when you are young and gay, you can feel so much hatred, so much rejection, so unwanted, so unwelcome, so worthless, so unaccepted and so misunderstood.
>
> "Other people throughout time have known the kind of pain and persecution which reaches deep into a person's heart. There have always been people who were made to feel hated and demeaned because of their color, their religion, their heritage, or their gender. But as much pain and suffering as these people have known, they also knew they were not alone. They always had someone else they could see who was just like them; someone to identify with. And most important of all, they had someone to talk to; someone to share the pain with.
>
> "When you are young and gay, you feel the same terrible depth of pain. But you look around and there is no one to talk to; no one to share the pain with. There is no one who has feelings like yours or who understands how deeply you hurt. You feel so isolated and so alone. And at times, that vulnerability and pain and isolation can be so terribly overwhelming."

(Steve L., personal communication, New Orleans)

9.7.2 Getting to Know Other Homosexuals

In the next stage, the individual *gets to know other homosexuals*, thus ending the sense of isolation. It is easier to come out if the individual finds acceptance in others, and those most likely to be accepting are other homosexuals. Most gays and lesbians were raised in the same anti-homosexual environment as others, and by coming into contact with other homosexuals, they can replace these negative stereotypes with a more positive attitude about homosexuality—and about themselves.

> "As I was growing up, I heard all of the jokes and stories about the lives gays lived. I saw all of the negative images that the media could dish up for public consumption. . . . I wanted to find someone I could share the rest of my life with.
>
> "And then I looked for that life and tried to find it. . . . The only place society had allowed gays to meet was in one small bar-filled pocket of the city. And so I turned to where I was accepted and where I could breathe. But then I heard society condemn me because of the lifestyle I 'chose' to lead.
>
> "In time, I grew to learn that there was more of a life to be had than just the narrow world which society tries to impose upon gays. I

met many happy and healthy gay people who helped me to understand and learn and grow."

(Steve L., personal communication, New Orleans)

Once contact is made with other gays and lesbians, a new way of expressing sexuality has to be developed. However, many homosexuals hide their sexual orientation from others for long periods.

> "But as bad as you hurt, you keep the pain to yourself. You fear being discovered by the people you love and need the most; for everything your world has taught you makes you afraid you will lose their love and friendship if they find out you are gay. The world gives you the pain, and then makes it impossible for you to talk about it because of fear.
>
> "So not only does the world isolate you from learning about your feelings and others who are like you, but you begin to isolate a part of yourself from family and friends. You begin to develop techniques of telling half-truths and skirting around questions. You learn how to hide inside of yourself and smother feelings. You learn how to be around other people without letting them get too close. You learn how to survive.
>
> "And then, you grow tired of hiding. You grow tired of not being able to share the beauty as well as the pain that fills your life. You grow tired of not being as close as you want to be to the people you care most about.
>
> "But the fear is still very strong. You find it is easier to avoid the questions by just staying away more often. And you don't have to find as much strength to hide and be silent. So you drift further and further from the people you love the most and you feel the pain and isolation building up inside."

(Steve L., personal communication, New Orleans)

9.7.3 Telling Others

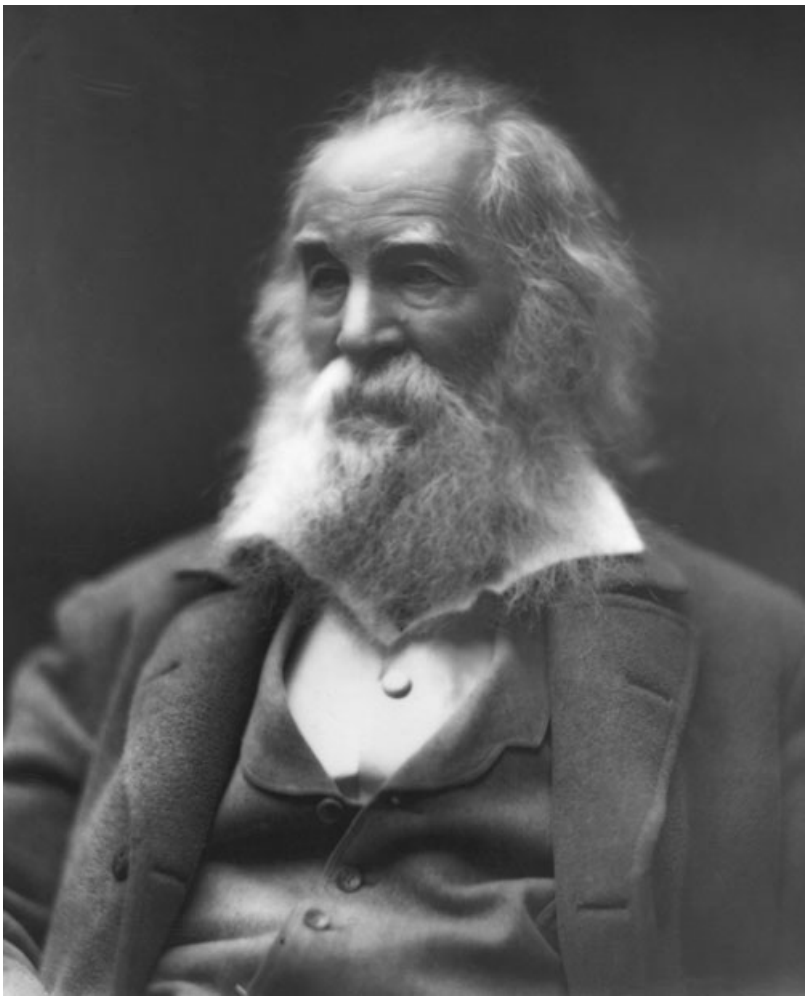
In the third, very difficult, stage, the individual *tells family and friends of his or her sexual orientation*. Telling a friend usually comes first (Rossi, 2010).

"I am a 25-year-old female. I've been close friends with 'Darla' since 7th grade. 'Darla' and I used to talk about girl things all the time (boys, dating, sex). I felt there was nothing we couldn't discuss.

"Two years after high school graduation, 'Darla' and I along with another mutual friend got together for pizza and to catch up on old times. 'Darla' then said she had something very important to tell us. She told us she was gay. She said she had those feelings since she was a child and only recently acted on them. I handled her news supportively, but our other friend told 'Darla' that she was 'disgusting' and 'gross.' I'm sure without a doubt that was the hardest day in 'Darla's' life."

(from the authors' files)

Figure 9–7



Walt Whitman. Many scholars consider his *Leaves of Grass* to be the greatest collection of poems ever written by an American.

Source: Bettmann/Getty Images

When an individual does finally disclose his or her homosexuality or bisexuality to the family, it often creates a crisis. Parents have raised their children with the expectations that they will be heterosexual. Verbal (and physical) abuse by parents (especially by fathers) is not uncommon (D'Augelli et al., 1998).

"My parents became aware of my sexual preference when I was 18. Since that time, I have endured numerous nasty conflicts with them. My mother told me that she would rather me be a prostitute, and my father told me I would never be anyone as long I was a 'faggot.' They threw me out immediately after graduation from high school and forbade me to enter their house. They took me back on their terms—that I would go straight and live what is in their opinion a good, decent, moral lifestyle. I agreed and abided for a few months, but found myself extremely unhappy. I ended up moving out after a fight with my father."

(from the authors' files)

Many gay, lesbian, and bisexual young people end up homeless and on the streets (Prendergast et al., 2002). Gay and lesbian individuals who had supportive parents during the coming-out process have better mental health and fewer behavioral risk behaviors than those whose parents were not supportive (Rothman et al., 2012). For those of you who are homosexual and have not yet revealed your orientation to your family, contact PFLAG for help as to how best to go about it.

The final stage is *complete openness about one's homosexuality or bisexuality*. This includes telling people at work; it completes the process, making one's homosexuality or bisexuality a total lifestyle. The important task for all adults, regardless of their sexual orientation, is to develop an acceptance of their sexuality (i.e., of themselves), to find acceptable ways to express it, and to learn to incorporate their sexuality into their total lifestyle and personality.

Personal Reflections

Gays, lesbians, and bisexuals: Have you told your family and friends of your sexual orientation? Why or why not?

Lifestyles and Relations

1. 9.8 Discuss homosexual lifestyles and the ability of homosexuals to parent.

Finding companions and sexual partners can be difficult for many gays and lesbians in rural areas and small towns where there may be little tolerance of homosexuals meeting together in public. In large urban areas there is usually a much larger number of people who are homosexual as well as a much greater acceptance of their lifestyle. In fact, 60% of gay men with partners live in one of 20 cities (San Francisco, Washington, DC, Los Angeles, Atlanta, and New York are the most popular) (Black et al., 2000). Lesbian couples are less likely to be concentrated in large cities.

Many heterosexuals believe that homosexuals are unhappy and lonely. However, studies have found no differences between cohabitating heterosexuals and cohabitating homosexuals in the relationship quality and satisfaction (and often fewer relationship problems) (Balsam et al., 2008; Gottman et al., 2004; Peplau & Fingerhut, 2007; Roisman et al., 2008). In fact, gay and lesbian couples may be better at being "best friends" than heterosexual couples (Peplau, 1988). Contrary to what many heterosexuals believe, most same-sex couples do not create "husband" and "wife" roles but instead assume financial and household responsibilities equally (Peplau & Fingerhut, 2007).

Women, whether straight or lesbian, tend to value commitment and romantic love (Leigh, 1989). Lesbian couples generally take a great deal more time touching and caressing one another than heterosexual couples, for whom sexual relations are often dominated by the goal-oriented man (Hite, 1976; Masters & Johnson, 1979). Manual stimulation of the genitals and oral-genital sex are the preferred ways of reaching orgasm for lesbians (Bell & Weinberg, 1978; Masters & Johnson, 1979). Many lesbians engage in tribadism, the rubbing of genitals against another's genitals or other body parts. The use of vibrators is common among lesbians (Schick et al., 2011), but very few use dildos (objects shaped like a penis).

There is a difference between the sexual lifestyles of most straight and gay men: Gay and bisexual men are much less likely to regard monogamy as important (see Peplau & Fingerhut, 2007) and thus have a greater number of lifetime sexual partners. A nationally representative sample of Australians found that the mean number of sexual partners for gay men was 32 (Grulich et al., 2003). Compared to heterosexual men, men who have sex with men are much more likely to have begun sexual relations at an earlier age, to have formed a new partnership in the past year, and to have concurrent partnerships (Glick et al., 2012).

A study of gay and bisexual men's recent (past 30 days) sexual behaviors found that 62.0% had engaged in oral sex, 49.0% in partnered masturbation, and 33.5% in anal intercourse (Dodge et al., 2016). Among those who do engage in anal intercourse, some highly prefer the receptive role (self-labeled as "bottoms"), others the insertive role ("tops"), but many self-label as "versatile" (Moskowitz & Hart, 2011; Wei & Raymond, 2011). Overall, heterosexuals and homosexuals are very similar in their sexual satisfaction (Holmberg & Blair, 2009).

Figure 9–8

Hillary and Julie Goodridge after getting married in Boston in 2004. Their lawsuit resulted in gay marriage becoming legal in Massachusetts.

Source: JIM BOURG/REUTERS/Alamy Stock Photo

9.8.1 Gay Marriage

In 2013, only 13 states recognized same-sex marriage and many others were attempting to ban it. In June 2015, the U.S. Supreme Court struck down attempts by states to ban same-sex marriage, making same-sex marriage legal across the country. Many other Western countries, including Canada, the Netherlands, Belgium, and Spain, had already legalized same-sex marriages. Being in a legal same-sex marriage helps gays' and lesbians' psychological well-being (Wight et al., 2013).

Attitudes about same-sex marriage remain diverse. Support has increased to 61% of Americans, up from 27% just two decades ago (Gallup, 2016b). Support is greatest among young people (over 75%). Of those who still oppose same-sex marriage, opposition is almost always on moral/religious grounds, with a typical response being "Because I don't believe God intended them to be that way" (Powell et al., 2015).

9.8.2 Gay Parenting

Should an openly gay or lesbian couple be allowed to raise a child? The 2000 U.S. census revealed that 250,000 children lived in households with same-sex parents (Doyle, 2005). Before we continue, read the following real-life story of Kerry and Val, a lesbian couple:

"Val and I have been together for 6 years. We have two children, a daughter, 5, Nicole, and a son, 2, Nicholas. We both wanted a family but

were a little afraid of the effects that our lifestyle would have on the children. We finally decided that in spite of our sexual orientation, we would still be loving, caring parents with much to offer our children.

"Next arose the problem of how to go about it. We ended up choosing a mutual friend of ours to father the children. Val took care of me while I was pregnant. We experienced all of the changes together: hearing the unborn baby's heartbeat, feeling it move, staying up with me when it was too uncomfortable to sleep. Val was with me all through labor and delivery.

"We both believe that a lot of love and a lot of time spent with our children is the key. We try to never be too busy to listen to them. We both are involved with Nicole's school (Val especially, she is a room parent for Nicole's class), friends, and activities. We also spend a lot of time involved in family activities such as going to the park or zoo, bike riding, camping, etc. We almost always include the kids in everything we do.

"Val and I believe that as far as the children are concerned, we will never lie or hide any information about our lifestyle or their pasts. Along with their everyday education, we will also include the information about our lifestyle as they are able to understand it. We are honest with everyone about our lifestyle. Our friends, families, and employers and coworkers all know we are gay. Once people really get to know us they realize that we are no different from anyone else."

(from the authors' files)

The topic of gays and lesbians as parents is viewed very negatively by many heterosexuals. Even some people who profess to be understanding and tolerant of homosexuality are opposed to gay and lesbian couples raising children:

"My feelings on homosexuals are the same as my feelings on heterosexuals. I have no problems with it. . . . I do have doubts about them having children."

"I think that homosexuality is the business of that person. Society should let them do their own thing. . . . I don't know if they should have children."

(All examples are from the authors' files.)

This negativity has been reflected in court custody cases as well. In a highly publicized case (*Bottoms v. Bottoms*), a Virginia judge denied a woman custody of her 2-year-old son because her lesbian relationship was "immoral" and illegal. If one wanted to, one could find cases where gay or lesbian couples were bad parents and their children suffered serious problems. However, the same is true of heterosexual couples. But overall, what does the scientific literature show? There is now an abundance of research that shows that children raised by openly homosexual parents are not different from children raised by heterosexual parents (e.g., see Bos & van Balen, 2008, and Patterson, 2009, for reviews). Their gender identities, gender roles, personal development, and psychological adjustment are the same as other children, and they grow up with a heterosexual orientation just as frequently as others. The most important thing for children's well-being is not the parents' sexual orientation but instead the positivity and well-being of the parents (Golombok et al., 2014).

The conclusion: "Research has indicated that lesbian, gay, and bisexual parents are as capable as heterosexual parents" (American Psychological Association, 2012, p. 18).

9.8.3 Media Portrayal of Homosexuals

The top male box office star in Hollywood in the 1950s was Rock Hudson, who was generally cast in leading romantic roles but who, in his personal life, was exclusively homosexual. But to admit that one was homosexual in those days was the kiss of death for one's career, so Hudson's studio arranged a marriage (on paper only) so he could keep his orientation secret. Montgomery Clift, another 1950s actor in many romantic roles, was also homosexual. Other leading actors of that day, including James Dean, were also known to have had sex with men, but they were always portrayed (on screen and off screen) as straight (Leland, 1995).

When Hollywood movies did portray a person as homosexual, he or she was almost always depicted or represented or characterized as a stereotype (e.g., 1996's *The Birdcage*). However, Hollywood and the arts have slowly begun to deal with the subject more honestly. For example, the 1993 movie *Philadelphia* starred Tom Hanks as an AIDS victim. Greater sexual and romantic content was portrayed in the 2005 movie *Brokeback Mountain* starring Heath Ledger and Jake Gyllenhaal. In 2000, Hilary Swank won an Academy Award for her role as a transgender man in *Boys Don't Cry*. The 2014 movie *The Imitation Game* told the story of Alan Turing, the British mathematician who built the first computer and broke the German enigma code in WWII but who was later treated badly because homosexuality was a crime in England.

Television has been slower to portray homosexuals in serious roles, but even that is changing. When actress Ellen DeGeneres' character declared her homosexuality on the April 30, 1997, episode of *Ellen*, the TV show became the first to be built around (and star) a lesbian. The show *Will & Grace* (1998–2006) helped to humanize homosexual characters, and today there are many TV shows that portray openly homosexual individuals in a matter-of-fact manner (without extreme stereotypes). These shows include *Modern Family* and *Grey's Anatomy*. Young gays and lesbians say that these positive role models helped them in their coming out process (Gomillion & Giuliano, 2011).

Figure 9–9

GIRL

VERLY

(upper left) Ellen DeGeneres starred in the first television show built around an openly homosexual individual; (upper right) Anderson Cooper is a well-known broadcast journalist; (bottom left) Tom Daley is a world champion diver and Olympic medalist; and (bottom right) Richard Grenell was the first openly homosexual spokesman for a U.S. presidential candidate.

Source: Jeff Vespa/Getty Images Entertainment/Getty Images; Hyperstar/Alamy Stock Photo; Jules annan/Alamy Stock Photo; ZUMA Press, Inc./Alamy Stock Photo

Can (Should) Sexual Orientation Be Changed?

1. 9.9 Discuss whether therapists should attempt to change sexual orientation.

Recall that in the not-too-distant past, homosexuality was viewed by the psychiatric profession as a form of psychopathology and that homosexuals could (or should) be "cured." Even during the era when sexual prejudice against homosexuals was much greater than today, when homosexuals were asked if they would choose to take a "magic heterosexual pill" to change their sexual orientation, only 14% of gays and 5% of lesbians said that they would do so (Bell & Weinberg, 1978). These results indicate that the large majority of homosexuals feel comfortable with their sexual orientation and do not wish to change.

For those individuals whose sexual orientation does cause them distress, should therapy be directed at changing their orientation or making them more comfortable with their orientation? Today, most attempts to change homosexuals' orientation are conducted by religious fundamentalist groups in what is called reparative therapy (see Beckstead, 2012). Some studies reported that these efforts had successfully converted homosexuals to a heterosexual orientation without causing psychological distress (Jones & Yarhouse, 2011; Karten & Wade, 2010). However, when you mix sexual behavior, religion, and politics, you can expect heated debate, and that is the case here. Some have claimed that gays and lesbians who seek reorientation do so not "voluntarily" (Murphy, 1992) but only because of family and societal pressure, discrimination, and prejudice (Allen & Oleson, 1999). Others claim that attempts to change sexual orientation result in psychological harm for many clients (Shidlo & Schroeder, 2002).

The controversy accelerated when the author of a study that had reported long-term meaningful sexual orientation change (Spitzer, 2003) later retracted his conclusion and apologized to the gay community (Spitzer, 2012). At about the same time, the president of one of the leading ministries involved in sexual orientation change efforts was quoted as saying that it was not successful 99.9% of the time (see Throckmorton, 2012). The American Psychological Association (2012) concluded that "reviews of the literature, spanning several decades, have consistently found that efforts to change sexual orientation were ineffective" (p. 14).

In 1994, the American Medical Association finally reversed a long-standing policy of recommending that psychiatrists make efforts to turn unhappy homosexuals into heterosexuals. The new policy states that most of the emotional problems of homosexuals are "due more to a sense of alienation in an unaccepting environment" and that "through psychotherapy, gay men and lesbians can become comfortable with their sexual orientation and understand the social responses to it" (AMA, 1994). Here is the current position of the American Psychological Association (2010):

> Is Sexual Orientation a Choice? No; human beings cannot choose to be either gay or straight. Can Therapy Change Sexual Orientation? No; even though most homosexuals live successful, happy lives, some homosexual or bisexual people may seek to change their sexual orientation through therapy, often coerced by family members or religious groups to try and do so. The reality is that homosexuality is not an illness. It does not require treatment. Gay, lesbian, and bisexual people may seek psychological help with the coming out process or for strategies to deal with prejudice, but most go into therapy for the same reasons and life issues that bring straight people to mental health professionals.

> "To be yourself in a world that is constantly trying to make you something else is the greatest accomplishment."

(Ralph Waldo Emerson)

Figure 9–10

Homosexuality is not just sexual attraction. It often includes companionship, affection, and love, often for a lifetime.

Source: Marcio Jose Sanchez/Pool/REUTERS/Alamy Stock Photo

Study Guide

Key Terms

- asexual
- bisexual
- coming out
- gay
- heterosexual
- homophobia
- homosexual
- lesbian
- LGBT
- LGBTQ
- pederasty
- sexual identity development
- sexual orientation
- sexual prejudice
- straight

Interactive Review

Answers can be found on p. 471.

1. In this chapter, sexual orientation is defined as (1) consistently made after adolescence in the presence of clear alternatives. Isolated instances of sexual behavior may or may not reflect one's sexual orientation. Recent surveys indicate that (2) % of the adult population self-identify as homosexual or bisexual, but a larger percent have had a same-sex sexual experience in their lifetime. A true bisexual would have a rating of (3) on Kinsey's 7-point rating scale.

   The (4) of the vast majority of homosexuals and bisexuals are just as strong and consistent with their anatomical sex as heterosexuals. Conformity or nonconformity with gender (5) does not always predict one's sexual orientation. Many homosexuals and bisexuals do not walk, talk, dress, or act any differently than anyone else.

   There are several major explanations for the origins of sexual orientation. Psychoanalytic explanations state that heterosexuality is the "normal" outcome and that homosexuality results from problems in resolving the (6) complex. However, later research does not generally support these claims. Homosexuals, as well as heterosexuals, have all kinds of parents, both good and bad, caring and cold. (7) regards homosexuality and heterosexuality as learned behaviors; good or rewarding experiences with individuals of one sex and/or bad experiences with individuals of the other sex (particularly during adolescence) would lead to a particular orientation. However, social and cultural studies show that environment alone cannot explain sexual orientation. In the (8) society in Melanesia, all boys engage in same-sex sexual behaviors for many years, yet the large majority grow up to have a heterosexual orientation.

   Recent studies suggest that biology plays a major role in the origin of sexual orientation. Studies with twins indicate a (9) factor, while anatomical studies have found differences in the (10) of heterosexuals and homosexuals. Many researchers believe that differences in (11) before or shortly after we are born predispose us to a particular sexual orientation. Nearly all agree that biological and social/cultural influences (12) to produce sexual orientation.

   Attitudes about homosexuality have varied considerably in Western culture. The (13) and (14) accepted homosexuality, as did the early Christians. It was not until Saint (15) that homosexuality came to be viewed as unnatural or "against the laws of nature" and not until the 1600s and 1700s that it was regarded as criminal. In the 1800s, the medical (psychiatric) model regarded homosexuality as an illness, and homosexual individuals were regarded as having pathological conditions in need of being "cured." In 1973 the American Psychiatric Association removed homosexuality as an official mental illness. Nevertheless, many people in the United States continue to have a harsh and negative attitude toward homosexuality.

   The process of (16) , or identifying oneself as homosexual, involves several often painful stages. The first stage is (17) . In the final stages, the individual attempts to gain the acceptance and understanding of friends, family, and coworkers. This is difficult in a

society filled with (18) , socially reinforced negative attitudes toward individuals, communities, and homosexual behaviors. Today, most metropolitan areas have well-established homosexual communities where individuals can openly associate.

The U.S. Supreme Court has now made same-sex marriage legal in all states. Many Americans oppose the idea of openly homosexual individuals raising children, yet research shows that children raised by homosexual parents are emotionally and mentally healthy, grow up to have normal gender identities and gender roles, and almost always have a heterosexual orientation. The official position of the American Psychological Association and the American Medical Association is that therapists (19) one's sexual orientation.

Self-Test

Answers can be found on p. 471.

A. True or False

- **T F** 20. In some cultures, same-sex sexual behavior is considered normal for boys during adolescence.
- **T F** 21. Homosexuals almost always act and/or dress differently from heterosexuals.
- **T F** 22. Bisexuals are people who are afraid to admit to themselves their real homosexuality.
- **T F** 23. Most homosexuals are unhappy with their sexual orientation and would like to become heterosexual.
- **T F** 24. A homosexual orientation indicates a gender identity problem.
- **T F** 25. A male homosexual can be made heterosexual by administering large doses of testosterone.
- **T F** 26. People who have had same-sex sexual experiences are, by definition, homosexual in orientation.
- **T F** 27. Women who have had same-sex sexual relations are more likely to be bisexual than homosexual.
- **T F** 28. Researchers have found a higher rate of concordance for homosexuality between identical twins than between nonidentical twins.
- **T F** 29. A bisexual is anyone who has had sex with both men and women.
- **T F** 30. Recent studies support Kinsey's findings that 10% of American men are homosexual.
- **T F** 31. The pathway to heterosexual sexual identity is smooth and uniform.
- **T F** 32. Many homosexuals and bisexuals have gender dysphoria.
- **T F** 33. Most lesbians have not had pleasurable sexual relations with men.
- **T F** 34. Extremely effeminate boys always develop a homosexual orientation.
- **T F** 35. If one identical twin is homosexual, the other twin always is too.
- **T F** 36. Studies have found that areas of the hypothalamus (in the brain) are different in male heterosexuals and homosexuals.
- **T F** 37. Children raised by openly homosexual parents are more likely to develop a homosexual orientation than children raised by heterosexual parents.

B. Matching

- 38. Henry has had a few same-sex sexual experiences but has had sex only with women since he turned 15 ten years ago.
- 39. Joyce has been married and enjoyed sexual relations with her husband but now prefers sexual relations with women.
- 40. Frank has had sex with both men and women.
- 41. Michael believes he is a woman and has sex only with men.
- 42. Carl sometimes enjoys sex with women but prefers sexual relations with men.
- 43. Tom is 12 years old, and his few sexual experiences have been exclusively with boys his age.
- 44. Alice enjoys sex with men most of the time, but she often enjoys sex with women as well.
- 45. Diane has had sex only with men but occasionally has homosexual fantasies.
- 46. Matthew occasionally goes to bathhouses and lets other men give him oral-genital sex.

- 47. Mary's gender identity is not consistent with her anatomical sex.
- 48. Steve is 19 years old, and his only sexual experiences have been with women, but all his sexual fantasies are about men.

1. probably heterosexual
2. probably homosexual
3. probably bisexual
4. probably transgender
5. not enough information to make a guess

C. Fill in the Blanks

- 49. In this book, sexual orientation is defined as distinct preferences consistently made after in the presence of clear alternatives.
- 50. Researchers believe that hormones may affect sexual orientation during which time of life?
- 51. According to this chapter, biological factors probably individuals to a particular sexual orientation.
- 52. The four stages of the coming-out process are (a) , (b) , (c) , and (d) .
- 53. Name four nonliving homosexuals who made significant contributions to humankind: (a) , (b) , (c) , and (d) .

Suggested Readings and Resources can be found on p. 462.

Chapter 10 Life-Span Sexual Development

> "The first debate I won was when, at 11, I persuaded a group of school friends that there was no truth in the exciting idea that penises could be put into girls to create babies. Their use as water pistols was accepted, but this new use had a strange attraction. The argument was decided when we realized that if it were true, our parents must have done this—which we all realized was inconceivable. After all, our parents were "old people."

—John M. Kellett, in *Psychological Perspectives on Human Sexuality*, pp. 355–379. L. T. Szuchman and F. Muscarella, Eds., 2000, John Wiley & Sons.

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 10.1 Explain infants' exploration of their bodies and their need for close physical comfort.
2. 10.2 Discuss genital exploration and sex play in young children.
3. 10.3 Summarize the changes that occur in boys' and girls' bodies at puberty and identify the hormones that are responsible.
4. 10.4 Discuss sexual behavior among adolescents.
5. 10.5 Explain how the sexual behavior of emerging adults often differs from that of younger and older age groups.
6. 10.6 Discuss the sexual lifestyles of adults, including marriage, cohabitation, and extramarital sex.
7. 10.7 Describe the sexual behavior of middle-aged individuals and the physical changes that come with aging.
8. 10.8 Explain the realities of aging that can directly affect sexuality in the elderly and discuss the prevalence of sexual relations among healthy elderly couples.
9. 10.9 Initiate talks with your own children about sex.

People are sexual beings. To deny our sexuality is to deny our humanity. It should come as no surprise, therefore, that our sexuality begins from the moment of birth and lasts until our death, even if we live a very long life.

Early Infancy (Ages 0–1)

1. 10.1 Explain infants' exploration of their bodies and their need for close physical comfort.

Ultrasound recordings have discovered that male fetuses have erections months before they are born (Calderone, 1983b). After birth, baby boys often have erections before the umbilical cord is cut. Similarly, baby girls can have vaginal lubrication in the first 24 hours after birth (Langfeldt, 1981).

An important part of emotional development involves the amount of hugging and cuddling that an infant has with its caregivers. Many physicians and psychologists strongly encourage parents to hold their babies soon after birth and to continue to give large amounts of hugging and cuddling throughout childhood. Monkeys raised in isolation and deprived of the opportunity of close physical comfort have difficulty forming relationships later (Harlow, 1959). The same seems to be true for children. Many years ago, a physician reported that 1 in 3 human infants in foundling homes died during the first year of life, even though they were well fed and provided with adequate medical care. What these babies were not receiving was cuddling and hugging—they apparently died from emotional neglect (Spitz, 1945, 1946).

As soon as infants gain sufficient control over their movements, they begin to touch all parts of their bodies. As part of this exploration, infants also touch their genitals. When this happens, infant boys and girls may continue to stimulate themselves. This happens because the nerve endings in the genitals are already developed at birth and transmit sensations of pleasure when stimulated. However, it is important to remember that infants do not comprehend adult sexual behavior. Their behavior is aimed at finding pleasurable physical sensations, not expressing sexual desire.

Although the initial genital self-stimulation of children may be random, once they discover its pleasurable component, such stimulation quickly becomes purposeful (Lidster & Horsburgh, 1994). Taking a child's hand away from his or her genitals may cause the child to make a face or noises (indicating irritation), and the child may quickly try to resume self-stimulation.

Early Childhood (Ages 2–6)

1. 10.2 Discuss genital exploration and sex play in young children.

Bodily exploration before the age of 2 is confined mainly to self-exploration (Figure 10–1). After the age of 2, however, children increasingly play together, and their natural curiosity now extends not only to their own bodies but to those of others. Studies have shown that sexualized behaviors increase dramatically in children after age 2, reach a peak period from 3 to 5, and then decrease until puberty (Elkovitch et al., 2009; Friedrich et al., 1991). Interest in the genitals is very common for boys and girls in this age group, as evidenced by undressing in front of others, sexual exploration games that involve showing one's body and genitals to others, trying to touch other children's genitals, and masturbation (see Elkovitch et al., 2009; Larsson & Svedin, 2002a; Ryan, 2000; Sandnabba et al., 2003). Let us examine some of the behaviors frequently observed in young children.

Figure 10–1

It is normal for young children to explore their own bodies.

Source: Laurence Mouton/PhotoAlto/Getty Images

As just mentioned, by the age of 2, children are very interested in their bodies. The fact that boys stand and girls sit while urinating is fascinating to children, and they will try to watch their siblings and parents bathing and urinating.

"When I was a very young girl, my parents brought me with them to visit some friends of theirs who had two young boys. One boy was my age and one was a couple of years older. I went to the bathroom with them and watched them urinate. My mother got very, very angry. This totally surprised, shocked, and confused me."

(from the authors' files)

Young children are interested in the physical differences between boys and girls and will play games that allow for sexual exploration, such as "playing doctor" and "playing house" (Sandnabba et al., 2003). Most of the time, these games are limited to viewing and touching genitals and are very normal behavior for this age (Elkovitch et al., 2009). (In 2011, a Wisconsin district attorney charged a 6-year-old boy with a felony for playing "doctor" with a 5-year-old girl.) More aggressive sexual behaviors like oral-genital contact and inserting objects into the vagina or anus are uncommon and may be an indication of sexual abuse (Elkovitch et al., 2009; Friedrich et al., 1991; Ryan, 2000). Sexual exploration games will not harm a child's development. What may be harmful is parents reacting too strongly when they "catch" their children engaging in sex play.

"I can still remember the day my mother caught me playing 'doctor' with my neighbor. I was 5 years old. She got so mad at me that she locked me up in the bathroom. I don't remember how long I was in there. I didn't understand what I had done wrong. I ended up crying myself to sleep on the bathroom floor."

"When I was 4, my cousin (age 5) and sister (age 3) had a slumber party. When we were all lying down we started asking questions and being curious. We then started 'playing doctor.' Well, my parents caught us and I was spanked and punished for a long time. I have very vivid memories of this event and now I do not have very positive feelings about sex or my sexuality."

(All examples are from the authors' files.)

Sexual exploration games are often played with playmates of the same sex (Larsson & Svedin, 2002b). This is probably more common than sexual contact between sexes because even at this age children usually play more with playmates of the same sex. Engaging in same-sex contact at this age does not mean that a child will become homosexual as an adult. Adult homosexuals may or may not have been involved in same-sex play in early childhood. The same is true of heterosexual adults.

Recall that Freud said the genitals were the focus of children's pleasure during the *phallic stage* (approximately ages 3 to 7) of psychosexual development (see Chapter 8). It is true that nearly all young children touch and explore their genitals, although young boys engage in genital touching more often than young girls (Friedrich et al., 1991; Sandnabba et al., 2003). Here, too, the way parents respond is very important.

"My sister has a 5-year-old little boy. . . . She was all worried that something was wrong with him. He would constantly play with his penis. She scolded him one day and told him that if little boys play with themselves like that it would fall off. . . . I am afraid that this could scar him for life."

"I remember distinctly how my initially unhealthy attitude towards my sexuality began. As a small child, I used to masturbate. My mother would hit the ceiling when she would catch me because my favorite time to do this was at nap time. She would yell and scream and slap my hands and tell me that it was nasty. Her contempt for my actions was so obvious that I could not help but develop a negative attitude towards my sexuality. I worried for a long time that I was the only person who did this and felt very guilty about it."

(All examples are from the authors' files.)

Most parents respond negatively to finding their young child exploring and touching his or her genitals (Gagnon, 1985). However, when you become a parent, try not to overreact. Allowing children to explore and satisfy their curiosity enables them to become comfortable with their bodies, both as a child and as an adult. Punishment or negative messages may lead to a poor body image and later sexual problems. It is okay to teach your children that it is not appropriate (as opposed to "bad") to touch their genitals in certain situations; in public, for example. According to one child expert, "The attitude of the parent should be to socialize for privacy rather than to punish or forbid" (Calderone, 1983a). If your child touches herself or himself at home, the best thing to do is ignore it. If you feel that you have to stop the behavior because it bothers you, do not scold; simply distract your child by getting her (or him) involved in another activity.

By now, you should understand that parents' responses to normal behaviors have very important consequences for children's later sexual development and their attitudes about their bodies. According to one group of researchers, "From the earliest period in life, the child's family will reciprocally influence the sexual characteristics of the child. The family establishes a 'psychosexual equilibrium' that is a function of the parents' sexual adjustment, the child's developing sexuality, and the impact of the child's sexual development on parental sexual development" (Friedrich et al., 1991). The way parents react to the sexuality of their children is often an indication of the way they feel about their own sexuality.

Figure 10–2

Children will attempt to satisfy their natural curiosity about the human body whenever they get a chance.

Source: Anne Heaton-Ward/Moment Open/Getty Images

Personal Reflections

Does the thought of young children examining and touching their own genitals make you uncomfortable? If so, why? How would you feel if you found your 5-year-old boy with his pants down playing "doctor"? Why? Would your reaction be any different if you found your 5-year-old girl with her pants down playing "doctor"? Why?

The Initial School-Age Years (Ages 7–11)

Freud believed that this time of life was a period of "latency," when children were not concerned with sexuality. Studies have found that American children in fact do engage in less overt sexual behavior at this time (Elkovitch et al., 2009; Friedrich et al., 1991), and most parents and teachers believe that sexual interest at this age is unusual or a problem (Ryan, 2000). By the time they begin kindergarten or first grade, children generally have developed a sense of modesty and inhibition about undressing in front of others and for the first time may start demanding privacy in the bathroom (Sandnabba et al., 2003).

Some researchers believe that the amount of sex play by American children does not slow down at this stage but is simply hidden more from parents. Several studies of recollections by adults found that the large majority of adults recalled sexual interactions with other children prior to puberty (see Larsson & Svedin, 2002b; Ryan, 2000). This included exposing oneself for others, looking at others, touching, and various sexual games. A majority could even recall being aroused. Activities involving any kind of penetration are still uncommon at this age and may be an indicator of sexual abuse (Elkovitch et al., 2009).

Children tend to segregate by sex by age 9. Thus, again, much of their sexual play is with same-sex children. Because almost all parents react negatively when they catch their children engaging in sexual exploration games, it is not surprising that sexual activity becomes less overt. Most adults remember feeling "guilty," "curious," or "confused" during their childhood experiences (Ryan, 2000). Girls are often treated more harshly than boys. This establishes a double standard—as a general rule, boys are allowed more freedom to explore their sexuality than girls.

Although the amount of overtly sexual play may decrease during the initial school-age years, curiosity about sex does not, and children will ask their parents questions such as "Where do babies come from?" Again, how parents respond will affect their children's responses (and willingness to ask questions of their parents about sex) in the future. Unfortunately, many parents are evasive or even negative (Ryan, 2000).

"My mother damaged my attitude about sexuality by responding to my question about the origins of babies by telling me that when a man and a woman kiss, it's called making love and this is where babies come from. Even today, she still refuses to discuss sex or sexuality."

(from the authors' files)

In summary, contrary to our culture's expectations, there is an abundance of evidence that sexuality develops steadily throughout childhood. One researcher concluded that we live in "a culture at odds with the bulk of evolutionary, developmental, and cross-cultural evidence demonstrating that children are sexual beings, whose exploration of sexual knowledge and play, is an integral part of their development as fully functioning human beings" (Frayser, 1994, p. 210).

Puberty (Ages 7–15)

1. 10.3 Summarize the changes that occur in boys' and girls' bodies at puberty and identify the hormones that are responsible.

Puberty (from the Latin *puber*, meaning "of ripe age, adult") is the time of life when we become capable of reproduction and first show sexual attraction. It does not happen overnight but instead is a *process lasting several years*.

Puberty is at least a two-part maturational process (Grumbach, 2002). In the first part, the adrenal glands start to mature (called *adrenarche*) when children are between the ages of 6 and 8. The adrenal glands secrete the androgen hormone DHEA (dehydroepiandrosterone), which is then converted to testosterone and estrogen. Notice that at this stage girls as well as boys experience an increase in androgens ("male" hormones).

In the second stage, the testicles and ovaries mature (called *gonadarche*), usually several years after adrenarche. In this stage, the pituitary gland begins to secrete FSH in high doses, stimulating the production of sperm in seminiferous tubules in boys and the maturation of ova in girls (see Chapter 3). Prior to this time, boys do not ejaculate (although they can have orgasms) and girls do not have menstrual cycles (although they, too, can have orgasms) (Janssen, 2007). In girls, the maturing ovary produces estrogen and progesterone, while increased levels of luteinizing hormone from a boy's pituitary stimulates production of testosterone in the testicles. The increased levels of hormones lead to a variety of body changes in girls and boys called secondary sex characteristics (e.g., breast development, facial hair). The changes in physical appearance create psychological changes in the way children think about themselves and others. Let us examine these changes in more detail and discuss how they affect adolescents' behavior.

10.3.1 Changes in Girls

Usually, the first sign that puberty is beginning in girls is the development of breast buds (at an average age of about 10 years (Biro et al., 2010). Soon afterward, a growth spurt starts (at about the age of 12). Many sixth- and seventh-grade boys suddenly realize one day that a lot of the girls in their classroom are taller than they are (a fact they may not discover until those first school dances). The reason for this is that the growth spurt in boys does not start, on average, until about age 14. Most of the boys eventually catch up with and pass the girls because girls generally stop growing by age 16 and boys keep growing until about 18, but those first couple of years can be awkward.

The development of breasts in girls during puberty (a result of increased levels of estrogen) is viewed with great attention by both girls and boys. Not all girls develop at the same rate, so insecurities may develop early. Some decide to speed things up on their own, as 11-year-old Margaret did in Judy Blume's novel *Are You There God? It's Me, Margaret:*

> I tiptoed back to my room and closed the door. I stepped into my closet and stood in one corner. I shoved three cotton balls into each side of my bra. Well, so what if it was cheating! Probably other girls did it too. I'd look a lot better, wouldn't I? So why not!
>
> I came out of the closet and got back up on my chair. This time when I turned sideways I looked like I'd grown. I liked it!

(

BLUME, J. (1970). Are you there, God? It's me, Margaret. Englewood Cliffs, NJ: Bradbury Press.)

Adolescent girls with either little or considerable breast development are more likely than others to have lower self-esteem (Yuan, 2012). The increase in estrogen levels also causes an increase in fatty deposits in the hips and buttocks.

Pubic hair generally starts to appear shortly after breast development begins, followed in a couple of years by the appearance of underarm hair (see Biro & Dorn, 2005; Biro et al., 2010; Susman et al., 2010). The growth of hair on new parts of the body results from increased levels of "male" hormones (mainly from the adrenal gland). These hormones also cause the sweat glands and sebaceous glands to develop, so that body odor and acne often become new sources of concern.

The first menstrual period (called menarche) occurs at an average age of between 12 and 13 (Brooks-Gunn & Paikoff, 1997; Herman-Giddens et al., 1997); 80% of girls start menstruating between 11 and 13.7 years of age (Chumlea et al., 2003). There is considerable variability, however, and it is normal for the cycles to be very irregular during the first few years after menarche. The rise in estrogen levels causes the vaginal walls to become thicker and more elastic and also results in lubrication during sexual arousal.

The average age for menarche has been dropping over the past few centuries (Lehmann et al., 2010). A study of New York City girls in 1934 found that the average age was 13.5 years, while the average age in Western Europe in the early 1800s was at least 14.5 years (Bullough, 1981). Recent studies have shown that the first stage of puberty in girls (breast development) has continued to occur earlier just in the past few decades (Biro et al., 2010). The reason for the decline in the past couple of centuries is believed to be better nutrition resulting in an earlier acquisition of some minimally required amount of body fat (the putative signal that tells the brain to start releasing FSH) (Currie et al., 2012; Lehmann et al., 2010). Girls who are overweight generally begin puberty earlier than those who are not (Rosenfield et al., 2009). In the past 50 years in the United States, early menarche has most commonly been seen in girls from low socioeconomic position, again probably due to poor (e.g., high-fat) diet (Krieger et al., 2015).

The reaction of a young woman to her first menstrual cycle will be influenced primarily by what she has been told. Menarche can be viewed as something very positive (a sign of "becoming a woman"), "a simple fact of nature," or "a curse" and something disgusting. Mothers generally pass on their own attitudes and beliefs about it (Uskul, 2004).

"My mother told me that menstruation was a 'nasty' experience. As a result, I always did my utmost to totally hide the fact that I was menstruating.

I didn't even want other women to know that I was having my period. I would refuse to purchase sanitary products out of the machines in restrooms if anyone else was in the restroom."

"Then, when my big moment came, instead of treating me as though something natural and exciting were happening, my mother reacted with embarrassment. I was very hurt when she told me to get my sister to show me how to wear a sanitary napkin. We never again talked about any of these things."

"My mother told me when I was very young that I would have a period around age 13 or so. . . . Finally, one month before my 15th birthday, I started my period. I remember being so excited 'it' finally came. I called my mom in the bathroom and told her. Well, she was so excited she started calling my grandmothers and her friends. When my dad came home he got all excited too. They were so proud I'd finally 'become a woman.'"

(All examples are from the authors' files.)

Which of these girls do you suppose began adolescence with good self-esteem about her body? Fortunately, today, more girls are viewing menarche as a positive experience than in past generations (e.g., Lee, 2009).

10.3.2 Changes in Boys

As mentioned earlier, pubertal development in boys lags about 2 years behind development in girls. The first noticeable change in boys is usually growth of the testicles and scrotum, the result of increased levels of testosterone (see Biro & Dorn, 2005; Susman et al., 2010). Testosterone then stimulates growth of the penis, prostate gland, and seminal vesicles. The growth of the genitals begins, on average, about the age of 11 to 12 and is completed, on average, by about the age of 15. Boys generally become capable of ejaculation about a year after the penis begins to grow.

When we sleep, about every 90 minutes we enter a phase called REM sleep. REM stands for "rapid eye movements" (our eyes move around under the eyelids during this phase). Many physiological events normally occur during this stage of sleep, including penile erection and vaginal lubrication. As a result of the erect penis during REM, the first experience many boys have with ejaculation is a nocturnal emission, or "wet dream" (and about 40% of girls also experience nocturnal orgasms). Some boys have nocturnal emissions frequently, while others have only a few experiences. Fewer fathers prepare their sons for nocturnal emissions than mothers prepare girls for menstruation, and as a result many boys are ashamed of or even frightened by these experiences.

"When I was 13 years old, I had a 'wet dream' for the first time. I was shocked to later find out that I did not have a disease. I honestly thought I had one."

"I was 15 years old, and one morning I woke up finding my sheets wet. I thought I urinated in bed at first until I realized it wasn't urine. I was ashamed and didn't want anyone to know what happened. I quickly changed my sheets."

(from the authors' files)

Recall from Chapter 1 that as boys, both Henry Havelock Ellis and Alfred Kinsey thought that their nocturnal emissions would lead to insanity and an early death. Because nocturnal emissions are not under voluntary control, there is no reason for shame. It is normal! It is therefore important to educate boys about nocturnal emissions before they begin to occur.

Many boys may also be initially frightened by the emission of a strange fluid from the penis that now occurs during masturbation. A case cited by sex therapist Bernie Zilbergeld (1978) is probably not unusual:

> "I kept stroking, my penis got hard, and the sensations felt better and better. Then I was overcome with feelings I had never before felt and, God help me, white stuff came spurting out the end of my cock. I wasn't sure if I had sprung a leak or what. I was afraid but calmed down when I thought that since it wasn't red it couldn't be blood. I kept on stroking and it hurt. I didn't know if the hurt was connected with the white stuff (had I really injured myself?) or if the event was over and my penis needed a rest. But I decided to stop for the moment. Of course, I returned the next day and did it again."

Many boys also develop temporarily enlarged breasts during puberty, called gynecomastia. This results from increased levels of fat due to rising estrogen levels (Barros & Sampaio, 2012). Gynecomastia usually disappears by the mid-teens, but unless boys are told why this is happening and that it is a normal, temporary condition, they may feel confused, embarrassed, or ashamed.

"When I was about 13 years old something started to happen to my chest. It seemed as though I was beginning to grow breasts. I went to my mother and showed her so she brought me to the doctor. I was a wrestler in middle school and all I could think about was how could I avoid taking off my shirt in public for one to two years."

(from the authors' files)

Pubic hair is the result of increasing testosterone levels and starts to grow after the genitals start to develop (Susman et al., 2010), but underarm and facial hair generally do not appear for another 2 years. The amount of body hair, however, is also determined by heredity. As with girls, these signs of puberty are starting at an earlier age (an average of 10.14 years)—a full year earlier than just a few decades ago (Herman-Giddens et al., 2012). Testosterone also causes development of the sebaceous and sweat glands with their accompanying problems (acne, body odor).

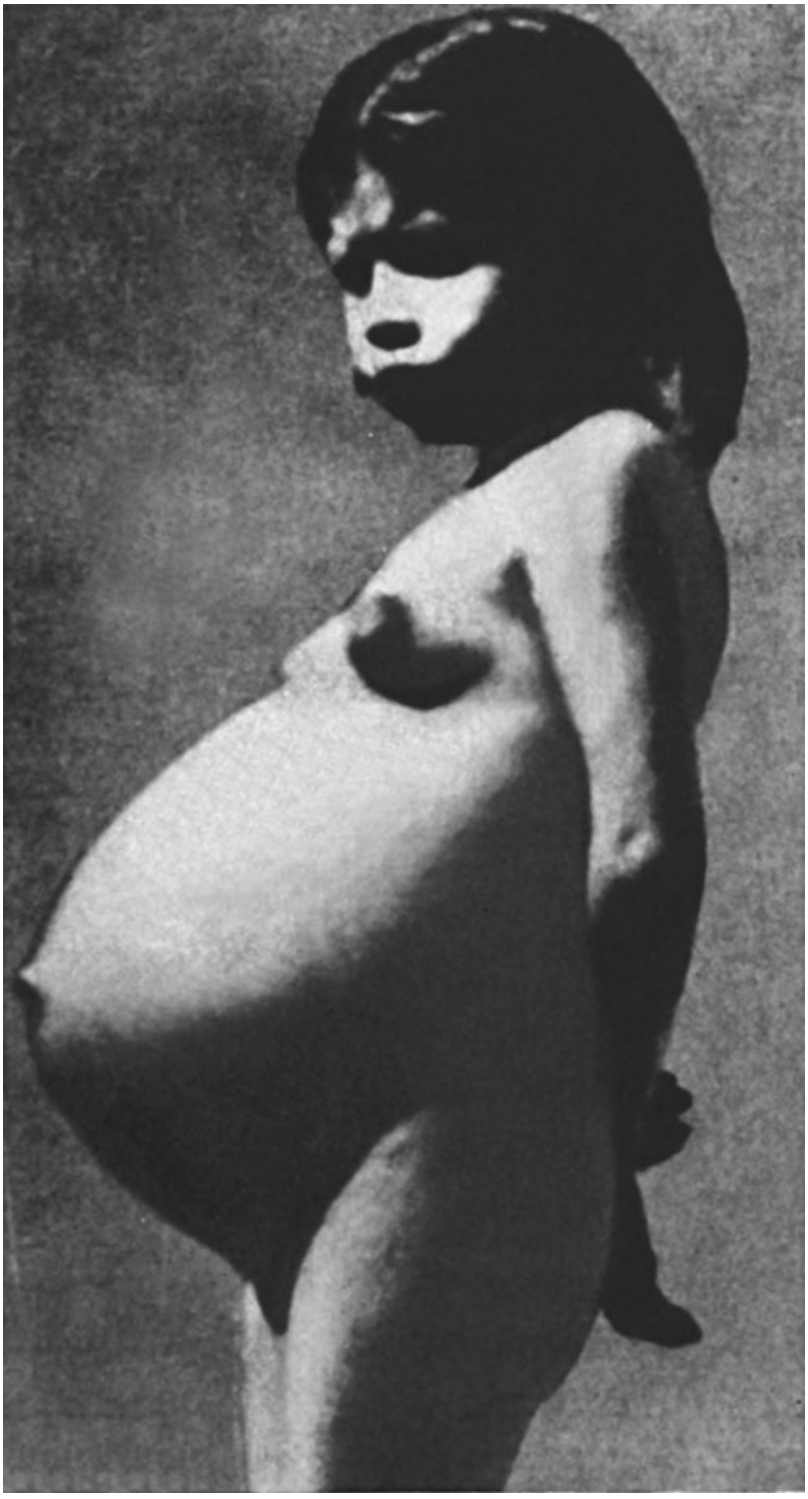
The appearance of facial hair is often as important to boys as the development of breasts is to young girls, for it is one of the few outward signs that

they are becoming men. Another change that is obvious to others is a deepening of the voice, a result of testosterone stimulating the growth of the larynx (voice box). This occurs today at an average age of about 12 to 13, but it may have occurred at a later age in past centuries. It was not uncommon in Europe at one time for boys who sang in the great church choirs to be castrated before puberty (with parental approval) in order to preserve their soprano voices. (If castration is done after puberty, by the way, it does not substantially raise a male's voice because the larynx has already undergone its change.)

10.3.3 Precocious and Delayed Puberty

Although the changes that occur during puberty generally begin about the age of 10 or 11, they have been known to occur much earlier. When secondary sex characteristics appear before the age of 8 in girls and 9 in boys, it is called precocious puberty (Cesario & Hughes, 2007). This is due to premature activation of adrenal or pituitary hormones and is 10 times more common in girls than in boys. The youngest girl known to have given birth was only 5 years old: a Peruvian Indian girl who delivered a baby by cesarean section in 1939 (Figure 10–3). This means, of course, that she was ovulating and having menstrual periods by the age of 4 or 5.

Figure 10–3



An example of precocious puberty. Lina Medina gave birth when she was 5½ years old.

Source: The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence, Lawson Wilkins, Fig 6 on page 253/Charles C. Thomas Publishers

There have been isolated outbreaks around the world of very young children developing breasts. This has happened to boys and girls as young as 6 months old. A study of thousands of children found that nearly half of the black girls and 15% of the white girls studied had begun to develop breasts, pubic hair, or both by age 8 (Herman-Giddens et al., 1997). A more recent study found that 15% of girls had breast development by age 7 (Biro et al., 2010). First menstruation still occurred after they had turned 12. It is speculated that the early development of secondary sex characteristics is due to early weight gain, hormones in meat and milk, or what are called environmental estrogens, chemical pollutants that resemble the female hormone estrogen (Cesario & Hughes, 2007).

In some children, the appearance of secondary sex characteristics and physical growth do not begin at the same age as in most children. This is called delayed puberty (Kaplowitz, 2010). Most clinical referrals are boys who have failed to grow (Maggi & Buvat, 2013). The usual treatment is to administer gonadotropin-releasing hormone or testosterone.

There is growing evidence that early and longer-duration puberty often leads to poor behavioral (especially sexual) and psychosocial outcomes, particularly in girls. Similar results are found for late-onset puberty in boys (Baams et al., 2015; Graber, 2013).

Personal Reflections

Try to recall the feelings you experienced during puberty as your body changed. Would better understanding of these events (via parents or sexuality education classes) have made it a more positive experience?

10.3.4 Sexual Behavior

Major changes are also occurring in the brain. These changes occur in many mammalian species and happen in areas of the brain that make it more likely that adolescents will engage in risk-taking behaviors (Spear, 2000). This could have evolutionary value by resulting in adolescents exploring new territories and moving toward independence. Sexual behavior is certainly a part of this.

Several studies have found that children's first sexual attraction occurs at age 10, about the fourth or fifth grade (Herdt & McClintock, 2000; Pattatucci & Hamer, 1995). Children of this age may have no understanding yet of sex, but they find themselves attracted to boys or girls. This occurs well before gonadarche and is true for both heterosexual and homosexual attraction. It coincides with rising androgen levels due to the maturation of the adrenal glands (Herdt & McClintock, 2000). This is further evidence that Freud's conception of a latency period between the ages of 6 and 11 is incorrect.

In the developmental process, sexual attraction is followed in order by sexual fantasy and sexual behavior. At age 11, about 25% of boys and girls have held hands and about 16% have kissed. At age 12, the numbers are 41% and 33%, respectively (Waylen et al., 2010). About 25% of adults recall "thinking a lot about sex" at age 11–12 (Larsson & Svedin, 2002). Nearly half of 11- to 12-year-old boys masturbate (but nearly no girls) (Arnal & Llario, 2006). By age 13, the sexual exploration games commonly played by young teens (such as "spin the bottle" and "post office") have a greater erotic content than the games of early childhood. However, only about 1% of 10- to 12-year-old children have actually engaged in sexual intercourse (Finer & Philbin, 2013).

Adolescence (Ages 13–17)

1. 10.4 Discuss sexual behavior among adolescents.

Adolescence (from the Latin *adolescens*) refers to the time of life between puberty and adulthood. The term was first used in the English academic literature in 1904 by psychologist G. Stanley Hall. In many nonindustrial cultures individuals are considered to be adults when they reach puberty. In our culture, adolescence is a transition period before adulthood, and a rather extended one at that.

For most adolescent boys and girls, the most important issue in their lives is self-identity (Erikson, 1968). Because of their rapidly changing bodies, the search for self-identity first focuses on body image and physical characteristics. "An important aspect of the developmental experiences of adolescents is the formation of a sexual identity and sense of self as a sexual being" (Graber & Brooks-Gunn, 2002).

Figure 10–4

Early adolescence is a time of great curiosity about sex. Most boys, and many girls, have begun masturbating by age 15.

Source: John Powell Photographer/Alamy Stock Photo

An adolescent's self-esteem is generally based on his or her subjective views of physical attractiveness. This is also true of teens' sexual esteem (Wiederman & Hurst, 1998). Broad-based self-esteem derived from one's accomplishments develops later. Thus, in the adolescent world there is usually a strong relationship between one's body image and one's overall quality of life (McCabe & Cummins, 1998). This may be especially true of girls, as men greatly prefer partners who are physically attractive (Regan & Berscheid, 1997). Unfortunately, many boys come to view girls as sexual objects rather than as persons. An American Psychological Association Task Force (2007) concluded that the sexualization of girls in the United States was pervasive and that this often had a negative effect on their cognitive functioning and mental health.

10.4.1 Masturbation

For many adolescents, the first experience with orgasm occurs during masturbation. The 2010 National Survey of Sexual Health and Behavior (NSSHB) found that for teens aged 15, 72.7% of boys and 43.3% of girls had masturbated (Fortenberry et al., 2010). Another study found that three fourths of adult men and women recollected having masturbated by age 18, and for most of them it was sporadic or continuous throughout adolescence (Ryan, 2000). Although many teens masturbate, nearly half feel that it is "harmful," "sinful," or "wrong" and feel guilty about it (Laumann et al., 1994; Ryan, 2000).

There are few programs attempting to communicate anything positive about masturbation. One researcher advised that parents should at least stop attaching guilt to the practice of masturbation in their children. If nothing else, it is surely the "safest" sexual outlet available (Gagnon, 1977).

10.4.2 Pattern(s) of Sexual Initiation

Many sex researchers today define petting as non-coital sexual contact below the waist. Any other physical contact is called necking. Sexual activity in early adolescence is usually necking but has progressed to petting by mid-adolescence (Graber & Brooks-Gunn, 2002).

Because of their lack of sexuality education, many teenage girls and boys are confused when girls first experience vaginal lubrication:

"When I first began to feel lubrication I was initially confused. I had no idea that I was supposed to get so slippery and dirty feeling and it almost freaked me out."

"The first time I felt wetness from lubrication I thought I had just peed on myself."

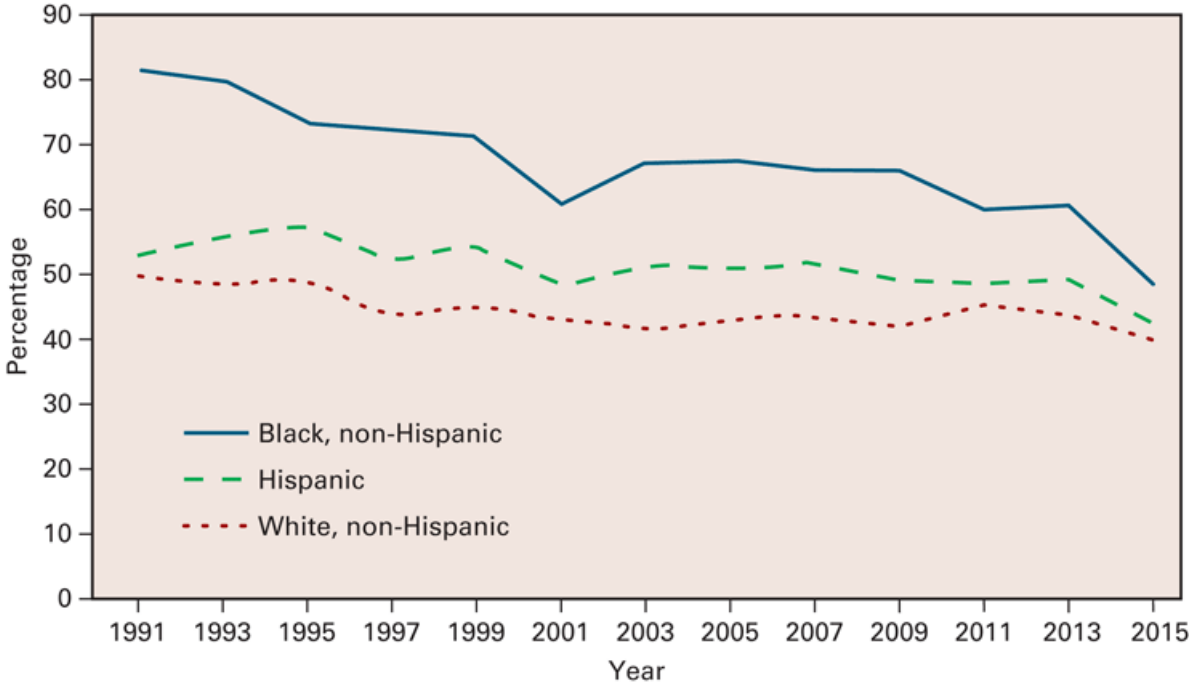
"I thought when I was first lubricating vaginally that my period started early. Once I realized it was a clear liquid I was kind of confused and disgusted. I would always feel embarrassed and it was hard for me to relax during any kind of sexual activity."

"When I first experienced my partner was wet, I thought what is going on here? Is this urine or something else? I then thought it was cum, but when I saw it was clear I didn't know what it was." (man)

(All examples are from the authors' files.)

There is no single pattern of initiation into partnered sexual behavior (Halpern & Haydon, 2012; Haydon et al., 2012). About half of teens have vaginal intercourse first, followed a year or more later by oral-genital sex, while almost one third initiate vaginal intercourse and oral-genital sex within the same year and, in fact, about one fourth have oral-genital sex before intercourse (Centers for Disease Control and Prevention, 2012d). There is little or no difference between boys and girls (Petersen & Hyde, 2011), i.e., cunnilingus is about as common as fellatio (Bay-Cheng & Fava, 2011). Many teens believe that oral sex is more acceptable and less risky.

Figure 10–5



Percentage of high school students who have engaged in sexual intercourse (from Eaton et al., 2010, 2012; Gavin et al., 2009; Kann et al., 2014, 2016).

Sources: Based on Gavin et al., 2009. Eaton, D. K., et al. 2012.

Figure 10–5 Full Alternative Text

The average age at which teens first have sexual intercourse has been dropping and is now about 16.1–16.2 (Liu et al., 2015). There is only a small difference between boys and girls (Petersen & Hyde, 2011). About 41.2% of American high school students have engaged in sexual intercourse, 3.9% before the age of 13 (Kann et al., 2016). Overall, the percentages are higher for black students than for Hispanic or white students. Over 58% of high school seniors have had sexual intercourse (Kann et al., 2016), and by age 19, over 75% of Americans have engaged in premarital sex (Liu et al., 2015). At least 5% to 6% of 17-year-olds have engaged in anal intercourse (Fortenberry et al., 2010). One study reported 10% (Halpern & Haydon, 2012). Over 11.5% of high school students have had four or more sexual partners, including 22.4% of twelfth-grade students (Kann et al., 2016).

The preceding statistics may have given you a false impression of how sexually active American teens really are. Surveys show that the number of sexually active teens decreased during the 1990s and continued to decrease through 2015 (Kann et al., 2016). The 2010 NSSHB study found that at any one point in time, only about 27% of 17-year-olds are having partnered sexual relations (Fortenberry et al., 2010). About 20% of 18-year-olds have not yet engaged in either vaginal intercourse or oral-genital sex (Halpern & Haydon, 2012). On the other hand, individuals who initiate sexual intercourse early in life are more likely than others to have had multiple lifetime and concurrent sexual partners (Haderxhanaj et al., 2014; Heywood et al., 2015).

Most teenagers are ambivalent about engaging in sex (Pinquart, 2010). They must weigh the positives and negatives of several, often conflicting, factors—e.g., relationships, sexual scripts, and beliefs about gender roles. They give multiple reasons for engaging in sex. Besides sexual pleasure, these include a desire for intimacy and an increase in social status (Ott et al., 2006). For many teenage girls, love and a committed relationship that is supposed to last are important before engaging in sex. Many girls view the loss of virginity as a.pngt to their partner (Frieze, 2005). These things are not as important for most teenage boys, and many view their virginity as a stigma and have negative feelings about it (Sprecher & Treger, 2015).

How do teenagers feel about their first experiences of sexual intercourse? Weis (1983) found that women experience a range of emotions during their first sexual intercourse. About one third have strongly negative emotional reactions (e.g., guilt, anxiety, shame, fear, regret), while another third have highly positive emotional experiences. For the final third, their experience is neither positive nor negative but an "Is that all there is?" response (e.g., disappointment, boredom). Men generally have more pleasure and less guilt than women during first intercourse (Higgins et al., 2010). For women, being in a committed relationship increases the likelihood that first intercourse will be a positive experience (Higgins et al., 2010; Reissing et al., 2012).

Another study found that about one third of the women surveyed suffered physical pain at first intercourse, while 28% said they had experienced no pain (Weis, 1985). Women with positive experiences and minimal pain generally had an extensive childhood and adolescent history of sex play (kissing, petting, masturbation, and often oral sex), had positive attitudes about their sex play, and had their first intercourse in a safe environment (no fear of discovery) with a caring partner. Those who had negative reactions and pain had little previous experience with sex play, had not planned it, and "gave in" to the man's pressure.

Most teens have experienced sexual regret and wish they had waited until they were older to start having intercourse (Martino et al., 2009; Oswalt et al., 2005). Women who have feelings of guilt after first intercourse are more likely than others to be sexually dissatisfied (e.g., have less enjoyment) as adults (Moore & Davidson, 1997). In contrast, individuals who had positive feelings about their early sexual experiences have greater enjoyment of sex as adults (Smith & Shaffer, 2013).

What differentiates teens who choose not to engage in premarital intercourse from others? Many teens who postpone sexual intercourse do so because they want to wait until marriage (Forste & Haas, 2002). The more religious a teen is, the more likely that he or she will postpone engaging in intercourse (Sprecher & Treger, 2015). Parental involvement also plays an important role (Browning et al., 2005; Parkes et al., 2011). The quality of the communication between parents and teenage children is positively related to the teenagers' values about sexual abstinence (see Addendum at the end of the chapter).

Personal Reflections

What would you tell a young teenager about sex? Why? Pretend you have an adolescent child who has just told you he or she is considering having sexual intercourse. What is your reaction? Does your answer change depending on the sex of the child? Why?

10.4.3 Peer Pressure

Although many teens engage in sex because they have positive feelings about it, many others who are sexually active are motivated by a desire for acceptance and social status (Ott et al., 2006). For most teens there is enormous peer pressure to engage in sex (Gillmore et al., 2002). What is peer pressure? It is your peer group's expectations of how you are supposed to behave. The more friends a teen has who are sexually experienced, the more likely it is that he or she will engage in sexual intercourse (Coley et al., 2013). As stated by one researcher, "Peer influence seems to be a major risk factor for mental health problems among early-maturing kids. 'If you're hanging around peers [who are] engaging in risky behaviors, you're more likely to engage in the same kinds of behaviors'" (Weir and Carter, quoted by Weir, 2016).

Figure 10–6

The biological changes that occur in adolescence lead to an interest in and the development of sexual behavior and sexual identity. Many teens engage in sex because of peer pressure.

Source: Exactostock/SuperStock

Most young people overestimate how many of their peers are actually having sex (Whitley, 1998). About one third of teenage boys have lied about "how far they have gone" (Jayson, 2010). What about those young men who do not wish to become sexually active yet?

"You were right about the fact that there is great pressure to engage in sex. I didn't have sex until I got married at the age of 22. My friends thought it was dumb for me to want to wait so I lied to them and told them that I had sex and made up a bunch of lies about it. I realize now it was dumb of me. If they were really my friends they would have understood my decision to wait."

"I am a 19-year-old sophomore and I have not yet had sexual relations. I made a promise to myself long ago that I would not have sex until I am married. I made this promise because of my own moral convictions and I am content with it. I have been the target of a great deal of laughter and ridicule because of this decision."

(All examples are from the authors' files.)

Many teenage girls also feel pressured to engage in sex:

"I had sex at 17 in my senior year. . . . So many of my girlfriends would talk about doing it with and for their boyfriends, and would ask me about my experience. I was so ashamed for never having done anything throughout my entire life. . . ."

"My first sexual experience was when I was 15. Everyone else was 'doing it' so I figured I should too. When it was over I cried. I wish I would have waited. Maybe not till I was married, but until I was more mature."

"I had my first sexual relationships at 14. . . . I realize now that my reason for these relationships was to be accepted, wanted, have a boyfriend and pleasing him to keep him."

(All examples are from the authors' files.)

For many girls, the need for emotional intimacy is an important part of finding their self-identity. Unfortunately, many mistake sexual intimacy for emotional intimacy. In many peer groups there is a double standard that also results in a negative sexual experience for many girls.

"I would let some of the guys from school touch my breasts because of the attention I got from them. I only got a bad reputation instead."

"Please talk about labeling women. When I was 15, I had some experiences with some older guys around 17. Well, I did some things that I regret. Word got around at my all-girl Catholic high school that I was a slut. You don't know what it is like to walk down a hall and have girls call you a slut. Guys wanted to go out with me for just one thing."

(All examples are from the authors' files.)

Personal Reflections

What kinds of pressure to engage in sex have you experienced (from dates, friends, the media, etc.)? Have you ever engaged in sex because of pressure (to please a boyfriend or girlfriend, to feel older, to be "like everyone else," etc.)? How have you dealt with the pressure? How could you deal better with the pressure?

Emerging Adulthood (Ages 18–25)

1. 10.5 Explain how the sexual behavior of emerging adults often differs from that of younger and older age groups.

The average age at marriage has increased dramatically in recent decades. The median age at which people first get married today is almost 26 for women and almost 28 for men (U.S. Census Bureau, 2008). This is an increase of more than 2 years of age since 1980 and more than 4 years since 1960. As a result, psychologist Jeffrey Arnett (2000) proposed that a new developmental stage of life has emerged in today's society —emerging adulthood. This is an extended period of being a single adult that occurs between adolescence and young adulthood. Both parents and their 18- to 25-year-old children agree that at this age people are not yet "grown up" adults (Nelson et al., 2007).

Emerging adults have more freedom from parental restraints and more opportunity for privacy than in the past. This age period generally includes frequent change as individuals explore their own identities in love, work, and worldviews. There is often an increase in risk behavior as well. This developmental stage is not found in all cultures but is common in advanced cultures where young people are allowed an extended period of independence and role exploration.

Young people today have a much more permissive attitude about premarital sex than did past generations (Elias et al., 2015; Twenge et al., 2015). At the age of 20, over 75% of emerging adults are sexually experienced and having sex regularly. For young adults, the number of sexual partners steadily increases the longer the individual has been sexually experienced, with close to one third having had multiple partners at age 20 (Liu et al., 2015; Vasilenko & Lanza, 2014). Nationally representative surveys have found that among unmarried persons aged 18 to 26, about 80% of the men and women had engaged in both vaginal intercourse and oral-genital sex, and at least 25% have engaged in anal sex (Herbenick et al., 2010c; Kaestle & Halpern, 2007).

Figure 10–7

Emerging adulthood is an extended period of being a single adult. The large majority of emerging adults are sexually experienced and have sex regularly.

Source: Marco Scisetti/Fotolia

Several sexual patterns are found during this age period. For some young adults, this is a period of sexual experimentation:

"This past year I have become very sexually active. I have a steady boyfriend. We love one another to death, but are involved in threesomes and sometimes foursomes. We enjoy sex and have tried everything imaginable. The persons involved in our 'parties' are his roommates. We consider ourselves 'one big happy family.'"

(from the authors' files)

Some young people engage in "sexting"—sharing sexual photos of themselves online or by text messaging. Only about 7% of teens younger than 18 have done this (Ybarra & Mitchell, 2014), but many more emerging adults have sent photos of themselves to others (Gordon-Messer et al., 2013). Teenage girls and young women are more likely to do this than teenage boys or young men.

An increasingly popular sexual lifestyle in recent years is hooking up—non-relationship sex without any commitment (Garcia et al., 2013). A closely related behavior, called *friends with benefits*, refers to sex with a friend without romantic commitment (Mongeau et al., 2013). Some studies have found that about two thirds of emerging adults have had sex with someone they were not dating (see Garcia et al., 2013), but others find that it is no more common today than in the 1980s and 1990s (Monto & Carey, 2014). One thing that is certain is that the number of people who report casual sex partners increases with age from adolescence to emerging adulthood (Lyons et al., 2015). It is more prevalent among people with less education.

The reason most emerging adults engage in this type of sexual relationship is to avoid romantic commitment (Bisson & Levine 2009). However, drinking is often a factor in engaging in casual sex (Lam & Lefkowitz, 2013).

While many emerging adults express positive feelings about their hook-up experience(s), many others express negative emotions, including regret (Bersamin et al., 2014; Garcia et al., 2013). Men are more likely to have positive attitudes about friends with benefits relations than women, many of whom hope that it will change into a romantic relationship (Lehmiller et al., 2011). About 1 in 10 college students who have initiated sexual intercourse later choose to engage in secondary abstinence (Rasberry & Goodsen, 2009).

Many emerging adults engage in a sexual lifestyle called serial monogamy—a series of relationships in which sex is reserved for just one person. The type of sexual lifestyle emerging adults choose to follow is strongly influenced by their level of religiosity (Lefkowitz et al., 2004).

The period of emerging adulthood is also a time in which most people gradually become less influenced by peer pressure and gain a better understanding of their own sexual motivations.

"I now make my own choices and give my opinions without being intimidated about what someone else might think. But most of all I have stopped confusing sex for the attention I was striving for. For example, I used to think that if I give him sex then that means he must like me or is my friend."

(from the authors' files)

Young Adulthood (Ages 26–39)

1. 10.6 Discuss the sexual lifestyles of adults, including marriage, cohabitation, and extramarital sex.

A national survey found that by age 44, 95% of Americans have engaged in premarital sex (Finer, 2007). However, relatively long-lasting monogamy is the norm for most adults aged 25 and older (Gotta et al., 2011; Seidman & Rieder, 1994). For people in this age group, about 80% of sexually active heterosexual men and 90% of sexually active heterosexual women report having had only one sex partner within the past year. Nearly identical findings were reported by Laumann's group (1994). However, there is a range of sexual and relational lifestyles even in this age group.

10.6.1 Marriage

People today may be postponing marriage, but the likelihood of a man marrying by age 40 is 81% and 86% for women (National Center for Health Statistics, 2009).

The frequency of sexual intercourse in the first year of marriage is usually high, an average of about 15 times a month in the first year. In fact, for the entire population, the frequency of sexual relations is highest for married couples in their mid-20s to mid-30s (Clements, 1994; Herbenick et al., 2010c; Laumann et al., 1994).

Figure 10–8

Relatively long-lasting monogamy is the norm for most adults aged 25 and older.

Source: Creatas Images/Thinkstock/Getty Images

The frequency of sexual relations generally declines after the first year or two of marriage. Why? Sex has to compete with other time demands, such as career advancement. Parenthood means less privacy and more demands and often results in exhaustion at the end of the day and less

marital satisfaction (see Ahlborg et al., 2008; Wendorf et al., 2011). Intimacy of communication and conflict style greatly affect relations (Schmiedeberg & Schröder, 2016). In short, sexual satisfaction is greatly intertwined with overall relationship satisfaction (McNulty et al., 2016).

Studies find that married couples today are more likely to use a variety of sexual techniques than in the past (see Jayson, 2012a, b). This is true for positions of sexual intercourse and for oral-genital sex. A majority of both men and women report marital sex to be very satisfying, more so than do singles (Clements, 1994; Laumann et al., 1994; Jayson, 2012a, b). Moreover, numerous studies have found that adults who get and stay married have higher levels of psychological well-being and even better physical health than individuals who stay single (e.g., Horwitz et al., 1996; National Center for Health Statistics, 2005).

Figure 10–9

The addition of children may change the pattern of sexual relations but not necessarily the frequency. Married couples in their mid-20s to mid-30s have sex more often than any other group.

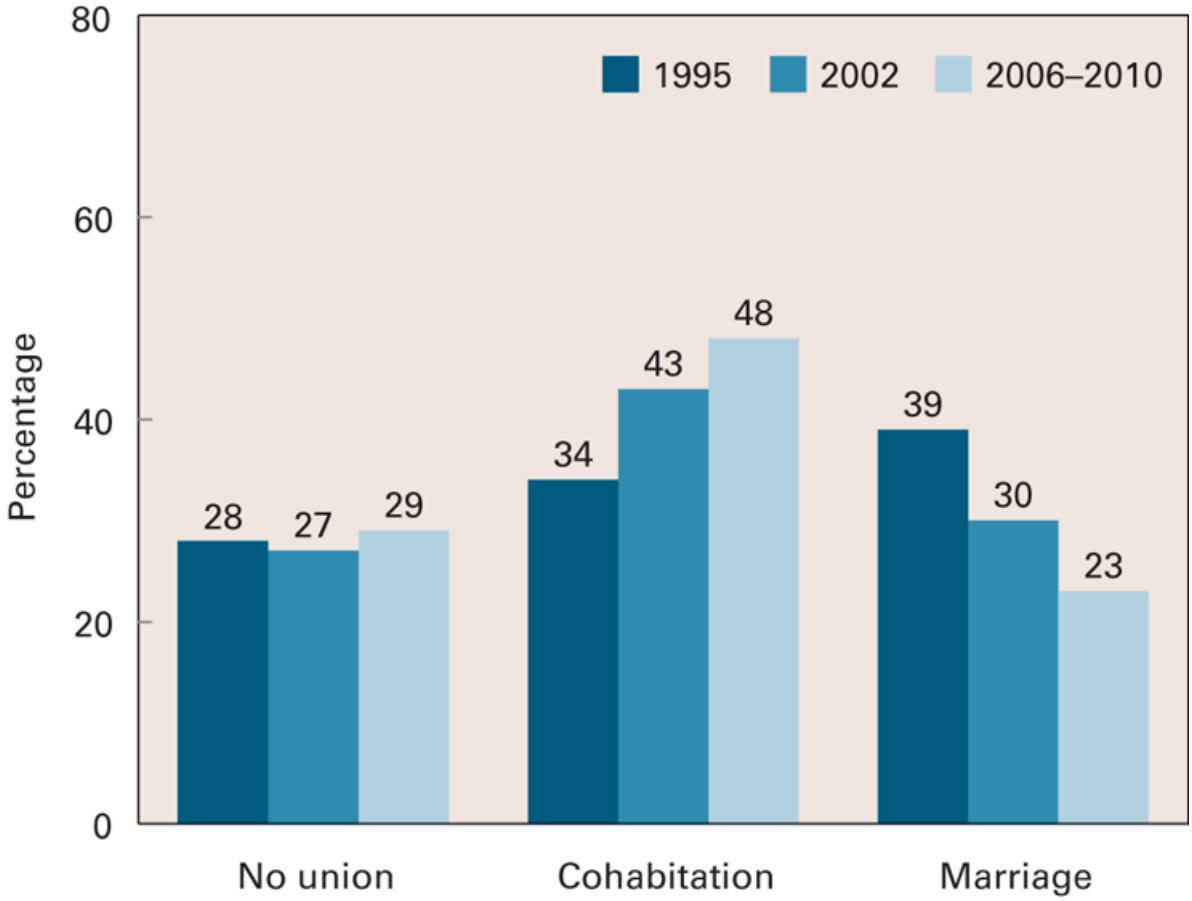
Source: Roberto Westbrook/Image Source/Alamy Stock Photo

Photo

10.6.2 Living Together (Cohabitation)

As with attitudes about premarital sex, more people today have a favorable attitude about premarital cohabitation than in past generations (Copen et al., 2013; Daugherty & Copen, 2016). For nearly half of all women and 70% of women who did not graduate from high school, their "first union" is not marriage—it is cohabitation (see Figure 10–10). This represents an increase in *cohabitation* of over 700% since the 1970 census. The length of cohabitation unions is getting longer as well. Forty percent of children live for some period of time in a cohabitating family. The increase in the number of couples living together may be one reason for the older age of couples today who marry for the first time.

Figure 10–10



Current marital and cohabitating status among women aged 15 to 44.

Source: Copen et al (2013) National Health Statistics Reports, No. 64, Figure 1.

Figure 10–10 Full Alternative Text

Today, cohabitors are a diverse group (Jayson, 2012b). Close to 63% have never been married, over half have some college education, and 41% have children. Over one third are 50 or older (Brown & Kawamura, 2010). Serial cohabitation (multiple premarital relationships) has increased by almost 40% since 2000 (Lichter et al., 2010).

People give a variety of reasons for cohabitating (Rhoades et al., 2009). About half hope to eventually marry their partner (Guzzo, 2009). Living together can be a test or trial period before marriage (there is much more to living together happily and successfully than simply enjoying sex), but it can also be an alternative to marriage (King & Scott, 2005). As cohabitation has become more acceptable, a greater number of couples who cohabitate are doing so for temporary convenience (Bumpass & Lu, 2000).

Does living together before marriage improve your chance of a later successful marriage? Interestingly, older studies found that couples who lived together before getting married were more likely than others to experience marital instability and get divorced (Bumpass & Lu, 2000; Dush et al., 2003). However, these data were collected at a time when cohabitation was considered to be unusual. Today, with nearly 50% of all heterosexual couples living together being unmarried, cohabitation before marriage is commonplace. So what do recent studies find? For women who had cohabitated only with their eventual husband, the divorce rate is not higher than for those who did not cohabitate first (Teachman, 2003; Tach & Halpern-Meekin, 2009). It is higher for people who have cohabitated with more than one person and for couples who had children while cohabitating.

10.6.3 Extramarital Sex—In Supposedly Monogamous Marriages

In their nationally representative sample, Laumann's group (1994) found that for people in their 50s, 37% of men and 12.4% of women had been unfaithful at least once. For people in their 30s, 27.6% of men and 26.2% of women admitted to having had an affair. Numerous other studies also find that among Americans, the prevalence of extramarital sex has been relatively high and higher for men than for women (Petersen & Hyde, 2011). However, extra-relational sex has decreased dramatically for both heterosexual and homosexual couples since the mid-1970s (Gotta et al., 2011).

These statistics on adultery refer to extramarital *sexual* relations. But, according to psychologist Shirley Glass, "That's a male definition [of adultery]. If you look at emotional involvement and sexual involvement short of intercourse, you add another 20%" (quoted in Mehren, 1991). Whereas men may have solely sexual affairs, women's affairs are almost always emotional or a combination of sexual and emotional (Banfield & McCabe, 2001). Many married persons, especially wives, have emotional affairs over the telephone or the Internet (Smith, 2011).

Throughout the world, nearly 90% of people believe that extramarital sex is "always" or "almost always" wrong (Widmer et al., 1998). Men are

more upset at the idea of their partners getting sexual with someone else than they are about an emotional attachment. Women, on the other hand, are more concerned about emotional infidelity on the part of their mates and are much more likely than men to forgive a partner for sexual infidelity (Buss et al., 1992; Wiederman & Kendall, 1999).

Why do so many people engage in extramarital sex (or sex outside of any supposedly monogamous relationship)? Both men and women cite sexual and emotional motivations— that their current relationship is unsatisfying in one or both of these aspects (Mark et al., 2011; Omarzu et al., 2012). Of course, there is also the excitement factor, as John Gagnon (1977) points out.

> Most people find their extramarital relationships highly exciting, especially in the early stages. This is a result of psychological compression: the couple gets together; they are both very aroused (desire, guilt, expectation); they have only three hours to be together. . . . Another source of attraction is that the other person is always seen when he or she looks good and is on best behavior, never when feeling tired or grubby, or when taking care of children, or when cooking dinner. . . . Each time, all the minutes that the couple has together are special because they have been stolen from all these other relationships. The resulting combination of guilt and excitement has a heightening effect.

(John Gagnon, 1977)

There is very little association between social background—including political leaning (ultraconservative versus ultraliberal) and religion or lack of it—and whether one engages in extramarital affairs (Janus & Janus, 1993). Whitehurst (1972) indicates that two things contribute to having "outside sex." One is simply opportunity. Women who work have more opportunity to meet other men and to have affairs than women who stay at home all day. The second contributor is alienation. People can grow apart and develop different interests over time. Thus, if you meet someone else who shares your interests, seems attractive, and seems attracted to you, this can lead to sharing other parts of your life as well.

10.6.4 Extramarital Sex—Consensual Arrangements

Some couples agree to have sex outside of the marital relationship. One such arrangement is open marriage, where both partners agree that it is okay to have sex with others. Even here, however, there are usually some agreed-upon restrictions, such as not having sex with a mutual friend or not having sex with the same person twice (Blumstein & Schwartz, 1983). Couples make these restrictions so that their primary commitment is to the marriage and thus the non-marital partner will not be viewed as competition.

Another arrangement that allows consensual extramarital sex is swinging (often called "wife swapping" or the "lifestyle"), where a married couple has extramarital relations together (deVisser & McDonald, 2007). Couples get together by answering ads in newspapers or swingers' magazines or by going to commercial clubs that encourage recreational sex. The sexual activity often includes sex between the women while the husbands watch, but male same-sex activity is much less common and in many cases forbidden. Here are some experiences of couples at a swingers' club in New Orleans:

"I knew that I might be interested in women, so we started out by exploring that. Once we started doing that, he wanted to get some action too . . . having sex with the women I brought home . . . rather than cheating on each other because we are sexually bored, we have fun together . . . and, you get to have no strings sex." (man 35, woman 26, married 3 years)

"The freedom to experiment and do it without deception. It is probably THE only time you will experience a relationship where both partners openly communicate about sex. No hiding, no wishing, no jerking off to your fantasy, no cheating, no guilt. Everything is 'out on the table' so to speak. It's wonderful." (man 37, woman 32, married 12 years)

(All examples are from the authors' files.)

Swinging reached its peak in popularity in the 1970s and then declined during the 1980s. Although there has been an increase in the number of swing clubs nationally, no recent research has been done to establish the overall prevalence. Except for the fact that they tend to be white, to be less religious than others, and to have had more premarital sexual experience, swingers are no different from other couples in psychological wellness and relationship quality (Rubel & Bogaert, 2015).

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Middle Age (Ages 40–59)

1. 10.7 Describe the sexual behavior of middle-aged individuals and the physical changes that come with aging.

Christian and Victorian views of sex emphasized that sex within a marriage was for procreation only and excluded sexual activities for pleasure. Thus, Western culture came to view older individuals who were no longer able to conceive as asexual. For example, many students believe that their own parents and grandparents love each other, but how many students think of their parents and grandparents as being sexually active? Here are a variety of responses from students in our course:

"I was about 14 when my mom told me she and my dad have sex. I was shocked and thought it was disgusting. I didn't want to hear it anymore."

"My parents don't have sex. They have other things to do."

"The thought of my parents actually possessing sexuality or having sex mortified me."

"And plus they are in their late 40s and early 50s— I just can't imagine them having sex."

"When I was a teenager, it would make me uncomfortable when they would go in their room and shut and lock the door because I knew what they were going to be doing and I just felt it was weird because to me, they were 'old.' Now that I'm in my 20s, it makes me feel good to know that my parents still love and care about each other, and it helps me to believe that I will have a positive sexual attitude well into my 40s and 50s."

"Sometimes I tease them a little when I catch my dad home late in the morning because I know he stayed home so they could have sex. I think it's great that they still love each other and express themselves sexually after being married for 25 years." (All examples are from the authors' files.)

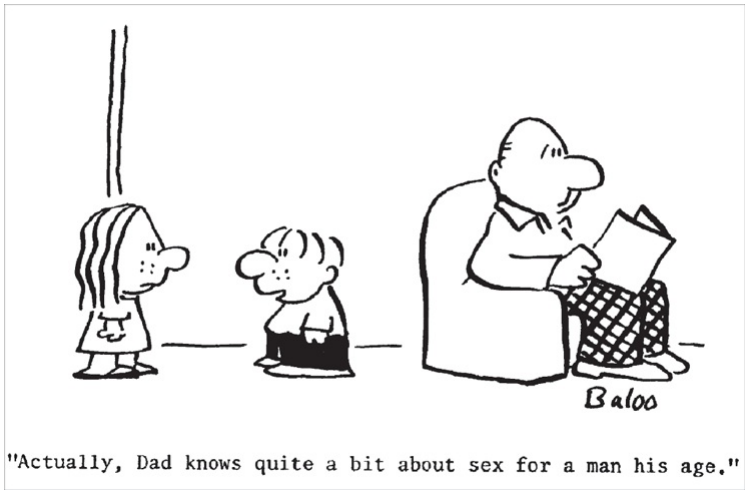
Figure 10–11

Over half of 45- to 54-year-old people with partners have sexual intercourse at least once a week. Do you believe that your parents still enjoy sex? When you become a parent, will you be embarrassed if your children know that you and your partner enjoy sexual relations?

Source: B2M Productions/Photodisc/Getty Images

Ask yourself these questions: "Do my parents enjoy sexual intercourse? How often? Do they enjoy using different positions? Do my grandparents enjoy sex? How often? Do they enjoy using different positions?"

Think about how you answered these questions, and then ask yourself: "What are my attitudes about sex?" *The way that you feel about sex now is the best estimate of how you will feel about it in the future* (Bretschneider & McCoy, 1988). If you enjoy sex now, why should you stop enjoying sex later in life? From the previous case histories, which students do you think will enter parenthood with more positive attitudes about sexuality? Believing that parents and grandparents are (or should be) asexual can have negative consequences when you become a parent yourself. How will you then regard your partner, and vice versa?



Rex May

"My husband and I were in what seemed an ideal marriage. Not only was our coupling wonderful, but we also shared an extremely intense sexual relationship as well. Two years into our marriage we were informed that we were going to be parents. My husband was great; he was so attentive and supportive during the time I carried our child. . . .

"He was a proud father. However, things were never the same between us after the birth of our daughter. There had been little sex between us since the baby, but I attributed it to his long hours. . . .

"I started sensing that my husband was distant. I told him he was growing away from us instead of with us. I asked him what was wrong. . . He said that ever since I became a mother that he no longer could see me as a sexual partner. I was a mom and that was something sacred that should be put on a pedestal. He said it was impossible to think of me in a sexual way anymore."

(from the authors' files)

Older people are aware that young people have negative stereotypes about them having sexual relations. This negative attitude is called ageism (see Nelson, 2016). Barring a tragedy, we will all grow old someday. These negative

attitudes must change if today's young people want to be treated decently when they are older.

Personal Reflections

Does the thought of your parents enjoying sexual relations make you comfortable or uncomfortable? Why? If you have difficulty viewing your parents as sexual human beings, what effect do you think that will have on your own sexual relationship when you and your partner become parents (and view one another as parents)? When you become a parent, will you be embarrassed if your children know that you and your partner enjoy sexual relations? Why?

10.7.1 Frequency of Sex

As mentioned earlier, national cross-sectional surveys have found that sexual activity is highest for people in their mid-20s to mid-30s (Clements, 1994; Herbenick et al., 2010c Laumann et al., 1994). Is there a sharp drop-off after that? Not really, at least not until the 60s. Although most surveys do show a decline in sexual activity for people in their 40s and a further decline in the 50s, the drop-off is very gradual, about only one or two times a month less than when they were younger (Clements, 1994; Herbenick et al., 2010a; Schick et al., 2010; Segraves & Segraves, 1995; Seidman & Rieder, 1994). A recent nationally representative survey found that about 56% of men and 70% of women aged 50 to 70 years had engaged in sexual intercourse in the previous year (Schick et al., 2010). A survey by the American Association of Retired Persons (AARP) found that half of people aged 50 and older *with partners* were having sexual intercourse at least once a week (Jacoby, 2005). When asked if sex is important to them, more people in their 30s, 40s, and early 50s say yes than do people in their late teens or early 20s (Clements, 1994).

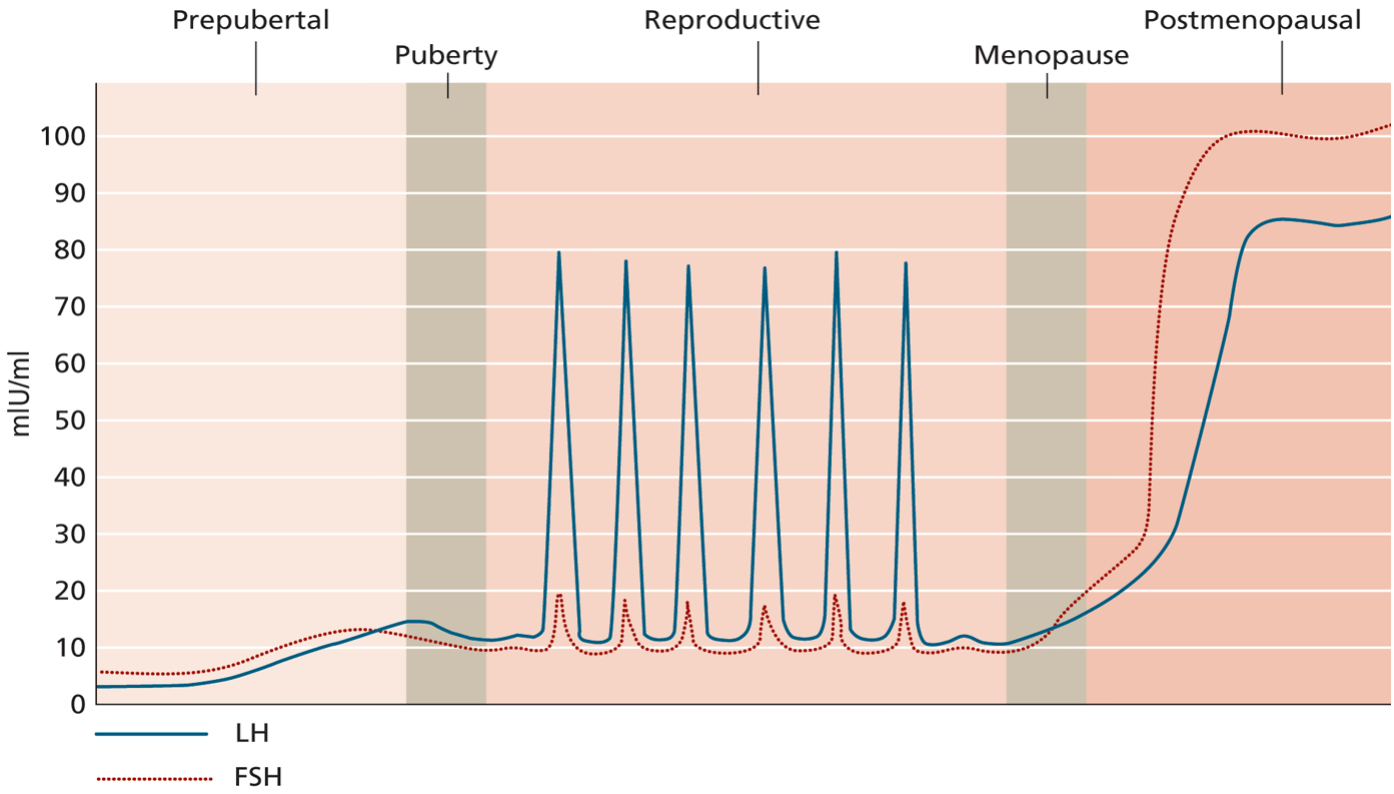
Within a relationship, frequency of intercourse is positively associated with relationship and sexual satisfaction (Costa & Brody, 2012). In a national survey, Laumann et al. (2006) found that the sexual well-being of men and women aged 40 to 80 years was strongly associated with both physical and emotional satisfaction with the partner and a good companionate relationship.

However, not everyone in their 50s is having sex regularly. For people in their 50s and older, two of the major factors that determine whether they are having sex are health and availability of a partner (Lindau & Gavrilova, 2010; Schick et al., 2010). By the time people reach their early 40s, there are many more single women than single men. There is also a double standard in our society. While many people frown upon women having sexual relationships with men much younger than themselves, most feel that it is okay for men to have relationships with younger women. Thus, women over age 40 generally have a more difficult time finding new partners than do older men (Carpenter et al., 2006). A survey by the AARP found that among people aged 55 to 59, about 90% of men have sexual partners, but only about 70% of women do (Jacoby, 1999). In other words, if everyone aged 40 or older (especially women) had the opportunity to have sexual partners, the statistical numbers for frequency of sex that you have just read would probably be even higher.

10.7.2 Female Sexuality: Physical Changes with Age

Recall from Chapter 3 that girls are born with a few hundred thousand ova (follicles) at birth and that several hundred begin to mature every month (McGee & Hsueh, 2000). As a woman ages into her 40s, her supply of ova is nearing exhaustion. Her ovaries do not respond as well to the pituitary hormones FSH and LH (see Figure 10–12), so that menstrual cycle irregularities are common after the age of 35. Cycles generally become less frequent and menstruation heavier than before (Mackey, 2009). Eventually, her ovaries atrophy (wither), and she quits having menstrual cycles entirely, thus ending her ability to have children. The last menstruation is referred to as menopause. The changes that occur in the few years that precede and the first year that follows menopause are called the climacteric (also called perimenopause) (see Sowers, 2000).

Figure 10–12



The pattern of secretion of pituitary hormones during a woman's lifetime. The large increases in FSH and LH after menopause are due to the loss of estrogen and progesterone from the ovaries.

Figure 10–12 Full Alternative Text

Four fifths of women experience menopause between 44 and 55, with an average age of 51 (Al-Azzawi & Palacios, 2009), but up to 10% experience it before age 40 (Bruno, 2005). Menopause is just a natural result of aging.

As the ovaries atrophy, they produce less and less gonadal hormones and eventually produce no progesterone and only minute amounts of estrogen. Testosterone levels often decrease as well. Most women will experience some symptoms as a result of these hormonal changes.

Estrogen and progesterone, you recall, inhibit release of FSH and LH from the pituitary. At menopause, the pituitary hormones are no longer inhibited and are released in large amounts. In addition to their reproductive role, these hormones affect the diameter of blood vessels, causing them to dilate. Subjectively, this physiological change is perceived as a *hot flash,* a sudden sensation of warmth or intense heat that spreads over the upper body, face, and head (see Kronenberg, 1994). The sensations last from a few seconds to 15 minutes or more and are very common at night, thus interfering with sleep. This can lead to fatigue, irritability, and depression. Hot flashes continue for an average of about 5 years after menopause, but as many as one third of women still experience them after 10 years (Freeman, 2014).

The loss of estrogen also causes the vagina to become thinner and less elastic, with a marked *decrease in the amount of vaginal lubrication* during sexual arousal. Postmenopausal women typically experience vaginal dryness (as a result of decreased lubrication) and changes to the labia, called *genitourinary syndrome of menopause* (Portman et al., 2014). If the vagina is not properly lubricated, sexual intercourse will be painful, so that some postmenopausal women may start avoiding sexual relations. This is unnecessary, however, if a woman and her partner accept vaginal dryness after menopause as a normal physiological response and not as an indication of lack of desire. The dryness can be countered with vaginal estrogen preparations (tablets, creams, rings; see Santoro et al., 2016) or a lubricant, such as K-Y Jelly (Herbenick et al., 2011).

A lot of attention has been given to the role of decreased estrogen levels in *osteoporosis*, a condition in which the bones become more brittle with age (see Rozenberg et al., 1994). There are over 250,000 hip fractures a year due to osteoporosis, resulting in up to 50,000 premature deaths in women.

What about sexual desire? Many students believe that women no longer have any interest in sex after menopause.

"I was surprised to find out that a woman still had a sexual desire after menopause. I always believed it to be a time of depression and no sex. Well, you learn something new every day."

(from the authors' files)

Figure 10–13

For most couples, sexual motivation is highly associated with the quality of the relationship.

Source: Wavebreak Media ltd/Alamy Stock Photo

For many women, menopause (natural or hysterectomy-related) causes no change in interest in sex (Hallstrom & Samuelsson, 1990; Kokcu et al., 2015; Segraves & Segraves, 1995), and some women actually show an increased interest in sex after menopause (Dillaway, 2005), possibly because they no longer have to worry about getting pregnant. Some women do experience sexual problems during the climacteric and at menopause, but there is not enough evidence to attribute this to decreasing estrogen levels (da Silva Lara et al., 2009; Nappi & Lachowsky, 2009).

The Rise and Fall (and Resurrection?) of the Medicalization of Menopause

Postmenopausal women have become a large segment of society that seeks health care or, depending on your perspective, that is targeted by healthcare professionals (see Houck, 2006, for a history). Dried ovaries from cows were promoted as preserving youth and vitality in women as early as the late 1800s. Estrogen was synthesized in 1928, and the U.S. Food and Drug Administration approved Premarin (estrogen from pregnant mares' urine) in 1942. In 1962, Dr. Robert Wilson published results of a study in a leading medical journal that claimed that estrogen and progesterone given together prevent breast and endometrial cancer. In a 1966 book titled *Feminine Forever*, Wilson claimed that estrogen "aside from keeping a woman sexually attractive and potent. . . preserves the strength of her bones, the glow of her skin, the gloss of her hair. . . Estrogen makes women adaptable, even-tempered, and generally easy to live with." The medicalization of menopause had begun.

Medicalization refers to "the process whereby the normal processes of pregnancy, childbirth, menstruation and menopause have been claimed and redefined by medicine" (Kaufert & Lock, 1997). Opponents of the medicalization of menopause claim that the negative expectations of deteriorating health are the result of culturally determined attitudes, promotions by drug companies, and media pressure and point out (correctly) that older women in our country are already healthier than older men and outlive men by many years (van Hall, 1997). Women in some other cultures or ethnic groups report few problems during menopause (see Box 10–A).

Box 10–A Cross-Cultural Perspectives

Menopause in Different Cultures

Menopause as a biological event is universal—all women worldwide will eventually stop having menstrual cycles and experience a decrease in estrogen levels. But what about the experience of menopause? Western health practitioners have medicalized menopause and portray the postmenopausal years negatively, as a time in which the body breaks down (but can be repaired by hormone replacement therapy). Western feminists, on the other hand, portray menopause not as a disease but as a normal part of aging that can bring liberation and joy. Which of these views is more realistic?

The experience of menopause is affected by life events (Pimenta et al., 2012). Richters (1997) reviewed cross-cultural studies of menopause and found many differences. For example, while a majority of American and European women experience hot flashes after menopause, hot flashes are uncommon among postmenopausal women in Japan (and many other areas of Asia) or the Mayans of Mexico (Avis et al., 2001; Beyne & Martin, 2001; Chim et al., 2002; Lock, 1994). The Mayans do not even have a word for it, but there is generally a very negative attitude in other Latin American cultures (Dulón-Pérez et al., 2013). In some areas of Greece, women experience hot flashes but do not think of them as medical symptoms that require going to a physician (Beyne, 1989).

Some, but not all, of these differences can be explained by the social position of women in different cultures (Avis et al., 2001; Richters, 1997). In cultures where women gain prestige and power in middle age, menopause may likely be viewed positively, in contrast to the United States, where older persons are often viewed as a burden. For example, in northwest Cameroon, women are believed to gain wisdom after menopause and thus rise in social status, while in parts of Nigeria postmenopausal women are granted more power (Best, 2002). Traditional Navajo women view menopause as a positive change of life status (e.g., being free of menstrual taboos) and (probably as a consequence) do not experience the same symptoms as Western women (Wright, 1983). Migration from one country to another can rapidly change the perception of menopause. Women in Italy generally have positive roles and positive attitudes about menopause (Donati et al., 2009), but Italian women who migrated to Australia came to view menopause negatively when those roles were no longer valid (

The Elderly Years (Age 60+)

1. 10. 8 Explain the realities of aging that can directly affect sexuality in the elderly and discuss the prevalence of sexual relations among healthy elderly couples.

"I didn't think that elderly people thought about sex. I thought when you got older you just lost all interest."

(from the authors' files)

In our culture elderly people are regarded as asexual human beings—neuters. Sex is something enjoyed only by the young and healthy. According to Rose and Soares (1993), "Evidence of sexuality among the aged is often joked about, dismissed, or defined as troublesome behavior. A sexually active older man is seen as a 'dirty old man' and a sexually active older woman is considered preposterous or embarrassing. This culturally embedded denial may be rooted in people's difficulty accepting the sexuality of their own parents."

What is the truth? Is it really unusual for elderly people to have an interest in sex? In recent years, there have been several national surveys (Dunn & Cutler, 2000; Fisher et al., 2010; Jacoby, 2005; Lindau et al., 2007; Laumann et al., 2005, 2009; Schick et al., 2010; Waite et al., 2009; see DeLamater, 2012, for a review). Let's see what they found.

Among people in their early 60s who have a partner, over 70% are having sex regularly. Over 50% of them have sexual intercourse at least once a week. In their late 60s and early 70s, about 50% of Americans are sexually active. In their late 70s and early 80s, about 25% to 40% of people are still sexually active (see Hyde et al., 2010). Notice that there is a decline in the prevalence of sexual activity with age. It is also true that elderly women are less likely to report being sexually active than elderly men (e.g., Fisher et al., 2010; Kontula & Haavio-Mannila, 2009; Lindau et al., 2007).

King Features Syndicate

Notice that even in the most elderly group there was still a sizable minority who were having sexual relations regularly. A new partner in later life can often reignite the sex drive:

> "There was an incredible chemical reaction with my second husband, for both of us. Quite different from the first marriage which evolves . . . this was an absolute click. Absolutely incredible! I mean, at that age. It was like a couple of teenagers. I can't tell you. Um, oh, we had a lot of fun. We really did. And, Ah, very romantic. . . . It's died down now, of course it has, but in the beginning it was, it was quite amazing. It really was. It was amazing . . . the instantaneous attraction. The ping. You know? The ease. It was enormously easy. That's the great aspect of sex—it should be easy." (Married 78-year-old woman, remarried at age 72)

> "I told the doctor one time and she said, 'Ohmigod! You have more sex than I do in a week!' We had a good sex life. I was really amazed . . . it was very, very good." (Widowed 81-year-old woman, remarried at age 63)

(From Clarke, 2006)

Is there any age at which sexual activity stops? Although it was not a representative sample, a study of 202 *healthy* men and women aged 80 to 102 found that three fourths of them still fantasized about sexual relations and enjoyed touching and caressing their partners. Nearly half were having sexual intercourse and a third were engaging in oral-genital sex (Bretschneider & McCoy, 1988). For some, sexual activity was limited by living arrangements and the availability of partners, not by a lack of interest. A more recent study found that 11% of Australian men aged 90 to 95 had had sex in the past year (Hyde et al., 2010). Half of men 75 and older said that sex was still important to them.

Now you know about frequency of sexual relations among the elderly, but what about quality? About two thirds say their sexual relations are extremely or very satisfactory, as good as or better than when they were younger (Dunn & Cutler, 2000; Jacoby, 1999, 2005; see also Heiman et al., 2011). Women describe their male partners as more "romantic" than when they were younger, and perhaps as a result a greater percentage of women were reaching orgasm regularly. Recall from Chapter 4 that sexuality for many women is directly related to how happy they are in a relationship. This is still true in the elderly years (Karraker et al., 2011; Trudel, 2002).

Figure 10–14

From the moment of birth to the day we die, we are all sexual beings.

Source: RosaIreneBetancourt 14/Alamy Stock Photo; BUSSY/A.L.LEHEUTRE/BSIP SA/Alamy Stock Photo

We must not ignore that there are several factors that can negatively affect sexuality in the elderly years, particularly health and availability of a partner (Fisher et al., 2010; Karraker et al., 2011; Lindau & Gavrilova, 2010; Schick et al., 2010). For example, the ratio of single women to single men that we discussed in the section on middle age becomes even more unfavorable to women over the age of 60. In the United States, women outlive men by an average of 7 years. For people aged 65 to 74, there are 123 women for every 100 men and 100 single women for every 27 single men. At ages 75 to 84, there are 151 women for every 100 men, and at ages 85 and older, there are 241 women per 100 men (Guralnik et al., 2000; Weg, 1996). About 26% of women aged 57 to 64, 39% aged 65 to 74, and 60% aged 75 to 85 do not have a sexual partner (Waite et al., 2009). Thus, for women, there is a real "partner gap." Many women may be interested in sex, but there is no opportunity (Karraker et al., 2011; Lutfey et al., 2009).

In the survey of people aged 80 to 102, the people were in good health (Bretschneider & McCoy, 1988). However, many older people experience medical problems and disabilities that substantially shorten their years of being sexually active (Hyde et al., 2012; Karraker et al., 2011; Lindau & Gavrilova, 2010; Minkin, 2016). Heart disease, stroke, arthritis, diabetes, prostate surgery, and problems due to alcohol, smoking, and overeating are common (Laumann et al., 2007; Lindau et al., 2007). In one survey, women listed "better health for their partner" as the number-one item that would most improve their sex lives (Jacoby, 1999). In another (Dunn & Cutler, 2000), 47% of elderly men said, "I have a medical condition that prevents us from having sex," and 43% of the women said, "My partner has a medical condition that prevents us from having sex."

Sexual problems among the elderly are also common (and are often associated with the medical problems). Laumann et al.'s (1999) nationally representative survey found that 11% of men aged 40 to 49 and 18% aged 50 to 59 have erectile disorders. The percentage of men with erectile problems increases to 30.7% for ages 57 to 64, and about 44% for ages 65 to 85 (Waite et al., 2009). About 20% of men aged 57 to 74 years were unable to reach orgasm and 28% had little or no interest in sex, with slightly higher percentages for men 75 or older (Hyde et al., 2012). Among women aged 57 to 74 years, about 40% had little or no interest in sex, and one third experienced pain during intercourse and/or were unable to reach orgasm. About one third of women and one fourth of men aged 57 to 74 said that they avoided sex because of these sexual problems.

About 14% to 17% of elderly men have tried Viagra, testosterone patches, or other sex-enhancement medications (Lindau et al., 2007; Schick et al., 2010). But what about these men's partners? Over half of them say that their partner's treatment has resulted in increased pleasure for them as well (Jacoby, 2005). However, medical treatment for impotency can also suddenly change the sexual equilibrium in a relationship (Kingsberg, 2000). A few women report that their male partners' treatment had decreased their pleasure. Remember, for most women, their sexual pleasure is directly related to the quality of the overall relationship and relationship unhappiness is the cause of many older women's lack of interest in sex (Jacoby, 1999; Kingsberg, 2000; Laumann & Waite, 2008; see Chapter 4).

The third major factor preventing some elderly people from enjoying sexual relations is the opportunity for privacy when one is dependent on others for care. This particularly affects the very elderly. Nowhere is our culture's negative attitude about sexuality and the elderly more apparent than in nursing homes (Clay, 2012). Administrators and staff in many nursing homes tend to have negative or patronizing attitudes about elderly patients engaging in sex (see Villar et al., 2015, for a review).

So what can we conclude about sexuality in the elderly years? Laumann and Waite (2008) concluded that:

> Sexual problems among the elderly are not an inevitable consequence of aging, but instead are responses to the presence of stressors in multiple life domains (poor physical or mental health, relationship problems).

Sexual opportunities are limited for single women, but for healthy men and women with healthy partners, sexual activity will probably continue throughout life if they had a positive attitude about sex when they were younger (DeLamater, 2012). In fact, *the best predictor of sexual desire in later life is not biomedical factors but instead a positive attitude about sex* (Bretschneider & McCoy, 1988; DeLamater & Sill, 2005).

Sex surveys tend to measure sexual behavior in terms of physical acts such as sexual intercourse and masturbation, but there is more to sexuality than this. Elderly people often report great sexual satisfaction with emotionally erotic experiences (Shaw, 1994). Sexual pleasure, for example, includes touching, caressing, physical closeness, and intimacy. These can often be achieved even in the most extreme cases:

> Mr. N was deaf, blind, and unable to talk due to a recent laryngotomy. He was quite dependent on Mrs. N who had severe arthritis and had a mastectomy years ago. They typically sat close together, in part to aid communication due to Mr. N 's impairments. But the way they held hands revealed great tenderness and affection. They slept in twin beds and indicated they no longer engaged in intercourse. Yet, they had a nightly ritual in which Mr. N helped his wife bathe and then gave her a massage in bed, which they described with some embarrassment and blushing. Interestingly, through this sensual routine, Mr. N, usually the more dependent of the two, was able to offer something of value to his wife.

(Rose & Soares, 1993)

Perhaps the biggest problem for elderly people interested in physical relations in our culture is ageism—the negative stereotypes of the aged as sexless (Barrow & Smith, 1992; Nelson, 2016). Many people poke fun at or discriminate against other people who are different from themselves, and this often includes the elderly. Again, unless there is a tragedy, all of us will be elderly some day. Do you enjoy sexual relations now? Do you ever want to give sex up? If not, how do you think you will feel if one day younger people think you are silly, preposterous, or even lecherous or perverted for wanting the pleasure of someone else's touch? The time to address these attitudes is now, not later. We are all sexual human beings, from birth to death.

Addendum: Talking with Your Children About Sex

1. 10.9 Initiate talks with your own children about sex.

When asked where he received his education, Mark Twain answered, "Throughout my life, except for the years I attended school." This is generally true for most people when it comes to learning about sexuality. Sexual learning begins in infancy and continues throughout childhood and adolescence. It is informal and is received from family, friends, the media, and the rest of the general environment.

During the preadolescent years, a child's parents are the most powerful influence on his or her beliefs and behavior. Even if parents never discuss sex with their children—and most do not—by their behavior and their attitudes, they still serve as role models from which their children learn.

As children approach their teenage years, their peer groups and the media (primarily television) become their primary sources of sexual information (American Academy of Pediatrics, 2010; Sprecher et al., 2008). The average child watches several hours of TV every day and is exposed to hundreds of references to sex in a year (Eyal et al., 2007; Kaiser Family Foundation, 2005). Between the amount of time that their children spend with peers and watching TV, it is obvious that parents have a difficult time competing as a source of sexual knowledge and values. Yet, despite all the public debate about AIDS and other sexually related matters, many parents continue to remain silent (Beckett et al., 2010; King, 2012; Sprecher et al., 2008):

"Sex was never a topic in my home when I was growing up. It led to embarrassment when I finally had to ask questions, but I could only ask my friends, never my parents. It shouldn't be like that, it shouldn't be embarrassing and I should have been able to talk to my parents."

(from the authors' files)

Surveys show that the vast majority of Americans favor sex education in schools (see Constantine, 2008). So why is there reluctance to teach it at home? Probably because most parents never received sex education themselves and thus are uncomfortable with their own sexual knowledge and feelings (Wilson et al., 2010).

Planned Parenthood, Hawaii

"I always hoped I would be able to handle such topics with my children, but I guess I was unable because it was never really discussed with me."

"If I had been educated earlier, beginning at age 9 or 10, I would have been able to help myself and my children with facts of life much better and much earlier."

(examples are from King & LoRusso, 1997)

When you complete this book, you should be ready to put an end to the cycle of non-communication that has existed between parents and each new generation of children. This part of the chapter is intended to help you initiate discussions of sexuality with your children so that they too may acquire factual information. We will try to answer some of the questions that often concern parents.

10.9.1 Which Parent Should Talk with the Children?

Most children would like to turn to their parents for information about sex. Unfortunately, only a few list their parents as their major source of information (American Academy of Pediatrics, 2010; King, 2012; Sprecher et al., 2008). When a parent does make the attempt to open communications about sexuality, it is almost always the mother (e.g., K. S. Miller et al., 1998; Ogle et al., 2008). This is true for sons as well as daughters. Fathers are notoriously silent! Not surprisingly, teenagers have more positive attitudes about their mothers as sex educators than they do their fathers (Feldman & Rosenthal, 2000).

One thing that prevents discussions between parents and children about sexuality is a defensive climate in the household (Rozema, 1986). When one or both parents have reacted negatively to the subject of sex in the past, children are less likely to open up or approach them with questions. Family communication about sexuality is most likely to occur in households that have an openness in the communication process and when parents have talked to their children about other personal topics as well (K. S. Miller et al., 1998; Raffaelli et al., 1998). Children may be more likely to

discuss sex with their mothers than their fathers because mothers are often viewed as more emotionally expressive, more likely to answer questions about intimacy, and, as a result, more approachable.

Fathers are doing a disservice to their children by remaining emotionally distant and appearing (to their children) to be unapproachable on the subject. Both parents should make the attempt to open lines of communication and, as you will soon learn, the earlier the better.

10.9.2 Does Telling Children About Sex Lead Them to Do It?

Some of you may worry that if you talk to your children about sex, it will increase the likelihood they will have sex (Jaccard et al., 2000). Studies have shown that children who have had sexuality education are no more likely (and perhaps are less likely) to have sexual relations, to get pregnant, or to contract a sexually transmitted infection than those who have not had sexuality education (Grunseit et al., 1997). In families that have developed strong loving relationships in which parents give their children much positive attention (including the quality of communication), children are less likely to begin sexual intercourse at a young age or engage in sexually risky behaviors (Clawson & Reese-Weber, 2003; B. C. Miller et al., 1998; Resnick et al., 1997). Do you need better reasons to talk to your children about sex?

10.9.3 Why Should I Talk to My Child About Sex?

Unless you are willing to keep your children locked up in a closet until they reach adulthood, *there is no avoiding their learning about sex*. Even if they stay home all the time and do nothing but watch TV and listen to the radio, your children will still see and hear thousands of references to sex every year. Do you really want to leave it to the soap operas and "shock jocks" to educate your children about this important subject? What kind of values do you suppose they will learn? Also, do not fool yourself. Children (in all likelihood your own as well) do talk about sex with their friends. Not only may your child's friends be misinformed, but do you want to leave it to your child's peer group to teach sexual values? By assuming the primary responsibility for your children's sex education, you not only can make certain that they are getting factual information, but at the same time you can stress the social and emotional aspects of sex and teach them values that you consider important. When parents teach their children about sexual activity and birth control, the children are much more likely to delay engaging in sexual intercourse and to use birth control when they do begin (Aspy et al., 2007; Parkes et al., 2011; van de Bongardt et al., 2014; see also Cox et al., 2015). June Reinisch, former director of the Kinsey Institute, said, "If parents are comfortable and have good information, they can be wonderful sex educators. They can contextualize the sexual information into the fabric of family values, ethics, morals and religious beliefs. Sex is embedded in all of these" (quoted by Henderson, 1990).

Personal Reflections

Someday you will probably be a parent (if you are not one already). Do you plan to educate your children about sexuality? If so, how? When will you begin?

10.9.4 Will a Single "Birds and Bees" Talk Suffice?

Do you really believe that one talk will prepare your child for a lifetime of sexual relations and problems? The answer is no! Experts say that it is a mistake to think that talking about sex means sitting down for one long, serious conversation. Even if you could fit all the necessary information and values into one talk, that one talk can hardly compete with the hundreds of hours of exposure to sexually related matters your child will receive while growing up. As Mark Twain said, education is a lifelong process. Communication between parents and children about sex and anything else should also be lifelong. Do not wait until your child has reached a certain age to have "the big talk." As researcher Carol Ford says, "Waiting until [age] 10 or 11 for 'the big talk' is less effective than incorporating the topic of sexuality into the course of everyday conversation. . . . Talk about what's on TV, and indicate whether you think it's acceptable or unacceptable behavior. . . . Discussions won't come easy, but if it doesn't go the way you wish, you can revisit the conversation a few days later" (quoted in Critchell, 2006).

Figure 10–15

Here is First Lady Barbara Bush with her granddaughter witnessing First Dog Millie giving birth. Moments like these provide parents a great opportunity to teach their children about sexuality.

Source: Time Life Pictures/White House/The LIFE Picture Collection/Getty Images

10.9.5 When Should I Start Talking with My Child About Sexuality?

When asked why she had not yet begun talking to her 13-year-old daughter about sex, a mother said, "I kept waiting for the right time. But I'm just too afraid to bring it up. I'm not sure what to say" (Roan, 1993). Many parents wait too long, and by the time they initiate a talk their children have already begun sexual activities (Beckett et al., 2010; Liddon et al., 2013).

As we hope you have learned by now, sex education is more than just explaining sexual intercourse. Children should be properly educated about their bodies. Many parents use childish names for parts of the body with boys and vague words like "privates" with girls (Martin et al., 2011). Teach them the correct anatomical terms for their genitals at the same time you teach them the names of the other parts of their bodies. "Penis" and "vagina" are not too difficult for young children to pronounce. American parents are notoriously silent about this. Teaching boys that they have a penis and girls that they have a vagina is honest and helps them attain a healthy attitude about sexuality.

"My mom never spoke with me about sex. This ignorance caused many misconceptions in my teenage years. So as a young, married adult I changed my attitude. No longer would I follow in the steps of my mother. I have 4- and 5-year-old boys now. They know the proper names for every part of their bodies. They know about exploring their bodies and when it is not appropriate for anyone to touch them. My mom says those words like 'wee wee' and 'petie.' That to me is just as disgusting as saying 'dick.' She becomes angry when I correct her, but she understands."

(from the authors' files)

It is also important to discuss with your children the physiological changes that start at puberty before they actually begin puberty. Some parents do not talk to their daughters about the menstrual cycle or to their sons about "wet dreams" until after they occur. These changes can be frightening to children, who may think that they are sick or dying.

"There is one thing I would personally put more emphasis on [in the book]. That is the importance of explaining menstruation in advance. From personal experience, I feel this is critical. I had no idea what was happening to me when I started menstruating for the first time. I can remember that I couldn't stop the bleeding and was scared to death and was afraid and embarrassed to tell anyone. I finally told a friend who was in the dark just as I was. She then told her mother. Her mother gave me a pad and said this would happen every month. That was the extent of communication on the subject."

(from the authors' files)

Be sure to explain the changes associated with puberty in girls to boys and the changes in boys to girls. Men should be able to relate to women with empathy and understanding, and vice versa. Ignorance about the physiological and emotional changes being experienced by the opposite sex is not a good basis on which to build relationships.

Children themselves are often the best guides as to when to initiate talks about a particular topic. It is common, for example, for young children to

ask where babies come from. If they are curious enough to ask questions about some sexually related matter, do not avoid discussing it. Never brush them off. If you do, they may avoid coming to you in the future and may rely instead on getting their information from somewhere else.

10.9.6 What Should I Tell My Children About AIDS and Other STIs?

With all the attention devoted to AIDS by the media today, children are naturally going to be curious about it. If you hear your child mention AIDS, be sure to take the opportunity to ask what he or she knows about it. Clear up any myths or misunderstandings. Remember, however, that you must teach your child about sexuality on a level that he or she can understand.

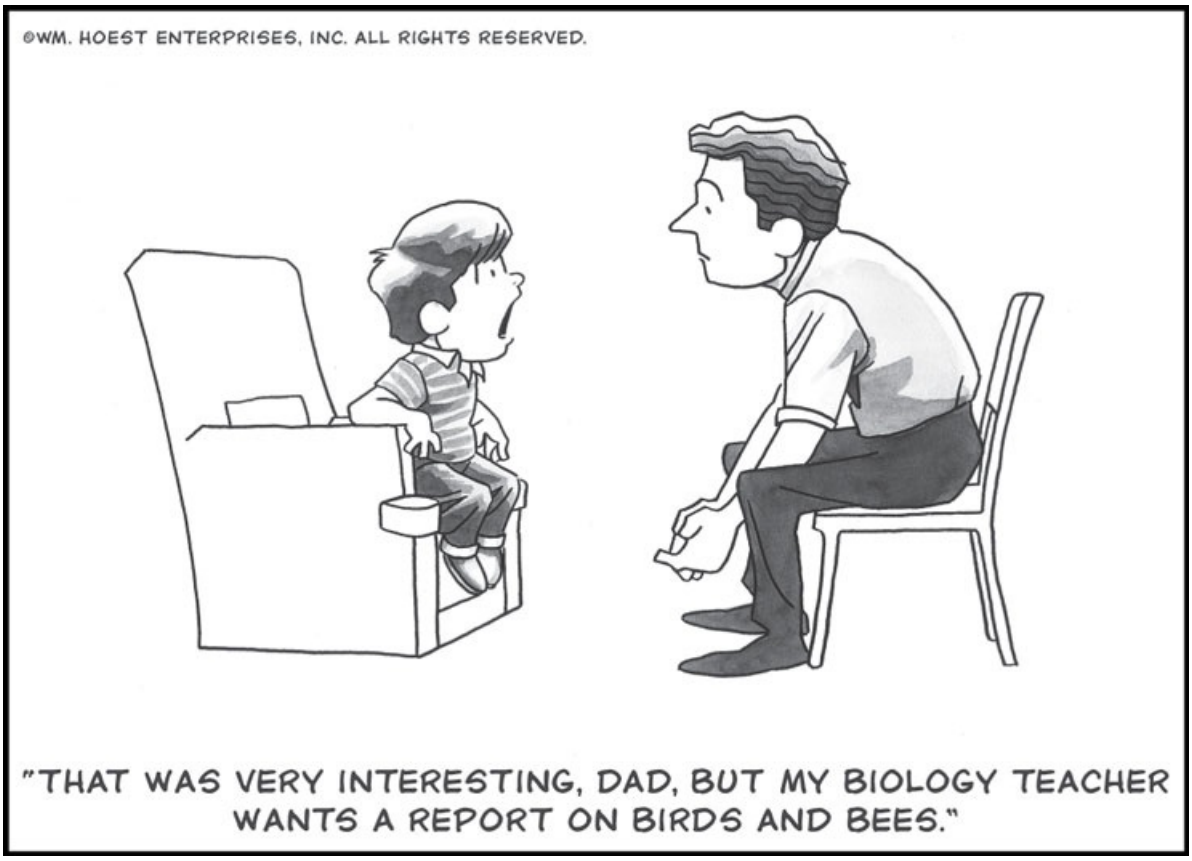
Most parents fear that in order to explain about AIDS, they must explain behaviors like anal and oral sex. This is really not necessary for preschool and elementary school children. Young children can be taught to be in charge of their own bodies—sexual responsibility—without being told what anal sex is.

What kind of questions is your child likely to ask? Children aged 9 to 12 will want to know about how AIDS is transmitted (e.g., whether they can get AIDS by holding hands, hugging, kissing, having sexual intercourse, or being in the same classroom with someone who has AIDS) and how they can tell if someone has it. Children at this age can also be taught about STIs such as gonorrhea, chlamydia, syphilis, and herpes (and told that they are caused by bacteria and viruses) (SIECUS National Guidelines Task Force, 1996). Teenagers will probably want answers to more explicit questions about transmission (e.g., whether they can get AIDS by French kissing, genital touching, or sexual intercourse) and prevention (including the use and reliability of condoms).

You should prepare yourself for questions like these so that you can give your child factual information about means of transmission, prevention, and treatment appropriate for his or her age. When answering questions, you can also discuss values with your child. No matter what your child's age, *you should not deny the pleasures of sex or resort to scare tactics*. Teaching children that sex is something good and pleasurable is as important as teaching that it must be handled responsibly.

10.9.7 How Detailed Should Sex Discussions Be?

Your discussions should be frank and explicit. Children do not want "birds and bees" analogies; they want factual information using real terms. In fact, euphemisms and analogies will only confuse them. At the same time, do not make things too detailed for your child's age level. Many parents tend to over-answer. *Keep your answers simple and age-appropriate*. Always check to see if your child understands what you have said. You may have to rephrase your answer to make it clear. Sometimes we give great answers, but not to the question the child asked. Remember, a child may not know what to ask or how to ask it correctly. When a 6-year-old asks where babies come from, for example, many parents worry that they must explain sexual intercourse in detail. Most questions about "sex" asked by children younger than 10 are really about biology (Snegroff, 2000). Keep your answer uncomplicated and tell the child only what he or she wants to know. In this case, you could explain that the baby is in a special part of the mother called a uterus (do not avoid explicitness by saying "tummy"—this is incorrect anyway) and that when it is ready to be born it comes out through an opening called the vagina.



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Discussions with your teenage children should definitely be frank and explicit. Parent-to-teen talks about sex tend to focus on values and beliefs rather than facts. In one study, we asked students and their parents if they had ever had a "meaningful" discussion about sex with one another (King & LoRusso, 1997). Over half of the students responded "no," yet for 60% of them one or both parents said that there had been meaningful discussions. Here are some responses by parents who believed that they had had meaningful discussions (but whose children disagreed):

"I believe children should be taught that total abstinence is the best way. . . . This is so because of God's law and the design for total inner peace and joy."

"My discussion with dealt with one's soul. A soul is not to be fragmented—not to be given away in bits and pieces. A soul is sacred—sex is sacred."

"They [the children] knew what was expected, and they behaved accordingly. . . . If you asked about teaching morality to my children, the answer is yes, and if you teach and live a good, healthy, moral life, it usually works."

There is nothing wrong with teaching your children values. However, do not substitute morality for factual information.

10.9.8 What If I Feel Embarrassed?

Many parents avoid talking to their children about sex because they are embarrassed or uncomfortable (Elliott, 2010; Jaccard et al., 2000). Chances are, your children will also be embarrassed (Ogle et al., 2008). Parents' talks with their children about sexuality are most effective when the parents are open, skilled, and comfortable. Many of you will not be able to avoid embarrassment at times, but the result—your child's education—is worth the initial discomfort of using real terms and direct language. Be honest. Let your children know that you are a bit embarrassed but that you are glad they asked to talk with you, that you will be happy to answer all of their questions, and that it is okay to talk to you about the subject. What you say to your children is important, but *how you say it is just as important*.

10.9.9 How Should I Talk with My Child?

Most important, *discuss—never lecture*. Also, be sure not to grill your child about his or her behavior or attitudes. Parents who try to dominate and assert themselves will probably be met with passivity (e.g., Lefkowitz et al., 2000), while those who take an open, collaborative approach will probably find that their children actively engage in discussions (K. S. Miller et al., 1998). In other words, allow your child to have his or her input. Two keys are that your children view you to be **"**askable**"** and **"**accepting**"** (Snegroff, 2000). "An accepting parent does not convey a negative attitude or exhibit negative behavior when a child's natural curiosity leads to a question or comment. They convey the impression that all questions are good ones and all comments can be discussed" (Snegroff, 2000). Your tone of voice is particularly important, for your child learns attitudes from your tone. Try to sound calm and relaxed at all times.

Remember, it is not necessary always to have formal talks; this may create tension. You can break the ice by briefly explaining and discussing sexually related matters that your child sees on TV or hears on the radio. Recall, too, that parent–child talks about sexuality are easier when the parents have a history of talking with their children about other personal topics (Raffaelli et al., 1998).

Avoid scare tactics. You must teach sexual responsibility without making your child afraid of sex—children should learn that sex is something good and positive and not something to feel ashamed or guilty about. Scare tactics probably will not work anyway, and they may cause emotional and psychological problems.

Personal Reflections

How do you suppose you would react if…

1. Your 5-year-old child asked you where babies come from?
2. Your 9-year-old child asked you what sex is?
3. Your 10-year-old child asked you what "French kissing" is?
4. Your 12-year-old son came home from school saying that he had to watch a "gross" movie about girls having their period?
5. Your 15-year-old son asked you about birth control?
6. Your 15-year-old daughter asked you about birth control?

Would your reactions to any of these situations discourage your child from coming to you in the future and talking to you about sex?

Figure 10–16

When talking to your children about sex, discuss—never lecture. Let them have their input. Remember, be "askable" and "accepting."

Source: Jack Hollingsworth/Photodisc/Getty Images

10.9.10 What About Morals? Aren't They Important Too?

Sex is more than a biological function. If you want your children to share your beliefs and values about sex, you must talk about them. Children who know that their parents disapprove of teenage sex are more likely to postpone having sex (Ford et al., 2005). However, your success in imposing your values upon your children will depend, in large part, on your overall relationship with them. Parents who generally have good loving interactions with their children are more successful in transmitting values than are parents who generally have poor interactions with their children (Resnick et al., 1997; Taris & Semin, 1997; Wilson et al., 2010).

When you discuss moral values with your child, there are some important guidelines you should follow. Most importantly, *you can emphasize your values, but do not preach or try to dominate*. It is not wrong for you to say how you feel, but if your child has developed some values that are different from yours, you must learn to discuss your differences rather than dictate. Remember, you want to create an atmosphere that allows your child to be comfortable so that he or she will come to you with any questions. If you always preach and pass judgment, your child may be reluctant to discuss sexuality with you at all, and then you will have no input.

One of the biggest dilemmas facing parents when discussing sexuality with their children is whether to emphasize global moralities or situational ethics. Global moralities are values that are supposed to apply to all people under all circumstances. An example is when parents tell their children that sexual relations should be reserved for marriage. As you recall, however, surveys show that well over half of all adolescents engage in premarital intercourse. Can you safely assume that your children will never have premarital sexual relations and that you can thus avoid the topic of birth control? The consequences of not talking about it, however, can be devastating (e.g., unwanted pregnancies and/or sexually transmitted infections).

Situational ethics emphasize the proper thing to do in particular situations (i.e., "We prefer that you not do it, but if you're going to do it anyway,

then…"). In this case, for example, it could be explained to an adolescent child that condoms substantially reduce the risk of both unwanted pregnancy and sexually transmitted infections.

Parent–child communication about sex has increased since 2002, but many parents still stress abstinence (60%) more than condoms (29%) (Stidham-Hall et al., 2012). We cannot tell you which of these two approaches to use. Only you can make that choice.

10.9.11 Can My Behavior Affect My Child's Attitudes and Behavior?

You should also be aware that *your own behavior can play a role* in your child's sexuality and moral values. It is important for children to learn that their parents share affection for each other. Hugging between parents and between parents and children teaches youngsters that the open display of affection is appropriate and appreciated.

"My husband and I have always tended to be very private about showing affection. I guess that's because our parents were that way. However, as a result of what I've learned in this class we've been hugging and kissing in front of our kids—who are both teenagers. They've noticed the changes and have even asked us about it, which has given us wonderful opportunities for open and frank discussions with them. Hopefully, it's not too late."

(from the authors' files)

At the same time, we live in a day when many parents are divorced and have boyfriends and girlfriends of their own. You must avoid appearing to be hypocritical. If you want your child to abstain from premarital sexual relations, for example, you must avoid premarital sexual relations or be very discreet yourself. What message do you suppose you are sending your children if you tell them it is wrong to engage in sex and they know that you are having premarital sexual relations?

Even if you never discuss sexuality with your children, your behavior will still serve as a role model. Unfortunately, many children acquire negative attitudes about sexuality by watching and listening to their parents. Many adults, for example, enjoy "dirty" jokes. What attitude do you suppose is conveyed when children overhear their parents laughing and snickering at jokes involving sex or body parts? Learning that there are "clean" and "dirty" jokes can lead to beliefs that sex is dirty, especially if other sources of information about sex are unavailable. Also, laughing at a child's use of obscenity or joking about it will only reinforce the behavior, making it increase in frequency (remember, you are a role model). If your child uses an obscenity, don't go overboard. Calmly explain what the word means. Often the child will not know. Reacting calmly tells children that they can discuss anything with you.

10.9.12 How Do I Know If I Have Succeeded?

You can judge the success of your attempts to educate your children about sexuality only by their willingness to come to you when they have questions and problems.

"I am a nontraditional student with three kids. I didn't know that I should start talking with them about sex at such a young age. My boys are 7 and 9 and my daughter is 5 years old. They are very receptive to our talks. And now they always want to talk to me about anything. 'Open lines of communications.' Thanks."

(from the authors' files)

All adolescents will have an interest in sex. They will want to know about dating, courtship, marriage, living together, starting a family, and many different things at different times in their lives. They will seek information about these and other matters from a variety of sources, and you will want to be one of them. This will only happen, however, if communication between children and parents is open and continuous.

Study Guide

Key Terms

- accepting
- adolescence
- ageism
- askable
- climacteric
- delayed puberty
- emerging adulthood
- global moralities
- gynecomastia
- hooking up
- menarche
- menopause
- necking
- nocturnal emission
- open marriage
- peer pressure
- petting
- precocious puberty
- puberty
- secondary sex characteristics
- serial monogamy
- sexual learning
- situational ethics
- swinging

Interactive Review

Answers can be found on p. 471.

1. People are sexual beings from the moment of birth. In infancy, self-stimulation of the genitals is motivated by a general attempt to explore the body and seek pleasure. As children grow, their curiosity about their bodies continues and, during early childhood, reaches a peak in the age period from (1) years old. Early childhood games such as "house" or "doctor" allow exploration of same-sex and opposite-sex individuals. In the initial school-age years, children develop a sense of (2) . Although overt sexual play may decrease, curiosity about the human body and sexuality does not.

   (3) is the time in life in which an individual first becomes capable of (4) and shows sexual attraction to others. Many bodily changes occur, the result of changing (5) levels, and these physical changes require many adjustments for young adolescents. Interest in sex increases dramatically at puberty, and earlier childhood games evolve into more erotic and consciously sexual games. The most important issue in the lives of most adolescents is (6) , and during these years there is a focus on body image and physical characteristics. Almost all teenage boys and a majority of girls masturbate, which is usually accompanied by sexual fantasies. Sex therapists feel that masturbation is a safe and healthy sexual outlet for teenagers. Surveys find that (7) of American high school seniors have engaged in sexual intercourse. For some teens, however, having sexual relations is not a positive experience, yet many engage in it because of (8) .

By the time people are in their mid-20s, most people's sexual lifestyle is characterized by (9) , either in marriage or by cohabitation. Most young people underestimate the frequency of sex practiced by older adults. Sexual activity is highest for people in their (10) , and only gradually declines up through the late 50s. Surveys indicate that married people have sex more often than singles and are happier with their sex lives than are singles.

As women grow older, their menstrual cycles become irregular and eventually stop entirely, which is called (11) . This usually occurs in a woman's late 40s or early 50s, and the change in hormones can result in hot flashes, a decrease in (12) , and osteoporosis. Men show a gradual decline in (13) beginning in their late teens. This also results in some physical changes, such as a decline in muscle mass and strength, less firm erections, less forceful ejaculations, and longer (14) periods. However, most elderly people continue to enjoy sexual relations as long as they remain otherwise healthy and have a partner. For healthy couples, the best predictor of whether they will enjoy sex in old age is (15) .

It is important for parents to learn to communicate with their children about sexuality in a positive manner. Your children will learn about sex regardless of whether you ever talk to them about it. (16) begins in infancy, and children receive it from their peers, the media, and your own behaviors. Avoid that one long "birds and bees talk" approach; communication between parents and their children about sexuality should begin (17) and be ongoing. Discussions with your children about sexuality should be frank and explicit. When talking to your children about sex, (18) is just as important as what you say. You should strive to create an atmosphere of love and caring, so avoid (19) and do not lecture to them. It is also important that your children view you to be accepting and (20) . You can emphasize your own sexual values, but remember that your own behavior will affect your child's attitudes and moral values. The only way you will be able to know whether your attempts to educate your children about sexuality have been successful is by their (21) .

Self-Test

Answers can be found on p. 471.

A. True or False

- **T F** 22. Ultrasound recordings have found that male fetuses have erections while still inside the uterus.
- **T F** 23. Children cannot masturbate to orgasm until they reach puberty.
- **T F** 24. The growth of pubic hair on girls is the result of increased levels of testosterone.
- **T F** 25. If a child is found engaging in sexual exploration games with another child of the same sex before age 7, it means the child is probably homosexual.
- **T F** 26. Couples who lived together before marriage are less likely than other couples to get divorced.
- **T F** 27. In a study of 202 men and women aged 80 to 102, it was found that nearly half still engaged in sexual intercourse.
- **T F** 28. The lack of vaginal lubrication in women who have undergone menopause is an indicator that their sexual desire has decreased.
- **T F** 29. The average married couple in their 20s or 30s have sex more often than young singles.
- **T F** 30. The average age at which girls have their first menstrual cycle has been decreasing over the last 2 centuries.
- **T F** 31. "Hot flashes" are due, in part, to increasing levels of pituitary hormones.
- **T F** 32. The best predictor of sexual activity for older women is the amount of vaginal lubrication they had when they were younger.
- **T F** 33. Boys often develop enlarged breasts during puberty.
- **T F** 34. In early childhood it is normal for children to engage in sexual behaviors that imitate adults.
- **T F** 35. The way parents react to the sexuality of their children is generally an indication of the way they feel about their own sexuality.
- **T F** 36. In terms of hormone changes with aging, men and women are very much alike.
- **T F** 37. In men, the production of sperm generally stops by the early 50s.
- **T F** 38. Most women show a decreased interest in sex after menopause.
- **T F** 39. In some cultures, hot flashes are uncommon among postmenopausal women.
- **T F** 40. Pubertal development in boys lags about 2 years behind development in girls.
- **T F** 41. If an adult man is castrated, it substantially raises his voice.

- **T F** 42. Girls as young as 6 or 7 have given birth.
- **T F** 43. Most teenage girls experience severe pain during their first sexual intercourse.
- **T F** 44. There is a strong relationship between social background (religious and political views) and whether one engages in extramarital affairs.
- **T F** 45. Children's first sexual attractions occur around age 10.

B. Matching

Which hormone changes are most likely to be associated with the following physical or behavioral changes?

- 46. breast development in girls
- 47. vaginal dryness at menopause
- 48. hot flashes in women
- 49. development of sweat glands (body odor, acne)
- 50. gynecomastia
- 51. pubic hair and body hair
- 52. menarche
- 53. less firm erection and longer refractory period
- 54. reversal of effects of menopause
- 55. decreased sexual desire in women (review from Chapter 3)
- 56. decreased sexual desire in men (review from Chapter 3)
- 57. children's first sexual attractions

1. increase in estrogen
2. decrease in estrogen
3. increase in testosterone
4. decrease in testosterone
5. increase in FSH and LH
6. increase in DHEA from adrenal glands

C. Fill in the Blanks

- 58. The decline in sexual activity among older single women is most often due to .
- 59. The changes that occur in women in the few years that precede and follow menopause are called .
- 60. Before age 2, bodily exploration is usually confined to .
- 61. Freud referred to what this chapter calls the initial school-age years as the stage of psychosexual development.
- 62. Development of breasts and growth of facial hair are examples of .
- 63. For many teenage girls, the need for is an important part of finding their self-identity.
- 64. Whitehurst believed that the two things most likely to lead to extramarital sex are and .
- 65. Puberty is at least a two-part maturational process. The two parts are called and .

Suggested Readings and Resources can be found on p. 462.

Chapter 11 Adult Sexual Behaviors and Attitudes

> . . . never before in history has there been such a huge disparity between the open display of eroticism in a society and that society's great reluctance to speak about private sexual practices.

—Robert Michael, John Gagnon, Edward Laumann, & Gina Kolata, 1994

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 11.1 Explain what is meant by "normal" sexual behavior.
2. 11.2 Identify the major historical sources of negative attitudes toward masturbation and discuss recent findings about this sexual activity.
3. 11.3 Explain why the incidence of some sexual behaviors often differs as a function of age, ethnicity, gender, and other demographic variables.
4. 11.4 Summarize the research findings about the frequency, quality, and role of sexual fantasies in enhancing sexual expression.
5. 11.5 Describe research on sexual intercourse frequency and duration, and explain why different cultures, as well as individuals within a culture, use different positions of sexual intercourse.
6. 11.6 Define fellatio and cunnilingus and describe the current research findings on these activities.
7. 11.7 Describe what is known about anal sex—types, prevalence, and preferences.
8. 11.8 Define what it means to be a "sexually healthy" person.
9. 11.9 Explain fornication, adultery, and sodomy laws and discuss their implications for heterosexual and homosexual individuals living in the United States and in other countries around the world.

For the human species to survive, men and women must have sexual intercourse. We need only look at the large number of people in the world to know that this is not an uncommon sexual practice. But what about other sexual behaviors—that is, behaviors that are not necessary for procreation? How many people engage in oral-genital sex? Is it "weird" for you or your partner to want to try different positions during intercourse? Is it normal to have sexual fantasies? Is masturbation unnatural and bad for your health? Many people are unsure about the answers to these questions and thus may have anxieties about whether the sexual behaviors they or their partners wish to engage in are "normal."

What Is Normal?

1. 11.1 Explain what is meant by "normal" sexual behavior.

Just what is "normal" sexual behavior? The honest answer is that it depends. Many factors are involved in determining "normality," including the historical time and the cultural or social context in which a person lives. During the Victorian era, for example, moralists and scholars argued that the only truly normal sexual behavior was heterosexual vaginal intercourse in the male-on-top "missionary" position. Other forms of sexual expression, including foreplay, were considered either pathological or acceptable only under very specific circumstances. Take kissing, for instance. In the early 1900s, Freud (1905/1938) suggested that kissing was merely a preliminary sexual activity "which should normally be rapidly passed, on the way to the definite sexual aim" (p. 564) of intercourse. He felt that anyone who lingered too long at this preliminary stage, showed a marked enjoyment of kissing or preferred kissing over intercourse, was abnormal and in need of immediate clinical intervention.

Today, few scientists or scholars would agree with the notion that enjoyment of kissing indicates underlying psychopathology or that missionary-style vaginal intercourse is the only acceptable form of sexual expression. Indeed, people (in Western culture, at least) regard a wide variety of behaviors to be normal. The 2010 NSSHB study found that roughly half of American men and women engage in more than one sexual behavior when having sex (Herbenick et al., 2010a; see Table 11–1). The study also revealed just how diverse those behaviors can be: The researchers found an astonishing 41 combinations of behaviors reported by participants during their last episode of sexual intercourse!

Table 11–1 How Many Different Things Do People Do During Sex?

Number of Behaviors	Percentage of Women	Percentage of Men
One behavior only (e.g., partnered masturbation, vaginal intercourse, oral-genital, anal)	46%	43%
Two behaviors only (e.g., masturbation + oral, oral + vaginal intercourse)	24%	22%
Three or more behaviors (e.g., masturbation + oral + vaginal intercourse)	26%	33%

Note that these percentages will not sum to 100% because some of the participants engaged in behaviors during their last sexual encounter that were not listed on the survey, and so we do not know what (or how many) acts they did with their partners.

Source: Herbenick, D., et al. (2010). An event-level analysis of the sexual characteristics and composition among adults ages 18 to 59: Results from a national probability sample in the United States. *Journal of Sexual Medicine*, 7 (Suppl 5), 346–361.

Table 11–1 Full Alternative Text

Of course, we must be careful not to be ethnocentric (see Chapter 1). What is considered to be normal sexual behavior in our culture may not be considered normal in other cultures, and vice versa. Take a peak ahead to Box 11–A and you will see that even in the United States there are major differences among ethnic groups in the prevalence of some sexual behaviors. What is considered normal also changes over the life span of an individual. We will return to a discussion of "normal" in the beginning of Chapter 14.

In this chapter you will read about several sexual behaviors that can be considered normal (in Western culture) from a statistical point of view. If a behavior is *statistically normal,* it means that a large number of people engage in it (in other words, it is a relatively common behavior). Keep in mind, though, that just because a behavior can be considered "normal," this does not mean that everybody engages in (or even approves of) it. Therefore, you should not consider yourself (or anyone, for that matter) to be "abnormal" if you have not engaged in some or all of the behaviors discussed here. It is best to think of normal behavior as a *range of behaviors*.

For any particular behavior, there is also the question of how frequently people engage in it. How often is normal? Averages can be (and are) computed, but you should not interpret "normal" as meaning only the average value. Again, normal involves a *range of values*. For example, what is the normal number of times per month that married women masturbate? The answer is a range (from zero to some higher number).

The incidence and frequency of the various sexual behaviors you will read about in this chapter were obtained from participants who were selected by researchers and who voluntarily agreed to take a sex survey. Be sure to review the section on surveys and sampling procedures in Chapter 1.

Personal Reflections

What was your emotional reaction, if any, on learning that a sizeable proportion of U.S. adults engage in multiple activities during sex? How about when you first saw the drawings for this chapter? Were your reactions primarily positive, primarily negative, or a mixture? Why do you think you responded in that way? Do you regard the behaviors discussed (and illustrated) as "normal"?

Masturbation

1. 11.2 Identify the major historical sources of negative attitudes toward masturbation and discuss recent findings about this sexual activity.

"Until I became sexually active with a partner, I masturbated every day. Even after marriage, I continue to masturbate." (man)

"The guilt I feel right after masturbating is so painful that I cry at times." (man)

"I have a steady girlfriend who satisfies my sexual needs. But sometimes I am not able to satisfy hers. This is the primary reason why I enjoy masturbating—because I don't have to worry about trying to satisfy anyone but me." (man)

"I am a man of faith and my spiritual and cultural upbringing teaches me that self-pollution is a sin. I have done it but I am disgusted by my own weakness. Masturbation is an offense to God and to your own body and soul." (man)

"Jacking off is great. I do it pretty much every day. Sometimes more. It's normal and natural and keeps me sane. If I couldn't get off, I'd go crazy. It's good stress relief." (man)

"I didn't masturbate until after I was sexually active, which was in college. In between sex with my boyfriends, I didn't know there were ways I could 'pleasure' myself with sex—and without a partner. Now, after finding it, I truly enjoy it." (woman)

"I had masturbated long before I became sexually active and, as long as I kept it to myself, I never seemed to have a problem with it. Now, when my boyfriend asks me if I ever masturbated, I can't help but feel guilty." (woman)

"I've masturbated since about the age of 14. I still do, with and without my husband present. I have no guilty feelings about it, not even when I was younger. There are times when I would rather masturbate than make love. Not that I would give up intercourse. It's just nicer sometimes." (woman)

"All through my childhood I thought that masturbation was something only guys could do. But *Cosmo* started printing all kinds of articles telling women to masturbate so they can show their partner what to do, and I got confused. I know I shouldn't be ashamed of my body, but I still can't bring myself to do it." (woman)

"I am 36 years old and never in my wildest dreams would I have thought I would be masturbating, but I did and I think it's great because I can stimulate parts that a male partner would not have the slightest idea about." (woman)

(All examples are from the authors' files.)

Attitudes About Masturbation

As you can see from these examples, there is a wide range of attitudes and emotions regarding masturbation (see Bowman, 2014; Kaestle & Allen, 2011). Some people clearly enjoy the act and find it both acceptable and pleasurable—a celebratory attitude that is reflected in Klimt's drawing (see Figure 11–1). Others are bothered, embarrassed, and even disgusted by it. Does it surprise you that people have such diverse attitudes? When you were growing up, what kinds of things did you hear about masturbation? Some of us were told (by friends, acquaintances, and sometimes parents) that masturbation or self-stimulation of the genitals, could cause us to go blind or deaf; cause nosebleeds, heart murmurs, acne, or painful menstruation; cause hair to grow on the palms of our hands; and finally, if we did not stop, result in insanity. Others of us were simply told that we had better not do it to excess. We were not told how much was excessive or what would happen to us if we went over "the limit," but the implication was always that something bad would happen to us. And still others of us were told that it was okay to do it but that we should not talk about it. In sum, we pretty much all got the message that masturbation was not quite appropriate—either as a topic of discussion or as a personal activity.

Figure 11–1

Woman Seated With Thighs Apart by Gustav Klimt conveys a positive attitude toward masturbation and the female body.

Source: Art Collection 3/Alamy Stock Photo.

Historical Perspectives.

Where does this message come from? Why does masturbation have such a bad reputation? Negative attitudes about masturbation have, in fact, been handed down from generation to generation for centuries. The Greek physician Hippocrates believed that masturbation (and other forms of non-procreative semen loss, such as nocturnal emissions) was harmful to men's physical health, causing spinal weakness and, eventually, death. Ancient Chinese cultures condemned male masturbation as a waste of *yang* (male essence), while the biblical Hebrews considered it "spillage of seed," punishable by death. The early Roman Catholic Church considered procreation to be the only legitimate purpose of sex, and masturbation and other sexual behaviors that did not lead to procreation were considered immoral. The Church's negative view of masturbation was formalized in the 1200s by Thomas Aquinas, who included it as one of the four categories of unnatural acts (Aquinas, 1265–1274/1968). Many scholars believe that the word *masturbation* is derived from the Latin words *manus* ("hand") and *sturpore* ("to defile") or *tubare* ("to disturb").

In 1741, a Swiss physician named S. Tissot published a book entitled *Onania, or a Treatise upon the Disorders Produced by Masturbation*, in which he expanded upon the medical views of Hippocrates. In his book, Tissot claimed that the unnatural loss of semen and overexertion of the nervous system associated with masturbation led to mental disease. As proof of this, he said, one only had to look at the many men in insane asylums who sat around openly masturbating. Tissot also asserted that the loss of one ounce of seminal fluid "enfeebles" more than forty ounces of blood. These views were accepted by many of Tissot's contemporaries as well as by subsequent generations of physicians in the 19th and early 20th centuries. In 1858, for example, Philadelphia surgeon George Calhoun was commissioned by the philanthropic Howard Association to write a report for the public about the "vice" of masturbation. He concluded that semen was produced more slowly than any other fluid in the human body and that its "excessive loss" (such as occurs during masturbation) therefore had disastrous consequences on the overall health of the individual (see Wong, 2002).

Noted American physician Joseph Howe came to a similar conclusion in 1889, writing that "masturbation is a universal vice in civilized countries" (p. 62) and painstakingly documenting the numerous physical maladies that would bedevil masturbating men (and, to a lesser extent, women). These included:

- misshapen genitals (in men, small, lopsided testicles and a thin, short penis that was cold to the touch, covered in varicose veins, and bent to

one side; in women, an elongated clitoris, reddened vaginal opening, and dry, dark-tipped labia)

- spinal cord tumors, brain hemorrhage, and cerebral anemia or "chronic softening of the brain"
- emaciation, flabby muscles, poor posture, and dragging feet
- skin conditions (acne, paleness, dark circles under the eyes)
- gastrointestinal issues (constipation, acid indigestion, bloating, gas)
- heart palpitations and enlargement
- vertigo, headaches, and memory problems
- epilepsy and seizures

According to Howe, most masturbators also would become sterile. However, if they did manage to reproduce, the harmful effects of masturbation would almost certainly be passed on to their children: "The child of masturbating parents enters the world with vitality so impaired that there is a constant invitation to the attacks of every affection" (p. 93). The notion that masturbation could cause illness not only in those who practiced it but also in their children was common, as illustrated in a page from a health manual published in the late 1800s (see Figure 11–2).

Figure 11–2

Fig. 10. A Deformed Child born to a Masturbator.

Illustration of the evils of self-pollution as commonly depicted in the late 1800s.

Source: Rick Grunder Books.

Given these widely held beliefs, it is hardly surprising that many Victorian-era parents were explicitly told by medical professionals to warn their children about masturbation and prevent them from practicing it at all costs. Here is the advice that Dr. Mary Melendy gave to mothers about what to tell their sons in her 1903 book *Perfect Womanhood*:

> Impress upon him that if these organs are abused, or if they are put to any use besides that for which God made them … they will bring disease and ruin upon those who abuse [them]…. He will not grow up happy, healthy and strong.
>
> Teach him that when he handles or excites the sexual organs, all parts of the body suffer, because they are connected by nerves that run throughout the system, this is why it is called "self-abuse." … The sin is terrible, and is, in fact, worse than lying or stealing!
>
> If the sexual organs are handled it brings too much blood to these parts, and this produces a diseased condition, it also causes disease in other organs of the body, because they are left with a less amount of blood than they ought to have….
>
> It lays the foundation for consumption, paralysis and heart disease. It weakens the memory, makes a boy careless, negligent and listless.
>
> It even makes many lose their minds; others when grown, commit suicide.

Professor G. B. Jefferis gave similar advice to mothers in 1896, exhorting them to tell their daughters the following facts about masturbation plainly and openly:

> Know that the same signs that betray the boy will make known the girl addicted to this vice. The bloodless lips, the dull, heavy eye surrounded with dark rings, the nerveless hand, the blanched cheek, the short breath, the old, faded look, the weakened memory and silly irritability tell the story all too plainly. The same evil result follows, ending perhaps in death, or worse, in insanity. Aside from injury the girl does herself by yielding to this habit, there is one other reason which appeals to the conscience, and that is, self-abuse is an offence against moral law—it is putting to a vile, selfish use the organs which were given for a high, sacred purpose.
>
> Let them alone, except to care for them when care is needed, and they may prove the greatest blessing you have ever known. They were given you that you might become a mother, the highest office to which God has ever called one of His creatures. Do not debase yourself and become lower than the beasts of the field….
>
> And you, Mother, knowing the danger that besets your daughters at this critical period, are you justified in keeping silent? Can you be held guiltless if your daughter ruins body and mind because you were too modest to tell her the laws of her being? There is no love that is dearer to your daughter than yours, no advice that is more respected than yours, no one whose warning would be more potent. Fail not in your duty.

(Jefferis & Nichols, 1896, p. 389)

But what was a parent of that era to do if his or her child continued to masturbate? Most physicians, including Howe, believed that the best cure for masturbation was a healthy lifestyle that included nutritious food, daily exercise, adequate sleep, proper hygiene, good companionship, and abstinence, along with appropriate medications as needed. Indeed, Dr. J. H. Kellogg (1887) and Rev. Sylvester Graham (1834) both invented mild, easily digestible food items (cornflakes and graham crackers, respectively) that they believed would help curb excessive sexual appetite and guard against self-pollution. Of course, some medical professionals advocated more extreme measures, including steel penis rings and chastity belts (see Figure 1–4). For children, Kellogg (1887) suggested bandaging the genitals and tying the hands as well as circumcision for boys (because the subsequent soreness would prevent masturbatory activities). For adults, he recommended inserting steel sutures through the penis to prevent erection and applying carbolic acid to the clitoris. Other practices during that time included electrical shock, acupuncture, and, in extreme cases, complete castration (complete removal of the genitals).

Contemporary Perspectives.

Times have changed. No modern-day physician in 21st-century America, for example, would advocate castration as a cure for masturbation (at least we hope not!). But negative attitudes are still widely found around the world. For example, the Roman Catholic Church's official doctrine on sexual ethics, *Persona Humana*, states that masturbation is an "intrinsically and seriously disturbed act" (Congregation for the Doctrine of the Faith, 1975). This official view was reaffirmed by Pope John Paul II in 1993 and again by Pope Benedict XVI in 2011. Similar views are espoused by other religious groups. According to Jewish religious law (*Halakha*), masturbation is as serious an offence as murder and a man who touches himself "below the navel" should have his hand chopped off (see *Mishneh Torah* 21:18; *Shulchan Aruch* Even Ha'ezer 23:1; *Talmud* Niddah 13a). Although some Jewish denominations (e.g., Conservative, Reform) have adopted a more flexible or forgiving view toward masturbation, others (e.g., Orthodox) continue to condemn it as one of the worst sins a person can commit. Masturbation also is generally forbidden under Sharia (Islamic) law.

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But how about in secular (non-religious) contexts? Consider the following situation. In 1994, U.S. Surgeon General Joycelyn Elders attended the United Nations World AIDS Day conference, where she was asked whether masturbation might be taught in school sex education classes as a potential way to prevent AIDS. She replied that masturbation was "something that is a part of human sexuality and it's a part of something that perhaps should be taught." (She later clarified that she was not suggesting that masturbation itself be taught in schools, but rather the idea that masturbation is a normal part of human sexuality.) One week later, she was fired by then-President Bill Clinton for having values contrary to administration policy and his own convictions. In response to Elders's firing, sociologist John Gagnon was quoted as saying, "It remains a puzzle for me why a relatively innocuous behavior evokes tides of anxiety and fear in otherwise well adjusted people." What do you think about masturbation? Where do you stand?

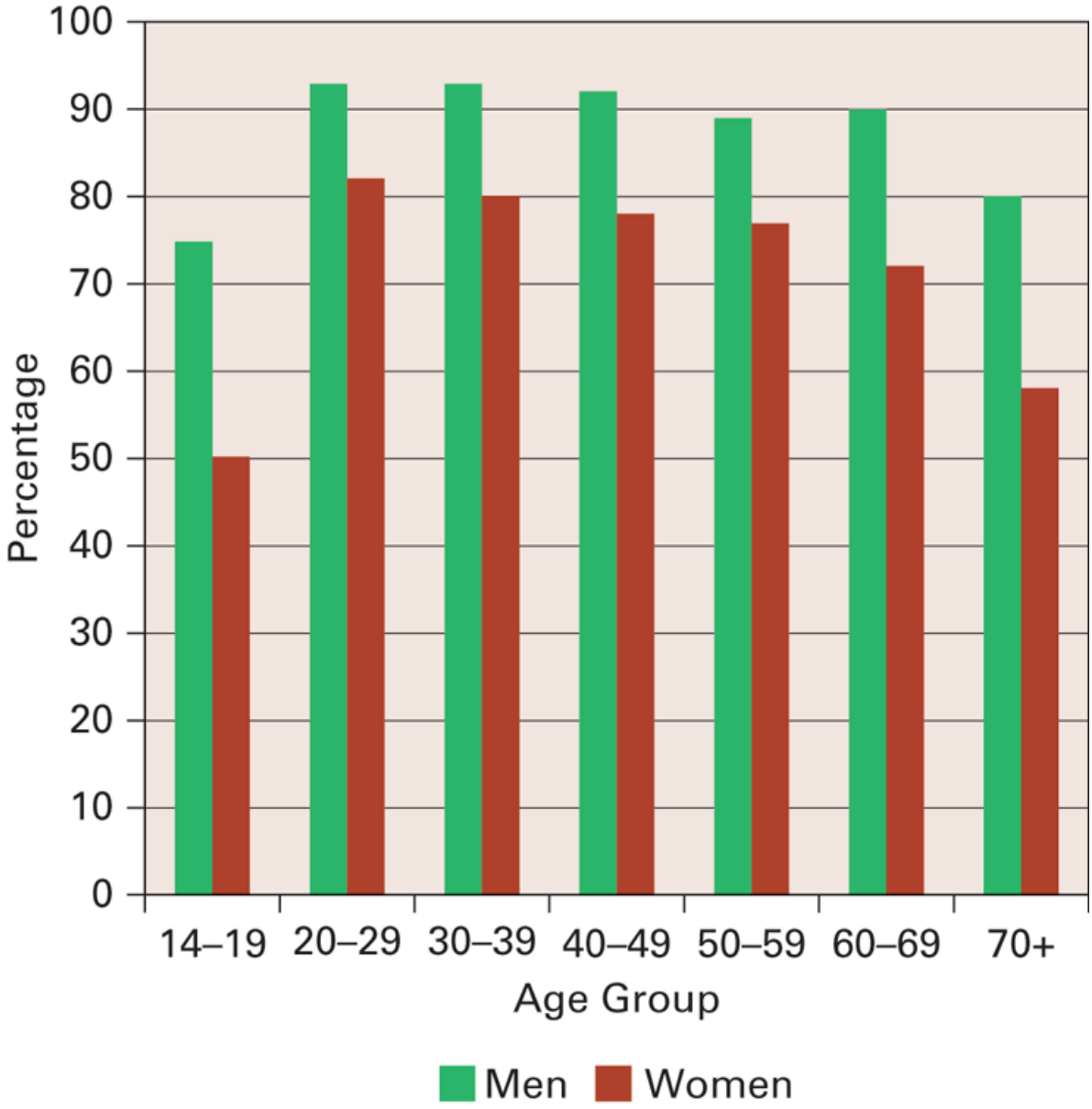
Incidence of Masturbation

With this long history of negative publicity and outright scare tactics, you might expect that very few people masturbate. But in actuality the large majority of people masturbate. This was true when your great-grandparents were young. Kinsey and colleagues (1948, 1953) found that 92% of the men they surveyed had masturbated by age 20. It was generally the first sexual experience to orgasm for adolescent boys. Only a third of the women in Kinsey's study reported that they had masturbated by age 20, but another third had done so by age 40 (a total of 62%). In other words, men were more likely to start masturbating before they experienced sexual intercourse, whereas many women did not start masturbating until after they started engaging in sexual intercourse.

Masturbation remains a significant component of most people's sexual behaviors across the life span. In their large national survey, Laumann and colleagues (1994) found that about 60% of men and 40% of women (aged 18–59) said they had masturbated in the past year (and about 25% of men and 10% of women reported that they masturbated at least once a week). Similar results were reported more recently in the 2010 NSSHB study (Herbenick et al., 2010c). Most participants had engaged in masturbation during their lifetime (see Figure 11–3). In addition, relatively high numbers said they had done so within the past 30 days (although rates were lower for the oldest participants in the study): 52% of teenage boys and 25% of teenage girls (aged 14 to 19), 66% of men and 50% of women in their 20s, 66% of men and 39% of women in their 30s, 60% of men and 39% of women in their 40s, 56% of men and 28% of women in their 50s, 42% of men and 22% of women in their 60s, and 28% of men and 12% of women aged 70 or older had masturbated in the past month. As you can see from these percentages, there is no age group in which lifetime or monthly masturbation rates are 0%. Clearly, a lot of people are doing it (or at least have tried it)! Recent research conducted with other

large samples of adults in the United States (Dodge et al., 2016) and other world regions (Western Europe, Oceania, the Middle East; Richters et al., 2003a; Shaeer et al., 2012) has found similar results. Even asexual men and women (who do not experience sexual attraction for any type of partner; see Chapter 9) masturbate, and they do so as often as their non-asexual counterparts (Yule et al., 2014).

Figure 11–3



Who masturbates? This figure shows the percentages of men and women in different age groups who report having ever engaged in masturbation.

Figure 11–3 Full Alternative Text

Although masturbation is one of the most commonly experienced sexual behaviors, the 2010 and 2016 NSSHB studies also revealed that people varied widely in terms of how often they engaged in it (see Dodge et al., 2016; Herbenick et al., 2010d; Reece et al., 2010e; Schick et al., 2010). Some (about one third of women and one fifth of men) had not masturbated at all in the past year; others had done so a few times; some had masturbated monthly and others weekly; and still others said they masturbated almost daily (about 11% of women and 26% of men aged 18–29). There are also clear age differences. Monthly rates of masturbation tend to increase for both men and women as they move through their teens, 20s, and 30s, then begin to drop during their 40s, continue to decline as they move through their 50s and 60s, and reach the lowest point during their 70s and beyond. Gender differences also exist. Men are more likely than women to have engaged in masturbation, and men who masturbate do so more often than women who masturbate. Interestingly, an oft-cited review of research on gender differences in sexuality concluded that although women report a lower incidence of masturbation than do men, their attitudes toward masturbation do not differ from those of men (Petersen & Hyde, 2011). Other demographic variables are also associated with likelihood of masturbation, including ethnicity and education level (see Box 11–A).

So, are all of these masturbating people risking their health or sanity? No. Masturbation, whether done once a year, once a month, or several times a day, does not cause any of the problems mentioned previously, and few doctors today, if any, would make such claims. (A discussion of choking oneself during masturbation is in Chapter 14.) *It is a perfectly normal human behavior*. How can we be so confident as to call it normal when historically it has been so condemned? Just look at the statistics—when a large majority of people have engaged in a particular behavior, it has to

be considered normal. Still, there are some who continue to feel guilty or wrong about it—nearly half of all people who masturbate, according to Laumann et al. (1994; also see Kaestle & Allen, 2011).

Methods of Masturbation

People differ in the way they masturbate, but men display less variation than do women. Almost all men masturbate by rhythmically stroking up and down the body and glans of the penis with one hand. They may differ in how much of the penis they stimulate and in the rhythm and pressure applied, but they generally use a stroking motion. In order to enhance arousal, many men fantasize and/or look at sexually explicit pictures while they masturbate. Heterosexual men typically do not use vibrators or dildos on themselves during masturbation (although they may use them on their partners), but about 40% of homosexual and bisexual men report having used a vibrator or dildo while masturbating (Reece et al., 2010b; see also Rosenberger et al., 2012).

Most women who masturbate do so by stimulating the clitoris, labia minora, and/or the entire vulva, and like men, many fantasize while engaging in this activity. Kinsey's group (1953) found that although very few women insert a finger (or any object) into their vaginas during masturbation, about 11% of women do stimulate their breasts. Recent surveys reveal that about 50% of women have used a vibrator and about 30% have used a non-vibrating dildo on at least one occasion while masturbating (Herbenick et al., 2009, 2010e). Indeed, many women regularly incorporate vibrators into their masturbatory activities—one study found that 19% of heterosexual women, 38% of lesbians, and 53% of bisexual women said that they had used a vibrator in the past month (Herbenick et al., 2010e). Examples of various types of masturbation aids (sex toys) can be seen in Figure 11–4.

Figure 11–4

Types of masturbation devices, commonly known as sex toys. Clockwise from bottom right, these include anal beads, "rabbit-style" vibrator (pictured upside down—the "rabbit" clitoral stimulator would be positioned on top during actual use), "travel-size" massager/clitoral/anal stimulator, penis or cock rings, dildo, masturbation sleeve, and g-spot/clitoral stimulator (also pictured upside down—the device would be inserted with the clitoral stimulator positioned upward).

Source: Bruce M King

"In the masturbation section I believe you should emphasize the importance of a vibrator for women. Methods of masturbation seem apparent to males, but I think women need more guidance in this area. In my experience a vibrator is the most intensely pleasurable way to masturbate."

"I tend to use a vibrator to masturbate. Sometimes I don't have a partner or I do but he's not available. In that situation, I use my little electric friend, my hands, and my imagination. Works every time!"

"I have a couple of different vibrators. One is a personal massager that provides good general clitoral stimulation, but it's really strong—I have to use a towel or it would hurt me. The other is a full-on vibrator with a realistic penis, a clitoral stimulator, and an anal insert/stimulator (but I don't

use that part—too painful and gave me a fissure [tear] once). That is my go-to vibrator. I always use the external part that stimulates my clitoris, but I don't always insert the penis part because it requires more effort (I might need lubricant, I have to clean it more thoroughly, etc.). I don't feel at all guilty about masturbating or using a vibrator—if anything, it's made me more comfortable and relaxed with respect to my body and sex."

(All examples are from the authors' files.)

Functions of Masturbation

Why do people masturbate? Quite simply, we do it because it feels good. Although masturbation certainly allows for sexual release when a partner is not available, it does not necessarily stop when one forms a sexual relationship with someone. Janus and Janus (1993) reported that 66% of the men and 67% of the women they surveyed agreed or strongly agreed that "masturbation is a natural part of life and continues on in marriage." In fact, rates of masturbation often remain high among people with partners (and generally equal to or higher than rates among single people). For example, in the 2010 NSSHB study, 69% of partnered women said they had masturbated in the past year, compared to 54% of single women (Herbenick et al., 2010d). High—and relatively equal—rates also were found among both partnered (77%) and single (84%) men in the 2012 NSSHB study (Dodge et al., 2016). Thus, having a partner does not appear to be associated with a reduction in masturbation. Moreover, the more sex a person has, the more likely he or she is to masturbate (Laumann et al., 1994). In other words, masturbation is not just a replacement activity that people use when they lack access to intercourse with a partner but, rather, is often a reflection of a sexually active lifestyle that involves a partner and includes regular intercourse.

Box 11–A Cross-Cultural Perspectives

Ethnic Differences in Sexual Behavior

1. 11.3 Explain why the incidence of some sexual behaviors often differs as a function of age, ethnicity, gender, and other demographic variables.

In this chapter you will read about several behaviors that are considered normal in American culture today. However, the statistics given for each behavior generally do not take age, ethnicity, education level, or other group differences into account. Are the behaviors discussed normal—that is, commonly practiced—across ethnic groups?

Let us consider masturbation. In their nationally representative sample, Laumann and colleagues (1994) found that two thirds of white and Latino men and a slightly smaller proportion of Asian American men had masturbated within the past year. Only 40% of African American men had masturbated in the past year. As for women, whites were more likely to have masturbated than African Americans or Latinas (see Table 11–2). Interestingly, although ethnic differences in masturbation rates continue to exist today, the size of these differences has diminished over time. For example, the 2010 NSSHB study revealed that rates have increased among Latinos and African Americans: 72% of Latino men (and 56% of Latina women) and 62% of African American men (and 54% of African American women) said they had masturbated in the past year (Dodge et al., 2010).

Table 11–2 Incidence of Sexual Behaviors (in the past year) Among Ethnic Groups and Educational Groups in the United States

Sexual Behavior	Whites	African Americans	Latinos	Asian Americans
Masturbation (in past year)				
Men	67%	40%	67%	61%
Women	44	32	35	no data
Oral-genital sex				
Men	81	50	71	64
Women	75	34	60	no data
Anal intercourse				
Men	26	23	44	15
Women	23	10	17	no data

Sexual Behavior	Less Than High School Graduates	High School Graduates	Some College	College Graduates	Graduate Degree
Masturbation (in past year)					
Men	45%	55%	67%	76%	81%
Women	25	32	49	52	59
Oral-genital sex					
Men	59	75	80	84	80
Women	41	60	78	79	79

source: From *The Social Organization of Sexuality*, by Edward O. Laumann. Copyright © 1994 University of Chicago Press. Reprinted by permission of the University of Chicago Press.

Table 11–2 Full Alternative Text

Ethnic differences have frequently been found for oral-genital sex as well. African Americans, especially women, are less likely than others to have engaged in this type of sexual behavior. Table 11–2 illustrates this pattern focusing on rates of oral-genital sex during the past 12 months—we see the lowest rates among African American men and women. A similar pattern is found when we examine lifetime rates (that is, the percentages of men and women in each ethnic group who have ever engaged in a behavior or tried it at least once). Laumann and his colleagues (1994) found that most white men and women reported having given (81% of men and 75% of women) and received (81% of men and 78% of women) oral-genital sex at some point during their lives. Lower rates were found for Latino participants. Specifically, 66% of Latino men and 56% of Latina women said they had given oral-genital sex to a partner, and 67% of Latino men and 62% of Latina women said they had received this act from a partner during their lifetime. The lowest rates were reported by African American participants, with 51% of men and 34% of women reporting having performed oral-genital sex on a partner and 60% of men and 45% of women indicating that they had received oral-genital sex from a partner at least once. More recent surveys have revealed a similar pattern in which African Americans are less likely than other ethnic groups to have engaged in oral-genital sex (Dodge et al., 2010).

Similarly, African Americans are less likely than people from other ethnic groups to have engaged in anal intercourse, at least in the United States (Carter et al., 2010; Champion & Roye, 2014; Laumann et al., 1994). For example, the 2010 NSSHB study revealed that 12% of African Americans, compared to 19% of Latinos, had engaged in anal intercourse during the past year (Dodge et al., 2010). However, this ethnic difference may be moderated by gender—in other words, the association between ethnicity and sexual behavior may differ depending on whether we are looking at men or women. Data from the 2006–2008 National Survey of Family Growth (Chandra et al., 2011), which included more than 13,000 men and women living in the United States, revealed that 27% of African American men had engaged in anal intercourse at least once during their lifetime. Consistent with earlier findings, this rate was lower than the lifetime rates reported by other groups of men: approximately

equal numbers of Latino and white men had tried anal intercourse at least once (39% and 38%, respectively). Thus, when considering men, experience with anal intercourse is lower among African Americans than other ethnic groups. However, the same pattern was not found among women. White women demonstrated the highest rate of lifetime anal intercourse experience (34%), followed by equal proportions of Latinas (25%) and African Americans (25%).

Sexual Behavior	Whites	African Americans	Latinos	Asian Americans
Anal intercourse				
Men	21	23	26	30	29
Women	13	17	25	22	29

Some of the ethnic differences in sexual behaviors that we see can be attributed to power disparities between men and women in relationships and the resulting differences in communication patterns and sexual decision making that arise (see Quadagno et al., 1998). For example, in many traditional Latino cultures, men are expected to make the reproductive and sexual decisions; in those cultures, a couple's sexual behaviors typically reflect what the male partner wants more than what the female partner wants. Indeed, one study found that only 16% of Latina women who had experienced anal intercourse actually found it to be pleasurable, but 80% said that the decision to engage in anal intercourse was always or almost always made by their male partner (Halperin, 1999). Other researchers have also noted that differences between men and women in sexual attitudes and rates of sexual behavior are typically smaller in cultures with greater gender equality (see Petersen & Hyde, 2010).

There are many factors other than ethnicity and gender that are associated with differences in sexual behavior, including age, education, marital status, economic status, and degree of acculturation. For example, while the lowest rates for oral-genital sex generally are found among African American women, rates are especially low for older African American women (Dodge et al., 2010; Quadagno et al., 1998). Ethnic differences also become less apparent as people become more acculturated (Meston & Ahrold, 2010; Okazaki, 2002). Education level is also associated with sexual behavior. Look at the bottom half of Table 11–2. As you can see, masturbation and oral-genital sex are more common among higher-educated groups. More recent surveys have also found that rates of masturbation and oral-genital sex increase as educational level increases, at least in the United States (see Chandra et al., 2011).

Do ethnic differences still appear when researchers control for these other factors (i.e., looking at white, African American, Latino, and Asian American people of the same age, marital status, education, income levels, etc.)? Here, there is some difference of opinion. Some studies find ethnic differences regardless of other factors (Laumann et al., 1994), but others do not (Quadagno et al., 1998). While more research is needed, it is probably safe to conclude that ethnic differences are not as great when we compare people of the same socioeconomic status. Another safe conclusion is that when it comes to sexual behavior, things will undoubtedly continue to change over time.

Why do people with sexual partners masturbate? It may have to do with *variety*—masturbation is a sexual experience that is different (not necessarily better) than sex with a partner.

"I masturbated a lot when I was without a partner, and now I still do. The orgasm is so different than those I get during intercourse…. My boyfriend doesn't understand … but I love making love with him." (woman)

"I masturbate pretty regularly, though more often some weeks. It's a regular part of my life, and it feels good and different from what my girlfriend and I do together. I don't do it out of any feeling of dissatisfaction. In fact, thinking about her, her body, my attraction to her, and our sex life is part of what makes me masturbate." (man)

(All examples are from the authors' files.)

Some people might wonder whether masturbation is habit-forming or whether it might prevent the development of "normal" adult sexual relations. Research reveals little justification for these fears. Not only is masturbation during adolescence not harmful to sexual adjustment in young adulthood, but masturbation during marriage is often associated with a greater degree of marital and sexual satisfaction (Hurlbert & Whittaker, 1991; Leitenberg et al., 1993). So if you suspect your partner of masturbating occasionally (or you are worried about masturbating when you have a partner), do not assume that there is something wrong with either one of you or with your relationship. Just because someone with a partner masturbates does not mean that he or she is unhappy with his or her sex life. There is only a potential problem if your partner's masturbatory activities interfere with your sexual satisfaction or with the overall health of your relationship (for example, if your partner prefers masturbating alone to engaging in sexual activities with you or masturbates a lot but shows little sexual interest in you, and this causes you distress). Then you two might need to talk about the situation or seek professional assistance.

Today, some therapists prescribe masturbation as part of their treatment for orgasm difficulties in women and for greater ejaculatory control in men (see Chapter 13). Thus, what was once a taboo is now often used as part of sexual therapy. This is not to imply, however, that all people should masturbate, particularly if they are comfortable with their sexuality. Just as it was once wrong to make people feel bad because they masturbated, it would be equally wrong to make people feel abnormal if they did not. The important point is that those who have a desire to masturbate should be able to do so without feelings of guilt or worries about their health.

Personal Reflections

What are your general feelings about masturbation? Primarily positive, primarily negative, or a bit of both? If you have masturbated, did you (or do you) find it to be a pleasurable experience, or do you feel guilty or embarrassed by it? Do you have negative feelings about rubbing, touching, or massaging other parts of your body (your feet, arms, or neck, for instance)? Consider masturbation in the context of a larger question: Are genitals reserved only for procreation (to have children), or are they also a source of pleasure?

Tribune Content Agency (TCA)

Sexual Fantasies

1. 11.4 Summarize the research findings about the frequency, quality, and role of sexual fantasies in enhancing sexual expression.

"My sister, who was much older than I, would always have friends over and I would fantasize about making love to them while masturbating." (man)

"Most of my sexual fantasies are either about my girlfriend or about a supermodel or celebrity. Usually the fantasies happen when I'm alone. When I'm with my girlfriend I tend not to fantasize a lot because I'm more in the moment." (man)

"I fantasize about what it would feel like to have sex with more than one woman at once. I've even thought about bondage. I don't know if I would enjoy it in reality, but sometimes I do think about it and it turns me on." (man)

"I enjoy being male, but have occasionally fantasized about what it is like to be female during lovemaking." (man)

"During sex I have sexual fantasies about making love to a woman…. I would view my husband as a woman." (woman)

"My sexual fantasy has been the same since age 16. The man uses me, sometimes beats me, and brings his other female partners around me. This fantasy bothers me." (woman)

"I have a lot of different sex fantasies. Some of them involve famous people, or characters from TV shows, or athletes, or guys I know. I think about what we would do and how it would feel to have them touch me. I make up little stories that are kind of romantic but always end up with orgasmic sex happening. I enjoy these fantasies." (woman)

"I have sexual fantasies while making love to my husband, usually about men I'm attracted to from work. I think about how it would be and when I come, it's stronger and harder than it usually is." (woman)

(All examples are from the authors' files.)

Recall from Chapter 1 that within Christianity there is a long history of condemnation of sexual thoughts, even if the thoughts are not accompanied by sexual behaviors (and even if the thoughts are of one's husband or wife). In the Victorian era it was thought that only men had sexual fantasies—women were considered relatively asexual. This, of course, is not true. Although men do tend to fantasize, daydream, and think about sex more often than women, most women also spend quite a bit of time thinking about sex (King et al., 2009; Regan & Atkins, 2006). In fact, more than 90% of women have had sexual fantasies (Leitenberg & Henning, 1995; Pelletier & Harold, 1988).

Given that just about everyone fantasizes, what do people fantasize about? For some, the fantasy might be soft and romantic—perhaps a tender G-rated interlude with a special person. For others, the fantasy might be highly sexual and explicit—an X-rated interaction with a highly desirable other. The specific content of sexual fantasies is almost limitless (see Kahr, 2008). Nonetheless, researchers have managed to group people's sexual fantasies into four general categories: (1) sexual intimacy fantasies (fantasies involving sexual activities with a specific known partner), (2) sexual exploration fantasies (fantasies involving experimentation with never-before-tried behaviors such as group sex or same-sex activities), (3) fantasies about impersonal or "forbidden" sex (for example, sex with strangers or questionable partners, watching others have sex, fetishes), and (4) fantasies with submission–dominance themes (Leitenberg & Henning, 1995).

For both men and women, fantasies of sexual intimacy with a specific known person are most common. Although people commonly fantasize about their current partner, researchers have also found that sizeable numbers of men and women fantasize about someone else when actually engaging in intercourse with their partner. One study revealed that 98% of men and 80% of women in heterosexual relationships reported having a replacement fantasy—a fantasy in which one imagines oneself having sex with someone other than the current partner—within the past 2 months (Hicks & Leitenberg, 2001). The replacement partner can be a friend, neighbor, former partner, current crush, celebrity, or someone else entirely. Now some of us might feel guilty or ashamed to find ourselves thinking about another person while having sex with our partners. But chances are very good that our partners have done the same thing. It is very common.

There are some gender differences in sexual fantasy content (see Boegart et al., 2015; Joyal et al., 2015; Leitenberg & Henning, 1995). For example, women's sexual fantasies tend to contain more elements of romance, commitment, and affection than do men's, and men's sexual fantasies tend to contain more explicit and visual imagery than do women's. In addition, although fantasies with dominance-submission themes are reported by relatively high proportions of both men and women, dominance fantasies (in which the partner is overpowered) are more common among men than women, whereas submission fantasies (in which the partner overpowers them) are more common among women than men. When considering these particular findings, let us be very clear. The fact that some women (and men) enjoy fantasizing about themes of sexual surrender or submission does not mean that they wish to be raped in reality (see Bond & Mosher, 1986; see Chapter 15). In fact, the typical submission fantasy for most women involves a highly attractive man who finds the woman irresistible and uses just enough force to overcome her initial reluctance and, eventually, arouse her (the fantasy usually culminates in mutually satisfying intercourse) (see Binova & Critelli, 2009; Critelli & Binova, 2008). Similarly, the fact that some men (and women) enjoy fantasizing about themes of sexual dominance does not mean that they wish to commit rape. Just like women's submission fantasies, the typical dominance fantasy for men involves a strong, powerful man who overcomes the resistance of a desirable but initially reluctant woman; in the face of his masculinity and forceful insistence, she becomes sexually aroused and eventually yields (this fantasy, too, usually culminates in mutually satisfying intercourse) (see Leitenberg & Henning, 1995). What men and women fantasize about may have very little relation to what they do—or wish to do—in real life.

Sexual fantasies can occur at any time and in any setting, and they can be deliberately generated or triggered by an external event (e.g., sexual

imagery in something one sees or reads). Surveys reveal that sizeable numbers of men and women fantasize during masturbation, while having sex with a partner, and even while working, studying, or doing other non-sexual activities (see Table 11–3).

Table 11–3 When Do People Have Sexual Fantasies?

Activity	Percentage of Women	Percentage of Men
While masturbating alone	69%	86%
While having sexual intercourse with a partner	76%	70%
While engaging in non-sexual activities (e.g., studying, working, daydreaming)	85%	93%

source: Based on Leitenberg, H., & Henning, K. (1995). Sexual fantasy. *Psychological Bulletin*, 117, 469–496.

Table 11.3 Full Alternative Text

Most people deliberately create sexual fantasies as a way of exploring and expressing their sexual feelings and enhancing their sexual experiences. Thus, it is not surprising to find that sexual fantasies often evoke positive emotions such as pleasure, happiness, and satisfaction. But sexual fantasies can also be a potent source of distress for their creators. About one fourth of all people who fantasize feel guilty about it (Leitenberg & Henning, 1995). In addition, a large majority of men and women experience sexually intrusive thoughts (SITs)—sudden, involuntary, unwanted, disruptive sexual thoughts (Byers et al., 1998; Wetterneck et al., 2011). For example, one study (Smith et al., 2011) found that 62% of university students reported having experienced at least one distressing intrusive sexual thought (the rest either had never experienced one or had experienced a disruptive but pleasant sexual thought). The most common intrusive and distressing thoughts involved experiencing forced sex acts that caused pain or harm (44%) or engaging in a sex act with someone other than the partner or with someone "inappropriate" (e.g., subordinate, authority figure, friend; 20%). What seems to determine the level of distress that a sexually intrusive thought causes is whether it is grounded in reality—the study found higher levels of distress among men and women who had actually previously experienced the sex acts contained in their intrusive thoughts.

It is important to recognize that the frequency and content of one's sexual fantasies and thoughts (intrusive or otherwise) do not indicate sexual dysfunction or signify any sort of personality disturbance or psychological problem (Leitenberg & Henning, 1995; Renaud & Byers, 2001). It is only when a sexual fantasy or thought causes intense or chronic distress that there might be a need for intervention (and in that case, the best remedy is to see a therapist trained to deal with these issues). In fact, far from being pathological, fantasies may provide a safe and private outlet for thoughts that, if actually engaged in, might be illegal, personally or interpersonally harmful, or socially inappropriate. In sum, daydreams, thoughts, and fantasies are a normal and healthy part of a person's sexual repertoire.

Personal Reflections

Do you have sexual fantasies? If yes, are you comfortable or uncomfortable with your fantasies? Have you ever shared your fantasies with your partner? If your partner told you about his or her sexual fantasies, what would your feelings be? Think about your favorite fantasy. Have you ever acted it out? Did the reality live up to or exceed the fantasy, or was it disappointing?

Sexual Intercourse

1. 11.5 Describe research on sexual intercourse frequency and duration, and explain why different cultures, as well as individuals within a culture, use different positions of sexual intercourse.

Among those Americans who are having sex, about 95% say that their sexual activity always or usually includes vaginal intercourse (Laumann et al., 1994). You learned in Chapter 10 (see Middle Age) that the frequency of intercourse declines with age, but how frequently do people in general have sex?

Frequency and Duration

The results of national surveys suggest that most married couples (at least, younger married couples) engage in sexual intercourse approximately one to three times a week (Herbenick et al., 2010d; Michael et al., 1994; Reece et al., 2010e).

Of course, tremendous variability exists both within and across individual couples. Some couples, as a result of various life events (such as job stress, financial worries, health issues, pregnancy or child care), might find their interest in having intercourse temporarily reduced—they just might be too sick or tired. At other times, they might find themselves with both the inclination and the energy to engage in sexual activities with each other. Thus, the rate of vaginal intercourse (or any sexual behavior) within any one couple is likely to fluctuate over time. There are also differences across couples—some couples engage in sexual activity quite frequently, whereas others have sex infrequently, if at all (Donnelly, 1993; Karraker & DeLamater, 2013). For example, in one study (Greenblat, 1983), married men and women were asked to recall how often they had sexual intercourse each month during their very first year of marriage; reports ranged from 1 (or an average of 12 times during that first year) to 45 (or 540 times that first year). Quite a wide range! Similarly, the 2010 NSSHB study found that about 20% of partnered heterosexual men and women had not engaged in vaginal intercourse at all with their partners during the past 12 months, whereas approximately 10% had engaged in intercourse four times a week or more (Herbenick et al., 2010d; Michael et al., 1994; Reece et al., 2010e). Couples clearly differ in how often they have sex.

Although most research on sexual frequency has focused on vaginal intercourse among heterosexual couples, we wish to point out that homosexual couples also differ greatly in how often they have sexual intercourse (defined here as genital contact). For example, one group of Dutch researchers (Deenen et al., 1994) asked more than 300 gay men who were currently involved in a committed relationship about their frequency of intercourse. Most men (43%) reported having sex one to two times per week, one fourth (25%) said they had sex three to five times per week, and a few (2%) reported having sex six or more times per week. The remaining men (30%) said they had sex less than once per week (but up to three times per month). Lesbian couples also exhibit a fair amount of variation in sexual frequency (see Blair & Pukall, 2014; Peplau et al., 1997). In one investigation (Cohen & Byers, 2014), 34% of homosexual women in committed relationships reported having sex at least once a day, 40% indicated having sex one to three times per week, and 26% said that they engaged in sexual activity less than once per week. Thus, sexual frequency differs considerably among all couples in established relationships.

What about single people? Are they having as much sex as their married or partnered counterparts? The media certainly seem to think so. Magazines, TV shows, movies, and music all hype the idea of the sexually energetic, adventurous, and active single guy or gal. How accurate is that portrayal? Is it true? The answer is not really. In general, surveys reveal that couples—whether heterosexual or homosexual, married or cohabiting—all have sex more often than single people (Michael et al., 1994). For example, among the 18- to 49-year-old participants in the 2010 NSSHB survey, the large majority of partnered women (85%) and men (75%) had engaged in intercourse at least once a month over the past 12 months—but 63% of single women and 49% of the single men had not had intercourse even once (Herbenick et al., 2010d; Reece et al., 2010e). Despite what the media tell us, being single does not produce as much sex as does being married or in a committed relationship:

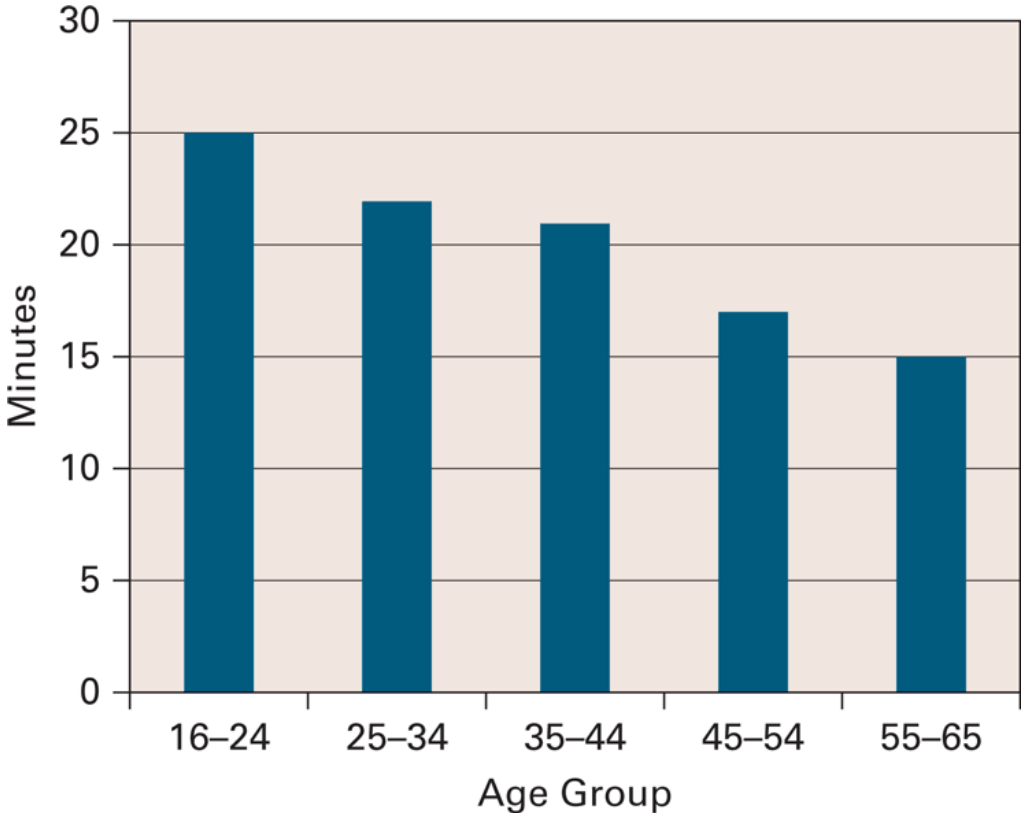
> We find that the critical factor that produces the most sexual activity is being part of a couple, whether it is a marriage or a cohabitation. Even though married life is not seen as very erotic, it is actually the social arrangement that produces the highest rate of partnered sexual activity. . . . What seems to produce the highest rates of partnered sex is an easily accessible partner.

(Michael et al., 1994, p. 118)

People differ in how often they engage in sexual intercourse, but do they also differ in terms of how long it lasts? Research reveals that the total shared event (which includes touching and other forms of intimacy before and after intercourse) typically lasts 15 to 60 minutes for most heterosexual and homosexual couples (Blair & Pukall, 2014). The act of intercourse itself, though, usually lasts 3 to 13 minutes (Corty & Guardiani, 2008). Not surprisingly, the greater the number and/or variety of individual sexual acts that partners do during their encounter, the greater the amount of time they spend having sex. Partners who engage in vaginal intercourse alone, for example, spend less time having sex than those who include foreplay activities (kissing, cuddling, stroking the partner's body) and/or oral-genital sex (Smith et al., 2012).

As with frequency, sexual intercourse duration declines with age—older men and women report lower average durations than do their younger counterparts (see Figure 11–5). For example, one large survey found that younger men and women (aged 16 to 44) reported that their most recent sexual encounter lasted about 22 minutes; older men and women (aged 45 to 65) said that their most recent sexual encounter lasted about 16 minutes (Smith et al., 2012). You will read more about frequency and duration in Chapter 13.

Figure 11–5



How Long Does Sex Last?

Source: Based on Smith, A. M. A., et al. (2012). Sexual practices and the duration of last heterosexual encounter: Findings from the Australian Study of Health and Relationships. *Journal of Sex Research*, 49, 487–494.

Figure 11–5 Full Alternative Text

Coital Positions and Locations

"Before I became sexually active, I believed that everyone who engaged in sexual intercourse did so in the missionary position in the privacy of their own bedroom. Now I look forward to new positions." (woman)

"[Our sex] was boring me. We always used the same position—his favorite one." (woman)

"My boyfriend has the concept that men should be in control of sex. Well, I say 'What about my pleasure?' My favorite position is 'me on top' because I'm guaranteed to receive an orgasm." (woman)

"I am a mature, responsible, middle-aged female. I am also an experienced diver with a mate who is equally comfortable under water. In my opinion, the most stimulating, exciting, and extraordinary sex on earth happens beneath the surface of the water. Complete sex beyond the grasp of gravity in a quiet, sensuous, foreign world is beyond our limited language to describe." (woman)

"I am a football player and I've had a lot of injuries. Sex is easier for me if my girlfriend gets on top. If we do it the regular way, my back starts to hurt and neither one of us has a good time because I can't focus on anything." (man)

"My goal is to try everything at least once. So far, I've done the usual style (missionary), doggy style, standing up, sitting, and side-by-side. I've done it inside, outside, in a car, and on an airplane and a train. I won't do it on a bus because that's just nasty. I'm going to try to do it all possible ways and places." (man)

"I like to be on top, but I also learned from my wife that it helps her have an orgasm if I raise her hips up on a pillow and then pull her forward into me while I'm kneeling in front of her. So I'm still on top but she also has a good time. It's important to me that the sex is fun for both of us." (man)

"My last girlfriend wanted to do it in the living room all the time. The problem was that she had three roommates and they would always walk in on us. It made me so uncomfortable. I was raised that sex is private. She also kept wanting to do different positions and use all these weird things like food and handcuffs. I felt like I was starring in a porno. She would always make fun of me and say I was too "vanilla" when it came to sex." (man)

(All examples are from the authors' files.)

According to several contemporary sex manuals, there are more than 100 different positions in which couples can have sexual intercourse (coitus). Despite this seeming variety, the first (heterosexual) sexual intercourse experience for most Americans is in the man-on-top, missionary position, that is, a face-to-face position in which the woman lies on her back and the man lies on top with his legs between hers. It is called the missionary position because Christian missionaries in foreign countries used to instruct natives that this was the only "proper" way to have sexual intercourse. Saint Paul believed that women should be subordinate to men during intercourse (i.e., on the bottom), and Saint Augustine said that any other position was unnatural and a sin against nature (see Chapter 1). In the 1200s, this attitude was formalized by Thomas Aquinas in his *Summa theologiae* (1265–1274/1968) and became the standard endorsed within Christianity (Brundage, 1984).

For many couples, particularly those who came of age during the '30s, '40s, and '50s, the missionary man-on-top position may be the only one they have ever used during sexual intercourse (Kinsey et al., 1948). Today, though, people seem to experiment with and enjoy a greater variety of positions. For example, one survey of college students found that 45% of men actually preferred the woman-on-top position (25% preferred man-on-top and 25% preferred man-from-behind). More women than men preferred man-on-top (48%), but sizeable numbers also preferred the woman-on-top (30%) and man-from-behind (15%) positions (Elliott & Brantley, 1997).

Preferences for sexual intercourse positions differ across cultures and are undoubtedly affected by the gender roles, sociocultural norms and expectations about sexuality and relationships, and other factors that characterize a particular society. For example, in cultures in which there is greater equality between men and women, the woman-on-top position is strongly preferred (see Box 11–B).

Box 11–B Cross-Cultural Perspectives

Sexual Intercourse

Do Americans have sex more or less often than people in other cultures? It depends on the other culture. People in Greece and Croatia, for example, report having sex 134 to 138 times a year, compared to 113 for Americans. People in China, on the other hand, report having sex only 96 times a year, people in India only 75 times, and Japanese people only 45 times (data from the Pfizer Global Study of Sexual Attitudes and Behaviors, see Laumann et al., 2006).

What about positions of sexual intercourse? Face-to-face is the preferred manner of sexual intercourse in all known cultures. In many African cultures, the most common position is with the partners lying side by side, while in Polynesian and many Asian cultures the most common position is with the woman lying on her back and the man squatting or kneeling between her legs (Gregersen, 1982). (By the way, it was the Polynesians who originally called the man-on-top position taught to them by European missionaries the "missionary position.") Actually, men and women in most cultures use more than one position for intercourse. Mangaians, for example, prefer different varieties of the man-on-top position, but use the man-from-behind position more often when their partner is pregnant (Marshall, 1971). More recent studies demonstrate that Taiwanese and Brazilian couples also practice a variety of positions, including man-on-top, woman-on-top, side-by-side, and sitting (Lee et al., 2010; Sacomori & Cardoso, 2010).

Some researchers believe that a culture's preferred position of intercourse is a reflection of women's social status (Goldstein, 1976). In cultures where a woman's sexual satisfaction is considered to be as important as a man's, woman-on-top is usually preferred. The ancient Romans preferred this position. In patriarchal, male-dominated cultures, however, the reverse is true (Langmyhr, 1976). There may be no better reflection of the relation between women's social status and coital position than in our own culture. Here, women's gender roles have changed dramatically since World War II. In the 1940s, Kinsey et al. (1948) found that over two thirds of the couples studied had never attempted any position other than man-on-top. More and more women began to enter the work force after that, and women's rights evolved rapidly in all areas. Today, the majority of couples in the United States have tried the woman-on-top position (e.g., Elliott & Brantley, 1997).

Couples experiment with different positions for a variety of reasons. For example, although the missionary position allows for emotional intimacy during intercourse—because the couple is face-to-face—it also has some disadvantages compared with other positions. People with chronic back pain or other debilitating physical issues often have difficulty maintaining the missionary position for long periods of time (Sidorkewicz & McGill, 2014). Similarly, in many heterosexual couples, the man is considerably heavier than the woman, which means that she has to support a great deal of weight in the man-on-top position (and more and more as the man gets tired). Some women may even have trouble breathing in this position. Anecdotally, women in our classes have also pointed out that they receive very little touching or fondling in this position because their male partners are too busy supporting themselves. With a woman's hips "pinned to the mat," she often has little control over the movements or tempo during intercourse; this can make it difficult to fully enjoy the experience. Men in our classes often say much the same thing, commenting that it is difficult for the partners to access each other's genitals or other body parts (e.g., breasts, chest) in the missionary position.

There are other positions that still provide eye-to-eye contact but allow greater freedom and involvement for the woman. As you will see in a later chapter, the woman-on-top position is recommended by many therapists for optimal sexual arousal in both participants. Not only is it generally a lot easier for the man to support the woman's weight, but it is also easier for the man or the woman herself to manually stimulate the clitoris (and most other parts of a partner's body) during intercourse.

Figure 11–6

Man-on-top, face-to-face ("missionary") position

Probably the main reason that most couples have sexual intercourse in different positions is to bring variety to their sex lives. Many a sexual relationship has become stale and boring by allowing it to become *ritualized*, that is, by having sex only at the same time of day, in the same place, in the same position. So how does a couple avoid

letting their sex life become a standardized "it's Thursday night so it must be time to have sex" ritual? The secret is to allow your sexual relations to be spontaneous, creative, and fun whenever possible. Some people get locked into a habit of never having sex until right before they go to sleep at night. If you and your partner are in the mood in the morning or afternoon, have sex then. Do not postpone it until later, when you might be tired.

Experimenting with different positions may allow couples to keep their sex lives exciting, fresh, and fun—the way things were at the beginning of the relationship. Although many sex manuals show drawings of couples in what appear to be hundreds of different positions, there are really just a few major variations that a couple can try: They can face each other or one partner can turn around, and they can lie down, sit, or stand up. Of course it goes without saying (but we will say it anyway) that couples should try different positions only because they want to and not because they feel pressured to do so.

Figure 11–7

Woman-on-top position

Figure 11–8

Man-from-behind position

Figure 11–9

A variation of the sitting position

People have sex not only in different positions but also in different locations. It is quite normal for couples to have sex in a variety of places, for example, on the couch, on the rug, in different rooms, or in any other place. There is no rule that states you can have sex only in bed (or, for that matter, only in your own home). A recent survey asking men and women (aged 18 to 59) where they had their most recent sexual encounter found that most (90%) said that it happened either in their own or their partner's house—but about 10% reported having sex in a hotel/motel or outside, in the car, or in some other public place (Herbenick et al., 2010a).

Dear Ann Landers:

My wife and I have been married 20 years. We have two sweet children and consider ourselves very fortunate. The problem is one we cannot discuss with our minister.

My wife believes that sex anywhere but in the bedroom is sinful according to the Bible. I say a change of setting can add extra pleasure, and so long as there is complete privacy, it is perfectly moral.

The place I have in mind is the car. We have a garage with a sturdy lock on the door. No one could possibly get in.

We are good Christians and want to know what the Bible says about this. Can you contact a religious scholar?

(Strictly Confidential in Kentucky)

Dear Strictly: Since the Bible predates the automobile by a couple of thousand years, there is no point in bothering a Christian scholar.

If you will settle for my opinion, here it is: It is perfectly all right for a married couple to make love anywhere they choose, providing it is private, safe, and reasonably comfortable.

(*Ann Landers* column. Esther P. Lederer Trust and Creators Syndicate, Inc. Reprinted by permission.)

If you and your partner are on the couch at home and get in the mood to have sex, there is nothing immoral, sinful, or indecent in spontaneously doing so right there.

Personal Reflections

How do you think you will keep your sexual relationship from becoming ritualized after 6 months, 6 years, 20 years, 60 years? The brain is your largest sex organ. Make sure you continue to use it to your advantage.

Oral-Genital Sex

1. 11.6 Define fellatio and cunnilingus and describe the current research findings on these activities

"I was highly against oral sex because I thought it was so nasty and demeaning. But when I experienced it, my attitude changed. I didn't realize what I was against could feel so damn good." (woman)

"… What did surprise me was the fact that I enjoyed giving more than receiving. I think it is a great way for two people to share very intimate moments." (man)

"I do engage in oral-genital sex, but really prefer it as foreplay. I don't like the idea of a guy coming in my mouth—it gags me!" (woman)

"It is a great way to relax, feel unpressured and not worry about pregnancy or how good you perform." (man)

"Oral sex is by far the most pleasurable sexual experience I have ever engaged in. It has produced some of the most intense orgasms that I have ever experienced, especially in the 69 position. I also very much enjoy orally stimulating my partner individually as much as being stimulated myself." (woman)

"My first wife made me do oral sex on her every single time we had sex. I didn't like it but I loved her so I did it. I ended up hating it. When I married my second wife, I was very up front with her – I'll do anything she wants but that." (man)

(All examples are from the authors' files.)

Sexual relations generally include a great deal of oral stimulation. One of the first sexual behaviors that most people engage in is kissing, which, of course, involves mouth-to-mouth stimulation. This usually progresses from "dry" kissing (lip to lip) to "wet" kissing (also known as "French" or "soul" kissing, involving the tongue) within a short time. It is also normal while having sex for people to kiss and lick other parts of their partner's body (the neck, for example). For many people, this includes their partner's genitals.

Oral stimulation of the penis is called fellatio (from the Latin *fellare*, meaning "to suck"), and oral stimulation of the vulva (clitoris, labia, vaginal opening) is called cunnilingus (from the Latin words for "vulva" and "licking"). These can be done either as part of foreplay or as the preferred sexual behavior, either by one partner at a time or by both at the same time (the latter is sometimes referred to as "69"). Many women report oral stimulation of the area around the clitoris to be more pleasurable than intercourse (the vaginal walls, you recall, have few nerve endings) and an easier way to achieve orgasm compared to intercourse (Richters et al., 2006). Many men also find fellatio (particularly orgasm during fellatio) to be more intense than intercourse (Janus & Janus, 1993). The pleasure, however, is not always reserved entirely for the recipient.

While it is true that most people prefer receiving oral sex to giving it (Brewster & Tillman, 2008; Laumann et al., 1994), many others enjoy orally stimulating their partner (and observing their partner's reaction) nearly or equally as much as being stimulated themselves. For many people, giving oral sex represents a moment of extreme intimacy.

Figure 11–10

Cunnilingus

Figure 11–11

Fellatio

How common are these behaviors? Believe it or not, they were very common when your great-grandparents were young (at least among Caucasians). Kinsey's group (1948, 1953) found that about 50% to 60% of the married people they studied had engaged in oral-genital sex. Today, about 70% to 90% of young men and women have engaged in oral-genital relations at least once by the time they reach their mid-20s (e.g., Chandra et al., 2011; Dodge et al., 2016; Herbenick et al., 2010c), and it remains a major component of many peoples' sexual behavior into their elderly years (Schick et al., 2010). However, there are some group differences. For example, the 2010 NSSHB study found that significantly more men (44%) than women (31%) reported having received oral-genital sex from a partner during their last sexual encounter (Herbenick et al., 2010c). The likelihood of engaging in this particular behavior is also associated with ethnicity and level of education (see Box 11–A).

Some individuals consider oral-genital sex unpleasant, and certainly no one should feel pressured to engage in a behavior just because other people do it or because a partner wants it. On the other hand, if you expect your partner to do it for you, then you should not have a double standard about doing it for him or her. Double standards in sexual relations can lead to serious problems in other aspects of the relationship.

"My girlfriend refuses to have oral sex with me, but thinks that it is just fine for me to do it to her! Even though I enjoy doing this to her, I don't think it is fair that she would not even try it." (man)

"My boyfriend and I are compatible emotionally, physically, and intellectually. But there is one flaw that tortures me daily: our oral-genital sex relations to this point have been very one-sided, and I am bewildered. My personal hygiene is wonderful but when I finally got the courage to ask him to give me cunnilingus he was mortified. Yet from the beginning I have not hesitated to give him fellatio when he requests. I felt like his pleasure was my reward. When he refused me I felt insulted and I cried for an hour. I just can't lose the feeling of very deep, very personal humiliation." (woman)

(All examples are from the authors' files.)

Some people may have reservations about engaging in oral-genital sex because of cleanliness concerns. Certainly, people ought to bathe regularly if they expect their partners to give them oral-genital stimulation. Even if partners practice good hygiene habits, however, they may still have some reservations about the cleanliness of genital secretions. In fact, mouth-genital contact is no less hygienic than mouth-to-mouth contact—the mouth harbors as many germs as the genital orifices. This assumes, of course, that neither person has a sexually transmitted infection, for these can be transmitted during oral-genital stimulation as well as during intercourse. On the other hand, there are no health benefits to swallowing genital secretions (such as curing acne, reducing depression, or boosting cardio health), as some individuals mistakenly believe (and the popular press has claimed).

Personal Reflections

Try to recall your reactions when someone first told you about French kissing (also called "wet kissing" and "soul kissing"). Was your reaction positive or negative? Was it hard for you to imagine allowing someone else to put his or her tongue in your mouth? Did your attitude change when you realized that most people engage in this behavior? Might this same process eventually change your attitude about any of the behaviors discussed in this chapter to which you presently have negative reactions?

Anal Sex

1. 11.7 Describe what is known about anal sex—types, prevalence, and preferences.

"In porn, you always see women having these great orgasmic experiences from anal sex, but believe me, that is completely fake (like all porn). Anal sex actually hurts. I've done it twice—once with a vibrator and once with my boyfriend. I will never make that mistake again." (woman)

"Last summer my boyfriend decided he wanted to try some of the different types of things…. I will never try sex again in the anus because it was so painful." (woman)

"I do very much enjoy anal stimulation, if done properly. For me, anal stimulation during oral sex has produced the 'ultimate' orgasm … if it is done gently and not forcefully." (woman)

"I like anal sex, probably a lot more than most females. When I first had anal sex, I didn't like it . . . . The difference is in how fast or slow the guy is in penetrating and also how turned on I am before he goes in." (woman)

"My boyfriend and I sometimes use a mini-vibrator while making love. While we're in the missionary position, I insert the vibrator through the anus. At the same time, he continues to penetrate. I receive the ultimate feeling in sexual pleasure." (woman)

"I think anal sex is gross. I refuse to put any part of my body into someone else's poop chute. It's unhygienic and absolutely disgusting." (man)

"This might sound strange, but I actually like to have that part of my body licked and massaged by my girlfriend. She doesn't mind doing it and I find it relaxing. It doesn't turn me on, exactly, but it feels good and she does it after we've made love if we have the time." (man)

"As a gay man, this is something that I have done with my partners. Mostly we touch each other or go down on each other, but if the relationship is serious then we will have intercourse that way." (man)

"I like it a lot, but my girlfriend doesn't. She says it hurts too much and she feels like a slut when we do it." (man)

"I tried it once with a girl I was seeing (it was her idea). It wasn't like what it looks like in porn films. First off, it was harder to do. I couldn't hardly get inside her and I was worried the whole time about losing my erection and also about hurting her." (man)

(All examples are from the authors' files.)

Anal sex refers to a variety of behaviors, including anal intercourse (insertion of the penis into the anus), insertion of other objects or body parts into the anus (e.g., fingers, hand [also called fisting], dildo, vibrator, anal beads), felching (sucking semen out of a partner's anus), and anilingus (oral stimulation of the anus, also called rimming). The anus has numerous nerve endings and is very sensitive to touch. The anal sphincter muscle undergoes rhythmic muscular contractions during orgasm in both men and women, and thus anal stimulation can further enhance pleasure.

Anal intercourse is a common experience among homosexual and bisexual men (see Table 11–4). In the United States, more than 50% of gay men and about 30% of bisexual men have engaged in anal intercourse within the past year (Dodge et al., 2016). But how common is it among heterosexual couples? Many heterosexual men and women harbor negative views about anal sex, including that it is abnormal, perverted, and indicative of homosexuality (even when the receptive partner is a woman; see Carter et al., 2010; Janus & Janus, 1993). Despite these widespread negative attitudes, though, the prevalence of anal intercourse appears to have increased rather dramatically among young people in recent years (McBride & Fortenberry, 2010). For example, national surveys reveal that in the 1990s, approximately 19% of young heterosexual men and women (aged 18 to 29) reported that they had experienced anal intercourse at least once with a partner (Michael et al., 1994). Today, surveys reveal a rise in lifetime experience rates, with between 30% and 40% of young adults (ages 18 to 29) saying that they have tried anal intercourse (see Benson et al., 2015; Chandra et al., 2011; Herbenick et al., 2010c). Because so few researchers have included homosexual women and/or lesbian couples in their studies, we know little about recent or lifetime experience with anal sex among these populations.

Table 11–4 How Common Is Anal Intercourse? Men's Lifetime Experiences

	Insertive Anal Intercourse	Receptive Anal Intercourse
Homosexual Men	84%	90%
Bisexual Men	75%	66%
Heterosexual Men	35%	3%

Note: This table illustrates men's self-reported lifetime (at least once) experiences with insertive (penis into partner's anus) or receptive (partner's penis into their anus) anal intercourse.

source: Based on Dodge, B., et al. (2016). Sexual behaviors of U.S. men by self-identified sexual orientation: Results from the 2012 National Survey of Sexual Health and Behavior. *Journal of Sexual Medicine, 13,* 637–649.

Table 11–4 Full Alternative Text

Of course, just because people say that they have had anal intercourse at some point in their lives does not mean that they do it every time they have sex or with every partner. In fact, although many of the young men and women in Laumann et al.'s (1994) national survey had experienced anal intercourse, only 1% of them had done so the last time they had sex with their partners. In addition, when the researchers asked participants about their sexual preferences, very few (only around 3%) rated anal intercourse as "very appealing."

A person's relationship status seems to play an important role in determining whether he or she is likely to be having anal intercourse. Research shows that people in serious or committed relationships are much more likely than single people or people in casual relationships to be actively

engaging in anal intercourse (Carter et al., 2010; Dodge et al., 2016). For example, 26% of the married 18- to 29-year-olds in the 2010 NSSBH survey reported having had anal intercourse at least a few times over the past year, but only 8% of same-age single men and women had done so in the same period (Herbenick et al., 2010d; Reece et al., 2010e). Recall that *any* sexual behavior is more likely among paired people (who have ready access to a sex partner) than among single people (who do not). Interestingly, paired people also give interpersonal reasons when explaining their decision to have anal sex, including a desire to please the partner, enhance feelings of emotional intimacy, signal the "seriousness" of the relationship, and engage in mutual sexual experimentation (Carter et al., 2010; Maynard et al., 2009). Unfortunately, people also sometimes have anal intercourse for negative interpersonal reasons, including (for men) a desire to dominate the partner and (for women) a need to prevent the partner from seeking alternate sex partners or from committing violence against them (see Billy et al., 2009; Carter et al., 2010; Maynard et al., 2009). For many heterosexual men and women, then, anal intercourse seems to be an activity they are willing to try—particularly when they are in a committed relationship with someone they love and trust—but not one that they frequently desire or regularly do.

For those who choose to engage in this behavior, some words of caution are necessary. First, the anal sphincter muscle contracts in response to attempted penetration, and attempts to force the penis (or any object) into the anus can result in injury. A water-soluble lubricant (like K-Y Jelly) should be used if you engage in this behavior. The muscle spasms do not relax until 30 to 60 seconds after penetration, so the receptive partner often experiences some initial discomfort, even if the insertive partner proceeds slowly and gently. Among adults engaging in cross-sex anal intercourse (i.e., insertive man, receptive woman), about 70% of women (and about 15% of men) report experiencing pain during the event (Herbenick et al., 2015). Moreover, anal sex will almost certainly result in rupturing of small capillaries (unlike the vagina, the rectum does not readily accommodate this kind of stimulation) (Agnew, 1986). Anal intercourse itself does not cause AIDS, but the ruptured capillaries maximize the chances of contracting HIV (the virus that causes AIDS) *from an HIV-infected partner.* If you are not in an exclusive relationship (and even if you are), it is wise to use condoms. Bear in mind, however, that condoms tear more often during anal intercourse than during vaginal intercourse (Silverman & Gross, 1997). In addition, bacteria that are normally found in the anus can easily cause infection if introduced into the vagina. Couples who engage in anal stimulation, therefore, should never put anything (finger, penis, objects) into the vagina that has been in contact with the anus unless it has been washed first.

Preferred Sexual Behaviors

By now, you should have a good sense of what people do sexually—both by themselves and with their partners. We have spent this chapter defining and examining the prevalence of sexual activities like masturbation, vaginal intercourse, oral-genital sex, and other behaviors. But is what people do with their partners sexually the same as what they would like to do?

To answer this question, Laumann and colleagues (1994) asked participants in their nationally representative study to report the specific activities in which they had engaged the last time they had sex. They also gave their participants a list of possible sexual activities and asked them to indicate how appealing they found each one to be (activities included seeing other people do sexual things, watching the partner undress, vaginal intercourse, receiving oral sex, giving oral sex, passive anal intercourse, active anal intercourse [for men only], and a variety of other experiences).

The results revealed that when it comes to both vaginal and anal intercourse, what people do reflects what they want to do. As we noted earlier in this chapter, Laumann et al. (1994) found that 95% of the people they surveyed had engaged in vaginal intercourse the last time they had sex. And it was by far the most preferred behavior, rated as either very or somewhat appealing by 96% of younger women and 95% of younger men (aged 18 to 44). Anal intercourse, on the other hand, was among the least preferred behaviors (rated as very appealing by only 5% of young men and 1% of young women), and it was also among the least performed (with fewer than 2% engaging in it during their most recent sexual interaction). Thus, people's preferences for both vaginal and anal intercourse are reflected in what they ultimately do with their partners.

However, it is a different story entirely when we consider oral-genital sex. Here, people seem to want more than they are getting. For example, although 33% of younger women found receiving oral sex to be very appealing, only about 24% actually received it from their partner the last time they had sex. Similarly, 50% of younger men rated receiving oral sex as very appealing, but less than one third experienced this during their last sexual encounter.

Interestingly, watching the partner undress was the second most preferred activity overall, although this particular event was rated as very appealing by more men than women in both the younger (50% versus 30%) and older (40% versus 18%) age groups. So, the next time you want to get your partner highly aroused, try undressing a little more slowly and seductively.

Personal Reflections

What sexual behaviors do you enjoy the most? The least? Why? Which ones would you like to try? If you are currently in a sexual relationship, is there a good match between what you are doing sexually and what you want to be doing?

The Sexually Healthy Person

1. 11.8 Define what it means to be a "sexually healthy" person.

You have now read about several sexual behaviors that relatively high numbers of people engage in. They are normal from a statistical perspective. Does this mean that you should try all these behaviors just because other people practice them? Do we judge sexual normality by the variety of sexual experiences or number of partners a person has had? No, not at all. Although sexual health can be defined in many ways (see Edwards & Coleman, 2004; Elders, 2010), one thing we know is that it should not be judged like a decathlon event in the Olympics. We define a sexually healthy person as someone who (a) feels positively about his or her sexuality (i.e., does not view sex as something naughty, bad, improper, or sinful and can engage in it without feeling guilty or anxious) and (b) feels free to choose whether he or she wishes to engage in any particular sexual behavior. By "feels free," we mean free of peer pressure, partner pressure, and social pressure. In today's world of epidemic sexually transmitted infections, sexual health also means freedom from life-threatening infections. Individuals should not engage in sex simply because they are being pressured by peers or a partner. A person can say "no" and still be sexually healthy. Similarly, saying "yes" does not prove that one is sexually healthy.

By our definition, someone who has engaged in a wide variety of behaviors with numerous partners but who gets little fulfillment from his or her sexual relations or who regards sex as shameful or dirty would not be considered sexually healthy. Conversely, a person who is sexually inexperienced but who regards sex as something good and positive (and perhaps worth saving for someone he or she loves or cares for) would be considered sexually healthy.

Sometimes we can tell someone's real attitude about sex by how that person treats his or her partner or partners. For example, some people claim to have a positive, healthy attitude about sex, but they pressure their partners to do things the partners do not want to do or judge their partners harshly for wanting (or refusing) to try certain sexual acts or for having done so in the past. Such behavior does not reflect sexual health.

There are many behaviors that a couple can engage in. This chapter covered only the most common ones. (We are reminded of the couple who told Dr. Ruth Westheimer [*Playboy*, 1986] that one of their favorite practices was having the woman toss onion rings over her partner's erect penis from various distances.) If partners view their sexual relationship as positive and satisfying and want to experiment with different techniques, should they or anyone else have any concerns? Most therapists take the view that any behavior between consenting adults done in private that does not cause physical, emotional, or psychological harm to anyone involved is okay.

Laws Against Consensual Sex

1. 11.9 Explain fornication, adultery, and sodomy laws and discuss their implications for heterosexual and homosexual individuals living in the United States and in other countries around the world.

Let us ask you a question: What do you do sexually behind closed and locked doors in your own home or apartment? If right now you are thinking that this is none of our business, you are absolutely right. Is it anyone else's business? Well, you might be surprised to find out that many states have laws prohibiting certain sexual acts, even if done by consenting adults in private.

As of 2016, a handful of states still have laws that make *fornication* (sexual intercourse between unmarried persons) and/or *cohabitation* (two unmarried individuals living together in a sexual relationship) a crime. The maximum penalty is generally 3 to 6 months in jail and/or a fine. *Adultery* (sexual intercourse between a married person and an extramarital partner) currently is a crime in 21 states and the military and historically has been considered a more serious offense because it violates the sanctity of the family. It is considered to be a very serious crime in other countries (see Box 11–C). Until very recently, many states also had laws that prohibited the sale of vibrators and other "adult sexual aids." (Alabama is currently the only state that continues to prohibit the sale of sex toys).

Box 11–C Cross-Cultural Perspectives

Illegal Sex Around the World

In the last part of this chapter you learned that many states prohibit and punish sexual behaviors such as fornication, cohabitation, and adultery (and have a history of criminalizing oral and anal sex among consenting adults, although that is no longer the case today). It may surprise you, then, to learn that we are one of the more permissive nations. In fact, many countries have laws against these sexual behaviors. Consider sodomy. As of 2016, sodomy laws criminalizing heterosexual and homosexual oral and anal intercourse have been repealed or overturned in North America (Canada, the United States, Mexico), Central and South America (with the exception of Belize, Guyana, and about 30% of the Caribbean Islands), and all of Europe. However, consensual sexual activity between men (and, in some cases, women) is a crime in approximately 80% of countries in Africa and approximately 40% of countries in Asia (notable exceptions are South Africa, which recognizes same-sex marriage, and all of the East Asian nations, including China, Japan, and Mongolia). If convicted, a person faces fines, imprisonment, hard labor, flogging or whipping, and sometimes even death. For example, male homosexual acts are punishable by life imprisonment in Sierra Leone (although oral sex between women is not illegal) and by death in Mauritania, parts of Nigeria and Somalia, Sudan, Yemen, Saudi Arabia, Iran, and the United Arab Emirates. These punishments are carried out. In 2011, three Iranian men were hanged to death for committing sodomy. Each had been sentenced to death under Article 108 (which defines sodomy as sexual intercourse between men) and Article 110 (which mandates "killing" as punishment for sodomy) of the Iranian Islamic penal code ("Six people were hanged," September 5, 2011). Four other men were similarly sentenced in 2012 ("Four Iranian men sentenced to death," May 14, 2012).

Fornication (defined as sex between unmarried persons) is also punishable in many countries. In Nigeria, women (and, to a lesser extent, men) who engage in premarital sex are routinely charged with fornication. If convicted, the usual sentence is flogging (sometimes in public). For example, in 2002, 19-year-old Adama Yunusa was sentenced to 100 lashes for having premarital sex with her fiancé, who was not punished (Onishi, 2002). Premarital sex is considered a punishable offense even in cases of rape. In the Maldives in 2013, a man was charged with raping his 15-year-old stepdaughter and killing the infant she had subsequently delivered. During the course of the investigation, police claimed to have found evidence that the teenager had engaged in consensual sex with another man. She was charged with fornication and sentenced to 100 lashes by a juvenile court (the sentence was subsequently overturned by the High Court following international outcry; Whiteman, 2013). Other countries impose harsher punishments for premarital sex (or premarital relations of any kind). In March 2013, a 27-year-old Pakistani soldier was convicted by a tribal court of establishing a relationship with an unmarried local woman (the two had fallen in love and planned to elope). Both he and his 19-year-old girlfriend were sentenced to death. The man was stoned to death, and the woman was shot ("Pak soldier publicly stoned," March 13, 2013).

And let us not forget adultery. Of all the sexual behaviors that can and have been criminalized, adultery seems to provoke some of the harshest sanctions. Adultery is a crime throughout much of Africa (e.g., Sudan, Somalia, Mali) and Asia (e.g., Saudi Arabia, Iran, Afghanistan, Pakistan, India, the Philippines, North Korea, South Korea). Perhaps reflecting the gender inequality that characterizes many of these countries, female adultery typically is punished more harshly than male adultery. (India provides an interesting exception to this general pattern—there, only married men can be charged with adultery). As with sodomy and fornication, punishment may include fines, imprisonment, flogging, and death. Although human rights organizations such as Amnesty International and Human Rights Watch have called for the repeal of capital punishment laws for adultery and other crimes, world news reports indicate that courts in Somalia, Sudan, Nigeria, Mali, Saudi Arabia, Iran, Afghanistan, and Pakistan have continued to regularly sentence convicted adulterers (particularly women) to death, usually by stoning (see Mullen & Popalzai, 2015).

Clearly, people in many countries around the world face multiple challenges on the road to achieving sexual health.

Source: Michael Crawford/The New Yorker Collection/The Cartoon Bank.

Are people in the United States ever prosecuted under these laws? Yes. Some states have successfully prosecuted teenagers for having premarital sex. One of the most well-publicized of these cases happened in Emmett, Idaho, in 1996, when 16-year-old Amanda Smizek and her boyfriend Chris (and several other teens) were charged with "criminal fornication." Amanda, who was pregnant at the time, pled not guilty but was convicted under the state's 1921 fornication law. She received a suspended sentence and was ordered to finish high school and attend parenting classes. Her boyfriend pled guilty to the misdemeanor charge; he received probation for three years, 40 hours of community service, and a $10 fine. More recently, in 2002, a 16-year-old boy was convicted in Georgia under that state's fornication law—he and his girlfriend were caught having sex in her room by her mother, who subsequently pressed charges against the boy. However, the Georgia Supreme Court overturned the charges (and the law) the following year.

Adultery laws are invoked much more frequently than fornication laws, and politicians in several states are even attempting to strengthen the laws against that particular behavior (Turley, 2010). Most of the current cases invoking adultery laws involve settlement or divorce issues. For example, a Kentucky court ruled in 2012 that a woman had forfeited her right to her dead husband's estate because she had committed adultery on one occasion prior to his death (however, that ruling was later reversed; *Griffin v. Rice*). In states with adultery laws, it is also not uncommon for one member of a quarreling married couple to file for divorce on the grounds of adultery or to press charges against the other to gain a financial or custody advantage during the divorce and settlement process.

Sodomy laws ban specific behaviors (usually non-penile/vaginal acts of intercourse) between consenting adults. At one time, nearly all the states had laws that forbade oral or anal sex, which were often referred to as "crimes against nature" (see Eskridge, 1999). These laws reflected the early Judeo-Christian attitude that the only natural sexual act is heterosexual intercourse because it is the only sexual behavior that can result in reproduction (see Eskridge, 1999, for a history of these laws).

In 2003, 13 states still had sodomy laws. In four of those states (Kansas, Missouri, Oklahoma, and Texas), the sodomy laws were aimed specifically at homosexuals, but in the remaining nine the laws did not distinguish between heterosexual and homosexual couples (Alabama, Florida, Idaho, Louisiana, Mississippi, North Carolina, South Carolina, Utah, and Virginia). The existence of sodomy laws meant, of course, that millions of married American couples were committing crimes for which they could potentially have been put in jail (up to 5 years or more in some states). In the words of New Orleans lawyer John Rawls, who filed a lawsuit against Louisiana's law, "If oral sex were enforced as a 5-year felony, everyone from the president to the speaker of the house to your next-door neighbor would have to go to prison" (Bell, 1998). However, when the laws were enforced, they were generally enforced only against homosexuals.

Does the U.S. Constitution guarantee us the right to privacy? Let us review the recent legal history on this issue. The U.S. Supreme Court originally

upheld sodomy laws in 1986 in a famous case involving a Georgia man who had been arrested for having oral sex with another man in the privacy of his own bedroom (*Bowers v. Hardwick*). However, in 1992, Kentucky's supreme court struck down that state's sodomy law, which was aimed specifically at homosexuals, and courts in Maryland, Tennessee, and Montana later struck down those states' same-sex sodomy laws.

In 1998, two Texas men were arrested when sheriff's deputies, who were responding to a false report of a burglary, caught them having sex in the apartment of one of the men. They were convicted under the Texas sodomy law, and their appeals were rejected by the state courts. The U.S. Supreme Court ruled on the case in 2003 (*Lawrence v. Texas*). In a 6-to-3 vote that overturned the Court's 1986 decision, the Supreme Court issued a broad-scoped decision that essentially invalidated all sodomy laws across the nation. Speaking for the majority, Justice Anthony Kennedy said that gays and lesbians (and all others) are "entitled to respect for their privacy…. The state cannot demean their existence or control their destiny by making their private sexual conduct a crime…. Adults may choose to enter upon this relationship in the confines of their homes and their own private lives and still retain their dignity as free persons." Nonetheless, most of the 13 states that had sodomy laws in place prior to the 2003 ruling have elected to keep those laws "on the books"—despite the fact that such laws have been ruled unconstitutional and therefore cannot be legally enforced (Frizell, 2014).

Personal Reflections

Do you believe that a couple should have the right to decide for themselves which sexual behaviors they engage in (assuming, of course, that it is done with mutual consent and does not cause physical or emotional harm to either person)? Or should a state serve as a higher moral authority and regulate the private consensual sexual activities of its citizens?

If you answered "no" to the second question, do you think that you or any other individual should pass judgment on others for their private consensual sexual behaviors?

Study Guide

Key Terms

- anal intercourse
- anilingus
- coitus
- cunnilingus
- fellatio
- masturbation
- missionary position
- replacement fantasy
- sexually healthy person
- sexually intrusive thoughts
- sodomy laws
- statistically normal (behavior or attitude)

Interactive Review

Answers can be found on p. 472.

1. This chapter presents several normal adult sexual behaviors. "Normal" is defined from a statistical point of view, and is best thought of as a (1) of behaviors or values. Thus, you should not regard yourself as abnormal if you have not engaged in all the behaviors discussed here.

   Historically, masturbation has been presented as unnatural, immoral, and bad for one's physical and mental health. In his landmark surveys of 1948 and 1953, (2) found that (3) % of the men and (4) % of the women surveyed had masturbated, thus demonstrating that masturbation is, in fact, a very normal human sexual behavior. More recent research shows that monthly rates of masturbation tend to (5) for both men and women as they move through their teens, 20s, and 30s, then start to decline, and reach their lowest point when people reach their (6) and beyond. Although ethnic differences in masturbation rates have been found, they are decreasing over time. In particular, studies show that rates have increased among both (7) . Most women masturbate by stimulating (8) , and about half have used a (9) on at least one occasion. Heterosexual men are less likely than (10) men to report having used a vibrator on themselves while masturbating. Modern medicine has also shown that masturbation has no negative medical consequences. Most men and women masturbate even when they are in sexual relationships. In fact, studies show that the more (11) a person has, the more likely he or she is to masturbate.

   For both men and women, (12) fantasies are the most common. In addition, most people have fantasized about someone else while having sex with their current partner—this is called a (13) fantasy. Compared with those of men, the sexual fantasies of women tend to contain more (14) . In addition, (15) fantasies are more common among men than women, whereas (16) fantasies are more common among women than men. Of course, just because a person fantasizes about something does not mean that he or she really wants to experience it. Fantasies are usually not an indication of sexual unhappiness or personality or psychological disorders.

   Research on frequency of sexual intercourse reveals that most young married couples have sex approximately (17) per week. Surveys also show that (18) have sex less often than couples. When we consider how long intercourse lasts, researchers have found that the entire shared event typically lasts (19) minutes for most couples. As with frequency, sexual intercourse duration generally (20) with age.

   The most common position for sexual intercourse in the United States is (21) -on-top, also called the (22) position. However, sizeable numbers of men and women also prefer other positions, including the (23) position. There is no "correct" way of having sexual intercourse except what is right for you and your partner. Making your sexual encounters spontaneous, exciting, fulfilling, and not ritualized may mean exploring a variety of times, places, and positions.

   Oral-genital sex, properly referred to as (24) and (25) , is common among many groups in the population. In addition, a considerable number of heterosexual couples have tried anal intercourse on at least one occasion. However, the prevalence of these behaviors differs among various groups in the United States. For example, (26) Americans are less likely than other groups to engage in oral-genital and anal sex. Similarly, masturbation and oral-genital sex are more commonly experienced by people with (27)

levels of education. And (28) men are more likely than heterosexual men and women to engage in anal intercourse.

A healthy and satisfying sexual relationship can contribute to one's overall physical and emotional well-being. (29) individuals consider sex to be a positive and good thing, and feel free to choose when, where, and with whom to engage in a particular sexual activity. Just because many people may be exploring a particular form of expression does not mean it fits into everyone's value system.

Until recently, several states had sodomy laws that prohibited (30) and/or (31) sex between consenting adults. Most people believe that they should have the right to decide for themselves what to do in privacy, and in 2003 the U.S. Supreme Court agreed. The same cannot be said in many other parts of the world, however, where sodomy and other sexual behaviors are severely punished.

Self-Test

Answers can be found on p. 472.

A. True or False

- **T F** 32. Very few women have sexual fantasies.
- **T F** 33. A person can be sexually healthy and choose not to have oral-genital (or any type of) sex.
- **T F** 34. Man-on-top (missionary) is the preferred position of intercourse in all cultures.
- **T F** 35. Masturbation leads to serious and negative health consequences.
- **T F** 36. Assuming that neither person has a sexually transmitted infection, oral-genital sex is no less hygienic than kissing.
- **T F** 37. Most married people who masturbate do so because they are unhappy in their sexual relationships.
- **T F** 38. The content of sexual fantasies usually does not indicate sexual unhappiness or personality or psychological problems.
- **T F** 39. Fantasizing about another person while having sex with your partner is usually an indication of a serious relationship problem.
- **T F** 40. Single people have sex much more frequently than married or cohabiting couples.
- **T F** 41. How often a couple has sexual intercourse is likely to vary over time.
- **T F** 42. Surveys have found that many people today have tried more than one position of intercourse.
- **T F** 43. Women's sexual fantasies are just as visual and sexually explicit as men's.
- **T F** 44. More people have tried oral-genital intercourse than have tried anal intercourse.
- **T F** 45. Generally speaking, men think, daydream, and fantasize about sex more often than women.
- **T F** 46. Only homosexual men can have anal intercourse.
- **T F** 47. Most people stop masturbating as soon as they establish a sexual relationship with someone.
- **T F** 48. When it comes to oral-genital sex, both men and women want to receive more of it from their partners than they are getting.
- **T F** 49. Until 2003, in many states a married couple caught having oral sex in the privacy of their own home could be sent to prison.
- **T F** 50. It is still possible in the United States to prosecute people for fornication.

B. Fill in the Blanks

- 51. Couples should not engage in anal and vaginal intercourse without washing in between those two activities because of .
- 52. One of the most common types of fantasy during sexual intercourse is .
- 53. A primary reason that many people continue to masturbate after forming a sexual relationship is .
- 54. Couples who always have sex in the same place and in the same manner risk letting their sex lives become .
- 55. Laumann and his colleagues (1994) found that the two sexual behaviors most preferred by Americans are and .
- 56. Laumann and his colleagues also found that masturbation is mostly a reflection of .
- 57. The preferred manner of sexual intercourse in all known cultures is .

- 58. is the position of intercourse usually preferred in cultures where a woman's sexual satisfaction is considered to be as important as the man's.
- 59. A sexually healthy person is someone who (a) and (b) .
- 60. Oral-genital sex is most common among -educated people.

Suggested Readings and Resources can be found on p. 462.

Chapter 12 Love and Relationships

> Like all great dramatic works, the story of each individual human life can, in many instances, be whittled down to one fundamental leitmotif: the question of who loves us (and who does not) and when and where and how love occurs.

—Ellen Berscheid & Pamela Regan, 2005

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 12.1 Discuss the history of love and the way early theorists studied love.
2. 12.2 Explain Sternberg's triangular theory of love and how different combinations of three components lead to different kinds of love experience.
3. 12.3 Describe Lee's different styles of love and his advice on how to find a satisfying and healthy love relationship.
4. 12.4 Define passionate love and discuss its characteristic features.
5. 12.5 Discuss the association between love and marriage in the U.S. and other cultures.
6. 12.6 Define companionate love and discuss its characteristic features and how it differs from passionate love.
7. 12.7 Discuss research on the biochemical basis of passionate and companionate love.
8. 12.8 Identify and discuss the factors that are important in attraction, including desirable partner characteristics, level of sexual experience, physical attractiveness, similarity, and receptivity.
9. 12.9 Describe the ways in which self-disclosure/communication and equity are involved in relationship development.
10. 12.10 Identify the prerequisites for a successful love relationship and ways to become a "better" partner. Discuss some of the major challenges that can derail love relationships, including habituation, disengagement, and jealousy and describe ways to effectively cope with these issues.
11. 12.11 Explain how people can cope with the breakup of a love relationship.

Poets write words to rhyme with it. Novelists glorify it in prose. Lyricists praise it in song. Philosophers wonder about its meaning, and politicians all support it.

What is this ubiquitous subject? Why, it is love, of course. Have we exaggerated? Think about it for a moment. How many popular songs that you hear are about love (first love, new love, lost love)? In fact, you may have to listen for quite a while before you find one that is not about love. When was the last time that you read a novel or saw a movie that did not include at least one romantic subplot?

Love is an emotion or experience that most of us consider to be extremely important to the quality of our lives. But what is *love*? There have probably been as many definitions of love as there have been philosophers, theologians, and scientists who have written about it (Berscheid, 2006; Reis & Aron, 2008). In fact, scholars have argued for centuries over whether different types of love exist and, if so, what features distinguish these types of love from one another. Noted psychoanalyst Erich Fromm stated the issue clearly in his classic book *The Art of Loving*:

> This desire for interpersonal union is the most powerful striving in man. It is the most fundamental passion, it is the force which keeps the human race together, the clan, the family, society. The failure to achieve it means insanity or destruction-self-destruction or destruction of others. Without love, humanity could not exist for a day. Yet, if we call the achievement of interpersonal union "love," we find ourselves in a serious difficulty. Fusion can be achieved in different ways – and the differences are not less significant than what is common to the various forms of love. Should they all be called love? Or should we reserve the word "love" only for a specific kind of union…?

(**erich fromm**, 1956, p. 18)

Scholars have equated love with some of the worst of human experiences—madness (Plato, in *Phaedrus*), neurosis (Askew, 1965), addiction (Peele, 1988), disease (Burton, 1951/1963), and suffering (de Rougement, 1969). Others have equated it with some of the best—affection (H. Ellis, 1933/1963), tenderness (Freud, 1912/1963), desire (Tennov, 1979), idealization (Reik, 1944), respect (Fromm, 1956), and compassion (Berscheid, 2010).

Which of these views is right? As you will see, these definitions may encompass only part (or none at all) of what people mean when they think of love.

This page contains the following errors:

error on line 8 at column 770: Expected '#' or '[a-zA-Z]', but got ' '.

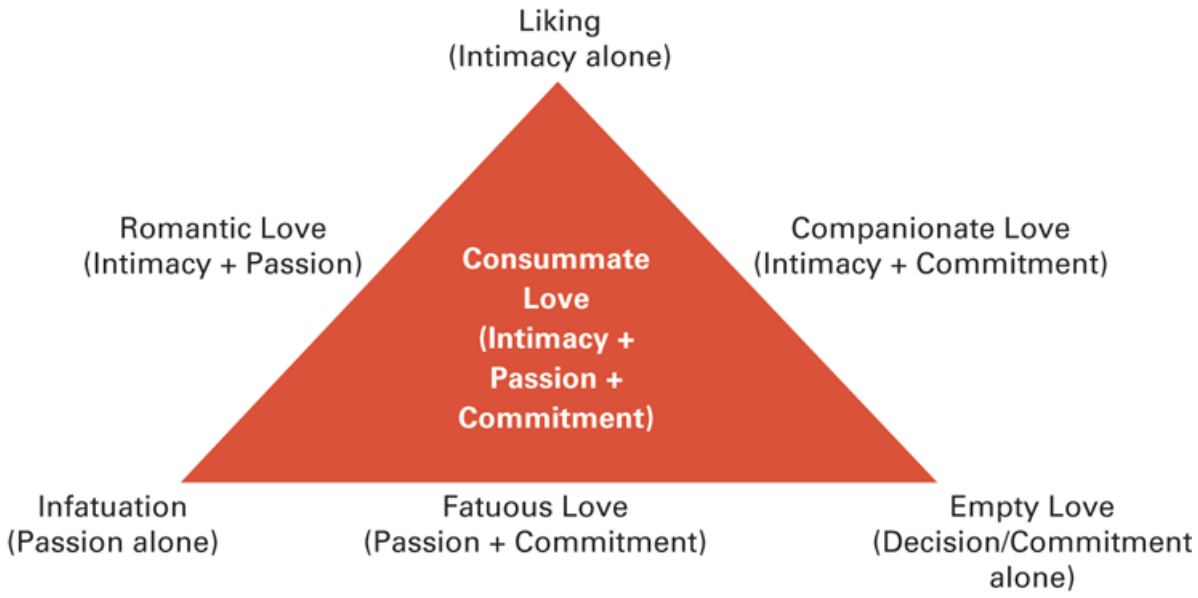
Below is a rendering of the page up to the first error.

Robert Sternberg's Triangular Theory of Love

1. 12.2 Explain Sternberg's triangular theory of love and how different combinations of three components lead to different kinds of love experience.

Based on statistical analysis of the self-reported experiences of men and women in dating relationships, as well as on existing psychological theory and research on love, Robert Sternberg (1986, 1987) proposed a *triangular theory of love.* He suggests that all the different positive emotions (particularly those related to love) that people can have for other individuals can be understood by the combination of three basic components that form the vertices of a triangle, as shown in Figure 12–2. The triangle should not be viewed as a geometric model, but rather as a useful metaphor for visualizing the way in which the three components are related.

Figure 12–2



Sternberg's triangular model of love. All the different ways in which people can love others are understood by the combinations of intimacy, passion, and decision/commitment.

Source: From *The Psychology of Love,* Editor: Michael Sternberg, Editor: Michael Barnes, © 1988. Reprinted by permission of the author.

Figure 12–2 Full Alternative Text

The first component (top vertex of the triangle) is intimacy. Intimacy refers to those feelings in a relationship that reflect warmth, closeness or bondedness, and other positive emotions. There are many signs of intimacy, including a desire to promote the welfare of the other, experiencing happiness with and having a high regard for the other, receiving and giving emotional support, having mutual understanding, and valuing the other person in your life (Sternberg & Grajek, 1984). The second component (the left-hand vertex in Figure 12–2) represents the experience of passion, or those drives involved in physical attraction, sexual desire and activity, and romance. The third component (right-hand vertex) is decision/commitment, which includes the decision to love another person and the commitment to maintain the relationship over time.

Sternberg believes that different levels and combinations of these three components result in eight different kinds of love experience. When all three components are absent or present in very low levels, the result is *nonlove.* This characterizes most of our casual relationships, where there is no love or friendship in any meaningful way. If the intimacy component is expressed alone without passion or decision/commitment, it results in *liking.* The word *liking* is not used in a trivial manner to refer to casual acquaintances but instead refers to the feelings of closeness, bondedness, and warmth that occur in true friendships. When passion is felt in the absence of the other two components, the result is *infatuated love,* or what we call "love at first sight." A person feeling passion alone is obsessed with the other person as an ideal rather than as the individual he or she is in reality. The decision and commitment to love another person without intimacy or passion is experienced as *empty love.* In our Western society, empty love often occurs at the end of stagnant long-term relationships, but in other cultures where marriages are arranged, it may be the first stage in a long-term relationship.

If you look at the triangle, you can see that there are four possible combinations of the components. If you combine passion and intimacy, the result is a *romantic love* experience in which two people are drawn together both physically and emotionally. A strong commitment may not necessarily have developed yet, and the lovers may even know that a permanent relationship is not possible, as in "summer love." This is the Romeo-and-Juliet type of love that poets, playwrights, and novelists are so fond of writing about.

The combination of intimacy and decision/commitment without high levels of passion forms *companionate love,* essentially a long-term committed friendship. Sternberg (1988) believes that most romantic love relationships that survive do so by eventually turning into companionate love relationships.

When a commitment is made on the basis of passion without the development of intimacy, the result is *fatuous love.* This combination typifies whirlwind romances, the kind we often read about involving Hollywood celebrities (who sometimes flee to Vegas for a quick weekend wedding after only a few days' acquaintance). Without the presence of intimacy, there is a high risk that the relationship will end once the passionate attraction fades (these romances are often over so quickly that there has been no chance for the intimacy component to develop).

Sternberg believes that complete love, or *consummate love,* is found only in relationships that include high levels of all three components—passion, intimacy, and commitment. It is his belief that this is the type of love that most of us strive for in our romantic relationships. Thus, other types of love relationships (for example, those that his model labels as "romantic love" or "companionate love") are viewed as lacking something (i.e., one or more of the three components). Do you agree?

Personal Reflections

Consider the different combinations of intimacy, passion, and decision/commitment that Sternberg identified. Which of the eight kinds of love relationship have you personally experienced? Which ones did you find to be the most personally satisfying?

John Lee's "Colors of Love" Theory

1. 12.3 Describe Lee's different styles of love and his advice on how to find a satisfying and healthy love relationship.

Just like Sternberg (1988), sociologist John Lee (1974, 1976, 1988) also drew heavily on earlier literature and philosophical discourse on love in developing his classification system, and like Sternberg, he also employed psychometric techniques (in this case, analysis of the events, behaviors, and emotions reported by people asked to describe their own individual "love stories"). The results of Lee's analysis eventually produced a typology containing six major types of love, each with characteristic features (see Table 12–2). In this novel approach, each variety of love (or style of loving) is likened to a primary or secondary color. Just as different colors result from blending red, yellow, and blue, the three primary pigment colors, Lee proposes that different styles of loving arise from blending three primary love styles—eros, storge, and ludus. Let us look at each of these and their various combinations and then see what makes a good match.

Table 12–2 Different Styles of Loving

Style	Characteristic Features
Eros (erotic love)	Passionate, emotionally intense, and sexual
Ludus (ludic love)	Emotionally controlled, commitment-shy, and game-playing
Storge (storgic love)	Steady, sturdy, and friendship-based
Pragma (pragmatic love)	Practical, rational, and focused on compatibility
Mania (manic love)	Jealous, obsessive, and needy
Agape (agapic love)	Selfless, unconditional, and partner-focused

Table 12–2 Full Alternative Text

12.3.1 The Primary Colors

Eros (named after the Greek mythological figure and similar to the love variety in C. S. Lewis's typology) is a highly passionate, intensely emotional form of love that is strongly based on physical attraction. According to Lee, an erotic lover typically has a specific physical type that turns him or her on. Erotic lovers look for physical perfection, knowing it is rare, and when they find someone who embodies their ideal, they quickly feel a strong physical attraction and intense emotions they perceive as love. It is as if they have always known this person they have just met—their romantic ideal. Thus, the erotic lover is inclined to feel "love at first sight" and wants to have an emotionally (and sexually) intimate relationship immediately. Because it is grounded so strongly in physical attraction, this is the most sexual of Lee's proposed love styles (indeed, he wrote that the erotic lover is "eager to get to know the beloved quickly, intensely—and undressed" [1988, p. 50]). Erotic lovers are very affectionate and openly communicate with their partners. However, they are usually quick to find flaws and shortcomings in their new partners, so that many of their relationships are quick to fizzle out because the partner cannot live up to their unrealistic ideal. Therefore, erotic love is generally very transient, and erotic lovers tend to fall in love often. Erotic lovers desire to have an exclusive relationship with their partners, but they are not jealous and do not try to possess them.

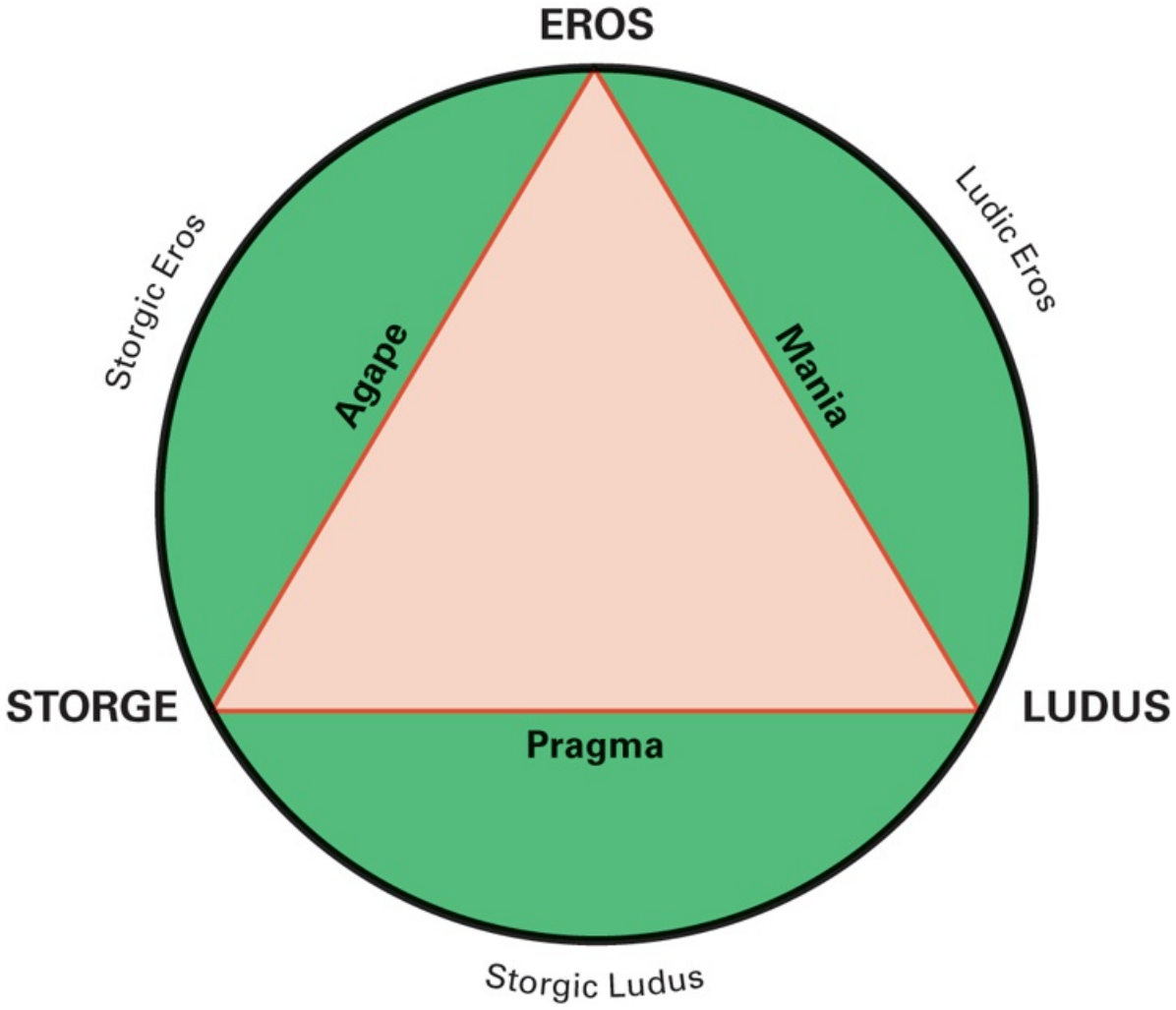
Ludus (from the Latin word for "game" or "entertainment" and pronounced "loo'-dus") is a self-centered type of love. The ludic lover values emotional control, avoids commitment, and treats love like a game. And he or she expects the partner (or partners!) to do the same—that is, to be a good sport, to follow the rules, to play for the sake of the game itself (rather than for a "prize" such as commitment or marriage), and to walk away calmly when the game is over. Ludic lovers are attracted by a variety of physical "types" and use sex for purposes of recreation and pleasure rather than for expressing intimacy or emotional connection. They try to avoid seeing the partner often enough to become dependent on him or her, or vice versa, and avoid jealous partners who might spoil the fun. Ludic lovers often see nothing wrong with having multiple partners. Some may use deception to prevent those partners from learning of each other's existence, but others choose to play the game honestly (and thus their partners know exactly what the romantic situation is). This commitment-shy type of love may seem empty to people who possess other love styles, but most ludic lovers look back on their relationships with pleasure.

Storge (from the Greek and pronounced "stor'-gay") is an affectionate type of love that develops from friendship slowly over time. It is essentially the same as Sternberg's companionate love. The storgic lover does not have a physical ideal and does not go looking for love but instead develops feelings of affection and commitment with a partner through experiencing activities that they both enjoy. Storgic lovers generally cannot recall a specific point in time when they fell in love, and they typically fall in love with someone already in their circle of acquaintances (unlike the typical erotic lover, who usually falls in love with a stranger). They are more practical than emotional, and their relationships lack the passionate emotional highs (but also avoid the dramatic downturns) of more passionate unions. In fact, storgic lovers are embarrassed by excessive shows of emotion from their partners and are typically shy about expressing their feelings openly. They also tend to be quite shy about sex and are more interested in talking about their shared interests than in exploring their mutual love through deep conversations or physical intimacy. A true storgic lover would probably find the content of much of this chapter (indeed, this entire book) somewhat distasteful.

12.3.2 The Secondary Colors

How many different love styles are there? You can get numerous colors by blending red, yellow, and blue, and the same is true for mixing the primary love styles. Look at the color wheel in Figure 12–3. The apexes of the large triangle within the circle represent the three primary colors. Each pair can be combined by going either around the circle or along the edge of the triangle. When you combine two things, new properties may emerge and others may be lost. No one, for example, could have predicted the properties of water by looking at the individual properties of hydrogen and oxygen. Let us now look at three of the combinations that can result from mixing the primary love styles (for other combinations, see Lee, 1988). Each of these secondary love styles contains properties of the primary styles that create it as well as its own unique features.

Figure 12–3



John Lee's color wheel of love styles.

Figure 12–3 Full Alternative Text

Pragma (from the Greek, for "pragmatic") is a rational or practical style of loving resulting from combining ludus and storge. Pragmatic lovers have the self-confidence and emotional control of ludic lovers—they know the kind of partner they want and will wait until they find someone who has those qualities. They are not seeking an exciting romance or passionate affair but instead (like the storgic lover) want to get to know the partner first and become friends and for love to then grow out of this friendship. However, unlike the storgic lover, the person with a pragmatic love style has a shopping list of qualities he or she is looking for in a mate and consciously and carefully sorts candidates to see if they have all the desired qualities. If a suitable mate cannot be found at work or in the community, the pragmatic lover may join organizations (e.g., church, club) or try online dating services to find a compatible partner. Pragmatic lovers want their partners to reciprocate signs of thoughtfulness and commitment but do not like excessive displays of emotion or jealousy. Sexual compatibility is not unimportant, but it is treated more as a technical skill that can be improved upon if need be rather than as the result of chemistry. A person with this love style views herself or himself as "in love" and tends to remain loyal and faithful as long as the partner continues to be a good match.

Mania (from the Greek, meaning love that hits like a lightning bolt) is a love style characterized by an intense, obsessive emotional dependency on the attention and affection of one's partner. People with manic love styles are "in love with love" (they are eager, even desperate, to fall in love). This is "head over heels" love in which one is obsessed with the loved one (i.e., extreme preoccupation and acute longing for exclusivity). Mania is similar to Sternberg's (1987) infatuated love. The manic lover is intensely jealous and repeatedly needs to be assured of being loved. As a result, manic lovers ride an emotional roller coaster: extreme highs when the partner is showing them attention and extreme lows when he or she is not.

This love style results from mixing eros and ludus. The manic lover falls in love passionately but lacks the self- confidence to deal with the intensity of his or her feelings. He or she may attempt to manipulate the tone of the relationship (e.g., by pulling back and not calling the partner) but at the same time is too dependent on the partner's love to remain confidently detached like the ludic lover (guess who ends up breaking down and calling first?). Because the manic lover is unable to break off the relationship, it is usually the partner who does so, leaving the manic lover devastated. Feelings akin to manic love are not uncommon in budding romantic relationships when the partners are still uncertain about each other's feelings and the status of their union—for the true manic lover, however, these feelings never subside. Of all the types of love Lee has identified, this is the one he believes is most likely to produce unhappiness (for both parties).

Agape (from the Greek, and pronounced ah-gah'-pay) is a selfless, altruistic love style that puts the interest of the loved person ahead of the lover's own interest, even if it means great sacrifice. It is similar to C. S. Lewis's (1960/1988) concept of Charity and is the style of loving proposed by Saint Augustine ("Love means: I want you to be") as a goal for all Christians. It is the result of combining eros and storge. Rather than yearning to find the perfect partner, the agapic lover becomes the devoted friend of those who need his or her love. Agapic lovers believe it is their

duty to love, and these feelings are often directed both toward their partner and to any others who need their love.

Lee believes that agape is the least common love style because the give-and-take that characterizes healthy adult relationships precludes one partner from ever being truly "selfless." He is probably correct. We must place certain conditions and expectations (for example, loyalty, fidelity, mutual respect, tolerance, and freedom from physical or emotional abuse) on our partners and ourselves if we are to maintain a satisfying and healthy relationship. Thus, true agape is not a realistic approach to an adult love relationship. (If you wonder whether you are a real agapic lover, ask yourself this question: If you found someone who was a better match for your partner than you are—better looking, smarter, funnier, basically a super-charged version of you—would you step aside? Would you let your partner go, knowing that he or she would be better off with this other mate? An agapic lover would.)

Lee notes that this way of loving is more likely to be found in another kind of union—that between a parent and a child. In addition, he observed that many men and women hold up selfless love as an ideal that they strive to attain in their romantic relationships. We may not be able to let go of our self-interest entirely, but most of us try to be as unconditional and as accepting as possible.

12.3.3 Finding a Good Match

Lee's theory has received support from the results of a large-scale study (Hendrick & Hendrick, 1986). Over 1,300 students were asked to agree or disagree with various statements about love. Their responses clustered into six different groups that closely fit the six love styles just reviewed. In addition, subsequent research has revealed some interesting gender and ethnic differences in love styles. Women tend to be more storgic and pragmatic than men, who tend to be more ludic and—you may find this surprising—agapic (Hendrick & Hendrick, 1987, 1988, 1995; Hendrick et al., 1984, 1998; Le, 2005; Regan, 2016).

Within the United States, Asian Americans tend to be less erotic and more pragmatic and storgic than other groups (e.g., Dion & Dion, 1993; Hendrick & Hendrick, 1986). Latinos, on the other hand, often score higher on ludus than other groups (e.g., Contreras et al., 1996). And cross-cultural comparisons reveal that Chinese adults endorse a more pragmatic approach to love than do Americans (Sprecher & Toro-Morn, 2002).

What is your love style? Did you recognize your approach to love from the preceding discussion? There are tests you can take to determine your love style (Hendrick & Hendrick, 1986, 2003). Sample items from the most commonly used measure, called the *Love Attitudes Scale*, are included in Box 12–A.

According to Lee (1988), you can also just review your own romantic experiences. When doing this, keep in mind that not everyone has one and only one love style, and that a person's love style may change over his or her lifetime and even during the course of a particular relationship. For example, the preoccupation and intense need associated with a manic love style may occur more often during the beginning stages of a romantic relationship, when the partners are uncertain as to their feelings and the future of their union. Later, these feelings may be replaced by more storgic or erotic feelings.

Box 12–A Find Your Love Style

The Love Attitudes Scale

Researchers Clyde and Susan Hendrick, along with their students and colleagues (e.g., Hendrick et al., 1998), were instrumental in crafting a method to measure Lee's love styles. Below are sample items from their Love Attitudes Scale. To find out your love style, you need to first answer the items using the response scale given below. Try to consider each item separately, and answer as honestly and accurately as possible. If you can, answer with your current dating partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. Otherwise, answer in terms of what you think your responses would most likely be if you were involved with someone. Once you have finished answering the items, the next step is to add up your ratings for each style. You will have scores for the three primary love styles and for the three secondary love styles. Is your relationship characterized by one particular style of love? Or is it more complex than that?

Response scale

1. strongly disagree
2. moderately disagree
3. neutral
4. moderately agree
5. strongly agree

Eros

- My partner and I have the right physical "chemistry" between us.
- I feel that my partner and I were meant for each other.
- My partner and I became emotionally involved rather quickly.

Ludus

- I have sometimes had to keep my partner from finding out about other lovers.
- When my partner gets too dependent on me, I want to back off a little.
- I enjoy playing the "game of love" with my partner and a number of other partners.

Storge

- It is hard for me to say exactly when our friendship turned into love.
- To be genuine, our love first required caring for a while.
- Our love is really a deep friendship, not a mysterious mystical emotion.

Pragma

- I considered what my partner was going to become in life before I committed myself to him/her.
- I tried to plan my life carefully before choosing a partner.
- In choosing my partner, I believed it was best to love someone with a similar background.

Mania

- If my partner and I break up, I would get so depressed that I would even think of suicide.
- When my partner doesn't pay attention to me, I feel sick all over.
- Since I've been in love with my partner, I've had trouble concentrating on anything else.

Agape

- I would rather suffer myself than let my partner suffer.
- I cannot be happy unless I place my partner's happiness before my own.
- I would endure all things for the sake of my partner.

Source: Hendrick, C., & Hendrick, S. (1990). A relationship-specific version of the Love Attitudes Scale. *Journal of Social Behavior and Personality, 5*, 239–254. Copyright © 1990 by Select Press, Inc.

Lee believes that the secret to finding mutual and satisfying love is to find a good match—not in the amount of love each person gives, but in the style of loving. There are some obvious bad matches—a manic lover with a ludic lover, for example. The ludic lover's detachment and emotional control will fuel the manic lover's obsessive need for closeness and "proof" of the partner's affection, and the intense possessiveness and emotionality of the manic lover will make the ludic lover want to run for the hills. Fortunately, most people end up pairing with partners who share their particular approach to love—that is, erotic lovers join up with similarly passionate partners, pragmatic people choose equally practical partners, and so on (Davis & Latty-Mann, 1987; Gana et al., 2013; Morrow et al., 1995).

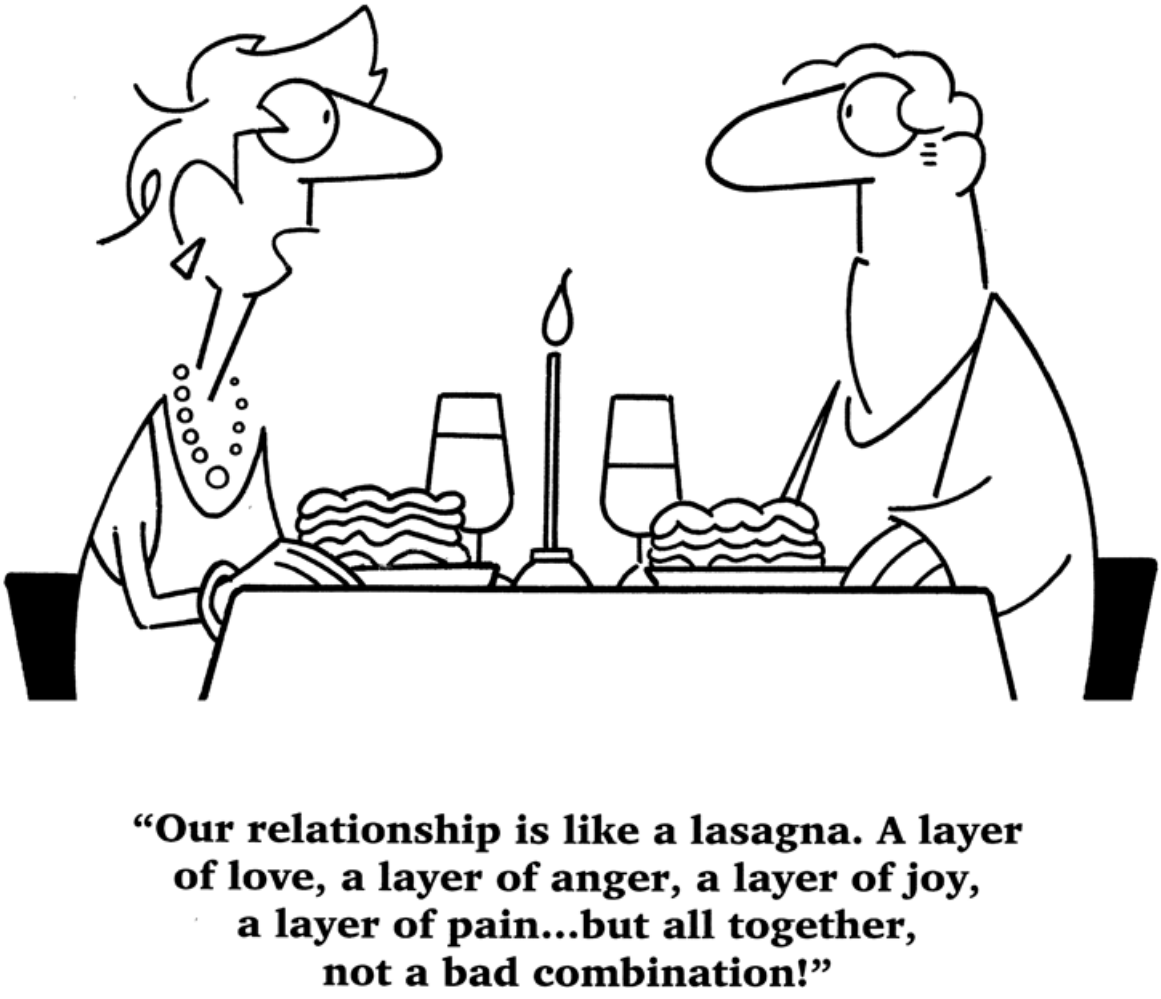
With the exception of mania and ludus, *a good match generally results from two styles that are close on Lee's chart* (see Figure 12–3). A pragmatic love style and storgic love style make a good match, for example. The further apart two love styles are, the less likely it is that they would make a good match. The erotic or manic lover, for example, is likely to find someone with a storgic approach to be dull and uninteresting. The storgic lover will similarly find the behavior of the erotic or manic lover to be overly emotional and uncomfortably demonstrative. A relationship between two people with mismatched styles is difficult to sustain and likely to end—not because they did not love each other but because they loved in different ways.

Studies have shown that certain love styles are more likely than others to be associated with relationship satisfaction. In particular, relationship well-being appears to be higher when partners have an erotic, storgic, or agapic orientation to love and lower when partners adopt a ludic love style (Fricker & Moore, 2002; Gana et al., 2013; Hendrick et al., 1988; Meeks et al., 1998).

So the next time you find yourself romantically interested or involved with someone, do not ask yourself how much this person loves you, but instead ask yourself *how* (in what style of love) he or she loves you and whether your colors make a good match.

Personal Reflections

What is your general approach to love? Which of Lee's love styles best describes you in your present or last relationship? Has your love style changed over time? If yes, how? If no, do you think that you are locked into this love style for future relationships? Why or why not?



Glasbergen Cartoons

12.3.4 Which Theory Is Correct?

At this point you may be a bit confused. Each of the theories we have considered in this chapter—those proposed by the early theorists and the contemporary ones created by Sternberg and Lee—is different. Each theorist uses different labels for the different types of love, and each theorist proposes a different number of loves that exist. Capellanus (1184/1960) and James (1890/1950) argued for the existence of just two kinds of love. Krafft-Ebing (1886/1945) and C. S. Lewis (1960) proposed four. Lee (1973) and Sternberg (1988) identified even more. So which theory, if any, is correct? This is a difficult question to answer. And maybe it ultimately does not matter. Some scholars suggest that maybe we spend too much time analyzing what love is:

> There are, to be sure, reasons for love, but there is good reason for us philosophers to abstain from overanalyzing them and rendering overly rational an emotion whose charm consists at least in part in the illusion that it cannot be explained by reasons.

(Robert Solomon, 2002)

We may never know with any degree of certainty which theory of love is correct. There are, however, a few conclusions about love that we can draw. First, every theorist who has put pen to paper and written about the nature of love agrees that love is important and that it is intimately connected with the quality of individual human life. Second, all theorists agree that multiple types of love exist—people do not just experience one kind of love in their relationships and for their partners. Third, all theorists agree that adult romantic love (the type of love people experience for their romantic partners) can be divided into two varieties—a version that is intense, emotional, fleeting, and sexually charged (and that is usually called *passionate love*) and a version that is durable, slow to develop, and filled with warmth and intimacy (and that is usually called *companionate love*). We will now turn to a consideration of these two special types of love.

Passionate Love—What It Means to Be in Love

1. 12.4 Define passionate love and discuss its characteristic features.

> I hope to hold you in my arms before long, when I shall lavish upon you a million kisses, burning as the equatorial sun.

*From a letter written by Napoleon Bonaparte to Josephine, Spring 1797 (*Hall, 1901*)*

> Marie! Marie! Oh let me repeat that name a hundred times, a thousand times over; for three days now it has lived within me, oppressed me, set me afire. I am not writing to you, no, I am close beside you. I see you, I hear you…. Eternity in your arms…. Heaven, hell, all is within you and even more than all.

Franz Liszt Letter to Marie d'Agoult, December 1834. (Fran Liszt 1811-86).

Of all the many varieties of love that have been identified, passionate love—the state of being "in love with" someone—has received the most attention from scholars. This is certainly understandable, for passionate love seems to be a universal human experience. By the time they reach college age or shortly thereafter, most young adults have fallen in love at least once (Regan et al., 2004), and there is clear anthropological evidence that passionate love is experienced by people living in almost all cultures (Jankowiak, 1995; Jankowiak & Fischer, 1992; Sprecher et al., 1994a).

Passionate love is important for another reason as well. It has become an essential part of the marriage contract in contemporary societies—nowadays, most people say they will not marry without it, and many people dissolve their relationships when it fades (see Box 12–B).

So what exactly is this thing we call "being in love"? Theorists and researchers have discovered that passionate love has a number of characteristic features, including the following:

- a swift and fairly sudden onset
- a relatively brief life span
- intense and often fluctuating emotions
- physiological arousal and its associated bodily sensations
- idealization of the beloved and/or the relationship
- mental preoccupation with the beloved and/or the relationship
- sexual attraction
- exclusivity or a focus on one specific individual

For example, passionate love *is quick to start and often equally quick to fade*. In his discussion of love, C. S. Lewis (1960/1988) called erotic love (his label for passionate love) "the most mortal of our loves" and reminded readers that "the world rings with complaints of his fickleness" (p. 113). Fromm (1956) similarly noted that the "explosive" experience of falling in love with someone is "by its very nature short-lived" (p. 48). Research with dating and married couples shows that feelings of passionate love do decline over time. Even though many people continue to report feeling in love with their partners, those feelings become less intense as their relationship ages (Hatfield et al., 1984; Sprecher & Regan, 1998).

Why does passionate love fade? Sternberg (1988) points to habituation or loss of novelty as the culprit. Comparing passionate love to substance addiction, he argues that a person in the throes of a passion "high" will inevitably become habituated to these feelings, so that over time the partner is no longer as stimulating as he or she once was. Once habituation occurs, Sternberg believes, even more time with the loved one cannot produce the earlier passionate response.

The fragility of passionate love may also be due to the fact that *it is an intensely emotional experience* and intense emotions go hand in hand with extreme physiological arousal (Berscheid & Walster, 1974). Imagine how you felt the first time you fell madly in love. Chances are you experienced the same emotions and bodily sensations that other people commonly report—joy, elation, rapture, and giddiness, for example, along with rapid breathing, a pounding heart, sweaty palms, a dry mouth, butterflies in the stomach, and light-headedness (Regan et al., 1998). The human body simply cannot maintain such a high state of arousal forever and eventually must return to its pre-aroused state. In fact, one of the things that probably makes the experience of being in love so special is its impermanence. Although some people flit from relationship to relationship, vainly seeking a passion that lasts, most of us know that we should sit back and enjoy the heady, wonderful experience of being in love while we can.

Not only are people in love filled with intense emotion, but they *tend to idealize their romantic relationships and their partners* (Barelds & Dijkstra, 2009; Murray & Holmes, 1999; Murray et al., 1996). Specifically, lovers often view their own relationships as superior to the relationships of other people ("Our marriage is so much better than theirs"), and they view their partners more positively than they view other possible partners ("My boyfriend/girlfriend is so much more interesting and attractive than those other men/women"). Lovers also frequently minimize any faults their partners may have by reworking them into virtues ("He's not rude, he's just incredibly direct and honest"). At the same time, they accentuate positive partner characteristics by emphasizing how those attributes benefit the relationship ("Because he's so direct, I never

have to guess how he's feeling, and this kind of open communication really keeps our relationship on track").

Passionate love *is also a highly sexualized experience*. Partners who are very much in love emphasize each other's physical qualities, find each other sexually appealing, and report a great deal of sexual excitement when thinking about each other (Hatfield & Sprecher, 1986; Regan, 2000; Sprecher & Regan, 1998).

> He's perfect in every way—his lips, his arms, his body. I get so excited when I know that I'm going to see him, and then when I do see him, I can't breathe I'm so full of want. When we're together I can't wait for him to touch me, to kiss me, to hold me. And when he does, it's like I lose myself in the moment–my body is just electric and alive and I'm not thinking at all. Just feeling the kiss, the touch, his body on mine. This is how I know that I'm really in love.

(From the authors' files)

People who are in love with each other also engage in sexual activity more often than those who are less in love (Aron & Henkemeyer, 1995). In fact, sex is one of the primary ways in which couples express and communicate their feelings of passionate love. They kiss, cuddle, hug, touch, hold, massage, "fool around," have sex—in short, they "make love" to show that they are in love (Buss, 1988; Marston et al., 1998).

Sexual desire or lust appears to be one of the most important characteristics of passionate love. Ellen Berscheid, one of the first social scientists to study love, observed several decades ago that passionate love is "about 90% sexual desire as yet not sated" (1988, p. 373). Most love theorists today agree (see Regan, 2006).

Figure 12–4

People who are passionately in love feel intense emotional and physical connection to each other. They spend a great deal of time thinking about their relationship and tend to see each other and their love through "rose-colored glasses."

Source: Flashon Studio/Shutterstock

So do the rest of us. When asked to think about what it means to be in love with someone, most men and women mention sexual desire as an essential feature of the experience (Regan et al., 1998). In fact, sexual attraction may be what differentiates passionate love from other types of love. Meyers and Berscheid (1997) asked a sample of college students whether there was a difference between the experience of being in love with and that of loving another person. A clear majority said there was and that it boiled down to sexual attraction. Almost all of the participants knew what it meant if someone told them "I love you, but I'm not in love with you." To them, it meant "I like you, I care about you, I think you're a marvelous person with wonderful qualities and so forth, but I'm just not sexually attracted to you."

Another characteristic that is unique to passionate love *is its exclusivity or tendency to be directed toward one specific person to the exclusion of all others*. Some kinds of love, like C. S. Lewis's (1960/1988) affectionate love or Sternberg's liking (friendship) and companionate love, are inclusive and can be experienced for multiple partners. At any given time, most people can identify a host of people they currently *love*—ranging from close friends, to family members, to former romantic partners. But they typically are *in love with* one and only one other individual (Meyers & Berscheid, 1997). It is certainly possible to be passionately in love with two people at the same time—it simply is not very common.

Personal Reflections

Have you or someone you know ever been in love with two people at the same time? If so, how did this experience make you (or your acquaintance) feel? Was it a "good" experience or not? How did the experience ultimately resolve itself—did you fall out of love with one or both of the other people?

12.4.1 How Do I Know If I'm Really in Love?

At some point in a romantic relationship, most of us will ask ourselves this very question. Is this person the one for us? Are we really in love?

Over the years, various love scales have been developed. These are used by researchers who need a reliable way to measure levels of love in groups of participants (so that they can, for example, determine the average amount of passionate love reported by married couples or compare husbands and wives). The most commonly used measure of passionate love is the *Passionate Love Scale* developed by Elaine Hatfield and Susan Sprecher (1986). The scale items are designed to reflect many of the essential ingredients of passionate love: intense physiological arousal ("Sometimes my body trembles with excitement at the sight of "), emotional highs and lows ("Since I've been involved with , my emotions have been on a roller coaster", "I would feel deep despair if left me"), sexual attraction ("I possess a powerful attraction for "), mental preoccupation (" always seems to be on my mind"), idealization ("For me, is the perfect romantic partner"), and exclusivity ("I would rather be with than with anyone else").

The Passionate Love Scale is useful for conducting research, but it is not meant to serve as a diagnostic tool. A high or low score in and of itself is not all that useful in determining whether any one person is in love with another. For that, it is probably best to do what Lee (1988) recommended that people do to identify their love styles: consider how well what you are currently experiencing matches up with the features of passionate love presented above.

For example, when you think about your partner, does your heart race? Do you get "butterflies" in your stomach? Do you have difficulty concentrating, and sometimes feel like you're on an emotional roller coaster? Do you find yourself imagining what your future life with your partner will be like, and daydreaming about your next encounter? Are you attracted to your partner—do the two of you generate a lot of "heat" or share a lot of "physical chemistry"? In your eyes, is your partner the epitome of perfection? Do other men or women seem less attractive to you now that you have met your partner? If you answer yes to these questions, you show all the signs of being in love.

Personal Reflections

Have you ever been "in love with" another person? If yes, which of the characteristic features of passionate love did you experience?

Box 12–B Cross-Cultural Perspectives

Love and Marriage

1. 12.5 Discuss the association between love and marriage in the United States and other cultures.

Passionate love is not some brand-new, modern-day phenomenon; there are references to it throughout history. However, it has only recently become linked with marriage. In colonial times, Americans agreed to marry more or less by arrangement in order to gain a partner to enhance economic and social success and produce children to carry on one's legacy (Rothman, 1984). Being in love was not considered a real reason to enter into marriage until the 1800s.

In fact, in a study conducted in the United States in the early to mid-1960s, about one third of the men and three fourths of the women surveyed indicated that being in love was not a necessity for marriage (Kephart, 1967). By the mid-1980s, this had changed; all but about 15% of the men and women now said that passionate love was a necessary prerequisite for marriage (Simpson et al., 1986). This change in attitude, mostly by women, was attributed to better economic status—financial independence allowed people to make relationship decisions based on romance.

Anthropologists initially believed that the linkage of love and marriage was a peculiarly American phenomenon. As Linton (1936) put it, "Our present American culture is practically the only one which has attempted to … make … [emotional attachments] … the basis for marriage" (p. 175).

Anthropologists have found that rules about marriage do, in fact, differ greatly across cultures. For example, marriage takes on different forms around the world, ranging from *monogamy* (one husband and one wife paired) to *polygyny* (one husband with multiple wives) to *polyandry* (one wife with multiple husbands) (Fisher, 1989; Frayser, 1985). Interestingly, despite this seeming variety of marital options, most women are in monogamous marriages (that is, they have only one husband, regardless of how many wives that husband may have). Similarly, although many cultures allow polygyny (Murdock, 1967), only about 10% of the men in those cultures actually have two or more wives (Fisher, 1989). This may be due to the fact that the number of marriageable men and women in most contemporary societies is roughly equal, which leaves very few "extra" women available for men who desire a polygynous marriage. In addition, the increased financial and social responsibilities that come with having multiple wives (and offspring) make it hard for most men to successfully sustain polygynous relationships. As noted by evolutionary scientists Martin Daly and Margo Wilson (1983):

> Polygynous unions remain rarer than monogamous ones … even within those societies that permit them. This is hardly surprising given male-male competition for wives and the pressures that are engendered when any substantial number of men are consigned to involuntary celibacy. Hence it is usually only a minority of wealthy, powerful men who have the means to acquire and maintain multiple wives.

(**daly & wilson**, 1983, pp. 282–283)

There are also cultural differences in how marriage partners are selected. People living in collectivist cultures tend to enter *arranged marriages* in which the spouse is chosen by parents, other relatives, or matchmakers. In these cultures, emphasis is placed on group harmony, the fulfillment of family (as opposed to individual) goals and desires, and the potential partner's social and demographic suitability. For example, potential spouses in India often are selected according to caste, religion, educational status, and other demographic factors, and a family considers how well the future spouse will meet their expectations and contribute to their social and economic success before giving the marriage the "green light." Arranged marriages are also common in other Asian and also Middle Eastern societies. In these cultures, love is not an essential feature of the marriage contract—a nice perk, possibly, if you can get it, but not a necessary condition in choosing a suitable mate.

So, are love-based marriages restricted to the United States and other Western, individualistic cultures? The answer is no. Although love and marriage traditionally have not been linked in collectivist cultures, there is evidence of a growing shift in attitudes that is occurring around the world. In the mid-1990s, a group of researchers (Levine et al., 1995) asked a large sample of adults from 11 countries to answer the question first posed by Kephart (1967): "If a man/woman had all the qualities you desired, would you marry this person if you were not in love with him/her?" Although a greater number of people from collectivist countries (e.g., India, Pakistan) than from individualist countries (e.g., the United States, England) said "yes," there was no country in which people were completely willing to marry in the absence of love. In fact, sizeable numbers of men and women in every country reported that they would not enter a loveless marriage. For example, the percentage of participants who said "no" in response to the question was as follows: United States (86%), England (84%), Mexico (81%), Australia (80%), Philippines (64%), Japan (62%), Pakistan (39%), Thailand (34%), and India (24%).

This increased emphasis on love as a basis for marriage has produced other changes in marriage around the world. In particular, attitude surveys and interviews indicate that growing numbers of young adults from cultures with a tradition of arranged marriage now want to select their own partners and to limit family involvement in their romantic choices (Harris, 2015; Schvaneveldt et al., 2005; Zaidi &Shuraydi, 2002; for a review, see Lieberman & Hatfield, 2006). Many of these cultures are experiencing a decrease in the number of arranged marriages (and a corresponding increase in the number of "love matches") that take place. For example, during the time of World War II, approximately 70% of new marriages in Japan were arranged by parents; but by 1988, only 23% of new marriages were arranged (Kumagai, 1995). Data collected more recently reveal an even greater decline in the proportion of arranged marriages: Among Japanese couples marrying in 2005, only 6.4% reported an arranged marriage (National Institute of Population and Social Security Research, 2005, as cited in Farrer et al., 2008). Similar changes have been documented in other countries (e.g., China, Nepal; Ghimire et al., 2006; Xu & Whyte, 1990). Clearly, people around the world want not only love in their marriages but also the freedom to choose their own spouses.

Companionate Love—What It Means to Love

1. 12.6 Define companionate love and discuss its characteristic features and how it differs from passionate love.

> … I do not know whether it may be in my power to write you again till I get to the Camp at Boston - I go fully trusting in that Providence, which has been more bountiful to me than I deserve, & in full confidence of a happy Meeting with you sometime in the Fall - I have no time to add more, as I am surrounded with Company to take leave of me - I retain an unalterable affection for you, which neither time or distance can change.

From a letter written during the American Revolutionary War by future-President George Washington to his wife, Martha, June 23, 1775

> You have been with me constantly, sweetheart. At Kangerdlooksoah I looked repeatedly at Ptarmigan Island and thought of the time we camped there. At Nuuatoksoah I landed where we were. And on the 11th we passed the mouth of Bowdoin Bay in brilliant weather, and as long as I could I kept my eyes on Anniversary Lodge. We have been great chums dear…. In fancy I kiss your dear eyes and lips and cheeks sweetheart; and dream of you and my children, and my home till I come again. Kiss my babies for me.

From a letter written by Arctic explorer Robert Peary to his wife, Josephine, August 17, 1908.

Another, equally important variety of adult romantic love is companionate love (Reis & Aron, 2008). Also called affectionate love, friendship-based love, and storge, companionate love is defined as the "affection and tenderness we feel for those with whom our lives are deeply entwined" (Hatfield & Rapson, 1993, p. 9). Berscheid (1985) observed that companionate love can be understood as a combination of altruistic love, attachment, and friendship. This conceptualization resembles Lewis's (1960/1988) definition of Affection as well as the definitions proposed by other contemporary theorists (e.g., Sternberg, 1988).

Companionate love has several basic features, including a *relatively slow onset, durability or permanence, closeness or interdependence*, and *feelings of affection, intimacy, and commitment*. It is also an *inclusive* kind of love. Unlike passionate love, which is typically felt for one and only person at a time, companionate love is often felt for a variety of partners (including lovers, friends, family members, and even pets) at any given time. When Meyers and Berscheid (1996) asked college students to list the people they currently loved and the people with whom they were currently in love, they found that, on average, students listed nine "love" partners and only one "in love" partner. We can companionately love lots of people at the same time.

Companionate love is also a much hardier experience than passionate love. In fact, it may grow stronger over time because it is grounded in intimacy processes (including caring, understanding, commitment, and attachment) that take time to ripen and fully mature (Hatfield & Rapson, 1993).

> Young love is a flame; very pretty, often very hot and fierce but still only light and flickering. The love of the older and disciplined heart is as coals, deep burning, unquenchable.

(Henry Ward Beecher)

Some scientists believe that romantic relationships may even progress in a linear fashion from passionate love to companionate love. For example, Sternberg (1988) suggested, "Most romantic love relationships that do, in fact, survive eventually turn into companionate love relationships: the passion begins to melt, but the intimacy remains. Passion may be replaced over time by long-term and deeply felt commitment" (p. 127). Well-known marriage scholar Bernard Murstein (1988) similarly observed:

> With unimpeded access to each other and as a result of habituation, bit by bit generalized, overriding passion and longing evaporate and are replaced by liking or trust, although in good marriages, passion may return on specific occasions…. Out of the evolving network of shared experiences as a couple—children, family, married life—comes something less ephemeral and more permanent than romantic love.

(p. 30)

Research supports the idea that companionate love is sturdy and durable. Many married and dating couples report that their levels of passionate love decline the longer they are together, but that their feelings of companionate love stay high or grow even stronger (Sprecher & Regan, 1998).

Compared with the experience of falling in love, companionate love is less emotionally volatile. This does not mean that people who love each other do not feel deep emotions, but simply that they do not find themselves riding the kind of dizzy emotional rollercoaster that passionate lovers do. Instead, companionate lovers report warm feelings of trust, intimacy, affection and friendship, caring, mutual respect and tolerance, loyalty, supportiveness and concern, and other positive emotions (Castañeda, 1993; Fehr, 1988; Lamm & Wiesmann, 1997).

Figure 12–5

Companionate love is a deep, warm, affection-based kind of love that can be experienced for many types of people, including friends, romantic partners, and family members.

Source: Bill Aron/PhotoEdit, Inc.

Closeness or interconnectedness is another important feature of companionate love. Partners who love each other deeply and companionately find that many aspects of their lives are connected—their thoughts, feelings, actions, goals, and outcomes are bound up in each other. A close relationship is defined as one in which the partners' thoughts, emotions, and actions—their lives—are strongly interdependent (Kelley et al., 1983). Companionate love is, at its core, close love: what one partner says, feels, does, or thinks has a direct impact on the other partner.

Although companionate love is not as sexualized an experience as passionate love, it is important to recognize that romantic relationships based on companionate love *often contain a warm, satisfying sexual component as well*. In fact, partners with high amounts of companionate love for each other often report an equally high degree of sexual intimacy—that is, they communicate openly and honestly about their sexual feelings and enjoy a satisfying sexual relationship (Sprecher & Regan, 1998).

Personal Reflections

Make a list of all the partners (family, friends, lovers, pets, and so forth) in your life you deeply love. Do your feelings for those partners match the characteristics of companionate love that researchers have identified?

The Biochemistry of Love

1. 12.7 Discuss research on the biochemical basis of passionate and companionate love.

There has been a great deal of scientific interest recently in uncovering the biological or neurochemical basis of love. Researchers interested in passionate love have focused on three specific *neurotransmitters* (electrochemical messages released by neurons or the cells of the nervous system) because of their association with mood and arousal: serotonin, dopamine, and norepinephrine.

There certainly are some striking similarities between the experience of falling in love and the effects of these neurotransmitters (Fisher, 2000, 2006). For example, people who are passionately in love often think about their beloved obsessively, and low levels of serotonin are implicated in the intrusive thinking common to obsessive-compulsive disorder. Passionate lovers also report feelings of euphoria and exhilaration coupled with heightened energy, loss of appetite, and sleeplessness. These same experiences are associated with increased concentrations of dopamine in the brain. And finally, people who are deep in the throes of passionate love tend to focus on specific events or objects associated with their partner and to remember and muse over things that the partner said or did. Increased levels of dopamine are associated with heightened attention, and increased levels of norepinephrine are associated with enhanced memory for new stimuli.

On the basis of these similarities, scientists suspect that passionate love is associated with high levels of dopamine and norepinephrine and low levels of serotonin (see Acevedo & Aron, 2014; Ortigue et al., 2010). There is some preliminary evidence in support of this hypothesis. One study found that when people who are deeply in love gaze at a photo of their partner, two areas of the brain that are rich in dopamine (the ventral tegmental area and caudate nucleus) become active (Aron et al., 2005). Another study revealed that people in the early phases of "falling in love" had the same level of serotonin as people with obsessive-compulsive disorder (and both groups had lower serotonin levels than a control group of healthy adults who did not have obsessive-compulsive disorder and were not in love; Marazziti et al., 1999).

Companionate love is thought to be associated with two neuropeptides, oxytocin and vasopressin (see Fisher et al., 2002). In the body, vasopressin acts to regulate water retention; in the brain, it is implicated in memory formation, temperature regulation, and (in women) the release of adrenal corticosteroids during pregnancy and lactation. Oxytocin acts on smooth muscle cells. Levels rise in both men and women during sexual arousal and orgasm and, in women, oxytocin is released during breast-feeding and labor. Because oxytocin appears to play an important role in mother–child bonding in both humans and non-human mammals (Hiller, 2004; Insel, 2000), it has come to be popularly known as the "cuddle hormone"; however, many researchers do not approve of this label, arguing that oxytocin has more nuanced and complex effects (see van Anders et al., 2013).

Some scientists believe that oxytocin and vasopressin are involved in the ability to form social attachments and to experience the deep feelings of closeness, affection, and intimate connection that form the basis of companionate love (Carter, 2014; Fisher, 2000; Young & Flanagan-Cato, 2012). In support of this hypothesis, one study found that children with autism (a developmental disorder characterized by severe social impairment and difficulty forming interpersonal bonds and lasting emotional attachments) exhibited reduced oxytocin levels as well as alterations in the endocrine oxytocin and vasopressin systems (Green et al., 2001). However, at least one other study (Taylor et al., 2010) has found an association between interpersonal difficulties and elevated levels of oxytocin (in women) and vasopressin (in men).

Thus, much more research is needed before we will have a clear understanding of the neurochemical underpinnings of companionate (or any type of) love. The reality is that both companionate and passionate love are complex experiences that cannot be reduced to one specific cause, biochemical or otherwise.

What Initially Attracts Us to Someone?

1. 12.8 Identify and discuss the factors that are important in attraction, including desirable partner characteristics, level of sexual experience, physical attractiveness, similarity, and receptivity.

Before a love relationship can even start, the two people have to first notice each other (Regan, 2011). Once they do, a number of factors come into play in determining whether their mutual awareness will generate attraction and then, hopefully, develop into a lasting relationship.

12.8.1 Desirable Characteristics

What attributes do people find especially appealing when considering a partner for a potential relationship? When it comes to love and romance, studies find that men and women overwhelmingly prefer someone with an exciting personality who is intelligent, emotionally stable, honest and trustworthy, and physically attractive.

The very first investigations of romantic partner preferences were conducted in the late 1930s and early 1940s (Christensen, 1947; Hill, 1945). In those studies, college students were given a list of characteristics and then asked to rank order them in terms of how important they were in a dating partner. The two most important characteristics were "dependable character" and "emotional stability." Less important features included "similar political background" (unimportant to both men and women), "good cook/housekeeper" (unimportant to women), and "good financial prospect" (unimportant to men).

More recent investigations have confirmed these results. Men and women today continue to emphasize characteristics related to a good overall personality and dependable character (such as expressiveness and openness, friendliness and sociability, emotional stability, honesty and trustworthiness, and a sense of humor). They also desire someone who possesses attributes reflecting a sound intellect (intelligence, educational status), and who is physically appealing (that is, who is physically attractive and healthy looking) (Regan et al., 2000).

Not surprisingly, what people find attractive in a romantic partner differs across cultures. A team of researchers led by David Buss (1989) surveyed over 10,000 men and women around the world (including Africa, Asia, Eastern Europe, North America, Western Europe, and South America) about their preferences in a spouse. Although men and women in all cultures emphasized the positive dispositional attributes mentioned above (such as dependable character and emotional stability), there were some cross-cultural differences. For example, the characteristics "good housekeeper" and "desire for home and children" were highly prized among people in Africa and South America but were considered unimportant by men and women in North America (the United States and Canada) and most of Western Europe.

When it comes to friendship, people emphasize the same basic set of dispositional attributes they do in a romantic partner. Studies find that both men and women desire a friend who has a great deal of the following characteristics, in order of importance: sense of humor, expressiveness and openness, warmth and kindness, exciting personality, and intelligence (Sprecher & Regan, 2002). It seems that when we seek a partner for a love relationship (regardless of whether that relationship is friendly or romantic in nature), we focus on attributes that reflect responsiveness and the ability to provide social and emotional support. And this makes perfect sense. Without warm, kind partners who are responsive to and concerned with each other's needs, any relationship is unlikely to survive for long (Berscheid & Regan, 2005; Fehr, 2008).

12.8.2 Moderate Sexual Experience

An individual's sexual history is another characteristic that influences how he or she is evaluated by others. In general, men and women prefer their potential dates or spouses to have lower, rather than higher, levels of prior sexual experience. Researchers consistently find that attributes like being "sexually easy" or "sexually available," "promiscuous," and "sexually experienced" receive very low desirability ratings from people rating potential romantic partners (Buss & Schmitt, 1993; Regan & Berscheid, 1997; Sprecher et al., 1997).

This does not mean that people want partners with no sexual experience whatsoever, though. Chastity or virginity (complete sexual inexperience) has become increasingly unimportant to both men and women when considering someone for a romantic relationship (although some cultures value chastity more than others; see Buss, 1989). It seems that people want someone with "just enough" sexual experience.

12.8.3 Physical Appeal

Around the world, people may seek a romantic partner with a moderate degree of sexual knowledge and an array of wonderful dispositional qualities, but research also shows that the thing they pay most attention to, at least initially, is how that partner looks. For example, men and women at speed-dating events initially pay much more attention to the physical characteristics of a potential date than to his or her interior qualities (Fletcher et al., 2014; see also Walster et al., 1966). This is likely due to the fact that someone's appearance is the primary piece of information that we have about a potential partner when we first meet—it takes time to determine whether someone also has a great personality and an honest, dependable disposition but appearance can be immediately evaluated. (Naturally, physical appearance factors become substantially less important once people move beyond their first interactions with each other and establish a relationship [see Eastwick et al., 2014].)

Certain body types and facial characteristics appear to be particularly desirable. In general, people are attracted to someone with an average body size (as opposed to an extremely thin or very overweight size). They also prefer someone with a waist-to-hip ratio (a measure of body fat distribution) that is typical for his or her biological sex—that is, an "hourglass" shape in women and a "tapering V" physique in men (Singh, 1993, 1995). In terms of facial appearance, people typically rate as most attractive faces that possess symmetry as well as an appealing combination of "babyish" features (such as relatively large, wide-set eyes and a smallish nose), sexually mature features (including prominent cheekbones and thinner cheeks, and, in men, a strong chin), and expressive features (like a wide smile and high eyebrow) (Cunningham, 1986; Cunningham et al.,

1990; Grammer & Thornhill, 1994).

12.8.4 Similarity and Receptivity

Similarity is another key factor in initial attraction. There is little evidence to support the old saying that "opposites attract" (Arrindell & Luteijn, 2000; Byrne, 1997). When evaluating strangers or potential partners, we seem to strongly prefer those who are "just like us"—that is, who have similar demographic characteristics (such as age, race or ethnicity, religion, and educational status), personality traits, values and attitudes, and interests and hobbies (Markey & Markey, 2007; Sprecher & Regan, 2002). Similarity also seems to promote attraction in existing relationships: The greater the similarity between friends, dating partners, or spouses, the more liking they feel for each other (see Fehr, 2008; Montoya et al., 2008).

Finally, there is *receptivity*—we tend to be attracted to and like people who we believe will respond positively to our attempts to initiate an interaction or a relationship (Bredow et al., 2008; Huston & Levinger, 1978). No one likes rejection. In fact, fear of rejection is one of the primary reasons people give for not initiating relationships with someone they find attractive (Vorauer & Ratner, 1996; Vorauer et al., 2003).

So, assuming that we meet someone who attracts us and who seems interested in us, what then determines whether our budding relationship will continue to grow and develop or instead will wither and die?

Personal Reflections

Here is a list of 10 partner characteristics that researchers have examined: emotional stability, kindness and compassion, honesty and trustworthiness, intelligence, good sense of humor, physical attractiveness, good financial prospect, friendliness and sociability, education, and self-confidence. If you could create the "perfect mate," how would you rank order these features? Which of them would be most important? Which would be least important? Would your ordering change if you were considering a best friend?

This page contains the following errors:

error on line 8 at column 770: Expected '#' or '[a-zA-Z]', but got ' '.

Below is a rendering of the page up to the first error.

Prerequisites for Love: Becoming a Better Partner

1. 12.10 Identify the prerequisites for a successful love relationship and ways to become a "better" partner. Discuss some of the major challenges that can derail love relationships, including habituation, disengagement, and jealousy and describe ways to effectively cope with these issues.

> If an individual is able to love productively, he loves himself, too; if he can love only others, he cannot love at all.

(**erich** Fromm, 1956, p. 60)

12.10.1 Accept Yourself

It may surprise you, but one of the most important prerequisites for being a good partner is *self-acceptance* (a positive self-concept). In order to love another, it is first necessary that one be able to love oneself.

Why is a positive self-concept so important? The comedian Groucho Marx once said, "I don't want to belong to any club that would have me as a member." If you cannot accept and love yourself, it will be impossible for you to accept that someone else might love you. And, like the comedian, people who cannot accept themselves generally reject other people.

People who feel positive about themselves are confident and self-sufficient—they do not require continual external validation. A positive self-concept does not mean that someone is self-centered or believes that he or she is always correct, good, and moral and can do no wrong. To accept oneself is to accept one's shortcomings as well as one's strengths—that is, "to accept myself for what I am" (Coutts, 1973). *The manner in which one is raised is important for acquiring a positive self-concept*.

"I think the reason I don't like myself is because of all the problems I had in the past…the absence of Mom and Dad, and when they were around so was abuse. I feel that since my parents couldn't accept me, why should I? I felt like a failure, the ugliest person alive, and basically trash. I had tried to kill myself."

(from the authors' files)

It is not unusual for children who have been neglected or abused to have negative self-concepts as adults and sometimes to be unable to be loving to others (in fact, abused children often become abusive parents). Having loving, caring parents or other caregivers during infancy and childhood teaches us not only that other people do nice things that make us feel good (and thus, that they are good), but that we are worthy of having someone else care about us. The trust that is gained by this experience generalizes to other people as we grow older (Collins & Feeney, 2004; Edelstein & Shaver, 2004).

Personal Reflections

Do you have a positive self-concept? Why or why not? If your self-concept is less than positive, what effects do you think this has on your ability to fully participate in a loving relationship?

12.10.2 Accept Your Partner

It is equally important that we accept our partners for who they are. Studies by Keith Davis (1985) have revealed that *acceptance of one another* and *understanding of each other's behavior* are essential characteristics of love relationships. Noted love theorist Elaine Hatfield (1988) similarly has observed that each person in a relationship must recognize his or her partner for who and what that person is. As hard as we sometimes are on ourselves, we are often harder on our partners because they are not everything we want them to be. Hatfield reminds us that real intimacy is not possible with an imaginary "perfect" partner: it can only occur when we recognize our partner's true character.

Of course, it is not always easy to achieve such recognition and understanding of our partners. Usually people try to look and act their best when they are first starting a romantic relationship, and work very hard to hide any perceived flaws that they fear might be a turn off to their new partner. It takes time before we feel comfortable sharing our innermost needs, feelings, emotions, and values.

In addition, we already discussed how, when people fall deeply in love, they tend to idealize both their lover and their relationship, seeing everything through "rose-colored glasses." This means that even if the partner reveals his or her "true" self to us, we may not actually see it (Felmlee, 1995, 2001).

The idealistic fantasies that we weave around our partners are normal and can have some very positive consequences. Some scholars, in fact, believe that positive illusions about the partner can keep us in a relationship when times get tough because they promote the belief that the partner is a good person and that the relationship is meant to be and will survive (see Murray et al., 2003).

Other scholars, though, argue the opposite. They believe that having an accurate, unbiased view of the partner, warts and all, is the key to having a happy, healthy relationship (see De La Ronde & Swann, 1998). Which perspective is correct?

It turns out that both are. Current evidence shows that realistic idealism—that is, acceptance of the partner for who he or she really is, coupled with an idealized overall view of the relationship—is most important (Regan, 2011). We are most happy, and our relationships are healthiest, when we have a realistic knowledge of the partner's most important attributes (good and not-so-good) but maintain a highly positive, idealized view of

his or her overall character and of our love.

Figure 12–6

For a loving relationship to develop, the partners must accept themselves and each other, acknowledging and embracing both similarities and differences.

Source: P. Broze/ONOKY - Photononstop/Alamy Stock Photo

I love to hear her speak, yet well I knowe
That music hath a far more pleasing sound;
I grant I never saw a goddess go;
My mistress, when she walks, treads on the ground.
And yet, by heaven, I think my love as rare
As any she belied with false compare.

(**shakespeare, sonnet** 130)

12.10.3 Communicate Positively

Acceptance (both of ourselves and our partners) gives us the potential to trust and love others, but for intimacy to really develop, there must be appropriate, responsive, and mutual self-disclosure by both parties. As we discussed earlier, relationships develop best when two people self-disclose to one another at about the same time, at about the same depth, on a similar topic, and with mutual responsiveness (Derlega et al., 2008; Dindia, 2000). If Jeff reveals some of his true thoughts and feelings to Connie, for example, it is expected that she will listen attentively and in a way that communicates caring and understanding and that she will reciprocate in a timely and appropriate manner.

Similarly, when conflict arises (and it will), partners should try to use positive communication strategies to resolve it (Cupach & Canary, 2003). Successful resolution requires, first, that each partner communicate openly and honestly with the other. Although it might seem difficult, it is essential that both partners clearly disclose their positions and their needs (Gottman, 1999). If we do not understand what our partner wants, how can we hope to achieve any sort of resolution? Second, the partners must remember to stay focused on the issue at hand—it is very easy to wander off topic, or become defensive, especially when emotions are running high (Gottman, 1998). Third, each partner should try to understand the other's perspective (put themselves in each other's shoes, if they can). Fourth, the partners should maintain eye contact to show that they are engaged in the conversation and actively listening to each other, and try to express positive feelings (and suppress negative ones) whenever possible. Finally, partners must be realistic and fair and aim for an equitable solution rather than a win-lose one. We must be willing to compromise. In the Addendum at the end of the next chapter (Chapter 13), we discuss specific ways to communicate effectively and positively about difficult issues or during conflict. Although our focus in the Addendum is on sexual communication, much of the information we provide can be usefully applied to nonsexual areas of a relationship as well.

Figure 12–7

Over time, many couples experience a growth in intimacy that ultimately leads to the development of a deep, lasting friendship.

Source: Laura Doss/Getty Images

12.10.4 Embrace Change

> The divorce rate is so high not because people make foolish choices, but because they are drawn together for reasons that matter less as time goes on.

(**robert sternberg**, 1986)

If there is anything that is unavoidable in life, it is change. Every couple will be faced with a variety of new challenges in life, including home ownership, vacation time, parenthood, finances, career-related issues, and, inevitably, aging. Two people who appear to be in complete harmony as they enter a committed relationship and start their life together are often surprised to find themselves in disagreement on how to handle these matters. Many couples, for example, report the child-rearing years to be the most stressful and least satisfying in their marriages (Ahlborg et al., 2008; Hendrick & Hendrick, 1983). Fixed gender roles—or, conversely, changing gender roles—may contribute to this (see Chapter 8). Today, there are the added challenges of two-job families and job-related moves far away from family and friends.

The partners themselves also will change over time. One of the most common things that many couples experience is a process called habituation. Think of your favorite food. What makes it your favorite food? The taste and smell are no doubt important, but we are willing to bet that another factor is that you do not have it very often. If you were served your favorite food every day for a month, do you think it would remain your favorite? Would we look forward to Thanksgiving turkey if we ate turkey every week? It's doubtful. This is why popular weekly TV shows eventually go off the air and why hit songs eventually drop off the *Billboard* "Hot 100" list. We grow tired of seeing and hearing them. The same is true of the ability of other people to stimulate us—socially, emotionally, intellectually, and, alas, sexually. Of all the challenges that a couple face in a relationship, habituation is certainly one of the greatest (Byrne & Murnen, 1988).

As we discussed earlier in the section on passionate love, the decline of passion is almost inevitable, for a large component of passion is novelty and fantasy. A new partner cannot continue to arouse strong emotions, and with the passage of time it takes greater and greater stimulation to cause the same response that once was brought about by a mere glance or touch. As the passion subsides and fantasy is replaced with reality, the result is often disappointment. A common reason couples give for divorcing is that they have "fallen out of (passionate) love" and are bored (see Roberts, 1992).

William Hamilton/The New Yorker Collection/The Cartoon Bank.

Although passion will decline with time due to familiarity and habituation, there is no need for *intimacy* (those feelings and experiences that promote closeness and bondedness) to decline. The key to maintaining a relationship is to acknowledge and accept the changes that are occurring and work to replace passion with those things that lead to companionate love. Some of the successful strategies couples use to maintain relationships include attending to one's partner (e.g., thinking about their partners, sharing activities), openness, a positive attitude, assuring one another, and working to establish a social network (Canary & Stafford, 1994).

Similarity, so important in establishing a relationship, can be maintained and habituation can be kept to a minimum by embarking on new activities together (Byrne & Murnen, 1988). For example, couples may find it stimulating to engage in new sports and games together, share new hobbies, try new sexual experiences together (see Chapter 11), join social groups, and/or plan vacations together.

In sum, couples in happy, long-lasting relationships display all the characteristics of sharing a best friendship—they embrace change and work to develop intimacy. As stated by Schwartz (1994, p. 28), "The possibility of achieving a deep friendship with a spouse represents the most exciting goal of marriage."

Personal Reflections

For those presently in a long-lasting relationship: Have the activities you share with your partner changed since you first began dating? Have new shared activities replaced old ones? Are you growing together or growing apart? If you feel that you are growing apart, what can you do to change this?

12.10.5 Stay Engaged

Sometimes, of course, couples do not grow together toward greater understanding, intimacy, and commitment but instead grow apart. Disengagement happens when couples stop paying attention and responding to each other (essentially, they become uninvolved in each other's

lives).

"I am married, yet feel as if I do not have a husband. He goes hunting every weekend during hunting season, and goes fishing a lot too. Between his softball league and poker games at the club, most weeknights are taken as well. Most of my time is taken up by the kids' activities and what social life I have is spent with other wives. Most of the time I am too tired to make love when my husband is in the mood, which is not very often. A friend recently described our marriage as 'married singles.'"

(from the authors' files)

There are three primary signs that a couple is disengaging from each other and from the relationship. The first is *emotional indifference*, which happens when the partners no longer feel any strong positive (e.g., love) *or* negative (e.g., anger, jealousy) emotion for each other. A second sign is *cognitive disconnection*, in which the partners come to view each other as unresponsive and detached, begin to pay less attention to one another, and distance themselves psychologically from each other. The third sign is *behavioral distancing*, which happens as the partners communicate less, become less involved in each other's lives and activities, and increasingly interact with each other in superficial (less intimate) ways (Barry et al., 2008; Gottman, 1999; Kayser & Rao, 2006).

Partners generally grow apart very slowly, and by the time they realize it, they may have little left in common. At this point, some people may think that it is easier to form a new relationship than to work at their present one. Indifference is a major relationship killer (Barry et al., 2008).

12.10.6 Trust Each Other

So is jealousy. Shakespeare, in *Othello*, gave a nod to the destructive power of jealousy by describing it as "the green-eyed monster which doth mock the meat it feeds on." How would you feel if your partner appeared to be forming an emotional attachment to a coworker and started spending a great deal of time with him or her? How would you feel if your partner and another person appeared to be sexually interested in one another? These are situations that typically cause many people to feel jealous. Jealousy is defined as an unpleasant emotional state "that is aroused by a perceived threat to a valued relationship or position and motivates behavior aimed at countering the threat" (Daly et al., 1982; see Harris, 2009). The perceived threat can involve more than the actual loss of a partner; it can also include loss of face, loss of self-esteem, and loss of feeling special (Cano & O'Leary, 1997). As an emotion, jealousy is hard to describe, but it usually involves anger and fear, including feelings of rage, hostility, anxiety, and worry (Guerrero et al., 2005).

Jealousy is associated with some dispositional characteristics, including chronic low self-esteem (Knox et al., 2007; Pines & Aronson, 1983). People who cannot accept themselves and who are unhappy with their lives are more likely than others to experience jealousy. In addition, as we discussed earlier, people with a manic love style are likely to experience feelings of intense possessiveness toward their partners and to become extremely (and often inappropriately) jealous (Lee, 1988).

However, these differences aside, just about everyone feels jealousy when faced with a partner's infidelity. Does it matter what type of infidelity it is? Research suggests that it does. Psychologists Margit Berman and Patricia Frazier (2005) asked a sample of men and women whose partners had been unfaithful to think about the infidelity and to indicate whether the sexual behavior or the emotional attachment had upset them the most. Equal numbers of men and women (53%) said that the sexual aspect of their partners' infidelity was the most distressing, and equal numbers (47%) said that the emotional attachment their partners had formed for the third party was the most upsetting. Clearly, some people are more bothered by sexual infidelity, whereas others are more concerned by emotional infidelity.

Researchers used to think that there were gender differences in jealousy, with men more likely to become jealous about a partner's sexual infidelity and women more likely to become jealous about a partner's emotional infidelity (Buss et al., 1992, 1999; Harris, 2002). However, more recent research finds that this is not the case—both men and women become jealous and considerably (and equally) distressed by both types of infidelity (Cann & Baucom, 2004; Harris, 2003; Leeker & Carlozzi, 2014).

Paradoxically, while jealousy is an emotional reaction to a perceived relationship threat, the expression of jealousy is likely to further damage the relationship (Cano & O'Leary, 1997). Withdrawing from or attacking one's partner, for example, may cause him or her to withdraw or attack, thus increasing the fear of loss, which, in turn, may increase or prolong the feeling of jealousy.

How, then, should you deal with occasional bouts of jealousy? First, acknowledge your feelings to your partner and describe what caused them (Anderson et al., 1995). If you choose to go to counseling (probably a good idea), go together—seek therapy as a couple (Cano & O'Leary, 1997). Second, trust your partner and work to maintain your partner's trust in you. Be faithful, and never purposely try to make your partner jealous to get attention (Sheets et al., 1997; White, 1980). Establish mutual trust, while at the same time respecting your partner's need for some personal freedom. If you can do this, your chances are good of keeping that green-eyed monster at bay.

Personal Reflections

Do you ever have feelings of jealousy? Have they ever interfered with your relationship(s)? What are the conditions that have caused you to become jealous in the past? Does your partner ever try to make you feel jealous? What things do you do to deal with these feelings or situations?

Ending a Relationship

1. 12.11 Explain how people can cope with the breakup of a love relationship.

> There is hardly any activity, any enterprise, which is started with such tremendous hopes and expectations and yet which fails so regularly as love.

(**erich fromm**, 1956)

Even if we do all these things to maintain our relationships, there are no guarantees. Research shows that the majority of adults have ended a close friendship within the past five years (Rose, 1984) and that about 45% of all first marriages (and 36% of all remarriages) in the United States end in divorce or permanent separation (Aughinbaugh et al., 2013). The loss of a love relationship is a common life experience for all of us.

12.11.1 Coping with Breakups

> Undo it, take it back, make every day the previous one until I am returned to the day before the one that made you gone.

(**rapoport**, 1994, p. 24)

We do not enter into a romantic relationship (or any relationship, for that matter) with the expectation that it will end. Thus, breaking up is one of life's most painful experiences. Many things commonly occur during the breakup process. Let us examine three of them (Weber, 1998; Weiss, 1975).

One thing that almost everyone engages in during a breakup is *obsessive review*, a "constant, absorbing, sometimes maddening preoccupation [of the other and the situation] that refuses to accept any conclusion" (Weiss, 1975, p. 79). We review, again and again, the relationship and the breakup, searching for reasons. "Why?" "What did I do that caused this?" This process can detract from all other endeavors but can be useful if it helps prevent breakups in future relationships.

Breaking up almost always includes *emotional and social loneliness* as well. Emotionally, you feel isolated, missing your ex-partner and everything that he or she brought to your life. But you can also end up socially isolated as well. Friends you had in common with your ex-partner may have to choose sides or, because they feel awkward, may avoid both of you. You may be left wondering who your friends are and where you fit in.

The third, common experience that people often have to deal with is that their *ex-partner is still around*. If you are the one who was left, he or she is a constant reminder of the rejection (and possibly a reminder to others that you are rejectable). On the other hand, if you are the one who broke off the relationship, your ex may be telling everyone how much you are to blame. Part of the process, then, is trying to "save face" (Weber, 1998).

To make matters worse, breaking up is usually a process, not limited to a clean break at a single point in time, and can seem to drag on and on as we try to deal with the psychological aftermath.

Psychologist Ann Weber (1998) has offered several suggestions to help the brokenhearted deal with their loss: (1) express your emotions (sorrow, anger) to someone who is a sympathetic listener, or write down your thoughts; (2) try to figure out what happened, and again, it may help to write it down; (3) do not idealize your ex, but instead focus on the real person, including his or her faults and shortcomings; (4) prepare to feel better (e.g., find what is funny or ironic in your experience) and expect to heal (think back on other physical or emotional injuries in your life and realize that you have always healed); (5) do not shut yourself off from others and let them know what you need from them at this time; and (6) take the perspective that your life is about to change and look at it as a new start. Do something new that you have always wanted to try—traveling, writing, entertainment, anything!

> And so, we take our lessons to heart. We take this heart, this new heart and self, full of hope, humor, and irony, and we face the world—a new world with uncharted possibilities and dangers. Perhaps we try once again, explore a new love, although it will not be the same. Then again, the pain reminds us we do not want it to be exactly the same. We have some memories and fantasies to cherish, some sense of hard-won meaning, the moral of the story. Together these help to forge a sense of promise. Thus, silly to risk it, but crazy not to, we try again, and we take heart.

(**weber**, 1998, p. 304)

Study Guide

Key Terms

- agape
- arranged marriage
- close relationship
- companionate love
- consummate love
- decision/commitment
- disengagement
- empty love
- equitable relationship
- equity
- eros
- exclusivity
- fatuous love
- habituation
- idealization
- infatuated love
- intimacy
- jealousy
- liking
- ludus
- mania
- monogamy
- nonlove
- passion
- passionate love
- polyandry
- polygyny
- pragma
- psychometric approach to love
- realistic idealism
- receptivity (role in attraction)
- romantic love
- self-acceptance
- self-disclosure

- similarity (role in attraction)
- storge
- triangular theory of love

Interactive Review

Answers can be found on p. 472.

1. There have probably been as many definitions and descriptions of love as there have been poets, philosophers, and scientists who study love. Early theorists based their models of love on (1) , existing literature, and previous philosophical or theological discourse. For example, C. S. Lewis identified four types of love; of those, (2) is the type that is based on familiarity and repeated contact and resembles the strong attachment seen between parents and children. Although all of the early theorists agreed that love is a complex experience, they disagreed about the (3) of love varieties that exist.

   Contemporary love theorists have adopted a (4) that involves collecting large quantities of (5) from people in (6) and then using statistical techniques to identify the different love types that those people are experiencing.

   Using this approach, psychologist Robert Sternberg has suggested that liking, loving, and all the other positive emotions we feel for other individuals can be understood by the combination of three components: intimacy, passion, and decision/commitment. According to this triangular theory, (7) is intimacy alone, without passion or commitment. (8) is liking plus feelings of passion without commitment, while (9) is intimacy and commitment without passion. (10) , which Sternberg believes to be true love, requires the presence of all three components together.

   Sociologist John Lee also proposes that there are many love types or styles of loving. (11) is based on intense emotions and feelings of attraction; (12) grows from friendship; (13) is rational and practical; (14) is possessive, jealous, and obsessive; (15) is emotionally controlled and commitment-shy; and (16) puts the interest of the loved person first. According to Lee, the degree of happiness an individual feels in a loving relationship depends greatly on how well his or her love style (17) that of the loved one.

   Today, all love theorists agree that adult romantic love can be divided (at a minimum) into two basic varieties. The first, called (18) refers to the state of "being in love with" another person. This type of love starts quickly, fades fast, and is associated with intense and often fluctuating (19) . It is also highly sexualized and associated with mental preoccupation and a tendency to (20) the partner or see only his or her positive qualities.

   Companionate love, on the other hand, is characterized by durability, closeness, and feelings of (21) . It is less (22) than passionate love, and tends to grow stronger over time.

   Many things initially attract us to another person. Research reveals that most people prefer certain desirable characteristics (such as a dependable character), (23) as opposed to extensive sexual experience, and good looks when considering someone for a romantic relationship. They also tend to like others who are (24) to them on various dimensions and who appear receptive.

   Relationships develop and are kept alive by both positive communication and self-disclosure and by (25) , which happens when the partners experience a relatively equal ratio of positive-to-negative outcomes.

   There are several things that we can do to become better partners and promote the health and well-being of our love relationships. One of the most important prerequisites for being a good partner is (26) . We also need to accept our partners for who they are, which is not always easy. Current evidence shows that (27) , defined as having an accurate view of the partner's most important attributes coupled with a highly positive, idealized view of his or her overall character, may be an essential ingredient to having a happy relationship.

   Change is unavoidable in life and in relationships. One of the most common challenges faced by many couples is a process called (28) . One way to counter the effects of this process is to acknowledge the changes that are happening and work to replace passion with those things that lead to companionate love, including (29) .

   Trust is another important part of maintaining a relationship. When we doubt our partner's commitment to us, we can experience (30) , which is an unpleasant emotional state that is aroused by a perceived threat to a valued relationship. Working to establish mutual trust is important in any successful relationship.

Self-Test

Answers can be found on p. 472.

A. True or False

- **T F** 31. Love has only recently become a topic of interest to scholars.
- **T F** 32. All theories of love propose that there are only two types of love people can experience.

- **T F** 33. The decision and commitment to love another person without intimacy or passion is experienced as empty love, according to Sternberg.
- **T F** 34. According to Lee, love styles are fixed and unchanging.
- **T F** 35. The ludic love style is a strong negative predictor of relationship satisfaction.
- **T F** 36. Passionate love is the basis for marriage in almost all cultures.
- **T F** 37. Sexual desire is one of the essential characteristics of passionate love.
- **T F** 38. It is relatively uncommon to be passionately in love with more than one person at a time.
- **T F** 39. Companionate love is characterized by feelings of deep affection and tenderness.
- **T F** 40. Companionate love is not associated with sexuality.
- **T F** 41. Passionate love may be linked with the action of the neurotransmitters serotonin and dopamine.
- **T F** 42. What people find attractive in a romantic partner differs across cultures.
- **T F** 43. People prefer the same basic set of dispositional attributes in a close friend that they do in a romantic partner.
- **T F** 44. Studies show that chastity (complete sexual inexperience) has become increasingly important to people when considering a romantic partner.
- **T F** 45. Fear of rejection is a major reason people do not initiate relationships with someone they like.
- **T F** 46. As a general rule, people are most attracted to opposites.
- **T F** 47. Self-disclosure is important in a relationship, but it is not necessary that both individuals self-disclose.
- **T F** 48. In order for a relationship to stay healthy, it is important that the partners communicate positively during times of conflict.
- **T F** 49. Disengagement is a process in which partners become less responsive to each other and less involved in each other's lives.
- **T F** 50. Both men and women become jealous if they perceive a partner to be sexually unfaithful.

B. Matching

- 51. agapic love
- 52. companionate love
- 53. consummate love
- 54. empty love
- 55. erotic love
- 56. fatuous love
- 57. infatuated love
- 58. liking
- 59. ludic love
- 60. manic love
- 61. nonlove
- 62. passionate love
- 63. pragmatic love
- 64. romantic love
- 65. storgic love

1. highly idealized love based on physical attraction, strong emotions, and feelings of intimate connection; these types of lovers typically

are turned on by a specific physical type and are inclined to feel "love at first sight" (but their feelings do not last long)

2. commonly known as being or falling "in love" with someone; theorists characterize this as an intense, emotional, sexually charged, and usually fleeting type of love
3. an affectionate type of love that develops from friendship slowly over time
4. a type of love relationship that results when commitment is made on the basis of passion without the experience of intimacy; leads to whirlwind romances that usually end when the passion starts to fade
5. a selfless love style that puts the interest of the loved person ahead of the lover's own, even if it means great sacrifice
6. commitment without intimacy or passion; often the first stage in arranged marriages
7. a self-centered, emotionally controlled approach to love in which the lover avoids commitment and treats love like a game
8. a type of relationship characterized by feelings of intimacy without passion or decision/commitment
9. a love that results when passion is felt in the absence of intimacy and commitment, where the lover is obsessed with the other person as an ideal
10. love characterized by an intense emotional dependency on the attention and affection of the partner; a jealous, possessive love in which one is obsessed with the loved one
11. a love found only in relationships that include intimacy, passion, and commitment
12. the combination of intimacy and commitment without high levels of passion; based on togetherness, trust, sharing, and affection
13. a rational or practical style of love; this type of lover consciously looks for a compatible mate (a "good match")
14. the type of love that characterizes most casual relationships, in which there are low levels of intimacy, passion, and decision/commitment
15. a love experience in which two people are drawn together physically and emotionally; this type of love has high intimacy and passion but commitment has not yet developed

C. Fill in the Blanks

- 66. Romantic love in Sternberg's model most closely resembles in Lee's theoretical model.
- 67. Companionate love in Sternberg's model most closely resembles in Lee's theoretical model.
- 68. Infatuated love in Sternberg's model most closely resembles in Lee's theoretical model.
- 69. C. S. Lewis's concept of Charity is probably closest to in Lee's theoretical model.
- 70. Today all love theorists agree that there are, at a minimum, two varieties of adult romantic love: love and love.
- 71. Around the world, the most common form of marriage practiced by both men and women is .
- 72. is defined as the "affection and tenderness we feel for those with whom our lives are deeply entwined."
- 73. Many studies have found that the first thing that we tend to focus on when meeting a potential partner is .
- 74. Primary signs that a couple is disengaging from each other and their relationship are (a) , (b) , and (c) .
- 75. Three things that commonly occur during breakups are , , and having to deal with the fact that your ex-partner is still around.

Suggested Readings and Resources can be found on p. 463.

Chapter 13 Sexual Problems and Therapy

> In the fantasy world of sex, nothing ever hurts, nothing rubs or chafes, nobody is anxious, no one is tired, there are no menstrual cramps, strange viruses, or pregnancy fears, nothing bad ever happens and everything fits perfectly; in the fantasy world of sex, erections function, orgasms are easy, desire surges, birth-control methods don't interfere with spontaneity, and bodies melt. In the real world, it doesn't always happen this way.

—Excerpt from *What Really Happens in Bed* by Steven Carter & Julia Sokol, 1989, M. Evans and Company, Inc.

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 13.1 Discuss the fact that sexual problems are common in all age groups, including young people.
2. 13.2 Explain how individual factors (including different beliefs, assumptions, and preferences) and relationship factors (including communication and overall well-being) may impact a couple's sex life.
3. 13.3 Identify the basic components of sexual therapy and the methods used to treat specific sexual dysfunctions. Discuss the pros and cons of the "medicalization" of sexual problems.
4. 13.4 Explain the difference between a sexual problem and a sexual disorder.
5. 13.5 Identify the primary sexual disorders that occur in men.
6. 13.6 Identify the primary sexual disorders that occur in women.
7. 13.7 Discuss postcoital dysphoria.
8. 13.8 Define hypersexuality and explain the debate about the concept of "sexual addiction."
9. 13.9 Explain the importance of a couple's overall relationship to sexual problems.
10. 13.10 Discuss how to talk with your partner about sexual differences and problems.

In this chapter you will learn about the types of sexual difficulties and dysfunctions that men and women may experience. Studies indicate that at least half of all sexually active people will experience a sexual problem at some point in their lifetime.

Sexual Problems Are Common

1. 13.1 Discuss the fact that sexual problems are common in all age groups, including young people.

In one nationally representative survey, Laumann, Paik, and Rosen (1999) found that in just the previous year sizeable numbers of Americans aged 18 to 59 reported having sexual problems lasting for several months. Specifically, 32% of women and 15% of men said they had lost interest in sex, 26% of women and 8% of men reported difficulty achieving orgasm, 16% of women indicated experiencing pain during sex, 10% of men said they had erectile difficulties, and 31% of men reported regular problems with premature ejaculation. In the United States, sexual problems are reported by people of all ages and ethnicities (see Table 13–1). They are equally common among adults living in other world regions, including Europe, Asia, and Oceania (Hendrickx et al., 2014; Lo & Kok, 2014; Mialon et al., 2012; Nicolosi et al., 2006; Peixoto & Nobre, 2015). What does this mean? Laumann concluded that "everyone is at risk … sooner or later. It's a myth that young, healthy people aren't going to have sexual problems" (quoted in Leland, 1999, p. 47).

Table 13–1 Percentages of American Men and Women Who Have Experienced Sexual Problems Lasting Several Months During the Previous Year by Age and Race/Ethnicity

	Lack of interest in sex		Can't reach orgasm		Can't get or maintain erection	Premature ejaculation	Difficulty with lubrication	Pain during sex
Respondents	**Women**	**Men**	**Women**	**Men**	**Men**	**Men**	**Women**	**Women**
Age								
18–29	32%	14%	26%	7%	7%	30%	19%	21%
30–39	32	13	28	7	7	32	18	15
40–49	30	15	22	9	9	28	21	13
50–59	27	17	23	12	9	31	27	8
65–74	38	29	33	23	45	28	43	19
75–85	49	24	38	33	44	21	44	12
Race/Ethnicity								
White	29%	14%	24%	7%	10%	29%	22%	16%
Black	44	19	32	9	13	34	15	13
Latino/a	30	13	22	9	5	27	12	14
Other	42	24	34	19	12	40	17	19

NOTE: Results from nationally representative U.S. samples. Information on 60- to 64-year age group not provided.

Sources: Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009.

Table 13–1 Full Alternative Text

In some cases, individuals have sexual problems regardless of who their partner is. Within a relationship, however, sexual problems frequently arise because of other difficulties in the relationship or simply because of individual differences—people are different in what they want and how often they want it. We will begin with a discussion of the individual differences and interpersonal issues that can create sexual problems within a relationship.

Individual Differences and Interpersonal Difficulties

1. 13.2 Explain how individual factors (including different beliefs, assumptions, and preferences) and relationship factors (including communication and overall well-being) may impact a couple's sex life.

Researchers and clinicians have identified a variety of individual and relationship factors that are associated with the overall quality of a couple's sex life.

Different Expectations About Sexual Interactions

The expectations that each partner brings to a couple's sexual interactions can contribute to the development of a sexual problem. For example, men and women often have different ideas about partnered sex and about the role sex should play in their relationships.

Women, to a greater extent than men, pay attention to the context in which sex occurs and adopt a partner-focused orientation, whereas men, to a greater extent than women, pay attention to the physical aspects of sex and adopt a goal-focused (orgasm-centric) orientation (see Basson, 2000; McNulty & Fisher, 2008). Indeed, when asked to give six responses to the question "What things do you personally like best in a sexual partner?" for a survey in our course, most of the men listed specific anatomical characteristics (e.g., "nice ass," "sexy legs") or sexual attributes (e.g., will perform oral sex, has no inhibitions). Women, on the other hand, were less concerned about anatomy and much more focused on partner behaviors that were affectionate in nature and that allowed them to feel respected and cared for (e.g., a partner who holds, hugs, caresses). Nearly every woman expressed a preference for a male partner who takes his time, sexually speaking. In fact, this was often voiced as a complaint—that the male partner was not taking enough time or paying sufficient attention to the woman's sexual (and nonsexual) needs.

"I would prefer a partner who takes his time. The best, most enjoyable sex I've had was with a man who was completely unconcerned about whether or not we actually "did it." We would spend hours making out, exploring each other's bodies. Totally fun. The worst, least satisfying sex I've had was with partners who basically wanted to stick their penises in me and do their thing without any concern for how I was feeling. Selfish lovers."

"I want more time! He's so focused on the sex act—and honestly I could care less. I want kissing, touching, feeling, both before and after. That's what matters to me. I can take care of my own orgasms, thank you very much. What I can't give myself is cuddling. Or kissing or holding. I love my man, but he is way too 'wham bam thank you ma'am' about the whole sex thing. I think he thinks that if it's good for him, then it's good for me. Well, it isn't."

"My boyfriend thinks that everything we do should end in sex. Kissing leads to sex. Hugging leads to sex. Holding hands leads to sex. Sometimes I want to kiss and not necessarily have to have intercourse."

(All examples are from the authors' files.)

These differing preferences and expectations about sex certainly can lead to tension between partners and create conflict in their relationship. Interestingly, men and women do seem to agree about one thing—both wish that foreplay and intercourse would last longer (Miller & Byers, 2004).

Figure 13–1

Studies have shown that one half or more of all couples have had or eventually will have sexual problems at some time in their relationship.

Source: Asiaselects/Alamy Stock Photo

Different Assumptions About Male and Female Sexuality

Men and women often have different initial sexual experiences, which can lead to incorrect assumptions about the opposite sex. The first sexual experience to orgasm for many men and women is masturbation. Recall from Chapter 11 that most men masturbate by moving a hand firmly up and down the penis at a continually accelerating rate as they approach orgasm. Women are more variable in their masturbation techniques, although most prefer some type of indirect stimulation of the clitoris. Relatively few women insert a finger into their vaginas during masturbation (although they may utilize a vibrator that provides vaginal penetration as well as clitoral stimulation). Moreover, it generally takes women longer to masturbate to orgasm than it does men. Without any evidence to the contrary, it is logical for people to assume that what feels best for them must feel best for others as well. Thus, men often assume that women greatly enjoy having their genitals vigorously stimulated during foreplay (as by rapid thrusting of a finger in and out of the vagina), when in fact this may not be the case. Similarly, a woman might assume that her male partner prefers gentle indirect stimulation, when in fact this may not be the case.

"When we were first becoming sexual, my girlfriend was very nervous about hurting my penis. I had to reassure her that she would not hurt me if she gripped it tightly and moved her hand pretty hard along it." (man)

"I finally got so sore that I had to tell my partner to insert more slowly and touch me more gently. Until I did, he was under the assumption that smashing his thumb all over my clitoris, followed by non-stop pounding, was the best way to satisfy me. What's funny is that once I said something, he was relieved. Turns out he wasn't enjoying himself so much either." (woman)

(All examples are from the authors' files.)

Differences in Desired Frequency of Sex

One of the most common sexual issues that people in a relationship face is a difference in the frequency with which they and their partners want sex to occur (Muise et al., 2016).

"My boyfriend wants to have intercourse much more often than I want. How do I make it more enjoyable for both of us?"

"My boyfriend only likes to have sex maybe once a day. I want to do it much more. Shouldn't he be wanting it all the time?"

(All examples are from the authors' files.)

If the difference between desired levels of sex and actual frequency is large enough, it can lead to sexual and relationship dissatisfaction (Willoughby et al., 2014b). However, it is important to remember that in relationships, people are generally only oversexed or undersexed relative to their partners' desires. *It is the couple who has the problem, not the individual person.*

Sexual desire fluctuates normally in both men and women—it is not set at a fixed level. This means that any one person's desire for sex will vary depending on his or her life circumstances (see Regan, 2015). For example, illness, stress, and fatigue can greatly affect sexual desire. If your partner is showing less interest in sex than he or she once did, this may be due to other things that are happening in your partner's life.

"When I stayed home and my husband worked, I did not understand his seeming lack of desire. Not that he didn't enjoy it, but it could be placed low on a list of priorities. He would tell me about his problems at work, and I was really interested in making love then. I didn't want to hear how obnoxious, rude, or unintelligent his boss could be. I took all of these 'excuses' as a personal put-down.

"....his decision to quit his job of 25 years. When he finally decided to do this, I said I would go out to work and became a Kelly Girl. I never turned down an assignment and gave it my all. Now I am receiving tension, problems with bosses, and plain being physically and mentally tired.

"When I came home from work, he would be ready to be cuddly and kiss. I'd start telling him about problems I had during the day. Finally, I told him, 'I can't believe I'm doing and saying the same things you did to me.' He then knew how it felt and so did I. Well, this same attitude spilled over to the bedroom."

(from the authors' files)

Personal Reflections

What do you do when your partner desires sex and you are not in the mood? What would you expect your partner to do if you desired sex and he or she was not in the mood? Why? Have you ever pretended to be tired or ill in order to avoid sex with your partner? If so, why? Do you think that responses like these are the best way to communicate with your partner about sexual needs?

Differences in Preferred Sexual Behaviors

Differences in the type of sexual activities each person wants to engage in can also lead to problems. Suppose, for example, that person A wants to have sex only in the missionary position and is in a relationship with person B, who wants to have sexual intercourse in a variety of positions and locations.

"My girlfriend and I are sexually active. I am tired of doing the same old missionary position. Whenever I mention a new position, she doesn't want to do it. I am so tired of the same old position I lose interest in sex. I don't want to even have sex sometimes."

"Lately I've wanted to try some things that I think would increase both of our sexual pleasure, but my boyfriend does not want to do this. He is old-fashioned when it comes to sex and gets upset when I even mention trying a new position or maybe sharing a sexual fantasy while we're making love. I'm tired of having sex in silence and on my back."

(All examples are from the authors' files.)

Who is responsible for the problem here? Is A inhibited, or is B abnormal? Suppose that instead of having a relationship with A, B was in a relationship with C, who wanted to try bondage and anal intercourse (which B does not want to try). Should B now be viewed as inhibited? Once again, it is all relative. It does no good to point a finger and put the blame on one partner. In fact, it is generally best not to allocate any blame whatsoever but instead to view the issue as a shared one and to work together to resolve it. One of the most effective ways to do that is for partners to openly disclose and discuss their sexual preferences. Such direct and open communication about sex helps each partner understand the other's perspective and may lead to a stronger and happier relationship—both in and out of the bedroom (Muise et al., 2016).

Interpersonal Conflict and Relationship Distress

Although sexual relations are only part of a couple's overall relationship, it is definitely the case that what happens in the sexual areas of a partnership can greatly impact what happens in the nonsexual areas. The reverse is also true. The nonsexual aspects of a couple's relationship can have an enormous impact on their sex life. Researchers consistently find, in fact, that relationship well-being is correlated with sexual satisfaction—that is, partners who are experiencing conflict and/or who are dissatisfied with the quality of their overall relationship tend also to be unhappy with the quality of their sex lives (Sprecher et al., 2018).

"My ex-husband is an alcoholic. The drinking made him lethargic, uninterested in going out, hard to talk with, and very, very negative. By the end of our marriage, I could barely stand to be in the same room with him. This affected every part of our relationship, including our sex life. He had no interest in sex, and I felt exactly the same way. It's hard to feel attracted to someone you despise."

"My girlfriend and I have had the usual ups and downs. I can say that when we're in a down phase, neither one of us is very sexual. Who wants to have sex with someone you're pissed off at? This doesn't mean that I lose all sex drive. But in those instances, I'll masturbate. It's easier than trying to deal with her if we're in the middle of a fight. I'm pretty sure she does the same."

(All examples are from the authors' files.)

The successful resolution of interpersonal conflict and other relationship problems and stressors requires that a couple be able to talk about their differences—something that many people find challenging. The addendum to this chapter provides you with some guidelines about how to effectively communicate with a partner (particularly about sex). When couples cannot work out their problems by themselves, they may need the aid of a counselor. Be sure that you pick one who is properly trained and certified. The names and addresses of certified marriage and family

therapists in your area can be obtained by contacting the *American Association for Marriage and Family Therapy* (*AAMFT*): www.aamft.org.

Sometimes partners may need to seek assistance from a counselor who specializes in sexual therapy. This is likely when the issue facing the couple (or the individual) is related specifically to sexual (as opposed to general relationship) functioning, is causing one or both partners a great deal of distress and anxiety, and is interfering with the overall health and well-being of the relationship.

Personal Reflections

Are you able to comfortably communicate your sexual values and needs to your sexual partner or your potential partner? If not, what barriers are preventing you from doing so? Do you create any barriers that may prevent your partner from comfortably communicating his or her sexual values and needs to you? Have you ever experienced a situation in which issues you and your partner had "outside" of the bedroom spilled over and created sexual tension or problems for you? How did you resolve the situation?

Sexual Therapy

1. 13.3 Identify the basic components of sexual therapy and the methods used to treat specific sexual dysfunctions. Discuss the pros and cons of the "medicalization" of sexual problems.

Compared with other types of therapy, sexual therapy is a relatively new and still evolving field. Until Masters and Johnson published their pioneering book *Human Sexual Inadequacy* in 1970, most people with sexual problems went to their family doctor, a urologist, or a psychoanalyst (the dominant form of psychological counseling practiced at the time). However, most medical doctors were not (and still are not) prepared to deal with such problems, and psychoanalysis generally involved (and still involves, when it is practiced) long-term treatment that lasted years and that viewed sexual problems as behavioral manifestations of deep-seated childhood conflicts rather than as issues in and of themselves (Berry, 2013).

Masters and Johnson (1970) originally believed that most sexual problems were the result of faulty learning and thus could be resolved in a relatively short period of time by using cognitive-behavioral therapy. This kind of therapy focuses on specific sexual behaviors and how people think and feel about them, using cognitive restructuring and behavioral modification to help people replace maladaptive responses with adaptive ones. For example, rather than look backwards at past events or unresolved childhood conflicts, Masters and Johnson focused on educating couples about sex, challenging and changing negative sex-related attitudes and beliefs, improving sexual communication between partners, and building specific sexual skills. In their view, the problematic thoughts and behaviors *are* the problem, and if those thoughts and behaviors can be changed, the client's sexual issues are resolved. The cognitive-behavioral approach dominated the field from 1970 through the late 1990s, and the original techniques developed by Masters and Johnson remain the core components of most sex therapies today (Atwood, 2015).

With the introduction of Viagra in 1998, sexual problems began to be viewed as a medical issue—and treated accordingly (Berry, 2013). In the medical model, physicians treat sexual problems with medical techniques (e.g., drug regimens, surgery) (see Cacchioni & Tiefer, 2012). Men with erectile difficulties could view themselves as having a "legitimate" medical problem that could be "cured" with a pill rather than having to consider the possibility that their sexual issues stemmed from psychological or interpersonal factors requiring cognitive-behavioral and/or couples therapy. For the pharmaceutical companies, the medical approach was so profitable that they began to attempt to solve female sexual problems with medications as well. Indeed, a drug called Addyi (flibanserin) was eventually developed to improve women's sexual desire (it was approved by the Federal Drug Administration in 2015). The popularity of this approach to sexual problems grew so quickly that Rowland (2007) asked, "Will medical solutions to sexual problems make sexological care and science obsolete?"

There are several things wrong with adopting an exclusively medical approach to sexual problems (see Tiefer, 2015). First, most medical doctors have not received the necessary training in how to deal with these particular issues (Coleman, 2012). Second, as we discussed earlier in this chapter, many sexual problems have non-medical origins—they stem instead from a person's sex-related beliefs and assumptions, partners' sexual preferences and communication styles, and the quality of a couple's relationship. A drug that impacts a specific aspect of one person's bodily function (e.g., through targeting various physiological responses) cannot "fix" these or other non-physical issues and thus cannot effectively or permanently "cure" a sexual problem. For example, research finds that most men treated with drugs alone for erectile dysfunction eventually become dissatisfied and experience a resurgence of their difficulties (Berry, 2013). Similarly, although Addyi (the drug developed to treat low sexual desire in women) was originally hailed as the "female Viagra," it carries serious side effects and is relatively ineffective at improving women's sexual functioning (see Tavernise, 2016). Many experts have raised ethical questions about the medical approach, accusing the pharmaceutical industry of "marketing" diseases and establishing a "disease state" in the minds of healthcare professionals and the general public in order to boost sales and make a profit (see Meixel et al., 2015). This is a valid criticism. In short, although some individuals experiencing sexual issues may benefit from drug therapy, medical treatment generally is not sufficient as a standalone solution for sexual problems (Althof, 2006; Tiefer, 2008).

Today, the pendulum has begun to swing back as therapists and physicians increasingly are recognizing that, because sexual problems often have multiple causes, effective treatment must be multifaceted (e.g., Brotto et al., 2016). In the biopsychosocial approach, "the cause and the symptom-structure of a dysfunction entail some combination of biological, psychological, and social factors" (Berry, 2013).

For a couple, sex therapy is only going to work if the partners are in a committed relationship, do not have major nonsexual conflicts, have good communication skills, and are motivated to help each other with the sexual problem (and in the relationship as a whole). If any of these factors are missing, then treatment will probably also include couples therapy to improve communication and resolve conflicts (Metz & Epstein, 2002).

If you ever think that you may need the help of a sexual therapist, be sure to check the credentials of therapists first. In some places, almost anyone can advertise as a "counselor." The names and addresses of certified sexual counselors and therapists in your area can be obtained by contacting the *American Association of Sexuality Educators, Counselors and Therapists (AASECT)*: www.aasect.org.

Components of Sexual Therapy

As illustrated in Table 13–2, sexual therapy has three general goals (Stephenson et al., 2013): first, to improve a person's sexual functioning; second, to increase his or her sexual satisfaction; and third, to reduce or eliminate his or her sexual distress. In order to achieve these goals, the process of therapy typically includes the following components.

Table 13–2 Three Goals of Sexual Therapy

Goal 1: Improve sexual functioning	Target and improve specific aspects of sexual response (e.g., level of sexual desire, subjective and physiological arousal, ease of achieving orgasm or ejaculation, pain during or after sexual activity)
Goal 2: Increase sexual satisfaction	Improve the client's subjective evaluation of the quality of his or her sex life (both the good and the not-so-good aspects of it)
Goal 3: Reduce sexual distress	Eliminate or reduce the client's feelings of stress, anxiety, worry, frustration, guilt, shame, and other negative emotions experienced in response to sexual activity

Source: Based on Stephenson, K. R., et al. (2013). Relationship satisfaction as a predictor of treatment response during cognitive-behavioral sex therapy. *Archives of Sexual Behavior, 42,* 143–152.

Table 13–2 Full Alternative Text

Medical History

Some sexual problems may result, at least partly, from underlying physical or medical issues. Circulatory problems (e.g., arteriosclerosis), hormone abnormalities (e.g., low testosterone levels), or anything that causes damage to the central nervous system (e.g., diabetes, spinal cord injury) increases a person's chances of developing a sexual problem (McCabe & Connaughton, 2014). Alcohol and drugs also often cause sexual impairment, as do major mood and anxiety disorders. It is important, therefore, that treatment include a complete *medical history* of the patient (and possibly a referral to a physician for a physical exam) before beginning therapy. Depending on the type of sexual problem, pharmacotherapy may be started at this time to help the client during cognitive-behavioral therapy (e.g., anti-anxiety drugs, medications to increase vaginal lubrication or to improve erectile strength).

"As I got older, sex became increasingly uncomfortable for me, to the point where we stopped completely. My husband thought I was losing interest in him but the truth was that it had nothing to do with him. I didn't want sex that was guaranteed to be painful. We argued over this many times and it did affect other areas of our relationship…. Part of therapy was learning how to communicate more effectively with each other, part was the two of us compromising on sexual matters, and part was finding a way to treat my physical issue. We eventually found a prescription, specifically a type of vaginal cream, that helped to make sex more comfortable for me."

(from the authors' files)

13.3.3 Sexual History

Nearly all sex therapists will take a complete *sexual history* of the client before treatment begins. These histories are very thorough, and the length of time devoted to a history will depend on how candid the client is about his or her past experiences. Some therapists prefer to work with couples because "There is no such thing as an uninvolved partner" (Masters & Johnson, 1970). Even when a person's sexual problem developed before the current relationship, the partner is involved because that issue is now part and parcel of their union. In fact, when one partner has a sexual problem, it is common for the other partner to develop one as well (McCabe & Connaughton, 2014).

"My wife suffers from fibromyalgia and there are times when she finds intercourse to be extremely painful, especially when I first insert my penis into her vagina. I am always so worried about hurting her that I've started having a problem myself—I can't get hard, even when she's feeling okay and wants us to try intercourse."

(from the authors' files)

Educational Information

The therapist will also provide clients with appropriate information designed to educate them about sexuality, to increase their knowledge of anatomy and about male and female sexual responses, and to correct any misunderstandings or inaccurate information they may have. Some of these inaccurate beliefs include the idea that clitoral orgasms are somehow less "valid" or "real" than vaginal orgasms, that men should be able to get an erection at the drop of a hat, and that "good sex" is always spontaneous, produces mutual and simultaneous orgasm, and yields total sexual satisfaction (see Dune & Shuttleworth, 2009).

"I thought that there was something wrong with me that I couldn't climax from intercourse but only when I masturbated or my partner gave me oral sex. It was really reassuring to learn that this is true for a lot of women and that there wasn't anything wrong with me or my body. Up to that point, I had felt guilty and ashamed." (woman)

"My wife thought that because I'm a man I should always be interested in having sex. Sometimes she'd initiate and I wouldn't be interested, especially if I was tired or dealing with stuff at work. I would make excuses and try to let her down nicely, but no matter what she'd get upset if I didn't want to. Therapy helped her understand that being a man doesn't mean you're some kind of super-charged sex robot. Both of us learned that we each have a right to say no to sex, and this doesn't mean we have a bad sex life or we don't love each other." (man)

(All examples are from the authors' files.)

Sensate Focus

Many people are goal- or performance-oriented during sexual relations. By focusing so much on the act of penetrative intercourse and the achievement of an orgasm, they never really learn how to give or receive physical pleasure in an affectionate, mutual, non-penetrative manner. Most therapists, therefore, instruct couples to use *non-demand mutual pleasuring techniques* when touching each other. Specifically, couples are instructed to go home, get undressed, and take turns touching each other without thinking about the goal of engaging in penetrative intercourse or having an orgasm. Touching the breasts and genitals is forbidden at first, but all other areas of the body are to be explored (see Figure 13–2). The receiver is instructed to focus on the sensations produced by the giver and to provide feedback as to what feels good and what does not. The giver learns what makes his or her partner feel good while simultaneously learning the pleasure of touching. Essentially, the couple learns to be sensual in a non-demanding situation. During their therapeutic sessions, partners then discuss how the exercises went and their feelings about the experience with the therapist, who can provide additional guidance about techniques and positions as needed.

Figure 13–2

Sensate focus is a non-demand mutual pleasuring technique in which a couple learns how to touch and be touched without worrying about performing or reaching a goal.

Masters and Johnson, who created these sensate focus exercises, often had patients spend several days doing this non-genital-oriented touching. The purpose is to reduce anxiety about sexual performance and teach nonverbal (and verbal) communication skills (De Villers & Turgeon, 2005). Eventually, the couple is instructed to include breast and genital stimulation in their touching, but to avoid orgasm-oriented touching. A successful outcome for the treatment of sexual problems is often directly related to the amount of sensate focus that is completed during therapy. Interestingly, research shows that mutual, affectionate, non-penetrative behaviors, such as cuddling and caressing, are associated with heightened sexual satisfaction (see Muise et al., 2016). This suggests that all couples, not just those experiencing sexual problems, can benefit from sensate focus techniques.

Personal Reflections

Stop and reflect on the physical interactions you have with your partner(s). In most of your interactions, are you able to engage in extended non-genital touching and caressing of your partner, or are you usually in a hurry to achieve some immediate genital or breast touching? Is your partner able to caress your arms, legs, neck, and so on, without you quickly attempting to steer the behavior toward sexual play? Why or why not?

Specific Exercises

After the sensate focus exercises are successfully completed, therapists generally assign specific exercises to help with the problem that led the person (and the partner) to seek treatment. These will be described as we discuss some of the most common types of problems. When the therapist allows sexual intercourse, it is almost always in a woman-on-top or side-by-side position, where neither partner is in total control. Therapists believe that these positions have much more erotic potential than the missionary position frequently used by many couples.

Classification of Sexual Disorders

1. 13.4 Explain the difference between a sexual problem and a sexual disorder.

As we have discussed, not all consensual sexual interactions proceed smoothly or generate a high degree of pleasure and gratification for the partners, and most men and women occasionally experience some disruption of sexual response (see Tambling & Reckert, 2014). These disruptions and problems do not necessarily reflect the presence of an underlying sexual disorder. The World Health Organization's *International Classifications of Diseases-10 (ICD-10)* defines sexual disorders as "a clinically recognizable set of symptoms or behavior associated … with distress and with interference with personal functions" (WHO, 2016b). The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* defines sexual disorders as "a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (APA, 2013). Notice that an important criterion in both classification systems is subjective distress—a sexual problem only becomes a "disorder" if the individual *considers* it to be one. What this means is that two people might exhibit the same disturbance in sexual function (for example, an inability to maintain an erection during intercourse or an absence of sexual desire), but only one (or neither) would be viewed as having a disorder. Similarly, a particular sexual response pattern might be considered problematic or disordered in one situation but not in another, depending on the individual's level of associated distress.

"My situation might seem strange to you. I've been married twice. With [name deleted], I had premature ejaculation but with [name deleted] I do not. Here's the thing that's strange—I haven't changed. I still ejaculate quickly, usually right after I enter. The difference is that [name deleted] needed me to last longer, and the fact that I couldn't made me (and her) miserable. Our sex life was hell. Now my sex life is heaven. [Name deleted] prefers masturbation and oral sex, which I am happy to do, and she doesn't care how long I last inside her."

(from the authors' files)

Two other criteria also must be met. To be classified as a true disorder, a sexual problem must have lasted for a good amount of time (usually at least six months) and must not be the result of some other personal or interpersonal issue (such as depression or other mental disorders; domestic abuse or other severe relationship traumas; major financial or occupational stress; medication or substance use; and medical conditions such as Parkinson's disease, diabetes, or heart conditions).

Sexual disorders are generally characterized as *primary* (lifelong; existing from the time the person became sexually active) or *secondary* (acquired; beginning after a period of relatively normal function), and as *global* (generalized; occurring across types of stimulation, situations, or partners) or *situational* (only occurring with some types of stimulation, situations, or partners).

As illustrated in Table 13–3, sexual disorders largely are classified according to the sexual response cycle as first described by Masters and Johnson (1966, 1970) and Helen Singer Kaplan (1979). The prevalence of these disorders is shown in Table 13–4. Thus, the four major categories are desire disorders, arousal (excitement phase) disorders, orgasm and ejaculation disorders, and sexual pain disorders. Be sure to review the sections on the Sexual Response Cycle in Chapter 4 before you read the following sections. Because there are important differences between the male and female sexual response cycles (and, consequently, the kinds of disorders that men and women are likely to experience), we have organized our discussion by gender. We discuss male sexual disorders first and then we consider female sexual disorders.

Table 13–3 A List of Sexual Disorders

NOTE: Disorders in italics are not yet recognized by the *DSM-5* or *ICD-10* classification systems but have been identified by experts in the field of sexual disorders and sexual therapy (e.g., Balon & Graham, 2015; Goldstein et al., 2016; McCabe et al., 2016a).

Desire Disorders	Arousal (Genital Response) Disorders	Orgasm and Ejaculation Disorders	Pain Disorders
Female sexual interest/arousal disorder (DSM-5)	Female sexual arousal disorder (ICD-10)	Female orgasmic disorder (DSM-5)	Dyspareunia (ICD-10)
Hypoactive sexual desire disorder (DSM-5)	*Persistent genital arousal syndrome*	Orgasmic dysfunction (ICD-10)	Vaginismus (ICD-10)
Hypoactive sexual desire disorder (DSM-5 and ICD-10)		Premature (early) ejaculation (DSM-5)	Genito-pelvic pain/ penetration disorder (DSM-5)
Male hypoactive sexual desire disorder (DSM-5 and ICD-10)	Erectile disorder (DSM-5 and ICD-10)	Delayed ejaculation (DSM-5)	*Non-coital sexual pain disorder*
		Orgasmic dysfunction (ICD-10)	*Benign coital cephalalgia*
			Dyspareunia (ICD-10)
			Benign coital cephalalgia
			Priapism

Table 13–3 Full Alternative Text

Table 13–4 Prevalence of Sexual Disorders: Results from Nationally Representative Population Surveys around the World

Type of Sexual Disorder	Men	Women	Country
Women			
Hypoactive sexual desire disorder	11	11	China (Hong Kong)
Hypoactive sexual desire	–	7	Korea
	6	14	Sweden
	–	6	United States (1)
	–	7	United States (2)
Men			
Erectile disorder[1]	5%	–	Belgium
	5	–	China (Hong Kong)
	5	–	Denmark
	3%	10%	Belgium

Sources: Aerts et al., 2014 (Switzerland); Christensen et al., 2011 (Denmark); Fugl-Meyer & Sjögren Fugl-Meyer, 1999 (Sweden); Hendrickx et al., 2014 (Belgium); Johannes et al., 2009 (United States 1); Park et al., 2015 (Korea); Rosen et al., 2012 (United States 2); Zhang et al., 2013, 2015 (China).

Table 13–4 Full Alternative Text

Type of Sexual Disorder	Men	Women	Country
	3	–	Sweden
Premature ejaculation			
	6%	–	Belgium
	4	–	China (Hong Kong)
	7	–	Denmark
	4	–	Sweden
	11	–	Switzerland
Orgasmic dysfunction			
	1%	7%	Belgium
	–	9	China (Hong Kong)
	2	6	Denmark
	–	10	Sweden
	–	3	United States (1)
Dyspareunia (painful intercourse)			
	< 1%	3%	Belgium
	–	8%	China (Hong Kong)
	< 1%	3	Denmark
	–	2	Korea
	< 1	4	Sweden

Male Sexual Disorders

1. 13.5 Identify the primary sexual disorders that occur in men.

In the following sections, we will discuss the primary sexual disorders that occur in men, such as hypoactive sexual desire, erectile dysfunction, premature ejaculation, and dyspareunia.

Hypoactive Sexual Desire

You were introduced to the term sexual desire in Chapter 4. The International Society for Sexual Medicine defines low sexual desire as "diminished or absent feelings of sexual interest or desire, absent sexual thoughts or fantasies and lack of a responsive desire. Motivations (defined as reasons/incentives) for attempting to become sexually aroused are scarce or absent" (see Rubio-Aurioles & Bivalacqua, 2013). To qualify as a sexual disorder called hypoactive sexual desire (APA, 2013; WHO, 2016), low sexual desire must have existed for at least 6 months, cause clinically significant distress for the individual, and not be due to an existing physical or medical cause or severe relationship or life stressor.

In men (and women), sexual desire decreases with age and regular fluctuations in desire also are common (Regan, 2015). As a result, it is not surprising that sizeable proportions of men report experiencing a lack of sexual interest or a problem with sexual desire at some point in their lifetimes. Surveys conducted in the U.S. indicate that about 15% of young and middle-aged men (18 to 59 years old) and about 27% of older men (65 to 85 years old) said they had been uninterested in sex for at least several months during the previous year (Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009). For some of these men—research suggests approximately 2% to 11%—this reduction in desire will be accompanied by personal distress and thus appropriately is labeled hypoactive sexual desire disorder.

Primary (lifelong) hypoactive sexual desire (in which a person has never had sexual feelings or felt sexual interest) is less common in men than it is in women (McCarthy & McDonald, 2009a). *Secondary* or *acquired hypoactive sexual desire* (in which a person is not currently experiencing sexual interest but has in the past) is sometimes produced by organic factors such as low testosterone levels (Buvat et al., 2013) or antidepressant drugs (see Werneke et al., 2006). However, only a few men with hypoactive sexual desire have abnormally low testosterone levels (Wespes & Schulman, 2002), and thus most cases are believed to be due to psychological or interpersonal factors (McCabe et al., 2016c).

Hypoactive sexual desire is often associated with depression, conflict with one's partner, severe stress (financial, work), or a sexually repressive upbringing. For probably half or more of the couples who enter therapy for sexual desire problems, one partner or the other has a coexisting sexual problem. Low sexual desire is very common in men with erectile problems, for example. In many cases, hypoactive sexual desire is a way of avoiding the sexual failure caused by the other sexual problem (DeRogatis et al., 2012; Rubio-Aurioles & Bivalacqua, 2013). Sexual desire disorders can also stem from a past trauma:

"When I was 15 I had sex with a prostitute. My friends encouraged me to do so. One week later I noticed two sores on my penis. I couldn't tell my parents, they would kill me. I couldn't sleep. I asked a friend for help. I remember how he looked at me. I felt rejected.... I was horrified.... His father was a doctor and he treated me. I remember the anxiety when he told me I had chancroid. I didn't know if it was curable.... Today, I'm afraid of having sex with anyone. I have not had relations with a woman in nearly 5 years."

(from the authors' files)

In its most extreme form, the avoidance of sex becomes phobic in nature and is called sexual aversion (Kaplan, 1987; WHO, 2016). The anticipation of any kind of sexual interaction (even conversation about sex) causes great anxiety, so persons with sexual aversion simply "turn it off" at a very early stage.

Of course, clinical intervention is necessary only if the loss of sexual interest causes significant personal or interpersonal distress. Low sexual desire is one of the most common reasons why couples enter sexual therapy, but it is also among the most difficult disorders to treat (Brotto & Luria, 2014; McCarthy & McDonald, 2009a). Indeed, many therapists report only a 10% to 20% success rate with conventional sex therapy techniques. One of the reasons is that hypoactive sexual desire frequently occurs in couples who have poor communication styles, experience a great deal of interpersonal conflict, and are unhappy with their relationship. Consequently, many therapists view desire disorders as a "couple issue" rather than a "personal problem" and adopt a multi-faceted approach to treatment (see Leiblum, 2010). For example, they begin with behavioral and cognitive techniques that are designed to increase pleasure and communication and decrease anxiety, and then incorporate both couples therapy (to resolve deeper relationship problems and rebuild intimacy) and individual psychosexual therapy (to help the person understand what it is that is causing anxieties about sex) (e.g., McCarthy & McDonald, 2009a).

Erectile Disorder

It is a rare man who will not experience an erectile problem at least once in his life, particularly as he ages. National surveys indicate that between 7% and 10% of young and middle-aged men (ages 18 to 59) and more than 40% of older men (ages 65 to 85) had erectile difficulties lasting several months or longer during the previous year (e.g., Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009). Any number of things can impair functioning and make it difficult for a man to get an erection, including fatigue, stress, alcohol, and drugs (McCabe & Connaughton, 2014). It is also quite common for men to have difficulty achieving or maintaining a full erection the first time they have intercourse or the first time they do so with a new partner, possibly out of nervousness or performance anxiety (which we will consider in greater detail in a bit).

"The first time my fiancé and I had sex I couldn't get it up. I wanted to, I willed it to happen with every fiber of my being, but my penis refused to cooperate. I couldn't believe it. We ended up laughing about it and what do you know the next time everything worked." (man)

"The very first time my boyfriend and I tried to have sex he couldn't get hard enough to do it. He was a virgin and it was his first time. We hadn't planned on sex and so we'd been up late talking and we were both tired. I was leaving in the morning to fly back to grad school and it was kind of a 'do it now or wait until summer' situation. I think the pressure got to him. I didn't feel bad about it and I made sure he didn't, either." (woman)

(All examples are from the authors' files.)

Does this mean that most men will eventually develop an erectile disorder? Not at all. Remember that a sexual problem only becomes a clinical disorder when it produces high and lasting distress in the individual (APA, 2013; WHO, 2016). Specifically, the term erectile disorder refers to the inability to get or maintain an erection adequate for "satisfactory sexual performance" for at least 6 months. This condition is sometimes called *impotence*, but most therapists do not use this term because it has negative connotations about a man's masculinity. Like other sexual disorders, erectile disorders can be *primary* (i.e., the man has always had difficulties) or *secondary* (i.e., the man has not had erectile problems in the past but does now); and *global* (i.e., the problem occurs in all situations) or *situational* (e.g., a man cannot get an erection with his partner, but can during masturbation). Solid estimates of the prevalence of this disorder are difficult to obtain due to the use of different diagnostic criteria and tools (see McCabe et al., 2016b), but national probability studies suggest that between 3% and 5% of adult men have erectile disorder.

Many erectile problems eventually resolve before turning into a true disorder, perhaps because so many have a physical basis (see Porst et al., 2013). Circulatory problems

(e.g., arteriosclerosis, hypertension, sickle-cell anemia), neurological disorders (e.g., resulting from accidents or pelvic surgery), prostate surgery, low testosterone levels, and groin injuries often result in erectile dysfunction (Laumann et al., 2007). A sizeable number of erectile problems are due to medications prescribed for other conditions, particularly antidepressants and the beta-blocking medications used to treat blood pressure and heart disease (e.g., McCabe et al., 2016c). Obesity (and diabetes), smoking, and chronic drug and alcohol use also are major contributing factors (Karadag, 2014; McCabe et al., 2016c). It is important, therefore, that a client with an erectile problem have a complete medical exam before treatment begins. Changes in medication and lifestyle often improve erectile function (Porst et al., 2013).

Figure 13–3

Serious stressors, such as financial or job-related issues, can lead to erectile problems or a loss of interest in sex.

Source: SuperStock / SuperStock

Erectile difficulties commonly are treated medically. Some of the first medical treatments for erectile dysfunction included vacuum devices (that force blood into the penis) and self-injection of drugs into the penis (Porst et al., 2013). For men who have suffered permanent nerve or vascular damage, *penile implants* can be used. However, most medical treatments involve oral medications: Viagra (sildenafil), Cialis (tadalafil), and Levitra (vardenafil). They work by relaxing smooth muscles in the penis, thus allowing arteries to expand and blood to rush into the penis. The pills act directly on the penis (not the brain) and work only when a man is sexually stimulated. About 90% of men who seek help for erectile disorder are treated with oral medication (Althof, 2006), and a sizeable number (14% to 22%) of men aged 45 and older have used these pills on at least one occasion (Jacoby, 2005; Lindau et al., 2007; Schick et al., 2010). Unfortunately, many young men are using these drugs recreationally, which can negatively affect their confidence when they attempt sex without the pills (Harte & Meston, 2012).

The medical model that has been widely adopted for the treatment of erectile disorders has failed to address some important issues (see Berry, 2013). First, there are major side effects associated with the use of oral medications, including headaches, indigestion, and blurred vision. Perhaps as a result, about 60% to 70% of men find them dissatisfying and discontinue their use (Berry, 2013). Second, even if they originate from a physical or organic cause, many erectile problems come to take on psychological meaning for the man (and his partner), and thus more than a pill will be needed to treat the issue. For example, a man who has a problem due to a physical cause (or a temporary problem due to medication) may become so apprehensive about sex that he becomes completely impaired. There are probably psychological and/or relationship problems associated with all erectile problems, even those that clearly originated with physical problems. Let us now discuss some of the psychological factors that may contribute to (or cause) erectile dysfunctions.

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Men with primary erectile dysfunction may have been raised in a sexually restrictive home environment in which sex was equated with sin and guilt (Masters & Johnson, 1970). Both cultural and religious factors may have played a role.

"I was raised a throughout my life.... I do remember in the seventh or ninth grade my father and I were talking about sex and he told me not to have sex until I was married or I would go to hell—I thought that for the longest time. Then when I discovered masturbation I felt terribly guilty, so I went to talk to a priest. He told me how wrong it was and gave me some prayers to say. From that time on I felt very guilty every time I did it.... I haven't had a full erection in 10 years (I'm 26)."

(from the authors' files)

An early traumatic experience might also result in primary erectile problems:

"At 16 years old...my best friend thought it was a shame I was still a virgin.... In a drunken stupor I was goaded into going downtown to pick up a hooker with my friend. The next day I walked tall and proud (although I felt no different), that is until I noticed a week later a greenish-yellow discharge on my underwear. A doctor diagnosed gonorrhea. I brought it up with my father, who became enraged. My brother laughed at me.... I did not date anyone for 3 years. Once I began, it took me 3 or 4 years to have sex.... I would get to the point of intercourse, then I would lose my erection."

(from the authors' files)

Situational erectile disorders are quite clearly psychological in origin:

"My husband doesn't stay hard when we make love. Everything is OK at the start, but then he gets soft in a minute or two. He stays hard when I give him oral sex or masturbate him."

(from the authors' files)

If this man's erectile problem were caused by something physically wrong with him, he would be unable to maintain an erection with any type of sexual activity.

For men who have acquired a secondary erectile disorder due to psychological factors, the most common cause is performance anxiety (Bancroft et al., 2005). Performance anxiety is a fear of failure.

"My girlfriend and I are sexually active. Since we first started having sex, I would have an orgasm but she wouldn't. She still hasn't had one, and we have had sex plenty of times. I feel that I am not doing my job as a man. I also feel embarrassed. It makes me feel I do not know much about sex. Lately...I have trouble getting an erection."

(from the authors' files)

It is also not uncommon for a man to experience erectile problems during first intercourse, as the quotations in the beginning of this section of the chapter attest.

Chronic anxiety, depression, and other mood disorders may contribute to the development of an erectile disorder (see McCabe et al., 2016c). So, too, can life stressors (such as unemployment) and conflict with the partner and the family (e.g., Boddi et al., 2016). According to Levine and Althof (1991), "Typically, the man does not fully appreciate his response to these life changes.... He avoids recognizing what these affect-laden events mean to him and only focuses on his loss of sexual confidence … He remains baffled by how he became dysfunctional."

Although an erectile problem in any of the previously mentioned situations is normal, many men are not aware of that and begin to worry about being "impotent." The next time they have sex, the anxiety caused by fear of failure can result in what is called spectatoring—observing and evaluating their own responses rather than focusing on the moment and experiencing sexual pleasure. Spectatoring is distracting, resulting in a loss of arousal, and it can lead to loss of an erection, which results in even greater anxiety the next time. The behavior becomes a vicious cycle, and what started as a normal response to fatigue, alcohol, drugs, or other factors can become a chronic psychological disorder.

In the traditional Masters and Johnson model of sexual therapy, men with an erectile dysfunction are usually assigned sensate focus exercises. Many men are amazed to find that they are able to get a full erection during these initial sessions. The reason, of course, is that the touching in sensate focus exercises involves non-demand pleasuring—the man does not have to perform but instead learns (or relearns) how to experience pleasure. When genital touching is allowed, the female partner is instructed to stop fondling the penis after the man gets an erection (see Figure 13–4). This is intended to teach the man that he does not have to use his erection immediately (many men with erection problems rush their performance for fear that they will lose their erection). With this "*teasing*" *procedure*, the man's erection comes and goes, and thus he also learns that loss of erection does not mean that he has failed, for it will come back again. When intercourse is finally allowed, it is always in a woman-on-top or side-by-side position, and the woman is the one who inserts the penis into her vagina. Thus, the man is not put in a position of feeling that he has to perform.

Figure 13–4

A commonly used therapy technique for men.

The long-term success rate of behavior modification techniques (when used alone) is often not good. On the other hand, the same thing can be said about drug treatments (e.g., Viagra), which focus on fixing the mechanics of erectile disorder while ignoring the personal and relationship problems that may have contributed to it. Thus, many therapists now adopt the *biopsychosocial approach*, which utilizes a combination of treatments (Aubin et al., 2009; Berry, 2013; McCabe et al., 2010; McCarthy & McDonald, 2009b; Rowland & Burnett, 2000). This will probably include not only pharmacology and some behavior modification techniques but also couples therapy that focuses on interpersonal issues and communication.

(Note to men: If you ever experience erectile dysfunction, your general practitioner will probably advise the medical approach. You might be better served with a multifaceted approach.)

Personal Reflections

Have you ever experienced performance anxiety during sexual relations (e.g., anxiety about pleasing your partner, maintaining an erection, reaching orgasm)? If so, what do you think is the cause of the anxiety?

Premature Ejaculation

"I have a problem with premature ejaculation. As soon as I start to have sex I ejaculate. I feel like the whole world is laughing at me.... All my other friends are having sex and doing it right."

(from the authors' files)

National surveys have found that about 30% of young and middle aged men (and more than 20% of older men) in the United States periodically experience premature ejaculation (Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009). Similar rates have been found in other countries (Montorsi, 2005). This is the most commonly reported male sexual problem (McCabe et al., 2016b).

How do we define premature ejaculation? How long does a man have to continue penetrative intercourse without being classified as a premature ejaculator? For men with lifelong premature ejaculation, 80% to 90% of them ejaculate within 60 seconds during partnered sexual activity and the remainder within 2 minutes (McMahon et al., 2013), compared to an average of about 3 to 13 minutes for other men (see Chapter 11). Thus, the International Society for Sexual Medicine (as well as the *DSM-5*) includes, as part of its definition of premature ejaculation, "ejaculation which always or nearly always occurs prior to or within about one minute" during partnered sexual activity (see McMahon et al., 2013). Short ejaculation time is not enough to diagnose a disorder, though. The short latency to orgasm following penile insertion must generate clinically significant distress in the man (*DSM-5*) and/or interfere with the ability of both partners to enjoy the sexual interaction (*ICD-10*). These additional criteria are important because, as noted by participants in the 2015 International Consultation on Sexual Medicine, there can be a considerable difference between "men who ejaculate before they wish and … men who find this bothersome enough to seek therapy" (McMahon et al., 2016b, p. 148). A man who ejaculates quickly but who is not bothered by this (and whose partner is not bothered by this) would not be considered to have a sexual disorder—he is simply a quick ejaculator.

"I have never been able to hold out long enough to actually get inside my girlfriend during sex. I can do all the stuff she likes, for as long as she likes, but I know that as soon as I go to enter it will all be over (literally). It's always been like this for me. My girlfriend calls me the 'king of foreplay.' Hey, as long as she's happy, I'm happy. I think society puts way too much emphasis on vaginal sex anyway. Sex is more than that."

(from the authors' files)

Therapists often view premature ejaculation primarily in terms of *absence of reasonable voluntary control* of ejaculation. According to this perspective, orgasm should not be a totally involuntary event, and a man should be able to have some control over when it occurs. Results from population surveys conducted around the world suggest that between 4% and 11% of men meet clinical criteria for premature ejaculation disorder—they ejaculate quickly and without reasonable control and experience significant personal distress because of this (see Table 13–4).

Many men who experience premature ejaculation are bothered by their problem and concerned about their partners' distress (Kempeneers et al., 2012). Indeed, early ejaculation may leave the partner sexually unfulfilled and contribute to relationship difficulties (Graziottin & Althof, 2011). A man who is disturbed by his own inability to exert any control over when he ejaculates may develop low self-esteem and performance anxiety (McCabe & Connaughton, 2014; Symonds et al., 2003). This, in turn, can lead to an erectile problem (and commonly does). Others may avoid dating new partners because of embarrassment or fear of rejection.

What causes some men to ejaculate more quickly than they (and their partners) would like? Premature ejaculation is usually divided into two types: lifelong (*primary*) and acquired later in life (*secondary*). Some cases are due primarily to psychological factors and others by organic factors (Waldinger & Schweitzer, 2006). Some types of injuries and illnesses have been known to cause premature ejaculation, as do some medications and non-prescription or illegal drugs (Mialon et al., 2012). There is also growing evidence that some men have "neurological constitution" premature ejaculation—a physiological (and perhaps genetic) predisposition to ejaculate quickly (Santtila et al., 2009). Acquired premature ejaculation is frequently associated with erectile problems (McMahon et al., 2013).

If premature ejaculation is lifelong and has an organic cause, therapy will probably include pharmacological treatment. There are several pharmacological agents that delay ejaculation (e.g., dapoxetine and other serotonin reuptake inhibitors, and/or topical anesthetics) (McMahon et al., 2013; Porst, 2011).

When the cause is due to psychological or relationship factors, pharmacological therapy is combined with cognitive-behavioral therapy. The *squeeze technique* was developed by Masters and Johnson (1970) and is still regarded as the most effective behavioral treatment. After a couple has completed the sensate focus exercises described earlier, the man's partner is instructed to manually stimulate his penis until he gets close to orgasm. The partner then squeezes the man's penis firmly between her (or his) thumb and first and second fingers for 3 to 5 seconds and discontinues stimulation until the man calms down and his excitement decreases. The partner repeats this three to four times before finally bringing the man to orgasm. This teaches the man that he has the ability to delay ejaculation.

Masters and Johnson (1970) reported success rates of 95%. However, long-term follow-up studies of behavioral therapy used alone showed disappointing results, with most men who successfully completed therapy later regressing to pretreatment levels of response (Schover & Leiblum, 1994).

Current consensus among therapists and other health care practitioners is that the best approach is multi-faceted, combining "cognitive and sex therapy with a pharmacologic agent of proven efficacy that has an easy-to-follow regimen" (Barnes & Eardley, 2007; see also McMahon et al., 2013).

Male Orgasmic Disorder

"My girlfriend and I are not ready to go all the way yet, but we do hand and mouth stuff. Unfortunately, I can't climax like this. She's not bad at it. I think it's just because I like her a lot and feel guilty."

(from the authors' files)

For most men, masturbation, intercourse, and other sexual activities typically result in orgasm and ejaculation. Indeed, one study found that about 95% of men reached orgasm during their last sexual encounter (Richters et al., 2006). This does not mean that a man who experiences the occasional difficulty ejaculating or having an orgasm is "abnormal." To the contrary, as illustrated in Table 13–1, it is quite common for men (particularly as they age) to find themselves unable to achieve an orgasm on more than one occasion (e.g., Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009). It is only when the problem persists over time (for at least 6 months) and is accompanied by clinically significant distress that we would consider it to be a disorder.

Male orgasmic disorder (referred to as *orgasmic dysfunction* in the *ICD-10* and *delayed ejaculation* in the *DSM-5*) refers to a marked difficulty achieving (or a complete inability to achieve) orgasm and ejaculation during partnered sexual activity. It can be *primary* or *secondary* and *global* or *situational*. Recent surveys indicate that between 1% and 2% of men suffer from this disorder (see Table 13–4). Although in some instances the issue can be traced to organic causes (e.g., drugs, alcohol, or neurological disease), most men with this disorder are able to reach orgasm/ejaculation either during masturbation or with manual or oral stimulation from the partner, indicating that the usual causes are psychological and not physical (McMahon et al., 2013).

Masters and Johnson (1970) reported that primary orgasmic disorder was often associated with a strict religious upbringing, a fear of getting a woman pregnant, and negativity and hostility toward the partner. Secondary orgasmic disorder is less common and often associated with some kind of previous psychological trauma. Apfelbaum (1989) found that men with orgasmic disorder are overly focused on performance and pleasing their partners and as a result are subjectively not as aroused (as they are during masturbation, for example).

Orgasmic disorder is difficult to treat effectively (see McMahon et al., 2013). Many therapists recommend what is called a *bridge maneuver*. The man is first taught to masturbate to orgasm while alone and then in the presence of the partner. Once this is successfully completed, the partner manually stimulates the man to orgasm. When this is consistently successful, the partner stimulates the man until he is very close to orgasm and then quickly inserts his penis into her vagina (assuming the partner is a woman). The idea is that if this can be done several times, the man will overcome his fears of ejaculating inside his partner's vagina. Apfelbaum (1989) also encourages men to be

more assertive with partners in letting them know what they find to be arousing. Bridge maneuvers can also be used by same-sex male couples if one partner has an orgasmic disorder.

Sexual Pain Disorders

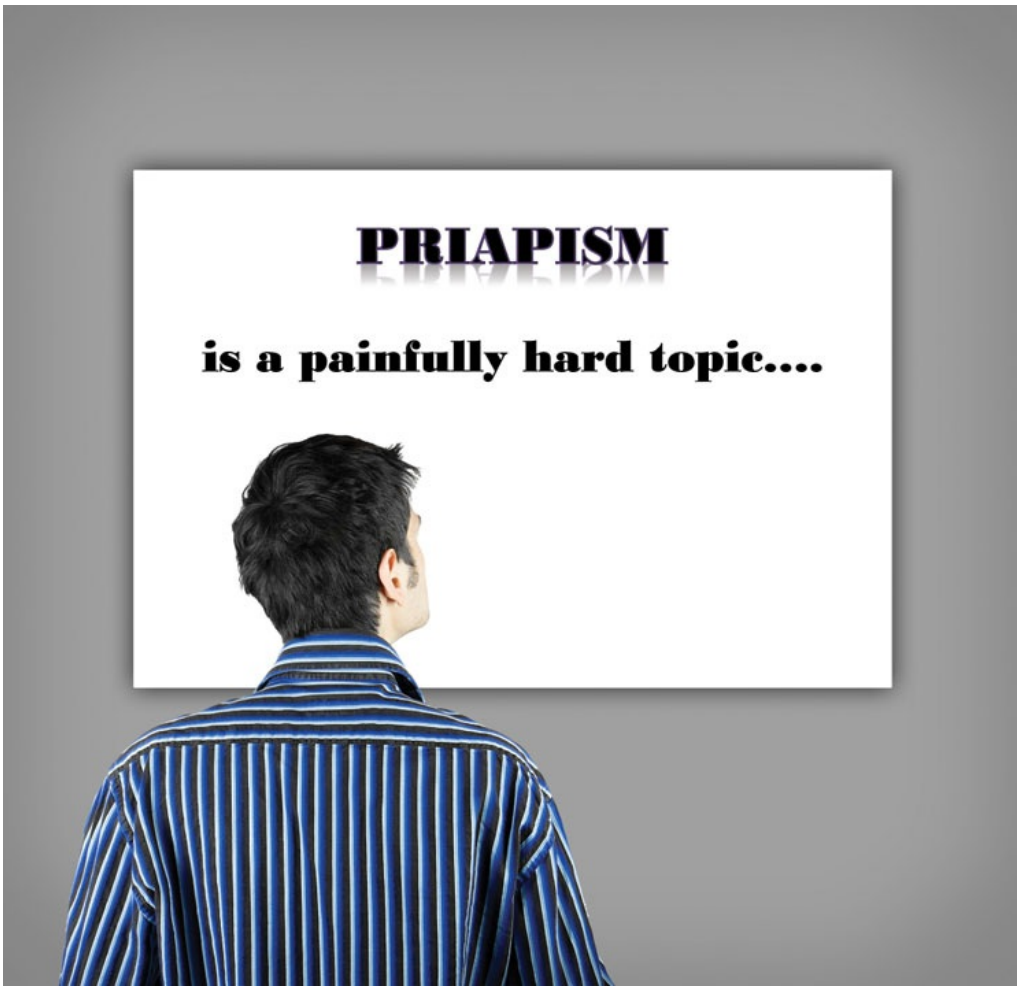
Painful intercourse is called dyspareunia (McCabe et al., 2016a). In men, it is an uncommon condition (see Table 13–4) that is usually, though not always, caused by a physical problem. The most common causes are prostate, bladder, or urethral infections (Davis et al., 2009), penile cancers (Skeppner & Fugl-Meyer, 2015), or the foreskin of the penis being too tight (a condition called phimosis). In a few cases, fibrous tissue deposits around the corpora cavernosa of the penis cause curvature or deformity of the penis and lead to pain during erection. This is called Peyronie's disease, a condition that can result in emotional distress and depression for the sufferer (Nelson & Mulhall, 2013).

If the physical factors responsible for dyspareunia are not quickly taken care of, dyspareunia can lead to other sexual problems. The anticipation of pain, for example, can become so great that it can lead to erectile problems or loss of sexual desire. The resultant psychological stress can also damage relationships. Remember, pain during intercourse is generally an indication that there is something physically wrong, so see a physician immediately before additional (and often greater) problems develop.

NOTE: The following two problems are generally not included as sexual pain disorders, but we have included them here because both do, in fact, involve pain.

To many men, the idea of having a *long-lasting erection* might seem appealing. Priapism is an uncommon condition in which the penis remains erect for prolonged periods of time, sometimes days (Burnett & Sharlip, 2013). It most often results from damage to the valves regulating blood flow away from the penis and can be caused by tumors, infection, chemical irritants (such as Spanish fly or some antidepressant drugs), erectile treatment drugs (such as Viagra), or blunt force trauma to the perineal region. Priapism is often painful, not to mention inconvenient, and men with this condition would gladly trade it for a normal erection. In some cases, priapism will resolve on its own and will not recur. However, any condition that restricts blood flow and deprives tissue of oxygen is potentially serious, and priapism is no different. Men who experience this would be well advised to seek immediate medical assistance. Treatments may include draining blood from the penis, injecting drugs that target blood flow (e.g., phenylephrine), or—in extreme cases—surgery to reroute blood flow (Salonia et al., 2014).

http://7poundbag.com/2014/01/15/wtf-january-15-2014/



robert_s/Shutterstock

Some men (and a few women) get severe headaches that start just before, during, or slightly after orgasm (see Diamond & Maliszewski, 1992). This condition is called benign coital cephalalgia ("benign orgasmic/sex headache"; alternative spelling: *cephalgia*). This is not a new problem and in fact was first reported by Hippocrates, the founder of modern medicine, in the fifth century b.c. It has been estimated that as many as 250,000 Americans may presently suffer from this problem. Most are men who are middle-aged, mildly obese, and somewhat hypertensive. The severe headaches may last for minutes or hours and are most common in men who suffer from migraines, but are usually not associated with any other serious disorder. The headaches are in the general category of "exertional headaches" and are generally caused by contraction of scalp muscles and increased blood flow to the head, neck, or upper body during intercourse. Treatment may include the teaching of relaxation techniques, medication for high blood pressure, or anti-inflammatory drugs (Domitrz, 2005).

Female Sexual Disorders

1. 13.6 Identify the primary sexual disorders that occur in women.

In the following sections, we will discuss the primary sexual disorders that occur in women, such as hypoactive sexual desire or sexual desire/arousal disorder, orgasmic disorder, and dyspareunia.

Female Sexual Interest/Arousal Disorder

Low sexual desire is by far the most commonly reported sexual problem by partnered women (in clinical practice, single women rarely seek treatment for lack of sexual desire; see Both et al., 2010). National probability surveys reveal that 30% to nearly 50% of American women reported a lack of interest in sex lasting a few months or longer over the past year, with rates highest among older women. Many women (roughly 20% to 40%) also reported recurring problems with genital arousal, including vaginal dryness and lack of lubrication (Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009).

These two problems—lack of sexual interest and genital arousal difficulties—often co-occur in women (Maserejian et al., 2012; Peixoto & Nobre, 2015). In addition, recall from Chapter 4 that many women do not separate desire from arousal (Basson, 2002c; Tiefer, 2000) and that the sexual response cycle of a sizeable minority of women (about 25%) is not as linear as that of men (for whom desire and arousal commonly are experienced as distinct events and in whom desire typically precedes arousal). Because of this, the *DSM-5* combines sexual arousal issues with sexual desire issues under the umbrella term female sexual interest/arousal disorder. However, there is ongoing debate over whether this is clinically appropriate (see Meana, 2010; Basson, 2014), and the *DSM-5* itself cautions that there may be "different symptom profiles across women" (p. 433) such that one woman may primarily experience issues with genital arousal whereas another woman may primarily feel a lack of desire (for example).

The *ICD-10* maintains the distinction between arousal and desire, specifying *female sexual arousal disorder* (defined as a failure of genital response; in this case, vaginal dryness or lack of lubrication) and *hypoactive sexual desire disorder* (defined as a loss of sexual desire) as separate disorders.

Of course, in both systems, to be classified as a disorder the sexual problem must be persistent (last over time) and must result in significant distress and/or interference with personal functioning (APA, 2013; WHO, 2016). It is important to note that about half of all women who say that they have little or no interest in sex do not regard this as a problem and, consequently, would not be viewed as having a disorder (see Fugl-Meyer & Fugl-Meyer, 1999). Indeed, desire commonly waxes and wanes over time in most relationships (Regan, 2015), and many women (and their partners) are aware of this sexual "fact" and not bothered by it (Herbenick et al., 2014).

Moreover, a discrepancy in desire between the partners—which many couples routinely experience (see our discussion at the beginning of the chapter)—is not sufficient to diagnose a sexual interest/arousal disorder (APA, 2013). A woman who wants less sex and/or who becomes less aroused than her partner does not have a disorder in the absence of other symptoms. With all this in mind, population surveys conducted around the world suggest that between 6% and 14% of women meet clinical criteria for a sexual desire disorder (see Table 13–4).

Low desire/arousal can have many causes. For example, it is frequently associated with other sexual problems (e.g., pain during intercourse) or sexual problems in the partner (Bitzer et al., 2013; Connor et al., 2011; McCabe & Goldhammer, 2012). Fatigue, stress, and both acute and chronic mental and physical health issues are also implicated in desire disturbances (see Regan, 2015). Interestingly, although sexual desire is associated with hormone levels (in both men and women), most women with low sexual desire do not exhibit low testosterone levels or other physical issues (Brotto et al., 2011).

The most common causes of disruptions in sexual interest/arousal are interpersonal ones (Regan, 2015). As we discussed in Chapter 4, sexual desire does not exist in isolation but is heavily dependent on the relational context. This is particularly the case for women (Bitzer et al., 2013; Maserejian et al., 2012): "Women's sexual inhibitions, avoidance, or distress can arise from betrayal, dislike, or fear of partner; partner's abuse or couple's unequal power; or from a sexual partner's negative patterns of communication" (Tiefer et al., 2002, p. 229).

"My husband was drunk on our wedding night. He could hardly walk and practically tore my clothes off. I wanted to kiss and hug and feel like I was loved, but all he wanted was to screw. I wasn't ready and it hurt real bad. He made me do things I didn't want to do. Afterwards he threw up in the bathroom and passed out. I cried all night. Now I still don't want him to touch me."

"My husband is constantly after me for sex but when we try he can't perform. He blames me for not being good enough in bed to please him. I don't want to have sex now at all and I avoid any situations that might lead to it. Our marriage is basically sexless because of me."

(All examples are from the authors' files.)

The women in the above quotations do not have a sexual disorder. Although some therapists might be tempted to diagnose them with hypoactive desire/arousal, the truth is that the "dysfunction" lies in the partner and his actions (Basson, 2001b; Tiefer et al., 2002). In one study of women referred for low sexual desire, one of the major contributing factors was lack of appropriate sexual stimuli provided by the partner, and "the most common needs expressed were those outside of the bedroom—an appropriate atmosphere, partner's consideration, respect, and warmth and physical affection..." (Basson, 2001c, p. 400).

"I find it much more pleasurable and rewarding to make love with my partner. We have times when we have sex but I enjoy making love much more. My partner caresses me and makes me feel more special and loved."

(from the authors' files)

As we mentioned in the section on male hypoactive desire disorder, low sexual desire is an extremely challenging disorder to treat. Drug and behavioral therapies are unlikely to work. Instead, treatment must be multidimensional and highly individualized, and incorporate techniques that help the partners improve communication and problem solving skills, build intimacy and trust, and resolve underlying conflict and problems in both the sexual and the nonsexual areas of their relationship (Bitzer et al., 2013; Leiblum, 2010).

Although it is not yet recognized as a disorder in the *DSM-5* or *ICD-10*, a few women suffer from persistent genital arousal syndrome (formerly known as *persistent sexual arousal syndrome*). In this condition, women who are otherwise physically normal have persistent genital arousal (e.g., vaginal congestion, lubrication) in the absence of sexual stimulation and without any accompanying feelings of sexual desire (Facelle et al., 2013; Leiblum & Nathan, 2001; McCabe et al., 2016a). The genital arousal is unwanted and intrusive and usually causes distress. We do not know what causes this syndrome, but it probably involves a host of physical (neurological, vascular), psychological, and pharmacologic causes. Effective treatments are still under investigation, but may include a combination of medical interventions (nerve blocking drugs and anesthetizing agents) and cognitive behavioral techniques (coping strategies, stress management) (Jackowich et al., 2016).

Female Orgasmic Disorder

Difficulty reaching orgasm is the second most commonly reported sexual problem in women (low sexual interest/arousal is first), but it is the most common problem for

which women seek sexual therapy (Laan et al., 2013). Large scale surveys have found that about 25% of sexually active American women aged 18 to 59 and about 35% of women over 60 said that they had been unable to achieve orgasm for at least several months of the previous year (Laumann et al., 1999, 2008; Lindau et al., 2007; Waite et al., 2009). In the United States, rates appear similar across racial and ethnic groups (see Table 13–1). Similarly, a recent review of existing studies concluded that although rates of orgasmic dysfunction vary considerably across countries, difficulties with this sexual response are common (and generally increase with age) among all populations of women (McCabe et al., 2016b). However, only about half of sexually active but non-orgasmic women say that their lack of regular orgasm causes personal distress (Laan et al., 2013).

Female orgasmic disorder is defined as "the persistent or recurrent difficulty, delay in, or absence of attaining orgasm following sufficient sexual stimulation and arousal, which causes personal distress" (Basson et al., 2000; see also APA, 2013; WHO, 2016). In addition, the sexual disturbance must not be better explained by a nonsexual mental disorder, medication, or a severe relationship or life stressor (e.g., partner violence) (APA, 2013). Approximately 3% to 10% of women in the United States and other countries meet clinical criteria for orgasmic disorder (see Table 13–4).

Female orgasmic disorder can be *primary* (lifelong; the woman has not been orgasmic since becoming sexually active) or *secondary* (acquired; the woman is not currently orgasmic but was in the past), and *global* (generalized; the woman is not orgasmic regardless of the type of stimulation, situation, or partner) or s*ituational* (specific; the woman is orgasmic in some situations but not in others). Many women's orgasm problems are situational—they may have great difficulty reaching orgasm during intercourse, but no difficulty during masturbation (Fugl-Meyer et al., 2006).

"I have never been able to orgasm during sex, but can reach it easily by myself. What am I (or is he) doing wrong?"

(from the authors' files)

Note that the definition of female orgasmic disorder assumes that there was "sufficient sexual stimulation and arousal." Therefore, one of the first questions to ask is whether a woman with problems reaching orgasm during sexual intercourse is receiving sufficient stimulation from her partner. For example, has there been enough foreplay?

"My problem seems like one that some of my friends have—short foreplay. It takes me a long time to reach orgasm. When we take a long time and work up slowly to lovemaking, I have intense orgasms. It is wonderful for both of us. But this happens very rarely. Because 'John' works a 9-hour work day and usually comes home exhausted, our lovemaking is short and to the point. He's satisfied and I lay there feeling nothing."

(from the authors' files)

In response to a survey question asked in our course ("What things do you personally like best in a sexual partner?"), well over half of the women who indicated that they were sexually experienced answered that they wanted their partner to take his time. Here are some examples:

"Lover takes his time and is as concerned with fondling and foreplay as he is with intercourse."

"Partner who likes to take time with foreplay and not rush into intercourse."

In addition, most women need clitoral stimulation to reach orgasm, with or without vaginal stimulation.

"Your class has also taught me how to talk to my boyfriend about sex. Stimulation of the clitoris manually has brought great joy to my sex life. I now even reach orgasm from it during sex."

(from the authors' files)

Recall that the inner two thirds of the vagina has relatively few nerve endings. During (heterosexual) sexual intercourse, the penis only indirectly stimulates the clitoris by causing the clitoral hood to rub back and forth over the clitoral glans. For many women, this is not enough clitoral stimulation to reach orgasm. Men should not feel inadequate if their female partners require manual stimulation of the clitoris during sexual intercourse to reach orgasm. *Therapists agree that clitoral stimulation during intercourse is a perfectly acceptable, normal way for a woman to receive (and her partner to provide) sexual pleasure and does not constitute "cheating."*

Women are much more likely to have an orgasm when the partner engages in foreplay and provides other types of sexual and nonsexual attention (Witting et al., 2008). Richters et al. (2006) found that only 50% of women reached orgasm in their most recent sexual encounter if it involved vaginal intercourse alone but that 70% of women reached orgasm if the sex included manual stimulation of the clitoris and/or cunnilingus in addition to intercourse.

However, not all cases of female orgasm problems can be blamed on insufficient physical stimulation. Ability to reach orgasm generally is not associated with personality traits and other individual characteristics (Zietsch et al., 2011), but it is often associated with the presence of other sexual problems (Laan et al., 2013). For example, sizeable numbers of women with orgasmic difficulties also experience low sexual desire (61%), difficulties with lubrication and other aspects of genital arousal (57%), and pain (21%) (Peixoto & Nobre, 2015). Pain, or the anticipation of it, would certainly decrease the chances of orgasm, and in these cases it must be addressed as a separate problem (see next section).

Sex is more than just the physical rubbing together of tissues. A healthy, positive attitude about sex and pleasure is also very important. Interestingly, Laumann et al. (1999) found that the prevalence of orgasm problems among women decreased as their education level increased, and education is associated with more positive attitudes about sex. Many cases of primary orgasmic disorder are associated with negative attitudes about sex or feelings of guilt about sex (often due to a sexually restrictive upbringing in which sexuality is presented as shameful rather than as something positive) (see Laan et al., 2013, for a review).

"I grew up sexually in marriage. In those days no one discussed sex, and my husband and I both only knew bits and pieces. I understood it to be very natural for women not to have orgasms. Therefore, if I did, my private Catholic girl school upbringing made me feel ashamed of my own natural desires and pleasures."

"I was told my whole life as a child and as an adolescent that because I was a woman, I was not supposed to feel sexual, or be sexual. My daddy told me that good women who wanted to be loved by a man did not feel sexual. A good man did not look for a woman who was sexual."

(All examples are from the authors' files.)

Simply telling a young woman that sex is now okay is not going to change these attitudes overnight. It may take years to overcome inhibitions about sex.

"I was raised as good girls don't, and if you do you are used property. After getting married, the morals were supposed to change. I had great difficulty in the transition of why it is OK now, after marriage. I am now divorced. I wish I would have had your class prior to marriage. It would have made the transition a lot easier."

(from the authors' files)

Performance anxiety can also contribute to orgasm problems. This can easily happen if a woman's partner expects or demands that she have an orgasm during sex. The subsequent spectatoring then makes the problem even worse.

“My husband and I have a really good sex life, but I don’t reach climax every time. This doesn’t bother me, but it really bothers him. I’ve started worrying about it so much that I’m now having fewer orgasms and starting to fake more.”

(from the authors’ files)

Many women pretend to have orgasms because they want to avoid “hurting their partner’s ego” (Muehlenhard & Shippee, 2010).

Recently, there have been attempts to “medicalize” women’s orgasm problems and treat them with drugs, but these approaches have not been successful. Effective therapy generally will include a variety of cognitive and behavioral techniques (Laan et al., 2013). Many therapists begin with sensate focus exercises. These non-demand exercises teach couples to take their time and learn what gives each partner maximum pleasure. After several days of this, the therapist will probably instruct the woman’s partner to manually explore her genitals, usually while both are sitting in the position shown in Figure 13–5. Therapists also commonly include masturbation therapy to allow a woman to become more aware of her own body and responses (Laan et al., 2013; Meston et al., 2004).

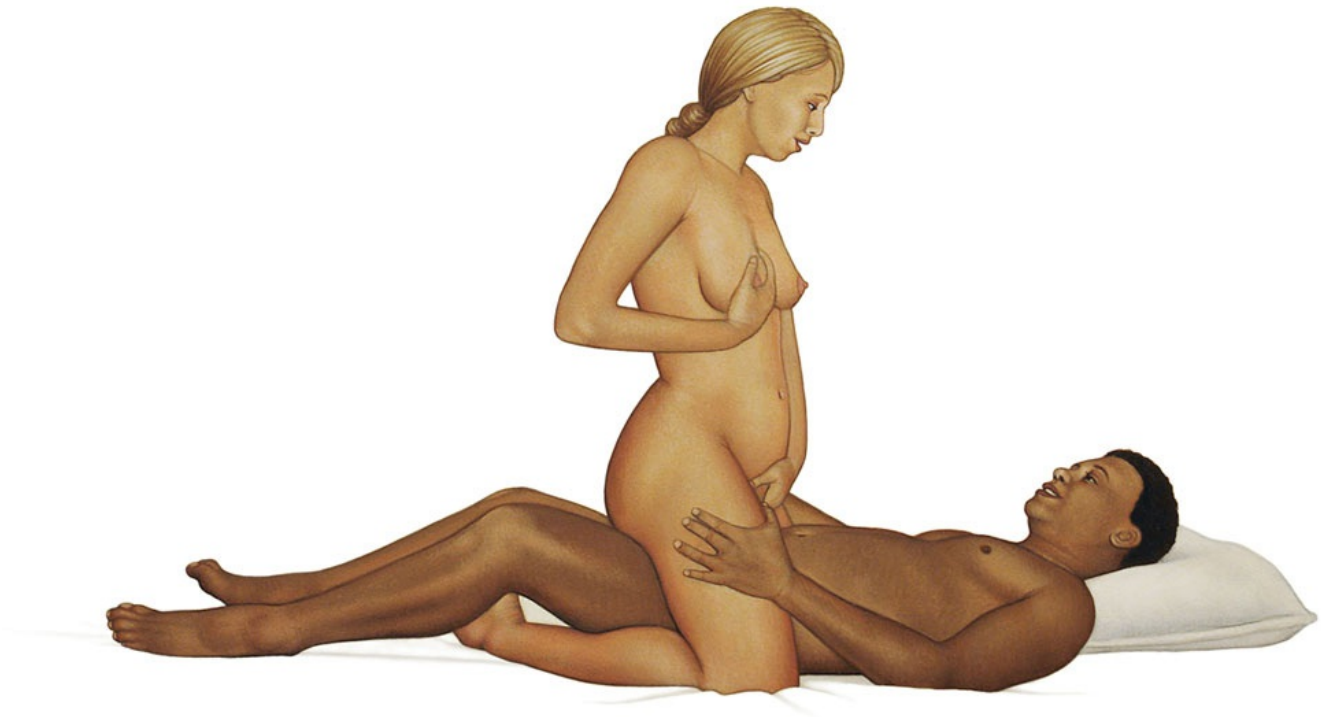
Figure 13–5

A commonly used therapy technique for women.

When the couple is finally told that they may resume sexual activity, they will almost always be told to use a position that allows the woman a great deal of control, such as woman-on-top. She will decide when intromission begins and initiate pelvic movements once they start. By this point in therapy, both she and her partner will be comfortable with manual stimulation of the clitoris during intercourse. The couple will have to try different techniques. With some practice, for example, the woman might be able to reach orgasm without manual stimulation by rubbing her clitoris against her partner’s pubic bone, or vice versa (in a “high-ride” position). One of the goals of therapy is to increase a woman’s sense of sexual autonomy, i.e., her sense that her behaviors are self-determined (Laan & Rellini, 2011).

If at this point you are thinking that female orgasm problems have been treated rather mechanically, as if the solution is nothing more than finding the correct manner of physical stimulation, you are correct. Recall that for many women (and men), sexual satisfaction is closely related to how emotionally involved they are with their partners and how happy they are in their overall relationship (Regan, 2015; Regan & Berscheid, 1999; Sprecher et al., 2018). Secondary orgasmic disorder is often due to a deteriorating relationship (the context in which sex occurs has become negative; McCabe et al., 2016c). In this case, couples therapy to improve the overall relationship is an important part of any treatment program (Laan et al., 2013; Meston et al., 2004).

Figure 13–6



For any sexual problem, when the therapist allows the couple to resume sexual intercourse, it is almost always in the woman-on-top position. Women with orgasm problems are encouraged to touch their clitoris (or have their partners touch it) during intercourse.

Personal Reflections

Are you able to "let go" totally during sex (i.e., no anxieties about nudity, sweat, odors, noises, facial expressions, etc.)? Regardless of how you answer ("yes" or "no"), what do you think has contributed to your ability (or your inability) to do so?

Sexual Pain Disorders

"How much of pain in sex is mental? What can I do to get myself out of anticipating that it is going to hurt?"

(from the authors' files)

There is still debate among experts about how to best characterize sexual pain problems in women (see Fugl-Meyer et al., 2013). However, at least two sexual pain disorders are currently included in major classification systems. The first is dyspareunia, defined as persistent or recurrent pain during intercourse (*ICD-10*; McCabe et al., 2016a). It is assumed that there is no problem with arousal and that there is sufficient lubrication when intercourse begins. A diagnosis of dyspareunia is only made if there is no other primary sexual dysfunction.

How common is dyspareunia in the general population? In the United States, estimates for women aged 18 to 59 vary between 8% and 21% (e.g., Laumann et al., 1999), with between 2% and 8% of women around the world reporting clinically significant levels of both pain and personal distress (see Table 13–4). There is cross-cultural variation, and some studies find higher percentages in older postmenopausal women (for a review, see McCabe et al., 2016b), but this may be due to vaginal dryness and other hormone-related physical changes (Krychman, 2011). There is increasing support for considering dyspareunia "as pain disorders that interfere with sexuality rather than as sexual disorders characterized by pain" (Binik, 2005; see Fugl-Meyer et al., 2013).

"....It hurt that bad! I figured that it would go away after I got more experienced, but it only got worse. It felt so bad that I could never orgasm during sex..."

(from the authors' files)

Dyspareunia has multiple causes (Fugl-Meyer et al., 2013; McCabe et al., 2016c). Many of these are physical or biological in nature. For example, chronic vulval pain (called *vulvodynia*) is commonly caused by inflammation of the vestibular bulbs. This can sometimes be alleviated with medications or surgery. Dyspareunia in women can also be caused by endometriosis (growth of the endometrium outside the uterus), pelvic inflammatory disease, yeast and other vaginal infections, Bartholin's gland infections, and urinary tract infections. Genital mutilation or cutting (still practiced in some cultures; see Chapter 4) contributes to dyspareunia in women who have been subjected to these procedures. There is also evidence that psychosocial factors, including mood or anxiety disorders, past sexual abuse, relationship dissatisfaction, financial stress, and lower levels of education are associated with the likelihood of experiencing persistent painful intercourse (Landry & Bergeron, 2011; McCabe et al., 2016c).

Dyspareunia may negatively impact other sexual (as well as nonsexual) aspects of a woman's life. For example, a woman who repeatedly experiences pain during intercourse may subsequently feel a reduced level of emotional intimacy with her partner and a loss of sexual desire, as well as personal feelings of shame or guilt (Ayling & Ussher, 2008).

"No matter how turned on I am, or how gentle he is, it hurts. Sometimes it hurts right away, sometimes after he's inside, sometimes after a minute or two. But it always ends up hurting. I feel like a complete sexual failure. What kind of woman am I, if I can't ever enjoy sex with my partner? It sounds bad, but I also wonder if it's him—if there's something wrong with the way he does it. Unless I cheat or leave him, I guess I'll never know. It totally sucks."

(from the authors' files)

Thus, treatment for dyspareunia often is multi-faceted, including relaxation exercises, pelvic floor exercises, cognitive-behavioral techniques, and couples counseling.

Vaginismus is the second recognized pain disorder (*ICD-10*; McCabe et al., 2016a). Vaginismus occurs when involuntary spasms of the muscles surrounding a woman's vagina cause full or partial closure of the vaginal opening; this makes insertion of any object (penis, finger, tampon, vibrator, etc.) difficult and often extremely painful, despite the woman's wish to do so. A pelvic examination may be impossible for women with this condition; thus, it has implications for a woman's physical health. To a man attempting intercourse, it feels like his penis is hitting a wall, and forceful attempts at penetration can be quite painful for the woman. It is not surprising, then, to find that dyspareunia and vaginismus often co-occur (Crowley et al., 2009; Peixoto & Nobre, 2015). Indeed, the *DSM-5* places both of these conditions in the category *genito-pelvic pain/penetration disorder* and states that in addition to physical difficulties with vaginal penetration and resultant pain, women may also demonstrate "marked fear or anxiety about … pain in anticipation of, during, or as a result of vaginal penetration" (p. 437).

"I was glad to see this topic addressed in your textbook and to know that it actually had a name. I was a virgin until I was 20 and when I did attempt intercourse, I encountered severe pain. My boyfriend at the time tried to be understanding, but it ended up tearing us apart. No matter how often we tried, we could not get it right."

(from the authors' files)

Up to 5% of all women have vaginismus (Fugl-Meyer et al., 2013). Unlike dyspareunia, which frequently (though by no means always) has a physical cause, the cause of vaginismus is usually *psychological* (Borg et al., 2011; Fugl-Meyer et al., 2013). It is normal for sexually inexperienced women to have anxieties before intercourse that may result in some degree of involuntary muscle contraction, but the vast majority of women soon learn to relax (and even gain voluntary control over these muscles). Vaginismus is often associated with very negative views about sex, a sexually restrictive upbringing (where sex is equated with sin), or hostility toward or fear of men (Borg et al., 2011). Treatment usually consists of cognitive-behavioral therapy which includes *systematic desensitization by gradual dilation of the vagina* (with a set of dilators). The use of dilators in an atmosphere that is free of sexual demand, so that there is no performance anxiety, allows the woman to slowly overcome her anxieties about having an object in her vagina. The success rate approaches 100% (Jeng et al., 2006).

Some experts recommend the inclusion of a third female sexual pain disorder in classification systems— non-coital sexual pain disorder. This refers to recurrent or persistent genital pain caused by sexual stimulation other than intercourse (Basson et al., 2000). The pain can be experienced during sexual arousal or orgasm.

Postcoital Dysphoria

1. 13.7 Discuss postcoital dysphoria.

Even when sexual intercourse is physically satisfactory and goes smoothly with no problems, some people experience what is commonly called "the postcoital blues" (Bird et al., 2011; Schweitzer et al., 2015). Specifically, despite the pleasurable sexual interaction they just enjoyed, they experience feelings of negative affect, which may include tearfulness, sadness or depression, loneliness, guilt or remorse, and irritability or anger. About 30% to 40% of men and women have experienced postcoital dysphoria on occasion. At present, it is one of the least researched sexual problems and little is known about why people sometimes experience these negative emotions after sex.

http://media4.s-nbcnews.com/i/msnbc/Components/ArtAndPhoto-Fronts/HEALTH/080130/vlrg_BlueAfterSex1.png

Source: tommaso altamura / Alamy Stock Photo

Hypersexuality: Addiction, Compulsion, or Myth?

1. 13.8 Define hypersexuality and explain the debate about the concept of "sexual addiction."

At the beginning of this chapter, you learned that two people in a relationship often differ in the frequency with which they desire sex, but that ordinarily neither one should be considered hyposexual (undersexed) or hypersexual (oversexed). We all recognize that sexual appetite—which includes both sexual urges as well as behavior designed to satisfy those urges—falls on a continuum, with some people occupying the low end and some the high end and with most of us probably residing somewhere in the middle. So how much or how little sexual appetite would be considered "unusual" or "extraordinary" (and thus be viewed as a problem)? The answer, of course, is that this is a matter of subjective judgment and will differ greatly across individuals, societies, cultures, and historical times. It is important to remember that sexual responses only become problems when a person views them as such, and they only become disorders when they meet clinical criteria (e.g., persist over time, cause personal distress, interfere with daily function).

As we discussed earlier, *hypoactive sexual desire* is the term generally used to describe sexual dysfunction occurring at the low end of the appetite continuum—that is, a habitual lack of sexual interest that causes a person significant distress and interferes with his or her normal functioning. However, a variety of terms have been used to describe *hypersexuality*, or sexual dysfunction at the high end of the appetite continuum (see Kafka, 2010). One that has been widely adopted by the popular press and general public (and some therapists) is *sexual addiction or sex addiction* (Carnes, 1983, 1991; Goodman, 1992). However, many scholars object to this label on the grounds that hypersexuality does not meet the physiological and psychological requirements of a true addiction (e.g., dependency, tolerance, withdrawal). For example, unlike other addictions (such as alcohol or drug addiction), the cognitive and behavioral symptoms of hypersexuality generally decrease over time and "tend to be fairly transient for most people" (Konkolÿ Thege et al., 2015, p. 1).

As a result, most scientists and mental health professionals prefer to use terms such as *compulsive sexual behavior* (Coleman, 1991), *sexual impulsivity* (Barth & Kinder, 1987), or *impulsive/compulsive sexual behavior* (Coleman, 2011) rather than sexual addiction. The World Health Organization refers to hypersexuality as *excessive sexual drive* in the *ICD-10* (2016). Interestingly, the American Psychiatric Association chose not to include any of these constructs in the most recent version of its *Diagnostic and Statistical Manual* (DSM-5, 2013). This decision was made after experts raised concerns over definitional criteria and the possibility that people who possess naturally high levels of sexual appetite would be inappropriately labeled as "disordered" and stigmatized (see Halpern, 2011; Moser, 2011; Winters, 2011). For the time being, clinicians and therapists who use the *DSM-5* must use the catch-all diagnosis "other specified sexual dysfunction" for clients presenting with hypersexuality.

Regardless of the specific label used, hypersexuality refers to a sexual appetite (meaning urges, thoughts, and/or behaviors) that is persistent, excessive, impulsive, and uncontrollable. People with hypersexuality are unable to resist their sexual impulses and compulsively engage in behavior designed to satisfy their urges, including viewing pornography, having cybersex or partnered (and oftentimes casual) sex, or masturbating (Kafka, 2010; Kaplan & Krueger, 2010). These persistent, uncontrollable urges and behaviors interfere with normal function in many areas of life—for example, by disrupting a person's ability to establish and maintain intimate relationships, fulfill work obligations, and complete important nonsexual activities and goals (Spenhoff et al., 2013). Not surprisingly, hypersexual individuals will often make repeated efforts to curb their sexual appetite, but without success.

It is important to recognize that hypersexuality is not the same as having a "high sex drive." One can have a great deal of sexual appetite and not be hypersexual. The hypersexual individual is distinguished from other people with high levels of sexual appetite by *the overwhelming nature of his or her urges and the compulsiveness with which he or she engages in sex*. It is the quality and not the quantity of sexual appetite that is important. For example, one of your textbook authors personally knows a couple who has sexual intercourse twice a day—once in the morning and once at night. They have been doing so for the entire length of their marriage (30 years and counting) and show no sign of stopping. Are they hypersexual? No. Both partners possess high levels of sexual desire, find their sexual interactions mutually pleasurable, and view sex as an important way to connect with each other, keep physically fit, and relieve stress. Although they have sex (and probably want to have sex) more often than the average couple (see Chapter 11), this is neither problematic nor distressing for them.

Similarly, hypersexuality should not be dismissed as merely "a convenient excuse for sexual indiscretions and marital truancy" (Lee, 2011). The large majority of people who have had extramarital affairs are not hypersexual (they are just unfaithful). The truly hypersexual individual "transforms sex into the primary relationship or need for which all else may be sacrificed including family, friends, values, health, safety, and work."

For example, *Newsweek* magazine ran a story in 2011 that showcased the real life stories of several individuals struggling with hypersexuality (Lee, 2011). One such person, a married 30-year-old woman called "Valerie," reported engaging in anonymous hookups in restaurant bathrooms, affairs with her husband's co-workers, and one night stands that were "too numerous to count" (p. 50). In addition, she called phone sex chat lines, compulsively watched online pornography, and masturbated so frequently that she was unable to go to work on some days. These acts, as you may imagine, not only put an enormous strain on her own personal well-being but endangered the health and welfare of her close relationships.

It has been estimated that approximately 3% to 5% of the population exhibit hypersexuality (Kaplan & Krueger, 2010; Lee, 2011). Rates are higher among men than women (Carvalho et al., 2015). For example, one large national survey (Hendrickx et al., 2014) found evidence of hypersexuality in 6% of the sample—85% of those individuals were men and 15% were women.

Hypersexuality is associated with a number of factors, including various personality characteristics (such as low agreeableness and high neuroticism or negative emotionality) (Miner et al., 2016; Pinto et al., 2013). Sexually compulsive men and women also are more likely than their non-hypersexual counterparts to report having experienced emotional abuse or neglect as well as exposure to pornography and parental hypersexuality during childhood (Griffiths, 2001; McPherson et al., 2013). These individuals often have low self-esteem and feelings of inadequacy and unworthiness as adults. They are often very lonely, and it is believed that their emotional pain may cause them to engage in behaviors (e.g., alcohol,

drugs, food, sex) that help them evade their internal discomfort (Bancroft & Vukadinovic, 2004). Many people with hypersexuality have mood and substance use disorders (for reviews, see Campbell & Stein, 2016; Kafka, 2010).

Figure 13–7

Tiger Woods with ex-wife Elin Nordegren (left) and Jesse James with ex-wife Sandra Bullock (right). Despite being married to talented, supportive, attractive wives, both men allegedly had numerous extramarital affairs and later sought therapy for hypersexuality.

Source: Hans Deryk/Reuters/Alamy Stock Photo, Featureflash Photo Agency/Shutterstock

Online hypersexuality (sometimes called *Internet sex addiction*) is a specific form of compulsive sexual behavior that is receiving increasing attention from scientists (Griffiths, 2001; Ross et al., 2012; Young, 2004). What distinguishes compulsive online sexual behavior from other hypersexual behaviors is the Internet's accessibility, affordability, and anonymity (Cooper, 1998).

"Mr. A was a 42-year old married man, an academic sociologist... he had increased his use of the Internet, spending several hours a day searching for particular pornographic images. He clearly articulated stress at the loss of control this behavior represented for him and also noted that he was spending more time on Internet downloads than he could afford. His behavior had also led to a marked decline in research productivity...When he masturbated to orgasm during the day (sometimes three or more times), he was often unable to achieve orgasm if he and his wife had sex that night."

(from Stein et al., 2001)

As many as 40 million Americans a day log on to porn websites (Lee, 2011). However, only a small number do so compulsively. One large study of 9,177 adults who had used the Internet for sex found that approximately 3% spent 20 hours or more per week engaged in online sexual activities (Cooper et al., 1999). Another study of Internet users found that 5% of the men and 2% of the women said that they felt addicted (Ross et al., 2012). Interestingly, there is a gender difference among sexually compulsive Internet users; men tend to target porn sites, whereas women tend to become involved in online relationships (Griffiths, 2001; Young et al., 2000). Of course, the greater the amount of time a person spends online pursuing sexual interests, the more likely it is that his or her personal and professional life will be adversely affected. Research finds that the partners of heavy Internet sex users are generally devastated when they discover the truth, yet this, too, rarely stops the behavior (Bergner & Bridges, 2002).

Therapy for hypersexuality is usually multi-faceted and often includes approaches that have long been used for alcohol and drug addiction (Kaplan

& Krueger, 2010). One difference is that rather than have individuals abstain completely from any and all sex (the way other addictions often are treated), therapists attempt to target and eliminate specific unwanted and problematic sexual behaviors (e.g., sex with strangers, sex with prostitutes, visiting porn websites; Lee, 2011). Additionally, treatment may include helping the individual find healthy, adaptive ways of dealing with his or her emotions and needs as well as teaching specific cognitive-behavioral strategies to help him or her learn how to replace maladaptive behaviors and prevent relapse (Coleman, 2011). For people in a relationship, these approaches are generally followed by couples therapy (Bird, 2006).

Box 13–A Cross-Cultural Perspectives

Sexual Therapy

The model of sexual therapy presented in this chapter is based primarily on contemporary Western, middle-class values (Lavee, 1991). The two most important assumptions in the model are that people engage in sex primarily for (physical) pleasure, and that men and women should be viewed as equal partners (Reiss, 1986). The model also assumes that men and women want to know about sex and that better communication makes for better sex. The highest levels of subjective sexual well-being are, in fact, found in cultures in which men and women have egalitarian roles (Laumann et al., 2006).

Not all cultures share these attitudes. Traditional American sexual therapy would not be accepted in many Chinese cultures (So & Cheung, 2005). Similarly, recall from Box 4–A that large parts of northern Africa and the Middle East (with primarily Islamic populations) are characterized by restrictive, patriarchal sexual regimes in which sexual pleasure is reserved for men and women's pleasure is deliberately contained and stunted by such practices as clitoral circumcision and genital mutilation. Many Latin countries also adopt a male-oriented sexual regime in which women's sexuality is strictly controlled and denied expression (Guerrero Pavich, 1986). In these cultures, a woman's difficulty in reaching orgasm is not considered important, and certainly would not constitute grounds for therapy. Even painful intercourse (dyspareunia, vaginismus) is considered unimportant unless it interferes with a woman's ability to engage in sex and reproduce (Aziz & Gurgen, 2009). For women in these societies, the only purposes of sex are procreation and the pleasure of the husband. For men, premature ejaculation is not regarded as a problem. Indeed, the concept of "premature" ejaculation presupposes that both partners are equal participants in sexual interactions and that women are deserving of sufficient stimulation (and time) to experience pleasure during sex (see Reiss, 1986). Interestingly, men do regard difficulty in getting and maintaining an erection as a problem, perhaps because this has implications for reproduction, and may seek therapy in order to become able to engage in intercourse (Osman & Al-Sawaf, 1995). However, both men and women reject the very idea of engaging in sensate focus exercises as a solution, for this is a mutual pleasuring technique (Lavee, 1991).

In sharp contrast to these patriarchal, restrictive sexual attitudes, as well as to the Western approach to sexual therapy, is the orientation adopted by many Hindu and Buddhist societies (Turner et al., 2006; Voigt, 1991). Tantric scriptures urge people to strive for the goal of transcendent unity and harmony, and sex is viewed as an opportunity for spiritual growth. While restrictive societies shun the idea of mutual sexual pleasure and Western therapists emphasize the mutual physical pleasures of sex, Buddhist societies emphasize spiritual union. For example, in this chapter orgasm is presented as resulting from proper physical stimulation and effective technique. Those who follow Tantrism, on the other hand, "understand orgasm as a product of deep relaxation and a profound level of contact between partners" (Voigt, 1991). Western culture emphasizes doing, stimulation, activation, and outcome-focus, while Tantrism emphasizes being, stillness, meditation, and process-immersion. Good sex is achieved not by focusing on one or the other partner but by focusing on the "between."

Concluding Thoughts

1. 13.9 Explain the importance of a couple's overall relationship to sexual problems.

It should be clear from reading this chapter that most people will experience disruptions of sexual response —lack of interest in sex, difficulties becoming genitally aroused before or during sexual activity, discomfort or pain, inability to reach orgasm, lack of sexual pleasure or satisfaction—at some point during their lifetime (and in nearly all of their relationships). Such disruptions are normal and, in the majority of cases, no cause for alarm. Most will resolve naturally and without medical treatment or therapeutic intervention. It is only when sexual issues do not resolve, and produce significant levels of personal (and interpersonal) distress, that therapy might be indicated. Even then, it is important for people to remember that sex is only one part of any partnership and that relationships provide more than just an opportunity for sexual expression (see Sedikides et al., 1994). Relationships provide other, even more important, benefits, including companionship, love, intimacy, security, social support, and an opportunity for self-growth and to fulfill personal goals and values (Regan, 2017).

If you and/or your partner find yourselves experiencing sexual difficulties, remember the general advice we provided toward the end of Chapter 12. First, accept yourself and your partner in your totality. Recognizing and accepting each other's true character, warts and all (and this includes your sexual attitudes, likes and dislikes, and issues), will go a long way toward sustaining your satisfaction both in and out of the bedroom.

Second, embrace change. Recognize that as people and relationships age, they will change and so will their sexuality. This is not an inherently "bad" thing. Sometimes the intense, passionate sex that often characterizes new partners (and new relationships) develops into a more intimate, affectionate (and no less satisfying) type of sex as partners become familiar with each other's bodies, learn what is likely to produce sexual pleasure, and grow more motivated to meet each other's specific sexual needs (see McCarthy & Farr, 2012; Muise et al., 2013).

And third, talk with each other! Openly communicating about sex (or any relationship issue) is not an easy thing to do, but in the Addendum to this chapter we provide some helpful tips. As always, our wish is for every person—male or female, old or young, partnered or single—to become and remain *sexually healthy*.

Personal Reflections

Almost all people experience sexual problems at some point in their lives. If you were in an ongoing relationship and were consistently experiencing a problem, would you go to a sexual therapist? Why or why not? If your answer was "yes," how long would you wait before you decided to go? Most therapists believe that the earlier therapy is initiated, the better the chance for a cure.

Addendum: Talking with Your Partner About Sexual Differences and Problems

1. 13.10 Discuss how to talk with your partner about sexual differences and problems.

    Why do Americans find it easier to have sex than to talk about it?—(Peggy Clarke, 1996/1997)

Communication is the act of making information known, the exchange of thoughts or ideas (to paraphrase the *American Heritage Dictionary*). This part of the chapter deals with communication between two people who have made a commitment to a long-term relationship. It assumes that each person genuinely cares for the other and that there is trust and intimacy. As you have just learned, most couples experience sexual differences or problems in their relationship (Laumann et al., 1999, 2009; Waite et al., 2009). How they work those problems out—how they communicate with one another about their differences and problems—will affect their sexual adjustment. "In many cases, sexual dysfunction problems cannot be addressed until communication improves" (Wincze & Carey, 1991, p. 110). Good communication also leads to a better relationship, and a better relationship generally leads to better sex (Cupach & Metts, 1991; Laumann et al., 2006).

Why Is It Difficult to Talk About Sex?

"I have a tendency to be the only person in a relationship that realizes that the other person is not psychic. I tell the other person what I want but usually I can never get accurate feedback."

(from the authors' files)

Intercourse means "communication," but there are few topics that people have more difficulty talking about than sex. One of the major reasons for this is that most people have little experience talking about sex in an intelligent and mature manner. Surveys in our courses consistently indicate that fewer than one third of the students we teach every semester have ever had a serious discussion with their parents about sex (King, 2012). Very few ever had a course in sexuality education during junior high or high school. Adolescents often avoid talking to members of the opposite gender about sex because they fear that this will be interpreted as an invitation or come-on. Thus, men generally have some experience talking about sex with other men, and women with other women, but many adults have great difficulty talking to members of the other gender about sex (Athenstaedt et al., 2004).

Are there any gender differences that may contribute to communication difficulties in heterosexual relationships? In the old but still popular book *Men Are from Mars, Women Are from Venus* (Gray, 1992), it is claimed that "not only do men and women communicate differently but they think, feel, perceive, react, respond, love, need, and appreciate differently. They almost seem to be from different planets, speaking different languages" (p. 5). However, research has shown that although there gender differences in communication do exist, the differences are not as large as popular books and the media would have us believe (for reviews, see Aries, 1998, and Burleson & Kunkel, 2006; see also Petersen & Hyde, 2011).

Nevertheless, there are some gender differences in communication styles. Starting early in childhood, men's communications are generally more concerned with self-assertion, dominance, and task completion, whereas women's communications are warmer, more collaborative, and other-oriented (Carli & Bukatko, 2000). Men also may be less likely to maintain eye contact during conversation, be less clear or neutral in their responses, and be more likely to withdraw (Klinetrob & Smith, 1996). During arguments, women are more likely to set the emotional tone. Many people believe that it is not masculine for a man to express his feelings and emotions (including during sex).

"Recently I was involved in a relationship with a very 'sex-typed' guy.... Every time I would try to talk to him about how I felt about things or let him know how my emotional needs were going unfulfilled, he would change the subject or dismiss the whole discussion as being 'sissified.'"

(from the authors' files)

All people of both genders need to express their feelings and emotions and be able to communicate them. The image of a man as "strong and silent" robs him of a fundamental part of his humanity and robs his partner of a true companion. The image of a woman as "emotional and expressive" puts all of the responsibility for communication on her.

Finally, power differences in a relationship can affect communication (Blanc, 2001; Quadagno et al., 1998). We are most likely to express an opinion, particularly a difference of opinion, to those persons we perceive as having equal status. In some relationships, there is a power imbalance; in heterosexual relationships, it is usually in favor of the man. Although the following suggestions for improving communication should be helpful to everyone, they will be most useful to individuals in an egalitarian relationship. (Resolving a major power imbalance in a relationship may require professional counseling.)

How Can My Partner and I Get Used to Talking About Sex?

One of the best ways to get used to talking with your partner about sex is to discuss together any sexuality-related topics in your daily news. Hardly a day goes by when there is not at least one article in print or online news forums about sexuality—for example, birth control and results of sex surveys. You could show your partner some selected topic in this book and start off with a statement like "I didn't know this" or "This is really interesting."

When you both become more comfortable talking about sexuality-related topics together, then you can more safely talk about your own sexual relationship. Often a good place to start is to talk about why it is difficult for you both to talk about sex. If, for example, your parents had a negative attitude about talking about sex, talk about that and how you would like to be different. Next you might talk about normal bodily functions

related to sexuality and how they affect your sexual relationship. Try talking about menstruation, for example. Many people have learned (and thus can unlearn) negative attitudes about that (see Chapter 3). When you and your partner are comfortable enough to talk about sexual differences (in attitudes, preferred behaviors, etc.), you might want to discuss when and how to talk about such matters in the future.

What If I Am Uncomfortable with the Language of Sex—What Words Should I Use?

Many of the commonly used words for our sexual anatomy and functions reflect the negativity about sex that is common in our culture. Words like *prick, cock, cunt, pussy, screw*, and *fuck* are common in conversations among men (Braun & Kitzinger, 2001; Fischer, 1989), but many women (and men) might feel uncomfortable using such words with their partners, particularly if they wish to express positive emotions (Geer & Bellard, 1996). Medically correct terms such as *penis, vagina*, and *sexual intercourse* may not have any negative connotations, but are so unerotic that they, too, may seem inappropriate in conversations between two people in a deeply emotional relationship. Euphemisms such as "go to bed with," "sleeping with," and "making love" may seem more erotic to some, but they are often inappropriate as well. Do we always "make love" when we have sex? Some couples develop a private vocabulary for body parts and sexual activities that is used only in conversations between themselves.

It is not for us to tell you what words to use with your partner when talking about sex. However, it is important that you both be comfortable developing and using a sexual vocabulary (Hess & Coffelt, 2012). Therefore, as part of the process of getting used to talking about sex, be sure to discuss this with your partner until you both agree on a vocabulary that is explicit and specific enough to convey your feelings and desires and that you also find non-offensive (yet still erotic).

When (and Where) Should I Try to Talk to My Partner?

When is a good time to tell your partner that you prefer different behaviors or wish to be touched or made love to in a different manner (or any other preference)? If you do it right after sex, you run the risk of making your comments sound like a report card or performance rating, and perhaps not a very good one at that. If you do it during sex, you might distract or frustrate your partner, and if you express your dissatisfaction before you start, that might cause performance anxiety.

Perhaps a neutral time would be best. Recall from the previous section that one of the general topics you and your partner might first discuss is when to talk about sexual differences. Whenever you do it, make sure you are not frustrated, angry, or highly emotional at the time. It is not so much when you discuss your differences but *how* you go about it, and your concerns may not be well received if you begin in a negative emotional state.

Finally, if you have most of your sexual relations in the bedroom, never worry about or discuss your sexual problems while in bed. If you do this too often, the bed can become a stimulus for sexual tension and anxiety; that is, just being in bed can cause you to start worrying. Save the bed for pleasant experiences and pick a neutral site like the living room for raising issues and addressing problems.

How Should I Approach My Partner with Concerns About Our Sexual Relationship?

Because of their inexperience in talking about sex—particularly sexual problems—many people say nothing and allow a problem to continue, with the end result often being increasingly greater frustration and/or anger. When they finally do get around to saying something, many people begin with statements like these:

"I don't like it when you..."

"You never..."

These types of statements accentuate the negative and are often met with defensive reactions and counter-accusations. This can quickly escalate into a full-scale argument.

There are few things that can so easily insult a person's ego as criticizing his or her sexual expression or interaction. Nearly everyone would like to believe that he or she is a good sexual partner. To try to solve your own frustrations by criticizing your partner, therefore, is asking for trouble. Sometimes people ask for feedback about sex and then get upset with the response. Some people, for example, ask questions like "How was it?" "Did you like it?" or "Wasn't that great?" after having sex. Sometimes they are really looking for a pat on the back or ego reinforcement rather than an honest answer, so this is really not a good time to express any negative reactions. Whenever possible, *accentuate the positive rather than the negative.* This is the most important advice that we can give you. Rather than beginning the conversation with "I don't like it when you...," try:

"I like it when you..."

"It really feels good when you..."

Your partner must do something that you like while having sex, so give him or her some positive reinforcement. Thousands of studies have shown that behaviors increase when they are reinforced, and praise is generally a powerful reinforcer for human beings.

Personal Reflections

Suppose that you are unsure of your partner's sexual desires and preferences, as well as whether he or she is totally aware of yours. How might you communicate with one another? Suppose your desires and preferences are not exactly the same?

What If I Think That My Partner Is to Blame—Can I Ever Complain?

If you have not expressed your concerns to your partner in a clear, specific manner (because you are uncomfortable talking about sex or for any other reason), do not lay the blame entirely on your partner. The problem has continued, at least in part, because you have allowed it to. Your partner cannot know what you want unless you tell him or her. It is wrong for you to think, or expect, that your partner should know what you want or how to please you. *You must take the responsibility for your own pleasure*, and you can do this only if you tell your partner of your needs and desires.

"My husband and I are very open about our sexual ideas and feelings. When I don't like something he's doing I tell him and he does the same. We are at our sexual peak and communicating openly is very important."

(from the authors' files)

Although we emphasized the use of positive reinforcement in the previous section, this does not mean that you can never complain or express anger. However, when you are angry, learn to control your anger. Express it only after you have calmed down. Ask yourself what your motivation is for expressing complaints. Is it to hurt or ridicule your partner, or is it for constructive change? Couples with good relationships accept that there will be differences, and sometimes even conflict, but they resolve those differences and conflicts in constructive, not destructive, ways. If you criticize your partner, make sure you criticize his or her behavior, not his or her character. There is a big difference between saying

"You are an uncaring person."

and saying

"You don't show me often enough how much you care."

If you must criticize your partner's behavior, be sure to praise other aspects of his or her behavior as well, such as:

"I wish you'd spend more time kissing me, but I love the way it feels when you…"

How Should I Express My Needs and Desires?

Most communications experts suggest that individuals use "I" language when expressing desires to their partners. That means beginning sentences with "I," followed by an expression of *your* feelings, desires, or thoughts (see Simmons et al., 2005). There are some important advantages to this. By directly stating your feelings, you are taking the responsibility for your own well-being. In addition, "I" sentences avoid the blaming or accusatory tone common in statements that begin with "You." Statements such as "You don't like to hug me anymore" or "You don't love me" attack the other person's character and may well be met with a defensive response. The statement "I would like you to hug me more often" more directly expresses your feelings and desires and is less likely to elicit a defensive negative response.

Questions that begin with "Why" ("Why don't you?...") are also often used to criticize a partner. Avoid those as well. Even sentences that begin with "We" can cause problems because they make assumptions about your partner's desires, moods, thoughts, or feelings. Do not talk for your partner.

When expressing your desires with "I" language, try to be as specific as possible. Vague statements such as "I want you to make love to me differently" will probably not be understood by your partner. On the other hand, he or she will easily understand statements such as:

"I want you to kiss my breasts more gently when we make love."

"I like it when you stroke my penis firmly."

"I want to have sex with you on top."

How Can I Find Out About My Partner's Desires and Needs?

Yes, it is important that you know and understand your partner's sexual desires and needs, but as a preliminary step, be sure that you are aware of your own. Once you are certain, a good place to start is with self-disclosure. Studies show that the more sexual self-disclosure there is in a relationship, the more sexual and relationship satisfaction partners generally experience (MacNeil & Byers, 2009; Rehman et al., 2011a).

"Two years into the marriage our relationship took a downward spiral. Sex began to get boring and felt like just another chore. We finally began to talk openly about what we wanted from one another sexually. After much discussion, we are more attentive to each other's sexual needs. When I think back to our 'down' times I am sorry we didn't talk openly earlier. Sex is once again pleasurable."

"My boyfriend and I of 2 years had never really talked about sex in a serious manner... we both felt really open that night so we played a game of 20 questions. The questions all had to deal with sexuality. For example, what we enjoyed, what he liked done to him, what I liked done to me, fantasies, etc. That one night opened the door for us to be able to talk about our sexual relationship in a serious manner. I felt more comfortable about what we were doing and why. It also brought us closer together as a couple. He told me after the conversation that night that he felt much closer to me than ever before."

(All examples are from the authors' files.)

Reveal to your partner (using "I" language) your thoughts, feelings, desires, and needs. This creates an environment of trust and understanding, and most people will self-disclose in return. Compare and discuss how each of you feels about different behaviors.

Figure 13–8

When talking with your partner, disclose your own feelings and desires by using "I" language, accentuating? the positive, and (like this couple) making eye contact.

Source: Wavebreak Media ltd/Alamy Stock Photo

Of course, you can also ask your partner about his or her preferences, but try to avoid questions that can be answered with one word such as yes-or-no questions. Think about it. What opportunity does your partner have to express his or her feelings if you ask questions like these?

"Did you like it?"

"Do you like me to kiss your neck?"

"Do you want to try different positions of intercourse?"

Questions expressed this way ask for a one-word "yes" or "no" answer. Instead, ask questions that are open-ended. For example, the previous questions might be rephrased this way:

"What are the things I do during sex that you like best?"

"Where do you like me to kiss you when we make love?"

"How do you feel about trying different positions of intercourse?"

When questions are posed like this, they place no limitations on your partner's response. Your partner is free to divulge any and all feelings and beliefs that he or she considers important.

Also keep in mind that your partner may not feel comfortable expressing his or her feelings or desires, perhaps out of concern that you will react negatively. To overcome this obstacle, *give your partner permission* to talk about a particular topic. In other words, let him or her know it is okay to talk about something (for example, how you like to be touched), without you getting upset.

Is Listening Important? If So, How Can I Become a Better Listener?

Effective communication is what holds close relationships together and enables them to grow. However, many people forget that communication requires not just talking, but listening as well. This is as true for sexual relations as it is for any other behavior. How well do you listen?

We may hear with our ears, but *we show how attentive we are with body language*—body position (Do you face your partner while he or she

talks to you?), eye contact, and facial expressions. Be supportive of your partner's attempts to communicate with you. In addition to positive body language, interact with him or her in a constructive manner. Make comments or paraphrase (reword) what your partner is saying so that you both are sure what the other is trying to say—not everyone conveys messages clearly. For example, suppose your partner tells you:

Partner: "I think I would like sex better if you were more affectionate."

You: "You mean you want me to touch you more gently during sex."

Partner: "No; the way you touch me is fine, but I want you to tell me how much you love me before we have sex."

By rewording your partner's first statement, it was clear to him or her that you did not understand, so your partner rephrased his or her wishes. Sometimes you may have to paraphrase your partner's message several times until you are certain that you have understood what he or she really means.

To improve your listening skills, try giving your partner a massage. Giving one another a massage strengthens relationships by promoting better communication (Comiskey, 1989). When starting the massage, it is normal to assume that what feels best to you will feel best to others as well. If you like your shoulders and neck massaged with a lot of pressure, for example, it is only natural that you will start off by attempting to please your partner in this manner. However, not everyone likes the same things you do. Your partner may prefer gentle massaging of the lower back. How will he or she communicate this to you? He or she may tell you, but it is important to realize that a person does not have to use words to communicate. When a massage really feels good, most people emit little noises like "ooh" and "aah." These responses should be just as effective as words in letting you know that what you are doing feels good. Listen to your partner's responses while you are massaging. If you listen well and care about your partner, you can modify your behavior and give a massage that pleases him or her instead of giving one that might please only you.

If you are a good enough listener to adjust a massage to please your partner, you can easily do the same while having sex. All of us want to believe we are (or will be) a good sexual partner, but to be one we must first be a good listener.

Personal Reflections

Suppose that you are in a long-term monogamous relationship that includes sexual relations. Suppose also that your partner often does not take as much time during foreplay as you would like and does not spend much time holding and touching you afterwards. This often leaves you sexually unfulfilled and frustrated. How would you go about correcting this situation? Be as specific as possible.

Is It Possible to Communicate Nonverbally?

The answer, of course, is yes. Actually, we have already partially answered this question in our answer to the last question. Things like eye contact, facial expressions, and interpersonal distance (how close you stand or sit next to someone) all express messages. Individuals in a relationship commonly use these types of messages to convey interest in sex (Vannier & O'Sullivan, 2011). Touch, in particular, is a very powerful means of *nonverbal communication.* As one person who studied communication and intimacy put it, "If intimacy is proximity, then nothing comes closer than touch, the most intimate knowledge of another" (Thayer, 1986).

When two people are communicating verbally, it is important for there to be agreement between the verbal and nonverbal aspects of the communication. How do you suppose your partner would feel if, while telling him or her how much you care, you were inattentive, turning away and making little or no eye contact?

Dealing with Anger and Conflict: An Example

In the real world, couples are going to have moments of anger and conflict. No section on communication would be complete without some advice about how to deal with our own anger and that of our partner. In fact, one of the best predictors of long-term success in a relationship is the manner in which couples handle their disagreements (Rehman et al., 2011b; Metz & Epstein, 2002). During a disagreement, couples can display a number of different patterns of communication: *mutual constructive communication, mutual destructive communication, mutual avoidance of communication*, or *demand/withdraw*. The demand/withdraw pattern in which one partner criticizes or nags and the other avoids can be particularly damaging. It is associated with a high degree of relationship dissatisfaction (Metz & Epstein, 2002) and is frequently observed in distressed couples (Eldridge et al., 2007; Gottman & Levenson, 2000). It is usually the person who is unhappy with the status quo and who has less power who initiates the conflict and assumes the role of demander (Baucom et al., 2010).

"My ex-girlfriend would get upset and demand to be left alone and would block me out if I tried to ask and understand what was bothering her. She pulled back into her shell for days and this behavior caused me stress because I did not know what was wrong, or if I could help. After several days she would open up but not discuss what it was that she had been upset about. She would just try and pick up where we left off like nothing happened. This occurred several times throughout our relationship. Notice I refer to her as my ex-girlfriend."

(from the authors' files)

In place of withdraw, or demand/withdraw, what can we do? The following metaphor is provided by Notarius, Lashley, and Sullivan (1997) to help couples deal better with their anger:

We ask partners to imagine a scenario in which one person is in the kitchen cutting up some vegetables for dinner right after the partners have had a huge fight and are not talking to each other. The anger in the relationship is palpable. Just as one partner happens into the kitchen, the person

cutting the vegetables slips and badly cuts a finger. There is blood spurting everywhere. At this point we ask both partners to state what would happen. With no exception to date, all couples report that there would be caretaking—every effort would be made to do whatever was necessary to take care of the wounded partner. In this scenario, there is a physical wound, and the wounded partner's body is taking care of alerting the other that attention is required. When one partner bleeds, the other takes care of him or her. If the other stood by and watched him or her bleed without providing care, this would be a powerful message indeed.

Now we ask couples to consider a similar scenario in which a partner suffers a psychological wound that causes "internal bleeding." The hurt is not visible to the world, and therefore support will not be immediately forthcoming. Instead, the injured party must "emotionally bleed" in order to get support. The likelihood of getting support in this scenario will be directly related to the clarity of the "emotional bleeding." If the wounded person decides to bare his or her teeth as some wounded animals do, then this is likely to keep away a potential caretaker. If, on the other hand, the wounded person decides to show the wound plainly to another, to "bleed," then caretaking will most likely follow. Thus, the advice we offer to couples is for partners to "bleed" when they are psychologically hurt. We say, "Show your wounds to your partner, and just as if you were physically bleeding, more often than not you will receive the caretaking you desire."

The primary difference between cutting oneself while slicing vegetables and suffering an emotional wound is that in the latter case, the other partner is usually held responsible for the injury. And in this case, the "emotional bleeding" that we encourage will be directed at the person blamed for the injury, who is also the potential caregiver. We find it useful to have the "bleeding" partner focus primarily on his or her own wound rather than on blaming the other for the injury. We remind couples that the goal is caretaking, and that at the moment anything that interferes with it will be self-destructive.

Satisfaction in Close Relationships, by Notarius et al., pp. 236-237. Copyright 1997 by Guilford Publications, Inc. Reproduced with permission of Guilford Publications, Inc.

Notice that in resolving their conflict and anger, the couple would employ several of the good communication tools that you have learned. These include "I" language, self-disclosure, listening, and attentiveness.

In any relationship, there will be both positive and negative interactions. John Gottman (1994) found that *the ratio of these positive and negative emotional interactions is the best predictor of whether a relationship will survive.* If the ratio is at least five positive interactions to one negative interaction, the chances of a successful long-term relationship are very good. Couples can achieve this ratio in a number of different ways (for example, lots of negative interactions but even more positive ones, mostly positive with only a few negative interactions, and so forth). The important point is that when positive interactions outnumber negative ones, satisfaction is likely to result. Gottman's group (1998) also found that couples are more likely to avoid negative interactions when addressing problems if: (1) the person who wants change (usually the initiator of the interaction) takes a "softened start-up approach" (caring, calm, and diplomatic rather than demanding or confrontational) and (2) the recipient of this communication accepts the influence and engages (instead of avoiding, withdrawing, and refusing to share power).

Personal Reflections

What communication style do you use when you are angry with your partner? Is it the best style for clearly conveying your emotions to your partner?

What If We Cannot Agree?

No one person will always be able to satisfy all the needs and desires of another. That is true even in the best of relationships. People simply have differences of opinion and different preferences. When this happens, good communication can only lead to an understanding of those things that the two of you disagree about. It is often helpful to agree that you disagree. However, if either you or your partner is greatly bothered because your needs and desires are going unfulfilled, then it would be wise to seek professional counseling. At the end of this chapter you can find the names and addresses of two organizations that will help you locate qualified professionals in your area.

Study Guide

Key Terms

- benign coital cephalalgia
- biopsychosocial therapy
- cognitive-behavioral therapy
- communication
- couples therapy
- demand/withdraw
- dyspareunia (male)
- dyspareunia (female)
- erectile disorder
- female orgasmic disorder
- female sexual interest/ arousal disorder
- hypersexuality
- hypoactive sexual desire
- "I" language
- intercourse
- male orgasmic disorder
- medical history
- medical model
- non-coital sexual pain disorder
- open-ended questions
- paraphrase
- performance anxiety
- persistent genital arousal syndrome
- Peyronie's disease
- phimosis
- postcoital dysphoria
- positive reinforcement
- premature ejaculation
- priapism
- self-disclosure
- sensate focus exercises
- sexual addiction
- sexual aversion
- sexual disorder

- sexual history
- spectatoring
- vaginismus
- yes-or-no questions

Interactive Review

Answers can be found on p. 472.

1. Studies have found that (1) _____ of all couples in the United States will eventually experience sexual problems. It is common for two people in a relationship to differ in their preferences for frequency and type of sex. This often results from different expectations and assumptions about sex. When this happens, it is best to consider the problem as the (2) _____ problem. If the problem persists and is causing stress and anxiety, it is advisable to seek professional help.

   The field of sexual therapy really began with Masters and Johnson (1970), who relied heavily on (3) _____ techniques. Today, most sexual problems are treated as (4) _____ problems, but this approach is not working well as a stand-alone therapy for many sexual problems. A better, multidisciplinary approach that recognizes the interpersonal and psychological aspects of sexual behavior is the (5) _____ approach. Most therapists will probably take a (6) _____ and (7) _____ history first. They may also provide (8) _____ to the partners. For most couples the first set of general exercises will be non-demand mutual pleasuring techniques called (9) _____. After completing these, the couple will then be assigned specific exercises. Many sexual problems are due to a failure to resolve conflicts in other aspects of the relationship, and thus sexual therapy may also require (10) _____ therapy.

   Sexual disorders are generally classified as primary or (11) _____ and as global or (12) _____. A persistent and recurrent absence of sexual fantasies, thoughts, and/or desire is generally known as (13) _____. At the other extreme, hypersexual individuals are distinguished by the (14) _____ with which they engage in sex. Painful intercourse, or (15) _____, can occur in either men or women and can have a variety of causes.

   The most common sexual problem specific to men under age 60 is probably (16) _____, which is often defined as a recurrent and persistent absence of (17) _____. Probably the most psychologically devastating male problem is (18) _____, which can have organic and/or psychological causes. The most common psychological cause is (19) _____. Difficulty reaching orgasm and ejaculating during partnered sexual activity is called (20) _____ and usually has a psychological cause. Some men suffer from benign coital cephalalgia, or (21) _____.

   For many women, lack of sexual interest/arousal is due to (22) _____. Some women experience involuntary contractions of the muscles surrounding the vaginal opening when they attempt intercourse, which results in pain. (23) _____, as it is called, usually has a psychological cause. The vast majority of women who go to sexual therapy do so because of problems (24) _____. This can be due to a variety of causes, including poor techniques by the partner, sexual repression during the woman's upbringing, and general relationship problems. When one member of a couple has a sexual problem, it is not unusual for the partner to develop a corresponding sexual difficulty.

   Communication is the exchange of information. Because of our culture's negative attitudes, many people feel uncomfortable talking about sex, even with their sexual partners. (25) _____ and _____ differences in a relationship also contribute to this difficulty. You and your partner can get used to talking about sex together by discussing sexuality-related articles in newspapers, books, and magazines. One of the first things you must do is agree on a comfortable (26) _____ to use when talking about sex. When talking about sexual differences or problems, be sure to emphasize the (27) _____ rather than the (28) _____ things that your partner does. That does not mean that you can never complain, but when you do, focus on your partner's behavior rather than on his or her character.

   Take responsibility for your own pleasure by expressing your feelings and desires to your partner in a clear, specific manner. Whenever possible, begin sentences with "I" rather than (29) _____. It is often easier to find out about your partner's sexual desires and needs if you first (30) _____. However, good communication is a two-way street; it requires that you also become a good (31) _____. In addition to communicating verbally, we also communicate nonverbally with (give four examples) (32) _____. Even with good communication skills, people will not always agree, but it is possible to agree that you disagree.

Self-Test

Answers can be found on p. 473.

A. True or False

- **T F** 33. In order to become a "disorder," a sexual problem generally must produce significant distress for the individual.
- **T F** 34. Chuck wants to have sex twice a week but is in a relationship with Sue, who wants to have sex every day. In this example, it is clear that Sue is hypersexual.
- **T F** 35. The most frequent sexual problem for women seeking sex therapy is difficulty reaching orgasm.

- **T F** 36. Stimulation of the clitoris during intercourse should not be necessary, and a woman should be able to be orgasmic through intercourse alone.
- **T F** 37. Performance anxiety can cause sexual problems in men but not women.
- **T F** 38. For an ejaculation to be considered "premature," it generally must occur within 1 minute of beginning sexual intercourse and without reasonable voluntary control (among other things).
- **T F** 39. Most women who have difficulty reaching orgasm do not enjoy sex.
- **T F** 40. Pharmacotherapy (e.g., Viagra) has proven to be an effective stand-alone therapy for erectile dysfunction.
- **T F** 41. Dyspareunia is usually caused by a physical problem.
- **T F** 42. Many men with psychologically caused erectile problems get full erections during sensate focus exercises.
- **T F** 43. Most women do not separate sexual desire from sexual arousal.
- **T F** 44. In some cases, female orgasm problems are the result of insufficient physical stimulation.
- **T F** 45. Low sexual desire in women is usually due to low testosterone levels.
- **T F** 46. Therapists are in agreement that hypersexuality is a form of addiction similar to alcoholism.
- **T F** 47. Erectile disorders are an inevitable part of the male aging process.
- **T F** 48. Most women with low sexual interest/arousal are distressed by it.
- **T F** 49. Headaches during orgasm occur mainly in men.
- **T F** 50. The sex therapy model presented in this chapter is applicable to most peoples of the world.

B. Fill in the Blanks

- 51. Most women need stimulation of the in order to reach orgasm, even during intercourse.
- 52. Most therapists believe that the position has the most erotic potential for both people during intercourse.
- 53. When a person begins to observe and evaluate his or her own sexual responses during sex, it is called , and can be a cause of sexual problems.
- 54. Sensate focus exercises are techniques.
- 55. In men, painful intercourse can be caused by the foreskin of the penis being too tight, a condition called .
- 56. Probably the most difficult sexual problem to treat successfully is .
- 57. The word *intercourse* means .
- 58. When communicating with another, it is important that there be agreement between the and aspects of communication.
- 59. One of the best predictors of long-term success in a relationship is the manner in which couples handle .
- 60. Feelings of sadness or anxiety after otherwise physically satisfactory intercourse is called .

Suggested Readings and Resources can be found on p. 463.

Chapter 14 Paraphilias and Sexual Variants

> One fact about human behavior that is so obvious that it needs no research program to establish its truth is that humans judge some sexual practices to be undesirable and change worthy. . . . The particulars surrounding these negative judgments made by mental health professionals about some sexual practices are, unfortunately, not so clear. For example, it is not clear on what grounds humans in general, or mental health professionals in particular, either do evaluate or should evaluate sexual practices. That is, should sexual practices be evaluated on the grounds of whether they harm others (if so, what kinds of harm, and how much harm, are necessary for the behavior to be regarded as a mental disorder?), or whether the sexual practices are unhealthy (utilizing this criterion is clearly problematic as it simply pushes the question to how properly healthy practices can be distinguished from unhealthy ones), or whether the behaviors deviate from a statistical norm, or whether the behaviors seem to be maladaptive in some evolutionary sense?

—D. Richard Laws & William O'Donohue, 1997

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 14.1 Describe the various ways one can define a sexual behavior as being unusual, unconventional, or abnormal.
2. 14.2 Discuss how culture is associated with sexual "(ab)normality."
3. 14.3 Explain the difference among sexual variants, paraphilias, and paraphilic disorders.
4. 14.4 Discuss the prevalence and co-occurrence of paraphilias and paraphilic disorders.
5. 14.5 Define and discuss the courtship disorders: voyeurism, exhibitionism, telephone scatophilia, and frotteurism.
6. 14.6 Define pedophilia and discuss its relationship to the courtship disorders.
7. 14.7 Identify and describe the paraphilias that focus on non-human objects for sexual arousal.
8. 14.8 Discuss and explain sadomasochism. Differentiate between "mild" sadomasochistic activities or fantasies, sexual sadism and sexual masochism (the paraphilias and the disorders), and the activities of those who belong to the BDSM subculture.
9. 14.9 Discuss the various theories of how paraphilias develop and the factors that are associated with paraphilias.
10. 14.10 Explain the possible reasons for why nearly all paraphiliacs are men.
11. 14.11 Discuss the treatment (therapy) for individuals with a paraphilic disorder.

In the classic edited book *Handbook of Sexology* (1977), noted sex researcher John Money astutely observed that "the problems of human sexuality … may be classified into too little, too much, and too peculiar" (p. 920). In Chapter 13, we addressed the first two sexual problems—that is, disruptions of human sexual response that fall under the category of "too little" (e.g., low sexual desire, lack of erectile function, insufficient lubrication, inability to achieve orgasm) and "too much" (e.g., priapism, hypersexuality). In this chapter, we focus on the third sexual issue mentioned by Money—sexual preferences and practices that are "peculiar." This, of course, begs the question, by what standards is a sexual urge, preference, desire, or activity deemed unusual, odd, peculiar, different, or abnormal?

What Makes a Sexual Behavior “Unusual” or “Abnormal”?

1. 14.1 Describe the various ways one can define a sexual behavior as being unusual, unconventional, or abnormal.

Remember that when it comes to sex, researchers typically differentiate “normal” from “not normal” (i.e., abnormal or unusual) in three ways. The *statistical approach* to normality (discussed in Chapter 11) involves relying on prevalence rates. A behavior is statistically normal if a large number of people engage in it (it is a relatively common act or preference). By this criterion, an abnormal behavior is one that is uncommon (only a few people engage in it). However, the fact that only a small number of people engage in a behavior does not necessarily render that behavior bad, immoral, wrong, or peculiar. For example, probably very few couples in the United States have sex at night outside in their backyards, but most of us would agree that this behavior is not unhealthy or a sign of mental illness. Thus, statistics alone cannot be used to determine sexual normality or abnormality.

The *sociocultural approach* relies on the extent to which a behavior is customary or normative within a given society or culture. From a sociocultural perspective, a sexual act or preference is considered normal if it is customary or widely accepted, and abnormal (“peculiar”) if it violates social customs, norms, and conventions. This means that a sexual behavior that is considered normal in one culture or historical time may be considered abnormal in another (see Box 14–A). For example, we discussed in Chapter 11 that masturbation was widely viewed as an unhealthy and deviant behavior in pre-21st-century America (and in many other societies) but is no longer viewed as abnormal today. Moreover, even at the same point in time in the same culture, what counts as “normal” might be a matter of context. If someone tried to sunbathe in the nude at the local public swimming pool, he or she would probably be arrested. On certain beaches along the West or East Coast, on the other hand, that same person could bathe or tan in naked splendor along with a great many other nude people. The point is that “normal” is not an absolute designation but is socially defined (and thus will change as societies change).

Figure 14–1

Walking on the beach naked might seem to be an unusual or unacceptable sexual practice, but if it is not done in front of unwilling observers, it would be considered a sexual variant, not a paraphilia.

Source: camera lucida lifestyle/Alamy Stock Photo

The *psychological approach* focuses on the psychological health of the individual and the impact that the individual's behaviors have on his or her health (as well as on others, such as the person's partner). From this perspective, a sexual preference or activity is considered to be abnormal if it makes an individual feel distressed or guilty, interferes with his or her ability to function effectively in ordinary interpersonal, social, and occupational roles, and/or causes harm to others. We have discussed this approach to normality/abnormality before. Recall from Chapter 13 that a disruption of sexual response (e.g., premature ejaculation) becomes a sexual disorder only if the man experiencing it (and/or his partner) considers it to be problematic and a source of distress.

The sexual preferences and behaviors that you will read about in this chapter are statistically uncommon and socially unconventional, and all of them have the potential to become psychologically problematic.

Box 14–A Cross-Cultural Perspectives

Sexual "Normality" and "Abnormality" Around the World

1. 14.2 Discuss how culture is associated with sexual "(ab)normality."

In Chapters 1 and 11, you learned that cultures differ in their sexual practices and what they consider to be "normal" or "abnormal." Some cultures, for example, have historically allowed children to engage in sexual relations with each other or with older individuals. This includes Sambian boys of Papua, New Guinea (see Box 9–A), girls in the Tiwi culture of the Melville Islands (Goodall, 1971), and boys of the Azande culture in Sudan (see Box 9–A). Sex historians Ford and Beach (1965) and Bullough (1976) also documented four cultures that allowed bestiality (sexual activity with animals). If these practices seem strange to you, remember also from Chapters 1 and 11 that in many parts of the world (particularly non-Western societies) kissing has been (and still is) regarded as a perversion or sexually abnormal activity (Ford & Beach, 1965; Gregor, 1985). Oral-genital sex, which is relatively common here, is almost totally unheard of in many African countries, and many cultures punish individuals who engage in sexual activities with members of their same sex, considering such behavior sexually deviant. Obviously, the culture and historical time in which one lives are important factors that determine not only how prevalent a particular behavior is but also whether it is viewed as "normal" or "abnormal" (Bhugra et al., 2010).

With increasing globalization and industrialization, human societies around the world are rapidly changing, and thus differences between cultures with respect to sexual preferences and practices are decreasing (see Ventriglio et al., 2016). Interestingly, however, some culture-specific sexual syndromes continue to exist. For example, in parts of China and Southeast Asia today there are occasional near-epidemic outbreaks of anxiety among men about shrinking penis syndrome—called *koro* (Bhugra et al., 2010). Similarly, anxiety about semen loss—a syndrome called *dhat*—is still found among men in parts of India (see Bhugra et al., 2007). Dhat is believed to stem from the Ayurvedic belief that semen is the end product of a long, complicated process in which food turns into blood, then to marrow, then to flesh, and finally into semen. Because this process requires a great deal of energy, semen comes to be viewed as a particularly precious product. Men with the syndrome report feeling excessively weak or depressed after losing semen during masturbation or wet dreams, and some seek clinical help. Seem strange? If so, keep in mind that in Western culture during the Victorian era medical doctors believed that loss of semen was more harmful to a boy or man than loss of blood and that excessive masturbation could lead to insanity and death (see Chapter 11). Also remember that concerns about penis size are common among many men in contemporary U.S. society (see Chapter 4).

Culture clearly is an important factor that influences our attitudes about what is sexually "normal" and "abnormal," and the prevalence (and types of) sexual preferences, practices, and problems will undoubtedly change with continued changes in globalization and industrialization.

This page contains the following errors:

error on line 8 at column 770: Expected '#' or '[a-zA-Z]', but got ' '.

Below is a rendering of the page up to the first error.

Prevalence and Co-Occurrence of Paraphilias

1. 14. 4 Discuss the prevalence and co-occurrence of paraphilias and paraphilic disorders.

In 2008, a New Jersey policeman and his girlfriend were arrested for allegedly committing sexual assault on three young girls. During the investigation, videotapes were found of the policeman having oral sex with five calves.

Prevalence estimates of paraphilias and their associated disorders are difficult to obtain. Social desirability concerns may prevent people from honestly reporting about any sexually variant urges or behaviors as well as about past or current paraphilias or diagnoses for paraphilic disorders. Moreover, existing studies suffer from a variety of serious methodological flaws (for a review, see Johnson et al., 2014). The fact that definitional criteria have changed over time further muddies the water and makes it hard to find reliable percentages to report. Most of the prevalence rates reported in the *DSM-5*, for example, were extrapolated from existing reports of single sexually variant acts among small nonclinical samples of men and women (and therefore may tell us very little about how common paraphilias are in the general population).

In addition, there is still disagreement among researchers and clinicians about how many paraphilias exist. For example, the *DSM-5* lists 8 paraphilias but notes that "many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual, or for others, rise to the level of a paraphilic disorder" (p. 685). The *ICD-10* lists 7 specific paraphilias as well as an "other" category that includes the most uncommon paraphilias (e.g., zoophilia, necrophilia) and those that are "too rare or idiosyncratic to justify a separate term for each" (p. 172). Other researchers have identified more than 30 individual paraphilias (e.g., Money, 1977). Table 14–2 contains a list of the paraphilias we present in this chapter.

Table 14–2 List of Paraphilias in Order of Chapter Presentation

Paraphilia	Source of Sexual Arousal and Gratification
Voyeurism	Observing people who are naked, in the act of undressing, or engaging in sex without their consent or knowledge
Exhibitionism	Exposing one's genitals to unsuspecting others for the purpose of sexual gratification (e.g., in public)
Telephone scatologia	Making obscene phone calls (e.g., describing genitals, sex acts)
Frotteurism	Rubbing one's genitals against others in public
Pedophilia	Prepubescent children (aged 13 or younger)
Fetishism	Inanimate object (e.g., panties, shoes) or body part not normally considered to be an erogenous zone (e.g., feet, toes, hair) Note: Called "partialism" if arousal is to body part
Transvestism (transvestic fetishism)	Dressing in clothing of the other sex/gender
Urophilia	Urine and/or the act of urinating
Coprophilia	Feces and/or the act of defecating
Mysophilia	Filth, filthy objects, and/or surroundings
Klismaphilia	Receiving, giving, or observing enemas being given
Zoophilia	Animals
(Sexual) Sadism	Inflicting pain or humiliation on others
(Sexual) Masochism	Receiving pain or humiliation from others
Asphyxiophilia	Restriction of one's own breathing
Necrophilia	Corpses (dead bodies)
Somnophilia	Unconscious or sleeping person
Vampirism	Sucking or extracting blood
Narratophilia	"Talking dirty"
Vomerophilia	Vomit or the process or act of vomiting
Stigmatophilia	Tattoos or scars

Table 14–2 Full Alternative Text

What we can conclude with some certainty is that, while all paraphilias and paraphilic disorders are uncommon, they are more likely to occur among men than women (APA, 2013; Money, 1977; WHO, 2016). This is why the pronouns we use in the examples we give in this chapter involve men's (as opposed to women's) behavior. We will consider the possible reasons for this robust sex difference later in the chapter. There is also reliable evidence that paraphilias co-occur. For example, two investigations conducted with outpatient and incarcerated sex offenders revealed that over half had engaged in multiple types of paraphilic sexual behaviors (Abel et al., 1987; Chan et al., 2015). Other researchers similarly have found that individuals in treatment for one type of paraphilia often meet diagnostic criteria for other paraphilias (see Heil & Simons, 2008). In fact, some types of paraphilias tend to cluster together more often than others (APA, 2013; WHO, 2016). Other paraphilias are related by their nature. For example, for several paraphilias the focus of arousal is on non-human objects, and thus they can be regarded as specific types of fetishism. In this chapter, we have loosely organized paraphilias (and their disorders) according to the *DSM-5*'s categorization scheme.

Autogynephilia (form of transvestism)	(male) Fantasy of self as a woman
Autoandrophilia	(male) Fantasy of self as having a more attractive body

The Courtship Disorders

1. 14.5 Define and discuss the courtship disorders: voyeurism, exhibitionism, telephone scatophilia, and frotteurism.

One group of paraphilias/paraphilic disorders often seen together collectively are referred to as *courtship disorders*—voyeurism, exhibitionism, frotteurism, and telephone scatologia (obscene phone calling) (Abel et al., 1987, 1988a; Bradford et al., 1992; Freund et al., 1997). Although these paraphilias generally are considered to be non-violent in nature (e.g., Krueger & Kaplan, 2000), at least half of the men who act on their urges also meet the criteria for pedophilia (sexual arousal to young children), and a sizable minority have also engaged in sexually coercive behavior and rape (Abel et al., 1988a; Baur et al., 2016; Freund & Seto, 1998).

These paraphilias are called courtship disorders because they resemble distorted aspects of normal courtship behavior (Freund & Watson, 1990). Freund and colleagues propose that humans normally go through a four-phase sequence when interacting sexually:

1. Finding phase—in this phase we locate and appraise a potential sexual partner.
2. Affiliative phase—in this phase we make verbal and nonverbal overtures (e.g., looking, smiling, talking) to the potential partner.
3. Tactile phase—here, physical contact (e.g., touching, hugging, petting) takes place.
4. Copulatory phase—sexual intercourse occurs.

According to Freund, what the courtship disorders have in common is that there is "extreme intensification or distortion of one of these four phases wherein the remaining phases are entirely omitted or retained in a vestigial way" (Freund et al., 1997). Individuals with these courtship disorders are almost always men, who have a "preference . . . for a virtually instant conversion of arousal into orgasm" (generally accomplished by masturbation). Let us take a closer look at these specific paraphilias.

14.5.1 Voyeurism

"Last month, I was sitting on my bed and I saw a shadow move across my window. I reluctantly peeked through the blinds and there was this man stroking his penis. Last night I got a phone call from a neighbor telling me someone was looking in my window. I reported it. Apparently, they've been trying to catch this guy for a while. I'm very frightened right now."

"When I was growing up, my parents rented out the downstairs rooms in our house to two women. I don't remember all the details but a young man was spying on them through the windows. He was masturbating while he watched them and this occurred repeatedly until my dad caught him."

(All examples are from the authors' files.)

What is a voyeur (from the French *voir*, meaning "to see")? Are men who like to look at naked women in magazines or at strip clubs all voyeurs? What about people who go to nudist colonies or men who enjoy looking at women (or other men) in revealing swimwear at the beach? What if a man sneaks a peek up a woman's skirt as she is sitting down or, if he is walking down the street, notices a woman (or man) undressing by a window and stops to watch? Although the word *voyeurism* is often used to describe such behavior, such sexualized "looking" behavior is common and normative in the United States and other societies, and these particular examples would not even be classified as sexual variants.

What sets voyeurism apart from this kind of socially acceptable watching is that the voyeur *repeatedly and preferentially* seeks sexual arousal and gratification from observing people who are naked, in the act of undressing, or engaging in sexual activities *without their consent or knowledge* (see Lavin, 2008). The voyeur is aroused by the invasion of the other person's privacy as well as by the risk of discovery, and thus is not interested in going to nude beaches, strip clubs, or other places where people know that they are being watched (Tollison & Adams, 1979). As we will see, many paraphilias involve activities that are potentially illegal, and voyeuristic acts are no exception.

Voyeurism represents a disruption of the first phase, the *finding phase*, of the normal courtship sequence (Freund et al., 1997) and it often co-occurs with other courtship-type paraphilias (exhibitionism being the most common other one) (Abel & Rouleau, 1990; APA, 2013). The great majority of voyeurs are men, and thus the term *Peeping Tom* truly does apply. (The term comes from the story of Lady Godiva, who according to legend rode a horse through her town naked to protest taxes imposed by her husband. The people were ordered to stay inside and not look, but Tom the tailor could not resist.) It is important to keep in mind that acts of voyeurism (e.g., peeking at a topless sunbathing neighbor) are common among teenage boys, and thus the *DSM-5* includes a minimum age requirement of 18 for this paraphilia.

Voyeurs often have low self-esteem, feelings of inadequacy and insecurity, shyness and poor social skills, and difficulty forming positive interpersonal relationships (Kaplan & Krueger, 1997; Tollison & Adams, 1979). Voyeurs may masturbate while observing their targets, or they may masturbate later while fantasizing about the incident. A voyeur whose paraphilia causes personal distress or leads him (or her) to engage in illegal activities or activities that harm others (such as publicly exposing his or her genitals, following or spying on another person, trespassing on private property, and so forth) would be designated as having *voyeuristic disorder*.

"I often 'do it' (masturbate) in my car while parked in areas where I can watch women. My social skills are poor, and I do not get on well with people easily."

"About two years ago a guy from my hometown got into trouble because he was spying on the guests at the motel where he worked. He drilled holes into the wall connecting two of the rooms, and when a couple would check in to one room he'd go into the other room and try to catch them

changing or having sex. He'd masturbate while looking at them. I'm not sure how they caught him but he lost his job and I think he may have gone to jail."

(All examples are from the authors' files.)

Voyeurism is among the most common of the paraphilias (Abdullahi et al., 2015). The majority of voyeurs are not dangerous, preferring to keep their distance, but there are exceptions (Kaplan & Krueger, 1997). If you are ever targeted by a voyeur, you should consider him (or her, but usually him) to be potentially dangerous. Immediately leave the area, call out for help, take whatever additional steps are necessary to protect yourself, and report the incident to the authorities.

Figure 14–2

Voyeurs repeatedly seek sexual arousal by secretly watching people undress.

Source: Michaela Begsteiger/Getty Images

14.5.2 Exhibitionism

"One day at sunset, I was walking back to my car in the . . . parking lot. As I was opening my car door I glanced over at the car facing mine. . . . This man was almost in a backbend over his driver seat masturbating at full speed. For a moment I was stunned and shocked. I just got in my car and drove off."

(from the authors' files)

Exhibitionism (from the Latin *ex*-, meaning "out," and *habere*, meaning "to hold") is defined as repeatedly exposing one's genitals to unsuspecting (nonconsenting) strangers in order to obtain sexual arousal and gratification (see Murphy & Page, 2008). It is considered to be a disruption of the *affiliative phase* of courtship.

Many men and women (some famous, others less so) have posed naked for magazines, starred in sexually explicit films or pornography, and participated in X-rated stage shows. Some of you may have "sexted" (sent explicit photos of your genitals to) a partner, gone skinny dipping, done some sunbathing on a nude beach, or walked around naked at home in the presence of a partner or friend. None of these activities are examples of exhibitionism because they involve willing observers. Others of you may have "mooned" someone on occasion or participated in "streaking" or engaged in flashing at events like New Orleans' Mardi Gras. Although these acts of "playful deviance" (Redmon, 2003) often involve involuntary observers, they are also generally not considered exhibitionism. This is because exhibitionists engage in their behavior *compulsively*—it is their *preferred* means of sexual arousal and they require *nonconsenting* observers. Thus, actions like sexting only reflect exhibitionism if they reflect compulsive behavior and involve involuntary participants (see Figure 14–4.)

Exhibitionism often co-occurs with other "courtship disorder" paraphilias. For example, in one study of outpatient sexual offenders (Abel et al., 1987, 1988a), 93% of those identified as exhibitionists also had engaged in other sexually atypical acts including voyeurism, telephone scatologia, and frotteurism (see also Bradford et al., 1992).

Figure 14–3

Exhibitionists repeatedly seek sexual arousal by exposing themselves to unwilling observers.

Source: Molotok289/Shutterstock

Most victims of exhibitionists, or "flashers," are women or children (Murphy & Page, 2008). Some studies have found that as many as 33% to 48% of women have been victims of exhibitionism on at least one occasion (Cox, 1988; Riordan, 1999). One fifth of the victims found the experience very distressing, and another one fourth said that their attitude about men or sex had been affected. Most victims say that the experience resulted in their limiting the number of places or areas they would go to alone.

Although women can and do engage in exhibitionistic behavior (Långström & Seto, 2006), existing data suggest that almost all individuals meeting the criteria for exhibitionism (the paraphilia) are male (APA, 2013). Indeed, the *ICD-10* notes that "exhibitionism is almost entirely limited to heterosexual males who expose to females" (p. 171). Most male exhibitionists started exposing themselves in their mid-teens or 20s, and half or more either are or have been married (Murphy & Page, 2008). The large majority of these men are described as shy and/or personally immature but otherwise without serious emotional or mental disorders. They typically have very low self-esteem, feel inadequate and insecure, fear rejection,

and have problems forming close, intimate (including sexual) relations (Blair & Lanyon, 1981; Marshall et al., 1991). Although this paraphilia is not generally associated with violence or aggression, there is some evidence linking exhibitionism and sexually coercive behavior (Baur et al., 2016).

Figure 14–4

New York mayoral candidate Anthony Weiner, whose congressional career ended after a sexting scandal in 2011, admitted to having continued to send (using the name "Carlos Danger") explicit messages and images to multiple women after his resignation.

Source: Bryan Smith/ZUMA Press, Inc./Alamy Stock Photo

Lance Rentzel was a star wide receiver for the Dallas Cowboys professional football team and had recently married one of the top young actresses in Hollywood. The Cowboys were headed to the Super Bowl in 1970, but on November 19, while in the middle of a slump, Lance exposed himself to a 10-year-old girl. The media soon discovered that he had been arrested for the same thing 4 years earlier while playing for the Minnesota Vikings—and in the midst of another personal slump. Lance Rentzel had always been a hero on the football field and felt that he had to be highly successful to please his family. In his autobiography and account of his exhibitionism, *When All the Laughter Died in Sorrow* (1972), he says that he felt pressure to prove his masculinity over and over again, and as part of this he avoided close, intimate relations with women and instead proved his masculinity to himself by sexual conquests. During times of stress, when he wasn't a "winner," Lance Rentzel resorted to exposing himself as a way to prove his masculinity.

Although most exhibitionists are of normal or above-normal intelligence, some cases of exhibitionism occur among people who are intellectually impaired, either since birth or as a result of a neurological disorder or age. In these cases, the cause is usually an inability to understand what society considers (or the individual previously considered) to be right as opposed to wrong (Zeiss et al., 1996).

Only about half of all exhibitionists have erections while exposing themselves, and they may or may not masturbate during the act (Langevin et al., 1979). But they usually do masturbate shortly afterward, while fantasizing about the experience, and their erotic turn-on is directly related to the victim's reaction of shock, disgust, and fear (Blair & Lanyon, 1981).

"I am an exhibitionist. Nothing brings me more pleasure than this activity. My preference is to be in my car at an intersection with two lanes. I will have my pants unzipped and my penis out. I cover myself with a jacket until the right moment. I wait until a woman in a tall vehicle—a van, minivan, or truck—drives up next to me. It's important that she be alone and that she be able to see down into my car. I'll remove my jacket and stare at her until she looks over, and then I'll start to stroke my penis. I will keep eye contact with her as long as I can. I have no desire to hurt her, I just want to shock her. If she looks startled or frightened this increases my arousal."

(from the authors' files)

Exhibitionists rarely attempt to molest their victims (APA, 2013); thus, the best response (if you are ever a target) is to give no facial or verbal reaction, leave the scene, and report the incident immediately. Interestingly, many exhibitionists compulsively expose themselves in the same location; perhaps the danger of being caught increases the arousal (Stoller, 1977). As a result, they are the most frequently caught paraphiliac offenders, comprising about one third of all arrests for sexual offenses.

[INSERT SCREEN BREAK]

14.5.3 Telephone Scatologia

"The calls came three to four times a night. The caller would make obscene suggestions about his penis, oral sex, and bondage, and say that he was 'masturbating to the sound of my voice and the thought of my pussy.' Then he would start moaning. I was very shocked and disgusted."

"One day I got a call on my cell from a number I didn't recognize. I answered anyway and heard a man's voice saying that he wanted to show me his 'big, thick cock.' I hung up. He immediately called back and left a message detailing how big and fat and juicy his cock was. I blocked the number and haven't gotten a call since."

(All examples are from the authors' files.)

Many of you may have made an obscene telephone call as a prank during adolescence. Although inappropriate, this behavior is different from that of the paraphiliac phone caller who repeatedly makes obscene calls as a primary source of sexual arousal and gratification. Telephone scatologia (from the Greek *skato*, meaning "dung," and *logos*, meaning "speech"; also called *scatophilia*) is often considered a kind of verbal exhibitionism (Price et al., 2001a, 2001b) and, like exhibitionism, it constitutes a disruption of the *affiliative phase* of courtship (Freund et al., 1997).

As with exhibitionists, the scatophiliac's arousal is proportionate to the victim's reaction of disgust, shock, and fear and to the sense of control it gives him (again, most are men) (Briken et al., 2005). One difference between telephone scatologia and exhibitionism is that many scatophiliacs desire complete anonymity—they do not want to meet their targets face-to-face (Milner et al., 2008).

Some scatophiliacs say nothing during their calls, whereas others describe their genitals or make sexually explicit comments. Some may even try to manipulate their target into revealing sexual information or engaging in an extended, sexually oriented conversation. Often, they masturbate while making their calls. In 2016, a close friend of one of your textbook authors received a phone call from a man claiming to be conducting a "national sex survey sponsored by the Kinsey Institute." He was well-spoken and seemed credible (the Kinsey Institute is a legitimate organization), and so she agreed to participate. However, after answering a few general questions about sexual attitudes, the caller asked her to describe in specific detail the best way for a "man to use his tongue to pleasure a woman during oral sex." By this time, he was gasping and breathing heavily, and she realized that he was masturbating. She hung up.

> In April 1990, the president of American University resigned after police traced obscene phone calls to his office phone. His victims were women who had advertised home day-care services in the local newspaper. He had degrees from Ivy League schools and was a well-known civic activist who had appeared on television hundreds of times as a spokesman for higher education.

(Gelman, 1990)

What can explain behavior like this on the part of a seemingly intelligent (and in this case, prominent) individual? Like the exhibitionist, telephone scatophiliacs often lack self-esteem (Price et al., 2001a). They feel inadequate and insecure and may have difficulty maintaining normal sexual relations, much like exhibitionists. They compulsively use the telephone for sexual interactions when they need to boost their esteem (by inducing shock and fear in their victims)—it is safe and distant and avoids intimacy. They can be anonymous yet verbally interact with the victim and fantasize visually all at the same time.

It is uncommon for telephone scatologia to be the only paraphilia displayed by an individual (Abel et al., 1988a; Bradford et al., 1992). Most have engaged in other sexually atypical behaviors (most commonly those involving the other courtship disorders, such as voyeurism).

Surveys indicate that more than half of adult women have received an obscene telephone call, and that 6% to 14% of men admit to having made such calls, making it one of the most common sexual offenses (see Price et al., 2001a, b) (although for the large majority of these men this is neither a recurring action nor their preferred means of arousal and thus does not represent a true paraphilia). Many obscene callers know the names of the people they call, which can make the experience particularly frightening to the victim. It is rare, however, for scatophiliacs to molest (or even approach) their victims.

If you should ever be a target, the best advice is to say nothing, hang up immediately, and block the number from your phone. If the calls persist, your phone or wireless network company may be able to cooperate in helping the police trace the calls. When the caller is identified, do not be surprised if he turns out to be someone you know or have met; that is often the case.

14.5.4 Frotteurism

"A year ago I went with a small group of friends from my high school to London. Well, we were on a very crowded tube [subway] and were packed in so tight that we could barely move. But the guy behind me was able to move. He kept rubbing up and down against me the whole ride. I just thought that someone kept pushing him against me. My friends told me that he looked like he was 'getting off' by doing that. I never wore those pants again because I felt used and dirty."

"I was at a club downtown and it was super crowded. My friends and I were dancing and this man came up behind me. I didn't notice him at first in the crowd. There were strobe lights going and we had our hands in the air and we were all moving together. But then I felt him rubbing up on me. I would try to move out of his way but he would be right back up on me. I could tell he had a hard on and at one point I felt his hands on either side of my waist. I tried to turn and tell him to back off but it was so crowded that I couldn't. Finally one of my friends noticed and started yelling at him to get off me and he actually knocked down some people running out of the club."

(All examples are from the authors' files.)

Frotteurism (from the French *frottage*, meaning "rubbing") involves the act of rubbing one's genitals against other people in public while fully clothed (see Lussier & Piché, 2008). It is considered to be a disruption of the third phase, the *tactile phase*, of the normal courtship process (Freund et al., 1997). Most frotteurists exhibit other paraphilias as well, most notably voyeurism, exhibitionism, telephone scatologia, and pedophilia (Abel et al., 1988a; Bradford et al., 1992). They are also likely to have engaged in a wide variety of non-sexual antisocial behaviors (Lussier & Piché, 2008).

Uninvited sexual touching appears to be a relatively common behavior among the general male population (see APA, 2013). For example, in a study of college men, about 30% admitted to having rubbed up against a woman in a crowded place (Templeman & Stinnett, 1991). Of course, most of these men are not frotteurists because this is not their preferred means of arousal and the behavior may have occurred only once or twice. Prevalence studies suggest that between 8% and 10% of men in nonclinical samples meet diagnostic criteria for the paraphilia (Johnson et al., 2014). We do not have reliable prevalence estimates with respect to the associated paraphilic disorder.

One study of nonincarcerated paraphiliacs found that the median number of acts of frottage was 29, but many frotteurists had committed the act several hundred times (Abel et al., 1987). How is this possible? Well, frotteurists typically seek out crowded buses or other places where bumping into strangers is less likely to be noticed or cause them to be arrested. And, of course, in a crowded setting, they can always pretend that their actions were unintentional ("Oh, excuse me, I didn't see you there.").

"Based on what we discussed in class today, I don't believe that I have a paraphilia because I get aroused by 'normal' sexual fantasies and activities more than by anything else. But I have done frotteur behaviors in the past and I will admit that I enjoyed them. I have deliberately rubbed my penis up against a woman in the bus, while standing in line to get into a dance, and at parties. I've also reached my arm across the front of a woman to feel her breasts and nipples. What amazes me is that I've been able to get away with it every single time. Most women assume that you are not deliberately trying to touch them, or maybe they're too embarrassed to say anything. The most that's ever happened to me was one woman at a college party turned around and looked at me and I immediately apologized and said 'I'm so sorry, excuse me' and she said no problem. I was able to keep touching her almost to the point of ejaculation. I don't do these things any more but at the time it was a thrill to see how far I could go."

(from the authors' files)

Should you become aware that you are being targeted in this way, try to move away immediately, and alert those around you and the authorities.

Pedophilia

1. 14.6 Define pedophilia and discuss its relationship to the courtship disorders.

In 2008, a man who regularly performed at children's birthday parties and swap meets as "Trim Trim the Clown" was arrested for molesting several young girls. According to news reports, 51-year-old David Lemus used his job to gain access to children and often committed the assaults while wearing his clown outfit. Pedophilia (from the Greek, meaning "love of children") is a condition in which a person experiences recurrent and intense sexually arousing urges or fantasies, and/or persistently engages in behaviors, involving sexual activities with children. Although the legal age of consent differs from state to state (ranging from 16 to 18), researchers and clinicians generally define a child as someone who is 13 years old or younger. Thus, we are discussing urges, fantasies, or behaviors involving *sexual relations between an adult and a prepubescent child* (see Seto, 2008). There is an additional criterion—to be considered pedophilia, the adult must be at least 16 years old and at least 5 years older than the child (*DSM-5*, 2013). This additional criterion is designed to protect an older teenager engaged in an ongoing consensual sexual relationship with a younger teenager (e.g., a 15-year-old dating a 13-year-old) from being labeled as sexually "deviant" and classified as a sex offender.

An isolated instance of sexual activity with a child (called *child molestation* or *child sexual abuse*) is both reprehensible and illegal. However, such an act does not necessarily qualify as pedophilia. To be designated as pedophilia, sexual relations with children must be the primary and preferred source of sexual excitement and gratification. Some pedophiles do not act on their urges; those who do, however, would be diagnosed with *pedophilic disorder* (and, if caught, would be charged with child sexual abuse or molestation).

Pedophilia is introduced here because it is frequently found to exist in individuals diagnosed with courtship disorders. Half or more of men diagnosed as voyeurs, exhibitionists, telephone scatophiliacs, or frotteurists also meet the criteria for pedophilia (Abel et al., 1988a; Bradford et al., 1992). Although less common than many other paraphilias, pedophilia is among the most serious. The victims of pedophilic adults who act on their urges often suffer long-term emotional and interpersonal damage. We will cover this paraphilia (and child sexual abuse in general) in greater depth in Chapter 15.

Fetishism, Transvestism, and Related Paraphilias

1. 14. 7 Identify the paraphilias that focus on non-human objects for sexual arousal.

The following sections will describe the paraphilias that focus on non-human objects for sexual arousal: fetishism, transvestism, urophilia, coprophilia, mysophilia, klismaphilia, and zoophilia.

14.7.1 Fetishism

> John's sisters began to complain that he was going through their dresser drawers. He denied it, but his mother found their panties under his pillow. This pattern continued, with John denying it each time their underwear was discovered under his pillow. In private, John would masturbate while playing with the female undergarments. His school work deteriorated and he was in repeated fights, resulting in his being sent to reform school at age 18. There, he continued to steal and masturbate with women's underwear.

(Case history courtesy of Dr. David Schnarch)

In anthropology, a *fetigo* (in Portuguese) is a carved wooden or stone object that is believed to have magical powers (usually by capturing or embodying a powerful spirit). The term *erotic **fetishism*** was coined by Alfred Binet (inventor of the first standardized intelligence test) in 1887. It generally refers to repeatedly achieving sexual arousal and gratification by handling or fantasizing about an inanimate object. A variation of fetishism, called *partialism*, is strong and recurrent sexual arousal to a specific part of the body that is not usually considered to be an erogenous zone (e.g., feet, toes, hair). For men who have fetishism as their primary paraphilia, it is not uncommon for them to also have secondary paraphilias —most commonly pedophilia, masochism, and transvestism (Abel & Osborn, 1992).

Some of the more common fetishes involve women's undergarments (panties, bras, or stockings), shoes (usually high-heeled) or boots, parts of the body, and objects made of leather or rubber (Darcangelo, 2008). Fetishes involving hard objects such as boots, leather, or rubber objects are often associated with sadomasochistic practices and fantasies. Heterosexual male fetishists are aroused by the theme of "femininity" in their preferred object, while homosexual male fetishists are aroused by the theme of "masculinity" in the preferred objects (Weinberg et al., 1994).

Figure 14–5

Is this an example of a foot fetish or a normal sexual variant? It depends. For this young man, his behavior is a paraphilia only if it is his preferred way of seeking sexual arousal.

Source: PhotoMediaGroup/Shutterstock

Fetishists are almost exclusively men (Darcangelo, 2008). When their fetish involves clothing or shoes, these men greatly prefer articles that have been used and have an odor. A man with a panty fetish, for example, would become highly aroused by a used pair of panties that retained vaginal odor but would probably not be very aroused by the same panties if they were new or clean.

"I work at a department store. One night I was folding towels when a man came over and started asking silly questions like, 'How often do you put rugs on sale?' I noticed that while he was talking, he kept glancing at my feet. He asked me where I got my shoes and if the inside was soft. He also asked if they held an odor. Not thinking, I said 'no' and took off a shoe. By this time, he had knelt down, picked up the shoe, and smelled it several times. He then gave it back and immediately left the store."

"I know a married man in his late 20s who has a fetish. He goes around asking women (the ones he has affairs with) for a pair of their dirty underwear."

"Okay, don't judge me for this, but I actually have sold my used panties online. There are specialty sites for this and you can make decent money if you are willing to post photos of yourself in the panties. The problem is that it starts to feel like porn after a while. Also, some of the customers would want other things, like more explicit photos or to meet in person. It got too sleazy and gross and I had to stop."

(All examples are from the authors' files.)

Be sure to remember the difference between a paraphilia and a variant. Most heterosexual men are aroused by women's panties, and many men have purchased sheer, lacy lingerie for their partners. Some of you may have even sniffed a pair of panties sometime in your lifetime. For the large majority of men, none of these activities are the end goal; they merely serve to enhance sexual activity with their partners. Many women, too, have favorite articles of clothing or outfits that they use to increase their own arousal or heighten their partner's sexual pleasure. These preferences do not constitute fetishism. The fetishist is focused exclusively on the object (e.g., panties, boots, stockings). The partner's personality or body cannot sustain arousal by itself; her (or his) only role is to serve as a vehicle by which to enact the fantasy. In its most extreme form, the fetishist does not need or desire the partner at all.

Sexual arousal to specific objects or body parts has been explained in terms of a two-step learning process involving both classical and operant conditioning (see Darcangelo, 2008). Other explanations will be considered later. Consider, for example, heterosexual men's arousal by women's panties. Most men's first exposure to women's panties comes during early necking or petting experiences, at which time they are highly sexually aroused. If panties are paired with this state of sexual arousal a sufficient number of times, a connection is created such that the panties themselves begin to elicit some degree of sexual arousal. This is an example of classical conditioning—the panties have become a conditioned stimulus (the man is conditioned to experience arousal upon exposure to them). A demonstration of this process was provided several years ago (Rachman, 1966). Under laboratory conditions, men were shown pictures of women's boots paired with pictures of nude women. After many pairings, pictures of the boots alone elicited sexual arousal (measured by penile blood volume). Men's sexual arousal can be classically conditioned to other objects as well (Lalumière & Quinsey, 1998).

Fetishism may also develop through operant conditioning mechanisms. Consider, for example, a teenaged boy masturbating and enjoying a sexual fantasy in the bathroom. While so engaged, he happens to pick up a pair of his mother's or sister's panties from the hamper and make use of them. The sexual gratification (e.g., orgasm) he subsequently experiences may become associated not only with the fantasy he was enjoying but also with the object he used (in operant conditioning lingo, the panties may become a reinforcer). Many men with fetishes first become attracted to their desired objects at a relatively young age (16 or so; see Abel & Rouleau, 1990), perhaps as a result of the object having been associated (through classical and operant conditioning) with their first experiences of sexual arousal and activity.

"Based on our discussion in class today, I believe I have a fetish. When I was about 12, I overheard some adults at a party talking about a wedding night ritual where the bride would cover her entire body with a sheet that had a hole in it near her vagina. The groom would lie on top of her and then insert his penis through the hole and into her body. I got aroused by this image and could not get it out of my mind. Later that same week I masturbated and experienced my first real orgasm. Since then I've continued to masturbate to images of a couple having sex this way and even made a sheet like the one I imagined. I have been in relationships and can function sexually with a woman but I prefer my fantasy. Masturbating with the sheet is more satisfying to me than other sex acts."

(from the authors' files)

How common is fetishism? We do not really know, but it appears to be relatively uncommon among men and virtually nonexistent among women (APA, 2013; Darcangelo, 2008). Fetishists rarely seek treatment, perhaps because they typically suffer little impairment in everyday functioning as a result of their paraphilia (although their sexual relationships may be affected). Of course, if the desire for a particular fetishistic object leads the individual to commit criminal acts (such as trespassing or theft) or causes him to experience significant distress, then a diagnosis of *fetishistic disorder* would be appropriate.

14.7.2 Transvestism

> "He was an officer in the army (respected by his fellow officers and men), a devoted husband, and a father. He also wore women's clothing at home, often passing as a female relative, and was known as 'aunt' to his child when he assumed his womanly role."

(cited in Hirschfeld, 1948, pp. 174–78)

Transvestism (from the Latin *trans*, meaning "across," and *vestia*, meaning "dress") refers to repeatedly dressing as a member of the opposite sex *in order to achieve sexual arousal and gratification.* In fact, transvestites experience orgasm while cross-dressing (Docter & Prince, 1997).

Most researchers regard transvestism as very similar to a clothing fetish (and thus it is often called transvestic fetishism), except that the clothing is worn rather than just held and looked at (see Wheeler et al., 2008). Transvestism frequently co-occurs with masochism, voyeurism, and exhibitionism (Långström & Zucker, 2005).

Figure 14–6

Transvestites are generally heterosexual men who cross-dress for purposes of sexual arousal and gratification.

Source: Karen Struthers/Fotolia; Zoonar GmbH/Alamy Stock Photo

Cross-dressing is not considered an example of transvestism if the clothing is worn as a fashion statement (as in the case of women who dress in "men's" clothing), as a costume or for entertainment or theatrical purposes (as with female or male impersonators, drag queens, and drag kings, for example), or as part of the process of gender affirmation (in which transgendered individuals cross-dress not for sexual arousal but as a way to claim and affirm their true gender identity). It is also common for young children aged 4 or 5 years (before they acquire the concept of gender constancy at age 6 to 7 years) to dress up as both mom and dad. And in some regions of the world (e.g., Murcia in Spain, Ghana in Africa), young men and women don clothing of the opposite sex during various cultural ceremonies and festivities (see Cano-López, 2011; Geoffrion, 2013).

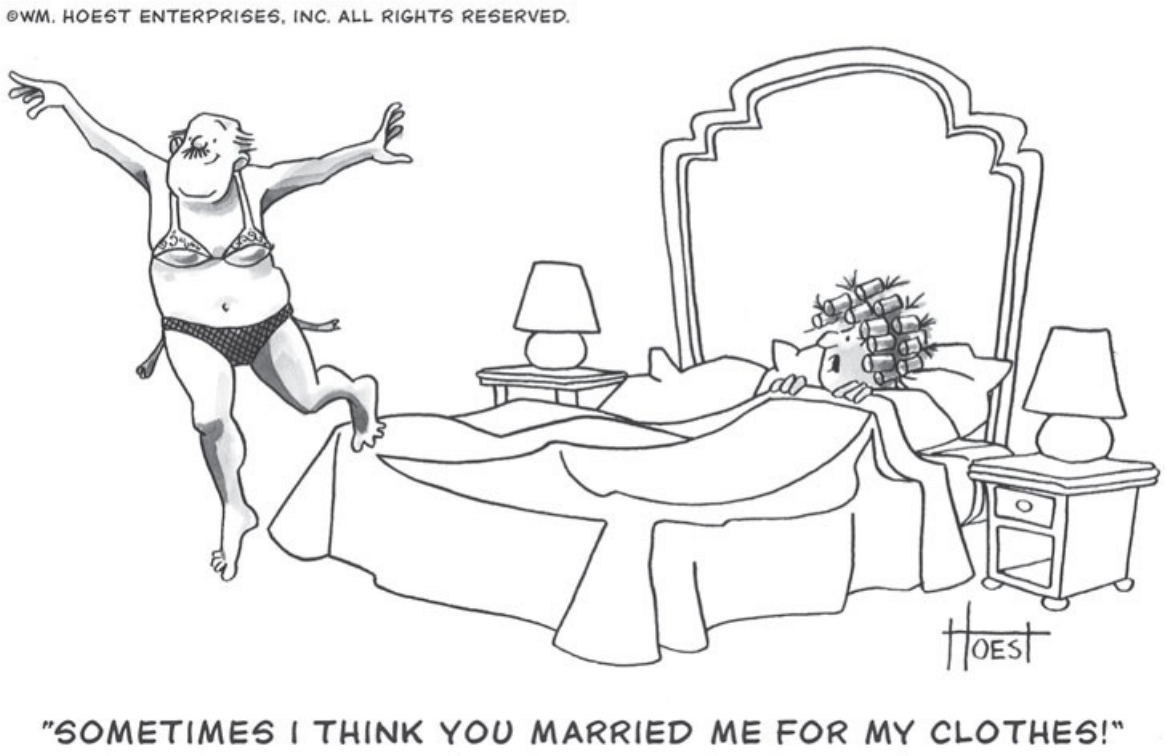
The large majority of transvestites are heterosexual men and most are married (Docter & Prince, 1997; Långström & Zucker, 2005). Most are college educated and in professional careers. About half are distressed by their transvestite activities (and thus would be classified as having *transvestic disorder*), but half are not (Långström & Zucker, 2005).

A few men completely cross-dress as women and walk about in public for short periods of time, but most transvestites cross-dress secretly in the privacy of their own homes. Many wear female undergarments under their male clothing during their cross-dressing. The transvestite may masturbate during a cross-dressing episode or during fantasies of cross-dressing or may use the clothing to become aroused enough to engage in sexual activities with a partner. About one fourth of the wives of transvestites accept their husbands' behaviors, but most only tolerate it, and many are distressed and resent it, especially if they discovered it only after they were married (Brown, 1994; Docter & Prince, 1997).

Fewer than 3% of adult men report ever having been sexually aroused by dressing in women's clothing (see APA, 2013). Thus, it is not surprising that transvestism is an extremely uncommon paraphilia (with early research suggesting rates no higher than 1% to 3% of the adult male population) (Bullough & Bullough, 1993; Långström & Zucker, 2005). However, there are sufficient numbers to form a transvestite (TV) subculture, with clubs, magazines, newsletters, and websites and other online forums.

Why do some men dress in women's clothing to achieve sexual gratification? Bullough (1991) suggests that transvestism can be viewed "as an attempt for males to escape the narrow confines of the masculine role." How does this paraphilia develop? Most transvestites started cross-

dressing before or during puberty (Wheeler et al., 2008), and some clinicians believe that the preference develops through a learned association of opposite sex clothing with sexual arousal (in the same manner that fetishes are acquired).



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Personal Reflections

Do you believe that it is okay for consenting adults to engage in any sexual behavior in private as long as it does not cause physical and/or emotional injury and does not interfere with normal social and occupational activities? Why or why not?

14.7.3 Related Fetish-Like Paraphilias

There are many less common paraphilias (see Milner et al., 2008 for an exhaustive list), some of which can be considered forms of fetishism because they involve sexual arousal and gratification from non-human objects (e.g., Money, 1986; Stoller, 1986). Each of these fetish-like paraphilias would be classified as a disorder if it produced significant distress to the individual, impaired his (or her—but most are men) ability to function, and/or resulted in harm to others. Several of these uncommon paraphilias involve sexual arousal from specific bodily discharges or activities that involve bodily functions (urophilia, coprophilia, mysophilia, klismaphilia). Let us examine a few of these uncommon preferences.

Urophiliacs (from the Greek *ouron*, meaning "urine") are sexually aroused by urine and/or the act of urination. They enjoy watching others urinate, and many are sexually aroused by urinating on their partner or having their partner urinate on them (referred to as "golden showers" in some circles). Some even drink urine, bathe in urine, or smell urine-soaked underwear. They may also enjoy keeping their bladders full or watching people wet their pants. Urination is commonly included as part of sadomasochistic activities.

"I personally know someone that was a urophiliac. He used to talk to one of my friends. She told me that every time they were together, he used to ask if he could urinate on her belly."

"My boyfriend likes to watch as I urinate. I even let him taste it one time."

(All examples are from the authors' files.)

Coprophiliacs (from the Greek *kropos*, meaning "dung") are sexually aroused by excrement and/or the act of defecation ("pooping"). They may play with or masturbate with feces. In some brothels around the world, coprophiliac patrons can pay to watch from under a glass as prostitutes defecate. Both urophilia and coprophilia are extremely rare, but there is a market for videos showing people engaged in elimination behavior or sexual activity involving urine or feces.

Closely related to urophilia and coprophilia is mysophilia (from the Greek *mysos*, meaning "uncleanliness"), which is sexual arousal caused by filth or filthy products or surroundings. For example, there are documented cases of people who are sexually aroused by sweaty clothing or used menstrual products (e.g., tampons).

Another paraphilia is klismaphilia (from the Greek *klisma*, meaning "enema"), obtaining sexual arousal and gratification by receiving or giving

enemas or watching others have enemas (Milner et al., 2008). Individuals who are aroused by this often have an interest in sadomasochistic activities as well. Many klismaphiliacs self-administer their enemas, but many others give and/or receive enemas with a partner. Some use warm water, while others use alcoholic solutions or coffee. Specialty sex products (e.g., aluminum nozzles) and pornographic media (often dubbed "water sports") are available on the Internet and at retail stores for use by people who enjoy fantasizing about or engaging in this practice. Both men and women have been noted to use enemas as part of their sexual activities, but—as with most other paraphilias—the majority of people with klismaphilia are men.

"I know a man who has a very high position within a large company. His favorite thing sexually is to be given an enema containing Tabasco sauce. He would hold the fluid in and masturbate."

(from the authors' files)

Bestiality is the act of having sexual contact with an animal. This contact includes the touching, licking, or rubbing of a person's genitals by an animal; touching, licking, or rubbing an animal's genitals; and performing oral, anal, or vaginal sex on an animal. Only a few studies have attempted to estimate the prevalence of sexual contact with animals. Kinsey and his colleagues (1948, 1953) reported that about 8% of the men and 4% of the women in his total sample had had sexual contact with an animal on at least one occasion. Seventeen percent of boys raised on a farm admitted to such experiences. A more recent study confirms that a fair number of people have had some form of sexual contact with an animal on at least one occasion (Alvarez & Freinhar, 1991). The large majority of people who have engaged in bestiality did so only once or a few times, often during adolescence (Tollison & Adams, 1979). It might have happened as a dare, as an initiation stunt, or out of curiosity.

"In my early teens my cousins and I penetrated a horse. I did it because of a dare. I've grown up now and have three children and a wife. Every now and then I think about what I've done and it makes me want to throw up."

"One night several years ago myself and a few acquaintances were sharing some college experiences. One of the group stated that to become a member of he had to have sexual intercourse with a goat."

"I masturbate with a vibrator and sometimes I let my dog lick my genitals while I'm doing this."

(All examples are from the authors' files.)

Animals cannot give consent, and so all instances of bestiality raise ethical and moral concerns. Moreover, should an act of bestiality cause injury or result in an animal's death, there are legal consequences. For example, in 2011, an Ohio man was jailed on charges of animal cruelty and assault on an animal when police received a tip about a website featuring videos of the man raping a dog he had recently adopted; the subsequent investigation revealed that he had assaulted several prior dogs, two of whom had to be euthanized because of their injuries (Vice, 2011). In 2013, a California man was arrested and charged with animal cruelty and sexual assault of an animal when home surveillance video caught him entering a neighbor's yard, drugging the neighbor's (female) dog, and then raping her (Altman, 2013). More recently, in 2016, a Washington man was charged with first-degree animal cruelty for raping (and then killing) an 8-year-old boy's service dog (Rose, 2016). In instances such as these, which involve penetrative and aggressive sexual assault on animals by adults, the perpetrators often have deeper psychological issues as well as a prior history of violence and criminal behavior. When the perpetrator is young, such acts may serve as a warning sign indicating an increased risk of future violent interpersonal behavior. For example, repeated prior childhood acts of bestiality, particularly those involving pain and harm to the animal, have been documented among juvenile men incarcerated for sexual assault (see Schenk et al., 2014).

Bestiality becomes a paraphilia, called zoophilia (from the Greek *zoon*, meaning "animal") when it is the preferred means of sexual arousal or gratification. In a study of 114 male zoophiliacs, the large majority preferred dogs or horses as sexual partners. "The most common sexual behaviors they reported ever having engaged in were performing oral-genital sex (81%), having vaginal intercourse with a female animal (75%), masturbating the animal (68%), and receiving anal intercourse from a male animal (52%)" (Williams & Weinberg, 2003). The two most common reasons given by the men were "pleasurable sex" and the "animal's love was unconditional."

> "My relationship with animals is a loving one in which sex is an extension of that love as it is with humans, and I do not have sex with a horse unless it consents. . ."

(cited in Williams & Weinberg, 2003)

In the example given above of the Ohio man charged with animal cruelty, the police recovered evidence in his home that clearly indicated that he was a zoophiliac—books about bestiality, an inflatable animal sex doll (a sheep), a web browser history indicating multiple visits to bestiality sites, and photos, journals, and videos documenting his bestiality activities. He also had advertised his services around town as a pet sitter and dog walker in order to obtain contact with the animals he desired.

Zoophilia is very rare and usually signals the presence of severe psychopathology. Zoophiliacs are often withdrawn, have poor interpersonal skills, and frequently have other paraphilias (Milner et al., 2008). They also may suffer from various neurocognitive conditions (e.g., dementia; see Almeida et al., 2013; Othman et al., 2014).

Sadomasochism

1. 14.8 Discuss and explain sadomasochism. Differentiate between "mild" sadomasochistic activities or fantasies, sexual sadism and sexual masochism (the paraphilias and the disorders), and the activities of those who belong to the BDSM subculture.

Sadism (called *sexual sadism* in the *DSM-5*) refers to the infliction of physical or psychological pain on another person for sexual arousal and gratification. The term is named after the Marquis de Sade (1740–1814), a French aristocrat and novelist who wrote stories, supposedly based on his own experiences, of beating and torturing women while being sexually stimulated himself (his works include the novels *Justine* and *120 Days of Sodom*). Masochism (or *sexual masochism*) refers to achieving sexual arousal and gratification by being made to suffer or from experiencing physical or psychological pain or humiliation. It is named after Leopold von Sacher-Masoch (1835–1895), a practicing masochist who wrote novels (e.g., *Venus in Furs*) about people receiving sexual pleasure from submission, suffering, and pain inflicted on them by others. If the partner of a sadist participates willingly, as is usually the case, then he or she is, of course, a masochist, and the linkage of the two behaviors is indicated in the term sadomasochism (S&M).

The terms *sadism* and *masochism* were originally coined by Richard von Krafft-Ebing, who also was one of the first to report clinical cases of these paraphilias:

> There was a man who habitually attacked young girls on the street with a knife, wounding them in the upper arm. When arrested, he said that he did it because he would have an ejaculation at the moment he cut them.

(cited in Krafft-Ebing, 1951, p. 223)

> A 28-year-old man would have a woman tie him up with straps he brought for that purpose. Then he would have the woman take whips (which he had also brought) and beat him on the soles of his feet, the calves, and backside until he ejaculated.

(cited in Krafft-Ebing, 1951, p. 261)

Sadomasochistic acts vary from verbal humiliation and the suggestion of pain to more dangerous activities including trampling, whipping, beating, and strangulation. For example, asphyxiophilia (also called *hypoxyphilia*) is a subtype of sexual masochism in which individuals achieve sexual arousal by restricting their breathing (and thus, in the process, depriving themselves of oxygen) (Hucker, 2011). This is often done using ropes, nooses, belts, or plastic bags.

"A friend of mine was a bodyguard to a call girl. He went on a call with her once where the customer liked having plastic (plastic wrap) around his head while she squatted over his face naked. He said the sounds the man was making while he was gasping for breath made him sick to his stomach."

(from the authors' files)

People with asphyxiophilia often engage in additional masochistic practices (e.g., bondage) and tend to have other paraphilias, including transvestism and fetishism (Hucker, 2011). This is a dangerous behavior that can easily result in death. Men masturbating alone constitute almost all known cases of fatal asphyxiophilia (Milner et al., 2008). You may recall that actor David Carradine (who starred in many TV shows and movies, including *Kill Bill*) allegedly died in this manner.

Today, sadomasochistic imagery is common in fashion, art, music, movies, literature, advertising, and other aspects of popular culture, which raises the issue of where we draw the line between normal experience and pathology. In Chapter 11, you learned that many people incorporate sadomasochistic themes into their sexual fantasies. Sizeable numbers of men and women also enjoy engaging in mild sadomasochistic activities with their partners during sex, such as when one partner lightly bites, slaps (e.g., on the buttocks), pinches, scratches, or pins down the other.

"I consider myself to be a normal sexual person … I love to be spanked." (woman)

"I figured I could ask you if it's 'normal' if you like to be bitten during sex? My arousal does not depend exclusively on biting nor does my boyfriend have to bite me hard, I just love it." (woman)

"I am a gay man in a long-term committed relationship. I find it incredibly arousing when my partner holds my wrists and pins my arms up over my head when penetrating me." (man)

"I like it when my girlfriend scratches her nails down my back during intercourse. For some reason I get really turned on when she does this. On more than one occasion she's left marks." (man)

(All examples are from the authors' files.)

Some couples even enjoy acting out "mock" sadomasochistic fantasies, which might include role playing, dressing up in costumes, and using various props (e.g., handcuffs, blindfolds, rope).

"My husband and I sometimes act out a fantasy where he's a pirate and I'm a barmaid he kidnaps and then has his way with. We both wear costumes and he shackles me (my ankle) to the bed with a plastic chain so I can't escape. Then he slowly undoes my blouse while I protest and try to get away. It goes on like this until we are both aroused and semi-naked and then we have intercourse. We don't do this often because as you can imagine it takes time and effort, but when we do wow—completely satisfying and we both have the most intense orgasm." (woman)

"Once my girlfriend handcuffed me to the bed. Then she straddled me and we had sex. I didn't want to do it at first but it turned out to be kind of amazing. For some reason the feeling that she was totally in charge got me off." (man)

(All examples are from the authors' files.)

14.8.1 Differentiating Between Mild Sadomasochistic Sex Play and Sadism or Masochism

So what differentiates this type of mild sadomasochistic "sex play" from the paraphilias of sexual sadism and sexual masochism? Recall that in order to qualify as a paraphilia, the preference or activity must be the primary and repeated means of sexual arousal and gratification.

"My most favorite sexual activity is bondage. This is usually done with a partner with whom I have had sex enough times to develop a feeling of trust. I explain that I will tie her spread-eagle to the bed and do anything to her that I want. After doing so, communication is active and only things that bring pleasure are done. At no time is fear or physical abuse implied. There has never been a bad experience to me or my partner during these adventures."

"The dominatrix commands me to clean a toilet, then 'rewards' me by allowing me to chew on one of her dirty socks."

"I have an arrangement with a call girl. I pretend to be a naughty little boy and when she catches me being bad she scolds me sternly and says she's going to punish me. She forces me to drop my pants and lie across her lap on the bed. She then spanks my bare bottom until I ejaculate."

(All examples are from the authors' files.)

To quality as a paraphilic disorder, the urges must produce significant personal distress, impair normal functioning, cause harm to another person, and/or be acted upon with a nonconsenting partner.

"There was this guy in my dorm. He would always try to show me and the other guys on our floor violent porn clips. He would say how he wanted to do those things to women. Choke them on his dick, twist their nipples, disgusting things like that. It made me sick. I've got a girlfriend and sisters, you know? I cut all ties with him about two years ago. Well, I guess he tried to do some of those things because I heard last month that he got arrested for sexual assault. I'm glad. He was not normal."

(from the authors' files)

Very few people (less than 1%) consider stronger forms of sadomasochistic activity to be sexually appealing (Laumann et al., 1994) and very few people meet diagnostic criteria for the paraphilias (and their associated disorders). These rare conditions are more likely to be seen among men than women (APA, 2013; Hucker, 2008), and in forensic and clinical settings (such as among incarcerated sex offenders) than in the general population. Even in those settings, however, prevalence rates are low (i.e., from about 2% to 5%; Yates et al., 2008). Sexual sadism disorder is most likely to be observed among two types of sex offender (Yates et al., 2008): those who murder their victims (sometimes called "lust murderers") and those whose assaults are specifically motivated by a desire to hurt and degrade their victims (called "sadistic rapists"; see Chapter 15). Lust murderers obtain sexual pleasure from the act of killing, and they are frequently serial murderers. Sadistic rapists use far more force to subdue their victims than is necessary and are sexually aroused by this gratuitous violence. Examples of these types of sex offender include Ted Bundy, Jeffrey Dahmer, and John Wayne Gacy.

Not surprisingly, sexual sadists who act on their urges share many features with other sexual assault perpetrators (Langevin et al., 1988). Some of these shared characteristics include abuse of alcohol and drugs, poor socialization, frequent history of childhood abuse, tendency toward committing non-sexual crimes as well as sexual crimes, and long histories of antisocial behavior. Sadists often engage in fetishism and transvestism as well (see Hucker, 2008).

14.8.2 The BDSM Subculture

There is a small but active community of men and women who regularly participate in sadomasochistic activities and who differ in important ways from individuals with sexual sadism and sexual masochism disorder (Holt, 2016). BDSM refers to sexual preferences, activities, and fantasy-based role play involving bondage and discipline (BD), dominance and submission (DS), and/or sadomasochism (SM). Within this subculture, BDSM activities are explicitly defined and constructed so as to be erotic (i.e., positive and pleasurable), voluntary and consensual, collaborative and scripted (mutually created and confined only to a specific episode), and playful and recreational (see Weinberg, 2006; Weinberg et al., 1984). It is not the actual experience of pain, humiliation, and submission or dominance, discipline, and coercion that excites participants, but the *appearance* of pain/submission and the *illusion* of dominance/control (Weinberg, 1987).

> What may appear to the uninitiated observer to be spontaneous behavior is often carefully planned. In this way, the kinds of uncertainties one faces in everyday life do not exist. All parties to the interaction must agree to participate. Forced participation is not acceptable within the subculture; it is only the illusion that individuals are coerced that is approved by sadomasochists. Participants must agree on what will take place during the scene and carefully discuss limits to the interaction, insuring that both derive pleasure from their participation. (Weinberg, 2006, p. 34)

BDSM typically involves the adoption of characteristic roles (e.g., a "master," "mistress," or "top" who dominates a submissive "slave" or "bottom") and the use of specific props, costumes, and verbal and nonverbal behavior that allows participants to fully occupy those roles (see Figure 14–7). Common fantasy themes that couples enact include boss and secretary, king/queen or master/mistress and slave, employer and servant, teacher and pupil, and parent and child (see Sandnabba et al., 1999; Weinberg, 2006).

Figure 14–7

Participants in BDSM activities and members of the BDSM community often wear leather garments and boots and use whips, chains, leashes, and collars in highly structured scenarios.

Source: Alexander Cherepanov/Alamy Stock Photo; Monika Habicher/Zoonar GmbH/Alamy Stock Photo

BDSM participants differentiate between *hurt* (pain that is pleasurable, such as in receiving a spanking) and *harm* (pain that is associated with physical or psychological damage or injury), and they generally are not interested in the latter (Holt, 2016). Hurt is erotically arousing only when it is part of the agreed-upon ritual. (Interestingly, BDSM activities between homosexual male partners tend to involve more harm [extreme violence] than do BDSM activities among heterosexual partners [Breslow et al., 1986].)

Moreover, within the BDSM community, violations of agreed-upon rules of conduct are considered serious and sometimes are handled by members who are specifically appointed to protect participants and mete out justice (see Holt, 2016).

"My partner and I belong to a very exclusive club of like-minded people who enjoy dungeon games. There are very specific rules and we are very careful to follow them both with ourselves and with others in the club. For example, we tell each other what we are going to allow and not allow, and exactly what is going to happen. We use safe words and we are in constant communication. At one play party, though, we saw a man beating a woman up 'for real'—grabbing her by the hair, slapping and kicking her, hitting her. She was bleeding and screaming for him to stop. The dungeon master had to step in and forcibly stop him or else I'm sure he would have killed her. It was horrible. That man is no longer a member of our club. Unfortunately, because our activities are considered deviant by the rest of the world, we have to rely on self-policing. We risk too much if we go to the authorities. My club is lucky because our dungeon master is ex-armed forces, so he's physically capable of intervening. He's also careful and well-respected, so my partner and I feel safe."

(from the authors' files)

Men are more likely than women to participate in BDSM activities (2:1 ratio), and many heterosexual women who participate do so to please their male partners (Breslow et al., 1985). BDSM participants tend to be heterosexual and well educated (often with prominent jobs), and they

generally also engage in "ordinary" (non-BDSM) consensual sex (Breslow et al., 1985; Hucker, 2011; Moser & Levitt, 1987; Sandnabba et al., 1999). Although most strongly prefer to enact a particular role (e.g., dominant or submissive), many switch between roles, and some may change their preferences over time (Sandnabba et al., 1999). Most people who engage in BDSM are socially and emotionally well adjusted with no psychopathology (Hucker, 2011; Weinberg, 2006). Interestingly, male (but not female) masochism often coexists with transvestic fetishism (APA, 2013).

Several explanations have been proposed to explain preferences for sadomasochistic sexual activity and the development of the paraphilias (see Hucker, 2008; Yates et al., 2008). Psychoanalytic explanations of sadism often focus on unconscious anger directed at one's mother, while masochism is sometimes explained as sadism directed at oneself. Behavior therapists, on the other hand, contend that sadomasochism results from early associations of pain or aggression with orgasm. One study found that 80% of male and 40% of female sadomasochists attributed their interest in S&M to childhood or adolescent experiences (Breslow et al., 1985). Other explanations have also been proposed (Cross & Matheson, 2006); as with all sexual preferences and paraphilias, there are probably multiple causes.

14.8.3 Other Paraphilias

The list is lengthy (see Milner et al., 2008), and only a few are included here. Perhaps the most bizarre paraphilia is necrophilia (from the Greek *necros*, meaning "dead")—obtaining sexual arousal and gratification by having sex with dead bodies. Almost all known cases involve men, although a few cases of female necrophiliacs have been reported (Rosman & Resnick, 1989). Most experts consider these people to be severely emotionally disturbed or psychotic. Necrophiliacs often seek employment in mortuaries or morgues in order to have access to their "partners." Some necrophiliacs murder in order to obtain corpses and thus can be regarded as both sexual sadists and necrophiliacs (Milner et al., 2008).

A few of the other paraphilias include *somnophilia* (sexual excitement and gratification from sexual activities with a sleeping or unconscious person; this may progress to necrophilia), *vampirism* (sexual arousal attained by extraction of blood); *narratophilia* (sexual arousal by using dirty language with a partner); *vomerophilia* (sexual arousal by focusing on the process of vomiting); *stigmatophilia* (sexual arousal by a partner who is tattooed or scarred); *autogynephilia*, where a man is highly aroused by the fantasy of himself as a woman (viewed as a type of transvestism) (Blanchard, 2005; APA, 2013); and *autoandrophilia*, where a man is highly aroused by the fantasy of having a more attractive male body (Lawrence, 2009).

[INSERT QUIZ FOR LO 14.8]

What Causes Paraphilias?

1. 14.9 Discuss the various theories of how paraphilias develop and the factors that are associated with paraphilias.

A paraphilia does not generate itself in a vacuum. (Money, 1977, p. 927)

One researcher concluded that paraphilias are "remarkably consistent in their phenomenology, but highly variable in their expression" (Fedoroff, 2011). However, after decades of research we still have very little understanding of what causes people to become paraphiliacs (see Laws & O'Donohue, 2008). Paraphiliacs come from all areas of society. Many are well educated, partnered, and successful in their careers (others are not, as we will discuss below). Various explanations have at times focused on genetic predispositions, abnormal brain function, negative experiences during development, psychological traits, and social/learning processes. It is probably the case that the cause of paraphilias is multifactorial (Ward & Beech, 2008).

Freudian (psychoanalytic) *theorists* believe that paraphilias are the result of arrested psychosexual development, often due to a failure to resolve emotional conflicts. In this theory, paraphilias serve as defense mechanisms to reduce anxiety. Although Freudian theory has the advantage of being very flexible, the effectiveness of psychoanalysis as a therapy for paraphiliacs is very debatable, and it is seldom used today.

Learning theorists (behaviorists) attribute paraphilias to (usually early) learned associations. Conditioning of men's sexual responses to a specific stimulus has been demonstrated in the laboratory (Lalumière & Quinsey, 1998). Recall, too, the study by Rachman (1966) regarding acquisition of a "fetish" to boots. Some individual case studies also lend credence to learning theory explanations. A man's fetish for plaster casts, for example, was traced to an experience he had at age 11 after he broke his leg (Tollison & Adams, 1979). He got an erection as the nurse held his leg and later masturbated while fantasizing about it. His repeated fantasy/masturbation episodes helped nurture and sustain the fetish. It is certainly the case that fantasy plays an important role in the developmental history of many paraphiliacs. About half of paraphiliacs recall having "deviant" sexual fantasies in their teens, well before acting out the behavior(s) (Abel et al., 1987; Marshall et al., 1991).

Some paraphilias and paraphilic disorders—particularly the courtship-related paraphilias (voyeurism, exhibitionism, telephone scatologia, and frotteurism), pedophilia, zoophilia, and sexual sadism—are associated with a particular developmental history and psychological profile (APA, 2013; Freund et al., 1997; Seto et al., 2014). Specifically, men with these preferences typically have poor social skills, low self-esteem, current mood, substance abuse, and personality disorders, histories of childhood abuse or neglect (or were raised in families where sex was thought of as evil and normal erotic development was inhibited), and a great deal of anger and hostility toward women. As a result, they often experience difficulties achieving intimacy, especially when they attempt to form sexual and/or romantic relationships.

Conventional sexual relationships (i.e., involving consenting adult partners) may be too complex and psychologically and interpersonally threatening for the typical paraphiliac. Fantasizing about (or engaging in sexual activities) with a known, familiar, and non-threatening object (e.g., a fetish, an animal, a child) is much less stressful and anxiety-provoking than attempting to form relationships with unfamiliar, unknown adult human partners (Kaplan, 2006). Paraphiliacs need to have a great deal of control in order to become sexually aroused—and sexual interactions among adult human "equals" is often unpredictable and comes with no guarantee of satisfaction. Think about this for a moment. What do a pair of panties, a dead body, an animal, a person who does not know she/he is being watched, and a young child—all of them objects of paraphiliacs' fantasies—have in common? These objects are *non-rejecting* and, therefore, psychologically "safe." Consider, for example, the following case history of necrophilia:

"Two males worked with me at . There we worked in the morgue and they used to always want me to watch one morgue while they watched another. Well, one day I went to their morgue after hearing about a young Puerto Rican female body which had been delivered after she died of a drug overdose. There was one guy on top of her and the other was waiting his turn. After talking with them, I found out that they had done this many times before. They tried to get me to do it but I refused, saying they were crazy. They said, 'No, you're crazy because this is the best. We have them any way we want, how we want and do whatever we want to them without any back talk!'"

(from the authors' files)

Some researchers have observed a similarity between paraphilias and other obsessive-compulsive disorders (e.g., Bradford, 1999). Recall from Chapter 13 the cycle of events that drives the individual who is hypersexual (or the sex addict, as some prefer to call such people). The individual is first preoccupied with obsessive thoughts, which lead to ritualistic behaviors, causing further sexual excitement, which eventually leads to the sexual act. The act, however, does not produce lasting relief; and in order to reduce the anxiety that almost immediately develops, the individual becomes preoccupied again and acts again (Carnes, 1991). In fact, there is a close association between hypersexuality and some of the paraphilic disorders (Kafka, 2008; Långström & Hanson, 2006). The fact that a great many paraphiliacs engage in their behaviors compulsively cannot be denied. Men with paraphilias engage in sexual activities much more often than most people (Kafka, 1997). This often includes compulsive masturbation, protracted promiscuity, and heavy use of pornography (Kafka & Hennen, 1999). As sexologist Eli Coleman explained it, the behavior of the paraphiliac "may initially be driven by the sexual excitement. . . . But the primary motivation is the reduction of stress and anxiety. There is usually a short-lived feeling of relief, followed by the recurrence of the anxiety" (quoted by Thompson, 1991; see also Coleman, 1991).

Research in recent years has suggested that men with paraphilias may have abnormal brain chemistry (Kafka, 1997), abnormal prenatal neurodevelopment (Rahman & Symeonides, 2008), and/or abnormal frontal-temporal lobe function (Joyal et al., 2007). Although a disturbance of brain development and function might be associated with the tendency to develop a paraphilia, it "does not explain why individuals differ in the particular manifestation of sexual impulsivity" (i.e., why some individuals become exhibitionists whereas others become voyeurs). Nevertheless, as you will see, pharmacological interventions designed to alter brain chemistry are playing an increasingly greater role in the treatment of paraphilias.

Of course, it is important to remember that paraphilias only become problematic and require treatment, from a clinical perspective, when they

interfere with the individual's social, work, or interpersonal functioning, cause him (or her) to experience distress, and/or result in harm to another (including coerced or nonconsensual activity).

[INSERT QUIZ FOR LO 14.9]

Why Are Paraphilias/Paraphilic Disorders More Common Among Men?

1. 14.10 Explain the possible reasons for why nearly all paraphiliacs are men.

An interesting question still remains: Why are the large majority of paraphiliacs men? Female paraphilias remain extremely rare, with the exception of masochism and perhaps klismaphilia (Hunter & Mathews, 1997). (The prevalence of women involved in child molestation—some of whom may have pedophilia—also is greater than once believed. You will read about this in the next chapter.) What might explain this state of affairs? One possible reason is that men experience spontaneous sexual urges more often than women (see Chapters 4 and 10), and perhaps their relatively greater levels of sexual interest contribute to a wish to experience (and the subsequent development of sustained interest) in new and unusual sexual activities.

A more probable contributing factor concerns socialization processes that differentially target men and women. Despite sociocultural changes in sexuality-related gender norms and expectations (see Chapter 8), men continue to be reinforced for expressing their sexual urges, actively seeking out sexual opportunities, and gaining sexual experience, whereas women are expected and taught to curb their sexual appetites, establish limits on sexual intimacy, and confine their sexual activities to committed, romantic partners and relationships (see Regan, 2015; Tiefer, 2004). These socialization processes may increase the likelihood that men, as opposed to women, will develop an interest in multiple and varied (and unusual) sexual preferences.

Similarly, many paraphilias involve engaging in risky, unconventional, and potentially dangerous and illegal activities (such as spying on people, exposing one's genitals to strangers, etc.). Growing up, boys are generally socialized to be assertive, bold, fearless, and adventurous (part of the stereotype of masculinity and maleness), and research consistently finds that men score higher than women on measures of sensation seeking, risk taking, and impulsivity, score lower than women on measures of punishment sensitivity (awareness of the potential negative consequences of risky and criminal activities), and are more likely than women to actually engage in criminal behavior (see Byrnes et al., 1999; Cross et al., 2011). These gender socialization processes may increase the likelihood that a man will develop a paraphilia and/or engage in behaviors in service of his sexual interests.

It is also the case that in our increasingly online world, more and more people are being exposed to "taboo" or "deviant" sexual practices that they might never have otherwise imagined (or thought to try). Researchers have noted that the Internet has dramatically altered the limits and boundaries with respect to sexuality (as well as violence). Specialty chat rooms, websites, forums, and pornographic media catering to every possible sexual preference or proclivity are readily available. The world of video games and online gaming has also experienced a rapid and dramatic alteration in form and content. For example, Young (2014) observed that "increasingly, activities such as assault, murder, torture, rape, cannibalism and bestiality are coded as possible and permissible in the world of virtual play." Men and boys are more likely than women and girls to play violent video games as well as online role playing games (and to view pornography), many of which present female characters in objectified and stereotypic ways and violent and sexually violent behavior as "normal" (Desai et al., 2010; Hartmann, 2015; Ivory, 2006). To the extent that boys and men more than girls and women are exposed to these practices, find them arousing, and incorporate them into their sexual fantasies and masturbatory activity, they may develop a sexual preference that ultimately becomes a paraphilia.

Together, these factors may explain (at least partly) why there is a higher prevalence of paraphilias and paraphilic disorders among men than women.

Therapy

1. 14.11 Discuss the treatment (therapy) for individuals with a paraphilic disorder.

If we still do not understand the causes of paraphilias, it should come as no surprise that we are still trying to find an effective therapy to treat them when they develop into disorders. Leading experts in the field generally conclude that few treatments produce long-term change (e.g., Laws & O'Donohue, 1997).

Why might this be? To begin with, one of the biggest problems is that the large majority of individuals with paraphilic disorders do not want to change. In one researcher's words:

> Throughout the assessment and treatment process, the clinician should begin with the assumption that the client does not wish to give up the atypical sexual behavior and will do everything possible to conceal important information from the therapist and to resist change. *(Paul Schewe, 1997)*

Others agree that many of those in therapy for treatment of their paraphilic urges or actions do "not fully and honestly report information" (Laws & O'Donohue, 1997).

Of the types of therapy that have been tried, cognitive-behavioral therapy has had some success (Laws & O'Donohue, 2008). However, the problem is that no type of therapy for *any* problem (not just paraphilias) has a high success rate unless the individual wants to change. This is one reason that therapy ordered by criminal courts is often unsuccessful; the individual does not come to therapy on his own. For many paraphiliacs, the urge to engage in the behavior is so strong that it never seriously occurs to them to try to stop (Money, 1986). The recidivism rate (the rate at which treated individuals return to their behaviors) is very high (Feierman & Feierman, 2000; Laws & O'Donohue, 2008).

Today, paraphiliacs are increasingly being treated for hypersexual (compulsive) disorder (Kafka, 2008). For those paraphiliacs who are considered to be hypersexual and/or those who engage in behaviors that cause harm to others (e.g., pedophilia, bestiality, sadism), *medical (pharmacological) approaches* to reduce the sex drive are commonly being used (Balon, 2013; Grubin, 2008). Reducing paraphiliacs' testosterone levels is one method. Surgical castration is not allowed in the United States. Instead, therapists use antiandrogen drugs (e.g., cyproterone acetate or medroxyprogesterone acetate) to reduce testosterone levels (Grubin, 2008). The most promising advance is in pharmacological treatment with drugs that regulate a brain chemical called serotonin (see Grubin, 2008). Serotonin inhibits many behaviors, including sexual behavior. These serotonergic antidepressant drugs (e.g., fluoxetine, sertraline) are also often used to treat obsessive-compulsive disorders, which again suggests a relationship between these two types of disorders.

It must be emphasized that these drugs are not cures. They "may reduce the strength of sexual urges, [but] they have no effect on the direction of the urge" (e.g., voyeurism, exhibitionism, etc.) (Grubin & Mason, 1997; see also Grubin, 2008). Instead, the drugs are used to curb the sexual urges while other therapies can be tried.

The medical treatment of paraphilias and paraphilic disorders raises a host of ethical issues. Many of the drugs used have extremely unpleasant side effects and sometimes people stop taking them. This may not seem like a cause for concern if the person's sexual preference only affects him (or her). But what about paraphiliacs who act on their urges and commit crimes or cause harm to others? Should society have the right to force an individual to undergo therapy or take drugs? This is not an easy question for many of us to answer. However, in several U.S. states (as well as in Australia and countries in the European Union) the answer is "yes"—drug treatment (and other forms of therapy) can be made a condition of parole for convicted sex offenders. We will consider a related issue in Chapter 15 when we discuss *sexual predator laws*. These are laws that allow states to continue to confine convicted sex offenders who have completed their prison terms if they have a diagnosed psychiatric disorder (often pedophilia or another paraphilia) and they have a high estimated likelihood of reoffending in the future. Although the U.S Supreme Court has upheld these laws, there is concern that they violate due process rights—should we be able to indefinitely detain someone who has served his (or her) prison sentence? Again, there is no easy answer and researchers, clinicians, and legal experts continue to debate this issue (see Wakefield, 2012).

One thing that everyone does agree on is that to have any chance of success, any therapeutic intervention for paraphilias or paraphilic disorders must be long term (Balon, 2013). A minimal treatment duration of 2 years has been recommended for mild paraphilias and at least 3 to 5 years for severe paraphilias (e.g., those involving sexual violence and/or reaching the level of a disorder) (Garcia & Thibaut, 2011).

The present consensus was summarized by Laws and O'Donohue (1997) in the first edition of their book *Sexual Deviance*:

> Because of our skepticism regarding changing our own orientations and the lack of evidence that paraphilic orientations are more modifiable, we believe that these problems are not "curable." That is, there is little evidence suggesting that a paraphilic orientation can be reliably and permanently replaced by a normal orientation. Rather, we believe that the assumptions associated with a relapse prevention model are the most tenable. The client may for his entire life have a paraphilic orientation, but the goals are to decrease the intensity of these interests and most importantly to learn skills to decrease the likelihood that he will act on this orientation. Thus, the goal of therapy is not a "cure," but rather the maintenance of abstinence from acting on the interest. (p. 7)

Has there been any progress since then? In the 2008 second edition, they concluded:

> We now have a 50-year history of . . . treatments, and it is entirely reasonable to ask: What have we got to show for it? The answer, sadly, is very little. (p. 13)

Personal Reflections

Do you engage in sexual practices that may be physically or psychologically harmful to yourself or others (e.g., exhibitionism, obscene telephone calls, voyeurism, sadomasochism, pedophilia)? If so, have you sought therapy to help with your behavior? If you have not sought therapy, why not?

Study Guide

Key Terms

- asphyxiophilia
- BDSM
- bestiality
- coprophilia
- courtship disorders dominance
- exhibitionism
- fetishism
- frotteurism
- klismaphilia
- masochism
- mysophilia
- necrophilia
- paraphilias
- paraphilic disorder
- pedophilia
- sadism
- sadomasochism (S&M)
- sexual variant
- submission
- telephone scatophilia
- transvestic fetishism
- transvestism
- urophilia
- voyeurism
- zoophilia

Interactive Review

Answers can be found on p. 473.

1. This chapter considers three different ways to define a sexual preference or behavior as unconventional or abnormal. The (1) approach defines a behavior as "normal" if most people engage in it. By this definition, abnormal behaviors are behaviors that are engaged in by relatively few people. The (2) approach focuses on the whether a behavior or preference is viewed as customary or accepted within a particular society or culture. The (3) approach defines a sexual preference or behavior as abnormal if it causes an individual to feel distressed or guilty, to experience problems in functioning efficiently in ordinary social and occupational roles, and/or to harm others. And, of course, what is considered unconventional or conventional, normal or abnormal, and common or unusual depends on the historical time and (4) in which the behavior is displayed.

   Paraphilias reflect persistent, intense urges to engage in uncommon or unusual sexual activities that do not involve (5) , (6) , and/or (7) partners. If a paraphilia is accompanied by significant levels of distress, impairs the person's ability to function in everyday settings, and/or causes harm or risk of harm to another person, it would be classified as a (8) . Unusual sexual behaviors that are engaged in once in awhile, perhaps to enhance sexual activity with a partner, but are not the preferred means of arousal

and gratification, are called (9) . Research reveals that paraphilias and paraphilic disorders are uncommon but are nonetheless more likely to occur among (10) . Interestingly, it is not unusual for several paraphilias to coexist in the same individual. One group of paraphilias commonly seen together are called (11) , because they reflect a disruption of the four-phase courtship sequence that often occurs when people interact sexually. This sequence includes a finding phase, (12) phase, (13) phase, and a copulatory phase. (14) experience a disruption of the finding phase and prefer to seek sexual gratification by watching people undress without their knowledge or consent. Two paraphilias that represent disruptions of the affiliative phase are (15) , achieving sexual gratification by exposing one's genitals compulsively in inappropriate settings, and (16) , repeatedly making obscene phone calls for purposes of sexual arousal and satisfaction. (17) is a paraphilia that reflects a disruption of the tactile phase and refers to repeatedly achieving sexual arousal/gratification by rubbing one's genitals against others in public places. These paraphilias are often associated with (18) , defined as experiencing persistent sexual arousal, urges, or actions involving sexual activity with (19) children.

(20) refers to achieving sexual arousal when using or fantasizing about an inanimate object or a specific part of the body. (21) , also called transvestic (22) , refers to sexual arousal and gratification from dressing as a member of the opposite sex. Other fetish-like paraphilias that focus on non-human objects for sexual arousal include (23) (sexual arousal from urine and/or the act of urination), (24) (arousal from feces and/or the act of defecation), (25) (arousal from filth or filthy products or surroundings), (26) (arousal from receiving, giving, or watching enemas), and (27) (arousal from sexual activity with animals). Some instances of sexual activity with animals, particularly those involving pain and harm to the animal, are associated with psychopathology and an increased likelihood of (28) .

(29) intentionally inflict pain and/or humiliation on others for sexual arousal and gratification, whereas (30) obtain sexual pleasure from having pain and/or humiliation inflicted on them. Sadomasochistic imagery is common in contemporary U.S. culture, and some people even enjoy acting out "mock" fantasies involving role playing, dress up, and props with their sexual partners. To be considered a paraphilia, these activities would need to be the person's (31) means of sexual arousal and gratification. People who regularly participate in sadomasochistic activities are members of the (32) community or subculture. Within this community, the activities are explicitly viewed and constructed so as to be (33) , (34) , (35) , and (36) . A variety of other paraphilias have been described, including (37) refers to sexual arousal from corpses or having sex with dead bodies.

As noted earlier, the large majority of paraphiliacs are (38) . Most describe themselves as heterosexual, but have difficulty maintaining intimate (particularly affectionate) relations. The paraphiliacs' behavior(s) allows them to have control over the objects of their sexual arousal. Therapy is generally unsuccessful in eliminating the paraphilia, often because the individual does not want to give it up. However, management of paraphiliacs is sometimes possible by administering (39) drugs that lower testosterone levels and reduce sexual desire.

Self-Test

Answers can be found on p. 473.

A. True or False

1. **T F** 40. Any unusual sexual behavior is called a paraphilia.
2. **T F** 41. Most heterosexual men who buy sexy lingerie for their female partners have a fetish.
3. **T F** 42. Young children who occasionally dress up in clothing of the opposite sex usually grow up to be transvestites.
4. **T F** 43. Most transvestites are heterosexual men and married.
5. **T F** 44. Exhibitionists often behave as if they wish to be caught.
6. **T F** 45.The classic example of "an exhibitionist" would be someone who works at a strip club.
7. **T F** 46. The best way to react to an exhibitionist is to show shock, fear, or disgust.
8. **T F** 47. A 14-year-old boy who peeks over the fence at his female neighbor whenever she sunbathes without her top on has voyeuristic disorder.
9. **T F** 48. A person may commit bestiality and not have a paraphilia.
10. **T F** 49. Most individuals involved in BDSM act out highly structured scenarios in which pain-inducing behaviors are more symbolic than real.
11. **T F** 50. Most paraphiliacs have difficulties with intimacy.
12. **T F** 51. The majority of paraphiliacs wish to be cured.
13. **T F** 52. There are several successful therapies for treating paraphilias and paraphilic disorders.

B. Matching

(Match the behavior with the name of the paraphilia that best fits it.)

- 53. asphyxiophilia
- 54. autogynephilia
- 55. bestiality
- 56. coprophilia
- 57. exhibitionism
- 58. fetishism
- 59. frotteurism
- 60. klismaphilia
- 61. masochism
- 62. mysophilia
- 63. necrophilia
- 64. pedophilia
- 65. sadism
- 66. sexual variant
- 67. somnophilia
- 68. telephone scatologia
- 69. transvestism
- 70. urophilia
- 71. voyeurism
- 72. zoophilia

1. Billy must seek crowded places in order to get away with this paraphilia.
2. Henry is trying to find employment in a morgue in order to act out his paraphilic fantasies.
3. Joe has volunteered to serve as counselor at the elementary school's summer camp to have access to the objects of his sexual arousal.
4. John is highly aroused by watching his partner have a bowel movement.
5. Fifteen-year-old Jack has just snuck out to the barn so that he can masturbate against the rump of his family's cow.
6. Allen repeatedly peeks in windows in order to become aroused.
7. Bert is hanging around the laundromat hoping to steal the object of his sexual desire from an unwashed basket of clothing.
8. Carl is crawling on his hands and knees and being pulled by a leash in order to get sexually aroused.
9. Stan asks his partner to urinate on him whenever they have sex.
10. Greg finds it arousing to wear frilly panties and a bra underneath his suit and tie.
11. Walter is waiting in his car in the grocery parking lot to show his penis to the first woman who walks by.
12. Susan gets highly aroused whenever she ties her partner up and orders him to lick her feet.
13. Sam gets highly aroused when his wife wears a negligee or teddy.
14. David is describing his erect penis to a woman in his class he has called but does not personally know.

15. Gene becomes sexually excited when he thinks about sheep, and the only way he can have an orgasm is by penetrating an anatomically correct "sheep" sex toy.

16. Lenny is becoming highly aroused by his partner's nasal mucus.

17. Paul has paid a prostitute to give him an enema.

18. Larry puts a plastic bag over his head when he is highly sexually aroused.

19. Bob has repeated fantasies about himself as a woman while masturbating.

20. Eddie can only achieve sexual satisfaction when his wife takes a sleeping pill and allows him to engage in sex with her after she's asleep.

C. Fill in the Blanks

1. 73. Transvestism is most closely related to _____.

2. 74. The most frequently caught paraphiliac offenders are .

3. 75. Telephone scatologia is most closely related to .

4. 76. For pedophilia, sex researchers generally define a child as someone who is years old or younger.

5. 77. Urophilia, coprophilia, mysophilia, and klismaphilia involve sexual arousal by and thus might be considered specific types of .

6. 78. The objects of paraphiliacs' sexual arousal (e.g., a pair of used panties, a dead body, an animal, a young child) have in common that they are .

7. 79. Today, many paraphiliacs are being treated for disorder.

8. 80. To be successful, clinicians generally agree that treatment for paraphilic disorders must be .

Suggested Readings and Resources can be found on p. 464.

Chapter 15 Sexual Victimization: Rape, Coercion, Harassment, and Abuse of Children

> Not only does [rape] harm the subordinated victim, those who care about her, and those whose fear of rape is increased by her rape, but it also injures society, which loses the full participation of those women who alter their behavior as a function of fear.

—Owen D. Jones, 1999

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 15.1 Define the concept of sexual assault and describe when sexual assault occurs (i.e., the three ways in which we understand sexual assault to have occurred).
2. 15.2 Define rape and discuss how legal definitions in the United States have changed over time.
3. 15.3 Discuss two methods for determining the prevalence of rape. Consider the "facts" (prevalence, location, relationship between victim and assailant) of rape in the United States.
4. 15.4 Describe and differentiate among different types of rape, including stranger rape, acquaintance rape, date rape, sexual coercion, marital rape, gang rape, and statutory rape.
5. 15.5 Discuss the topic of same-sex sexual assault. Explain why reliable estimates of the prevalence of this type of assault are hard to find. Discuss the characteristic features of male rape.
6. 15.6 Discuss laws pertaining to and prevalence of sexual assault around the world. Explain the factors that seem important in predicting the amount of sexual violence that exists in a particular culture and the best way to reduce sexual violence.
7. 15.7 Identify and explain the different factors associated with rape.
8. 15.8 Identify several myths about rape and explain why they are not true.
9. 15.9 Describe post-rape posttraumatic stress disorder and other reactions to rape.
10. 15.10 Describe sexual harassment in the workplace and the classroom and ways to deal with it.
11. 15.11 Discuss the difference between pedophilia and child molestation and describe the different ways to classify (and the characteristics of) pedophilic child molesters.
12. 15.12 Describe the devastating long-term effects that can result from sexual abuse of children.
13. 15.13 Discuss prosecution of and treatment options for sex offenders.

> Sara left the party at midnight. Although it was late and she lived a good distance away, she felt perfectly safe walking home alone through the city. After all, she was young and strong and had taken a self-defense class. It was cold and the walk seemed to be taking forever, so Sara decided to leave the main street and take a shortcut she knew. As she turned down the dark alley, she heard footsteps behind her. She glanced back and saw a strange man following her. Sara quickened her pace, but before she could reach the end of the alley, she was struck hard and knocked to the ground. She screamed and struggled to get up, but the man hit her repeatedly in the face and knocked her down again. He tore her clothes off and raped her.

When we ask students in our classes to define sexual assault, many provide stranger rape scenarios similar to the one above. That is, they describe a violent sexual attack in which a woman is physically forced by a male stranger to have vaginal intercourse with him. This attack typically takes place when the woman is alone in a potentially dangerous situation (like in a "bad" part of town or at night in a dark alley).

Stranger rape is certainly one type of sexual assault that can and does occur, but it is by no means the only one (or the most common). It might surprise you to learn that men can be victims and women can be perpetrators of sexual violence. The assailant and victim may be strangers, as in the scenario above, but they can also be acquaintances, friends, or dating partners. They may even be living together or married. They might be related. The forced sexual act can involve vaginal intercourse, or it may involve any of a number of other sex acts, including kissing, oral or anal intercourse, or fondling. And physical force may not be used at all. As you will see in this chapter, sexual assault comes in a variety of forms, including rape, coercion, harassment, and the abuse of children. Let us begin by clearly defining the concept of sexual assault.

Sexual Assault

1. 15.1 Define the concept of sexual assault and describe when sexual assault occurs (i.e., the three ways in which we understand sexual assault to have occurred).

Broadly speaking, sexual assault refers to unwanted or nonconsensual sexual contact (Christopher, 2001; Muehlenhard et al., 1991). More specifically, sexual assault occurs when a person engages in sexual activity (1) as a result of physical force or the threatened use of physical force, (2) as a result of coercion (e.g., manipulation, pressure), or (3) when he or she is unable to consent or resist (e.g., under the influence of drugs or alcohol, asleep, unconscious, younger than the legal age of consent). In addition, the unwanted or nonconsensual sexual activity refers not only to intercourse (vaginal, oral-genital, or anal) but also to penetration by a foreign object (e.g., finger, bottle) and touching or fondling of a person's breasts, buttocks, or genitals. In the United States, sexual assault is a crime (although this is not the case in many other countries; see Box 15–A). The first type of sexual assault we will consider in this chapter is rape.

15.3.1 Rape

1. 15.2 Define rape and discuss how legal definitions in the United States have changed over time.

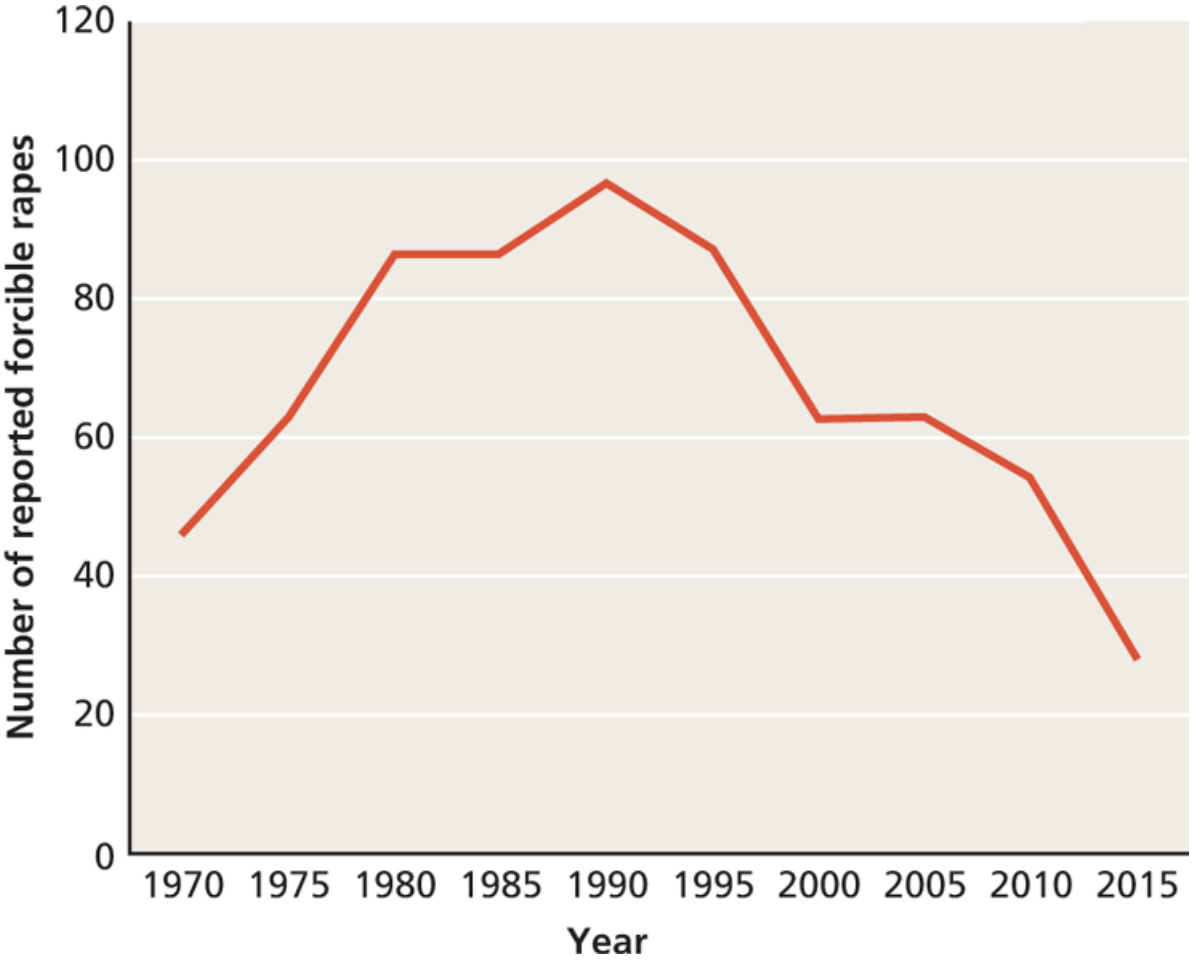
In the United States, definitions of what constitutes "rape" have changed dramatically over time. For example, in 1929, rape was legally defined by federal authorities as "the carnal knowledge of a female, forcibly and against her will." This meant that only instances in which a man forcibly penetrated a woman's vagina with his penis were considered to be rape. Oral and anal penetration, penetration with foreign objects or body parts other than the penis, rape of men, rape of women by women, and non-forcible rape were all excluded—they did not "count" as crimes. This overly narrow definition prevented many victims from reporting their assaults and made it difficult to accurately estimate the prevalence of sexual assault across the nation. As a result, many law enforcement and victims' rights agencies began to demand that a broader definition of rape be adopted. Finally, in late 2011, the federal government agreed. Today, rape is legally defined as anal or vaginal penetration (no matter how slight) with any body part or object or oral penetration by a sex organ of another person, without the consent of the victim or when the victim is incapable of giving consent (U.S. Department of Justice, 2012). Force by the assailant or physical resistance from the victim is no longer required to determine whether rape has occurred. Note that this official definition, while certainly more inclusive than the previous one, is still focused on penetration of the victim (and thus excludes cases in which the victim is made to penetrate another person; see Stemple & Meyer, 2014).

Prevalence of Rape

1. 15.3 Discuss two methods for determining the prevalence of rape. Consider the "facts" (prevalence, location, relationship between victim and assailant) of rape in the United States.

How prevalent is rape? There are two basic ways to answer this question. The first involves analyzing *crime data* or cases reported to law enforcement. Every year since 1930, the Federal Bureau of Investigation (FBI) has collected crime data from law enforcement agencies across the nation. These data are published in annual reports that provide information about the prevalence of various types of violent (and non-violent) crime, including rape. When considering the numbers, it is important to remember that all FBI reports about rape generated prior to January 2013 are based on the 1929 definition (and thus refer only to forcible penile-vaginal intercourse). According to these annual crime reports, rates of forcible rape in the United States rose steadily from 1960 and reached a peak in 1992 with 109,062 reported cases (U.S. Department of Justice, 2010). Since then, the rape rate has declined dramatically. For example, there were 67 million more people living in the United States in 2015 than in 1992, but the number of reported cases had fallen to 90,185 (with 22,863 arrests) (U.S. Department of Justice/Federal Bureau of Investigation, 2016). Figure 15–1 illustrates this change. The decrease is heartening, but the numbers are still too high: In 2015, a woman was forcibly raped every 6 minutes.

Figure 15–1

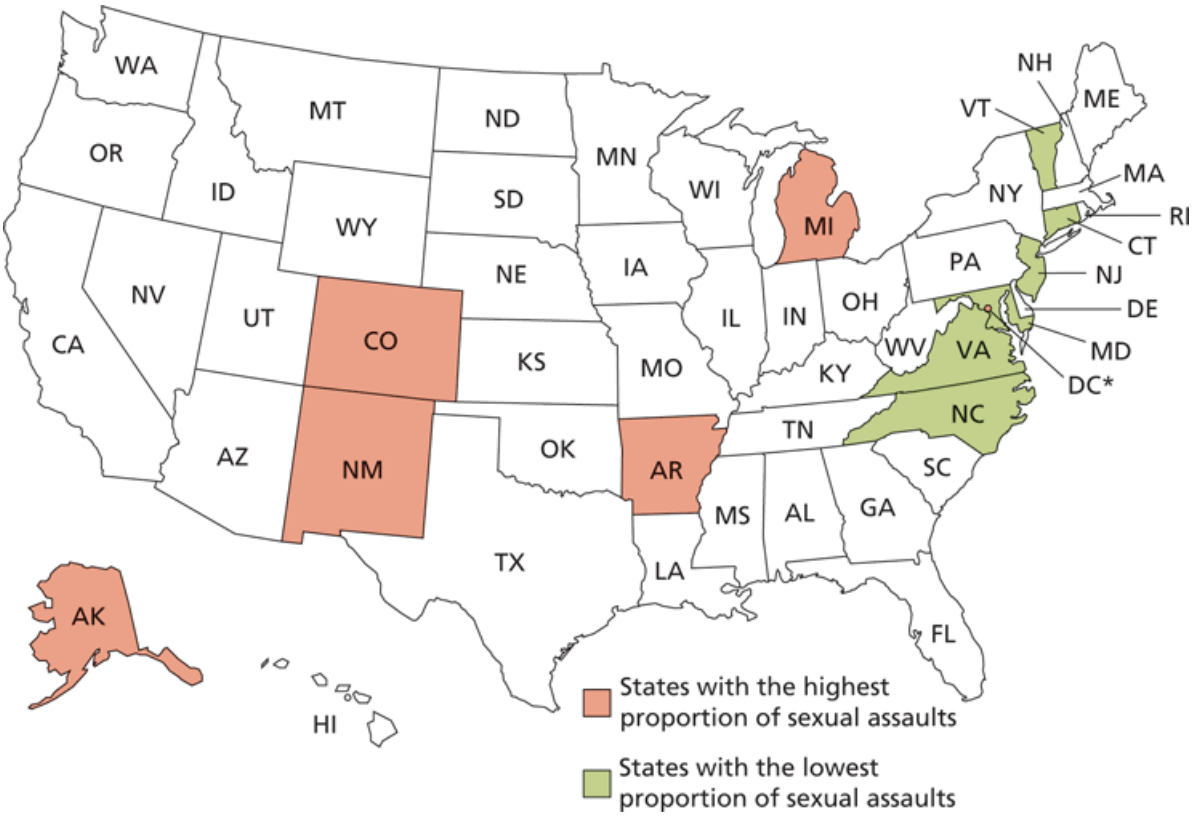


This figure shows the number of cases of forcible penile-vaginal rape (pre-2013 definition) reported to law enforcement agencies per every 100,000 women during the past 45 years. National crime data reported by the FBI (U.S. Department of Justice, 2010, 2012, 2015) and the U.S. Census Bureau (2012) suggest that rates of rape reached a high point during the 1990s but then began to decrease. In 2015, the forcible rape rate was about 28 per 100,000 women.

Figure 15–1 Full Alternative Text

Some states in the United States are more assault-prone than others (see Figure 15–2). For example, FBI crime statistics for 2015 reveal that Alaska, Colorado, Arkansas, Michigan, and New Mexico (and the District of Columbia) had the highest number of reported sexual assaults per 100,000 inhabitants. The lowest rates were reported in Connecticut, Vermont, New Jersey, Maryland, Virginia, and North Carolina (U.S. Department of Justice/Federal Bureau of Investigation, 2016).

Figure 15–2



Which states are the most and the least rape-prone? Data collected by the FBI in 2015 revealed that the highest proportion of (reported) sexual assaults occurred in Alaska (which had the highest), New Mexico, Colorado, Arkansas, Michigan, and the District of Columbia. States with the lowest proportion of (reported) sexual assaults included Vermont, Connecticut, New Jersey (which had the lowest), Maryland, Virginia, and North Carolina.

Source: U.S. Department of Justice/Federal Bureau of Investigation (2016, September). *Crime in the United States, 2015.* Retrieved from https://ucr.fbi.gov/crime-in-the-u.s/2015/crime-in-the-u.s.-2015/.

Many experts believe that national crime reports like those provided by the FBI seriously underestimate the amount of sexual violence that women (and men) experience (see Kilpatrick & McCauley, 2009; Stemple & Meyer, 2014). This is because only rapes that are reported to law enforcement are included. Yet we know that rape is one of the most underreported crimes. About two thirds of rape victims never report their assault to the police or other authorities (Bureau of Justice Statistics, 2016a).

A second, more accurate, method of determining rape prevalence involves using data from *victimization surveys*, in which women (and men) are directly asked about various types of sexual and nonsexual violence they may have experienced. Two of the largest ongoing surveys are the National Crime Victimization Survey (NCVS) conducted by the U.S. Department of Justice/Bureau of Justice Statistics and the National Intimate Partner and Sexual Violence Survey (NISVS) conducted by the Centers for Disease Control and Prevention. In these surveys, large numbers of U.S. residents are contacted and asked about their experiences with various types of sexual assault (including rape, forced sexual contact, sexual coercion, and so forth). The results yield much higher numbers than those provided by law enforcement records. For example, in 2015, NCVS data revealed that about 369,000 women (and almost 63,000 men) in the United States reported having experienced rape, attempted rape, or forced sexual contact (Bureau of Justice Statistics, 2016c). This yields a rate of 226 sexual assaults per 100,000 women—considerably higher than the rate of 39 sexual assaults reported by law enforcement for the same year.

The statistics we have presented are for a single year. What about lifetime prevalence? The most recent NISVS survey found that about 1 in 5 (or 20%) of all women and 1 in 50 (or 2%) of all men have been the victims of rape or attempted rape in their lifetimes (Breiding et al., 2014). Similarly, about 20% of women in college and 12% of girls in high school have been forced to have sexual intercourse when they did not want to (Eaton et al., 2012; Gavin et al., 2009; Gray, 2014).

15.4.1 Other Statistics

Women between 12 and 34 years of age are the most frequently reported victims of rape (Bureau of Justice Statistics, 2016b). However, *anyone can be a victim of rape*, including men (a topic we will discuss later in the chapter), children, the elderly, and the disabled. For example, approximately 66,000 non-institutionalized physically and/or mentally disabled men and women were sexually assaulted during 2013 (Harrell, 2015). Children are also vulnerable to assault. A study by the National Victims Center, which included both reported and unreported rapes, found that 29% of victims were under the age of 11. Karen Hanna of the National Victims Center says that young people are frequently the target of rape because "the youngest are the least likely to fight back and often don't realize they are victimized" (quoted in Sniffen, 1994). Even infants can be the victims of rape. In 2012, a California man was sentenced to 37 years in prison for raping his girlfriend's 5-month-old daughter. He had met the woman online and began to visit her in Missouri, where the abuse occurred over several months (Cheever, 2012). The infant's mother received a life sentence for her role in the assault (Mann, 2012). And in 2013, an Ohio man was executed by lethal injection for raping his girlfriend's 6-month-old daughter (who died during the assault) (Associated Press, 2013).

Similarly, although people 65 or older are less likely than other age groups to be sexually assaulted, thousands are raped each year. For example, approximately 9,700 women age 65 or older were sexually assaulted in 2015 (Bureau of Justice Statistics, 2016b). In fact, the grandmother of one of your textbook authors was raped by a teenager when she was 85 years old. Late one night, a young man broke into her house, forced her to take her clothes off, and then beat, tortured, and raped her over a 2-hour period. Sexual assaults of the elderly often occur in nursing homes or other residential care facilities (Rosen et al., 2010). The perpetrators are usually other residents, and assault is more likely to happen if the victim is physically or mentally impaired (e.g., non-ambulatory, suffering from dementia). These and other such instances serve as potent—and heartrending—reminders that anyone can be victimized. For that reason, it is very important that we take steps not only to protect ourselves from this type of crime but to ensure that vulnerable others are not victimized. We will consider ways to prevent rape later in this chapter.

For now, let us discuss a few more statistical "facts" about rape. First, contrary to the stranger rape scenario provided at the beginning of the chapter, most rapes do not occur in dark alleys located in "bad" parts of town. As illustrated in Table 15–1, most (over two thirds) of sexual assaults happen at home—either at the victim's own home or at the home of a friend, relative, or acquaintance (Planty et al., 2013; Sinozich & Langton, 2014). Rapes are less likely to happen at school or in other public areas.

Table 15–1 Where Do Sexual Assaults Happen?

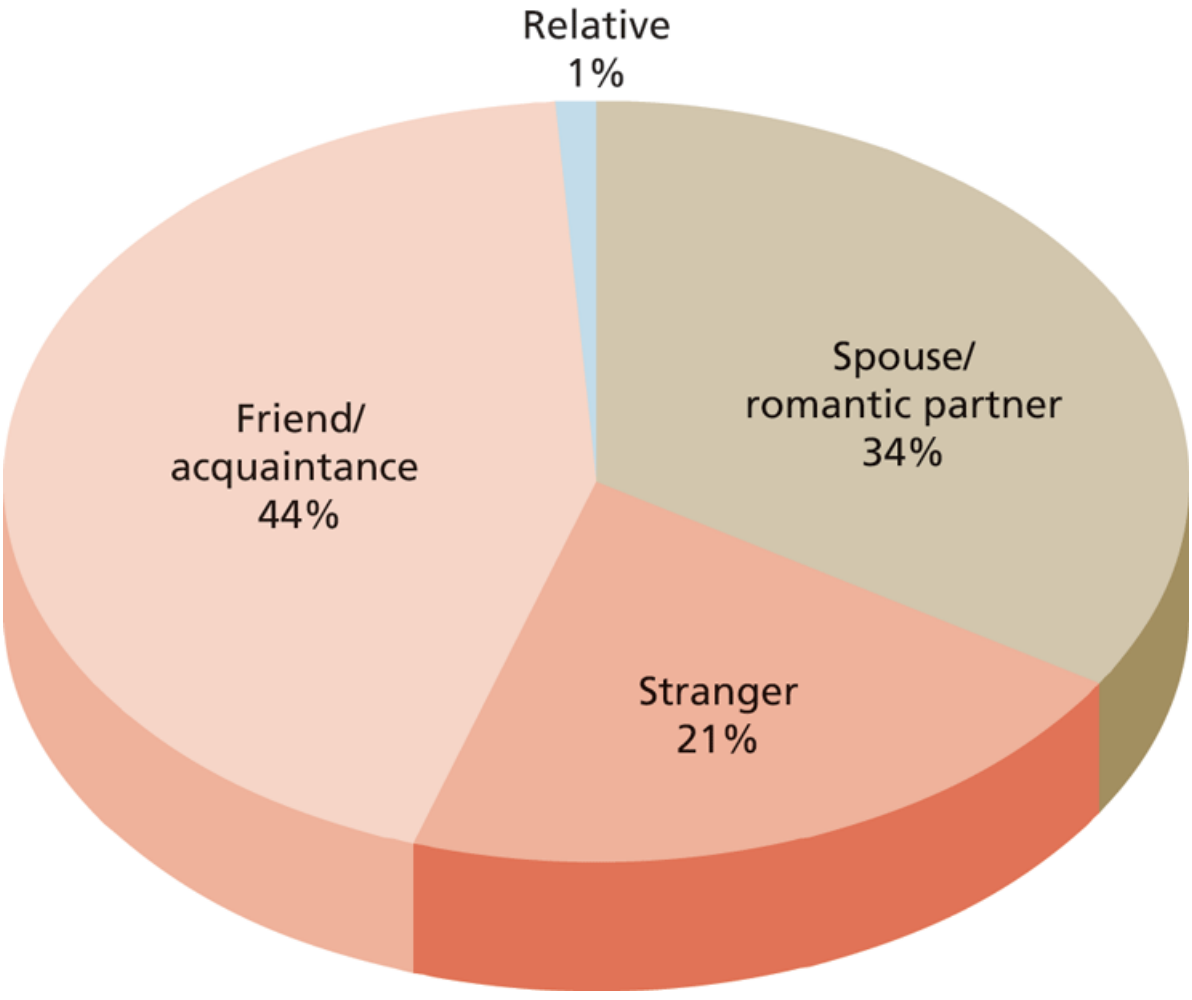
Location	Percent
At home	
At the victim's own home	67%
At the home of a friend, relative, acquaintance of the victim	12%
In an open area or on public transportation (e.g., park, field, playground, street, on a bus, in a train station, airport, or bus depot)	5%
In a commercial building, parking lot, or garage	10%
At school	8%

Source: Planty, M. et al. (2013). *Special report: Female victims of sexual violence, 1994–2010*. Bureau of Justice Statistics. Retrieved from http://bjs.gov/index.cfm?ty%3Dpbdetail%26iid%3D4594

Table 15–1 Full Alternative Text

Women are much more likely to report a rape if they are raped by a stranger; thus, most men convicted of rape generally are strangers to their victims. However, *most rapes are committed by someone the victim knows*. NCVS data for 2010 to 2015 indicate that only 21% of women were assaulted by a stranger; the rest (79%) were raped by someone they knew (Bureau of Justice Statistics, 2016d). Specifically, approximately 44% were victimized by an acquaintance, 34% by a spouse or romantic partner, and about 1% by a relative (see Figure 15–3). A national study conducted by the Centers for Disease Control and Prevention found a similar pattern (Black et al., 2011). The majority of rape victims were assaulted by someone they knew (a friend, acquaintance, romantic partner, or family member)—in fact, only 14% were raped by a stranger.

Figure 15–3



Relationship between rapists and their victims according to NCVS data for 2010–2015 (Bureau of Justice Statistics, 2016d).

Personal Reflections

Have you ever been the victim of a sexual assault? (We realize that this may be a difficult question to answer or even to think about.) If your answer is yes, did you report the assault to the police or anyone else? Why or why not? Were you worried about the consequences for yourself or your assailant, or the response you might receive from authorities? If your answer is no, do you know anyone who has been sexually assaulted? Did that person report the assault?

Types of Rape

1. 15.4 Describe and differentiate among different types of rape, including stranger rape, acquaintance rape, date rape, sexual coercion, marital rape, gang rape, and statutory rape.

Researchers often classify rapes according to various structural characteristics, including the motivation of the rapist and/or the relationship that exists between the rapist and the victim (e.g., stranger, acquaintance, spouse), the age of the victim (e.g., legally of age or underage), and the number of assailants. In this section of the chapter, we discuss different types of rape.

Stranger, Acquaintance, and Date Rape

We have already defined *stranger rape* as referring to a rape committed by someone the victim does not know. But remember that most rapes are committed by someone the victim knows, and many occur during or after social encounters (e.g., on a date). This type of rape often is called acquaintance or date rape. A recent survey of nine college campuses sponsored by the U.S. Department of Justice revealed that approximately 90% of undergraduate women who had been raped on campus knew their assailant—and he was a current or former friend, roommate, or dating partner or a casual acquaintance (Krebs et al., 2016; also see Sinozich & Langton, 2014).

Here are a few examples:

"I met this guy in one of my college classes. We had four very fun dates. We would go to movies, dancing, parties, and he would always act like a perfect gentleman. On our fifth date, he had a little too much to drink. Our friends dropped us at his apartment because he did not want to drive. I knew I was there for the night. I was not worried because he had always treated me with such respect. But that was soon to change. He became very aggressive with me. He told me he wanted to have sex with me because he cared for me so much. I begged him to leave me alone. I tried to fight him off, but I was not strong enough…. I was raped."

"Robby lived around the corner while I was growing up. I thought of him like a brother, so when I was 17 and he asked me if I was still a virgin, I was not embarrassed to tell him that I was. About a month later a bunch of us went out and after too much to drink, I passed out. I thought I was safe since I was with friends, but he made them leave and I woke up with his fat 270 pound body on top of me. It was horrible and I passed out again. There went 5½ years of friendship and trust."

"I had just started dating this guy. We were taking it slow, or so I thought. One afternoon, we were fooling around on the couch in his apartment, and he suddenly picked me up and started carrying me into the bedroom. We were still kissing and I was thinking 'what is happening here' then we were on the bed and he was on top of me pulling my skirt up. I was like 'oh no this can't be happening' and I tried to push him off and get him to look at me but he was so focused. I couldn't do anything to stop him. After awhile I stopped struggling and just waited for him to finish."

(All examples are from the authors' files.)

The expression *date rape*, though purely descriptive in intent, has turned out to be unfortunate because people often assume that it is somehow less harmful than rape by a stranger (see Krahé, 2000). People tend to attribute more blame, and are less sympathetic, to victims of date rape than to victims of stranger rape (Bridges & McGrail, 1989; Cowan, 2000). Even the victims themselves often are confused about how to interpret their assault. One national survey found that more than half of college women who were forcibly raped either did not consider their assault to have been rape or were unsure if they had been raped (Fisher et al., 2000). Students in our own classes sometimes exhibit the same confusion:

"I went out with this guy and he made me do oral sex on him. I didn't want to and I said no, but he just held my head down there until I did it. He didn't hurt me. That isn't rape, is it?"

"I don't love my boyfriend any more. I never did like our sex and now I never have those feelings for him. But every time I see him he expects it. It's not like he's raping me, but I wish he'd stop."

"Is it rape if we're engaged to be married? Usually I want to have intercourse when he does, but even if I don't, we do it anyway. He makes me. I don't think that's rape."

"During my freshman year in college I was home for Christmas break. Me and my high school friends all got together to celebrate New Year's. We hired some hotel rooms and we were drinking and having a really good time. I ended up alone with one of my best guy friends. We were talking on the sofa and he basically got on top of me, pulled up my dress, and pushed inside me. I guess it wasn't really rape because I didn't say stop even though I didn't want him to do it."

(All examples are from the authors' files.)

Many women do not regard sexual assault as rape unless the assailant was a stranger or there were high levels of violence (Bondurant, 2001; Kahn et al., 2003; Krahé, 2000). *We cannot emphasize enough that rape by a date or an acquaintance, with or without the presence of physical force, is no less real than rape by a stranger.*

How often are women forced into unwanted sexual activity during dates? One early survey of college men found that 26% admitted to having made forceful attempts at intercourse while on a date that had caused their partners to fight, cry, or scream (Kanin, 1967). Similar results were reported two decades later by Koss et al. (1987), who found that 25% of college men said they had used some form of sexual aggression on a dating partner (about 8% admitted actually having raped or attempted to rape a partner). A more recent study found that 18% of a sample of undergraduate men reported perpetrating some form of sexual violence on dating partners or acquaintances (with 6% admitting to forcible rape or

attempted rape; Gidycz et al., 2007). On the basis of this research, some scientists have proposed the concept of the opportunistic rapist (Prentky et al., 1988)—a person whose primary motivation for committing assault is sex (as opposed to an urge to hurt or dominate the victim) and who rapes impulsively when an opportunity arises. Opportunistic rapists may have distorted attitudes and beliefs about sex roles and female (and male) behavior that negate normal social inhibitions and probably account for the majority of date rapes.

Very few date or acquaintance rapes are ever reported to the police (only about 5%), and nearly half of the victims have never told anyone (Koss et al., 1988). Victims of rape often blame themselves (a phenomenon we will discuss more thoroughly later in the chapter), and this is particularly true when the rape is committed by someone the victim knows.

"When I was 16 I was raped by four guys at a college frat party. In a way I still blame myself for being put in that position…. It was my fault for getting drunk. Especially at the age of 16. Guys take advantage of young 16-year-old girls."

"Exactly 6 months ago today, I was 'date raped.' Though before taking your course, I blamed myself, now I see it was him and not me who was in the wrong. I actually felt responsible and as if I had provoked it."

"I think it was probably my fault that it happened. I knew that he liked me, but I only agreed to go out with him because I had a crush on his best friend and I knew we'd spend the whole time talking about him (the guy I really liked). Stupid me, I end up alone in the front seat of the car with this guy forcing himself on me. Totally my fault—I should never have led him on."

"It happened at camp. This boy I knew came into my cabin when I was taking a nap. I woke up and he was already inside me. He held my mouth shut and after he told me he couldn't help himself because I was so sexy. When I look back I think that maybe he was right—I did flirt a lot and act older than I was."

"My mom says that nice girls don't get raped. If you act like a lady, guys will treat you like one. What she doesn't know is that I was raped at prom by my boyfriend. He said it was our special night. He got drunk and he took me behind the hotel and raped me. I was a virgin and I never told anyone because I thought it was something I did that made him treat me like that."

(All examples are from the authors' files.)

15.4.2 Sexual Coercion

Most people have no difficulty defining sex without consent of the partner as rape if the act involved physical force, violence, or the use of a weapon. But what about sex that occurs as the result of coercion? Sexual coercion refers to situations in which physically or verbally coercive tactics are used to gain sexual compliance from another person (Christopher, 2001; Muehlenhard et al., 1991). Some of our case examples above illustrate the use of *physically coercive tactics*—such as taking advantage of a partner who is asleep or unconscious or getting a partner heavily intoxicated in order to have sex. In 2006, almost half a million women reported having been raped while either unconscious or awake but incapacitated due to drugs or alcohol (Kilpatrick & McCauley, 2009). Indeed, one survey of college students found that 1 in 5 women (20%) had experienced an alcohol-related sexual assault (Howard et al., 2008). Unfortunately, victims are less likely to report an assault involving the use of alcohol (or any drugs) to authorities (Wolitzky-Taylor et al., 2011).

Since the 1990s, several drugs have become notorious for their use as "date rape drugs," which render victims unconscious, incapacitated, and usually with little to no memory for the events (including rape) that happen while under the drug's influence. These odorless, tasteless, and powerful tranquilizers include flunitrazepam or Rohypnol ("roofies"—now illegal in the United States), gamma hydroxybutyrate (GHB or "liquid ecstasy"), and ketamine ("special K"). Some rapists even use their own prescription medications (typically sleep aids or anti-anxiety drugs) to help them commit their assaults. For example, in August 2016, former NFL player and broadcaster Darren Sharper was sentenced to 20 years in prison for multiple counts of rape (as well as various drug charges). He would invite women to parties at his house, spike their drinks with the sleep aid zolpidem (Ambien, which has become known as the "new rape drug"), and sexually assault them. Because zolpidem takes effect rapidly and exits the body quickly, its presence is difficult to detect with drug testing. This, coupled with the drug's amnesia-like effects, makes it difficult to prosecute offenders.

Figure 15–4

Former NFL player Darren Sharper was convicted in 2016 of using prescription drugs to render women unconscious before sexually assaulting them.

Source: Southcreek Global/ZUMA Press, Inc./Alamy Stock Photo

Some of our case examples illustrate the use of *verbally coercive tactics*, such as making someone have sex by pleading, becoming angry, verbally threatening to end the relationship, making the other person feel guilty for refusing, or continuing to persist in the face of the other person's objections. Surveys of young adults reveal that men and women are equally likely to experience sexual coercion. About 8% of women and 7% of men report having engaged in unwanted sexual activities (e.g., oral, anal, and penile-vaginal intercourse) because their partners used verbal coercion (Kaestle, 2009).

Figure 15–5

Rubens' *The Rape of the Daughters of Leucippus* (1617), although a great work of art, has been criticized for glorifying rape.

Source: The Abduction of the Daughters of Leucippus by Castor and Pollux. Ca. 1618. Oil on canvas, 224 x 210.5 cm, Alte Pinakothek, Bayerische Staatsgemaeldesammlungen, Munich, G/Erich Lessing/Art Resource, New York

"Many times my boyfriend forced me into having sex when I didn't want to. He thought that kissing always led to sex and when I said 'No,' he would become very angry."

"Sometimes I would not be in the mood and he would say things like his balls would explode if I didn't let him, or that he'd leave me and find a better girlfriend. Usually I'd just give in because it was easier than continuing to argue."

"When I was a freshman, this guy I liked asked me to give him a back rub. I did, even though I was super naïve and nervous about doing it right. Then, he asked me to give him a hand job. I didn't want to—I had never even seen a penis in real life. But I did it because I liked him so much. One night later that week he came to my dorm room and said he wanted to have sex with me. He said if I cared for him, I'd do it, and we'd be closer. I wanted him to like me so I gave in."

(All examples are from the authors' files.)

Although some researchers have been criticized for calling experiences like these "rape," this is not the real issue. The real issue is whether it is permissible to have sex with people without their mutual and full (non-coerced, non-forced) consent, *and the answer to that is always "no."*

Personal Reflections

Have you ever used sexual coercion to have sex with someone when she or he did not want to? This includes (but is not limited to) purposely getting someone drunk to have sex; taking advantage of someone who was asleep, unconscious, or otherwise physically or mentally incapacitated; and using anger and/or threats to break up, put-downs, and other verbal tactics to get sex. If so, why do you suppose you acted like this? What effects might your behavior have had on those you coerced?

It is sometimes difficult to determine whether a sexual situation is fully consensual. For one thing, men and women differ in how they interpret many of the cues and behaviors that occur during dates and other social situations. Men are much more likely than women to assume that various interpersonal behaviors signal a desire for sex (see Abbey, 1982; Abbey & Melby, 1986; Zellman & Goodchilds, 1983). One study (Kowalski, 1993) found that men believed that a woman who performed any of the following behaviors either before or during a date with a man wanted to have sexual intercourse with him: accepted his invitation for a date, had dinner with him, maintained eye contact with him during the date, smiled at him during the date, allowed him to pay for dinner, and complimented him. Women, however, did not believe that those same behaviors signaled an interest in sex—they assumed the woman was just being friendly. Clearly, men and women do not always agree about the meaning or the significance of common dating behaviors. This lack of shared understanding may partly explain why some men force or coerce sex from their dating partners—they mistakenly believe that their partners are willing participants who also want sex.

"I have sometimes had to work a little harder to get a woman in the mood, but that's not rape. That's seduction. Trust me, if a woman lets you take her out, flirts with you, sits close to you, lets you walk her to the door, she wants it. Women can't come right out and admit it, because they're afraid they'll look bad. I can always tell, though. If I'm walking her to the door, I know I'm getting some."

"I have never forced a woman to do anything she didn't want to. I did have a situation once that was kind of weird but it definitely wasn't rape. What happened was that I was at a party with this girl I knew and she was really coming on to me—laughing at everything I said, giggling, touching my arm, etc. Things were going great so when I finally got her alone I kissed her and we started to have sex. I think she had second thoughts at one point because she sort of struggled with me. But she didn't mean it because when I held her down to calm her she got real quiet and then once we got going again she enjoyed it. She wouldn't have gone with me in the first place if she didn't want to have sex."

"I raped a girl in college. At the time I didn't realize what I'd done. I thought it was consensual. We were drinking and I was hammered. I remember thinking she was hot. I got her back in my room and made a move on her. Got her clothes off and had sex. Passed out. Fast forward a year and I run into her at a reunion. She tells me that night changed her life. That she didn't want to be with me but I held her down, took her clothes off, and raped her. She had to go to therapy and is still messed up. I truly thought it was consensual."

(All examples are from the authors' files.)

Importance of Communication

Of course, the easiest way to resolve any misunderstanding is to openly and honestly communicate with each other. But this also poses a problem, as men and women often communicate poorly and inadequately when it comes to sex. Sometimes they fail to communicate at all about their intentions or desires. Research reveals that very few men and women explicitly and directly ask their partners for sex—instead, they tend to use indirect, nonverbal methods that can be misinterpreted or not noticed by the partner (see Regan, 2017). For example, a man who walks a woman to her door after a date and kisses her goodnight may believe that he is signaling his interest in having sex. His date, however, may simply think he is thanking her for a nice evening and that he would like to see her again.

In addition, people sometimes fail to accurately communicate their true intentions or wishes. Muehlenhard and her colleagues found that over one third of the college women they surveyed admitted to having engaged in token resistance—saying "no" when they meant "yes"—during sexual encounters (Muehlenhard & Hollabaugh, 1989; Muehlenhard et al., 1996). Another form of ambiguous communication is compliance—agreeing to sexual activity when you do not really want to (Vannier & O'Sullivan, 2010). Some studies have found that between 30% and 50% of women say that they have complied with a partner's sexual request when they did not want to (Shotland & Hunter, 1995; Sprecher et al., 1994b). Men who have had experiences with women who offer token resistance or who engage in compliance are likely to push ahead with another partner when she says "no." Clearly, it is very important for both men and women to directly and honestly communicate their true intentions to one another to avoid situations that can potentially lead to date rape.

Personal Reflections

Men: Have you ever ignored a date or acquaintance saying "no" to your sexual advances? Why?

Women: Have you ever said "no" to a date's or partner's sexual advances when you did not mean it? Why? If you answered "yes," what are some possible repercussions of your behavior? Is there a better way to communicate with others about your sexual desires?

Everyone: Have you ever been in a situation where you didn't communicate directly with a partner about your true sexual intentions or desires? Why do you think you did this—what prevented you from being open and direct? What do you think you could do in the future to be more direct with a partner?

The use of alcohol can further complicate interpersonal communication about sexual intentions (Abbey et al., 1998; Bernat et al., 1998). As we noted earlier in this section, alcohol and drugs are involved in many instances of date rape, with some surveys suggesting that about half of date rapists and their victims had been drinking before the attack (Ullman et al., 1999; see Noel et al., 2009). It is best to make a firm decision about your sexual behavior for a social occasion before it begins (and before you start to drink alcohol) and then to communicate your sexual intentions clearly and verbally to your partner. This will prevent some unwanted sexual experiences. It will not, of course, stop someone who would use force to have sex or who would take advantage of a defenseless (e.g., intoxicated) person. When this occurs, it is rape, and no less real than any other type of rape.

15.4.3 Marital (Intimate Partner) Rape

"In the fifth year of my marriage I was raped by my husband after a violent physical attack. He blamed me for the attack and also said it was my

obligation to provide sex whenever he desired it…. My marriage ended quite bitterly. For the last 3½ years I was blaming myself for what happened."

"I married when I was really young and it was an abusive relationship. My husband not only beat me but also raped me. The smallest thing would set him off, like the dinner was not cooked to his liking or I didn't answer him fast enough if he asked me a question. He would hit me with his fists or kick me. Many times he would then rip my clothes off and rape me. It only stopped when my parents figured out what was happening from the bruises and helped me get away from him."

"My ex-husband repeatedly had sex with me without my consent. Looking back, I believe our marriage was overall a good one except for that area. He wanted sex more often than I did, and he wanted to do things that I didn't like. I wasn't a battered wife by any means. The only time he ever laid a hand on me was for sex. I remember one camping trip we went on when we were first married. He wanted oral sex and I said no but he took my head and forced himself inside my mouth. This was basically how our sex life was. Whatever he wanted, whenever he wanted it, we did, and if I refused he made me. Over time I learned that it was best to give in."

"He made me have sex with his friends while he watched. He would force me to strip for them, give them lap dances, go down on them, and have sex with them, sometimes more than one at the same time. Writing this now, it seems unreal. How could this have happened to me? I'm a smart, educated, strong woman. But it happened. The first time, I thought he was kidding, and I laughed. He slapped me so hard that I actually bounced off the wall. From there on, it just got worse. It seemed the more I cried, the more excited he got. It's like he enjoyed watching me humiliate myself. It was horrible. I am in therapy but still have nightmares about the things he made me do."

(All examples are from the authors' files.)

In the 17th century, a chief justice of England named Sir Matthew Hale wrote, "The husband cannot be guilty of rape committed by himself upon his lawful wife. For by their mutual consent and contract, the wife hath given herself up in this kind." This idea found its way into the American system of justice (which is based on British common law) where it became part of the criminal code in the 1950s. Called the *marital rape exemption*, this doctrine stated that marriage implied "a kind of generalized consent" from a wife to a husband's sexual demands and that behavior from a husband that resembled rape therefore was different from the actual crime of rape. This doctrine was adopted by all states, most of whom interpreted it to mean that a husband could not be prosecuted for the rape of his wife. In the 1970s, Nebraska became the first state to abolish the marital rape exemption, and other states eventually followed. Finally, in 1993, marital rape (nonconsensual sex in which the perpetrator is the victim's spouse) became a crime in all 50 states and the District of Columbia. However, it remains one of the most difficult crimes to prosecute, in part because many states impose stringent restrictions on the filing of spousal rape charges (such as requiring the wife to have an existing restraining order against her husband at the time of the attack or requiring evidence of extraordinary violence).

Researchers who study sexual violence in marriage (and other long-term, committed romantic relationships) have identified three different kinds of marital or intimate partner rape, each with its own characteristic features (see Finkelhor & Yllö, 1985; Groth, 1979; Monson & Langhinrichsen-Rohling, 1998; also see Marshall & Holtzworth-Munroe, 2002). The first, *battering rape* (also called *anger rape*), occurs in the context of domestic abuse. The victim experiences forced sex as well as physical violence and coercive control from her spouse. In these relationships, the perpetrator engages in multiple forms of aggression and often uses sex as a means to express anger and hurt the partner. This type of marital rape is illustrated in the first and second case examples above.

The second type of marital sexual assault is *force-only rape* (or *power rape*). Force-only rape typically does not involve severe physical violence—the perpetrator generally is not physically abusive but will use force or coercion to obtain sex from an unwilling partner. This type of marital rape is illustrated in the third case example. Here, the perpetrator's intent is not to cause harm (although injury can result from the assault) but to control the couple's sexual interactions and to exert dominance over the partner.

Sadistic rape (also called *obsessive rape*) is much less common than the other two forms of marital rape and is motivated by a sadistic desire to sexually torment and mistreat the partner. The perpetrator is obsessed with forcing the partner to engage in degrading, deviant, and painful sexual activities. An obsessive rapist gets a great deal of pleasure from a partner's humiliation and is willing to use physical violence to achieve these sexual goals. The final case example we provided above illustrates this type of intimate partner rape. The section on sexual sadism disorder in Chapter 14 may be helpful in understanding this type of rapist.

Interestingly, studies of convicted (often serial) rapists have also provided evidence for the existence of these three types of assault pattern—although the victims are usually strangers as opposed to romantic partners (see Groth et al., 1977). Many of these rapists can be classified according to whether their underlying motivation for committing sexual assault stems from anger, power, or sadism (see McCabe & Wauchope, 2005; Pardue & Arrigo, 2008).

Personal Reflections

Do you ever use sex to express power, dominance, control, or anger—to a stranger or an intimate partner? If so, under what circumstances? Why do you think you use sex as an outlet for these desires and emotions?

It is difficult to obtain reliable estimates about the prevalence of marital/intimate partner rape, but surveys reveal that about 10% to 14% of married women (and about half of battered wives) in the United States have been victims (Martin et al., 2007). These rapes tend to be more physically violent than rapes by acquaintances (Finkelhor & Yllö, 1985; Stermac et al., 2001) and often involve the use of drugs or alcohol by the perpetrator (Coker et al., 2000). Estimates are even more difficult to obtain in other countries, in part because many do not recognize marital rape as a crime and thus those assaults are not documented by authorities (see Box 15–A).

15.4.4 Gang Rape

In December 2012, the world was stunned by reports of the vicious (and ultimately murderous) rape of a 23-year-old physiotherapy student in the Indian city of New Delhi. After seeing a movie, the young woman and her male companion had boarded a bus for the return trip home. During the ride, the man was beaten and injured, and the young woman was raped by each of the six other passengers (including the driver) and penetrated with an iron bar. Both were then thrown from the bus and left on the road. Despite multiple surgeries, the internal injuries caused by the rape were so severe that the victim died 12 days later (see "Delhi gang-rape victim dies," December 28, 2012). (On April 2, 2013, in response to widespread public pressure, the Indian government passed a law imposing harsher sentences for perpetrators of gang rape. Unfortunately, these measures do not appear to have been effective at stopping gang rape and other forms of sexual violence; see Perry & Pokharel, 2016).

Figure 15–6

Students in New Delhi gather to protest against sexual violence and demand justice for recent rape victims.

Source: Sajjad Hussain /AAFP/Getty Images

Gang rape refers to cases in which a victim is assaulted by more than one attacker. Sadly, this type of sexual violence against women is common in many parts of the world (see Box 15–A). In the United States, about 10% of rape victims are assaulted by multiple (two or more) assailants (Planty et al., 2013). Some gang rapes are committed on college campuses by members of fraternities (within which there is often an emphasis on heavy drinking and machismo, and a higher likelihood of rape myth acceptance [see later section]; Sanday, 1990; McMahon, 2010).

"When I was 16, I was a very attractive and rebellious teenager. One Friday night my friends and I decided to go to a fraternity party. I did some drugs and I drank a lot of alcohol. I danced with a lot of guys and then a guy that I liked for some time asked me to dance. We danced for some time and he finally asked me to go to a little private party in the back room. When we went into the room, I saw four of his friends standing around a bed. The guy I was with started to kiss me while his friends began removing my clothes. I tried resisting, but with five pairs of hands holding me, it didn't do much good. After they each had a turn, they just left me there and told me if I told anyone, that they would kill me."

"I was raped by three guys at a frat party. My roommate and I had been invited to join the sister sorority and we were both excited to be going to our first big party. We were all having a good time, drinking and dancing. I ended up going with this cute guy to the game room in the back of the house to play pool. When we got there, these two other guys were there and one of them said we should play a different game. The guy I was with picked me up and put me on the pool table and started kissing me. I tried to get off but he was pushing against me and my legs were trapped. He pushed my skirt up and got on top of me and it was awful. Then his two friends did it. I was crying and I lay there until they were gone."

(All examples are from the authors' files.)

Gang rapes often have a dynamic of their own. Individuals acting alone may not be capable of sexual assault, but being a member of a group often creates special circumstances in which feelings of personal responsibility and accountability for one's actions are lost (O'Sullivan, 1991). A person who commits rape with the cooperation and involvement of other assailants can evade or diffuse responsibility ("After all, it isn't like I'm the only one doing it") and even justify his actions ("They're all doing it, so it must be okay"). Furthermore, taking part in gang rape may be a way of demonstrating loyalty to the group, and hesitant individuals may decide to take part in order not to be seen as cowards (Sanday, 1990).

"I'm not proud of what I did and looking back I can't explain it. I got into college on a football scholarship. Small school, nothing that would lead to a career, but those guys were still the big men on campus, you know? Everyone loved them, and I was the new kid and I wanted them to like

me. After my first game, there was a party at [name withheld]'s house. There was this townie there—cute, totally star struck, excited to be there. I was hanging out when one of the guys I had become friendly with told me he had something to show me. He took me to a bedroom and there was the townie, lying on the bed with another player on top of her. I could see she was crying, her makeup was running all down her face. I stood there, and I guess I was in shock because I didn't do anything when my friend started in on her. Then he said it was my turn. I should have left but I didn't. I don't know why, maybe because I wanted to fit in with them."

(from the authors' files)

Perpetrators of gang rape are more likely to be strangers to the victim than single perpetrators of rape, and gang rapes tend to be more violent and cause more injury to the victim than rapes committed by individuals (Morgan et al., 2012). This may partly be due to the dynamics that develop within groups; specifically, each individual member loses inhibitions and may feel challenged to outdo the others (Gidycz & Koss, 1990). They may even bait one another into hideously shocking acts, as the savage rape we mentioned in the opening to this section demonstrates.

15.4.5 Statutory Rape

All states in the United States have laws addressing sexual activity involving minors (children). In addition, many states have laws that specifically address the crime of statutory rape, sometimes referred to as *carnal knowledge of a juvenile*. These laws make it illegal for an adult to have sexual intercourse with anyone under the *legal age of consent*, even if that person has consented to the activity. Across states in the United States, the age at which a person is considered legally competent to consent to sex ranges from 16 to 18. (Around the world, the age of consent varies more widely, ranging from 12 in some countries to 20 in others.) The rationale behind these laws is that underage individuals are not capable of giving informed consent to sex because they are not yet able to fully comprehend the meaning and consequences of sexual relations. Thus, these laws are designed to protect children and adolescents from being taken advantage of by older individuals. With the increasing numbers of sexually active adolescents, many states have also implemented *Romeo and Juliet laws*, which protect teenagers who have consensual sex with other, slightly younger teenagers from being charged with statutory rape, as long as the two are within a certain age gap. Thus, a 17-year-old boy who has sex with his 15-year-old girlfriend has not committed statutory rape; however, a 25-year-old man who has sex with his 15-year-old girlfriend has.

Both men and women can—and do—commit statutory rape. However, there appears to be a double standard with respect to how society treats male versus female perpetrators. Situations involving adult men who engage in sexual acts with minors generally are met with social outrage and the perpetrators are often prosecuted (see later section, "Sexual Abuse of Children"). But when the perpetrator is an adult woman who victimizes an adolescent boy, the law takes a different stance. There are multiple documented instances (in Arizona, California, Kansas, Ohio, for example) in which teenage boys have been ordered to pay child support when the women who molested them became pregnant and had children (see Smith, 2014). This double standard essentially re-victimizes these young men.

Statutory rape laws often apply to mentally disabled individuals as well as juveniles. A landmark case was the Glen Ridge gang rape. In 1989, seven teenagers were arrested in Glen Ridge, New Jersey, for enticing a mentally impaired 17-year-old girl to have sex. In addition to intercourse, she was assaulted with a stick, a broom handle, and a miniature baseball bat. Although the victim allegedly agreed to have sex and had been sexually active since the age of 12, the defendants were convicted after the prosecution showed that she had an IQ of 64 and the social skills of an 8-year-old and thus could not fully understand her actions. Remember, engaging in sexual activities with someone who cannot legally consent (or resist)—whether due to age, physical incapacitation, or cognitive or mental impairment—is assault.

Same-Sex Rape and Coercion

1. 15.5 Discuss the topic of same-sex sexual assault. Explain why reliable estimates of the prevalence of this type of assault are hard to find. Discuss the characteristic features of male rape.

"A man can't be raped. It's a well-known fact."

"Only a woman can get raped."

"There is no such thing as a female rapist."

"A man who gets raped is probably gay. Even if he thinks he's straight, he's probably not."

"Only a gay guy would rape another guy. Seriously."

(All examples are from the authors' files.)

These comments, made by several students in our classes, reveal some common (and inaccurate) beliefs about rape, including the notions that only women can be raped, that men cannot be raped, and that only gay men can be victims and/or perpetrators of male rape (see McGee et al., 2011; Turchik & Edwards, 2012). It is definitely the case that most sexual assaults involve a male perpetrator and a female victim. However, rape and coercion can and do occur between same-sex individuals, irrespective of those persons' sexual orientation. Thus, women can be assaulted by other women and men can be assaulted by other men (and also by women). And a homosexual (or heterosexual) person can be assaulted by a homosexual (or heterosexual) person.

Crime data on same-sex assaults is limited because—as we have discussed—the FBI only recently expanded its definition of rape beyond male-to-female forced vaginal intercourse. National surveys, though, reveal that instances of women being raped by other women are relatively uncommon in the general population. For example, only 6 out of 1,000 female respondents in Laumann et al.'s (1994) survey reported having ever been forced by another woman into unwanted sexual activity. Rates of female same-sex assault are higher among prisoners, with about 7% of female prison inmates reporting having been sexually assaulted by another inmate and an additional 2% reporting victimization by prison staff (Beck et al., 2013).

Estimates of male rape (rape in which the victim is male) are particularly difficult to obtain, in part because so few men are willing to report their assaults to the authorities. However, national victimization surveys reveal that almost 2% of men (or nearly 2 million men) reported having experienced rape or attempted rape in their lifetime (Black et al., 2011; Breiding et al., 2014). In 2015, approximately 63,000 men in the United States reported having been the victims of some form of sexual assault (Bureau of Justice Statistics, 2016c). This yields a rate of 40 sexual assaults per 100,000 men.

Male rape shares some commonalities with male-to-female rape. First, like women, men tend to be raped by men. Second, and again like women, men are more likely to be assaulted by someone they know than by a stranger. In 2015, only 22% of male rape victims were assaulted by a stranger; the rest (78%) were raped by a friend or acquaintance (Bureau of Justice Statistics, 2016d). However, male rape victims are more likely than female rape victims to have been raped during childhood. In fact, the majority of male victims are under the age of 19 at the time of their assault (Choudhary et al., 2012).

"I am a 24-year-old male. I am writing this because I feel it can help others in my situation. At 9 years of age, I was raped by three friends. They invited me in[to] their house to play 'strip poker.' I didn't know how to play, so I lost my shirt. Last, but not least, my underwear came off. At this point, the oldest, aged 16, told me to play with his penis. I refused and he punched me in the face. I started to cry and he hit me over and over. I still remember the look on his face. Well, anyway, they all took their penises and proceeded to rape me. I still have nightmares about it. I still remember the blood, the pain, and the shame. What happened to them? Nothing. I never told anyone until this year."

"When I was in 6th grade, my best friend (he was older by two grades) and I used to masturbate together. We weren't gay, we liked girls, but we were curious about our bodies and how they were changing. I don't remember whose idea it was but one day we masturbated each other. We did that for awhile. Then one day he said we should try something different, that he'd heard grown ups did. He told me to suck his penis. I didn't want to but he said he'd flatten me if I didn't. After that, I had to do it almost every time. Except one day he didn't make me do it. Instead, he raped me. We were naked and he was wrestling with me and shoving me around on the bed. I was under him, facing away, and I felt him pushing into me. I remember how much it hurt and thinking that it was wrong though at the time I didn't realize that I had been raped."

(All examples are from the authors' files.)

Among adult men, sexual assault is more common in some populations than others. For example, men who identify as gay or bisexual tend to experience particularly high rates of sexual victimization. Approximately 12% to 40% of gay or bisexual men report having been physically forced or coerced into unwanted intercourse, many by a partner (see Peterson et al., 2011). High rates are also found among prisoners. Although most male prisoners are not raped (Turchik & Edwards, 2012), prison remains an environment in which adult men are more likely to experience sexual assault at the hands of other men. Recent national crime statistics reveal that 13% of men in jail or prison reported having been sexually assaulted at least once during the past 12 months by another inmate. Most (92%) of these men were non-heterosexual (i.e., homosexual or bisexual) (Beck et al., 2013). Regardless of their own sexual orientation, men who are raped in prison often have multiple assailants (i.e., they experience gang rape), and those assailants are usually heterosexual (Cotton & Groth, 1982).

15.5.1 Can a Man Be Raped (Sexually Assaulted) by a Woman?

"Men can't be raped by women. Rape is a male act against women, not a female act against men."

"It's physically impossible for a woman to rape a man. It just wouldn't work."

"I do not think that a man can get raped by a woman. Not unless he secretly wants to be. His penis wouldn't respond unless he actually wanted to have sex with her."

(All examples are from the authors' files.)

Despite the beliefs expressed in the comments from our students, the answer to the question posed above is "yes." There are, in fact, many ways in which a man can be sexually assaulted by a woman. He can be penetrated anally by the woman with a finger or other object, he can be forced or coerced into giving or receiving oral sex, or he can be forced or coerced into vaginally or anally penetrating a woman with his penis.

Box 15–A Cross-Cultural Perspectives

Sexual Assault Around the World

1. 15.6 Discuss laws pertaining to and prevalence of sexual assault around the world. Explain the factors that seem important in predicting the amount of sexual violence that exists in a particular culture and the best way to reduce sexual violence.

We have focused most of our discussion of the topics included in this chapter on the United States. However, sexual assault is not limited to the United States—in fact, sexual violence toward women occurs with even greater frequency in many other parts of the world. This is particularly true in countries with a patriarchal cultural orientation that emphasizes strict gender roles, glorifies male dominance and aggression, and promotes the subservient status of women. These countries typically adopt a highly restrictive attitude toward female sexuality (see Chapter 11, Box 11–C) while at the same time encouraging male sexual harassment and exploitation of women. Not surprisingly, they also tend to exhibit the highest rates of sexual assault. For example, South Africa has the dubious distinction of being known as "the rape capital of the world," with an estimated 600,000 rapes occurring annually. According to Interpol, a woman is raped every 17 seconds and about half of all women will be raped at least once in their lifetime. This means that a woman living in South Africa has a greater chance of being raped than of learning to read. A large community survey conducted by Rachel Jewkes of South Africa's Medical Research Council (Jewkes et al., 2009) revealed that almost 30% of men had committed rape, with about 10% stating that they had participated in gang rape. Most rapists (73%) had committed their first sexual assault before the age of 20, and approximately half (46%) reported that they had raped multiple women.

It is important to recognize that accurate information about the prevalence of sexual assault in many countries—particularly patriarchal, sexually traditional ones—is difficult, if not impossible, to obtain. This is because some forms of sexual violence against women are not considered to be crimes. For example, marital rape is a crime in North America, South America, and Western Europe. However, a man is legally entitled to rape his wife in approximately 40 other countries in Africa (e.g., Kenya, Uganda, Nigeria), the Middle East (e.g., Iran, Jordan, Saudi Arabia), and Asia (e.g., Pakistan, Afghanistan, China). A community survey of more than 1,100 married women in China revealed that almost one third (32%) had been forced to have intercourse by their husbands, usually repeatedly and over a period of 5 or more years; of those women, 40% had experienced physical injury as a result of the rape(s) (Parish et al., 2007). Even higher estimates have been reported by other researchers. A national survey in Zimbabwe found that 78% of married women had been forced to have sex by their husbands (Feldman & Maposherre, 2003). In some countries, marital rape is illegal only if the wife is under a certain age (e.g., younger than 13 in Singapore, younger than 15 in India). And in other countries (e.g., Lebanon, Malta), a man cannot be prosecuted for rape if he subsequently marries his female victim.

Rape is even used as a punishment in some parts of the world. In 2002, a village council in Pakistan ordered that 30-year-old Mukhtar Mai be gang raped because her preteen brother was suspected of having had relations with a girl from a rival clan (Mai's brother was also raped—shortly after the accusation, he was kidnapped and sodomized by three men from the rival clan). Mai refused to be silent about her assault, and she has since become a crusader for women's rights in Pakistan and around the globe (Moreau & Hussain, 2005). Unfortunately, assaults like the one Mai experienced continue to occur. In 2014, village elders in a community in India ordered the gang rape of a young woman (who was seriously injured during the assault) because she was in a relationship with a man from a different community (Smith, 2014).

Even in places where (non-marital) rape can be prosecuted, many rape victims are afraid to come forward because they fear they will be blamed for the attack. Those fears are justified. In Islamic countries and other areas of the world, victims of rape are regarded as "dishonored" and are cast out by their communities— or worse. In Somalia, 13-year-old Aisha Duhulow was raped by three men while traveling on foot to visit her grandmother. She sought protection from local authorities, who instead charged her with adultery and sentenced her to death under Sharia (Islamic) law. Aisha was taken to a football stadium, buried up to her neck in the middle of the field, and then stoned to death by 50 men in front of a crowd of spectators ("Rape victim stoned to death," November 4, 2008). Victim-blaming is especially common—and harsh—in cultures that do not place a high premium on gender equality and the prevention of sexual assault. Is it any wonder that many rape victims stay silent?

Researchers, human rights advocates, and many policy makers believe that the sexual victimization of women will remain prevalent in any country that is marked by a rigid gender hierarchy and ideas of manhood that center on violence and sexual entitlement. We know that sexual assault is much less likely to occur in cultures that place a high value on the contributions of women, emphasize cooperation and equality between men and women, and explicitly attempt to raise boys to be non-aggressive (see Watson-Franke, 2002). Education—about sexuality, about ethical treatment of others (both sexually and nonsexually), and about gender equality—may be our best hope for reducing sexual victimization in our own country and around the world. Such education must begin early. What type of values will you teach your children?

Many people have difficulty believing that a man can be made to get an erection, especially while experiencing fear, terror, disgust, lack of desire,

and other unpleasant emotions, but it does happen. Sarrel and Masters (1982) reported several instances in which men had been kidnapped by a woman or a group of women who then forced them (often with use of a weapon) to engage in sexual intercourse. Indeed, almost 4% of the men who participated in a recent national survey reported having been physically forced to sexually penetrate a woman; an additional 5% said they had been coerced into performing unwanted sexual intercourse with a woman (Black et al., 2011; also see Breiding et al., 2014). Similar rates are found among high school students, with 5% of boys reporting having been forced to have intercourse when they did not want to (Eaton et al., 2012).

"It happened in my dorm. We were having a party and I had met up with this girl I was friends with. We were hanging out in my room listening to music and doing shots before going down to the party. She leaned over and kissed me and even though I didn't like her that way I was kind of drunk and one thing led to another. Then she started to unbuckle my belt. This snapped me out of it and I pushed her off and said something about not ruining our friendship. She stopped and made some joke and we did more shots. I must have really been out of it because the next thing I remember is me flat on my back with my pants down and her on top of me having sex. I did not want this to happen. For a long time after I was worried I'd gotten an STD."

"I am a firm believer that if you are too drunk to give consent then you should not take advantage of someone or be taken advantage of. I personally have been in a situation where I was too inebriated to consent. A girl I had known had taken advantage of me while I was at a party. I woke up naked, passed out in a bathroom. When I used to tell people my story, I would get mixed messages. Some people would validate my betrayal, and most other guys would laugh it off. The majority of the time people were confused as to how my penis functioned if I 'didn't want it.' I realized at a very young age that men suffer from sexist stereotypes just as much as women. Although men are expected to take control of sex, there needs to be an equality in blame. You should not allow yourself to lose consciousness, and you should not take advantage of someone who has lost control of themselves. We need to bring awareness to the dangers of nonconsensual sex regardless of your gender."

"I have been raped by my wife. She is a good person but with many mental problems. On two occasions she has hurt me by putting the handle of a wooden spoon inside my anus. Both times when I was asleep. I do not want to tell anyone. I am ashamed of this."

"I work really long hours and I'm a full-time student. I'm too tired for sex. I tell this to my girlfriend, but she thinks I need to 'man up and do my duty.' She will keep on carping at me until I agree. If I can't get an erection, she'll work me with her mouth or hand until I'm hard enough to have intercourse. I do it until she comes and then I stop. Usually I don't even finish myself. I definitely don't enjoy myself and I would rather not do it."

(All examples are from the authors' files.)

Women themselves report using coercion and force at times to make their partners comply with their sexual demands (see Anderson & Struckman-Johnson, 1998; Muehlenhard & Cook, 1988; Struckman-Johnson et al., 2003). In fact, Muehlenhard (1998) found that nearly as many men as women had been the victims of sexual coercion. However, there is an important difference: The coercion used by men is often physical, whereas the coercion used by women is generally verbal (see also Larimer et al., 1999; Próspero & Fawson, 2010).

Male victims of rape often suffer long-term problems similar to those of female rape victims (see "Reactions to Rape"). In addition, many male victims report feeling guilt or that something is wrong with them, because they were able to physically respond under sexually coercive or forced circumstances (Masters, 1986; Sarrel & Masters, 1982). However, research shows that erections and ejaculations are only partially under voluntary control and can occur in the absence of desire or physical pleasure under times of extreme duress (Bullock & Beckson, 2011). *We wish to reiterate in this section that anyone can be sexually victimized and that victims are not to blame for their assaults.* Simply because a man is physically able to get an erection and perform intercourse even to the point of ejaculation does not mean that he wants to engage in this activity or that it is consensual.

Factors Associated with Rape

1. 15.7 Identify and explain the different factors associated with rape.

Rape is a complex phenomenon that undoubtedly is associated with many variables and that stems from multiple sources. Comprehensive reviews of the sexual assault literature as well as large-scale empirical investigations have identified a number of factors that may serve to encourage or inhibit the likelihood of rape perpetration (see Gannon & Ward, 2008). In general, these factors can be divided into three broad classes or categories: personal factors, interpersonal factors, and environmental (social/cultural/evolutionary) factors (see Table 15–2).

15.7.1 Personal Factors

With respect to personal factors, we have already discussed the fact that biological sex is associated with rape—most perpetrators are male and most victims are female. In addition, men and women also differ in their perceptions and beliefs about rape. For example, when asked to evaluate scenarios depicting date rape, men usually view the female victim as being more sexually willing than do women. Moreover, men also believe that the female victim is more responsible for the rape, and that the male assailant's behavior is more justified, than do women (for a review, see van der Bruggen & Grubb, 2014).

Other personal or disposition characteristics, including the extent to which people subscribe to and enact traditional gender roles, also are associated with sexual coercion and rape. Hypergender is defined as the dispositional tendency to endorse and rigidly adhere to exaggerated gender role stereotypes. Men with high levels of *hypermasculinity* believe that violence is manly, that danger and risky behavior are exciting, that dominance and competition are appropriate ways of interacting with other people, that emotion and cooperation (and other "feminine" attributes) are inappropriate and unmanly, and that women are sexual objects (Burk et al., 2004; Corprew et al., 2014; Mosher & Sirkin, 1984). Women with high levels of *hyperfemininity* define themselves by their ability to attract and hold a man, have traditional views of women as socially and economically subordinate to men, view themselves as sexual objects, value stereotypically "masculine" behavior on the part of men, and endorse the use of their own sexuality, physical attributes, and "femininity" to influence men (Murnen & Byrne, 1991; Nowatzki & Morry, 2009). Table 15–3 provides some examples of items from commonly used scales for measuring hypergender. Hypermasculine men and hyperfeminine women typically agree with these (and other) statements.

Table 15–3 Some Items That Measure the Sexual Beliefs Associated with Hypergender (Adherence to Extreme and Exaggerated Gender Role Stereotypes)

Hypergender	Sample Items (Sexual Beliefs)
Hypermasculinity	• Get a woman drunk, high, or hot and she'll let you do whatever you want • Prick teasers should be raped • Any man who is a man needs to have sex regularly • You have to fuck some women before they know who's boss • Some women are good for only one thing
Hyperfemininity	• I would have sex with a man if I thought I could get him to do what I want • I sometimes say "no" but really mean "yes" • Men need sex more than women do • A "real" man is one who can get any woman to have sex with him • I sometimes promise to have sex with a man to make sure he stays interested in me • It's okay for a man to be a little forceful to get sex • When a man I'm with gets really sexually excited, it's no use trying to stop him from getting what he wants

Sources: (1) Mosher, D. L., & Sirkin, M. (1984). Measuring a macho personality constellation. *Journal of Research in Personality, 18,* 150–163. (2) Murnen, S. K., & Byrne, D. (1991). Hyperfemininity: Measurement and initial validation of the construct. *The Journal of Sex Research, 28,* 479–489.

Table 15–3 Full Alternative Text

Given the nature of these items, you probably will not be surprised to learn that research consistently finds that hypermasculine men respond positively to rape depictions, report a higher likelihood of committing rape in the future, and are more likely to actually have sexually assaulted their partners than non-hypermasculine men. Similarly, hyperfeminine women have a less negative reaction to rape depictions and report experiencing more sexual coercion than non-hyperfeminine women (for a review, see Regan, 2017).

In addition to demographic (e.g., biological sex) and dispositional (e.g., hypergender) factors, research conducted with convicted rapists as well as community and college samples of men who report perpetrating sexual assault or coercion reveal that most possess a particular set of attitudinal and cognitive characteristics. These include "heteronormative" attitudes and beliefs about sex roles and male and female behavior (e.g., that men are entitled to sex, that men should dominate women sexually), strong acceptance of rape myths (see later section in this chapter), acceptance of violence toward women, and denial of personal responsibility for their own actions (e.g., Eaton & Matamala, 2014; Polaschek & Gannon, 2004; Ryan, 2004; Ward et al., 2007). Men who physically force sex on women also tend to objectify women (viewing them as no more than an object or body part) and to possess hostile attitudes toward them (see DeGue et al., 2010; Hipp et al., 2015; Murnen et al., 2002). Moreover, most rapists lack empathy—the ability to see things from the victim's perspective (Abbey, 2005; Marshall, 1996). Instead, many are able to see things only from their own distorted perspective—believing, for example, that their victims wanted to have sex with them or deserved to be raped (Blumenthal et al., 1999).

What other personal factors are linked with the likelihood of committing rape? Studies show that most convicted rapists are young men of low(er) socioeconomic status. The large majority of them are no different from men convicted of other crimes in terms of IQ, psychiatric illness, and other personality variables (see Gannon & Ward, 2008).

There is also no compelling evidence to show that rapists, in general, are either oversexed or sexually deprived. Although a few studies have found higher than normal levels of testosterone in sex offenders, this appears to be the case only for the most aggressive offenders (Studer et al., 2005). And other studies have shown that many rapists have regular access to sexual partners (wives or girlfriends) with whom they live (Groth & Burgess, 1977).

Men who commit rape are, however, more sexually aroused than non-rapists by rape-related stimuli. Early phallometric studies (in which erectile responses to sexual stimuli are measured) consistently showed that, compared to other men, rapists became more sexually aroused while listening to audiotapes of rape and less sexually aroused while listening to tapes of consensual sex (Abel et al., 1977; Barbaree et al., 1979; Quinsey et al.,

1984). More recent research reveals that it is not the presence of violence or victim injury that most rapists find arousing but rather the absence of the victim's active consent to sex (see Harris et al., 2012). Only that subset of rapists known as *sexual sadists* (see section on marital rape and also the discussion in Chapter 14 about sexual sadism) becomes aroused by rape stimuli involving violence and victim injury (Lalumière & Quinsey, 1994; Seto et al., 2012). In the real world, these men are likely to become aroused by watching violent pornography, especially while drinking (Davis et al., 2006). In fact, many rapists (not just sexually sadistic ones) have a history of drug or alcohol abuse and also report having been drinking prior to the assault (Davis et al., 2008; Looman et al., 2004; Seto & Barbaree, 1995).

15.7.2 Interpersonal Factors

In the section on acquaintance and date rape, we discussed some interpersonal factors that may contribute to sexual coercion and assault. Recall that people often fail to clearly and directly communicate their intentions and wishes about sexual activity, and that both men and women often misinterpret each other's behavior in sexual (or potentially sexual) situations (e.g., assuming sexual interest when no such interest is present, or assuming lack of sexual interest when interest is actually present). Misinterpretation, token resistance, compliance, and other indirect and ambiguous forms of sexual communication increase the chances of sexual victimization (see Krahé et al., 2000).

Within existing relationships, power differentials or inequities may also serve as risk factors for sexual coercion and rape. For example, some romantic relationships are characterized by marked asymmetry of influence, where one partner has much more influence (socially, financially, behaviorally, etc.) on the other. In those relationships, the power is not evenly distributed, and this can create a situation in which one person feels more entitled to sex (as well as other things). Coercive, nonconsensual, or forcible sex therefore may occur—because the less powerful partner feels unable to refuse or resist.

What about the family relationships and developmental history of rapists? Comparisons of adult and adolescent sex offenders with non–sex offenders consistently find that the groups differ on several major interpersonal/developmental factors, including parental neglect and sexual (and other forms of) abuse (Latzman et al., 2011; Prentky et al., 1989; Seto & Lalumière, 2010). Specifically, unusually high numbers of sex offenders were themselves emotionally, physically, or sexually abused as children, were neglected by their caregivers, and/or were raised in a family environment that included abuse by the father directed at the mother. In addition, they often report early exposure to sexual violence (directly among family members or indirectly through the viewing of violent pornography [Kjellgren et al., 2010; Seto & Lalumière, 2010]). With this type of developmental history, a child or adolescent may well come to view aggression toward women (or men) and coercive or forced sexual activity as "normal."

15.7.3 Environmental (Social and Cultural) Factors

We have already identified some environmental (sociocultural) factors that are associated with sexual assault. For example, in college, peer pressure to gain sexual experience, to drink heavily, and to participate in the campus "party culture" may increase men's likelihood of perpetrating sexual coercion or rape as well as women's vulnerability to sexual victimization. Recall that on college campuses, rape (particularly gang rape) is more likely to be committed by men who belong to "male only" groups (e.g., fraternities, organized athletics) that emphasize heavy drinking and adherence to hypermasculine gender roles.

The fact that sexual assault appears to be a fairly common college experience has forced many institutions to reexamine their policies and reaffirm their commitment to providing a safe campus climate. In 2014, the University of Montana in Missoula came under federal scrutiny (along with 54 other colleges and universities) for the way campus administrators dealt with instances of sexual assault—many involving women who had been raped by football players, another male-only group that emphasizes masculinity and group loyalty (Gray, 2014). More recently, in 2016, the members of the men's soccer team at Harvard University were suspended from competition when an investigation revealed that they participated in a yearly ritual (shared via email and publicly archived) in which they sexually ranked the new freshman members of the women's soccer team by assigning them numbers and potential sexual positions (Pearce, 2016). Group rituals such as this may increase the likelihood that a man will view the objectification and sexual coercion of women as acceptable—and perhaps act on those beliefs.

Another potent sociocultural factor that is implicated in rape concerns the media. Television shows, movies, and advertisements commonly make use of sexually coercive and/or violent imagery (a topic we will explore in greater detail in Chapter 16). Exposure to such imagery may promote a social or cultural climate that is accepting of nonconsensual sexual activity as well as other forms of inappropriate sexual conduct. Indeed, researchers have found that viewing even short music video clips that sexually objectify women increases both men's and women's tendency to blame female victims of sexual harassment (Bernard et al., 2016).

Figure 15–7

Rape often has an immediate impact on, as well as long-lasting consequences for, the victim. If you have ever been a victim of sexual assault, just listening to a lecture about the topic can bring back bad memories and upsetting emotions.

Source: Science source

Similarly, take another look at Box 15–A and the earlier section on marital rape. Why is the incidence of rape so much higher in some countries than in others? Why do some cultures refuse to criminalize rape at all, allow husbands to rape their wives, or use rape as a way to punish women? Studies have found that rape is most common in societies that glorify violence by men, particularly when the society is also sexually repressive (Baron et al., 1987; Sanday, 1981). These societies not only encourage boys to be aggressive, but have distinct gender roles for men and women, with men regarding women's roles as inferior. In many world cultures (including our own), the stereotypic gender role for men with respect to sexuality is "active, aggressive, thrusting and powerful," whereas the stereotype gender role for women with respect to sexuality is "passive, powerless, submissive and receptive" (Moore, 1994). Many theorists believe that the way in which boys and girls, and men and women, are socialized to accept and adopt these traditional sexual scripts creates a culture that supports and condones male sexual violence against women (Burt, 1980; Byers, 1996; Mosher & Anderson, 1986; also see Mugweni et al., 2012).

15.7.4 War Rape

Instances of war rape (rape that is committed by soldiers, combatants, or civilians during times of war, armed conflict, or military occupation) provide a particularly chilling example of the way in which social factors are implicated in sexual assault. Throughout history, men of victorious armies have raped the women of defeated nations (see Gottschall, 2004). For example, when the Japanese army invaded China in 1937, the soldiers raped virtually every woman and girl in the wartime capital of Nanking. Sadly, such acts continue to occur today. International news media and human rights organizations have documented recent cases of war rape in African conflict zones (e.g., the Sudan, Democratic Republic of the Congo) as well as in other world regions experiencing political unrest (e.g., Columbia, Afghanistan, Chechnya). For example, in 2014, almost 300 girls (some as young as 12) were kidnapped from a school in Chibok, Nigeria, by members of the terrorist organization Boko Haram (see Human Rights Watch, 2014). The reason? To destabilize the Nigerian government and force a return to so-called traditional Islamic values (which, according to Boko Haram leaders, forbid the education of women). In the ensuing months and years of their captivity, the girls have been sold as slaves and into prostitution (for an average of $10), forced into marriage with their captors, and regularly sexually assaulted (in one [failed] hostage negotiation, the "proof of life" provided by the kidnappers was video footage of several girls being raped). Some were murdered, and most have not been rescued.

Theorists suggest that actions such as these—in which the men from one group systematically victimize girls and women affiliated with men from another group—occur in patriarchal cultures in part because they serve to demonstrate power and to destroy the national, regional, or ethnic pride, manhood, and honor of the vanquished (or targeted) group (Brownmiller, 1993). Scholars observe that as women are the creators (through reproduction) and the nurturers of family and community, the victimization of women by invading forces is a particularly potent means of destabilizing communities, exerting social control, and displacing the targeted group—particularly in societies that place a high value on male honor and pride.

Other Environmental (Evolutionary) Factors

Some theorists have focused on a different type of environmental factor in attempting to explain rape—specifically, the physical and social environment in which the minds (and bodies) of our earliest human ancestors evolved (e.g., Thornhill & Thornhill, 1992; Thornhill & Palmer, 2000). Basically, these evolutionary theorists posit that ancestral men who actively pursued sexual opportunities and had sex with many partners had higher reproductive success (produced more offspring who survived to sexual maturity) than men who did not. Consequently, the propensity to pursue sexual opportunities (sometimes persistently, coercively, and aggressively) became part of men's evolved mating psychology (because ancestral men who lacked this propensity did not produce as many offspring and, essentially, died out). This view has remained controversial, partly because it is impossible to go back in time, examine the ancestral environment, and test these evolutionary ideas and partly because so many people misinterpret the ideas themselves (for example, as saying that men have a "rape gene," that rape is "natural," or that men are "programmed" to commit rape).

In a thoughtful review, Jones (1999) pointed out that evolutionary theory does not argue that there is a gene responsible for directly heritable features specific to rape, that men are naturally rapists, or that sexual aggression is part of our "heritage." Rather, this theory suggests that rape is possibly a byproduct of other preferences and behaviors that were adaptive for humans in the ancestral environment. For example, "If eager pursuit of possible sex partners on average increases reproductive success, and if such pursuit occasionally results in non-consensual sex … then rape behavior could be a byproduct of a psychology evolved by direct selection to pursue eagerly, and persist in obtaining, possible sex partners (p. 857)" In evaluating this perspective, it is important to remember that evolutionary theorists believe that humans are fundamentally social animals, and that the human mind was designed above all else to prefer and seek out cooperative, mutual, and positive interactions and relationships with other humans (see Cosmides & Tooby, 1997; Regan, 2002). In fact, this may explain why most men (and women) do *not* commit sexual (or other forms of) assault and why all forms of assault tend to produce serious and harmful psychological consequences for the victims.

Table 15–2 Variables Associated with Sexual Assault

Category	Individual Variables

Personal Factors	• Biological sex
	• Hypergender
	• Attitudes and beliefs
	  ◦ hostility toward women
	  ◦ objectification of women
	  ◦ belief in acceptability of violence toward women
	  ◦ denial of personal responsibility for actions
	  ◦ lack of empathy and perspective taking
	• Sexual arousal to rape-related stimuli
	• Antisocial/dominance personality
	• Alcohol and drug use or abuse

Interpersonal Factors	• Power differences or inequity between partners
	• Domestic abuse
	• Sexual (mis)communication
	  ◦ indirect, nonverbal, ambiguous disclosures or actions
	  ◦ token resistance
	  ◦ compliance
	• Family/developmental history
	  ◦ exposure to sexual violence
	  ◦ exposure to neglect or physical abuse
	  ◦ exposure to inter-parental abuse

Environmental Factors	• Peer pressure • Membership in hypergendered "male-only" groups (e.g., fraternities, athletics) • Media (exposure to sexually exploitative and aggressive imagery) • Social or cultural norms, customs, and laws that promote gender inequity, male sexual dominance and privilege, and male aggression • (Possible byproduct of) evolutionary processes associated with reproductive success in ancestral environment

Table 15–2 Full Alternative Text

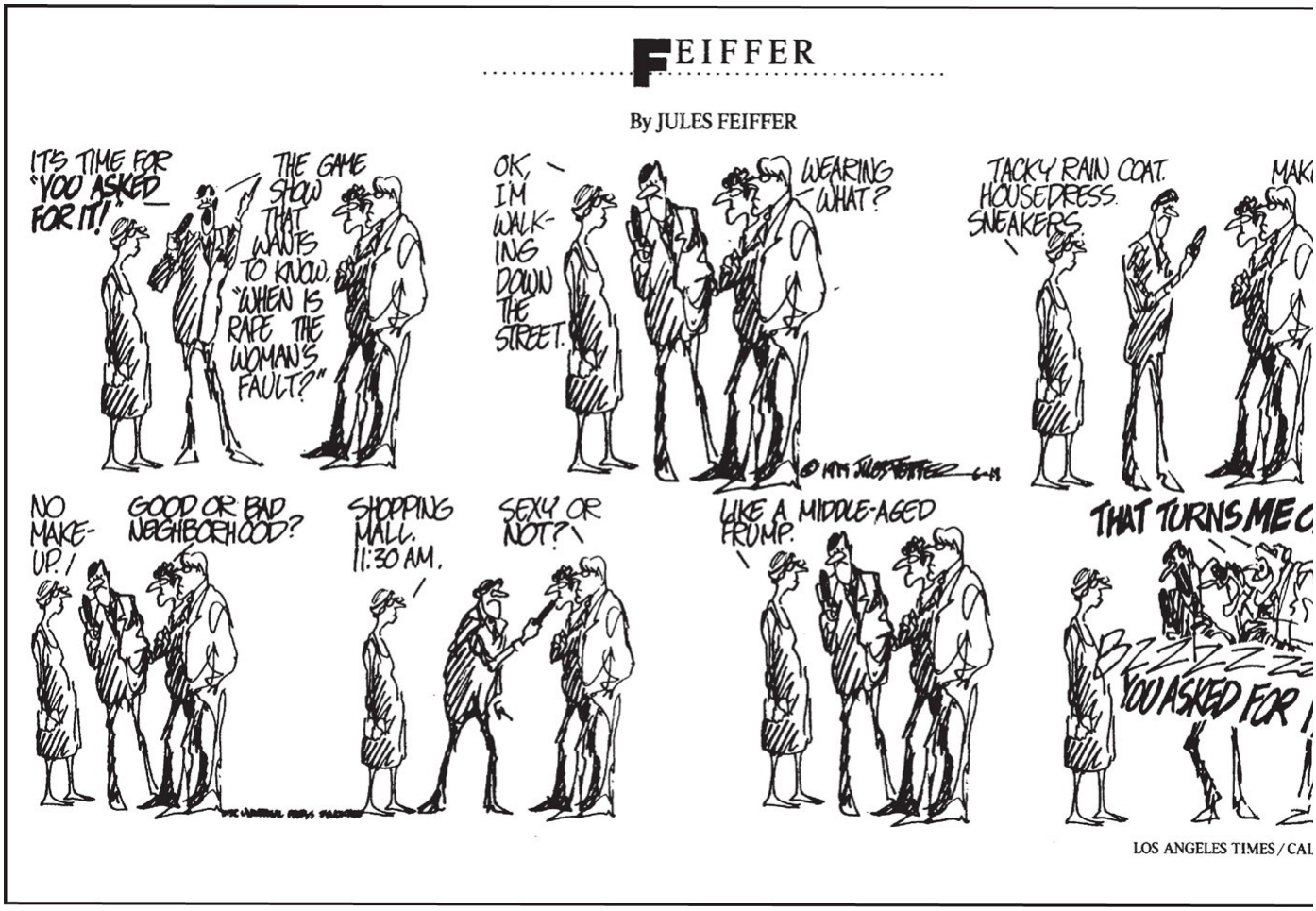
Putting All the Factors Together

As you have seen, scientists have targeted many different factors in their efforts to understand rape—where it comes from and why rapists commit their crimes. Today, it is generally acknowledged that no one factor can be said to definitely produce sexual assault and that there are multiple paths to sexual aggression.

Some theorists have attempted to put these various factors together and provide a comprehensive theory of rape. Malamuth and colleagues were among the first to do so (Malamuth, 1986; Malamuth et al., 1993; Malamuth & Malamuth, 1999). They proposed that sexual aggression or "rape proneness" results from several converging factors: evolution (resulting in different mating strategies for men and women, as discussed above), environmental and developmental variables (e.g., culture, early socialization, family environment, peer influence), and current dispositional tendencies and situational dynamics. According to this model, each of these factors can serve to inhibit or encourage sexual aggression. For example, the likelihood of sexual aggression is highest among men with a developmental history involving harsh and exploitative interactions at home and among peers (e.g., abuse, violence), who have a promiscuous and impersonal orientation toward sex, who possess antisocial and dominance-oriented personality traits, who hold hostile and defensive attitudes toward women (and receive satisfaction from dominating and controlling women), and who have a history of frequent alcohol and pornography use.

Marshall and Barbaree (1990) offered another integrated model that is very similar except that it gives greater importance to early developmental factors (e.g., abuse, family violence) that result in an inability to inhibit aggressive behavior. Both theories acknowledge the importance of situational cues and socially created inhibitors. How important are these factors? Recall the research that found that (convicted) rapists, but not non-rapists, were sexually aroused by listening to tapes of or viewing rape scenes (see the section on characteristics of rapists). Are there any situations in which "normal" men might also respond to rape scenes, becoming aroused as rapists do? Barbaree and Marshall (1991) found that many men could become aroused by rape scenes when they had been drinking—remember that most date rapes occur when the man or both people have been drinking (Ullman et al., 1999). Barbaree's team also found that normal men's reactions to rape scenes became more like those of rapists if a woman had made them angry just before testing (this was done purposely as part of the research). How might these men behave if they incorrectly believed that a woman had "led them on"? As Barbaree concluded, "With the right combination of factors, most men can be aroused by violent sex" (cited in Goleman, 1992).

More recently, Ward and Beech (2008) have proposed a theory of rape that integrates three causal factors: brain development (evolution and genetics); social/cultural environment and personal circumstances; and "three core neuropsychological factors (i.e., the motivational, emotional, action selection/control, and perception/memory systems)." Although these integrated theories differ in some respects, the important point is that scientists now agree that rape and other forms of sexual assault have multiple causes.



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Description

Rape Myths

1. 15.8 Identify several myths about rape and explain why they are not true.

By this point in the chapter, you have probably learned some facts about rapes and rapists that have challenged the beliefs you held before enrolling in the course. Mistaken beliefs about rape are so widespread that they are often referred to as rape myths (Burt, 1980; Chapleau et al., 2008). These myths serve the function of placing the blame on the victims and justifying the actions of the perpetrator. In general, men are more accepting of rape myths than women (Johnson et al., 1997; Jones et al., 1998; McGee et al., 2011; for a review, see Edwards et al., 2011). This is particularly the case for men who accept conservative gender-role stereotypes as well as for those who associate power with sex (Chapleau & Oswald, 2010). Let us examine some of these incorrect beliefs about rape.

Myth 1: Women Who Are Raped Usually Provoked the Attack by Their Dress and Behavior.

Many people, including some women, believe that date rape is acceptable if a woman engages in certain behaviors (Gibbs, 1991; Monroe et al., 1990). Studies conducted over the past 30 years consistently show that about one third to one half of respondents believe that a woman was at least partially to blame for rape if she wore a short skirt or tight top or went braless, went to the man's home or room, or was drinking alcohol (Burt, 1980; Goodchilds & Zellman, 1984; McGee et al., 2011; Monroe et al., 1990; for a review, see Thomas et al., 2015). As a result, many rape victims blame themselves.

"I still don't know exactly who to blame. I know that some of the blame goes to the guys who did it [the gang rape], but I do still feel that some of the blame should be placed on me because I was drinking."

"I guess maybe it was my fault or at least partially my fault because I agreed to go with him when I didn't even like him. If I had never gone to his apartment in the first place, he wouldn't have had the chance to rape me."

"When I told my mom what happened, she said that she was sorry but maybe this would teach me to cover up more in the future. She said that if you put it out there for boys to see, they can't help wanting to touch it."

(All examples are from the authors' files.)

These attitudes are learned early in life. For example, a survey was taken of 1,700 seventh to ninth graders (Kikuchi, 1988). Opinions about male behavior toward a woman on a date included the following:

- 29% of the boys and 20% of the girls said that a man has a right to force his date to have sexual intercourse if she has had sexual intercourse with other men.
- 22% of the boys and 10% of the girls said that a man has the right to have sexual intercourse without the woman's consent if he had spent a lot of money on her.
- 48% of the boys believed that it was okay for a man to force a date to have sexual intercourse if she let him touch her above the waist.

Rape myth acceptance has important consequences. When rape cases go to trial, jurors who believe in rape myths are less likely than others to vote for conviction (Gray, 2006; Schutte & Hosch, 1997). A jury in Ft. Lauderdale, Florida, acquitted a homeless man on trial for rape because his victim was wearing a lace miniskirt at the time. The jury foreman was quoted as saying, "She asked for it." The man was a serial rapist who was later convicted of another rape.

This tendency to blame rape victims for their assaults seems particularly odd considering that we do not tend to blame victims of other crimes for their circumstances. Our first thought after hearing about a store robbery is usually not "I wonder what the store owner did to deserve this." When we hear about a carjacking or child abduction, do we automatically assume that the vehicle owner was doing something to provoke the crime or that the child is to blame for his or her kidnapping? Were the people who were injured when the bomb exploded during the Boston Marathon in April 2013 "asking for it"? How about those hurt in the September 2016 bombing in New York?

Rape is about the behavior of the perpetrator, not the victim. So, if you have ever thought that it is women's behavior that leads to rape, please stop for a moment and reexamine your attitude.

Personal Reflections

Is a man entitled to sexual intercourse when a woman agrees to go out with him or because he spent money on her or because she went to his house or apartment or because she kissed him or made out with him? Men: If you answered "yes," do you communicate these expectations to your dates before you go out?

Myths 2 and 3: Women Subconsciously Want to Be Raped; No Woman Can Be Raped if She Truly Does Not Want to Be.

These two closely related ideas are also widely believed (Burt, 1980; Holcomb et al., 1991). Although many women have submission fantasies, this does not mean that they actually wish to be raped (see Chapter 11, Sexual Fantasies). In fact, recall that the typical female submission fantasy involves an attractive man who finds the woman irresistible, masterfully overcomes her initial reluctance by arousing her, and then makes

passionate, orgasmic love to her. Most women do not fantasize about realistic rape scenarios (most men don't either). And even if they did, this does not mean that they harbor a secret desire to actually experience this. Most of us have fantasized about things we would never do in real life; the difference between fantasy and reality is that we are in control of our fantasies. Real rape involves someone else taking away all of your control.

Related to the myth that women subconsciously wish to be raped is the notion that a man cannot penetrate a woman unless she cooperates and holds still (thus, a woman who gets raped must have cooperated). This notion is encapsulated in the phrase, commonly applied to sexual assault, that "you can't thread a moving needle." Sadly, even judges are not immune to this misguided assumption. During a 2014 rape trial in Canada, judge Robin Camp asked the 19-year-old victim (who was assaulted during a house party), "Why couldn't you just keep your knees together … so he couldn't penetrate you?" He then acquitted the defendant. (This ruling was subsequently overturned, a new trial was scheduled, and Camp himself came under review by the Canadian Judicial Council for his comments and handling of the case).

Recall that force is not a necessary condition for sexual assault—a woman may be raped while unconscious, incapacitated, and/or frightened or coerced into passivity. Moreover, most rapists are bigger and stronger than their victims, some use a weapon, and a good number of assaults involve more than one perpetrator (see Planty et al., 2013). Finally, in our culture (as in many others), men typically are reinforced for being active, competitive, and assertive while growing up, while women typically are reinforced for being cooperative and passive. The end result is that most women would not even know how to fight back if they were assaulted. In a nutshell, women do not secretly wish to be raped, and the presence or absence of physical force on the part of the perpetrator and physical resistance on the part of the victim cannot be used to determine whether sexual assault "really" occurred.

Figure 15–8

Most communities now offer rape crisis counseling.

Source: Dana White Productions/PhotoEdit, Inc.

Myth 4: Women Frequently Make False Accusations of Rape.

The false accusations of rape by a stripper against some members of the Duke University lacrosse team in 2006 reinforced many people's beliefs that women frequently lie about being raped. However, analysis of national and local (e.g., university) crime statistics shows that the percentage of reported rapes that are false is actually lower (around 2% to 6%) than for most other crimes (see Lisak et al., 2010). We do not automatically doubt people when they claim that they were the victim of some other type of crime. So why do you suppose some people are so quick to doubt a woman's accusation of rape? Many researchers blame the legal system and the media (news, television, movies), both of which have a long history of perpetuating the notion that women lie about being raped (see Edwards et al., 2011).

Reactions to Rape

1. 15.9 Describe post-rape posttraumatic stress disorder and other reactions to rape.

The opening quotation of this chapter observes that sexual violence harms not only the victim but all those who care about her (or him) as well as society as a whole. In this section, we examine common reactions to rape, always keeping in mind that not every individual affected by sexual violence will respond in the same way.

By the Victim

In their initial reactions and long-term coping strategies, many victims of rape go through a form of posttraumatic stress disorder (Boeschen et al., 1998; Foa & Riggs, 1995; van der Walt et al., 2014). Formerly called *rape trauma syndrome* (Burgess & Holmstrom, 1974), this group of clinical symptoms is now referred to as post-rape posttraumatic stress disorder (or simply posttraumatic stress disorder [PTSD]). First, victims experience an *acute phase,* which begins right after the rape and typically continues for several weeks. During this phase, the victim's body has to recover from the physical damage that may have been caused by the rape. About half of all forcible rape victims suffer minor to severe injuries, ranging from cuts and bruises to internal injuries, broken bones, gunshot wounds, or genital trauma (Planty et al., 2013; Thomas et al., 2015). In addition, the victim must begin to recover from the psychological damage that was done (Arata & Burkhart, 1996; Rynd, 1987). Some victims become very expressive about their feelings and may cry and experience severe depression, become angry or fearful, and/or experience great anxiety. Others may have what is called a controlled reaction, as if they were trying to deny that the rape had affected them in any way. However, these victims must also work through a great deal of anguish and may become expressive later. Many rape victims experience dissociative symptoms (restricted affect, detachment from other people, concentration problems) (Foa & Riggs, 1995). Moreover, those victims who believed rape myths prior to their rape may subsequently experience guilt and self-blame, which makes the depression even worse (Weiss, 2009). Because the trauma for many victims is long-term, rape victims may well be referred to as *rape survivors*.

"The lectures on rape were traumatic for me because I could remember everything so vividly. But I stuck with the lecture so I could find out if it was my fault. Now I don't feel as dirty."

"Physically, I am healed. Mentally, I am not. I still struggle with depression. I cry for no apparent reason and I have problems sleeping. I'm afraid in situations where I wasn't afraid before. I survived but I'm not whole yet. I don't know if I ever will be."

(All examples are from the authors' files.)

Next, the victim enters a *period of long-term reorganization*. In this stage, the rape victim attempts to regain control of her or his life (including taking steps to prevent rape from occurring again) and may move or change jobs. Each of us wants to believe that our world is a relatively safe, secure, and predictable place and to feel that we have control over our lives and what happens to us. This belief allows us to reduce our fears and anxieties about the world so that we can function efficiently and effectively in it. However, when a violent crime such as rape is committed, our belief system is shaken and our security is threatened. Rape victims often feel as if they no longer have any control over what is going to happen to them. Many of the reactions to rape are attempts by victims to reassert control over their lives.

"After I got over the initial trauma of what had happened to me, I realized that I had to do something to change my life. I got a security system, and I made arrangements with a friend to carpool to work. I took self-defense classes and I carry pepper spray. I never go out alone at night unless I have my dog with me. I move purposefully—I look around and I'm alert. I refuse to be a victim. This is my life and no one will ever mess with it again."

(from the authors' files)

Many victims lose their desire for sex and have trouble becoming sexually aroused (Burgess & Holmstrom, 1979; Gilbert & Cunningham, 1987). They may find it difficult to trust others and to enter into romantic/sexual relationships. Reread the stories of the two young women who were gang raped. Here are some of their long-term reactions to the assaults they experienced:

"I talked to other rape victims and I worked through my guilt and blame. I still have a lot of fears about sexual relationships and have not had a sexual relationship since I was raped."

"After, it was hard for me to get close to anyone. When I finally did meet someone, it took me a long time to be okay with the sexual part of our relationship. We would start to get intimate and then my thoughts would flash back to the pool table and my body would shut down."

(All examples are from the authors' files.)

Other victims have long-term psychological problems or begin engaging in high-risk behaviors, including having multiple sexual partners (Howard & Wang, 2005; Lang et al., 2011; Ullman, 1996). With rape victims who initially suppress their feelings, it is not unusual for symptoms to emerge months or even years after the incident:

"The first thing I went and did after your class today was run to my car and cry for a half hour. Fourteen years ago I was raped."

(from the authors' files)

Unfortunately, some victims of sexual abuse are later revictimized. Research has revealed that a sizable minority of rape victims have been sexually assaulted before (Acierno et al., 1999; Cohen & Roth, 1987; Ellis et al., 1982; Turchik et al., 2009).

"When growing up, I was raped by five males in my neighborhood…. The speaker and your lectures helped me to realize that it wasn't my fault…. Recently, I was raped again … and it was very traumatic to me. When I told a close friend of mine, she reacted as if I had done it. She just couldn't understand how it could happen to me twice, and to be honest, neither can I."

(from the authors' files)

Studies have found that some (though by no means all) people attribute greater blame to a repeat victim than to a first-time victim, regarding her as the type of person to get herself into rape situations (Schult & Schneider, 1991). Counseling to eliminate self-blame thus is very important for repeat victims.

Just like female victims, male victims of rape also suffer long-term psychological consequences (Peterson et al., 2011; Walker et al., 2005; Weiss, 2010). If their assailant was another man, male victims are also likely to experience some doubts about their sexual self-identity (Peterson et al., 2011).

"I worried a lot about my masculinity. What kind of man gets raped? This is the question I asked myself. Was there something about me that was attracting other men? It took me a long time and the support of my wife and friends to come to the realization that the rape was not about me giving off some homosexual or feminine vibe."

(from the authors' files)

Recovery is made even more difficult because male victims are even less likely than female victims to tell anyone else and thus are less likely to seek counseling. Those men who do report their assault run the risk of an additional negative consequence—revictimization by a system that is designed to assist female victims and that often does not recognize that men, too, can be sexually assaulted:

"I was raped in the parking lot after I'd been out clubbing. Even worse than the attack was the way I was treated by the cops after I called them. They didn't believe me. There were two of them and they kept looking at each other and saying stuff like was I sure, maybe this was a misunderstanding, maybe I'd had too much to drink and things had gotten out of hand with my boyfriend. I told them that I wasn't gay, that I had a girlfriend and I'd been attacked but they smiled like yeah right. I was hurt, I was freaked out, and all they did was humiliate me. I wish I'd never reported it."

(from the authors' files)

Sexual assault has both immediate and lasting consequences and can negatively impact all areas of a victim's life—regardless of who that victim is.

Personal Reflections

Have you ever been the victim of rape or sexual coercion? If so, has it affected how you feel about yourself and your relationship with others? If it has affected you in any way (including leaving you with any sense of self-blame), have you ever sought counseling? If you have not sought counseling, why not?

By Significant Others

A rape victim's significant others—partner, friends, and family—must also deal with their reactions and emotions. It is very important that they recognize the legitimacy of the victim's reactions to the assault and respond in a supportive and empathetic manner. What types of support are most likely to help? Research suggests that of all the various types of support we can provide to partners in need, *emotional support*—support that conveys empathy, warmth, understanding, concern, and nurturance—is the most likely to alleviate distress (see Regan, 2017). We can provide emotional support in a number of ways: by verbally expressing care and concern for the victim, by providing opportunities for the victim to express her (or his) feelings, and by offering supportive companionship (by being there when we are needed). It can be difficult to put our own feelings aside when someone we care about has been victimized, but focusing on ourselves and our own feelings and reactions, rather than on those of the person in need, is not beneficial.

Perhaps the most devastating thing that can happen to a rape victim *after* the attack is if her partner, friends, and/or family members blame her, perhaps because they believe in rape myths. This makes recovery all the more difficult (Davis et al., 1991).

"My girlfriend … about 1 year ago (3 years into the relationship) was walking alone on her college campus and was violently raped. I somehow held her responsible for 'letting' this happen to her. Both her parents also blamed her. I know I treated her with a little less respect after this happened. Now I feel like a complete schmuck. I realize that she had no control over what happened. Fortunately, her therapist convinced her that it was not her fault."

"I am ashamed to admit that I broke up with my girlfriend after she told me she'd been raped during a vacation she took with her friends. At the time I told her that I believed her, but I lied. I figured that she'd done something to put herself in that situation or that she'd hooked up with someone and was afraid I'd find out so she made up a story. I pretended to be on her side, but as soon as I could, I broke up with her. I now know this was the wrong way to behave."

(All examples are from the authors' files.)

If someone you care about is ever the victim of rape, do not ask questions such as "Why did you have to go there?" or "Why were you out so late?" or "What were you wearing?" Questions like these imply that the rape must have somehow been the victim's fault. Instead, think of ways

you can show the victim that you are available to help in whatever way you can. And consider therapy. Both victims and their partners often find counseling very useful in learning how to cope with rape.

What Happens When a Rape Is Reported?

In most metropolitan areas, the police department has special units for dealing with rape victims. The investigation of the case will be carried out by a detective from a rape investigation unit. Most large cities now have *rape victim advocate programs* as well. These programs provide a specially trained counselor to be with the victim from the initial investigation through the prosecution. After the initial investigation, the victim is referred to a hospital for a medical exam.

As we have discussed, the majority of rape victims do not seek medical care after being assaulted (Resnick et al., 2000; Tjaden & Thoennes, 1998). However, to maximize the chance of a successful prosecution, it is very important to get a medical exam as soon as possible after a rape. It is crucial not to wash, douche, or change clothing after being raped, as doing so may destroy vital evidence (such as semen in the vagina) needed by the police to catch the rapist and prove that the crime was committed. The use of DNA evidence has substantially increased successful prosecution of rapists (Leinwand, 2009). Some victims are initially reluctant to prosecute but later change their minds. If a medical exam has taken place, this option is still available. Without such medical attention, a successful prosecution (or even an attempted prosecution) is less likely.

Box 15–B Sexuality and Health

Sexual Victimization, Pregnancy, and STIs

The majority of rape victims do not seek medical care after the attack (Resnick et al., 2000; Tjaden & Thoennes, 1998; Zinzow et al., 2012). But they should. In addition to the immediate physical trauma that may occur during rape, the victim of sexual abuse also faces the risk of pregnancy and/or sexually transmitted infection. One early national survey found that 5% of rape victims became pregnant as a result of their attack (Holmes et al., 1996). About 32,000 pregnancies a year result from the rape of women aged 18 and older, with even more pregnancies occurring from the rape of younger girls. Half of these pregnancies are terminated by abortion. Unfortunately, although medical organizations generally recommend that rape victims receive counseling about and provision of emergency contraceptives, many hospitals fail to follow these guidelines (see Patel et al., 2008, 2012).

In addition to pregnancy, sexual assault victims also run the risk of contracting STIs. Perhaps not surprisingly, STI rates are higher among victims of rape than among the general population. Some studies find infection rates of 33% or higher among victims seeking medical treatment, meaning that one third or more of rape victims test positive for at least one sexually transmitted infection (Beck-Sagué & Solomon, 1999; Glaser et al., 1991; Jenny et al., 1990; Jo et al., 2011). Among male sexual assault victims, rates of STIs are around 18% (see Peterson et al., 2011).

STIs are very common, so it is likely that not all of the infected victims in these studies had contracted the infections during rape. STIs that are found in the first 24 hours after the assault may represent preexisting conditions. Nevertheless, studies have verified that many rape victims do, in fact, acquire STIs at the time of the rape (Glaser et al., 1991; Jenny et al., 1990). For example, one group of researchers found an overall STI prevalence of 27% among a sample of female sexual assault victims who were virgins at the time of their attack; of those, 20% had contracted chlamydia, 5% had contracted gonorrhea, and 2% tested positive for cytomegalovirus (herpes virus) (Jo et al., 2011). As a result, medical organizations recommend that all rape victims be treated with a variety of medications shortly after the rape (e.g., Patel et al., 2008).

What about the possibility of becoming infected with HIV, the virus that causes AIDS, during a rape? The large majority of rape victims have fears about contracting HIV (Resnick, 2002). However, remember that it is difficult to spread HIV from person to person—and most AIDS experts believe that the chance of getting HIV during a rape is extremely low (Gostin et al., 1994). Chances are higher if genital injury occurs and if there are multiple, infected perpetrators or repeated assaults (as may occur within sexually violent marital or dating relationships; see Feldman & Maposhere, 2003; Watts et al., 2010).

To this point, we have considered only the immediate effects of rape. In the 30 years that follow childhood rape, victims are much more likely than others to have multiple sexually transmitted infections (Wilson & Widom, 2009).

Preventing Rape

In general, there are three basic perspectives or approaches regarding the prevention of rape. *The first approach focuses on the rapist* and primarily consists of legal deterrents to prevent rape. Malamuth (1981) found that many men indicated that they would commit rape if they were certain they would not get caught. An approach focusing on the rapist would call for more police officers on patrol, more lights in dark parking lots, tougher laws that are more rigorously enforced, more arrests, and longer prison sentences for rapists. However, this approach has been criticized for focusing too much on the symptom (rape behavior) and not enough on the underlying cause (the inclination to rape and the individual factors that support this predisposition). There is some evidence that certain kinds of therapy may reduce the likelihood that a rapist will re-offend. For example, several studies have found that male sex offenders who complete a cognitive-behavioral therapy program focused on managing their sexual arousal patterns, reducing their sexual preoccupation, and enhancing their self-regulation skills are less likely to commit another rape than offenders who do not receive such treatment (see Pullman & Seto, 2012). Unfortunately, most rapists do not receive any clinical help until they have already committed sexual assault; thus, as a preventive measure, this approach has limitations.

The second approach focuses on the potential victim. The first part of this approach involves decreasing the chances that a woman will be the target of a rape. Women are often urged to avoid situations that might increase the likelihood of rape (e.g., refraining from picking up hitchhikers, leaving a drink unattended at a party, walking alone at night). They are also taught to keep deadbolts on doors, to avoid advertising the fact that

they might live alone, and so on. The second part of this approach involves increasing a woman's ability to react to, and therefore prevent, an attempted rape. Women are urged to learn at least a little bit about self-defense. Forceful resistance generally does not increase the assailant's level of violence, and it generally does reduce the chances that he will complete the rape (Brecklin & Ullman, 2005; Marchbanks et al., 1990; Ullman, 1998; Ullman & Knight, 1991). Consequently, women are encouraged to resist. Verbal assertiveness can also help prevent an attack, especially if a woman is assertive when she is first approached. Brodsky (1976) reported that being assertive and fighting back are most likely to be successful when the rapist initially is polite or hesitant or precedes the attack with conversation. A problem with this approach to rape prevention is that by placing the responsibility for preventing rape in the hands of the victim, women (and men) who are raped may feel that they have somehow failed and that the rape was their fault. This approach also does not deal with the underlying causes of rape.

A final approach is based on a *social systems perspective*. From this point of view, rape is caused by factors in the surrounding socio-cultural context that create an environment that is conducive to sexual violence. Such factors include (but are by no means limited to): (1) socialization processes that support the acquisition of rape myths; (2) rigid gender roles that emphasize male aggression and female passivity; (3) sexual double standards (e.g., husbands are entitled to make sexual decisions but wives are not); and (4) peer group norms that promote exploitative attitudes toward women and the use of coercive sexual strategies. There is clear evidence that rape is more common among societies with high levels of these factors (see Box 15–A). From this perspective, rape prevention starts by targeting harmful social attitudes and beliefs and by promoting sexually healthy attitudes and behaviors, in school, at home, in church, in the media, and so forth. Indeed, there is evidence that sexual assault education programs on college campuses do, in fact, result in a reduction in rape myth beliefs and rape-supportive attitudes (Breitenbecher, 2000; Foubert et al., 2010).

Personal Reflections

What do you think? Is a tougher law-and-order approach to rape needed? Should more women become prepared to deal with attempted rape? Is this enough? Will rape ever stop being a serious problem in our society? Why or why not?

Sexual Harassment

1. 15.10 Describe sexual harassment in the workplace and the classroom and ways to deal with it.

In July 2016, the CEO of Fox News Channel, Roger Ailes, resigned after charges of sexual harassment were brought against him by talk show host Gretchen Carlson. Carlson alleged that her career suffered after she rejected Ailes's sexual advances. (In September 2016, the *New York Times* reported that the parent company of Fox News, 21st Century Fox, had publicly apologized to Carlson and reached a settlement agreement with her and at least two other women. Ailes has since passed away.) A year later, in April 2017, Fox News Channel's top political commentator, Bill O'Reilly, also left the network amidst multiple allegations of sexual harassment.

Figure 15–9

Roger Ailes, ex-CEO of Fox News Channel

Source: Fred Prouser/ REUTERS/Alamy Stock Photo

Such cases are far from uncommon. Indeed, each year for the past 15 years, between 12,000 and 16,000 people filed sexual harassment charges with the U.S. Equal Employment Opportunity Commission (EEOC) and its associated state and local agencies around the country (U.S. EEOC, 2012). More claims are filed by women (84%) than by men (16%), and about 20% of claims, on average, reach meritorious resolution (meaning that there is sufficient evidence to support the charge of harassment and the claim is resolved in favor of the claimant). Of course, because many victims of harassment do not report their experiences to authorities or file formal charges, the actual prevalence rate is likely to be much higher (see McDonald et al., 2011). Indeed, recent surveys reveal that between 40% and 50% of women and about 30% of men have experienced sexual harassment in the workplace at least once in their lifetime (Das, 2009; McLaughlin et al., 2012; for a review, see Quick & McFadyen, 2016).

Definition

What is sexual harassment? In 1980, the EEOC established a legal definition of sexual harassment in the workplace:

> Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute unlawful sexual harassment when (a) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (b) submission to or rejection of such conduct by the individual is used as the basis for employment decisions affecting the individual, or (c) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

Behavior is considered harassment when it persists after the recipient has indicated that it is unwanted. Over the past two decades, the EEOC has

updated the definition of sexual harassment to include same-sex harassment (e.g., a male employer and male employee, a female employer and female employee) and has clarified that harassment may also be perpetrated by coworkers as well as employers.

Types of Harassment

Sexual harassment sometimes involves requests for sex in exchange for employment or work-related opportunities (e.g., a manager offers to hire a job candidate in exchange for oral intercourse, a boss promises a promotion in exchange for sexual intercourse). Instances of "quid pro quo" (in Latin, meaning "this for that") harassment may be more readily recognized as inappropriate. However, remember that *a victim does not have to show that sexual favors were demanded in exchange for job benefits* in order to prove harassment. Sexual conduct that creates a hostile or offensive work environment also constitutes sexual harassment. Examples of this type of conduct include (but are not limited to):

- Verbal or written behavior, including comments about a person's clothing, physical appearance, or body; sex-based jokes, stories, or innuendos; telling rumors about a person's sex life; sexually suggestive language.
- Nonverbal behavior, including gestures or facial expressions of a sexual nature; following a person; blocking a person's freedom of movement or invading a person's space; inappropriately touching a person or a person's clothing; kissing, hugging, patting, stroking, or sexually assaulting a person.
- Visual imagery, including images, posters, drawings, pictures, screensavers, calendars, or other displays of a sexual nature present in the workplace.

How do the courts decide whether there is a hostile work environment? In a 1991 decision (*Ellison v. Brady*), the Court established the *"reasonable woman" standard:* When examining the particular workplace, would a reasonable woman conclude that there was sexual harassment that resulted in a hostile work environment (see Gutek et al., 1999)? Charges of sexual harassment are usually prosecuted as civil suits (rather than criminal cases) under Title VII of the Civil Rights Act of 1964, which bans discrimination in employment based on sex.

Obviously, harassment can take many forms, some more serious than others. Gruber (1990) subdivided harassment of women into five types: pressure for dates/relationships (experienced by about 13% of women), sexual comments (28%), sexual posturing (24%), sexual touching (17%), and sexual assault (1%). Using these more restrictive terms, O'Hare and O'Donohue (1999) found that 12% of women in the workforce had been pressured to cooperate sexually in order to be treated well. Here are three examples of sexual harassment in the workplace provided to us by students:

"My boss started off saying nasty jokes. Then he began to relate the jokes to his own personal experiences. Next he started making comments about how big my breasts were or how my butt looked in jeans. At this time I got real scared."

"I use to work part-time at [chain store]. My last manager was always complimenting me on my body, staring at me, trying to be near me, etc. It made me feel so uncomfortable. It got harder and harder to go in to work knowing that he'd be there. One day he said that I was 'so hot' that I probably drove my boyfriend 'wild in bed.' That was it for me. I needed the work, but I quit that same day."

"I started working as a legal assistant at the second largest law firm in New Orleans. I was assigned to two young associates. One of the associates was 28, engaged to be married, and took interest in helping me learn how the trial process is handled. I began to notice little things that 'Rich' did that were making me feel uncomfortable. First, compliments or personal remarks about my looks. Then he would make insinuations in front of others about how late we worked the night before, and how well we worked together. All of these were said in a manner that made me extremely uncomfortable.

The last straw was the touching, at first on the back as I was typing or reading, but later on the thighs and calves. I went to my superior and we met with the head of personnel and the director of our law department. I quit that day without pressing charges or causing a big fuss. Why? Because the department I worked in was the Labor Department. 'Rich' defended sexual harassment cases and won. He actually defended employees against sexual harassment—he knew better."

(All examples are from the authors' files.)

It is clear from these case histories that some male employers simply do not "get it." Certainly more men than women feel that the problem of sexual harassment has been exaggerated, and many men also believe that women should not be offended when men show sexual interest in them (Dietz-Uhler & Murrell, 1992). This is particularly the case among men who also endorse traditional gender role stereotypes. Men are also more likely than women to blame female victims of sexual harassment and to excuse a male perpetrator's conduct (see Bernard et al., 2016). Although men do recognize certain overt behaviors as harassment (e.g., offering favors in return for sex), many do not view less overt behaviors (e.g., sexual jokes and remarks) as harassment. Why? While women focus on the power relationship between them and the harasser, men attend to the sexual aspects of the situation, which they tend to define very broadly (Perry et al., 1998). Thus, men generally take the issue of sexual harassment less seriously than women. The U.S. Supreme Court's application of the "reasonable woman" standard in hostile environment cases is a clear indication that the courts realize that many men and women see the same behaviors differently.

Why is this a serious issue to women? Sexual harassment *usually occurs in a relationship where there is unequal power*, such as employer-employee or teacher-student relationships (MacKinnon, 1979). This makes the victims of harassment very vulnerable, especially if they are economically dependent on their jobs. Not surprisingly, victims of harassment display a wide variety of responses, from passivity or leaving the field to confrontation and reporting the behavior (O'Donohue et al., 1998). Victims may feel that there is no recourse. Who do you complain to if it is the boss who is doing the harassing? If a woman refuses sexual advances or objects to an offensive work environment, she might be the target of

retaliation (e.g., she may be passed over for raises and promotions, given poor ratings, or even fired). If she quits, she may be ineligible for unemployment compensation. Whether she is fired or she quits, she will be unable to ask for references from this employer because he will no doubt invent reasons for her termination having to do with poor performance. The end result is that victims of sexual harassment often have negative outcomes related to their jobs (e.g., job satisfaction, withdrawal), psychological health (e.g., depression and lower self-esteem), and physical health (Chan et al., 2008; Quick & McFadyen, 2016).

Figure 15–10

Many women regard this type of behavior by a male supervisor to be inappropriate and a form of sexual harassment. Do you suppose that this man would behave the same way with a male employee?

Source: Dmytro Zinkevych/Alamy Stock Photo

Sexual Harassment of Students

Harassment in College

Sexual harassment is most likely to occur in settings in which there are power differences between people. College campuses are certainly an example of this. Studies have found that 30% or more of women college students and about 20% of male college students have been sexually harassed by an instructor or staff member (e.g., Dziech & Hawkins, 1998; Kalof et al., 2001; Rosenthal et al., 2016). Students are also frequently targeted by classmates. Recent surveys of undergraduate and graduate students reveal that about 34% of women and 20% of men experience sexual harassment from other students (Krebs et al., 2016; Rosenthal et al., 2016).

Harassment can be direct (e.g., an instructor who offers a good grade, or a classmate who promises help with an assignment, in exchange for sex) or less obvious (e.g., a teacher or staff member who insists on repeatedly hugging the student or seeing the student alone, a classmate who "drops by" unexpectedly when the student is already in bed). The majority of students who are harassed by classmates report experiencing unwelcome sexual advances, gestures, comments, and jokes, with smaller numbers saying that they received sexually explicit photos or videos or that a classmate exposed his (or her) genitals to them (see Krebs et al., 2016).

As can happen in the workplace, instructors, staff, and peers can create an offensive environment for a student even if there are no direct propositions or threats:

"It was during my second semester in college when I became the target of sexual harassment from my instructor. The ordeal started when he began to stare at me in class for long periods of time. I grew uncomfortable and more importantly, self-conscious. I couldn't figure out why he was staring at me. He then began to approach me and make small talk. In between 'Hello' and 'How are you?' he would squeeze in a compliment. Eventually his compliments became suggestive, and before long, he was making blatant sexual innuendoes to me in front of the class. He would say, 'I can't concentrate on my lectures with you sitting in the front row looking like that' or 'You sure do make it hard (emphasis on hard) on a guy.'

Once, when I wore a skirt to class, he asked, 'Did you wear this for me?' as he fixed his eyes on my legs. On another occasion as I was picking up my school bag he tapped me on the shoulder and said, 'Don't bend over in those jeans like that.' Once he said he'd like to take me to lunch

and have me for dessert.

I finally had enough and I began to sit in the back of the lecture hall. He would come to me after class and tell me he 'missed me in the front row.' That was when I quit going altogether. I had four friends in class who knew what was going on and they insisted after about two weeks of absences that I come back to class. They begged me to press charges against him.

The day I returned, my professor asked me where I'd been and told me that 'if I knew what he was thinking I could charge him with sexual harassment.' The next week I wore a tie to class and he touched my tie and commented, 'I'd like to tie you up.' A girl I didn't know approached me after class and offered herself as a witness if I wanted to file a formal complaint. I wanted to do just that. However, I was and still am very concerned about my grades; I was sure that if I charged him with this behavior he would have penalized me through my grade."

(from the authors' files)

It is *never* appropriate for an instructor to make sexual or even romantic overtures to a student presently enrolled in his or her class or under his or her supervision. It is also never appropriate for a staff member or fellow student to engage in the type of unwelcome sexual advances or requests for sexual favors that we discussed earlier. As in the workplace, students who are the victims of sexual harassment may feel that there is no recourse, and the experience often results in negative emotional effects. The U.S. Supreme Court ruled that under Title IX of the Education Amendment of 1972, schools can be held liable for not taking action (*Franklin v. Gwinnett County Public Schools*, 1992; see also *Fitzgerald v. Barnstable School Committee*, 2009). Do you know if your campus has established a policy about sexual harassment?

Harassment in Middle and High School

As we have seen, although sexual harassment typically occurs in situations in which there is a power disparity between the target and the harasser (e.g., worker-supervisor, student-instructor), it also occurs between peers. In 2011, the American Association of University Women (AAUW) commissioned a national survey to investigate the prevalence of sexual harassment among students in grades 7 to 12 (Hill & Kearl, 2011). The results revealed that sexual harassment is, sadly, a part of "everyday life" in middle and high school. According to the survey results, nearly half (48%) of all students reported experiencing some form of sexual harassment either in person or online during the current academic year. More girls (56%) than boys (40%) were harassed. Similar percentages were reported more recently in a large survey conducted with sixth-grade students from 36 schools throughout the Midwest (Rinehart & Espelage, 2016).

The most common forms of sexual harassment reported by students were unwelcome sexual comments, jokes, or gestures (reported by 33%), being called gay or lesbian in a negative way (18%), and being shown or sent sexual images that they did not want to see (13%). In addition, 8% of students reported being touched in an unwelcome sexual way, 7% said that someone had flashed or exposed himself or herself to them, 6% indicated having been physically intimidated in a sexual way, and 2% reported having been forced to do something sexual they did not want to do. Girls were more likely than boys to experience most of these forms of sexual harassment.

To many adults, these incidents may appear relatively "minor." The harassers themselves certainly seemed to think so: When asked why they had harassed someone, the majority (44%) agreed with the statement that "It's just part of school life/it's no big deal." Sizable numbers also said that they were just trying to be funny (39%) or that they were "being stupid" (34%). But sexual harassment, even in the form of "stupid jokes," has very serious consequences for the students who experience it. Almost all the boys and girls (87%) said that the harassment had a negative effect on them. Specifically, one third (32%) reported that they did not want to go to school as a result, about one third (31%) said that they felt sick to their stomach as a result of the harassment, and another third (30%) indicated that the harassment caused them to have a hard time studying. Trouble sleeping was also a commonly reported problem (22% of girls and 14% of boys). A sizable number of students stayed home (12%) as a result of the harassment, and some (4%) even changed schools.

As with other forms of sexual victimization, many targeted students (50%) did not report their harassment. Those who did were most likely to tell a parent or other family member (27%) or a friend (23%). Only 9% of students reported the incident(s) to teachers, guidance counselors, or other adults at school. When questioned about their reasons for not reporting harassment, students mentioned doubts that anything would change, fears that reporting would make the situation worse, and concerns about the reactions of school staff members.

Clearly, the personal toll of harassment in middle and high school is severe. So is the educational impact. Not surprisingly, students who experience harassment from peers become less engaged with school, feel alienated from their teachers, and show reduced academic achievement (Gruber & Fineran, 2016). School personnel and parents must be vigilant in working together to protect children from this unfortunate and all-too-common experience. The good news is that there are ways to make this happen. Research reveals that school climate plays a major role in inhibiting (or encouraging) harassment. When the campus climate is characterized by norms that support cooperation, safety, and mutual respect, when staff members model prosocial behavior and commitment to gender equality (and demonstrate willingness to intervene in instances of harassment), and when staff-student interactions are positive and respectful, instances of peer harassment decrease (see Rinehart & Espelage, 2016). In addition, there is evidence that both student-led and teacher-led intervention programs (particularly those that focus on the development of socio-emotional learning skills, including empathy and problem solving) reduce both sexual harassment perpetration and victimization (Connolly et al., 2015; Espelage et al, 2015).

The AAUW report offers recommendations for how to effectively respond to sexual harassment in school settings and is available online at www.aauw.org.

Personal Reflections

Think back over your time as a student in elementary, middle, and high school, and college. Did you experience sexual harassment? If yes, what

form(s) did the harassment take? Did you tell anyone? Why or why not? What do you think your school could have done—and what do you think schools today could do—to effectively deal with harassment and reduce its occurrence?

Stalking and Unwanted Sexual Attention

There are several behaviors that, although they do not meet the legal definition of sexual harassment, do involve unwanted sexual attention and can potentially pass into the realm of criminal conduct. For example, sizable numbers of men and women (probably including many of you) have experienced *obsessive relational intrusion*, defined as "repeated and unwanted pursuit and invasion of one's sense of physical or symbolic privacy by another person … who desires or presumes an intimate relationship" (Spitzberg & Cupach, 2007). In everyday terminology, this phenomenon is called stalking (or, if it involves online forms of communication or contact, *cyberstalking*). Stalking behavior possesses three characteristic features: (1) intentional and persistent contact (or attempted contact) by the stalker/pursuer that is (2) unwanted by, and (3) psychologically aversive (offensive or unpleasant) to, the recipient/target. In addition, although legal definitions vary across the United States (and around the world), stalking behavior typically becomes a crime when it poses a credible threat that places the target in reasonable fear for his or her safety (see Cupach & Spitzberg, 2004; Meloy, 2007).

How common is stalking? A national victimization survey found that 16% of women and 5% of men have been the target of stalking at some point during their lifetime (Black et al., 2011). A review of multiple stalking studies provided similar estimates—between 12% to 16% for women and 4% to 7% for men (Dressing et al., 2006). For many victims, the stalker is someone they have known, and a good proportion of these are ex-partners (Björklund et al., 2010; Buhi et al., 2009; Purcell et al., 2009). For example, one study found that two thirds (66%) of female stalking victims and 41% of male victims were stalked by a current or former intimate partner (Black et al., 2011).

Stalking can last from several months to several years. The most commonly experienced stalking behaviors include receiving unwanted calls, messages, or.pngts (see McNamara & Marsil, 2012). However, many victims also report experiencing more invasive and threatening actions from their stalkers. For example, researchers have found that in 10% to 40% of stalking cases, the stalkers engaged in the following behaviors: threatening to physically harm the victim or the victim's family or pets, photographing or recording the victim without consent, following the victim from place to place, damaging the victim's property, trespassing, breaking into the victim's home, exposing themselves to the victim, and forcing the victim to engage in sexual behavior (see Brewster, 2003; Cupach & Spitzberg, 2004). Some stalkers kill their victims. A faculty colleague of one of your textbook authors was stalked by a former graduate student in 2004. One day, after several months of inappropriate and harassing behavior, the man followed the victim to her house, broke in, and then stabbed and beheaded her (he committed suicide by walking onto a highway an hour after the murder).

Only about half of stalking victims ever seek help, and those who do usually obtain assistance from friends rather than from the police or other authorities (Buhi et al., 2009). Unfortunately, researchers have yet to identify the most effective ways to manage or cope with stalking situations. However, some professionals recommend that targets of stalking clearly communicate that the attention is unwelcome and unwanted, cease all further contact (if possible); inform others (friends, family, coworkers, instructors, etc.) of the situation; document all stalking-related incidents; go to the authorities if the situation does not stop; increase security at home, on campus, and in the workplace; and devise an escape plan should a threat arise (see Regan, 2017).

How to Deal with Sexual Harassment

The number of sexual harassment cases reported to the EEOC doubled during the 1980s and more than doubled again in the 1990s (it has remained about constant since then). Still, relatively few victims ever decide to take formal action.

Sexual harassment (and other forms of unwanted sexual attention, such as stalking) can often be prevented if the recipient takes immediate action at the first sign of inappropriate behavior. Such action requires clear and direct communication as well as personal assertiveness. Unfortunately, some women (and men) are uneasy about being assertive for fear that they will appear "unfriendly" or "impolite." If you ever find yourself in this situation, keep in mind *that you are not the one who has behaved improperly*. Giving the harasser a firm "no" (or saying that you will not tolerate being talked to like that) is expressing your right to personal dignity.

If the harasser continues his or her behavior after you have delivered a clear message that it is not appreciated, then you will have to take other steps to deal with it. When the harassment is blatant, persistent, and highly offensive, as in the example of the university professor in the case history, strong measures are necessary. Talk to the harasser, or write a letter to him or her relaying the facts and again expressing clearly and firmly that the behavior must stop. Document all the episodes of harassment (dates, places) and list all witnesses. The very next time the behavior occurs, follow the grievance procedure of your company or school and report it. *Those companies and schools that have implemented grievance procedures will protect you against retaliation*. If you should be treated unjustly, report the problem to the EEOC or file a civil suit (remember, companies and schools can now be held liable for not taking action). And remember that if you are ever in physical danger or believe yourself to be in physical danger, inform the authorities (notify your local police department and/or campus or workplace security office, and seek a restraining order).

Personal Reflections

Have you ever been the victim of sexual harassment by a supervisor, employer, or instructor? Have you ever been the target of stalking behavior from a coworker, classmate, acquaintance, or former partner? Did you report it? If not, why not? Are you familiar with your campus's procedures for dealing with sexual harassment? If you are not familiar with the procedures, where can you go to find out?

Sexual Abuse of Children

1. 15.11 Discuss the difference between pedophilia and child molestation and describe the different ways to classify (and the characteristics of) pedophilic child molesters.

In 1992, a former national "teacher of the year" was sentenced to a year in jail for molesting boys at his cabin home. In 2000, an award-winning pediatrician had his license revoked after dozens of accusations of sexual abuse. In 2002, a former priest was accused of sexually molesting more than 150 children over 30 years. And a decade later, in 2012, many of us followed the trial of retired Penn State assistant football coach Jerry Sandusky, who was subsequently convicted of 45 counts of sexual abuse of young boys.

How common is sexual abuse of children? The answer depends in large part on how one defines child sexual abuse (see next section). One review of research conducted around the world found that in the United States most studies report between 10% and 20% of girls and fewer than 10% of boys are victims of child sexual abuse (Pereda et al., 2009). Similar prevalence rates were found for Canada, Asia, and many European countries. South Africa had alarmingly high rates. Another review calculated the prevalence of severe child sexual abuse (involving at least genital touching) in the United States to be 17% for women and 8% for men (Putnam, 2003).

As these data show, nearly twice as many girls as boys are targeted as victims. An early 1985 *Los Angeles Times* poll found that for about 15% of all victims, the abuse continues for more than a year. Other studies have found that at least 10% to 15% of victims are abused by more than one adult (Conte et al., 1986; Tufts New England Medical Center, 1984).

Laumann et al. (1994) found that sexual contact with children usually involved fondling the genitals but that 10% of the girls and 30% of the boys who had been molested had also been forced to perform oral sex. Fourteen percent of the girls had been forced into vaginal intercourse, and 18% of the cases involving boys included anal intercourse.

Victims can be any age. As we noted in the section on rape, even young infants can be sexually molested. For example, of the instances of child sexual abuse investigated by Child Protective Services in 2011, 3% of victims were under 3 years old, 14% were between 3 and 5 years old, 16% were between 6 and 8 years of age, 19% were between 9 and 11, 26% were between 12 and 14 years old, and 22% were 15 to 17 years of age (U.S. Department of Health and Human Services, 2012).

In the United States, there has been a decline in the number of substantiated (reported) child sexual abuse cases since the early 1990s (Finkelhor & Jones, 2003; Jones et al., 2001). This may be due, in part, to more vigorous prosecution of offenders and increased public awareness.

What Is Child Sexual Abuse?

An early review of research on victim outcomes associated with child sexual abuse concluded that victims were, on average, only "slightly less well adjusted" than individuals who had not been abused (Rind et al., 1998). The authors found so little connection between sexual abuse and harmful effects that they suggested that we stop using the term "child sexual abuse" and instead simply refer to "child-adult sex." Not surprisingly, the article was met with a storm of protest (see Garrison & Kobor, 2002) and many rebuttal articles (e.g., Dallam et al., 2001; Ondersma et al., 2001). Even the U.S. Congress voted to condemn the article. However, a previous review had also found that many sexually abused children experienced few long-term negative effects (Kendall-Tackett et al., 1993), and other studies had even reported that some victims recall their experiences as having been positive or pleasurable (e.g., Haugaard & Emery, 1989; Okami, 1991; Rind, 2001). The controversy continues today (see Rind & Tromovitch, 2007 vs. Najman et al., 2007).

One outcome of this controversy has been a reexamination of the term "child sexual abuse." Haugaard (2000) points out that each word in this phrase has been defined in multiple ways. Consider, for example, the concept of "child." As we discussed earlier in this chapter, the age of consent (the line legally separating a child from an adult) differs across the country and around the world. Thus, in some states in the United States, a "child" is legally defined as anyone under 16, whereas in others a "child' is anyone under 18. Within psychology and psychiatry, the term "child" generally refers to *prepubescent children (13 years of age or younger)*. The legal and scientific communities also generally stipulate that the sexual contact (abuse) must be by an adult (someone who is at least 16 years old) and who is at least 5 years older than the child. The Laumann et al. (1994) survey used this definition.

What is sexual abuse? The word "sexual" can include a variety of acts, ranging from a sexual advance or being spoken to in a sexual manner to an incident of indecent exposure (none of which involve physical contact) to inappropriate touching or acts of penetration (oral, vaginal, and anal). The behavior might be one isolated incident or long term. And "abuse"? There is no uniform definition here (in fact, each state in the United States has its own legal definitions of the actions that constitute child abuse, sexual or otherwise).

Here is what the American Psychological Association says about child sexual abuse:

> There is no universal definition of child sexual abuse. However, a central characteristic of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as exposure, voyeurism, and child pornography.

(http://www.apa.org/pubs/info/brochures/sex-abuse.aspx)

Keep in mind that when we discuss sexual contact between children and adults, we must also consider the culture (see Nieto, 2004). You read in Chapter 9 (see Box 9–A) that sexual relations between adults and children (generally pederasty) are the norm in some cultures and have been so

at times in Western culture as well. There is no question, however, that such contact is not normal or acceptable in Western culture today. The power difference between adults and children in Western culture makes sexual consent between them impossible and unacceptable (Schmidt, 2002).

The end result is that the term "child sexual abuse" has become a broad catchall phrase that, as a concept, presently has little discriminative power. *Depending on how abusive behavior is defined, prevalence rates will be high or low. The effect of abuse will also depend on the type or severity of the abuse as well as other victim and perpetrator characteristics.*

Who Molests Children?

The stereotype of a child molester is often that of a dirty old man who hangs around playgrounds offering candy to young boys and girls and snatching them away when their parents are not looking. However, this is usually not the case. Studies conducted in the United States and other countries have found that in the large majority of molestation cases, the molester is an adult known to the victim and very often a relative (Aydin et al., 2015; Laumann et al., 1994; U.S. Department of Health and Human Services, 2016; see Table 15–4).

Table 15–4 Relationship of Child Molesters to Their Victims, as Recalled by Adults Who Had Been Sexually Abused as Children (Aged 12 or Younger)

Abuser	Abused[a]	
	Women (17%)	Men (12%)
Stranger	7%	4%
Acquaintance	29%	40%
Family friend	9	4
Older brother	9	4
Stepfather or mother's boyfriend	9	2
Father	7	1
Other relatives	29	13
Teacher	3	4
Other	20	21

[a]Total percentages exceed 100% because some victims were abused by more than one person.

Source: From *The Social Organization of Sexuality* by Edward O. Laumann. Copyright © 1994 by the University of Chicago Press. Reprinted by permission of the University of Chicago Press.

Table 15–4 Full Alternative Text

"When I was 12 years old I was sexually molested by my sister's boyfriend. My mother and sister earlier that day had a doctor's appointment and he had offered to keep an eye on me while they were gone. . . .He dared me to do sexual things. If I refused he would then get forceful toward me and out of being scared I went along with it. He forced me to have oral sex on him."

"When I was little (ages 5–7), I was molested. My parents worked but let me stay with our elderly neighbors. The old man did this to me. He taught me how to kiss and touch his penis. He did this when his wife would either go to the store or leave out of the room. I hated it. What I can't understand is why: why me. . . ."

"I was molested by my mother's boyfriend when I was in seventh grade. He moved in with us and when she was at work, he would come to my room and lie in the bed with me. He would touch me and kiss my breasts and genitals."

(All examples are from the authors' files.)

Researchers have attempted to classify molesters in many different ways. Some focus on whether the molester has pedophilia or not. You were introduced to the topic of pedophilia in Chapter 14. Recall that **pedophilia** is a paraphilia (an unusual sexual preference) in which prepubescent children are the preferred or exclusive source of sexual arousal and gratification. (Sexual attraction to pubescent children is called *hebephilia* by some scientists [Blanchard et al., 2009], although the American Psychiatric Association does not recognize this as a paraphilia). Recall also that there is an additional criterion—to be considered pedophilia, the individual must be at least 16 years old and at least 5 years older than the child (*DSM-5*, 2013).

Not all pedophiles act on their urges. Thus, some researchers (Howells, 1981; Lanyon, 1986) distinguish between preference molesters (pedophiles who act on their urges and molest children; the *DSM-5* would classify these individuals as having *pedophilic disorder*; see Chapter 14) and situational molesters (non-pedophiles whose primary sexual interest is toward adults but who engage in sex with children, often impulsively and during times of stress, and who recognize their actions as abnormal). The distinction between pedophilia and child molestation can seem confusing—just remember that child molestation is a criminal act that has to do with behavior, whereas pedophilia is a clinical diagnosis that has to do with sexual preference. Thus, not all child molesters are pedophiles, and not all pedophiles are child molesters. That being said, many pedophiles do molest children (see Hall & Hall, 2007). The results of a recent large community investigation revealed that men who repeatedly fantasized about sexual activity with children (pedophiles) were, in fact, more likely to act on their urges and engage in sex acts with children (that is, commit child molestation) than men who did not fantasize about children (Dombert et al., 2016).

Consequently, in this part of the chapter we focus on pedophilic offenders—that is, on adult men (or women) who are sexually attracted to and who sexually assault children.

"I am sexually aroused by children. My specific preference is for 6- to 7-year-old girls, blonde and very fair. I collect children's clothing or toy catalogs and masturbate to the pictures but have never acted on my urges with a real child. I know my desires are not normal and I refuse to hurt a child." (example of a pedophile, non-molester)

"I am only writing this because it is anonymous. I am attracted to children, specifically young boys. I have a collection of pornography and my fantasies involve oral and anal sex with these boys. Once I did have the opportunity (on a trip) to pay to have sex with a boy like the ones I fantasize about. So yes, I guess I have committed molestation." (example of a pedophile, preference molester)

"I got really drunk one night and fooled around with my younger cousin who was visiting. She was only 12 and I got her to masturbate me. It's

totally gross and wrong. She didn't even have boobs yet. I was drunk and horny." (example of a non-pedophile, situational molester)

(All examples are from the authors' files.)

In their thorough review of the literature on pedophilia and child molestation, Hall and Hall (2007) noted that pedophilic offenders are often classified along a couple of primary dimensions. The first dimension concerns whether they are exclusively attracted to children (called *exclusive or "true" pedophilia*) or whether they are attracted to both children and physically mature adults (called *non-exclusive pedophilia*).

The second dimension concerns the sex and age of the preferred child target. Most pedophilic offenders have a clear preference pattern. Men who are sexually attracted to male children only are referred to as *homosexual pedophiles*, men who prefer female children only are called *heterosexual pedophiles*, and men who are attracted to both male and female children are categorized as *bisexual pedophiles*. It is important to note that the terms "homosexual," "heterosexual," and "bisexual" in this instance do not refer to the men's own self-identified sexual orientation but rather to the sex of their preferred child target (thus, a man who prefers boys may or may not be "homosexual" in terms of his own sexual identity, and so forth). Studies reveal that bisexual pedophilia is less common than homosexual and heterosexual pedophilia. However, bisexual and homosexual pedophilic offenders typically have abused more children and committed a greater number of acts of sexual molestation than heterosexual pedophilic offenders. (This does not mean that homosexual or bisexual men are more likely to be pedophiles than heterosexual men; rather, it simply means that men who abuse boys [and who may or may not self-identify as "homosexual"] and men who abuse both boys and girls [and who may or may not self-identify as "bisexual"] have more victims, on average, than men who abuse girls [and who may or may not self-identify as "heterosexual"]). For example, in one study of male pedophilic offenders who were undergoing treatment, men who targeted girls (non-relatives) had averaged 20 victims each, whereas those targeting boys (non-relatives) had averaged nearly 200 victims each (Abel et al., 1987).

"I am a victim of child sexual abuse. I was 6 years old and my godmother's fiancé was the predator…. He made me do everything from vaginal penetration to oral-genital sex…. Later it was found that he did this to four of his six children, myself, two of my cousins and six other children." (woman)

"When I was little (around 10), I took piano lessons from the boy across the street. He was much older, in his early 20s. He used to touch me between the legs during my lessons and put his finger inside me. I finally told my friend and she said he'd been doing it to her as well. She told our parents and there was an investigation. He had done it to two other girls in the neighborhood." (woman)

"I had an unusual upbringing, having gone to boarding school throughout my childhood and adolescence. Sexual abuse was not uncommon, and I was myself victimized, as were most of my friends, by the same man. At the beginning of each term, he would select two or three special boys for his attentions, and this went on my entire time there. He was at that school until his retirement. By my reckoning, then, he sexually molested close to 100 boys." (man)

(All examples are from the authors' files.)

Pedophiles typically have not only a preferred sex but also a preferred age range. Those who are attracted to female children often prefer girls who are between the ages of 8 and 10, and those who are attracted to male children tend to prefer boys between the ages of 10 and 13.

So what factors conspire to create sexual attraction to children and the likelihood to abuse them? What does a pedophilic child molester "look like" personally, developmentally, demographically, socially? Many pedophilic child molesters—estimates range from 30% to 90%—were themselves the victims of sexual abuse as children (see Bailey et al., 2016; Hall & Hall, 2007; Jespersen et al., 2009; Putnam, 2003). Research reveals that these men typically have low self-esteem, lack social competence, and have issues with impulse control (Dreznick, 2003; Miner et al., 2010; for a review, see Ward & Beech, 2006). Many are respectable and otherwise law-abiding citizens (Lanyon, 1986). They often possess distorted cognitions about their actions (i.e., they rationalize their behavior, minimize the harm they cause, and believe that their actions have positive effects on the child/children) (Blumenthal et al., 1999; Bumby, 1996; Katsuta & Hazama, 2016). However, there are few other characteristics that are consistently and strongly correlated with pedophilic offending (Lanyon, 1986; Okami & Goldberg, 1992). In short, there is no single offender "profile"; pedophilic child molesters are a heterogeneous group.

One thing that is well established is that preferential sexual interest in children often begins during adolescence and remains relatively stable across the life span (Grundmann et al., 2016; Tozdan & Briken, 2015). Similarly, deviant behavior—actual molestation of children—also typically begins early in life. One study found that the median age for the first sexual offense against a child was 16 (Groth et al., 1982). Adolescents are responsible for about one third of child sexual abuse cases (Koch, 2010). Very young children (6 to 12 years old) who sexually abuse other children have often been sexually abused themselves and/or have come from highly chaotic families (De Angelis, 1996; Elkovitch et al., 2009).

Figure 15–11

The stereotype of the "child molester" is generally of a dirty old man who hangs around playgrounds or school yards offering candy to young children and then luring them away. The reality, of course, is that child molesters are a diverse group and come from all walks of life.

Source: Angela Hampton Picture Library/Alamy Stock Photo

Tragically, the true pedophilic molester, in order to satisfy his sexual urges, often finds positions where he has access to children (teacher and "other" category in Table 15–4). Pedophiles have been found in positions as teachers, scout leaders, camp counselors, and even ministers or priests.

"I entered a monastery for boys…. As a novice, I was told to go to confession daily and the Father Superior would counsel me in both Christian education and my personal life. Confessions were very informal. The Father Superior heard them from 7:30 p.m. until midnight in his room…. One night he said, 'And do you know how they took oaths in the Old Testament? One would put his hand on the other man's genitals. But there was no sexual connotation intended.' I was a little puzzled and didn't ask any questions.

About a week later I went to see one of the brothers for confession, but he told me that the Father Superior wanted to see me…. He said, 'Do you want to take an oath like in the Old Testament?' I was stunned and didn't really know what he meant. Finally he took my hand and placed it under his robe on his penis. I was shocked and pulled my hand away immediately, but he said, 'Don't be afraid, there is no sexual intent here. You are keeping a very ancient form of taking an oath.' As he was saying this he took my hand again and placed it on his penis. I wanted to pull back, but I was afraid he would go into another temper tantrum…. He didn't do anything else that night, but he talked to me about how much we had to be obedient children. He often stressed obedience—total obedience. (This was how he set us up. We must be totally obedient.)

Then it happened. One night we were talking and he said, 'Do you want to kiss my penis?'—I was so naive. I didn't know what he was talking about. He said, 'Do you want me to kiss your penis? That's how much I love you.' I said no, but then he said, 'Don't you think I love you? There is no sexual intent. It is a pure act of platonic love.' Then he drew me closer to him, he opened my robe, unzipped my pants, put his hands into my underwear, brought my penis into the open and kissed it.

It later turned into fellatio…. He taught me what he wanted done to him. He had orgasms every time that 'I went for confession.' I was instructed never to have orgasm. Never! 'That would not be good for me spiritually.'

I have some very deep scars and am now receiving therapy."*

(from the authors' files)

In today's technological world, pedophilic molesters often use online chat rooms to find and seduce victims. The children are generally aware that the predator is an adult, and thus some researchers believe that this is an example of statutory rape (Wolak et al., 2008). The *Dateline NBC* television series "To Catch a Predator" (2004–2007) made Americans aware of just how pervasive the problem is. In city after city, host Chris Hanson and his team had adults posing as very young adolescents visit online chat rooms. The series exposed hundreds of men who had sent sexually explicit messages (and often explicit photographs of themselves) and set up a meeting with someone they thought was a child.

About half of online sex offenders have also committed offline assault of a child (see Seto et al., 2011). Researchers typically classify people engaging in computer-based pedophilia into four general categories (see Hall & Hall, 2007): (1) cruisers, who use the Internet for mutual sexual gratification without direct physical contact (e.g., cybersex in chat rooms); (2) masturbators, who use the Internet for passive self-gratification (e.g., viewing child pornography); (3) stalkers, who try to gain direct physical access to children; and (4) networkers or swappers, who use the Internet to communicate with other pedophiles and trade information, pornography, and child victims. The latter two groups are the most potentially dangerous, as they are contact-driven and the most likely to actively seek children for abuse. The other two groups are fantasy-driven and less likely to seek direct contact with children (see Briggs et al., 2011).

Personal Reflections

Are you ever sexually aroused by children? If so, have you ever sought counseling? If you have not sought counseling, why not? Would it be better to seek counseling before you acted on an urge or afterward?

Female Perpetrators of Child Sexual Abuse

Just a few decades ago most experts believed that child sexual abuse by women was extremely rare. Today, experts realize that this is not true. As one researcher stated, "The traditional images of women as non-violent and as protectors of vulnerable others, particularly children, are increasingly acknowledged as flawed and as constituting a barrier to the recognition of some women's harmful potential" (Logan, 2008). More recently, abuse by women was brought to the nation's attention with the case of Mary Kay LeTourneau, a married (with children) Seattle teacher who gave birth to two children by one of her teenaged students (whom she later married). The United States has seen dozens of cases like this in the past several years (e.g., Eversley, 2010), including the 2015 arrest of Utah high school teacher Brianne Altice, who was convicted of engaging in sexual acts with three male students. Interestingly, female teachers who sexually molest their students appear to be motivated by different factors than male teachers who abuse students. Male predator teachers tend to be sexually motivated and opportunistic (in the words of one expert, they are "in it for the sex"), whereas female predator teachers tend to be relationship oriented and to romanticize their victims (they are "in it for the love") (LaRosa, 2014). Women teachers also receive lighter sentences, perhaps due to the fact that many people have a hard time viewing teenage boys as "victims" and thus are likely to conceptualize their rapes as "sexual initiation" rather than as molestation (see section on statutory rape). Of course, cases involving female teachers and teenage students constitute only a portion of the sexual abuse perpetrated by women against children.

As with abuse by men, estimates of sexual abuse by women vary widely. Earlier research suggested that women perpetrators were responsible for about 4% to 5% of cases of child sexual abuse (see Cortoni & Hanson, 2005). However, data collected more recently indicate that the prevalence of child sexual abuse perpetrated by women is actually much higher. McLeod (2015) examined national statistics on child sexual abuse and found that 20% of substantiated cases reported to child protective services involved a female perpetrator.

Who are these women? After reviewing the literature, Hall and Hall (2007) proposed seven different types of female sex offenders: (1) the experimenter, who is typically an adolescent or young adult who molests out of curiosity (e.g., the curious babysitter); (2) the male accompanied molester, who willingly participates in molestation with a male partner; (3) the male coerced molester, who passively participates in molestation that is orchestrated by a (typically abusive) male partner; (4) the nurturer or caregiver, who has caregiving responsibilities for young children (e.g., cleaning, dressing) and who uses those responsibilities as justification for the abuse; (5) the psychologically disturbed molester, who has some form of acute psychosis; (6) the teacher or lover, who is typically an adult in a position of authority and who views the sex as a consensual relationship between willing partners (as we discussed in our opening paragraph to this section); and (7) the traditional offender, who (like her male sex offender counterparts) molests children for sexual gratification purposes.

There is thus considerable heterogeneity among female sex offenders. However, research does reveal some commonalities across types. On average, the "typical" female offender is young (20s and 30s), has been a victim of prolonged sexual and/or physical abuse in her own childhood, has poor coping skills and an existing psychological issue (most often depression, substance abuse, or a personality disorder), has a dysfunctional personal life (often involving domestic abuse), and has various cognitive, learning, and/or physical disabilities or difficulties (Grayston & DeLuca, 1999; Hall & Hall, 2007; Wijkman et al., 2010). These factors may work together to create a situation that inhibits normal boundaries against sexual contact with children:

> These variables speak to how female sexual offenders present as a group of people dealing with complex layers of trauma, disability, illness, vulnerability, and personal circumstances that comorbidly exacerbate their inappropriate boundary and offending behavior development.

(McLeod, 2015, p. 110)

Female offenders generally prefer very young victims (Peter, 2009; Wijkman et al., 2010). Who are these victims? They are almost always known to their female molesters, and are often their own children (see McLeod, 2015).

Child Pornography

"Directly after high school I worked at a photo developing store. One day while sorting some pictures I noticed that the first six shots were of boys that looked to be no older than 10 having fellatio and sodomy with each other. The last eight pictures introduced an older man of about 40 years old. I, of course, showed my manager and he called the police. When the man's wife came to pick up the pictures she was arrested. She was charged with passing pornographic material through our store. Her husband was given a heavier sentence—20 years. He was a prestigious teacher at an uptown school and a career pedophile. In that year alone he had molested 12 boys."

(from the authors' files)

By the mid-1990s, over 15% of material downloaded from commercial bulletin boards was pedophilic—that is, depicted sexual acts involving children (Rimm, 1995). Today, it is even more common (Jenkins, 2001). *Creating, distributing, and possessing such material is illegal*. The U.S. Supreme Court ruled unanimously in 1982 (*New York v. Ferber*) that publishers and distributors of child pornography can be prosecuted for child abuse without requiring the prosecutors to prove that the material is obscene, thus avoiding arguments about First Amendment rights. In 1990, the Supreme Court upheld an Ohio law that made it a crime even to possess pornography showing children under the age of 18. In 2008, the court ruled that it was a crime to advertise and promote child pornography online. Adults who participate in child pornography in any capacity can be prosecuted, as illustrated by the case of Jared Fogle, a former spokesman for the Subway® sandwich chain. Fogle was arrested in 2015 on federal charges of possessing and distributing child pornography (as well as paying for sex with children; see Figure 15–12). He pled guilty to the charges, was ordered to pay restitution to his victims, and is currently serving time in a federal prison.

Figure 15–12

Jared Fogle, a former spokesman for the Subway® sandwich chain, was arrested in 2015 on federal child pornography charges.

Source: Nancy Kaszerman/ZUMA Press, Inc./Alamy Stock Photo

Research indicates that the nature of child pornography has changed over time. Specifically, men who view and use child pornography are doing so at increasingly younger ages (beginning in their late teens and 20s), the images are of increasingly younger children, and the depicted sex acts are increasingly violent and severe (see Wolak et al., 2011).

Could looking at child pornography cause someone to molest children? Experts disagree, with some suggesting that child pornography may provide an outlet for deviant sexual urges and thus reduce the likelihood of committing child molestation, and others arguing that viewing child pornography may stimulate an offender and encourage him to act on his desires. Which view is right? On the one hand, at least one study has found that men charged with a child pornography offense (a study in which blood flow in the penis was measured) were considerably more sexually aroused by children than by adults (Seto et al., 2006). Another study found a correlation between viewing child pornography and self-reported likelihood to engage in sexual activity with children (Seto et al., 2015). It is possible that men who watch child pornography and become aroused by children may be more inclined to actually molest a child. On the other hand, we must remember that correlation is not causation. We cannot assume, based on this research, that viewing pornographic material or becoming aroused by children will inevitably cause a man to commit a sexual offense. Indeed, examinations of the criminal records of child pornography offenders demonstrate that relatively few (only 2% to 4%) subsequently commit a contact sexual offense against a child (though they may commit another child pornography offense; see Seto et al., 2011). Thus, we still have no conclusive evidence as to whether viewing child pornography actually increases the risk of child sexual abuse. Regardless, child pornography is a serious crime that causes major damage to the children forced to participate in it.

Effects of Child Sexual Abuse

1. 15.12 Describe the devastating long-term effects that can result from sexual abuse of children.

Recall that, upon reviewing the literature, a group of researchers published a report in which they concluded that child sexual abuse generally was not associated with long-term psychological harm (Rind et al., 1998). Other researchers, however, have come to the opposite conclusion, asserting that survivors of child sexual abuse experience lasting and pervasive negative outcomes (see Maniglio, 2009; Putnam, 2003; and Wilson, 2010, for reviews). Who is right?

Considerable research has now shown that, in fact, there is no single "post-sexual abuse syndrome" with a specific course or outcome (e.g., Beitchman et al., 1991, 1992; Ruiz, 2016). Instead, the effects of adult-child sexual relations represent a continuum of experiences. The results of many studies combined indicate that sexually abused children can be described as falling into one of four groups (Saywitz et al., 2000):

1. 1.Children with no detectable problems (although as many as one third may be included in this group, about 10% to 30% of children with no initial symptoms develop problems later [see Finkelhor & Berliner, 1995; Gomes-Schwartz et al., 1990; Kendall-Tackett et al., 1993]).
2. 2.Children with problematic symptoms (e.g., anxiety, low self-esteem) that do not reach clinically disordered proportions.
3. 3.Children with major clinical/psychiatric symptoms (e.g., depression).
4. 4.Children with posttraumatic stress disorder and other major psychiatric disorders (at least half of abused children are included in these last two groups).

Several factors determine which outcome(s) a molested child is likely to experience, including the nature of the abuse, the child's own personal characteristics (age, gender, ethnicity, personality and other dispositional traits), and the existing social support system surrounding the child. Some children are more resilient than others, and in some cases the abuse is less severe. *The greatest harm in terms of long-lasting negative effects is often seen in cases where the abuse is frequent or long-lasting; where the abuse involves penetration, force, threats, or violence; where the abuser is a father figure (e.g., father, stepfather, close neighbor, teacher, coach, priest or minister); and where there is little support from the mother or other primary caregivers* (Beitchman et al., 1992; Hall & Hall, 2007; Kendall-Tackett et al., 1993; Molnar et al., 2001; Rind & Tromovitch, 1997; Tyler, 2002). In those situations, the most common harmful effects are poor self-esteem, affective disturbances (ranging from feelings of fear, guilt, anger, and confusion to major mood disorders such as depression), anxiety disorders (including symptoms of PTSD, panic attacks, and generalized anxiety disorder), body image disturbances and eating disorders (particularly in girls and women), substance abuse problems and/or disorders, personality disorders, and suicidal thoughts and behavior (Cutajar et al., 2010; Hall & Hall, 2007; Leonard & Follette, 2003; Paolucci et al., 2001; Tyler, 2002).

Figure 15–13

This self-portrait by a victim of child sexual abuse shows the emotional suffering that is often experienced long after the crime.

Source: Anonymous

In addition to these clinical symptoms, individuals molested as children frequently exhibit poor sexual health as adults, including higher levels of sexual dysfunction and greater amounts of high-risk sexual behavior (e.g., unprotected intercourse, multiple sexual partners) (Homma et al., 2012; Lacelle et al., 2012; Mullen et al., 2000). Some victims, particularly boys, display aggression and violent behavior (see Hornor, 2010). Because of their psychological vulnerability, many victims of severe childhood abuse

also experience revictimization again in childhood (Finkelhor et al., 2007) and/or later in life as adults (Noll et al., 2009).

Like victims of rape, victims of child molestation have a tendency to blame themselves, especially if they were younger than 10 years old and the abuse was by a family member (Barker-Collo, 2001). Self-blame is a particularly problematic consequence of abuse, as it is associated with continued maladjustment in adulthood.

"I was sexually abused for 9 years as a child by my older sister's husband. For years I believed it had happened because there was something wrong with me."

"I blamed myself for the abuse. For a long time I believed that it was something about me that made him single me out. I hated myself, felt dirty and disgusting, for such a long time."

(All examples are from the authors' files.)

A review of many studies concluded that about two thirds of all victims of child sexual abuse show substantial recovery during the first 12 to 18 months (Kendall-Tackett et al., 1993). Even for these individuals, however, some symptoms, such as sexual preoccupation and aggressiveness, may worsen (Friedrich & Reams, 1987). About 10% to 24% of all abused female children not only fail to improve over time but actually get worse (see Kendall-Tackett et al., 1993). As adults, these women experience problems (e.g., emotional distress, drug and alcohol abuse, suicide attempts) that are just as great as those observed in women presently being abused (McCauley et al., 1997).

It is important to recognize that not all of the problems that some victims experience can be attributed to the sexual abuse (Fassler et al., 2005; Friedrich, 1998; Kendall-Tackett et al., 1993; Saywitz et al., 2000). Many experience other severely stressful life events that existed even before the sexual abuse began (e.g., dysfunctional family, generally maltreated in other ways).

About half of all child victims never inform their parents or another adult of the abuse (Paine & Hansen, 2002), and reactions that are perceived by the child as less than supportive can greatly add to the negativity of the experience (Jonzon & Lindblad, 2005). Consider, for example, the following two cases:

"At the age of 9, I was molested by a man right outside of my neighborhood. I told my mother what had happened. I was very hurt and scared, but instead of talking to me, my mother refused to talk about it and acted as if it was my fault. Years later I discovered the man had done the same thing to other children. By then it was too late, I was already emotionally scarred." (woman)

"I was about 8 years old when I was sexually abused by a friend of my father. I refused, but he beat me up and made me have sexual intercourse with him. Later the same night I told my father, but my father, instead of going to the police as I thought, beat me very harshly with a wood stick." (man)

(All examples are from the authors' files.)

There are several factors that seem to help many abused children recover from their molestation experiences, including being actively engaged in school, having adequate support from a caregiver, and possessing the personal attributes of hope and expectancy that things will improve (see Williams & Nelson-Gardell, 2012).

Recovered (False?) Memory Syndrome

"For the first time, when I was 17 a boyfriend reached out to touch me in a sexual manner. In that split second, I flashed back to when I was 9 and my uncle (by marriage) was molesting me. Until that moment I had no conscious memory of that event. I began to scream and cry and the poor guy didn't know what to do other than bring me home. I recently found out that this man repeatedly molested all seven of my female cousins."

(from the authors' files)

When childhood sexual abuse was not traumatic and occurred when they were very young, many people go for years without thinking about it. At some point, they may recall what happened—some may experience some degree of distress, but many do not (McNally & Geraerts, 2009). But how about when the abuse *was* traumatic? One of the most bitter debates in the field of sexual abuse today is whether people can forget sexually traumatic past experiences and later remember them. On the one hand, there are therapists who believe that sexual abuse can be so traumatic that individuals, in order to cope, forget or suppress memories of the event, often for many years. Later, either spontaneously or while undergoing therapy, the individual remembers the past events. Many studies have documented that people can experience amnesia for nonsexual traumatic events (e.g., disasters, combat) (Arrigo & Pezdek, 1997). Many others have reported cases of sexual abuse victims who said that they also had experienced some degree of amnesia about the events for a period of time (e.g., Feldman-Summers & Pope, 1994; Gold et al., 1994; Herman, 1992; Wilsnack et al., 2002). These studies find that, on average, about 50% of all victims report some amnesia (see Kristiansen et al., 1996). Proponents of the idea of repressed (and true) memories of abuse cite evidence that few claims of amnesia are false (Hovdestad & Kristiansen, 1996). In one study, women with well-substantiated cases of childhood sexual abuse 20 years earlier were interviewed. Over one third did not recall the abuse (Williams, 1994).

On the other hand, there are researchers who claim that most "recovered" memories are, in fact, false memories created by overzealous therapists working with vulnerable people (e.g., Loftus, 1997a, 1997b; Ofshe & Watters, 1994). These claims are bolstered by lab studies demonstrating that people can be induced to "remember" events that never occurred (Brainerd & Reyna, 1998; Zaragoza et al., 2001). For example, many children can be led to falsely remember a serious animal attack that never actually occurred (Porter et al., 1999). Sexually abused women with posttraumatic stress disorder are especially likely to show this effect in the lab (Bremner et al., 2000). Moreover, there are documented accounts of abuse victims who have later retracted their "memories" (e.g., De Rivera, 1997).

Today, most people take a balanced view, accepting that in some cases memories of abuse are false but that in other cases repressed memories are true. The important thing to remember is that if someone you know remembers an incident in his or her past involving sexual abuse, the appropriate response is not to dismiss those memories but to be supportive and empathetic.

Incest

The term "incest" comes from a Latin word (*incestus*) meaning "impure." Incest refers to sexual activity between relatives who are too closely related to marry. All known cultures have some form of law or social rule prohibiting incest (see Fisher, 1992; Frayser, 1989). In the United States, incest is illegal (although some states allow first-cousin marriages under special circumstances, such as if the individuals are age 65 or older and/or are infertile; see Box 15–C). One reason incest is illegal is that this type of mating has the highest probability of producing offspring with serious genetic defects (Thornhill, 1992). Until recently, many people thought that incest was rare, but it happens much more often than people might (or might want to) believe. Look again at Table 15–2. About 8.5% of all women and 2.4% of all men in Laumann et al.'s (1994) nationally representative survey said that they had been sexually abused by a family member before the age of 13. Only about 2% of adult-child incestuous relations ever get reported to authorities (Russell, 1984), and some victims do not understand that what happened to them was abuse (Kikuchi, 1988).

Although they have received little attention by researchers, polyincestuous families are not uncommon (Faller, 1991). In these families, there are both multiple abusers and multiple victims, both across generations and within the same generation. Victims often become abusers and in many cases view the activity as acceptable or even expected. It is common in polyincestuous families for women to participate as well (Faller, 1987; McCarty, 1986). In over half of such families, there are also abusers and victims from outside the family (Faller, 1991).

Much more is known about specific types of incest. After you have read about these, we will return to a discussion of family dynamics in incest.

Incest Between Siblings

Sexual contact between siblings (which includes *brother-sister incest, brother-brother incest,* and *sister-sister incest*) is more common than parent-child incest. For example, survey research reveals that about 2% of men and 5% of women were coerced or forced into sexual activities by their brothers as children (Beard et al., 2013; Stroebel et al., 2013a). About 2% of men and 3% of women report having been sexually abused as children by their sisters (O'Keefe et al., 2014; Stroebel et al., 2013b). In cases of sibling incest, the family dynamics are frequently found to be dysfunctional, often including physical abuse and heavy use of alcohol (see Ballantine, 2012; Cyr et al., 2002; Tidefors et al., 2010).

"I was a victim from age 4 until 13. My two brothers continually cornered me and forced me. My mother worked and was much too busy or tired to observe. She did not believe me when I tried to tell her. To this day, I still have problems sexually, emotionally, and mentally. My way of solving it was to move away (1200 miles away)."

"My brother was my first sexual partner. Makes me want to puke to admit that. At first it was just kissing and touching, but later it moved to intercourse. He wasn't forceful but it was so disgusting to me. My dad was an alcoholic and my mom was never around, so I had no one to tell. It stopped when I went away to college. To this day we haven't spoken about it. I sometimes see my brother but we never mention it."

(All examples are from the authors' files.)

Professionals have continued to debate about the long-term effects of sibling incest. Some believe that if the experience occurs between siblings of nearly the same age, if there is no betrayal of trust and both children are mutually involved in the activity, and if the children are not traumatized by adults in cases where their activity is discovered, then it may be viewed as "sex play" and part of the developmental process (Finkelhor, 1980; Steele & Alexander, 1981). However, as you can see from the previous case histories, most instances involve sexual contact that is initiated by one sibling and that is unwanted by the other sibling. Here, the effects are often quite negative, with many survivors exhibiting long-term issues with anxiety, depression, hostility, and low self-esteem (Beard et al., 2013; Carlson, 2011; Cyr et al., 2002; Stroebel et al., 2013a, 2013b; Thompson, 2009). This is particularly so when the incest involves coercion, threats, force, or betrayal of trust (Canavan et al., 1992). Only about 12% of all people with childhood sibling incest experiences have ever told anyone, and "the pain of secrecy" adds to the negative experience (Finkelhor, 1980). As a result, most professionals view any instance of sibling incest as problematic and advocate for early and sensitive intervention (see Ballantine, 2012).

Parent–Child Incest

"At the age of 5, I was the oldest of two children (my little sister was one year old). My mom would go to church and leave me in the care of my father. He would take out his penis and have me look at it and touch it, but I didn't know what was happening. It stopped for a while, but then he would try to put his tongue into my mouth. At the age of 8, after my mom had another baby, he would touch my vagina and lay on top of me (all 195 lbs.). At the age of 11, he got into my bed trying to take off my panties. I put up a fight but they were removed. He then took out his penis … I am a sophomore here at UNO, and it still hurts. I try to get over the hating of my father, but I don't really care what he thinks about me." (woman)

"My father began to molest me when I was 12—on the night after my mother's funeral. I am an only child and he explained that since my mother was gone I was going to have to function as the 'woman' of the house. At first I was only required to function as a woman in the evenings (and most mornings too), sharing his bed as my mother had. As I grew older additional chores were added such as cooking and cleaning. It was always explained that if I truly loved him I would never hesitate to do his bidding—oral and anal sex, giving him showers, dressing him, etc. Finally I managed to get the courage to leave my father…. Throughout my entire adult life I have never had a successful relationship. I'm not gay, but I don't know how a man should act. I only know how to function as the 'lady of the house.'" (man)

"I was 12 years old … my dad would touch me a lot. That was the year I started to get my breasts. In the middle of the night I would be woken up by my dad feeling my breasts. I would act as though I was still sleeping. One day when my mom went to the store my dad made me go in his room so he could shave around my vagina. When doing this, he got naked … he kept telling me that I needed to learn how to shave myself down there because guys don't like it hairy …"

(All examples are from the authors' files.)

Of all the types of incest, parent-child incest probably evokes the greatest emotional response in people. This may be because so many of us agree that it is the role of parents to nurture, provide for, and protect their children, not turn them into sexual objects for their own selfish needs.

Adults who commit incest with their children come from all walks of life. In 1991, former Miss America Marilyn Van Derbur brought public attention to this issue when she revealed that she had been repeatedly assaulted sexually beginning at age 5 by her father, a millionaire businessman, socialite, and philanthropist—a true "pillar of the community" (Figure 15–14).

Figure 15–14

In 1991, former Miss America Marilyn Van Derbur announced that her father (seen here congratulating her in 1958) had sexually abused her when she was a child.

Source: AP Images

Parent–child incest is relatively uncommon, having a prevalence rate of around 1% and accounting for only 10% of all incest cases (Finkelhor, 1979; Stroebel et al., 2012). However, nearly 80% of arrests involve *father (or stepfather)–daughter incest*. Stepfathers are more likely to victimize their children than are biological fathers (Finkelhor, 1979), but both types of cases occur. Fathers who commit incest are generally shy and publicly devoted family men who appear to be quite average, but in their own homes they are very domineering and authoritarian—"king of their castle"— with strong feelings of entitlement and a sense that they "own" their children (Meiselman, 1978; Pemberton & Wakeling, 2009). In relations with their children, they are often overprotective, selfish, and jealous. Incestuous fathers, obviously, have the capacity to become sexually aroused by children (and nearly half of all incestuous fathers also molest other children; Abel et al., 1988b).

The role of the mother (or other primary caregiver) in father–child incest is critical, and her response, or lack of any, is often as traumatizing to the child as the molestation. Consider, for example, the responses of the following five victims, four of whom were not protected by their mothers and one of whom did receive appropriate support:

"My mother didn't believe me. Even at age 19, I still feel resentment for her for not protecting me and for not believing me. At the time she was totally dependent on him (stepfather) and the thought of losing him was unthinkable."

"I thought every father did that to their daughter. I thought it was a part of growing up, especially because my mom knew about it."

"I eventually told my mother and she told me that it was nothing, that he probably thought it was her and she didn't mention it again."

"I grabbed onto her leg saying—screaming, crying—'Don't leave me please. I don't want to be here with him!' She said I had to behave and then left without even looking at me. From this moment on I knew she was not going to listen to me, let alone protect me. This is why I am angry today."

"When I turned 13, my dad said it was time I learned how to be a woman. He said he would teach me how to kiss. It progressed from regular kissing to French kissing. I didn't like it and one day I told my mom what was going on. She threw him out of the house, and I felt really bad about it but she said it wasn't my fault, that there was something wrong with him. She believed me and this helped me recover from what happened."

(All examples are from the authors' files.)

Sadly, some mothers who become aware of incest do not take any action. What stops them? Researchers note that those who fail to intervene are often emotionally distant from their children and dependent on their husbands for financial and other support (Finkelhor, 1984). Many were victims of child abuse themselves (Summit & Kryso, 1978) and continue to suffer physical abuse within the marriage (Truesdell et al., 1986). These factors may inhibit their ability to both acknowledge the abuse that is occurring and take decisive steps to end it.

In some cases, the mother is the abuser (Wijkman et al., 2010). *Mother–child* incest has generally been regarded as rare, but some believe that it may be underreported because surveys rarely ask specific questions about this type of incest (Lawson, 1993). Mother–son incest typically occurs in disrupted families where the mother seeks emotional support and physical closeness from her son rather than from other adults (Krug, 1989). Mothers who abuse their children often were sexually and/or physically victimized as children themselves (Grayston & DeLuca, 1999).

Although research suggests that grandparent-grandchild incest is quite uncommon (e.g., Cupoli & Sewell, 1988; Kendall-Tackett & Simon, 1987), this type of abuse certainly can and does occur.

"I only had to see him when we visited in the summer. He would get me downstairs in the cellar alone…. He would touch my vagina and I remember it hurting all of the time. He would sometimes take his penis out of his pants…. I never talked to anyone about it. One time I briefly talked to my sister about it at his funeral. She asked me why I did not seem sad…. She said it happened to her also."

(from the authors' files)

Effects on Children

Not surprisingly, given what you learned earlier about the impact of child sexual abuse and sibling incest, the impact of parent–child incest can be devastating. Much of the research in this area has focused on the impact of father–child incest. This may be due in part because that form of incest generally involves frequent, long-term abuse, and in many cases there is vaginal and/or anal penetration. Recall that these are precisely the factors that often cause the greatest long-term harm in child molestation cases (Hall & Hall, 2007; Tyler, 2002).

As with so many instances of child sexual abuse (or any form of sexual assault), victims often blame themselves (often with encouragement from the father [Barker-Collo, 2001]). Consider, for example, the feelings of the following two victims:

"I am 18 now and I believe that it was my fault. No matter how I look at it, I feel as though I could have prevented it."

"[I] still question myself about if there was something I could have done to prevent it, or worse yet, if there was, somehow, something I did to cause it."

(All examples are from the authors' files.)

Self-blame may be particularly likely if victims experienced any degree of physical pleasure during the abuse:

"In my mind, I blamed me, not him. To make matters worse, somewhere along the way my 12-year-old adolescent body had my first orgasm. I hated it, hated myself, hated him…. I couldn't understand something I hated feeling good. Heavy, heavy guilt trip."

(from the authors' files)

Children who are victims of incest frequently exhibit the same constellation of symptoms as other sexual assault victims, including posttraumatic stress disorder, anxiety, depression, other mood disorders, lowered self-esteem, and feelings of helplessness (Lindberg & Distad, 1985; Stroebe et al., 2012). Some develop eating disorders and/or substance use disorders (Hall et al., 1989; Snyder & Rubenstein, 2014). However, as with other types of child molestation, there is no definite or typical "incest syndrome" (Haesevoets, 1997).

"I've always felt alone, disassociated. Even when I'm with friends I don't feel like a part of the group. In class, I've never felt like I belonged."

"… But deep down I feel really disgusted about my body."

"By the time I was 13, I had found alcohol and drugs as a safe haven from the immense pain inside me. By the age of 17, I was a full-blown alcoholic experiencing blackouts."

(All examples are from the authors' files.)

Victims of child incest may also suffer from a variety of sexual problems (Easton et al., 2011). Some abused children may even victimize other children in an attempt to "work out" the distressing events (Johnson, 1989). As adults, they may be unable to form close, trusting relationships because they expect to be betrayed, rejected, and further abused (Cole & Putnam, 1992). This can lead to avoidance of relationships or, at the other extreme, promiscuity. Male and female incest survivors tend to become sexually active before their peers who have not experienced incest, and they have more sexual partners, are more likely to engage in casual sex outside of their primary relationship, and are more likely to have sex for money (see O'Keefe et al, 2014; Stroebel et al., 2012; Thompson, 2009). Child incest victims are also a likely target for revictimization later in life.

"I find I cannot have open relationships with guys. It is hard for me to trust anyone. For the one time I tried to open up to a guy, I ended up even more hurt. I am 20 years old and I cannot even kiss a guy, much less give a simple hug to someone."

"My relationships with men have all been abusive, even to the point that I have been battered and raped on several occasions…. I choose men that are very similar to my dad … mainly because that's all I know."

(All examples are from the authors' files.)

Personal Reflections

Have you ever been the victim of child sexual abuse? If so, has it affected how you feel about yourself or your relationships with others? If it has affected you in any way (including leaving you with any sense of self-blame), have you ever sought counseling? If you have not sought counseling, why not?

Box 15–C Cross-Cultural Perspectives

Incestuous Inbreeding—A Universal Taboo?

As we mentioned earlier in this chapter, every known human society has rules banning sexual intercourse and, consequently, marriage between closely related individuals (Fisher, 1992; Frayser, 1989). In fact, incest is so frowned upon (and forbidden) that it has often been called the universal taboo, with many theorists proposing reasons for its widespread prohibition. One of the major theories came from Freud (1913), who believed that most people actually prefer close kin as mating partners:

> [It is] beyond the possibility of doubt that an incestuous love choice is in fact the first and regular one….

(Freud, 1920/1953, pp. 220–221)

But inbreeding can lead to serious genetic defects in offspring (Thornhill, 1992) and would eventually ruin a society if it were practiced widely. Freud believed that it was for this reason that societies make rules against incest.

A second, much different theory was proposed by Edward Westermarck in 1891. He believed that close physical contact between two people during childhood naturally results in loss of sexual attraction. Findings of several anthropological studies have been used as support for this theory (e.g., McCabe, 1983; Pastner, 1986; Shepher, 1971; Wolf, 1970). However, Nancy Thornhill (1991) has proposed that incest rules are not aimed at close family members (because of the Westermarck effect) but instead are directed at more distant kin (cousins) and special kinds of adultery (e.g., a man and his father's wife). Inbreeding between cousins, she says, "can concentrate wealth and power within families to the detriment of the powerful positions of (male) rulers in stratified societies." Thus, she proposes that rules against incest were designed by powerful men to prevent families from gaining too much control in a given society.

Claude Lévi-Strauss (1969) offered yet a fourth explanation. His "alliance theory" says that the incest taboo exists not to prohibit marriage within the family but is "a rule obliging the mother, sister, or daughter to be given to others." It ensures that women are exchanged between groups rather than kept concentrated within one extended family. According to Lévi-Strauss, "The incest taboo is where nature transcends itself. It brings about and is the advent of a new order."

There is no question that incestuous inbreeding is viewed very negatively in many parts of the world. In the United States, for example, marriage between parents and their biological children, between brothers and sisters, between uncles and nieces, and between aunts and nephews is illegal. Incestuous unions between parents and children and brothers and sisters are also prohibited around the world, although this type of incest appears to have been historically practiced in some cultures. At one time, among the Egyptians, Incas, and Hawaiians, brothers and sisters married within royal families (Gregersen, 1982). Indeed, the Egyptian pharaoh Rameses II married both his younger sister and several of his daughters.

There is much greater cross-cultural variability when it comes to marriage between less closely related individuals, such as first or second cousins. Some countries forbid it outright. For example, first cousin marriage is illegal in much of Eastern Asia, including North and South Korea, the Philippines, China, and Taiwan. Similarly, over half of the states in the United States prohibit marriage between first cousins; the remaining states allow first cousin marriages or permit them only under very specific circumstances (for example, if the two partners agree to genetic counseling, if they are older than 65, if they are infertile, etc.). Other countries are less restrictive. First cousin marriage is permitted in the United Kingdom and other Western European nations, Japan, Islamic regions of Africa, and many Middle Eastern countries (e.g., Saudi Arabia, Iran, Iraq). Indeed, recent surveys conducted in Afghanistan, Oman, Lebanon, Syria, and Turkey revealed that about 20% to 40% of all marriages were between first cousins (see Akbayram et al., 2009; El-Keshen & Saadat, 2013; Islam, 2012; Othman & Saadat, 2009; Saify & Saadat, 2012).

Are there sociological or economic factors that might predict the acceptance and practice of incestuous inbreeding? Yes: In those areas of the world where it is practiced, it is most common among either poor, uneducated rural people or very rich land-owning families (see Bittles et al., 1991). It is also more likely to be found among insular groups who place high value on ethnic purity or selecting a mate from within one's own ethnic or clan affiliation. For example, high rates of first cousin marriages have been documented among Gypsy populations in Europe and among Bedouin clans in the Middle East (see Martin & Gamella, 2005; Raz & Atar, 2005).

In conclusion, mother–son incestuous inbreeding is practically unheard of in any culture, and with rare exceptions, all cultures similarly frown upon father–daughter and brother–sister relations. However, marriage between first cousins does occur and is much more commonly practiced than many of us might have guessed.

Preventing and Dealing with Child Sexual Abuse

The first thing to do to minimize the chance of your child becoming a victim of sexual abuse is to *educate yourself*. You should be able to talk openly and candidly about sexual matters, including sexual abuse, with your child. You should be aware of the fact that young children who tell people about being molested are almost never making the stories up. Remember that most molesters are known to their victims, so do not doubt your child if he or she tells you that the molester is someone you know.

The next thing to do is to *educate your child*. As we have indicated in previous chapters, it is important that children know the correct names for the parts of their anatomy. Children should not be ashamed of their bodies, but they should also know which parts of their bodies are personal or private and should not be touched by other people. Discuss this with all family members present— it is difficult for incest and other forms of abuse to develop in families in which there is open and honest communication and no secrets. Finally, it is crucial that your child know that he or she can communicate with you about sexual matters in general. If you are always open to discussion about sex, your child will be more likely to confide in you.

Know what to do if your child is molested or approached by a molester. Reassure him or her that talking to you about it was the right thing to do. Let your child know that being molested was not his or her fault and stress that it is the adult who was wrong. Do not confront the molester in front of your child, and let your child know that he or she will not be harmed by the molester. Finally, contact the police, even if you do not intend to press charges. By doing so, you may help them prevent further child abuse. (In addition, be aware that any teacher, school principal, doctor, or nurse who suspects child abuse is required by law in all 50 states [and the District of Columbia] to alert the authorities. If you currently are in or are thinking of entering those professions, you have a special responsibility to the children in your care.)

Figure 15–15

Many well-known people have been the victims of child sexual abuse, including actress Teri Hatcher (left), actor and game show host Drew Carey (right), actress Ashley Judd, comedians Roseanne Barr and Billy Connolly, and talk show host and media mogul Oprah Winfrey.

Source: Frank Trapper/Corbis/Getty Images; ZUMA Press, Inc./ Alamy Stock Photo

There are certain signs to look for that may indicate that a child has been a victim of sexual abuse. A victim may suddenly begin to have episodes of depression, crying, or other out-of-character changes in mood or personality. He or she may begin to want to be alone or become afraid to go to a certain place or see a certain person. A victim may suddenly start to have problems at school or with discipline. Remember, if abuse is occurring, a victim may be unwilling or fearful to ask for help (abusers often threaten their victims). If you are a parent, do not write off these types of behaviors as a phase. Something serious might be happening to your child. Be sensitive and kind, and talk openly and honestly with him or her.

Prosecution and Treatment Options for Sexual Offenders

1. 15.13 Discuss prosecution of and treatment options for sex offenders.

In this final section of the chapter, we explore prosecution of sex offenders, as well as available treatment options for rapists, child molesters, and their victims. Prosecution of and treatment options for sexual offenders (rapists, child abusers, sexual harassers, and so forth) have become more common, due in part to changes in the legal, political, and social/cultural landscape that have raised awareness of the "facts" of sexual assault and sexual victimization. However, despite these changes, it is important to recognize that in the United States (and countries around the world) many offenders still manage to escape prosecution (and most do not receive treatment).

Prosecution of Rape

In the past, almost half of all rape charges were dismissed before trial. However, with increased education (of the public, police, and courts) there have been dramatic changes in the manner in which rape victims are treated by the courts. For example, the U.S. Supreme Court has upheld broad rape-shield laws that make prosecution easier and help to prevent the victim from feeling as if she (or he) is on trial. In 1991, the Court ruled that states can enact laws that bar an accused acquaintance rapist from introducing evidence that he and his victim had previously had consensual sex. In addition, a victim's past sexual history is no longer allowed to be introduced during trial. The Federal Rules of Evidence (numbers 413–415) do allow rapists' and child molesters' past sexual offenses to be introduced in court (Eads et al., 2000).

Previously, evidence of emission of semen had to be found before an assault could be called a rape. Today, many states no longer require evidence of ejaculation for rape to be charged (although prosecution is made easier when semen is found during the medical examination, especially now that there is DNA testing; Leinwand, 2009). Some states have implemented additional laws designed to protect victims and punish perpetrators. For example, in September 2016, the governor of California signed Assembly Bill 2888 (AB 2888) into law. This bill closed a loophole in state law that allowed convicted rapists to receive probation (as opposed to a mandatory prison sentence) when the victim was unconscious or too intoxicated to resist during the assault. AB 2888 was inspired, in part, by the case involving ex–Stanford University student Brock Turner. Turner was convicted of sexually assaulting an unconscious woman behind a fraternity house in 2015 but was released on probation after serving only 3 months of his sentence. This case made national headlines, in part because of the victim's impassioned plea for justice during sentencing and the extremely mild sentence subsequently handed down by the judge (see Baker, 2016). (Turner himself asked for probation on the grounds that his actions were a "mistake" caused by "poor decision making and excessive drinking." His parents also pleaded on his behalf. In written letters to the judge, his mother Carleen stated that Brock was "crushed" by the verdict and simply "wouldn't survive" in prison, and his father Dan argued that Brock should not be unduly punished for only "20 minutes of action"; see Samuels, 2016).

As a result of AB 2888 and other reforms, rape victims today are more likely to report the crime than in the past (Clay-Warner & Burt, 2005). Unfortunately, as the Brock Turner case illustrates, some victims will find themselves feeling as if they are being re-victimized by a flawed criminal justice system.

Figure 15-16

Former Stanford undergraduate Brock Turner was convicted of sexual assault in 2016.

Sources: Stephen Lam/REUTERS/Alamy Stock Photo

Prosecution of Child Sexual Abuse

In a case that went before the U.S. Supreme Court, the Court stated, "Child abuse is one of the most difficult crimes to detect and prosecute, in large part because there often are no witnesses except the victim" (*Pennsylvania v. Ritchie,* 1987). One of the greatest issues impeding successful prosecution was that the Sixth Amendment of the U.S. Constitution guarantees that in criminal cases, the accused has the right to confront all witnesses against him (or her). Face-to-face confrontations were often very traumatic for children, who, in addition, were no match for shrewd and manipulative defense lawyers. However, in 1990 the Supreme Court ruled that individuals being prosecuted for child abuse had no guaranteed right to face-to-face confrontations with their young accusers if the children would suffer emotional trauma as a result. The Court upheld state laws that allowed use of videotaped testimony and testimony by one-way closed-circuit television. Courts are also allowing minors to testify with the aid of anatomically correct dolls so that they can show what happened to them. In the case of young girls, genital trauma and tearing of the hymen also can be used to validate the occurrence of sexual abuse (Berkoff et al., 2008).

Conviction of Sex Offenders

As the extent of sexual abuse of children has become better known, the states and federal government have taken a tougher stand. In 1990, Washington became the first state to pass a "sexual predator law" that allows the state to confine sexually violent pedophiles and rapists in mental institutions beyond their prison terms if it can be shown that it is likely that they will commit similar crimes again. Today, 20 states have enacted similar civil commitment legislation. Now generally called sexually violent predator laws, these statutes typically have three requirements: (1) conviction for a sexually violent crime, (2) a mental abnormality or psychiatric disorder (often pedophilia), and (3) a strong estimated likelihood to reoffend unless confined in a secure facility.

These laws have been challenged on grounds of constitutionality (e.g., does it meet standards of due process to continue to incarcerate someone who has served his [or her] full sentence?). However, the U.S. Supreme Court upheld the constitutionality of this type of civil commitment in a 1997 decision involving a Kansas man who had sexually abused children his entire adult life (*Kansas v. Hendricks*). The U.S. Supreme Court upheld the law again in a 2000 case and upheld a similar 2006 federal law in 2010 (*U.S. v. Comstock*). The issue becomes even more controversial when we consider juvenile sex offenders, whose numbers are increasing every year. If they are not stopped early in their abusive careers, their behavior may continue to escalate. However, because of their age, there remains the possibility they can learn new behavior and respond positively to treatment. Should society focus on incarceration or therapy? There are no easy answers. (See Martin & Pruett, 1998, for a thoughtful review; see also Wakefield, 2012.)

There are about a quarter of a million convicted sex offenders on probation nationwide. "Megan's law," as it was originally called in New Jersey, resulted from the publicity that followed the rape and murder of 7-year-old Megan Kanka in 1994 by a convicted pedophile who was living across the street from the Kanka family. This law requires sex offenders to register with local authorities and for those authorities to notify communities when a convicted sex offender moves into a neighborhood. All states now have versions of Megan's law on the books (see Scott & Gerbasi, 2003). A federal law (the Adam Walsh Child Protection and Safety Act) was subsequently passed in 1996; this law established a nationwide registry to keep track of sex offenders and set uniform standards for sex offender registration and community notification. However, some experts worry that by preventing sex offenders from successfully reintegrating back into the community, these laws may do more harm than good (Bonnar-Kidd, 2010).

Personal Reflections

As you have learned, several states have passed sexually violent predator laws that require that molesters identified as career predators be confined for life. Our society will no doubt continue to debate this sensitive issue, weighing the rights of offenders against the rights of victims and future victims, for many years to come. What do you think is best?

Therapy for Rapists

When considering therapeutic interventions for sexual assault, it is very important to keep in mind that most of the research has focused on convicted male rapists. Remember that these men typically engage in forcible stranger rape, often against multiple victims, and thus are not representative of the majority of men who commit sexual assault. That being said, clinicians have observed that one of the biggest problems in treating men arrested for rape is their tendency to deny or minimize their offenses (Thakker et al., 2008). Recall that most rapists have distorted cognitive beliefs and attitudes and that it is not uncommon for rapists to believe that their victims wanted to have sex.

Programs generally combine cognitive techniques with traditional behavioral techniques (see Thakker et al., 2008), and many employ antiandrogen hormone treatment to reduce sex drive (Grossman et al., 1999; Marshall et al., 1993; Polaschek et al., 1997). A successful outcome depends, in part, on how well the therapist can tailor the treatment program to the particular deficits and needs of the individual rapist (Eccleston & Owen, 2007; Reid et al., 2011; Thakker et al., 2008; Thakker & Gannon, 2010).

Therapy only works, of course, if the rapist wants to change. One major stumbling block to treatment success is that many rapists are reluctant to engage in therapy, and even among those who do, the dropout rate is high (see Polaschek et al., 1997). Several studies in the 1990s found that the recidivism rate (the percentage of offenders completing therapy who rape again) was about 20% in the first 5 years (Greenberg et al., 2000; Hanson, 2000; Prentky et al., 1997). More recent reviews have reported lower recidivism rates of about 10% within 5 to 10 years and about 20% within 15 years (Abracen et al., 2011; Harris & Hanson, 2004). Although these numbers are certainly higher than we would like, the reality is that most rapists do not reoffend (see Thakker et al., 2010), and modern therapy programs do seem to result in a modest reduction in recidivism

(see Thakker et al., 2008).

Therapy for Child Molesters

For the non-pedophile incestuous molester, a family systems approach is often chosen as therapy. Here, therapy for each family member is combined with therapy for each pair of family members and is followed by therapy for all the family members together (Lanyon, 1986). Group therapy with other families is also often included. In cases involving father-child incest, positive change is most likely to occur if the father can accept responsibility for what he has done and the mother can accept responsibility for what she has not done. The child, on the other hand, must learn to believe that he or she is not responsible. The father must also give up his complete authoritarian rule, and each family member must learn to become more independent. Among rapists and child molesters, the recidivism rate is lowest for incestuous offenders (Greenberg et. al., 2000).

As for the non-pedophile (situational) molester, whose sexual attraction is primarily to adults, many experts believe that society is best served by seeing to it that he or she receives therapy. Most therapists use cognitive-behavioral approaches. For juvenile sex offenders in particular, treatment is often effective (Reitzel & Carbonell, 2006). The same is true for female child abusers (Sandler & Freeman, 2009).

The outcome of therapy for pedophilic child molesters is less certain (see Hall & Hall, 2007). For these men, sexual orientation is primarily and repeatedly directed toward children, and they have little or no sexual interest in adults. As you have already learned, many of these men have victimized dozens, and in some cases hundreds, of children (Abel et al., 1987), yet they typically display considerable denial and defensiveness (Grossman et al., 1992). Some therapists consider pedophilic disorder to be incurable but treatable (Cloud, 2002). The antiandrogen drugs cyproterone acetate and medroxyprogesterone acetate are sometimes effective in lowering sex drive, which may allow clinicians to attempt therapy while the subject is not so intensely driven to commit his crimes (Bradford & Greenberg, 1997; but see Jordan et al., 2011). As with rapists, a comprehensive cognitive/behavioral/social therapy approach is generally used today (Barbaree & Seto, 1997; Polaschek et al., 1997). Unfortunately, reviews of available studies suggest that treatment often does not work (see Grønnerød et al., 2015). Indeed, the judicial system is full of examples of pedophilic offenders who have been caught, been confined, and undergone therapy time and time again. One study found that 14% of child molesters had been rearrested 3 years after release from prison, 30% after 10 years, and nearly half after 20 years (Prentky et al., 1997; see also Beech et al., 2012; Hanson, 2000; Harris et al., 2011). These types are often referred to as career pedophiles or, more recently, as career sexual predators. Prentky argues that simply allowing offenders to complete their prison terms and return to the community is dangerous and that community notification laws such as Megan's law are shortsighted. This is the reason that state and federal laws now allow such offenders to be confined in institutions after they have served their prison terms (see Conviction of Sex Offenders).

Therapy for Victims

For many victims, initial therapy may have to be geared to their posttraumatic stress (Mueser & Taylor, 1997). Abuse-focused cognitive-behavioral therapy has proven particularly effective in reducing the fear and distress experienced when recalling traumatic events (Cohen et al., 2000; Saywitz et al., 2000). Eventually, however, the victim must overcome any self-blame, and the involvement of the victim's partner and family can be very beneficial here (Cohen & Mannarino, 2000; Grosz et al., 2000; Sims & Garrison, 2014).

For counseling, contact RAINN (Rape, Abuse, and Incest National Network, online at www.rainn.org/index.php) for information about the rape crisis center nearest you. Services include a 24-hour rape crisis line and programs for victims of adult and child sexual assault and incest as well as programs for families and friends of victims.

Study Guide

Key Terms

- acquaintance (date) rape
- battering (anger) rape
- compliance
- date rape
- gang rape
- hyperfemininity
- hypergender
- hypermasculinity
- incest
- male rape
- marital (intimate partner) rape
- opportunistic rapists
- pedophilia
- polyincestuous family
- post-rape posttraumatic stress disorder
- force-only (power) rape
- preference molesters (pedophiles)
- rape
- rape myths
- rape-shield laws
- (obsessive) rape
- sexual assault
- sexual coercion
- sexual harassment
- sexually violent predator laws
- situational molesters
- stalking
- statutory rape
- stranger rape
- token resistance [to sex]
- war rape

Interactive Review

Answers can be found on p. 473.

1. Sexual assault occurs when a person does not want to have sex but does so as a result of real or threatened use of (1) , as a result

of (2) , or when he or she is unable to (3) .

In the United States, definitions of what constitutes rape have changed dramatically over time. Historically, the only type of rape that "counted" as a crime was (4) . Today, however, the federal government has adopted a broader definition, and now rape is defined as (5) .

There are two basic ways to estimate the prevalence of rape. The first involves analyzing (6) , or the number of cases officially reported to law enforcement. According to these reports, the rape rate has (7) steadily since 1992, though it still remains too high. Many experts believe that national crime reports like those provided by the FBI seriously (8) the amount of sexual violence that women (and men) experience. A second, more accurate method of determining rape prevalence involves using data from (9) . The results of these surveys typically yield much (10) numbers in terms of rape prevalence.

Most rapes are committed by (11) and happen at (12) . Most victims are women between (13) years of age, but anyone can be a victim of rape, including children, the elderly, the disabled, and men.

Rape by a date or an acquaintance is no less real than rape by a stranger. Rape is rape. Research reveals that about 25% of college men have admitted to using some form of sexual aggression on a dating partner, with between 6% and 8% admitting to actually having committed (14) . Sometimes, unwanted sex occurs not as a result of physical force, but as a result of (15) , which is defined as the use of physically or verbally coercive tactics to gain sexual compliance from another person who does not want to have sex. Taking advantage of someone who is asleep, unconscious, or drunk is an example of a (16) tactic, whereas pleading with someone or threatening to end the relationship unless the person complies is an example of a (17) tactic. Some instances of date rape may happen because men and women often misinterpret (18) . In addition, people sometimes fail to accurately communicate their true intentions or wishes. Examples of this include (19) , which is when someone says "no" but really means "yes," and (20) , which is when someone agrees to sex when he or she really does not want to.

Rape in which the perpetrator is the victim's spouse is called (21) , and it has been a crime in the United States since 1993. Estimates of this type of rape are difficult to obtain, as many victims do not report the crime. Some rapes involve more than one assailant, and these (22) rapes are usually more violent than rapes committed by individuals (and are, sadly, quite common in many parts of the world). All states have laws addressing sexual activity involving minors. In addition, many states have specific laws that make it illegal for an adult to have sex with anyone under the age of consent; this crime is generally called (23) rape. The mentally handicapped are often protected by these laws as well.

Research on male rape reveals that men, like women, tend to be raped by (24) . Unlike women, however, male rape victims are more likely to have been raped during (25) . Although some people have difficulty believing that a man can be raped by a woman, it does happen. Indeed, just like male perpetrators, women themselves report using coercion and even force to make their partners comply with their sexual demands. There is a difference between the type of coercion used, however: The coercion used by women is generally (26) , while that used by men is generally (27) .

Several personal factors are associated with rape or the likelihood to commit rape, including (28) , which is the dispositional tendency to accept (and to follow) exaggerated gender role stereotypes. In addition, research reveals that most rapists possess (29) attitudes and beliefs about sex roles and male and female behavior, strong acceptance of (30) , and a tendency to (31) responsibility for their own actions. In addition to these distorted attitudes and beliefs, many rapists also show a lack of (32) .

Interpersonal factors are also implicated in rape. Many men who commit sexual assault have developmental histories characterized by parental (33) as well as early exposure to (34) . A variety of social and cultural factors are associated with rape, as well. Rape is much more common in sexually repressive societies that promote and glorify (35) and where large numbers of people conform to conservative stereotypic gender roles and women occupy an inferior social and economic position.

Many mistaken beliefs about rape are so widespread that they are called myths. This chapter considered four rape myths, including the notions that (36) , (37) , (38) , and women frequently make false accusations of rape. None of these myths is true, but people who believe them tend to blame the victim for being raped.

Rape victims experience short- and long-term reactions in what is called (39) . In the acute phase, a victim's reactions may be either expressive or (40) . In the period of (41) , the victim attempts to regain control of her or his life. Long-term sexual problems are not uncommon. The reactions of a victim's partner and family are important to the recovery process, and it is crucial that they do not attribute blame to the victim.

If you are ever raped, it is important to report the crime immediately and get a medical exam as soon as possible. Do not wash, douche, or change clothes until the exam is completed. Today, most police forces have specially trained units, including counselors, to work with rape victims, and the U.S. Supreme Court has approved broad (42) laws to protect victims from feeling as if they are on trial during court proceedings.

There are three basic approaches to rape prevention. One focuses on the rapists and advocates the creation of safer physical environments and tougher laws and punishments. Another focuses on potential victims and suggests educating women to be less vulnerable to assault. The third, a (43) perspective, advocates changing society's values and its attitudes toward how men and women interact with one another.

Unwelcome sexual advances, requests for sexual favors, and other unwanted verbal or physical conduct of a sexual nature in the workplace or classroom is called (44) . The Supreme Court has ruled that this also includes the creation of a hostile or offensive work environment, and that a victim does not have to prove that sexual favors were demanded in exchange for job benefits. Companies and schools can be held liable for not taking immediate and appropriate corrective action.

Another form of unwanted sexual attention that many people experience is stalking. Stalking behavior possesses three characteristic features, which are (45) . This type of behavior typically becomes a crime when it poses a credible threat that places the target in fear for his or her (46) .

We now know that sexual abuse of children is more widespread than previously believed. Most victims are molested by (47) . We can divide child molesters into two classifications: the (48) molester, or "true" pedophilic offender, whose primary sexual orientation is to children, and the (49) molester, whose primary sexual orientation is to adults. Pedophilic sex offenders have been further classified according to whether they are sexually attracted to male children, female children, or both. For example, a man who is sexually attracted to both female and male children would be identified as a (50) , regardless of his own sexual orientation. Of pedophiles who have been caught, those who target girls average about 20 victims each, while those who target boys average nearly (51) victims each. Although most pedophilic offenders are men, women also commit child sexual abuse. Research reveals that the "typical" female offender is young, has poor coping skills and an existing psychological issue, and has herself often been the victim of prolonged childhood (52) . The effects of sexual abuse on children are often long-lasting, but there is no single "post-sexual abuse syndrome."

Sexual relations between relatives who are too closely related to marry is called incest. (53) incest is more common than parent–child incest, although father–daughter and stepfather–stepdaughter incest account for 80% of all arrests. Incestuous fathers often appear to be shy and family-oriented publicly, but are dominating and authoritarian in their own homes. In these cases, the mothers are usually aware that the incest is going on. It is important for children who have been sexually abused to receive counseling and support from professionals and organizations familiar with sexual abuse.

Today, many states have enacted (54) laws that allow a person who has been convicted of a violent sex crime to be civilly committed after he (or she) has served a full prison sentence if it can be demonstrated that he (or she) possesses a mental disorder and poses a continued threat to the community.

Self-Test

Answers can be found on p. 474.

A. True or False

- **T F** 55. A man or woman who has sex with an unconscious person has committed sexual assault.
- **T F** 56. An adult woman cannot be raped if she truly does not want to be raped.
- **T F** 57. Rape was originally defined as forcible male-to-female vaginal penetration.
- **T F** 58. The percentage of reported rapes that are false is lower than for most other crimes.
- **T F** 59. Anyone can be a victim of rape, including a man.
- **T F** 60. If a woman willingly makes out with a man, she cannot charge him with rape if he then forces her to have sexual intercourse.
- **T F** 61. Verbally pressuring someone to have sex is a form of sexual coercion.
- **T F** 62. Many (convicted) rapists believe that their victims want to have sex with them or deserve to be raped.
- **T F** 63. Almost all rapists are found to have some sort of major psychological dysfunction.
- **T F** 64. Marital rape is a crime in the United States.
- **T F** 65. Muehlenhard and colleagues found that over one third of all college women had said "no" to a date when they really meant "yes" (to having sex).
- **T F** 66. A man cannot be convicted of rape if the woman agreed to have sexual intercourse.
- **T F** 67. A man cannot be raped by a woman.
- **T F** 68. Both men and women can commit statutory rape.
- **T F** 69. Many victims of rape do not show any emotional reactions afterwards.
- **T F** 70. A man who tells sexual jokes, makes sexual references, and/or stares obsessively at a female coworker cannot be prosecuted for sexual harassment unless he demands sexual favors.

- **T F** 71. Most child molesters are known by their victims.
- **T F** 72. All pedophiles are child molesters.
- **T F** 73. Sibling incest is more common than parent–child incest.
- **T F** 74. All cultures have some form of incest taboo.
- **T F** 75. Victims of sexual abuse tend to blame themselves.

B. Matching

- 76. physical coercion
- 77. gang rape
- 78. opportunistic rape
- 79. verbal coercion
- 80. token resistance
- 81. preference molester
- 82. force-only (power) rape
- 83. compliance
- 84. sexual harassment
- 85. situational molester
- 86. bisexual pedophile
- 87. stalking

1. Albert is tired and really does not want to engage in intercourse, but he gives in when his wife asks him for sex.
2. Brad considers himself to be heterosexual, but he is sexually attracted to both male and female children.
3. Chris is sexually attracted to adults, but he has fondled a child and had the child touch his penis. He considers his behavior abnormal.
4. Doug tells crude sexual jokes and makes sexual comments to his female employees.
5. Katie threatens to end their relationship if her boyfriend refuses to have oral sex with her.
6. Frank is sexually aroused and impulsively forces his date to have sex with him when they are alone.
7. Grant and May are married. Although Grant is not generally physically abusive to May, he uses coercion or force when she is unwilling to have sex.
8. Susan initially says "no" and pulls away from her date when he begins to unbutton her blouse, even though she really does want to have sex with him.
9. Ian has no interest in adults as sexual partners. He is only attracted to children, and has engaged in sexual activities with several of the children in his neighborhood.
10. Before making any sexual advances, Donald makes sure to buy his dates several drinks in order to "loosen them up."
11. In college, Karen was sexually assaulted at a frat party by two of her classmates.
12. Although they broke up over a year ago and she made it clear that she does not want to see him, Jana's ex-boyfriend keeps following her around campus, showing up at her work, and sending her.pngts and text messages.

C. Fill in the Blanks

- 88. People with mental disabilities are often protected against sexual abuse by the same laws that protect .
- 89. Give four examples of sexually coercive behavior: , , , and .
- 90. In rape, the individual responsibility for things a person does can be diffused or forgotten.

- 91. The majority of date rapes are probably committed by rapists.
- 92. In the of post-rape posttraumatic stress disorder, victims attempt to regain control of their lives.
- 93. Charges of sexual harassment are usually prosecuted as civil suits under Title VII of the of 1964.
- 94. Sexual harassment usually occurs in a relationship where there is .
- 95. Research has shown that the more a man believes in , the more accepting he is of sexual harassment.
- 96. Teenagers who have sex with other teenagers are often protected from prosecution for statutory rape by laws.

Suggested Readings and Resources can be found on p. 465.

Chapter 16 Selling Sex: Social and Legal Issues

> Morality is about right and wrong, and that's what laws attempt to put into legal form. Can you think of one law which doesn't declare one behavior right and its opposite wrong? The truth is, all laws legislate morality (even speed limits imply a moral right to safety on the roads). And everyone in politics—conservatives, libertarians and liberals—is trying to legislate morality. The only question is whose morality should be legislated?

—From "Legislating Morality," by Frank Turek, July/August 1999, *New Man Magazine*

Learning Objectives

When you have finished studying this chapter, you should be able to:

1. 16.1 Describe the history of sexually explicit material (art, literature, etc.) among ancient and pre-contemporary human civilizations.
2. 16.2 Discuss the increased availability of sexually explicit media in contemporary societies.
3. 16.3 Explain the role that the Internet has played in increasing access to sexually explicit material and discuss the various types of content available (video, webcam, fan fiction).
4. 16.4 Discuss the differences (and similarities) between erotica and pornography and explain the legal definition of obscenity.
5. 16.5 Describe trends in, attitudes about, and reasons for pornography use.
6. 16.6 Compare and contrast the findings and recommendations of the two government commissions formed to evaluate the impact of pornography. Explain the association between pornography use and sexual arousal, risky sexual behavior, psychological well-being, and relationship adjustment.
7. 16.7 Discuss the association between pornography use and sexual violence.
8. 16.8 Identify the pros and cons of legalization versus censorship of pornography and discuss ways in which we can reduce the harmful effects of pornography (particularly for children and teenagers).
9. 16.9 Describe the historical legacy and contemporary legal status (and prevalence) of prostitution in the United States and around the world.
10. 16.10 Discuss how prostitution has historically been defined and current legal definitions in the United States.
11. 16.11 Distinguish between the different types of prostitution that occur.
12. 16.12 Describe the factors associated with entrance into prostitution and the outcomes that the majority of prostitutes experience.
13. 16.13 Describe the characteristics of people who pay for sex and their reasons for doing so.
14. 16.14 Discuss the types of human trafficking that occur around the world and delineate the steps we can take to stop this global trade.
15. 16.15 Discuss the continuing controversy over how to conceptualize prostitution (particularly with respect to legalization) and compare the different perspectives that have been used to understand this type of commercial sex.

Sex is an important part of most people's lives. It is a key component of gender identity, sexual orientation, and other aspects of our self-concepts; it can provide physical pleasure and emotional satisfaction (as well as distress and anxiety); and it can be given and received as an expression of desire, affection, and love. Sex is also a marketable commodity. People can buy and sell sex directly, as happens in prostitution, or indirectly, as occurs when someone purchases an X-rated DVD or pays to access online content (e.g., videos, live webcam feeds, and adult websites).

Around the world, sex is big business. For example, the sex industry contributes 2% to 14% of the gross domestic product in some Asian countries such as the Philippines and Indonesia (Empel, 2012). The annual revenues in the United States for sexually explicit material are between $10 and $20 billion (Byassee, 2008). This is more than Americans spend to watch all professional sports. Hollywood makes about 400 mainstream films a year, but the porn industry makes 11,000 (Paul, 2004). Prostitution revenues are over $52 billion a year worldwide (Altman, 2001).

In this chapter, we will explore two types of commercialized sex (pornography and prostitution) and the legal and ethical issues they raise. As you might suspect, these are controversial topics. Even existing laws and regulations about pornography and prostitution are controversial. Some people object to any attempt by the government or other authorities to regulate their private lives (including what they watch, what they buy and sell, and what they do with their own bodies). Others just as vehemently argue that the government has a duty to protect citizens from activities or materials that cause harm to the individual or contribute to social injustice. Our intent is not to persuade you to adopt a particular perspective. Rather, our goal is to provide you with historical context and up-to-date scientific information as a way of stimulating your own thinking about these topics. We begin with a discussion of sexually explicit media, with a particular focus on pornography.

Sexually Explicit Media: Historical Perspectives

1. 16.1 Describe the history of sexually explicit material (art, literature, etc.) among ancient and pre-contemporary human civilizations.

Sexually explicit media—drawings, paintings, sculpture, literature, and other forms of art or communication that depict or describe human sexual anatomy and behavior—are not new to our modern society. Archaeologists have discovered detailed cave etchings and stone carvings of sex acts and genitalia that date from the time of human prehistory. For example, the small stone carving generally known as "The Woman of Willendorf" is believed to have been created during the late Paleolithic period (about 22,000 to 24,000 years ago). As you can see in Figure 16–1, she possesses pronounced sexual features, including large breasts, a clearly visible vulva, and labia majora.

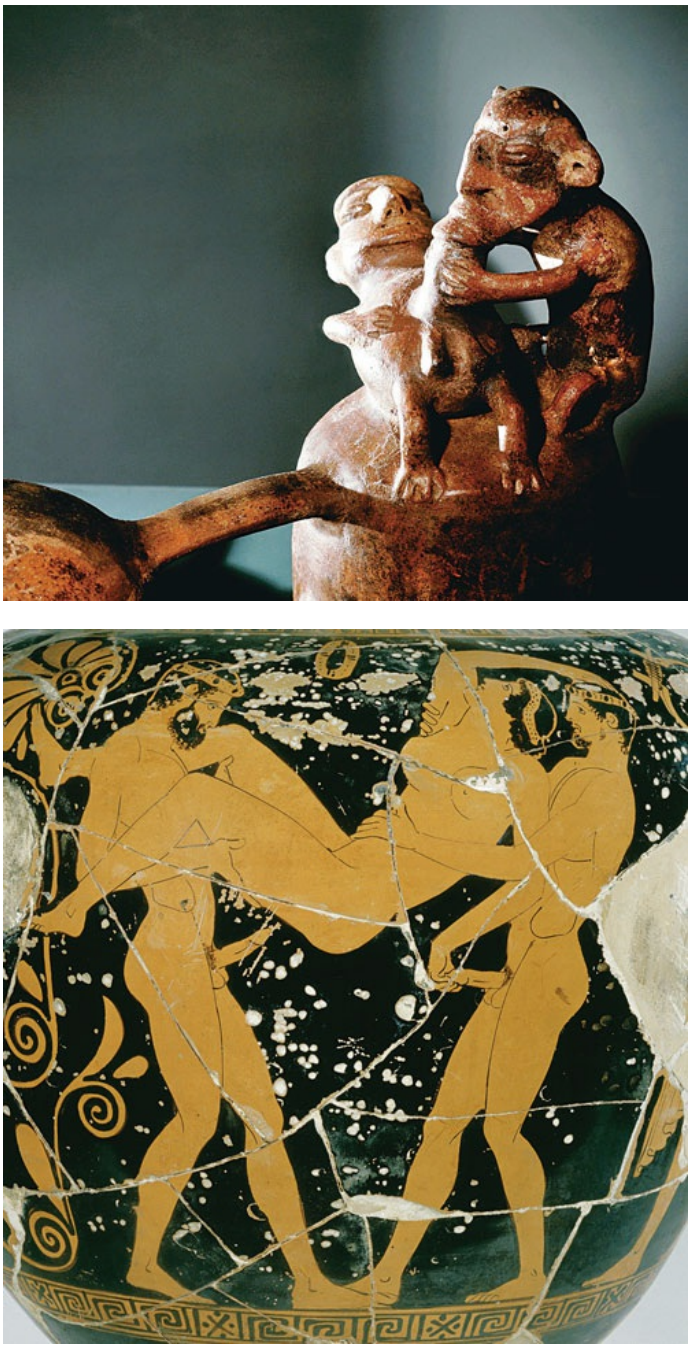
Figure 16–1

The Woman of Willendorf was discovered in the early 1990s and is believed to have been carved during the late Paleolithic period. The small figure stands approximately 4.5 inches high and has highly detailed external sexual anatomy, including breasts, vulva, and labia majora.

source: Hercules Milas/Alamy Stock Photo

In ancient Greece and Rome, phallic (from the Greek word *phallus*, meaning "penis") worship was common. Monuments, statues, carvings, and pottery of the penis (sometimes greatly enlarged) have been found throughout the ruins of Greece, Rome, Pompeii, and pre-Columbian Mexico and Peru. Greek and Roman art commonly showed humans engaged in sexual intercourse, fellatio, and group sex. Temple carvings from 16th-century India graphically portray humans engaging in every imaginable variety of sexual behavior (see Figures 16–2 and 16–3).

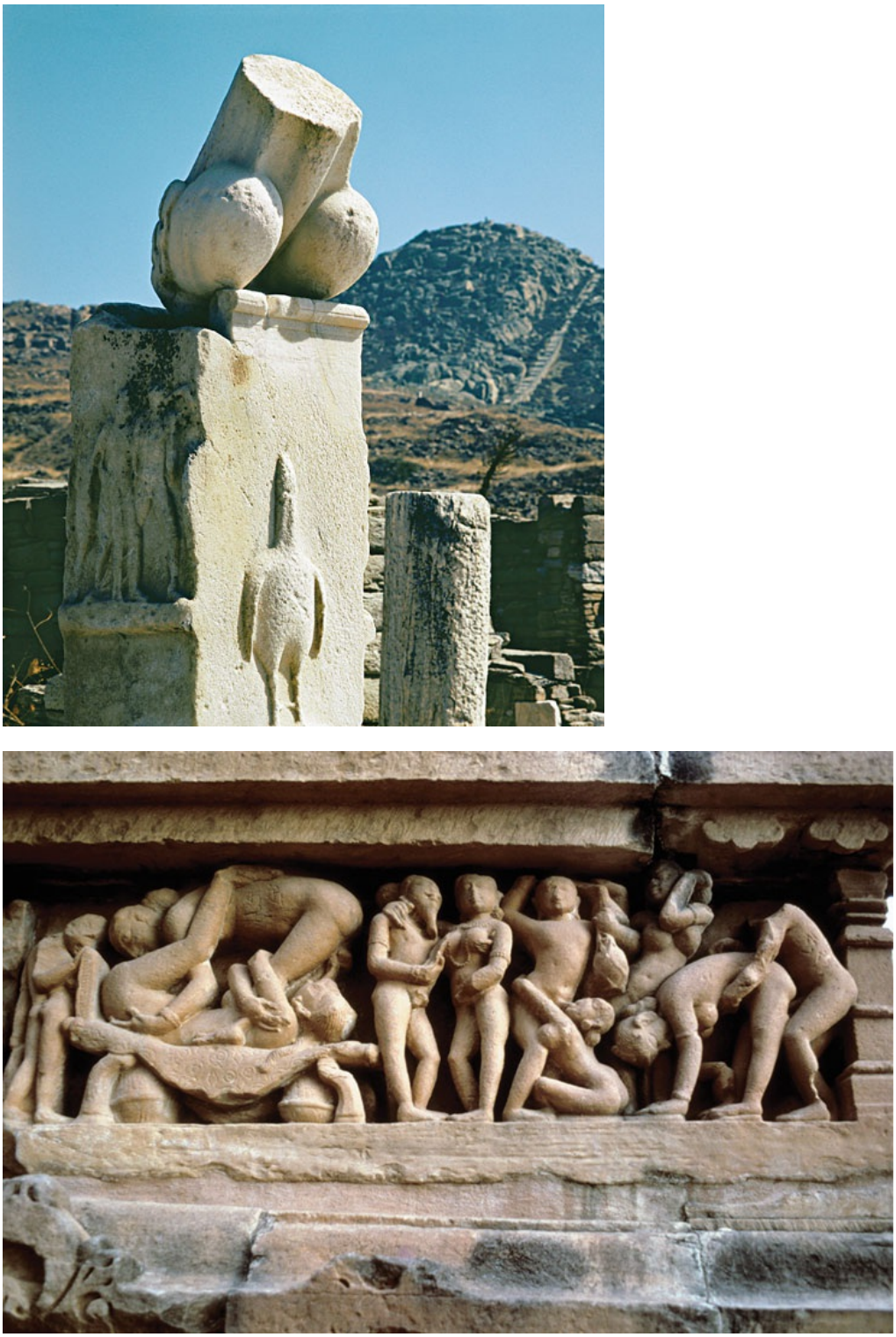
Figure 16–2



Sexual themes in art have been common throughout history. Pottery from ancient Peru (left). Vase from ancient Greece (right).

Source: (left) Werner Foreman/Topham/The Image Works; (right) Polygnotos (5th b.c.). Red Figure Vase, Side A: Erotic Scene, 5th b.c. Height: 0.415 m. Photo: Christian Larrieu. Musee du Louvre/RMN Reunion des Musees Nationaux, France. SCALA/Art Resource, NY

Figure 16–3

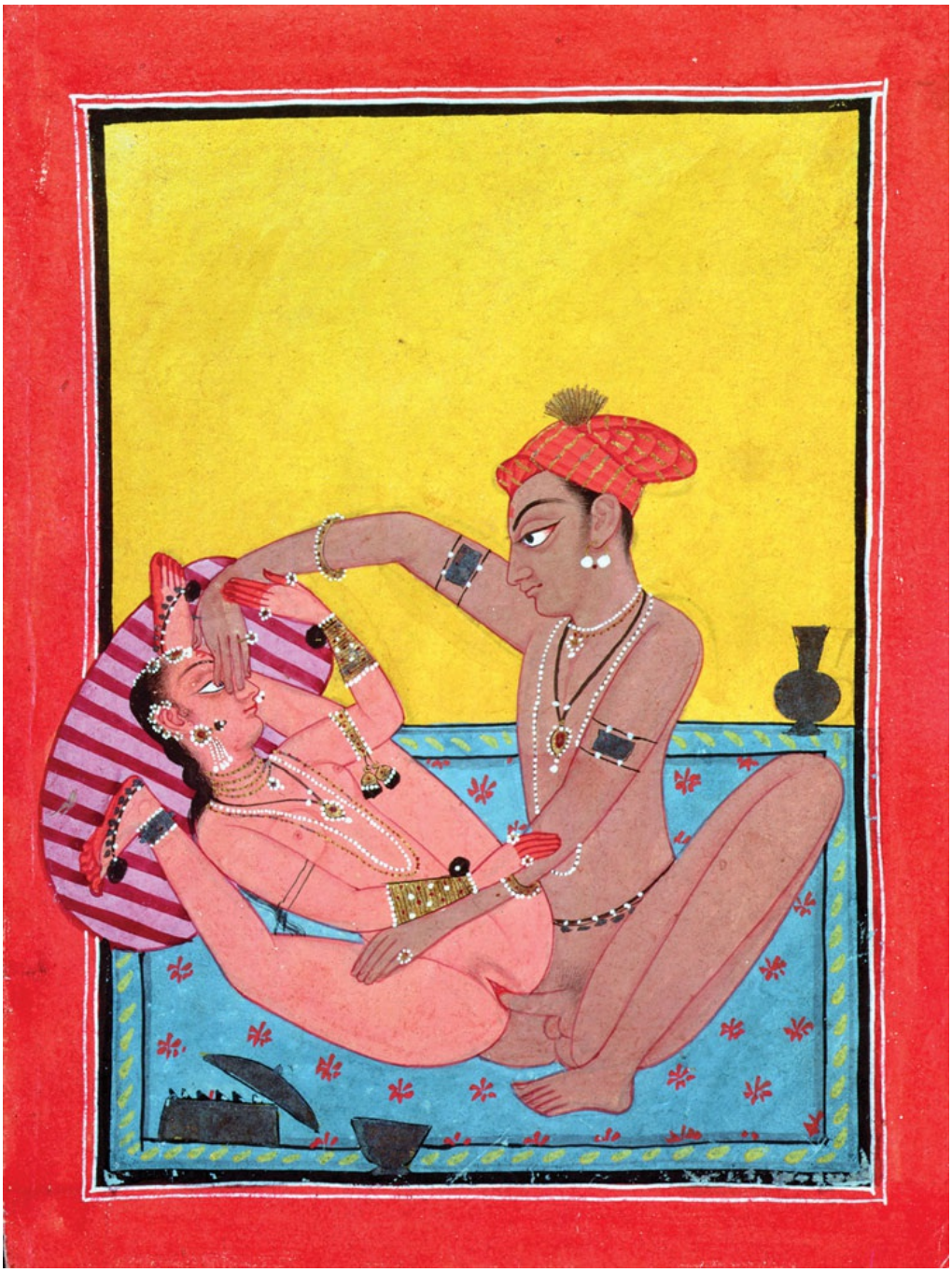


A phallic monument from 4th-century (b.c.) Greece (left). Temple carvings from 16th-century India (right).

Source: (left) Dionysos sanctuary, Delos, monumental phallus with a relief of the phallus-bird, a symbol of the God, carried in procession or drawn on a chariot during Dionysian rites. Inscription says monuments were donated by Karystos, son of Asbelos. Around 300 BCE, Delos, Greece, Erich Lessing/Art Resource, New York; (right) Dr. Suresh Vasant/ephotocorp/Alamy Stock Photo.

Similarly, across the centuries and around the globe, a wide array of sexually explicit manuscripts, prints, and portfolios were created and distributed. Perhaps the most famous is the *Kama Sutra*, a 5th-century (or thereabouts) guide to love, courtship, marriage, and family life that is attributed to the Indian philosopher Vatsyayana. Approximately 20% of the text is devoted to a discussion—with accompanying illustrations—of types of sexual activity (ranging from kissing to oral-genital contact to mutual masturbation to vaginal intercourse) and specific positions for engaging in "sexual congress" (Figure 16–4). Other early examples of sexually themed media include the Japanese erotic woodblock prints known as *shunga* ("picture of Spring;" Spring was a common euphemism for sexual activity), which reached their zenith during the Edo period (see Figure 16–5), and *I Modi* (meaning "the ways"), a pamphlet containing images of couples trying out various intercourse positions that was published in 1524 by the Italian engraver Marcantonio Raimondi.

Figure 16–4



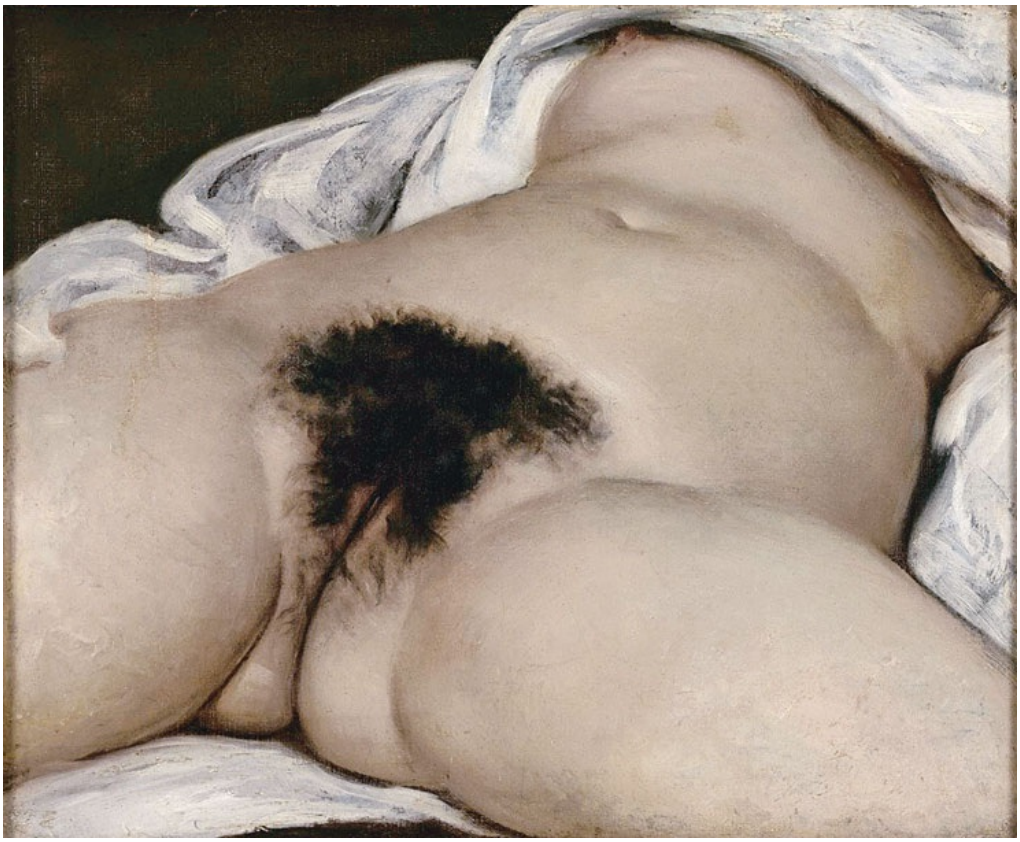
An example from the *Kama Sutra*, a 5th-century guide to family life in India that contained information about sexual activities and ways for couples to enhance sexual pleasure. Source: Lovers in extravagantly open posture, not mentioned in the 'Kama Sutra', Mankot, Punjab, mid-18th century (gouache on paper), Indian School, (18th century)/Private Collection/Bridgeman Images

Figure 16–5

The Dream of the Fisherman's Wife, by Katsushika Hokusai (circa 1814). Japanese erotic woodblock prints known as *shunga* reached their height of style and popularity during the Edo period spanning 1603 to 1868. This print, which depicts a woman enjoying sex play (kissing and cunnilingus) with two octopi, is loosely based on the (non-erotic) story of Princess Tamatori (which would have been well known to the audience of the day). It is the most famous of Hokusai's body of work and was featured in the TV series *Mad Men* (a large print was prominently displayed on the office wall of character Bert Cooper and later in character Peggy Olson's office). Source: ART Collection/Alamy Stock Photo

Post-Renaissance European art and literature also frequently had sexual themes. Rembrandt's *The Four-Poster Bed* and François Boucher's *Hercules and Omphale* (see Figure 16–6) are classic examples of this. Auguste Rodin celebrated the human body in his drawings and sculptures (e.g., *The Kiss*), as did many other artists of his time. John Cleland's 1748 erotic novel *Fanny Hill* (originally titled *Memoirs of a Woman of Pleasure*) contains vivid descriptions of various sex acts, such as solo and mutual masturbation, fellatio and cunnilingus, vaginal intercourse, and bondage and discipline.

Figure 16–6



Art with erotic themes from post-Renaissance Western culture. Rembrandt's *The Four-Poster Bed* (1646) (top left). Boucher's *Hercules and Omphale* (1730s) (top right). Gustave Courbet's *The Origin of the World* (1866) (bottom).

Source: (top left) "Ledikant" or "Le Lit a la francaise". Etching, 1646. Inv. RvR 264 (B.186), The Pierpont Morgan Library, New York, NY, USA, The Morgan Library & Museum/Art Resource, New York; (top right) SuperStock; (bottom left) Gustave Courbet (1819–1877), "The Origin of the World." 1866. Oil on canvas. 46 X 55 cm. RF 1995-10. Musee d'Orsay, Paris, France. Reunion des Musees Nationaus/Art Resource, NY

Obviously, the creation, distribution, and enjoyment of sexually themed material are not "new" human experiences! What is new, though, is how widely available such material has become in contemporary societies.

Sexually Explicit Media in Contemporary Societies

1. 16.2 Discuss the increased availability of sexually explicit media in contemporary societies.

It might surprise you, given what you have just read about our seemingly sex-filled cultural history, that the easy access to sexual content we enjoy today is a relatively recent phenomenon (at least in the United States). For example, nudity and sexuality were common in silent movies featuring the Hollywood "sex symbols" of the 1910s and 1920s (Theda Bara, Greta Garbo, Clara Bow, Rudolph Valentino). However, with the development of "talkies" (motion pictures with synchronous sound) in 1927, major movie studios feared that the government would become too involved in regulating the film industry. To forestall government interference, studio executives voluntarily established their own set of production (censorship) standards. The Production Code (initially called the Hays Code) specified images and topics to be avoided, many of them having to do with sexuality (including nudity, suggestive dancing, homosexuality [called sex perversion], "excessive and lustful kissing," and "lustful embraces"). An official seal of approval was granted only to movies that followed these standards. Code enforcement was fairly lax during the Great Depression but was in full force by the late 1930s. Consequently, big studio movies made during that time were heavily censored and are relatively devoid of sexual content. (Film star Mae West, famous for her breezy sexuality and provocative quips ["I used to be Snow White … but I drifted"], would deliberately add blatantly sexual lines to her scripts in hopes that censors would focus on those and overlook other racy but less explicit dialogue.)

This state of affairs began to change during the 1950s when producers and studio executives realized that they could release mainstream movies without the Code's seal of approval and still turn a profit. Although nudity remained taboo, sexually suggestive scenes and dialogue concerning gender identity, sexual desire, and premarital sex (and even incest and rape) occur throughout the dramas (e.g., *A Place in the Sun, Carmen Jones, A Streetcar Named Desire, Peyton Place*) and romantic comedies (e.g., *Calamity Jane, Gentlemen Prefer Blondes, The Moon Is Blue, Some Like It Hot*) of the decade. Such movies were often considered scandalous, but they were well received by critics and audiences alike (and many are considered "classics" today).

The 1950s also saw the birth of *Playboy*, the first U.S. magazine specifically marketed as adult entertainment for men. Hugh Hefner's magazine featured nude photos of women along with cutting-edge interviews and social commentary and had more than a million subscribers by 1959. (*Playboy*'s success allowed Hefner to create a publishing empire that today has segued into other markets.)

During the 1960s, commercially released films were characterized by increasingly frank treatments of sexual topics, including adultery and seduction (*The Graduate*), premarital sex (*That Touch of Mink, Splendor in the Grass*), spouse swapping (*Bob & Carol & Ted & Alice*), and casual sex (*Tom Jones*, the James Bond films). Print media also became more explicit. For example, in an effort to compete with *Playboy, Penthouse* became the first men's magazine to show female pubic hair and full frontal nudity.

We are fairly certain that very few of the movies or magazines mentioned above would unduly shock a modern audience. Even movies that were considered extremely sexually provocative and controversial when they were released in the 1980s (*Body Heat, 9½ Weeks, The Postman Always Rings Twice*) and 1990s (*Wild at Heart, Basic Instinct, Body of Evidence*) would probably not raise many eyebrows today, especially among younger viewers. This is due, at least in part, to the fact that we have become so inundated with sexual imagery that we are increasingly desensitized to it. Now, graphic sexual content shows up regularly on TV programs and in movies, in the pages of books and magazines … and especially on the Internet (Cooper et al., 2000).

Sexually Explicit Media and the Role of the Internet

1. 16.3 Explain the role that the Internet has played in increasing access to sexually explicit material and discuss the various types of content available (video, webcam, fan fiction).

The Internet has been a true game changer when it comes to access to sexually explicit material. In the past, the only way to directly obtain pornographic or erotic books, magazines, comics, and videos was in stores or through mail order. A man or woman who wanted to watch a "dirty movie," for example, had to drive to the local video store, enter a back room where the "specialty items" were housed, carry the tape or DVD to the register, and then complete the rental process under the watchful and knowing gaze of the sales associate. We have no doubt that the possible embarrassment of this experience kept many people away.

Today, though, thanks to the Internet, sexual material is readily available in the privacy of our own homes. Internet-enabled devices allow us to buy, sell, distribute, and watch just about anything sexual we can imagine—professionals and amateurs, of all orientations, ages, and ethnicities, having every possible kind of sex, by themselves or with every possible type of partner (same-sex, other-sex, both, or group; spouse, neighbor, stranger, or relative), using every possible position and every type of prop. Chat rooms, bulletin boards, and forums catering to specific sexual interests allow individuals to meet each other and exchange fantasies and information. Have a fetish? With the push of a few keys you can find other people who share your preference. (Please be cautious, though—stay off the dark web and never provide identifying information in online forums. Also be sure that you understand the difference between legal and illegal pornography; see our discussion below.) In short, the Internet has ushered us all into the next "sexual revolution" (Cooper et al., 2000).

Reliable statistics on Internet pornography and erotica are difficult to obtain due to the fluidity of site visitation and the fact that many adult website operators do not publish information abustomer usage or revenue. However, researchers estimate that there are now well over 4 million websites devoted to pornography (Young, 2008) and that Internet porn is a multi-billion-dollar-a-year global industry (Brown et al., 2007).

Figure 16–7

Explicit sexual material was once available only in X-rated movie theaters or from video stores, but today it is readily available on the Internet.

Source: Ulrich Baumgarten/Getty Images

Many websites allow users to download or watch sexually explicit videos. These include subscription-based sites such as those hosted by *Playboy, Penthouse*, and other adult entertainment companies as well as free sites where viewers can share their own homemade videos. Some of the most widely known free sites are YouPorn, Pornhub, RedTube, and XVideos. Not surprisingly, free sites receive greater traffic than subscription-based sites, with the larger sites averaging between 7 and 16 million views every month from users around the world (Ruvolo, 2011). Most Internet users (about 80%) who visit porn websites do so on an occasional basis; these recreational users average about 1 hour a month online (Paul, 2004). Only about 5% to 6% of men are compulsive users, averaging over 11 hours a week (Cooper et al., 1999; Ross et al., 2012). (See Chapter 13 on hypersexuality.)

Webcam sites that offer live streaming of sex acts (for a fee) are also available (Paasonen, 2010). The most popular of these is LiveJasmin, a video chat site that allows subscribers to log in, select a "model," and make requests. About 32 million people visit LiveJasmin each month. Almost all customers are men, almost all models are women in eastern Europe or southeast Asia (who receive an hourly wage for their work and no benefits), and the most requested act is for the model to strip while the customer watches and gives directions (Ruvolo, 2011).

There are also a plethora of websites devoted to erotic fan fiction (or *fanfic*). On these sites (such as adult-fanfiction.org), people share sexually explicit artwork and stories featuring characters from existing books, comics, movies, television shows, and other published works (e.g., *Harry Potter, the Twilight Saga, Lord of the Rings, Star Trek, Sherlock Holmes*). Fan fiction ranges from romantic and mildly erotic to extremely sexually graphic and includes heterosexual, "slash" (homosexual, usually male-male), and group pairings as well as solo sexual activities (see Driscoll, 2006; Kustritz, 2015 Tosenberger, 2008; Tresca, 2013). Whereas men and boys are the primary consumers of online video and webcam pornography, women and girls appear more likely to access (and create) erotic fanfic (MacDonald, 2006). What might explain this? Some scholars believe that erotic fan fiction provides a more "welcoming sexual space" (Fallon, 2015) for adolescent and adult women than other online sexual forums because it allows them to explore their sexual desires and identities indirectly through characters with whom they have an established emotional connection (Day, 2014; Fallon, 2015).

Pornography and Erotica: What's the Difference?

1. 16.4 Discuss the differences (and similarities) between erotica and pornography and explain the legal definition of obscenity.

So far in this chapter, we have used the labels "erotica" and "pornography" to describe media that contains sexual content. Because these terms share a common theme (sexuality), they are often used interchangeably by people in everyday life (including us, to be honest). However, they actually have different social, scientific, and legal meanings. Let us take a moment to tease apart their differences.

Erotica (from the Greek word *erotikos*, meaning "of love" or "caused by love") is a general term for art, literature, and other media that has an uplifting sexual theme. Such work is meant to be artistic and to present a positive, intimate, and celebratory vision of sexuality and the human body. Pornography (from the Greek words *porne*, which means "prostitute," and *graphos*, meaning "depicting or writing about") is a general term for entertainment media that is designed to generate sexual arousal in the consumer and whose primary purpose is commercial rather than artistic. Pornography is often (though not always) more graphic, impersonal, and explicit and less intimate and celebratory in its depiction of sex than is erotica.

Pornographic material can be further divided into legal and illegal forms. In the United States, *legal pornography* refers to sexually explicit material that is protected under the First Amendment and thus is legal to own, create, and distribute. This is the most common type of pornography and the one people are most likely to have viewed, purchased, or been exposed to in their lifetimes. The nude centerfolds in *Playboy* magazine, the sexually explicit video clips making their rounds on the web, and the X-rated DVDs for sale on Amazon, eBay, and a hundred other online and brick-and-mortar specialty stores are all examples of legal pornographic media. Legal pornography is the focus of the research covered in this chapter.

Illegal pornography refers to sexually explicit material that is categorized as obscenity and that therefore is not protected under the First Amendment. Child pornography is an example of this kind of material (see Chapter 15 section on child pornography). In determining whether an image, film, or other form of media is obscene, courts rely on a three-part standard that was established by the U.S. Supreme Court in 1973 (*Miller v. California*). According to the Miller Test (also commonly called the Three-Part Obscenity Test, or TPOT), material is considered obscene if

1. the "average person, applying contemporary community standards" would find that the work appeals to "prurient interest"

   (Author note: "prurient" means "excessive or unwholesome desires")

2. it depicts or describes sexual conduct as defined by state law in a "patently offensive" way

   (Author note: "patently" means "blatantly, clearly, or visibly")

3. it lacks "serious literary, artistic, political, or scientific value"

   (Author note: this standard is often referred to as the SLAPS test)

In their opinion, the justices further specified that the term "sexual conduct" mentioned in the second standard was broad and could include, depending on state law, actual or simulated sexual acts, masturbation, excretory functions, and exhibition of the genitals.

In reading over the three standards of the Miller Test, you will no doubt be struck by the fact that they are short on specificity and long on subjectivity. Who, for example, is the "average person" referenced in the first standard? You? Your parents? The guy who works down the street at the dry cleaner's? How do we precisely determine contemporary community standards? (And with so many of us connected electronically and forming a global community, does it even make sense to try?). How can we tell whether an image, film, or book lacks serious value or causes unwholesome interest? These are not easy questions to answer because every person has his or her own subjective understanding of what is offensive versus what is acceptable and what should be prohibited versus what should be allowed. (We will discuss the thorny issue of censorship in greater detail later in the chapter).

Not only is it often difficult to apply legal standards in deciding whether sexual material is obscene or not, but the boundaries between erotica and pornography themselves are blurry. For example, some people might regard Boucher's 18th-century painting of *Hercules and Omphale* (see Figure 16–6) as erotic—an artistic and tasteful celebration of the passionate union of two lovers. Others might view it as pornographic—an explicit and arousing scene of breast fondling, kissing, and foreplay. Some might even find it to be personally obscene (though it would not meet the legal standard)—an immoral and gratuitous display of nudity and unbridled lust. Many perspectives are possible, and there is generally no "right" legal, moral, or social way to view a particular piece of sexually themed material. (See Box 16–A.)

Personal Reflections

Ask some friends or family members to look at any of the images at the beginning of this chapter (or in other chapters, such as Chapter 11). Ask for their reaction—do they consider the material to be erotic or pornographic? Do any of them find the images obscene? If their responses differ from each other (or from your own), explore this—ask them what led them to their conclusion. Remember to be courteous and sensitive to the fact that multiple perspectives are possible and there is no "right" or "wrong" reaction.

Box 16–A Personal Perspectives

Sculptural Vulvae: Erotic or Pornographic, Artistic or Obscene?

Marina Santana (Figure 16–8a) is an artist from southern California whose work explores aspects of human sexuality. Among her recent projects is a series of porcelain vulvae designed to celebrate the diversity of women's external anatomy. To create each piece, Santana begins with a photograph. She then molds the figure by hand, allows it to dry, and fires and glazes it. Finally, "pubic" hair (actually human head hair donated by friends) is applied. Figure 16–8b presents some of these pieces.

Figure 16–8a

Marina Santana

Source: Marina Santana © 2017.

Figure 16–8b

Sculptural vulvae by artist Marina Santana.

Source: Isai Favela © 2017.

Not surprisingly, Santana has received a range of reactions from people who view her work. Here are some of the responses our own students gave after attending a gallery exhibition:

“This art tells women that just as there is a multitude of race/ethnic groups so too is there a multitude of vagina appearances. No two vaginas are identical and we must embrace this beautiful organ and not feel as if we are abnormal due to not being an exact duplicate of what is considered beautiful by mainstream media.”

“When I first saw the sculptures, I was in awe because they were so amazing. I loved the fact that the artist constructed multiple sculptures of different types of vulva. I was always insecure about how my own genitals looked, and this experience made me realize that we are all different and that this uniqueness is wonderful. Her sculptures were probably the coolest thing I have ever seen.”

“Even though the sculptures were replications, I just couldn’t bring myself to go near them because it didn’t feel appropriate.”

“I was extremely uncomfortable seeing these and frankly I found them to be excessively explicit and not suitable for general viewing. There is a reason we call them ‘private’ parts.”

(All examples are from the authors’ files.)

What does Santana think when faced with these mixed reactions? In her own words, “Western media has a profound effect on people, particularly women, and the way that they perceive themselves, their bodies, and sex. I want to engage with my viewers. If [my work] gets people talking, good or bad, I am satisfied.”

What are your own thoughts and feelings about these sculptures?

If you would like to view other pieces of Santana’s artwork, her website is located at https://marinasantana.jimdo.com/.

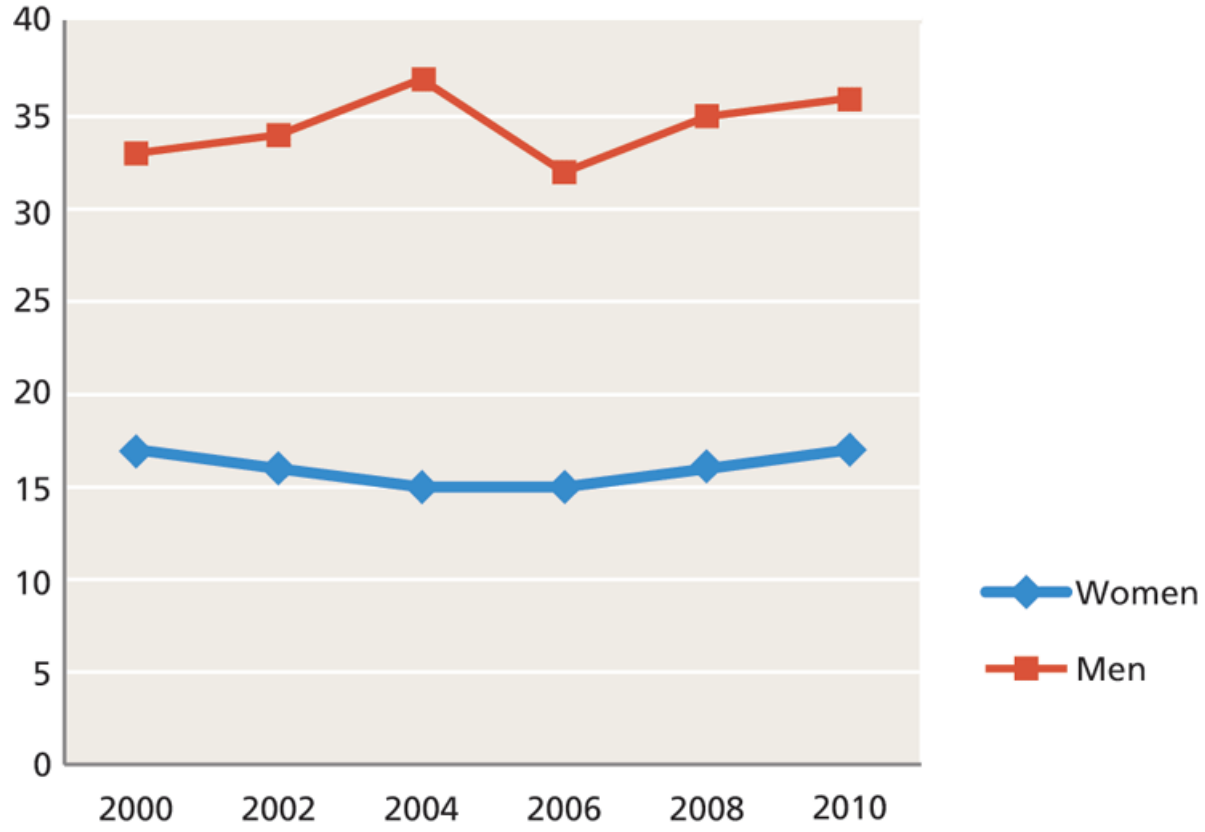
Pornography Consumption: Trends, Attitudes, and Motives

1. 16.5 Discuss trends in, attitudes about, and reasons for pornography use.

As we noted above, men (especially young men) are the primary users of online (e.g., websites, webcams) and offline (e.g., magazines, DVDs) pornography (see Petersen & Hyde, 2010; Wright & Bae, 2015). For example, in a large 2010 national survey, men and women ranging in age from 18 to 89 were asked to indicate whether they had watched at least one pornographic movie in the previous year (Wright, 2013a; Wright et al., 2013). Twice as many men (36%) as women (17%) responded affirmatively. Similarly, among teenagers, more boys (approximately two thirds) than girls (one third) say that they have visited a sexually explicit website (Braun-Courville & Rojas, 2009; also see Peter & Valkenburg, 2016). Men also view pornography more frequently than women. One survey of U.S. college students found that men watched sexually explicit media once or twice a week, on average, whereas women averaged once a month or less (Willoughby et al., 2014a).

Interestingly, although news and pop culture commentators frequently assert that pornography consumption has risen dramatically in recent years, research does not support this claim. As you will see in Figure 16–9, from 2000 to 2010 the proportion of adult men and women who viewed pornography at least once in the past year has remained fairly stable (Wright, 2013b; Wright et al., 2013). It is worth noting, however, that rates of pornography use are generally higher among younger (compared with older) adults in the United States and other countries (Hald et al., 2013a; Wright et al., 2013).

Figure 16–9



Percentages of adult men and women (age 18 to 89) who report having viewed at least one pornographic video during the past 12 months. Data based on Wright (2013b) and Wright et al. (2013).

Figure 16–9 Full Alternative Text

Of course, despite increased ease of access, not everyone chooses to view sexually explicit commercial media. Moreover, a sizeable number of teenagers and young adults hold negative attitudes toward pornography (see Price et al., 2016). As with viewing behavior, women and men tend to differ in their attitudes, with women having a more negative opinion of pornography than men (Olmstead et al., 2013).

Here are some representative views of students enrolled in our own courses. Men were generally positive about sexually explicit material:

"I do feel as though *Spice, Playboy*, and porn videos should be available. Reason being my parents didn't have that talk to me about the birds and bees. I learned from the streets, friends, and porn videos."

"I really don't have a problem with porn. There is a huge market for it and a ton of people enjoy it. The only problem is that the Internet has made it easy for kids to access it."

"I think that there is nothing at all wrong with sexually explicit material. It serves a need in our society, as evidenced by its success. If people didn't want it, they wouldn't buy it, and the companies providing it would collapse and become bankrupt."

"I personally find porn boring. It's always the same thing—oral on him, sometimes oral on her, sex from the front, sex from the back, usually more oral for him, then he cums on her face or stomach. Real sex is more interesting and far far more pleasurable. But that doesn't mean I think porn is bad. I guess I have no strong feelings one way or the other."

Women were more variable in their views:

"I for one am bothered by sexually explicit material. Women are exploited while men are hardly shown. It bothers me to flip through the channels of the TV and see a naked woman bouncing across the screen."

"I personally think that sexually explicit magazines are degrading to women in that they reinforce feelings men have about women as mere sex objects, put on earth to please them."

"My husband and I use pornography sometimes when we make love. It turns us on and it's a shared experience. We like more sensual, story-based porn, which is getting harder to find these days. We watch and fool around and then have sex. It's a great part of our sexual bag of tricks, so to speak!"

"I own some porn DVDs and I do sometimes look at them before I masturbate. But I don't know a single woman, including me, who enjoys the kind of sex shown in porn in real life. No woman likes getting pounded like that with no clitoral stimulation, no full body contact, nothing but wham, wham, wham in the most ridiculous contorted positions. And no woman has an immediate orgasm either. Porn's unrealistic and probably has screwed up thousands of relationships."

(All examples are from the authors' files.)

People not only have varying attitudes about pornography, but they also have different motives for seeking it out. Most people use pornography because of its ability to produce sexual arousal (we will say more about this in a bit). However, many adolescents and young adults who view X-rated films or visit porn sites are often motivated by curiosity, an interest in exploring their own developing sexual identities, and a desire for information (though, as many subsequently learn, pornography often provides misinformation) (Bryant & Brown, 1989; Hald & Malamuth, 2008; Peter & Valkenberg, 2010).

"My boyfriend was very misinformed about females when I first started dating him. He didn't know what they like/disliked or what a woman's anatomy should look like. He now has a more accurate view of things. He got his info from porno movies."

"My sister and I watched some porn to learn how to do oral sex on a guy. It looked easy and the girl who was doing it seemed to like it. But when I went to do it on this guy I met I almost threw up. It was not easy and I didn't like it."

"Pornography? If it's not violent, I don't have a problem with it. I used to think it was gross, but I've viewed it with my fiancé and we were actually educated. We were both pretty inexperienced and we learned many positions that we would like to try out and never thought of before."

"I looked at porn because as a virgin I wasn't sure how sex worked. I had questions that none of my friends could answer because none of us had had sex. We watched porn to learn."

(All examples are from the authors' files.)

Pornography may also allow people a way to safely "try out" sexual behaviors on their own and expand their sexual horizons (much like sexual fantasy does)—all without having to worry about contracting a sexually transmitted infection, about their partner's possible reaction, or even about finding a partner (Bryant & Brown, 1989). Many people who watch pornographic films also masturbate while viewing them.

"My favorite fantasy involves oral sex. I don't like it in real life because I get too self-conscious to enjoy it. I don't watch a lot of porn (my mind is a better arousal mechanism) but the porn I like the most is oral. I can experience it without actually having my partner do it to me."

"I am not gay, but I have wondered what it would be like to have sex with a guy. To get a blow job from him and then you know, enter him. I don't have any interest in really doing this. But sometimes I watch it. I will put on a video and masturbate."

"For some reason I find the idea of group sex to be highly arousing. I wouldn't want to do it, that would be gross, but the thought of people having sex all together, like a Roman orgy, turns me on. I'm not a fan of porn, but I have an X-rated version of *Caligula* and it has a scene like that. I guess it's a way for me to imagine what it would be like."

(All examples are from the authors' files.)

The Effects of Pornography

1. 16.6 Compare and contrast the findings and recommendations of the two government commissions formed to evaluate the impact of pornography. Explain the association between pornography use and sexual arousal, risky sexual behavior, psychological well-being, and relationship adjustment.

One of the most enduring questions about pornography concerns its possible (harmful) impact on those who use it regularly. The U.S. federal government, in fact, has authorized two large-scale investigations designed to determine whether exposure to sexually explicit media contributes to antisocial and other maladaptive behavior.

In 1968, President Lyndon Johnson appointed an 18-member Commission on Obscenity and Pornography (composed of scientists, psychiatrists, senators, attorneys, and members of the clergy) who spent two years studying the issue. There was little existing research available, but after considering the evidence and sponsoring their own study, the Commission concluded that there was no significant link in adults between exposure to sexually explicit materials and sex crimes or other deviant or harmful behavior. They recommended the repeal of all laws prohibiting adults (but not children) from accessing pornography and advocated the teaching of sex education in public schools:

> Failure to talk openly and directly about sex has several consequences. It overemphasizes sex, gives it a magical, non-natural quality, making it more attractive and fascinating. It diverts the expression of sexual interest out of more legitimate channels, into less legitimate channels. . . . The Commission believes that interest in sex is normal, healthy, good.

Richard Nixon was president when the Commission's report was released in 1970. He promptly rejected it, stating:

> I have evaluated that report and categorically reject its morally bankrupt conclusions and major recommendations…. The Commission contends that the proliferation of filthy books and plays has no lasting harmful effect on a man's character. If that were true, it must also be true that great books, great paintings, and great plays have no ennobling effect on a man's conduct. Centuries of civilization and 10 minutes of common sense tell us otherwise…. Pornography can corrupt a society and a civilization. The people's elected representatives have the right and obligation to prevent that corruption…. American morality is not to be trifled with. The Commission on Pornography and Obscenity has performed a disservice, and I totally reject its report.

The Commission's investigation did suffer from several major flaws, including a heavy reliance on interviews and anecdotal (as opposed to scientific) data and very little examination of violent and degrading pornography, which are the most potentially problematic forms of sexually explicit media.

Consequently, in 1985 President Ronald Reagan created another commission, the Attorney General's Commission on Pornography (often called the Meese Commission after Attorney General Edwin Meese). Like the earlier panel, this Commission consisted of attorneys, members of the clergy, psychologists, and psychiatrists as well as a social worker and an investigative reporter. After considering the available evidence, the members of the Commission released their report in 1986 (see Figure 16–10).

Figure 16–10

With the bare-breasted *Spirit of Justice* behind him, U.S. Attorney General Edwin Meese accepts the Report of the 1986 Commission on Pornography. Later, U.S. Attorney General John Ashcroft ordered that the statue be covered with drapes when he spoke. What is artistic to some people is obscenity to others.

Source: (left) Cynthia Johnson/The LIFE Images Collection/Getty Images; (right) Joe Marquette/AP Images.

One of the key contributions of the report was its acknowledgement that not all sexually explicit material is the same, and thus different types of pornography may have a different impact on individuals and on society as a whole. Specifically, the commission concluded that:

1. Nudity itself is not "much cause for concern," though children should perhaps be protected from very graphic and provocative displays.

2. There is no direct association between *nonviolent and non-degrading pornography* and antisocial behavior. The Commission cautioned, however, that this type of pornography is less common than violent and degrading material and that it can be harmful "in some settings and when used for some purposes."

3. There is an association between *nonviolent but degrading pornography* and attitudes supportive of violence against women (e.g., rape myth acceptance; see Chapter 15). The Commission noted that degrading sexually explicit material represents the "predominant proportion of commercially available pornography" and observed that long-term exposure to such material may produce an increased likelihood of "sexual violence, sexual coercion, or unwanted sexual aggression in the population so exposed."

   (Author note: Degrading pornography refers to material that depicts "people, usually women, as existing solely for the sexual satisfaction of others, usually men, or that depicts people, usually women, in decidedly subordinate roles in their sexual relations with others, or that depicts people engaged in sexual practices that would to most people be considered humiliating.")

4. There is a causal link between exposure to *violent pornography* and rape-supportive attitudes as well as physically aggressive behavior against women. The Commission observed that these effects are more pronounced when the woman is depicted as ultimately experiencing arousal, orgasm, and satisfaction as the result of the sexual assault, and they noted that this theme was "unfortunately very common in the materials we examined." Finally, the members concluded that it was the linkage of sex and violence that was problematic as opposed to the degree of sexual explicitness. That is, "as long as the violence is presented in an undeniably sexual context"—as happens in many non-

pornographic mainstream "slasher" films—the harmful effects hold.

Unlike the earlier commission, this group of experts did not advocate abolishing existing laws with respect to pornography. Rather, they urged more consistent and rigorous enforcement of obscenity laws. However, they also explicitly cautioned against relying too heavily on the law and infringing on people's First Amendment rights. Moreover, the Commission reminded the government and the public that positive efforts must also happen throughout society to counter any harmful impact caused by exposure to pornography:

> Action against harmful pornography, whether by law or by social action or by individual condemnation, is in the final analysis a negative approach. It is an attempt to eliminate a harmful message, and such attempts are frequently appropriate. But they cannot succeed by themselves. These essentially negative and reactive efforts must be accompanied by positive efforts. If there are certain attitudes that people ought not to have, then what attitudes ought people to have, and how can those attitudes best be inculcated? What will be taught in the schools? What forms of behavior will be publicly admired? What will the mass media encourage? What will we expect of each other in interpersonal behavior?

The Commission also called for additional research on the consequences of exposure to sexually explicit media. In the 30-plus years since the Commission's report, scientists have most definitely heeded this call. We turn now to a discussion of this large and growing body of research.

Pornography and Sexual Arousal

Not surprisingly, one of the most common effects produced by exposure to pornography is increased sexual arousal. Laboratory experiments demonstrate conclusively that both men and women become aroused by sexually explicit media. For example, in one early study (Heiman, 1977) men and women listened to a series of audiotapes that varied in sexual content while various devices (a penile strain gauge for men, a vaginal photoplethysmograph for women; see Chapter 4) recorded their level of physiological/genital sexual arousal. The results were clear—both men and women became significantly more physiologically aroused by the sexual tapes than by the nonsexual tapes. Other researchers have found the same results (e.g., Heiman & Hatch, 1980; Henson et al., 1979; Morokoff & Heiman, 1980).

Of course, this research focused on the impact of short-term exposure to sexually explicit content. Long-term or continued exposure to pornography actually leads to a reduction in sexual interest and arousal (Lipton, 1983). This phenomenon is known as *sexual habituation*. Over time, the novelty of the material wears off and it loses its ability to stimulate sexual excitement.

Interestingly, research suggests that women are able to become sexually (genitally) aroused to a greater variety of sexual stimuli than are men. Multiple studies have revealed that men's arousal to pornography is category-specific—that is, they become most aroused by images of the categories of people they prefer as sex partners. What does this mean? Well, that heterosexual men show greater sexual arousal to sexually explicit images involving women (such as a woman masturbating alone, a woman engaging in sexual activity with another woman, or a woman engaging in intercourse with a man) than they do to sexually explicit images of men (such as a man masturbating alone or engaging in sexual activities with another man) and that homosexual men show the opposite pattern (that is, greater arousal to images of men than to women). Women's sexual arousal, however, is less category-specific. For example, both homosexual and heterosexual women become sexually aroused by depictions of male–female, female–female, and male–male sexual activity and even by animal (primate) copulation (see Chivers, 2010; Chivers et al., 2004, 2007). Women appear to be a bit more flexible in their sexual responses to pornography, at least physiologically speaking!

It is important to remember that sexual responses have cognitive and emotional components as well (see Chapter 4). The fact that people can and do become physiologically aroused by pornography tells us very little about the *meaning* they attach to their responses. Two individuals viewing the same sexually explicit material may become genitally aroused and yet have very different subjective reactions to their arousal (Chivers et al., 2010). One person may feel aroused whereas the other may not; one may report negative emotions whereas the other person may report positive emotions or no emotions at all. In fact, research indicates that although both men and women become physiologically aroused by pornography (i.e., experience vasocongestion and other genital responses), men generally have a more positive emotional reaction and report higher levels of subjective sexual arousal than do women (Allen et al., 2007; Murnen & Stockton, 1997; also see Petersen & Hyde, 2011). Other studies have found that women's subjective arousal to sexually explicit material is often greater when the theme is female-initiated/female-centered and "romantic" as opposed to male-initiated/male-centered and not romantic (Laan et al., 1994; Quackenbush et al., 1995; see Rupp & Wallen, 2008).

16.6.2 Pornography and Risky Sexual Behavior

Research suggests that pornography use is associated with the development of more sexually permissive attitudes in adolescents and adults (e.g., positive attitudes toward casual sex and extramarital sex; Owens et al., 2012; Wright, 2013a; Wright et al., 2013, 2014). It is also associated with an increased likelihood of engaging in certain types of risky or permissive sexual behavior (for reviews, see Harkness et al., 2015; Owens et al., 2012). For example, men and women who view pornography with some regularity (e.g., at least once in the past year) report having had a greater number of sex partners overall, a greater number of casual sex partners, and a younger age at first intercourse than those who use pornography less often or not at all (Morgan, 2011; Wright, 2013b; Wright & Arroyo, 2013; Wright et al., 2013). They also are more likely to report having engaged in prostitution (exchanged sex for money) and extramarital sex (Wright, 2013b; Wright & Arroyo, 2013; Wright & Randall, 2012). One recent study found that among college students, pornography use was associated with an increased likelihood of experiencing one of the riskiest sexual encounters—a casual hookup involving penetrative intercourse without a condom while intoxicated (Braithwaite et al., 2015a; also see Braithwaite et al., 2015b).

Among samples of men who have sex with men (MSM), those who watch "bareback" pornography (sexually explicit media depicting unprotected anal intercourse between men) are less likely to report using a condom when having anal sex themselves (see Nelson et al., 2014; Stein et al.,

2012). In one interesting recent experiment, researchers selectively exposed men in an MSM club to two types of pornography: "unprotected sex" videos showing men having condomless anal intercourse and "protected sex" videos showing men using condoms during anal intercourse (Jonas et al., 2014). When surveyed, the men who had been exposed to images featuring unprotected anal sex reported a lower likelihood of using protection themselves than the men who had been exposed to safe sex images. It seems that what we see can influence what we do, sexually speaking.

16.6.3 Pornography and Psychological Well-Being

In addition to predicting risky sexual behavior (unprotected sex, casual sex, sex while drunk or intoxicated, etc.) that can produce negative physical health outcomes, pornography use is associated with adverse mental and psychological outcomes, including a greater number of depressive symptoms, higher anxiety and stress levels, and poorer overall quality of life (see Levin et al., 2012; Weaver et al., 2011).

Among men, frequency of pornography viewing also is associated with negative body image. Specifically, higher users worry more about their physical appearance and express greater dissatisfaction with their body shape and size, including their degree of muscularity and body fat, than lower users (Tylka, 2015). This may be a reflection of the objectifying manner in which the actors are filmed in pornographic visual media—as a dehumanized collection of genitalia, often viewed in extreme close-up rather than as complete individuals (see Klaassen & Peter, 2015). Recall from Chapter 4 that many men have concerns about penis size and wish their penises were larger. Pornography that showcases close-ups of seemingly enormous penises capable of becoming rock hard at the drop of a hat (and staying that way for an extended period of time) may exacerbate this situation. Indeed, about 40% of men seeking penile enlargement surgery state that their concerns developed during adolescence when they were first exposed to pornography (Mondaini et al., 2002). The more Internet pornography that men watch, in fact, the greater their dissatisfaction with the size of their own penises (Cranney, 2015).

"The first time I ever saw another man's penis was in a porn film. It was huge! About that time I started to worry about my own size, because I definitely was lacking in comparison."

"I have only seen other guys' 'equipment' in porn mags and videos. Every one of them is like the size of my forearm. For the longest time I thought there was something wrong with me."

"In porn, guys never fail. They can be with many women and every time their penis works. Gets hard, gets off, gets hard again. When my girlfriend and I first started to have sex, I thought I had a problem because my penis didn't work that way."

(All examples are from the authors' files.)

Similar concerns are expressed by male and female teenagers and emerging adults. Sizeable numbers report feeling that pornography puts undue pressure on them with respect to body appearance and sexual performance (Löfren-Mårtenson & Månsson, 2010; Mattebo et al., 2012; for a review, see Owens et al., 2012).

16.6.4 Pornography and Relationship Well-Being

In the 2013 movie *Don Jon* (starring Joseph Gordon-Levitt), the title character's use of online pornography, which he attempts to hide from his girlfriend, creates tension between them and eventually leads to the demise of their relationship. Research does indicate that women are more likely than men to view pornography use as unacceptable once two people are in a committed romantic relationship (Olmstead et al., 2013).

Is there a connection between pornography use (by one or both partners) and relationship well-being? Research suggests that the answer is yes. Men and women who consume higher amounts of pornography report less satisfaction with their current relationship and less commitment to their partner, engage in a greater amount of extradyadic flirting behavior, have more positive attitudes toward extramarital infidelity, and are more likely to actually commit infidelity (Lambert et al., 2012; Morgan, 2011; Wright et al., 2014).

Moreover, their *partners* are less satisfied with the quality of the relationship (at least, the female partners of heterosexual men). Clinical researchers have found that women who believe their spouses use excessive amounts of sexually explicit media experience high levels of distress and typically report feeling betrayed, sexually objectified, undesirable, and inadequate (Bergner & Bridges, 2002; Zitzman & Butler, 2005, 2009). Similar results have been found among college student samples. Women whose male partners use pornography exhibit lower levels of relationship satisfaction and self-esteem than women whose partners do not (e.g., Stewart & Szymanski, 2012; Szymanski et al., 2015). One study examined the association between undergraduate women's current psychological health and their former partners' pornography consumption (Tylka & Kroon Van Diest, 2015). The results revealed that the more pornography a woman's prior partner had used, the greater her subsequent relationship anxiety, body shame, and eating disorder symptomatology and the lower her current level of self-esteem and body appreciation (also see Albright, 2008).

Pornography and Sexual Assault

1. 16.7 Discuss the association between pornography use and sexual violence.

One of the most enduring concerns that policy makers and scientists have had about pornography concerns its possible contribution to sexual coercion and violence. Research investigating this question can be divided into three categories: (1) research that explores the link between pornography exposure and attitudes that support sexual assault (such as rape myth acceptance), (2) research that examines the relationship between pornography exposure and self-reported sexual assault, or (3) research that focuses on pornography exposure and actual (observed) physical aggression (such as delivering electric shocks to a woman in a laboratory setting).

16.7.1 Pornography and Rape-Supportive Attitudes

Recall from our earlier discussion the Meese Commission's (1986) conclusion that exposure to degrading but nonviolent pornography (the most common type of pornography) and to violent pornography produced attitudes in viewers that were supportive of violence against women. Subsequent research has confirmed the association between these types of pornography and rape-supportive attitudes.

Among men, amount or level of pornography consumption in general (regardless of type) is positively correlated with attitudes that support violence against women (Hald & Malamuth, 2014), with the perception that women are nothing more than sex objects ("sexual playthings," Peter & Valkenburg, 2007, 2009), with hostile sexism (an adversarial view of male–female relations in which women are viewed as seeking to control men, as unreasonably demanding in personal and professional situations, and as sexually manipulative) (Hald et al., 2013b), with rape myth acceptance (Allen et al., 1995b; Foubert et al., 2011), and with opposition to affirmative action policies promoting women (Wright & Funk, 2014). For example, in one investigation, the researchers found that men's pornography use was associated with perceived peer approval of forced sex (e.g., the belief that one's friends approve of getting a woman "drunk or high" to have sex), the perception that sexual aggression against women is unlikely to be punished, hostility toward women, and rape-supportive beliefs (e.g., "When women talk and act sexy, they are inviting rape") (Thompson & Morrison, 2013).

Most researchers have focused on the impact of pornography use on men's rape-supportive attitudes (perhaps because men are the primary consumers of sexually explicit media as well as the primary perpetrators of sexual assault). However, pornography also affects female viewers in a similar manner. Among teenage and adult women, amount or level of pornography consumption is positively associated with opposition to affirmative action policies promoting women (Wright & Funk, 2014), perceptions of women as sex objects (Peter & Valkenburg, 2007, 2009), and acceptance of rape myths (Allen et al., 1995b).

16.7.2 Pornography and Self-Reported Sexual Assault

Research indicates that pornography use is associated with men's self-reported likelihood of committing sexual assault. The first empirical demonstration of this occurred in the 1980s. During that decade, researchers began conducting laboratory experiments in which they exposed "normal" male volunteers to films or audiotapes containing (a) scenes of mutually consenting sexual activity, (b) scenes of non-sexual aggression against women, or (c) scenes that were both sexually explicit and aggressive toward women. The results of these studies revealed that men could and did become aroused by scenes that contained violent sexually explicit material (Malamuth & Donnerstein, 1984). In fact, they were often more aroused by violent sexually explicit scenes (e.g., of naked women bound and appearing distressed) than they were by scenes of women enjoying sex (Heilbrun & Seif, 1988; Malamuth, 1981). (Subsequent research has demonstrated that men with lower IQs, higher levels of aggressiveness, and preexisting rape-supportive attitudes are especially likely to be aroused by violent pornography (Bogaert et al., 1999; Davis & Bauserman, 1993; Linz, 1989; see Kingston et al., 2009), and that alcohol increases arousal to violent pornography (Davis et al., 2006; Noel et al., 2009)).

This research also demonstrated that male participants exposed to violent sexually explicit scenes became less sympathetic toward female rape victims, showed greater belief in rape myths (viewing rape victims as more responsible for their assaults), and *were more likely to indicate that they would commit rape themselves* if they were certain that they would not get caught (see Linz, 1989 or Malamuth & Donnerstein, 1984 for a review). Interestingly, the same result pattern was observed in men exposed to nonviolent but degrading pornography (i.e., in which women are portrayed as sexual objects and in which there is a clearly unequal balance of power) (Zillmann & Bryant, 1982).

Researchers working in the 1980s and 1990s made a distinction between types of pornographic material based on the presence or absence of violence and degradation (so did the Meese Commission, you will recall). At the time, this made sense. Scenes of male-perpetrated sexual violence and/or humiliation against women were relatively uncommon in existing X-rated films and magazines (Barron & Kimmel, 2000). Over the years, however, the lines between types of pornography have blurred. Sexually explicit material has become increasingly aggressive, "hard core," and degrading to women (see Bridges et al., 2010; Dines, 2010). Thus, it is not surprising that more recent research finds that men who view "regular" pornography report an increased behavioral intention to rape compared to men who do not view pornography (Foubert et al., 2011).

Of particular import is the finding that exposure to pornography predicts not only what men say they might do but also what they actually do. Prospective investigations, in which participants are followed over time, demonstrate that men who use pornography at one point in time are more likely to engage in sexually aggressive behavior at a later point in time, including sexual coercion and attempted or completed rape (D'Abreu & Krahé, 2014; Thompson & Morrison, 2013). Similarly, a recent analysis of the results of 22 separate studies found that pornography use predicted actual reports of physical and verbal sexual aggression (Wright et al., 2016). Specifically, men (and, interestingly, women) who consumed relatively greater amounts of pornography were more likely to report having used physical force, threats of physical force, or verbal coercion to obtain sex compared to those who consumed lower amounts.

16.7.3 Pornography and Actual Physical Aggression

For both ethical and practical reasons, it would be impossible to conduct an experiment to determine whether systematic exposure to sexually explicit material (violent or not) would cause a man to sexually assault a woman. However, researchers have been able to explore whether exposure to pornography in a controlled laboratory situation produces physically aggressive behavior.

In the typical laboratory experiment of this kind, male participants are randomly assigned to view various types of pornography (or to a no-pornography control condition). They are then given the opportunity to physically aggress against another person (for example, by administering electric shocks as part of a learning paradigm). The participants believe that the shocks are real and that they cause physical pain to the "learner" (however, no shocks are actually received). Research using this paradigm reveals that exposure to violent as well as nonviolent sexually explicit media produces aggressive behavior (electric "shocks"), with stronger effects seen for exposure to violent sexually explicit media (for a review, see Allen et al., 1995a). Interestingly, the effect is specific to female targets—men typically do not aggress against other men after viewing violent (or other types of) pornography (e.g., Donnerstein & Berkowitz, 1981).

Based on these three strands of research, it is no wonder that researchers continue to raise concerns about frequent use of pornography, particularly among men who score high on risk factors for sexual assault (e.g., Kingston et al., 2009; Malamuth et al., 2012; see Chapter 15).

Some researchers believe that the real focus of concern should be the level of violence in media as opposed to its degree of sexual explicitness (Linz et al., 1987).

> The most clear and present danger. . . is all violent material in our society, whether sexually explicit or not, that promotes violence against women.

(Donnerstein & Linz, 1986*)*

These researchers argue that sexual material is not inherently harmful but that it can become so when violent and/or demeaning themes are introduced (Anderson et al., 2003; Linz, 1989). There is solid evidence in support of this contention. For example, men who frequently view non-pornographic lifestyle magazines or television shows that sexually objectify women hold stronger rape-supportive attitudes than men who view such media less often (e.g., Wright & Tokunaga, 2016). Men who are exposed to non-pornographic R-rated "slasher" films that contain both sexual and violent content exhibit attitudinal changes similar to those observed in men exposed to violent and degrading pornography (e.g., Linz et al., 1984, 1988). The point is that any kind of media that presents violence in a sexual context, that objectifies and demeans women, or that contains the combination of both sexual and aggressive content is potentially problematic (see Linz & Donnerstein, 1994).

Unfortunately, this is precisely the kind of material that is common today in R-rated movies, in TV programs and reality shows, and in magazines and video games (Beck et al., 2012; Bleakley et al., 2012). So what should we do, as individuals and as a society? Many scientists suggest that stricter laws and regulations are not the solution. Rather, they propose that education about the effects of viewing pornography and other problematic content is the best way to help people make better choices about which programs, movies, and books they choose to expose themselves (and their children) to. We will consider this issue in greater detail in the next section of the chapter.

Personal Reflections

Assuming you have been exposed to pornography, how do you think that it has affected you? Did you find it arousing? Do you think it changed your attitudes toward sexuality, gender roles, sexual coercion and assault, and so forth?

Continuing Controversies About Pornography

1. 16.8 Identify the pros and cons of legalization versus censorship of pornography and discuss ways in which we can reduce the harmful effects of pornography (particularly for children and teenagers).

What should we do about sexually explicit material? Should we remove all restrictions to the sale and distribution of hard-core material to adults (i.e., make it completely legal), or should we attempt to ban all such material? There are good arguments for both cases.

On the one hand, a majority of young Americans now accept sexually explicit content in the mass media and believe that adults should have the right to obtain it (Carroll et al., 2008). Most young men, along with a sizeable minority of women, also believe that pornography has had a positive impact on their lives (Hald & Malamuth, 2008; see also Weinberg et al., 2010). Some sex therapists even recommend the use of pornography as a way of improving sexual functioning for individuals and couples (see Kohut & Fisher, 2013; Robinson et al., 1999).

On the other hand, we are really just in the first generation of Americans who have had easy access to sexually explicit material their entire lives (via the Internet). The research presented earlier indicates that frequent exposure to pornographic media can have harmful psychological and interpersonal consequences for men and women. Early exposure (during childhood and adolescence) may be particularly problematic. Surveys indicate that pornography is the number one concern children have about the Internet (violence is another major concern); they report feeling shocked, frightened, confused, and disgusted at witnessing sexually explicit and also violent online content (see, for example, Livingstone et al., 2014). Teenagers share their younger counterparts' concerns. They commonly report being anxious and confused about the sexual messages they feel that pornography sends them (see Mattebo et al., 2012; Owens et al., 2012).

Moreover, there is a clear gender disparity within the industry of pornography. Women who work in porn are on the receiving end of a disproportionate amount of physical and psychological degradation and abuse (see Dines, 2010). Many scholars now consider pornography essentially just another form of prostitution for women (see MacKinnon, 1996; Tyler, 2015). As we will shortly discuss, prostitution is associated with a host of negative outcomes for the women who engage in it. Thus, there are many reasons to be concerned about pornography's impact—on those of us who view it and on those who work within the industry.

Unfortunately, there is no easy answer when it comes to pornographic media. As we have discussed, obscenity laws are designed to protect all of us, regardless of age, from exposure to "indecent" and potentially damaging material. Indeed, there have been numerous attempts by citizens, school boards, and local governments to ban sexually oriented materials that they consider offensive (there still are—visit the American Library Association's Office for Intellectual Freedom at www.ala.org/bbooks/frequentlychallengedbooks for a list of the books that are challenged each year for having sexual and other types of content). Similarly, Congress has attempted several times to criminalize the transmission of pornographic material over the Internet. The producers or distributors of the materials, along with others, invariably protest these efforts on the grounds of First Amendment rights. The First Amendment of our Constitution guarantees, among other things, that Congress "shall make no law. . . abridging the freedom of speech, or of the press." Did our nation's founders truly intend this to cover the type of sexually graphic (and often demeaning and violent) material that each of us can easily access today? Probably not, but the issue becomes where to draw the line. With the exception of child pornography (which is a crime to possess, create, or distribute either over the Internet or offline), the U.S. Supreme Court has repeatedly ruled in favor of First Amendment rights.

Today, many experts believe that the best way to counter pornography (as with all media) is through education rather than censorship (see Linz et al., 1992). There is, in fact, solid evidence that this might be our best bet for reducing the negative effects of exposure to sexually explicit and/or violent material. For example, studies show that when men and women receive and actively think about educational information about sex, rape myths, and the fictional nature of media depictions, either before or after they are exposed to sexually violent media, the impact of that media is reduced (e.g., Allen et al., 1996).

The truth is that pornography is a potent agent of socialization. Through watching pornography, children, adolescents, and emerging adults learn about sexuality, including how men and women are "supposed" to look, behave, feel, and communicate during sexual interactions (see Tylka, 2015). Much of the pornographic media available today portrays people (particularly women) in depersonalized and rigidly stereotypic ways, and emphasizes the physical and genital aspects of sex (the "doing") while ignoring the emotional, cognitive, and interpersonal aspects (the "meaning"). In the typical pornographic script, men and women are merely a collection of body parts that always work, and sex is a casual activity devoid of intimacy and affection. The best way to counteract this script is via open and responsive communication about sexuality (see the Addendums in Chapters 10 and 13 for suggestions about how to do this). Parents, teachers, and others (including those who create and distribute sexual media) have the ability—and the obligation—to present an alternative, more holistic, egalitarian, and "sex positive" script. By limiting children's exposure to graphic sexual and violent media, by encouraging teens and young adults to limit their own exposure to such material, and by providing context for interpreting any images that are seen, parents (and others) can perhaps counter the negative outcomes we have discussed in this chapter. In sum, all of us need to be responsible consumers of media and to provide the younger generation with the tools to also become informed consumers.

Ken Benner/CartoonStock Ltd.

We conclude by noting that we are one of the few countries in the world whose people have true freedom of expression. Many of us are offended by at least some of the sexually explicit material that is around today, but many of us also worry that allowing others to have the power to ban such material might eventually infringe on our own presently enjoyed freedom of expression. After all, there are those who would ban passages in the Bible, along with such American literary classics as *The Scarlet Letter, The Grapes of Wrath, The Great Gatsby, An American Tragedy, Their Eyes Were Watching God, The Color Purple*, and *Gorillas in the Mist*, on the basis of their sexual content. What do you think should be done?

Personal Reflections

If you had the power to do it, would you ban pornography or allow unrestricted access? Are there certain types of pornography you would allow and types you would prohibit? Would you specify an age restriction or not? What are your reasons?

Prostitution

1. 16.9 Describe the historical legacy and contemporary legal status (and prevalence) of prostitution in the United States and around the world.

Today, the term sex work is frequently used to refer to the exchange of any sort of sexual services for money or goods. Examples include (but are not limited to) stripping or erotic dancing; providing erotic massages ("happy endings"), phone, or Internet sex; and participating in live (establishment-based or online) sex shows, pornography, and, of course, prostitution. Of all the forms of sex work that exist, prostitution is the one that has received the most sustained attention from law enforcement personnel, government officials and policy makers, public health workers and human rights advocates, and researchers.

16.9.1 A Brief History of Prostitution

Prostitution is often referred to as "the world's oldest profession." While this is probably not true (cooks, barbers, and scribes have been around just as long or longer), the exchange of sex for money has existed for as long as the recorded history of human beings (Lerner, 1986; Parsons, 2005). In ancient Hebrew culture, it was not a crime for a father to prostitute his daughter, and ancient Middle Eastern cultures often forced women who were captured during wars to serve in brothels (in fact, brothel prostitution has a long association with slavery). Historically, prostitution was used by governments as a means of generating income. For example, brothel keeping was formally instituted by officials throughout the ancient world—including China, Rome, and Greece—as a way of increasing state revenue.

In the Bible, Jesus told Mary Magdalene to "go, and sin no more," but prostitution flourished in Europe during the Middle Ages, and the Church had a somewhat tolerant attitude about it. Saint Augustine believed that prostitution was necessary, as did Saint Thomas Aquinas, who, although he considered prostitution a sordid evil, reasoned that just as a palace would become polluted without sewers, the world would become immersed in lust without prostitution (see Bullough & Bullough, 1997). Parisian prostitutes even adopted Mary Magdalene as their patron saint.

In Victorian times (mid-19th century to early 20th century), the upper class maintained a public attitude of purity and prudery, but prostitution was a common sexual outlet for husbands. The poverty and squalor of life in the lower class pushed many young women into prostitution, and it has been estimated that there were as many as 80,000 prostitutes in London at any one time. Prostitution was legalized and regulated by an act of the British Parliament in 1860.

In colonial America and the early years of the United States, Puritanism in the North and the availability of slave women in the South kept prostitution to a minimum. Immigration and industrialization, however, resulted in larger urban areas, and prostitution flourished in the latter half of the 19th century. Houses of prostitution (brothels) were commonplace, especially in the West, where men greatly outnumbered women. Ship captains imported thousands of women from the Orient and Central and South America to be forced into prostitution. San Francisco's population reached 25,000 in the early 1850s, and this included 3,000 prostitutes (Tannahill, 1980). Storyville, a 16-block district of legalized prostitution in New Orleans from 1897 to 1907, employed as many as 2,000 prostitutes at any one time (Warner, 1997).

Opposition to prostitution in the United States began to grow during the first part of the 20th century. Illinois became the first state to pass laws against prostitution in 1908. Federal laws passed at the start of World War I shut down many of the houses of prostitution that had existed near service bases (there were no cures for gonorrhea or syphilis at that time, and many men were being rejected for service because of infections). Today, Nevada is the only state in the United States that allows some form of prostitution (Brents & Hausbeck, 2000). Districts with fewer than 700,000 residents may issue business licenses to brothel keepers. However, many of these counties choose not to. As of 2017, only eight counties permitted brothel prostitution. All other forms of prostitution (e.g., street prostitution, escort and outcall services) remain illegal.

Figure 16–11

A Nevada brothel.

Source: Stephen Saks Photography/Alamy Stock Photo

What about prostitution in the rest of the world? Although social scientists and public health workers note that prostitution probably occurs in every single nation, all aspects of prostitution (e.g., selling, buying, pandering) are currently illegal in most African, Asian, Middle Eastern, and Eastern European countries. Prostitution is completely legal only in a few European nations (e.g., Germany, the Netherlands) as well as in New Zealand. In these countries, it is legal to advertise, sell, or buy sex and to keep a brothel or other establishment where sex is sold, and prostitutes must register and pay taxes. Some countries have adopted a *limited legality approach* in which the sale and purchase of sex between individuals (i.e., prostitute and client) is allowed but brothel keeping, pimping, and other forms of procuring or facilitating prostitution are illegal (e.g., Austria, Belgium, Argentina, Chile, Bolivia, Australia). And still others have adopted a *decriminalization policy* where it is not illegal for a person to sell her or his own sexual services, but it is illegal for someone to purchase sexual services, run a brothel, rent rooms or apartments to individuals engaged in sex work, or to advertise, pimp, or procure others for sex work. In these countries, which include Sweden, Norway, Iceland, and Canada, prostitutes are safe from prosecution, but customers, pimps, brothel keepers, and escort agency owners or managers are subject to fines and other criminal sanctions. Interestingly, even countries that have legalized or decriminalized prostitution prohibit or restrict (e.g., to certain areas during specific hours) the type known as street prostitution (see Types of Prostitution, below). We will consider issues and continuing controversies about the legalization versus criminalization of prostitution in the final section of this chapter.

Regardless of its legal status, prostitution is big business, estimated to generate between $186 and $300 billion a year in global revenue (Fondation Scelles, 2016; Havocscope, 2015). (However, as we will discuss later, very little of this money actually ends up in the hands of the prostitutes themselves.) How common is prostitution? Estimates vary widely, perhaps due in part to people's concerns about admitting to being involved in a socially stigmatized (and, depending on where they live, an illegal or criminal) activity. Moreover, a good number of prostitutes are underage, from marginalized groups, and/or the victims of trafficking. Consequently, many prostitutes are not easily visible or accessible to researchers and statisticians and thus are not represented in prevalence estimates. That being said, the worldwide number of people (primarily women and girls) engaged in prostitution is roughly estimated to be 30 million (Fondation Scelles, 2016). Across Western countries, about 1% of individuals have exchanged sex for money (Vanwesenbeeck, 2013). What about in the United States? One study found that 3.5% of American teens had exchanged sex for drugs or money (Edwards et al., 2006). In 2015, approximately 20,000 women and 11,000 men were arrested for engaging in prostitution and commercialized vice, defined as "the unlawful promotion of or participation in sexual activities for profit, including attempts" (Federal Bureau of Investigation, 2015).

Personal Reflections

Have you or someone you know ever exchanged sex for money (or money for sex)? If so, how did this make you feel? Would you feel comfortable admitting to having engaged in this activity to another person, including a doctor or a researcher? Why or why not?

Defining Prostitution

1. 16.10 Discuss how prostitution has historically been defined and current legal definitions in the United States.

Historically, prostitution was viewed as an activity practiced by promiscuous women who willingly and deliberately used their sexuality to corrupt men and who were not selective in practicing their immoral vice (see Flowers, 1994). Echoes of this outdated conceptualization can be seen as recently as 1968, when the Oregon Supreme Court ruled that "the feature which distinguishes a prostitute from other women who engage in illicit intercourse is the indiscrimination with which she offers herself to men for hire."

Today, prostitution is legally defined (in the United States and around the world) simply as sex for hire; that is, prostitution is viewed as an act or a profession in which a person knowingly engages in sexual activity for money or some item or service of value. For example, Oregon state law now defines prostitution as a crime in which "a person engages in, or offers or agrees to engage in, sexual conduct or sexual contact in return for a fee" (OR Stat. § 167.001 [2015]). (Notice that there is no longer any mention of prostitution as a specifically female act or any language referring to the indiscriminate offering of sexual access.)

Some states even specify the exact nature of the sexual activity that cannot be exchanged for money. New Mexico state law defines prostitution as engaging in the following sexual activities for hire—"sexual intercourse, cunnilingus, fellatio, masturbation of another, anal intercourse, or the causing of penetration to any extent and with any object of the genital or anal opening of another" (N.M. Stat. § 30-9-2 [2015]). North Carolina law is even more specific. In that state, it is illegal to "willfully" take money for performing, offering to perform, or agreeing to perform vaginal intercourse, other sexual acts (including cunnilingus, fellatio, analingus, anal intercourse, and genital or anal penetration with an object), and sexual contact (including the touching—even through clothing—of another person's or one's own "sexual organ, anus, breast, groin, or buttocks" and "ejaculating, emitting, or placing semen, urine, or feces on another") (N.C. Gen .Stat. § 14-204[a] & § 14-203[5] [2013]).

These legal definitions raise some interesting questions about the nature of prostitution. For example, consider a person who uses his or her sexuality for a job or career promotion or who allows a date to have sex with him or her in return for a.pngt, a meal in a fancy restaurant, or an expensive vacation. Are these instances of prostitution? Some prostitutes, in fact, feel that what they do is no different from what is done by a woman (or man) who remains married to and has sex with a partner she (or he) is no longer attracted to for reasons of economic security or financial gain. What do you think—is there a difference? If so, is the difference dependent on the relationship between the person offering the sex and the partner, as suggested by the 1968 Oregon Supreme Court ruling—such that a prostitute will have sex with anyone for a fee, whereas non-prostitutes (presumably) are more selective in their choice of partner? Or is the difference one of degree, such that an act of prostitution is distinguished from other acts of sexual exchange by the explicitness and directness of the "contract"? We have no easy or simple answers for you, but we encourage you to consider how our understanding of prostitution has been (and will no doubt continue to be) shaped by changes in the historical, social, economic, and political landscape.

Figure 16–12

Streetwalkers solicit in public and are the lowest-paid type of prostitute. They typically have sex with four to five men a day.

Source: Barry Lewis/Alamy Stock Photo

Types of Prostitution

1. 16.11 Distinguish between the different types of prostitution that occur.

There are several different types of prostitution, all of which can generally be differentiated by whether they occur outside (e.g., in the street, park, or other public setting) or inside (e.g., in locations or settings such as bars, hotels, clubs, massage parlors, brothels, or private residences) (Munk, 2009; Weitzer, 2012; see Table 16–1). Not surprisingly, some settings are associated with greater risks (and lower profits) for the prostitutes.

Table 16–1 A Typology of Prostitution

Primary Setting	Examples
Outside	• Street, park (commonly called streetwalking or hustling)
Inside—establishment-based	• Bar, hotel, casino, club • Massage parlor • Brothel • Window room • Bathhouse • Escort agency
Inside—outcall (to a hotel or private residence)	• Personal advertisement

Table 16–1 Full Alternative Text

16.11.1 Street Prostitution

Street prostitution (streetwalking) occurs outside and is the riskiest and least profitable form of sex for hire. It is also illegal in most parts of the world. Even countries that allow prostitution generally do not permit public solicitation by prostitutes or curb crawling ("kerb crawling" in Northern Europe, defined as driving slowly along public roads in search of prostitutes) by customers. Street prostitutes account for about 10% to 20% of all female prostitutes and nearly all of arrests (more than 90%), probably because of the visibility of their activity to law enforcement officers and community members (who may call the authorities) (Lucas, 2005). Most female streetwalkers are "protected" by a pimp, who usually takes a large share of the earnings (Williamson & Cluse-Tolar, 2002). Sexual activity between a streetwalker and customer generally takes place in the customer's car, in an alley or behind a commercial building, or in a room in a cheap hotel or apartment where the manager is aware of what is occurring. The typical streetwalker has sex with four to five men a day, and the sexual activity often involves giving oral-genital sex (Freund et al., 1989; Monto, 2001).

16.11.2 Establishment-Based Prostitution

Establishment-based prostitution is common around much of the world (e.g., Taylor, 2006). B-girls (or bar girls) identify customers in bars, hotel lobbies, casinos, or clubs, generally with the approval of the owners or managers (who often take a cut of the profits or else financially benefit by the customers the prostitutes attract). Open solicitation, however, is generally frowned upon, so nonverbal messages are often used to transact business. The price is usually higher than for a streetwalker's services, and the sexual activity generally takes place in the customer's room or a room the prostitute has rented. Some B-girl prostitutes have pimps, who also take a cut of their earnings. For example, "Candy," a 33-year-old woman known to your textbook authors, works in the bars along several streets in New Orleans' French Quarter. She earns between $50 to $200 a night and turns all of the money she makes over to her pimp, who provides her with protection, clothing, and jewelry (she has four children, is on welfare, and has no savings).

Massage Parlors

More recently, sexual services have increasingly been offered through thinly disguised storefronts such as *massage parlors* (it should be noted, however, that many of these parlors are legitimate). Women who work in these massage parlors are often called "hand whores" because toward the end of the massage they generally rub the client's thighs and groin area and let it be known that for a "tip" they will massage the genitals or perform other sexual acts. Because massage parlor prostitution is illegal in the United States, it is not uncommon for customers to use special terminology when scheduling a session to determine if sex is on the menu, such as asking whether the masseuse provides "full body" or "full service" massage or "happy endings." As with B-girls, massage parlor prostitutes often make very little money. The fee for the massage itself is paid directly to the owner, and thus they are completely dependent on the tips they receive from customers.

Figure 16–13

Some massage parlors are fronts for prostitution.

Source: Victor W. Adams/Alamy Stock Photo

Brothel Prostitution

Brothel prostitution represents another establishment-based type of prostitution. As we noted earlier, this type of prostitution is the only type of prostitution currently legal in the United States (and only in parts of Nevada). Women typically work in cycles, staying at the brothel for several weeks and working as continuously as possible, returning home to rest, and then going back to the brothel for their next "shift." Most brothels follow a standard script, illustrated in Figure 16–14. Specifically, the customer enters the premise and waits in the front room or "parlor." Next, the women who are currently working enter, stand in a line, and introduce themselves to him. Once he selects a particular prostitute, he goes to her room and negotiates a price (although some brothels have set fees, most do not and the rooms are usually "bugged" so that management can listen in to the price negotiation). As is common with all types of prostitution, brothel workers only receive a portion of the money they bring in. Management typically takes half, and the taxi drivers that shuttle customers to and from the brothel also receive a cut of the money the worker earns. Thus, it is not uncommon for a woman to take home only 20% of her total earnings. In other parts of the world, many brothel workers (particularly those who have been trafficked) earn even less.

Figure 16–14

Prostitutes line up before a potential customer in the parlor room of a Nevada brothel.

Source: John van Hasselt/Sygma/Getty Images

Window Prostitution

One variation of brothel prostitution is *window prostitution*, common in Amsterdam's famous Red Light District (Seals, 2015). Here, women sit or stand in small, separate "window rooms"—small rooms with floor-to-ceiling glass windows—through which they can be easily viewed by passersby (Weitzer, 2012; see Figure 16–15). When a window prostitute attracts a client, she closes the drapes to signal that she is engaged, takes him behind a partition at the back of the room, and has sex with him. Historically, this type of prostitution provided better working conditions and earnings for women than other types (Seals, 2015), but this began to change in the early 2000s as organized crime (drugs, money laundering, human trafficking) increasingly infiltrated the business. As a result, the Amsterdam government implemented policies designed to clean up the Red Light District, and many of the less reputable establishments have now closed (see Associated Press, 2007).

Outcall Prostitution

Figure 16–15

Window prostitutes in Amsterdam's Red Light District.

Source: Graham Prentice/Alamy Stock Photo

Another type of "inside" prostitution involves outcall work. Here, prostitutes advertise their services through an agency, broker, social networking site, or ad listing service (e.g., Craigslist) and then make arrangements to meet their clients at a designated indoor location (typically a hotel room or private residence). Although most people use the terms escort and call girl interchangeably, there are a few differences. *Escorts* are typically under exclusive contract to an agency that maintains a website with photos and descriptions of each woman and is responsible for screening and scheduling clients (Castle & Lee, 2008; Logan, 2016). Because they often provide social as well as sexual services, such as meeting a client for dinner and/or accompanying him to business events or parties, escorts charge more than other women who engage in "inside" prostitution (e.g., B-girls, brothel prostitutes). For example, one of your authors' graduate students put herself through school working as an escort. She had several regular clients in the Los Angeles entertainment industry and earned about $10,000 a month over a 14-month period (this work also caused her a great deal of stress and she ultimately was not able to finish her degree). The foreign sex tourism industry in particular has capitalized on the escort business, attracting male clients from around the globe with promises of a "total girlfriend experience" courtesy of attractive women guaranteed to deliver unconditional acceptance, fun and relaxation, and, of course, "exotic" sex (see Gezinski et al., 2016).

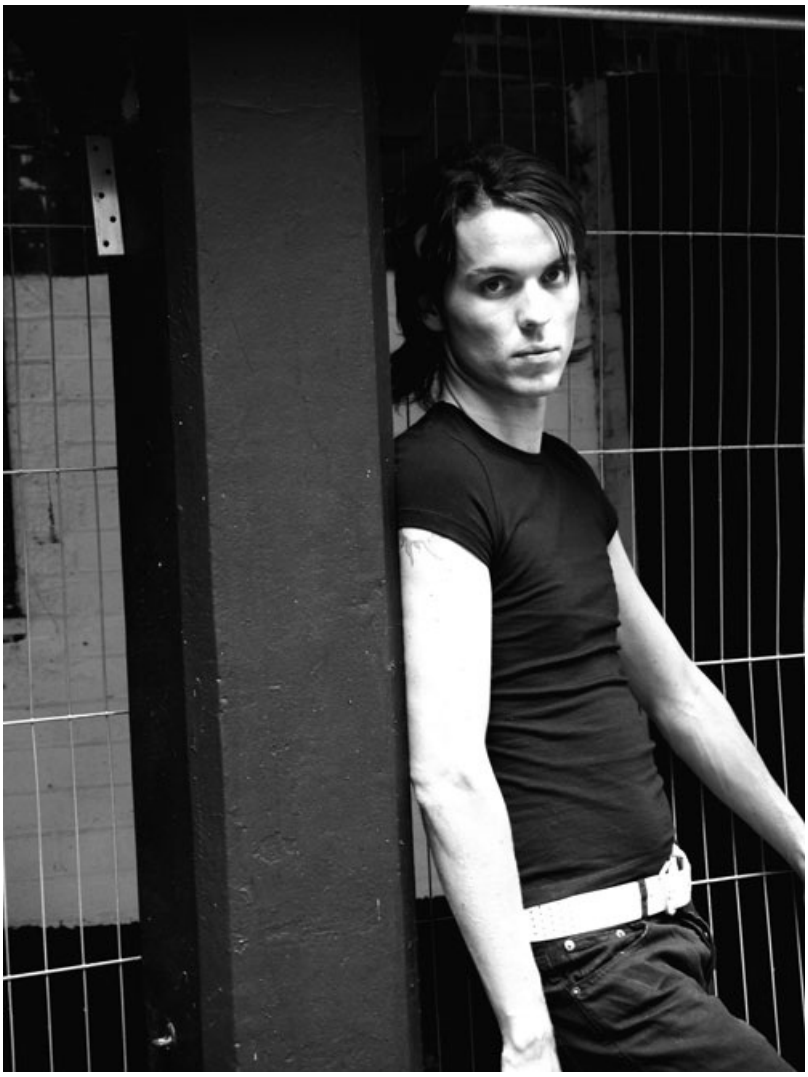
Call girls, like escorts, typically charge more than brothel, bar, or club prostitutes. Unlike escorts, they often are not assigned to one specific agency but instead may use a broker or verification service agent. Brokers and verification agents maintain databases of client information and—for a fee—will access that information on behalf of the call girl and verify a new client's place of employment, name, and history of problems with other prostitutes. Many call girls maintain their own websites and also advertise online through various ad listing or social networking sites (Empel, 2012). One of the largest and most utilized sites around the world for "adult" ad listings is Backpage.com. However, the site closed its adult advertising section to U.S. customers on January 9, 2016, after a congressional panel released a report alleging that company employees deliberately altered ads to remove evidence of prostitution and child sex trafficking (Hawkins, 2016). Regardless of how they advertise their services, call girls typically make appointments by phone, email, or text. Many have regular customers, and most work out of their own residences (Lucas, 2005).

16.11.3 Male Prostitution

Prostitution—like pornography use—is characterized by gender asymmetry. Specifically, most of the people who sell sexual services are female, and most of the people who buy sexual services are male. However, male prostitution does occur (and men and boys can be sexually trafficked; see discussion below).

Hustlers or rent boys work outside on the street or in the park and often near train or bus stations, public toilets, and gay bars (Munk, 2009). They are similar to female streetwalkers in that they receive the lowest fees for their sexual services, face the highest risk of arrest, and almost always service male clients (Earls & David, 1989). Like B-girls, they may work near a particular bar, club, or theater. Many are teenagers or young adults who are homeless and/or runaways and who engage in prostitution simply to survive (Finkelhor & Ormrod, 2004). One thing that distinguishes hustlers from female streetwalkers is that the majority of them do not work for a pimp (Logan, 2016).

Figure 16–16



Like their female counterparts, hustlers solicit in public, typically service men, and are the lowest-paid type of prostitute.

Source: t-lorien/E+/Getty Images

In the United States, male brothel prostitutes are practically nonexistent. There are no male-only brothels in Nevada (the only state that legally allows prostitution), and no existing brothels currently employ male workers. Two brothels, the Shady Lady Ranch (in 2010) and the Kit Kat Guest Ranch (in 2012), were the first to hire male prostitutes, but these men failed to generate sufficient interest or income and left the business shortly thereafter.

Figure 16–17

"Markus," Nevada's first official male brothel prostitute. Preferring to call himself a "surrogate lover" rather than a prostitute, Markus worked for only two months and served fewer than 10 clients.

Source: Shady Lady/Splash News/Newscom

In other parts of the world (e.g., Czech Republic, Brazil), young men sell their sexual services in specialized bars and clubs, saunas, or bathhouses that function similarly to brothels (Bar-Johnson & Weiss, 2015; Logan, 2016; Mitchell, 2015). For example, in Brazilian bathhouses, male clients pay an entrance fee that entitles them to enjoy music and dancing, to purchase food and drink, and to meet a number of *garotos* (a term that literally means "boys" but is used in bathhouses—and disparagingly by locals—to refer to young male prostitutes). If a mutually acceptable financial arrangement is reached with one of these young men, the client will rent a room or suite, thus providing additional income to the bathhouse owner. Garotos live off the tips they receive, often supporting both themselves and family members (Mitchell, 2015). Some clients are willing to provide additional financial support for a favorite prostitute, but this arrangement inevitably ends (as each garoto "ages out" of his trade and is replaced by younger, more desirable men).

As with women, the safest and most potentially lucrative category of prostitution for men is outcall work. Unlike women, who typically are under contract with an agency or use a brokerage or verification service, outcall male prostitutes are almost always self-employed (Logan, 2016; McLean, 2015). It is common for them to advertise their services online through their own or a friend's personal website or through commercial social networking sites and ad listing services. Until recently, the most popular and successful of these sites was New York–based Rentboy.com, which charged a monthly $59.95 membership fee and skirted U.S. prostitution law by prohibiting its clients from making any direct mention of sexual services or fees. However, after raiding Rentboy.com's Manhattan-based offices in 2015, federal and local agents finally gathered sufficient evidence to file prostitution charges against CEO Jeffrey Hurant. On October 7, 2016, Hurant pled guilty to promoting prostitution and the Rentboy.com site was shut down (Grindley, 2016).

Men who are available for sex with or without accompanying social activities (e.g., dinner, theater, company events) are referred to as escorts in the same way women are. Escorts may have regular clients, but they do not typically enter into exclusive arrangements with them. Gigolos (also called "male companions" or "kept men") do. These men establish relatively exclusive, long-term relationships with their partners (who are usually wealthy, older, single women) and serve as a consistent source of sexual and social companionship. The term "gigolo" has fallen out of style in

recent years, and people increasingly use the term "male escort" to refer to men who engage in any type of outcall work.

Many women who hire escorts are interested in more than sex. For example, the following account is from a 22-year-old student working as a male escort. He said that most of his female clients are in their 30s and 40s and 80% are single.

"Being a male escort is not all that people perceive it to be. In this day and age you have women that are successful, and in order for them to stay that way they must constantly work harder than any man they're in competition with. This causes women to be subjected to long hours of work and devotion to their jobs, leaving them with no time at all for a personal life. Every time they attempt to have a relationship, they end up neglecting either work or their partner. That is the point where I come in. I am the individual that can be there for them when they need someone either as a friend or a lover. One of the misconceptions of being a male escort is that they only have sex with their clients. That may be true for females, but in the male's case, out of ten women, only five of them only want sex. Three of them want to be held while watching a movie or listening to music. And as for the other two, they want someone who they can go to events with, someone who can carry on intellectual conversation and stand by their side as their showpiece."

(from the authors' files)

Like their female counterparts, men who hire male escorts also are often interested in obtaining more than sex. For example, a recent survey of men from the United States, Canada, and the United Kingdom who hired male escorts revealed that in addition to engaging in sexual activity, they also cuddled, watched shows, shared meals, took walks, and shopped with their paid companions (Wolff et al., 2014).

Contributing Factors and Outcomes Associated with Prostitution

1. 16.12 Describe the factors associated with entrance into prostitution and the outcomes that the majority of prostitutes experience.

Aside from gender (such that women are more likely to be working as prostitutes than men), there are very few consistent demographic predictors of prostitution. Research reveals that prostitutes (and other commercial sex workers) come from all walks of life. They may be cisgendered or transgendered, heterosexual or homosexual (or bisexual), young or old, and from any racial or ethnic background.

What factors, then, contribute to whether a woman (or man) enters prostitution? Not surprisingly, research reveals that the primary reason is economic hardship (see Table 16–2). Most prostitutes come from a background of chronic poverty, have others who depend on them for financial support (children, partners, parents), and possess little education and few other viable job prospects (Farley, 2004; Karamouzian et al., 2016; Nerlander et al., 2016). Some are homeless (Reilly et al., 2014). Thus, selling their bodies is often their only means of economic survival. This is particularly true for street and establishment-based (e.g., bar, brothel, bathhouse) prostitutes both in the United States and around the world (e.g., Bar-Johnson & Weiss, 2015; Kiernan, 2016; Onyango et al., 2015). Interestingly, even escorts and women and men who engage in prostitution on a part-time basis do so mainly to supplement their existing incomes—they exit as soon as they have enough money (Johnson, 2016; Lucas, 2005).

Table 16–2 Prostitution: Common Risk Factors and Outcomes

Risk Factors	Outcomes
Table 16–2 Full Alternative Text	
Economic hardship • Chronic poverty • Current financial need • Homelessness • Lack of alternative employment opportunities	Continued economic hardship
Chronic substance use and addiction • Alcohol • Drugs	Chronic substance use and addiction • Alcohol • Drugs
Abuse • Sexual abuse • Physical abuse • Emotional abuse	Abuse • Sexual assault • Physical assault
	Physical health issues • STIs and STDs • Unwanted/unintended pregnancy
	Mental health issues • Depression and anxiety • PTSD symptoms • Feelings of shame and stigmatization • Feelings of loneliness and isolation • Low self-esteem
	Social and interpersonal issues • Lack of access to social support • Difficulty developing and sustaining friendships and romantic relationships

The large majority of street and establishment-based prostitutes are habitual users of alcohol and other addictive drugs (e.g., heroin, crack cocaine; Nerlander et al., 2016; Potterat et al., 1998). For some, drug use and addiction precedes entrance into prostitution—in other words, they begin to sell or trade sex as a means of gaining access to drugs. For example, a recent study exploring the experiences of male street prostitutes working in urban cities in the United States and Ireland revealed that in both countries, the principal predisposing condition for entrance into prostitution was drug addiction (McCabe et al., 2014). For others, prostitution precedes drug and alcohol use and abuse—that is, they begin to use drugs as a means of coping with the (often grim) realities of prostitution (Coutts et al., 2016; DeRiviere, 2006; Farley, 2004). Unfortunately, drug and alcohol use and addiction further worsen a prostitute's economic situation. Many spend half or more of the money they earn to support their drug habit (see DeRiviere, 2006).

Another predisposing factor is childhood abuse. Many prostitutes, particularly those who work on the street, have a history of childhood physical, emotional, and/or sexual abuse (McCabe et al., 2014; Vanwesenbeeck, 2013). As a result, many experience severe self-esteem and self-identity problems and have a lower degree of overall psychological health than other people. It is not surprising, given this familial and psychological history, that so many street prostitutes are runaways—teenagers or young adults who have left home with little money and no job prospects and who are forced to sell their bodies to survive (Dittmann, 2005; Nixon et al., 2002).

The abuse that so many prostitutes experience during childhood continues to permeate their lives even after they leave home. In the United States, most outcall and legal brothel prostitutes report physically safe working conditions (O'Doherty, 2011). However, violence is a common occurrence for women (and men) who work on the street and in bars or clubs, both here in the United States and in other countries. Almost all of those prostitutes report multiple instances of physical and sexual assault at the hands of clients, pimps, establishment owners and managers, and even police (e.g., Bar-Johnson & Weiss, 2015; Kiernan et al., 2016; Monto, 2004; Sherman et al., 2015).

Sadly, research indicates that the more a female prostitute fears physical violence from a customer and the greater her financial need, the less likely she is to ask for, insist on, or successfully negotiate condom use (e.g., Feldenhaer et al., 2016; Onyango et al., 2015; Robertson et al., 2014). The same holds true for male prostitutes. Those whose only source of income is sex work (and who thus are completely financially dependent on their customers) are more likely than those with other sources of income to agree to condomless anal sex (Biello et al., 2017). Consequently, street and bar prostitutes—the group of prostitutes in the most precarious physical and financial situation—often do not use safe sex strategies and are at a particularly high risk for STIs and unwanted pregnancies (e.g., Dong et al., 2015). In fact, a recent survey of multiple studies exploring HIV-positive status among female sex workers in the United States revealed an average prevalence rate of 17%, well above the national average (Paz-Bailey et al., 2016).

Many prostitutes suffer from mental health issues, including depression, anxiety, and symptoms of posttraumatic stress disorder, coupled with deep feelings of hopelessness, loneliness, shame, stigmatization, and social alienation (Chudakoff et al., 2002; Farley et al., 1998, 2003; Sardana et al., 2016; Simon et al., 1992; for a review, see Love, 2015). Most have difficulties establishing and maintaining positive romantic relationships and feel unable to seek social support from friends and family (primarily due to fears of stigmatization if they disclose their sex work) (Bellotto et al., 2015; Smith et al., 2015). Almost all wish that they could leave prostitution (Farley et al., 2003). In short, working as a prostitute "can be as traumatic as going to war" (Farley et al., 1998).

Who Pays for Sex—and Why?

1. 16.13Describe the characteristics of people who pay for sex and their reasons for doing so.

There is more research on the people who sell sex than on those who purchase it from them. This is no doubt due to the fact that women and men who enter prostitution, as we have discussed, are at risk for a number of extremely adverse outcomes, and scientists and healthcare professionals are eager to identify ways to effectively intervene and improve these life circumstances.

That being said, there is a small but growing body of scientific work on the customer who buys sex. For example, national surveys conducted in the United States reveal that most purchasers are men (often called *johns, tricks*, or *scores* by prostitutes). In Laumann et al.'s (1994) national survey, 17% of the men (but only 2% of the women) over the age of 18 said that they had paid someone for sex. More recent national surveys have revealed similar prevalence rates, with about 14% of men reporting having ever paid for sex and 1% saying that they had done so within the past year (Monto & Milrod, 2014). Only a very small percentage of American men indicate going to prostitutes regularly for sex (Monto, 2004). Prevalence rates differ around the world. For example, in some Asian countries, as many as 40% of men have paid for sex (Empel, 2012).

Not surprisingly, almost all men who purchase sex from women report being heterosexual (Milrod & Monto, 2012). Other than that, they appear to be a fairly diverse group. For example, their ethnicity tends to reflect the locale in which their purchase(s) occurred, and they display a wide range of ages, annual incomes, professions, employment histories, educational achievement, relational statuses, and other demographic attributes (e.g., Busch et al., 2002; Milrod & Monto, 2012; Monto, 2004; Monto & McRee, 2005; Pitts et al., 2004). Thus, in many respects, men who buy sex appear to be similar to men who do not.

There are a few key demographic differences between men who utilize the services of outcall prostitutes (escorts or call girls) and those who frequent street prostitutes (see Milrod & Monto, 2012; Monto & McRee, 2005). In particular, compared with men who buy sex from streetwalkers, men who purchase sex from escorts tend to be older, more educated, and white; are more likely to be married; and have higher annual incomes (they are also less likely to be arrested due to the "inside" nature of the transaction).

So why do some men make the decision to pay a woman for sex? When asked by researchers, the primary reasons men give include a desire for sexual excitement, thrills, or novelty; the chance to have sex with a woman "who really likes sex;" an opportunity to enjoy sex freely without having to make an emotional investment; the lack of an existing sexual partner; and feelings of shyness or social inadequacy around women (see Busch et al., 2002; Pitts et al., 2004; Monto, 2004; Milrod & Monto, 2012). Men who pay for sex with street prostitutes tend to want sex and nothing but sex—the encounter is brief and typically involves oral-genital sex (as opposed to other activities), and they report enjoying the feeling of sexual power and entitlement that the experience of buying sex provides (Busch et al., 2002; Monto, 2001). However, men who pay for the services of escorts and call girls tend to want more than just sex—their sessions last longer and involve a greater variety of sexual activities (kissing, vaginal intercourse, fellatio, cunnilingus, etc.), and they often seek emotional as well as sexual gratification (e.g., Empel, 2012). For example, in one study (Milrod & Monto, 2012), men who used outcall services were asked which characteristics they liked the most and which they liked the least in an escort. Two of the attributes men reported as most appealing were "happy and cheerful personality" and "acts like a girlfriend not a prostitute." The ones they liked the least? "Emotionally cold," "rushes the session," and "businesslike demeanor." (The latter is particularly ironic given that they have, in fact, paid for sex—a business transaction for all intents and purposes.) The researchers concluded that men who use outcall services are looking for "the girlfriend experience."

Like men who pay to have sex with women, men who pay to have sex with other men come from all walks of life (Morse et al., 1992). Those who seek out street hustlers are often married or in a committed relationship and typically describe themselves as heterosexual or bisexual—they are motivated primarily by their sexual desires, wish to keep their same-sex sexual interests hidden, usually want oral sex, and often do not use condoms (Morse et al., 1992). Most men who hire male escorts, however, identify as homosexual or bisexual and are very similar to men who hire female escorts in their demographic characteristics and reasons for choosing to purchase sex (Grov et al., 2014, 2016). That is, they are primarily white, employed full-time, and financially secure, and they pay for relatively lengthy sessions (averaging one to two hours) during which they engage in multiple sexual activities (the most common being kissing and oral-genital sex). In addition, they generally are seeking intimacy and emotional connection from the escort as well as sexual gratification (see Tewksbury & Lapsey, 2016).

Sex Trafficking

1. 16.14Discuss the types of human trafficking that occur around the world and delineate the steps we can take to stop this global trade.

It is reasonably safe to conclude that the majority (perhaps all) of people who choose to pay for sexual services are fully consenting (Monto, 2004). However, we cannot draw the same conclusion when considering those who *provide* sexual services. Recall that most street and establishment-based prostitutes come from backgrounds characterized by chronic poverty, violence, and substance addiction and can find no other way to support themselves (Farley, 2004). They do not choose to become prostitutes. Rather, prostitution is thrust on them as the only option for survival (and their trade is thus appropriately characterized as "survival sex work"). In fact, in many countries, 10% to 15% of street children have exchanged sex for money simply in order to be able to eat (Marshall & Wood, 2009).

In addition, many people (including children, teenagers, and young adults) are forced into prostitution—sold by their families, coerced by their partners, kidnapped and enslaved by traffickers, or deceived by employment agents who falsely promise lawful and legitimate work. Sex trafficking, along with forced labor, debt bondage, involuntary domestic servitude, and child soldiering, is one of the various forms of human trafficking or modern slavery that exist around the world today (U.S. Department of State, 2016). The human trafficking industry is the second-largest (drug trafficking is first) and the fastest-growing criminal enterprise in the world, generating more than $32 billion a year in revenue and enslaving over 27 million people (U.S. Department of Health and Human Services, 2017). About 20% (more than 5 million) of these individuals are forced to engage in commercial sex work or sold as private sex slaves. Children and other special populations (including migrant workers, undocumented immigrants, displaced or homeless persons, individuals with disabilities or sexual/ethnic/religious minority status) are particularly vulnerable to exploitation. In the United States, for example, approximately 300,000 children are at risk for sex trafficking every year (U.S. Department of Health and Human Services, 2017). Indeed, in January 2017, three men in Texas were sentenced to prison for the sex trafficking of five teenage girls (Contreras & Buch, 2017). The men had used social networking sites to identify and contact the underage runaways. They then took the girls home and advertised their services on Backpage.com. Over a 2-week period, the men scheduled 240 "dates" for the girls and earned $48,000. Unfortunately, this is not an isolated incident (see, for example, Rosenberg, 2016).

Globally, the sex trafficking situation is even more dire. For example, in 2014, when Islamic State (IS) fighters seized control of the Sinjar Mountain region in Iraq, they enslaved women and girls from the religious minority communities living there (primarily Yazidi and Christian). These girls and women were then.pngted to soldiers or sold as concubine-slaves to men in other communities as part of peacekeeping and revenue-generating efforts (Fondation Scelles, 2016). A slave price list created by IS (and given to the UN Security Council by local area activists) specified that customers "are allowed to purchase only three items," although men from Turkey, Syria, and Gulf countries were not subject to this restriction. The cost of a sexual slave was dependent on her age. The youngest captives cost the most ($172 for an infant or girl up to 9 years old, $130 for a 10- to 20-year-old), with older women costing less ($86 for women in their 20s, $75 for women in their 30s, and $43 for women between 40 and 50). Modern slavery incidents like this—in which girls and women are treated as "items" to be bought and sold—are all too common.

Figure 16–18

A young Peruvian girl working in a brick factory. Slave labor is one of the primary forms of human trafficking around the world, with children often sold into servitude by their families or kidnapped by traffickers.

Source: Jan Sochor/Alamy Stock Photo

Figure 16–19

An Angolan child soldier. The militias in some countries (including those supported by the government) use children to guard checkpoints, serve on the front lines, and work as servants and sex slaves to military personnel.

Source: Jack Picone/Alamy Stock Photo

Figure 16–20

A child begging in India. In many countries, children are kidnapped by human traffickers and forced to beg. In many instances, they are deliberately starved and maimed in order to increase their earning potential.

Source: Tim Gainey/Alamy Stock Photo

Most victims of sex trafficking are girls and women, although boys and men can also be targeted and forced into prostitution and other forms of commercial sex work (e.g., pornography, live sex shows, sex tourism, illicit massage parlors). Once they are trafficked and enslaved by their handlers, most victims find it impossible to escape. In addition to sexual abuse, they routinely are subjected to physical and emotional trauma (Varma et al., 2015), are provided with barely enough resources to survive (Skinner, 2010), and have limited or no access to outside help. Although many countries (including the United States) have enacted anti-trafficking laws and implemented policies designed to protect vulnerable populations and assist victims, many others have not (see Orme & Ross-Sheriff, 2015; U.S. Department of State, 2016). The governments of these nations—which span the globe (e.g., Venezuela, Algeria, Sudan, Zimbabwe, Syria, Iran, Turkmenistan, Russia, North Korea, Papua New Guinea)—do not prosecute trafficking offenses, make no effort to prevent human trafficking or reduce the demand for sex tourism or commercial sex acts, and provide no services for trafficking victims. With no protection, children and adults enslaved by traffickers have very little chance of escape. Many will not survive their ordeal, succumbing to disease, malnutrition, overdose, injury, suicide, or murder.

What can we do, as individuals, to help put an end to modern sexual (and other forms of) slavery? The U.S. Department of Health and Human Services has some advice for us. First, we can we can take steps to be informed and to inform others about the basic "facts" involving human trafficking (a handout is available from www.acf.hhs.gov/sites/default/files/otip/trafficking_infographic508.pdf). Second, we can make sure that we travel to and buy goods and services only from countries whose governments have a solid record of anti-trafficking laws and policies (a list of these "Tier 1" countries can be found at https://www.state.gov/j/tip/rls/tiprpt/2016/258696.htm). Third, we can recognize that trafficking still occurs in those countries (including the United States) and that some women (and men) working in the commercial sex industry or in any type of job involving unskilled labor (such as migrant, domestic, factory, or restaurant work) may be doing so as the result of coercion, force, or fraud. And fourth, if we suspect that someone is being victimized in this manner, we can act! We can contact the National Human Trafficking Hotline via email (help@humantraffickinghotline.org) or phone (1-888-373-7888).

Figure 16–21

A young prostitute prepares to work with her first clients of the day in Siliguri, West Bengal, India.

Source: Jonathan Alpeyrie/Getty Images

Figure 16–22

An Afghan boy forced into bacha bazi ("boy play"). This longstanding and institutionalized form of child molestation occurs between older men and younger boys. The boys are dressed as girls and expected to dance for (and perform sexual acts with) their patrons.

Source: Aref Karimi/AFP/Getty Images

Continuing Controversies About Prostitution

1. 16.15 Discuss the continuing controversy over how to conceptualize prostitution (particularly with respect to legalization) and compare the different perspectives that have been used to understand this type of commercial sex.

Research suggests that attitudes toward prostitution are somewhat mixed around the world. In one large-scale survey, for example, approximately 48,000 adults living on six continents were asked to provide their opinion about the subject (Chon, 2015). More than half (54%) agreed that prostitution was "never justifiable," whereas the remaining 46% indicated that it was "somewhat justifiable" depending on circumstances. People are divided in their opinions, and even a single individual may hold multiple, contradictory views when it comes to this particular topic.

16.15.1 Legal Status

One of the biggest controversies about prostitution concerns its legal status. Earlier in this chapter ("A Brief History of Prostitution") we considered the different legal approaches that the United States and other world nations have taken to prostitution (see Figure 16–23). Recall that in many countries, prostitution is illegal and people who sell or buy sexual services or who facilitate the exchange of sex for money in any way are subject to arrest and criminal prosecution. A handful of countries, such as Germany and New Zealand, have taken the opposite legal stance, allowing any adult to buy or sell sex or run a brothel or commercial sex shop as long as licensing and other regulations are met (street prostitution, however, remains illegal or is confined to certain areas and hours of the day).

Figure 16–23

A Continuum of Legal Approaches to Prostitution.

Laws pertaining to prostitution run the gamut from completely legal (all forms of sexual commerce—buying, selling, facilitating—are permitted under the law) to completely illegal (it is a crime to sell, buy, or facilitate the sale or purchase of sex). It is important to note that the governments of many countries do not have official laws, rules, or regulations pertaining to prostitution; thus, we have no way of knowing how they deal with it.

Source: Go Sign: Dawn Hudson/Shutterstock; Exclamation Sign: alexwhite/Shutterstock; Red Exclamation Traffic Sign:123RF; Stop Sign: Creation/Shutterstock

Figure 16–23 Full Alternative Text

Other nations, including the United States, fall somewhere in between these two extremes. Some, like Australia and Belgium, have adopted a limited legality approach that allows a prostitute and client to exchange sex and money without fear of arrest but prohibits all other prostitution-related activities (such as pimping, brothel keeping, and running an escort service). Some, such as Sweden, Canada, and France, have opted to decriminalize prostitution; here, only the person who directly sells sex (the prostitute) is exempt from prosecution. All other aspects of prostitution are illegal, and thus customers, pimps, agents, brothel keepers, procurers, and so forth can be arrested and charged.

Which of these legal approaches, if any, is the "right" one? You will probably not be terribly surprised to learn that the answer to that question is the subject of a great deal of (often heated) debate. Almost everyone, it seems, has an opinion about what the legal policy concerning prostitution should be—scholars and scientists, law enforcement personnel and government officials, health professionals and human rights advocates, community activists, members of the public, and even the women and men directly involved in the sale and purchase of sex.

16.15.2 Prostitution as "Work"

Some people fall on the legalization side of the aisle, arguing that prostitution is best understood as a form of work and thus should be respected and treated as any other legitimate business enterprise (Barry, 1995; Bullough & Bullough, 1997). Academics, organized groups of prostitutes (e.g., English Collective of Prostitutes), and activists are particularly likely to endorse this perspective, as evidenced in their use of the terms "service provider" and "sex worker" to describe women who sell sex and "clients" or "customers" to describe men who pay for sex (see Coy, 2012; Niemi, 2010). In the eyes of these individuals, prostitution "takes the form of empowered entrepreneurs doing prostitution independently and on their own" (Jeffreys, 2012, p. 75).

Government officials and lawmakers who adopt this business model approach to prostitution usually cite practical (as opposed to philosophical) considerations (see Seals, 2015). They typically focus on the benefits to personal and public welfare that legalization ostensibly provides. For example, Nevada's legalization of brothel prostitution in 1971 was driven, in part, by a desire to hold existing brothel owners accountable for the working conditions in their establishments (and collect tax and licensing fees, no doubt). As "legitimate" business owners, brothel keepers in Nevada became—and continue to be today—subject to the same health and safety regulations as other business owners. Subsequent laws passed in the state also focused on improving worker safety and public welfare, including requiring prostitutes to undergo regular health checks and customers to use condoms (Brents & Hausbeck, 2005).

Similarly, the Sex Purchase Act (sexköpslagen) passed by the Swedish government in 1999 was specifically designed to improve public safety and promote an array of beneficial social outcomes, including reducing violence against women, discouraging men from using prostitutes for sex, disrupting the ties between prostitution and organized crime (such as drug and human trafficking), and decreasing the number of women who became involved in prostitution (see Levy & Jakobsson, 2014).

In sum, the legalization/decriminalization perspective suggests that according prostitution the status of a legitimate commercial enterprise has positive effects from both a philosophical perspective (by viewing women as empowered individuals free to make the choice to sell access to their bodies) as well as a practical perspective (by providing authorities with the means to more effectively regulate prostitution and reduce or eliminate its more problematic aspects).

On the other side of the aisle are those who are not convinced by these claims and who question the value of widespread legalization. For example, many researchers and activists agree that prostitutes should not be treated as criminals (see Coy, 2012). However, they believe that prostitution itself lacks the characteristics of a traditional commercial enterprise and thus should not be legalized and treated as a business (see Miriam, 2005). For example, the "product" being sold—access to one's genitals and bodily orifices and command over one's body—is qualitatively different from the products sold in other businesses or service industries. Similarly, the sale of the prostitute's "product" exposes her to physical risks (such as tearing, abrasions, life-threatening diseases, pregnancy, and violence) that are not typically experienced by other service professionals.

16.15.3 Other Social Considerations

Moreover, a number of scientists and scholars argue that conceptualizing prostitution as merely another form of work ignores the larger social context in which it occurs (see Dines, 2010; Jeffreys, 2012). For example, prostitution is a highly gendered phenomenon (such that men provide the demand and women provide the supply), and it is particularly likely to flourish in environments characterized by social and economic gender inequality (see Coy, 2012, 2016; Coy et al., 2011). These individuals argue that the "sex as trade" model focuses too heavily on the supply side of the "business" of prostitution (that is, on whether women have the right to sell their bodies) while ignoring the demand side (i.e., whether men have a right to purchase access to women's bodies). In this view, the establishment or acknowledgment of any profession in which men demand sex and women supply it (like prostitution) *presupposes that men have a legitimate right to be sexually serviced* (Coy, 2012; Miriam, 2005).

> The "sex work" model of agency occludes the reality that it is men's demand that makes prostitution intelligible and legitimate as a means of survival for women in the first place.

(Miriam, 2005, p. 9)

These scholars contend that the commodification of a woman's body (as something to be legitimately bought and sold) contributes to the oppression of all women and impedes a society's progress toward gender equality. It follows that prostitution may only truly fit into a business model if it occurs in a society characterized by socioeconomic, political, and sexual equality among men and women (and other groups) and where the demand for paid sex is not exclusively generated and dominated by men.

16.15.4 Does Legalization Work?

Still other researchers have criticized the business approach to prostitution on the practical grounds that it simply does not work. For example, the argument in favor of legalized prostitution views sex workers as entrepreneurs who control their own livelihood and are free agents in the marketplace. However, the reality is that most legal prostitutes work for someone else or to support a male partner. Consequently, a sizeable portion of the proceeds from legal sex work goes to pimps, brothel owners, or agents, with little going to the women providing the actual sex. Indeed, an economic analysis conducted by DeRiviere (2006) revealed that, on average, prostitutes working legally in Canada earned around $27,000 a year—but they paid more than one third of these earnings (over $10,000) to pimps or agents, leaving them with an annual income of less than $17,000 (well below the average annual income of $41,000). It is worth noting that about $14,000 of this "leftover" income went to drugs, alcohol, and medical treatment for injuries inflicted by customers—all items viewed by the women as essential in order to be able to conduct their legal "business."

Similarly, legalization gives prostitutes the right to become salaried employees, pay into pension funds, and obtain health insurance. However, most employers avoid having to provide these and other benefits by classifying sex workers as "agents," "independent contractors," or "part time workers" (see Sullivan, 2007). As such, prostitutes generally have little control over their working conditions and are subject to the whims of the owner or manager—they do not receive breaks, sick leave, or vacation time, have no access to medical care, and do not get paid if client traffic is slow. Furthermore, although prostitution is usually a temporary job, it often has a permanent long-term effect on a woman's earning potential and career prospects. Most women who enter prostitution do so when they are very young, and they miss out on the formal education and work-related opportunities that other people their age typically receive (e.g., career counseling, work experience, on-the-job training, networking) (DeRiviere, 2006; Sullivan, 2012).

Legalization also does not appear to have produced the positive social benefits it was intended to, such as eliminating sex trafficking and reducing the number of women who enter prostitution. In fact, in many cases it appears to have had the opposite effect. After legalizing brothel prostitution, the Australian state of Victoria experienced a dramatic increase in the number of brothels (both legal and illegal) as well as "a large-scale trafficking industry of girls and women into Victoria. . . to meet this new demand" (Sullivan & Jeffreys, 2002). Furthermore, most brothel keepers in Victoria continue to operate outside of the law. Many have links to organized crime (including sex and drug trafficking and money laundering) and want to avoid the regulatory oversight that comes with licensing; others do not want to pay the licensing fee or have to upgrade their establishments to meet local health and safety codes (see Sullivan, 2012). In sum, treating prostitution as a business does not seem to have uniformly improved the working conditions or life circumstances of prostitutes or to have had much of a positive impact on public health and welfare (Cho, 2016).

So what is the answer when it comes to prostitution? The truth is that there is no one "right" way to approach the many complicated legal (and moral) questions surrounding this or any type of commercialized sex (Carline, 2011). Perhaps a more nuanced approach is needed. Some advocates, for example, recommend a combination of (1) decriminalization (to avoid further punishing the women who sell sex), (2) education of the public as well as the men who purchase sex (to combat common misperceptions

about prostitutes and the social stigma associated with prostitution), and (3) more specialized and effective support and exit services for those involved in sex work (see Coy, 2012).

Our own view gives primacy to sexual education and sexual health (see Chapter 11). Without sharing our private opinions about the ethics, legality, or legitimacy of sex work, we affirm the importance of being knowledgeable about the realities of prostitution, pornography, and other forms of commercial sex. And we maintain our conviction that it is the right of each individual person to live a sexually healthy life—to feel positively about her or his sexuality and to be able to choose to engage (or not engage) in sexual activity free from any pressure (including social and economic pressure). How you feel about prostitution, as well as the other topics presented in this chapter, is of course up to you.

Personal Reflections

How do you feel about prostitution in this country: Should it remain illegal (as it is in all but some Nevada counties), or should we attempt to legalize and regulate it? Why? Do you think that prostitution is best characterized as a free choice enterprise or as a harmful social practice? Ask yourself—would you feel comfortable working in, operating, or owning stock in a brothel? How would you feel if your romantic partner or one of your brothers or sisters decided to become an escort? Or if one of your children aspired to be a prostitute? These are often not easy questions to answer.

Study Guide

Key Terms

- B-girls
- brothel prostitution
- call girl
- erotica
- escort
- establishment-based prostitution
- gigolo
- hustler
- obscenity
- outcall prostitution
- pornography
- prostitution
- rent boy
- sex trafficking
- sex work
- sexually explicit media
- street prostitution (streetwalking)

Interactive Review

Answers can be found on p. 474.

- Sex is a multibillion-dollar-a-year business. Sexually explicit media are not new to our contemporary society. Detailed cave etchings and stone carvings have been discovered that date from (1) . Written material has also been discovered, including the 5th-century Indian guide to love, courtship, marriage, and family life that is called the (2) .

  In the United States, commercially released films often contained sexual content until the movie industry voluntarily developed the (3) in 1927 in an effort to prevent (4) . Some of the topics that were banned from being show in films included (5) , (6) , and (7) . Today, of course, movies and other commercial media routinely contain sexual themes and content.

  The (8) , in particular, has made it possible for just about everyone with access to a computer, cell phone, or other web-enabled device to access sexually explicit content. Although reliable statistics are difficult to obtain, it is estimated that the web porn is a (9) -dollar-a-year industry. Internet users can download or watch pornography from adult websites, visit (10) sites that offer live streaming of sex acts, or visit sites devoted to erotic fan fiction. Research indicates that (11) are the primary consumers of online video and webcam pornography, whereas (12) are more likely to access erotic fan fiction sites.

  (13) is a general term that refers to media with an uplifting sexual theme meant to be artistic and present an intimate and celebratory vision of sexuality. Sexually explicit commercial media that is specifically designed to generate arousal is generally referred to as (14) . In determining whether sexually explicit media is protected by the First Amendment (or not), courts rely on the (15) . The three provisions of this test specify that material is obscene (and thus not protected by the First Amendment) if (a) the average person, applying (16) , would find that the material appeals to prurient (unwholesome) desires or interests; (b) the material depicts sexual conduct in a patently or blatantly (17) as defined by state law; and (c) the material lacks (18) .

  Research on the use of pornography in the United States reveals that about (19) as many men as women have watched at least one pornographic movie in the past year. Interestingly, despite what social commentators often claim, the rates of pornography consumption in recent years appear to have (20) . However, rates of pornography use are generally (21) among younger than older adults. Men generally have a more (22) attitude toward pornography than women. Although most people use pornography because it produces sexual arousal, teenagers and young adults often are motivated by (23) and (24) .

Because of concerns about the possible harmful effects of pornography on those who use it, the federal government has authorized two large-scale investigations. The Commission established in 1968 by President Johnson concluded that exposure to pornography (in adults) was (25) with sex crimes and other deviant/harmful behavior. However, the Commission established in 1985 by President Reagan concluded that nudity was not harmful but that exposure to (26) and (27) pornography was associated with rape myth acceptance and other attitudes that support violence against women. Finally, the Commission concluded that one type of pornography—specifically, (28) pornography—did cause physically aggressive behavior against women.

Subsequent research has shown that both men and women become physiologically aroused by sexually explicit material. However, continued exposure generally produces a reduction in sexual interest. This phenomenon is known as (29) . Research also reveals that men's arousal is category-specific; that is, heterosexual men are most aroused by images of (30) having sex, whereas homosexual men are most aroused by images of (31) having sex. Women, on the other hand, are capable of becoming physiologically aroused to many different types of people engaged in sexual activity. Interestingly, although both men and women become genitally aroused by pornography, men generally have a (32) emotional reaction than women and report higher levels of (33) .

Pornography use is associated with an increased likelihood of engaging in certain types of risky sexual behavior, including (34) , (35) , and (36) . Among college students, pornography use is associated with a higher likelihood of experiencing one of the riskiest types of sex: (37) . Frequency of pornography use is also associated with several psychological outcomes, including (38) and, among men in particular, (39) . In fact, the more pornography that men watch, the less satisfied they are with (40) . Finally, research reveals that men and women who watch pornography tend to report less (41) with their current relationship and less (42) to their partner. They are also more likely to flirt with others and to commit infidelity.

Research has generally confirmed the Meese Commission's conclusion about the association between pornography and rape-supportive attitudes. Among both men and women, amount or level of pornography consumption is positively associated with (43) . In addition, exposure to sexually explicit material with violent themes often results in men becoming (44) toward rape victims, having greater belief in (45) , and being more likely to say that they would (46) . Prospective investigations, in which participants are followed over time, demonstrate that men who use pornography at one point in time are more likely to engage in (47) at a later point in time. In fact, both men and women who view greater amounts of pornography are more likely to report having used (48) to obtain sex compared to those who view lower amounts. Finally, laboratory experiments using male participants reveal that exposure to both violent and nonviolent pornography actually produces (49) against women (but not men).

It is no wonder that scientists and government officials are concerned about exposure to pornography. However, many behavioral scientists believe that sexually explicit material is not harmful in and of itself, but that it can become harmful when it includes themes/scenes that are (50) and/or (51) . There is solid evidence in support of this contention.

Should we ban or allow pornography? Most people find some types of sexually explicit material offensive, but attempts to censor or ban this material raise questions about First Amendment rights. We know that children and adolescents are concerned about the sexual (and also the violent) images they are exposed to online. We also know that most pornography portrays women (and men, though less so) in a demeaning manner and emphasizes the (52) aspects of sex while ignoring its (53) aspects. Many experts emphasize the importance of (54) about sexuality with children, adolescents, and each other and encourage parents, teachers, and those who make pornographic media to present a more holistic, personal, intimate, and "sex positive" script to counteract the harmful outcomes we have discussed in this chapter. The bottom line is that there may always be a tension between First Amendment rights and the desire to protect the public interest. It is not easy to decide where to draw the line.

Prostitution is illegal in all parts of the United States except for a few counties in (55) . In many countries, prostitution is illegal; however, some countries have adopted a (56) approach in which an individual prostitute and client can exchange sex and money but brothel keeping, pimping, and other forms of facilitating prostitution are illegal. Other countries have adopted a decriminalization approach, in which only the individual who (57) sex is exempt from arrest and prosecution.

Worldwide, the number of people (mostly girls and women) engaged in prostitution is estimated to be around (58) . In Western countries, about (59) % of individuals have exchanged sex for money (in the United States, about 3.5% of teens have done so).

There are different types of prostitution, all of which can be differentiated by whether they occur outside or inside. Among female prostitutes, (60) occurs outside and is the riskiest and least profitable form of sex for hire (for the women who engage in it). Women who solicit in bars, hotels, casinos, or clubs are referred to as (61) ; like street prostitutes, many of them have pimps who take the majority of their earnings. Another establishment-based type of prostitution is (62) , which is the only type of prostitution currently legal in the United States. Another type of "inside" prostitution involves outcall work, in which prostitutes advertise their services through an agency, broker, ad listing service, or personal website. Women who work as (63) and (64) typically charge more than brothel, bar, or club prostitutes. Male streetwalkers are often referred to as (65) , and like their female counterparts, they usually cater to men. Escorts and gigolos, however, may also have (66) clients.

The primary reason most individuals engage in prostitution is (67) . Many prostitutes also were abused as children and have a history of (68) . Unfortunately, prostitution itself is likely to further contribute to these issues. Many prostitutes continue to suffer financially, are likely to experience violence at the hands of their clients, and also suffer from a variety of mental health issues, including (69) . Most have difficulties establishing positive romantic relationships and feel unable to seek (70) from friends and family.

Research on the customer who buys sex reveals that only (71) American men go to prostitutes regularly for sex. Those who

purchase sex from women are almost all (72) , though they are a fairly diverse group. Men who buy sex from escorts are more likely to be white, married, and more educated and have higher (73) , compared to those who use the services of streetwalkers. Men who pay for sex from streetwalkers tend to want (74) , whereas men who go to escorts and call girls seem to want what has been described as (75) (both sexual and emotional gratification).

Sex trafficking is a global problem. Over (76) million people are enslaved each year, with approximately (77) % forced to engage in commercial sex work or sold as private sex slaves.

Attitudes about prostitution are mixed around the world, with many completely opposed to it and others feeling that it is at least somewhat acceptable under some circumstances. People who believe in legalization often argue that prostitution should be understood and treated as a(n) (78) . Opponents of legalization argue that prostitution lacks the characteristics of a traditional commercial enterprise and that viewing it as such ignores the (79) in which it occurs. Regardless of which perspective people adopt, research shows that legalization has generally not had much of a positive impact on the life circumstances of prostitutes themselves or on (80) .

Self-Test

Answers can be found on p. 474.

A. True or False

1. **T F** 81. Each year, Americans spend more on sex than they do on professional sports.
2. **T F** 82. Sexually explicit media is a recent human invention.
3. **T F** 83. Early (1910s–1920s) American movies featured more nudity and sexuality than movies in the 1930s and 1940s.
4. **T F** 84. It is easy to obtain reliable information on Internet pornography and erotica because most adult website operators publish statistics about site visitation and revenue.
5. **T F** 85. Almost all customers who visit live streaming (webcam) porn sites are male.
6. **T F** 86. Some scholars believe that erotic fan fiction sites create a more "welcoming sexual space" for women and girls.
7. **T F** 87. The major difference between erotica and pornography is that erotica is artistic and pornography is obscene.
8. **T F** 88. In the United States, legal pornography refers to sexually explicit and arousing commercial material that is protected under the First Amendment.
9. **T F** 89. About twice as many men watch pornography as women.
10. **T F** 90. Pornography usage has dramatically increased in the past several years.
11. **T F** 91. Both of the Presidential Commissions formed to investigate the impact of pornography concluded that it had no negative effects and should be completely legalized.
12. **T F** 92. Research suggests that people who watch a lot of pornography eventually become habituated to it (find it less arousing).
13. **T F** 93. People who use pornography tend to have more sexually permissive attitudes than people who do not.
14. **T F** 94. People who watch a lot of pornography are less likely to cheat on their romantic partners.
15. **T F** 95. Men who watch pornography are more likely to believe that their friends approve of forced sex than men who do not watch.
16. **T F** 96. Brothel prostitution has a long historical association with slavery.
17. **T F** 97. In the United States, prostitution is legal only in Nevada and New Mexico.
18. **T F** 98. Most women and men who enter prostitution do so because they really enjoy sex.
19. **T F** 99. Many prostitutes have a background characterized by childhood abuse and current drug and alcohol use/abuse.
20. **T F** 100. Those countries who have elected to legalize prostitution, this appears to have produced a great many social benefits, including reducing sex trafficking and reducing the number of women who enter prostitution.

B. Matching

Suggested Readings and Resources can be found on p. 466.

1. 101. B-girl
2. 102. Brothel
3. 103. Call girl
4. 104. Gigolo
5. 105. Hustler
6. 106. Curb crawler
7. 107. Pimp
8. 108. Streetwalker
9. 109. Window prostitute
10. 110. Escort

1. Legal and licensed establishment in Nevada where customers can come and pay to have sex with the women who work there
2. Monica solicits customers out of a bar she hangs out at in the evenings.
3. Joey advertises his services on the Internet and is paid by older women to have sex and accompany them to social events.
4. Phoebe works out of her own apartment, and her clients must make an appointment to have sex with her.
5. Ross takes 75% of the money earned by six women who do tricks on the west side of town.
6. Chandler drives along the street at night looking for women to pay for oral-genital sex.
7. Sam accepts money from men on the street who want to have sex with him.
8. Rachel works in Amsterdam. Every night she stands in front a window on the street and tries to solicit customers.
9. Bonnie works for an exclusive agency that sets her up on "dates" with financially stable businessmen; she then makes arrangements to provide additional sexual services for a fee.
10. Lydia walks the streets at night looking for customers willing to pay her for sex.

Suggested Reading and Resources

Chapter 1

- American Academy of Pediatrics. (2010). Policy statement—Sexuality, contraception, and the media. *Pediatrics*, 126, 576–582. Excellent article on why abstinence-only education cannot overcome the omnipresent media message of "non-abstinence."
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- Wiederman, M. W. (2001). *Understanding sexuality research.* Belmont, CA: Wadsworth Thomson Learning. A short but excellent book on methodology problems in sex research with many real-world examples.
- Kinsey Institute for Research in Sex, Gender, and Reproduction, Indiana University www.Kinseyinstitute.org
- SIECUS (Sexuality Information and Education Council of the U.S.) www.siecus.org
- Society for the Scientific Study of Sexuality www.sexscience.org
- *National Geographic*'s television series "Original sin: Sex." This series covers the history of sex, sex education, and government interference in sex education.

Education websites

- American Social Health Association's www.iwannaknow.org
- Columbia University's Health Education program www.goaskalice.columbia.edu
- The National Campaign to Prevent Teen and Unplanned Pregnancy's www.StayTeen.org and www.Bedsider.org
- Planned Parenthood's www.plannedparenthood.org/teens
- www.scarleteen.com

Chapter 2

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- Schover, L. R. (1997). *Sexuality and fertility after cancer.* New York: John Wiley & Sons. Many survivors of cancer suffer sexual problems. This book will help.
- Zilbergeld, B. (1999). *The new male sexuality.* New York: Bantam Books. An excellent source of information about male sexuality and health, this book also provides information about female sexual anatomy.
- American College Health Association www.acha.org
- American Cancer Society www.cancer.org
- National Cancer Institute Cancer Information Service1(800) 4-CANCER www.cancer.gov

Chapter 3

- Adler, J. (2004, December 20). Toxic strength. *Newsweek*, 45–52. An excellent article on the use and dangers of anabolic steroids among teenagers.
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- Steinem, G. (1978, October). If men could menstruate. *Ms*. A humorous and political view of menstruation.
- www.redwebFoundation.org Provides menstrual awareness and education
- www.celebrategirls.com Provides suggestions and special kits to celebrate girls' first menstruation
- http://www.livescience.com/51693-best-period-tracking-apps.html Phone app for tracking menstrual cycles
- http://www.womenshealthmag.com/health/ Phone app for tracking menstrual cycles

Chapter 4

- Association of Reproductive Health Professionals (2008). *What you need to know about female sexual response*. This brief fact sheet provides a nice summary of existing models of the female sexual response cycle. Available as a free download at http://www.arhp.org/publications-and-resources/clinical-fact-sheets/female-sexual-response
- Association of Reproductive Health Professionals (2010). *Talking with patients about sexuality and sexual health*. This article provides information geared toward health care providers about how to communicate with their clients about sexual matters. Helpful for the rest of us, too—having a better understanding of the physician/professional side of things may make it easier for us to communicate with our doctors about sexual issues. Available as a free download at http://www.arhp.org/publications-and-resources/clinical-fact-sheets/shf-talking
- Association of Reproductive Health Professionals (2011). *Size up your sex life*. This is an easy-to-use web-based self-assessment tool designed to let women find out how aspects of their health, self-concept, relationships, and well-being are contributing to their overall sexual health and to provide helpful advice and information (men may also use this tool, though some of the questions may not apply). This free online quiz is available at http://www.arhp.org/sexlife/
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Chapter 5

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- Lothian, J., & DeVries, C. (2010). *The official Lamaze guide: Giving birth with confidence* (2nd ed.). Seattle: Amazon.

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- www.americanpregnancy.org From the American Pregnancy Association
- www.childbirthconnection.org Childbirth connection
- www.lamaze.org Lamaze International
- www.resolve.org Resolve: The National Infertility Association
- www.womenshealth.gov From the U.S. Department of Health and Human Services
- Phone apps for tracking pregnancy. There are many of them; as an example: www.womenshealthmag.com/health/

Chapter 8

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- Accord Alliance (for individuals and families affected by disorders of sex development) www.accordalliance.org
- Kinsey Institute for Research in Sex, Gender, and Reproduction, Indiana University kinsey@indiana.edu
- Our Bodies Ourselves www.ourbodiesourselves.org
- Documentary film "Too Fast to Be a Woman: The Story of Caster Semenya" www.youtube.com/watch?v=f-UXOLE_tCg

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- PFLAG (formerly Federation of Parents and Friends of Lesbians and Gays) www.pflag.org
- National LGBTQ Task Force www.thetaskforce.org

Chapter 10

References To Help Parents

- *Ask Me Anything* by Marty Klein. New York: Simon & Schuster, 2003. Prepares parents to give straightforward answers to anything their children might ask.
- *Dr. Ruth Talks to Kids* by Dr. Ruth Westheimer. New York: Aladdin Paperbacks, 1998. Aimed at children aged 8 through 14. *Time* magazine (May 24, 1993) says that Dr. Ruth's book provides an excellent middle ground between books that teach abstinence only and those that favor a more comprehensive approach.
- *From Diapers to Dating: A Parent's Guide to Raising Sexually Healthy Children from Infancy to Middle School* (2nd ed.) by Debra Haffner and Alyssa Haffner Tartaglione. New York: Newmarket Press, 2004.
- Garcia, J. R., et al. (2013). Sexual hook-up culture. *Monitor on Psychology*, 44 (February), 60–67.
- Graber, J. A., & Brooks-Gunn, J. (2002). Adolescent girls' sexual development. In G. M. Wingood & R. J. DiClemente (Eds.), *Handbook of women's sexual and reproductive health*, pp. 21–42, New York: Kluwer Academic/Plenum Pub. An excellent review of the hormonal, behavioral, and psychological changes.
- Houck, J. A. (2006). *Hot and bothered: Women, medicine, and menopause in modern America*. Cambridge, MA: Harvard University Press. The history of the social and medical construction of menopause.
- *It's Perfectly Normal: Changing Bodies, Growing Up, Sex and Sexual Health* by Robie Harris and Michael Emberley. Cambridge, MA: Candlewick Press, 2009. For children approaching puberty.
- Jacoby, S. (2005, July/August). Sex in America. *AARP The Magazine*. Sexual behavior of middle-aged and elderly Americans.
- Michael, R., et al. (1994). *Sex in America*. Boston: Little, Brown. Results of the Laumann et al. survey, the most scientifically conducted survey ever done. Written for the general public.
- Moore, S., & Rosenthal, D. (Eds.) (2006). *Sexuality in adolescence: Current trends*. New York: Routledge. A scholarly book by two experts in the field.
- *The New Puberty: How to Navigate Early Development in Today's Girls by Louise Greenspan and Julianna Deardorff. New York: Rodale, 2014.*
- *The What's Happening to My Body? Book for Boys* by Lynda and Area Madaras. New York: Newmarket Press, 2007. For children approaching puberty.
- *The What's Happening to My Body? Book for Girls* by Lynda and Area Madaras. New York: Newmarket Press, 2007. For children approaching puberty.
- *What's Happening to Me? A Guide to Puberty* by Peter Mayle and Arthur Robins. New York: Kensington Pub. Corporation, 2000. For children approaching puberty.
- *What Your Child Needs to Know About Sex (and When): A Straight-Talking Guide for Parents* by Fred Kaeser. Emeryville, CA: 10 Speed Press, 2011. Dr. Kaeser was director of health for New York City Public Schools.
- *Where Did I Come From?* by P. Mayle and A. Robins. Secaucus, NJ: Carol Publishing, 2000. For young children.
- Wingart, P., et al. (2007, January 15). Understanding menopause: The new prime time. *Newsweek*, 38–63. Almost everything you may want to know about menopause.

Chapter 11

- Comfort, A. (2009). *The joy of sex: The ultimate revised edition*. New York: Harmony. A fully revised edition of a nicely illustrated, well-written sex manual. A best seller since it was first published in 1972.
- Kahr, B. (2008). *Who's been sleeping in your head? The secret world of sexual fantasies*. New York: Basic Books. All about sexual fantasies, with interesting examples based on years of clinical work.
- McBride, K. R., & Fortenberry, J. D. (2010). Heterosexual anal sexuality and anal sex behaviors: A review. *Journal of Sex Research*, 47, 123–136. A thorough review of results of survey studies about anal intercourse.
- Kerner, I. (2004). *She comes first.* New York: HarperCollins. A clinical sexologist tells men how to please a woman.
- Kerner, I. (2006). *He comes next.* New York: HarperCollins. A clinical sexologist tells women how to please a man.
- Michael, R., et al. (1994). *Sex in America: A definitive survey*. Boston: Little, Brown. A reader-friendly version of the Laumann et al. (1994) study, adapted for the general public. Set the standard for national sex survey research, and is still considered a "go-to" book for information about who does what, with whom, and how often. Available on Amazon.com.

- Petersen, J. L., & Hyde, J. S. (2011). Gender differences in sexual attitudes and behaviors: A review of meta-analytic results and large data sets. *Journal of Sex Research*, 48, 149–165. Excellent review of research examining gender differences in all types of sexual attitudes and behaviors.
- Recent and past results from ongoing national sex surveys conducted in America and Britain can be found on the following websites. Articles are free for download. (1) The National Survey for Sexual Health and Behavior (NSSHB) in the United States: http://www.nationalsexstudy.indiana.edu/(2) The National Survey of Sexual Attitudes and Lifestyles (NATSAL) in Britain: http://www.natsal.ac.uk/home.aspx

Chapter 12

About love

- Berscheid, E. (2010). Love in the fourth dimension. *Annual Review of Psychology, 61,* 1–25. Outstanding overview of scientific efforts to understand love. Available online at http://www.annualreviews.org/doi/pdf/10.1146/annurev.psych.093008.100318
- Fisher, H. (2009). *Why him? Why her?* New York: Henry Holt & Co. The author is an expert on attraction and love; here, she discusses the many factors (including brain chemistry) involved in these human life experiences.
- Fromm, E. (1956). *The art of loving*. New York: Harper & Row. An oldie but a classic.
- Jankowiak, W. R. (2008). *Intimacies: Love and sex across cultures.* New York: Columbia University Press. An in-depth look at how different cultures treat love.
- Lewis, C. S. (1988). *The four loves*. New York, NY: Harcourt Brace. A delightful example of an early love theory. Was first published in 1960 but is readily (and inexpensively) available in electronic and paper versions.
- Slater, L. (2006). This thing called love. *National Geographic*, February. Explains why we cannot keep feelings of passion alive forever.

About relationships

- AAMFT (American Association for Marriage and Family Therapy; www.aamft.org). This organization provides names and contact information of certified marriage and family therapists in your area, as well as information on accredited MFT programs (for those of you considering a career in this field) and upcoming conferences.
- Gottman, J. M., & Silver, N. (2015). *The seven principles for making marriage work (revised edition)*. New York: Harmony (an imprint of Crown Publishing). A good introductory, popular press book focused on building effective communication between partners.
- Regan, P. C. (2017). *The mating game: A primer on love, sex, and marriage* (3rd ed.). Thousand Oaks, CA: Sage. Written for students, this introductory text discusses all aspects of romantic relationships (attraction, courtship, love, sex, conflict, infidelity, therapy, etc.).
- Schnarch, D. M. (2009).*Passionate marriage: Love, sex, and intimacy in emotionally committed relationships.* W.W. Norton (reprint edition). Written for the public; focuses on the subject of keeping relationships vital and is one of the most frequently recommended books by members of the Society for Sex Therapy and Research. An audio version (read by the author) was released in 2014 and is available on Amazon.com.

Chapter 13

About sexual functioning

- AASECT (American Association of Sexuality Educators, Counselors and Therapists; www.aasect.org). This organization provides names and contact information of certified sex counselors and therapists in your area, as well as information about becoming a counselor (for those of you considering a career in this field) and upcoming conferences.
- Association of Reproductive Health Professionals (2010). *The top 10 things you need to know about female sexuality*. This article provides information geared toward health care providers about women's sexual function and how to communicate with their clients about sexual matters. Helpful for clients, too—having a better understanding of the physician/professional side of things may improve communication about sexual issues. Available for free download at https://www.arhp.org/Publications-and-Resources/Clinical-Fact-Sheets/SHF-Top-10
- Association of Reproductive Health Professionals (2011). *Size up your sex life*. This is an easy-to-use web-based self-assessment tool that lets women find out how aspects of their health, self-concept, relationships, and well-being are contributing to their overall sexual health (men may also use this, though some of the questions may not apply). The free online quiz is available at http://www.arhp.org/sexlife/
- Heiman, J., & LoPiccolo, J. (1992). *Becoming orgasmic: A sexual and personal growth program for women.* New York: Simon & Schuster. Highly recommended by members of the Society for Sex Therapy and Research. This is an older book, but it remains highly relevant, and copies are easy to find on Amazon.com.
- Lee, C. (2011, December 5). This man is addicted to sex. *Newsweek*, pp. 48–55. A good introduction to hypersexuality and sexual addiction. Available online (entitled "The Sex Addiction Epidemic") at http://www.newsweek.com/sex-addiction-epidemic-66289
- Meana, M. (2012). *Sexual dysfunction in women*. Cambridge, MA: Hogrefe Publishing. Written for mental health professionals, but an easy

(100 pages in length) and informative read.

- Rowland, D. L. (2012). *Sexual dysfunction in men*. Cambridge, MA: Hogrefe Publishing. Written for mental health professionals, but an easy (108 pages in length) and informative read.

- The New View Campaign: Challenging the Medicalization of Sex (http://newviewcampaign.org/). This is Dr. Leonore Tiefer's anti-medicalization of sexuality website, "formed in 2000 as a grassroots network to challenge the distorted and oversimplified messages about sexuality that the pharmaceutical industry relies on to sell its new drugs…The goal of the New View Campaign is to expose biased research and promotional methods that serve corporate profit rather than people's pleasure and satisfaction. The Campaign challenges all views that reduce sexual experience to genital biology and thereby ignore the many dimensions of real life."

- Tiefer, L. (2004). *Sex is not a natural act and other essays*. Westview Press. Written by one of the foremost experts on sexuality (and an outspoken critic of the "medicalization" of sexuality), this is an insightful, fascinating look into the consequences of living in our hypersexualized Western society. This is a personal favorite of your textbook authors.

- Weeks, G., & Winters, J. (2002). Sex: What problem? *Psychology Today.* A brief but excellent introduction to hypoactive sexual desire and the issues it causes for many couples. Available online at https://www.psychologytoday.com/articles/200209/sex-what-problem

- Zilbergeld, B. (1999). *The new male sexuality.* New York: Bantam Books. A readable book about male sexuality and overcoming problems. Remains one of the most frequently recommended books on male sexuality by members of the Society for Sex Therapy and Research. New and used copies are available on Amazon.com.

About relationships

- AAMFT (American Association for Marriage and Family Therapy; www.aamft.org). This organization provides names and contact information of certified marriage and family therapists in your area, as well as information on accredited MFT programs (for those of you considering a career in this field) and upcoming conferences.

- Gottman, J. M., & Silver, N. (2015). *The seven principles for making marriage work (revised edition)*. New York: Harmony (an imprint of Crown Publishing). A good introductory, popular press book focused on building effective communication between partners.

- Schnarch, D. M. (2009). *Passionate marriage: Love, sex, and intimacy in emotionally committed relationships.* W.W. Norton (reprint edition). Written for the public; focuses on the subject of keeping relationships vital and is one of the most frequently recommended books by members of the Society for Sex Therapy and Research. An audio version (read by the author) was released in 2014 and is available on Amazon.com.

Chapter 14

- American Psychiatric Association (2013). *Paraphilic disorders fact sheet*. Available online at http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf. Discusses the conditions required for a paraphilic disorder diagnosis, as well as the reasons for changing some of the diagnostic categories and requirements that were used in earlier versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

- Balon, R. (2013). Controversies in the diagnosis and treatment of paraphilias. *Journal of Sex & Marital Therapy*, 39, 7–20. Well-written and informative article by a leading expert in the field. You may request the full article (if your university or college library does not have access) from the author at ResearchGate using the following link: https://www.researchgate.net/publication/233422187_Controversies_in_the_Diagnosis_and_Treatment_of_Paraphilias

- Gershon, M. (2015, January 15). BDSM versus the DSM: A history of the fight that got kink de-classified as mental illness. *The Atlantic*. Interesting discussion of how social and clinical understandings of what is "normal" versus "abnormal" with respect to BSDM-related activities has shifted over time. Available at http://www.theatlantic.com/health/archive/2015/01/bdsm-versus-the-dsm/384138/

- Krafft-Ebing, R. von (1886). *Psychopathia sexualis*. This original work has been reissued in multiple editions and is widely (and inexpensively) available on Amazon.com. It was written for a professional/scientific audience and the language and views reflect the time in which Krafft-Ebing lived, but this classic work is filled with case histories and represents the first attempt to identify and classify the various paraphilias/paraphilic disorders.

- Laws, D. R., & O'Donohue, W. (Eds.). (2008). *Sexual deviance: Theory, assessment, and treatment* (2nd ed.). New York: Guilford Press. Solid introduction to theories and treatment of various paraphilias. Available on Amazon.com (and the earlier edition is also widely and inexpensively available).

- Money, J., & Lamacz, M. (1989). *Vandalized lovemaps.* New York: Prometheus. Contains detailed (and interesting) case histories of people with particular paraphilias. Widely available (many versions) on Amazon.com.

- Sadomasochism and related activities at *The Huffington Post* (selected articles). The online magazine has a section featuring multiple articles on various forms of BDSM "sex play" as well as interviews with people involved in the BDSM community. Available at: http://www.huffingtonpost.com/news/bdsm/

Chapter 15

General Resources and Information

- Parents: For an updated list of books and materials that are appropriate for children and adolescents, contact SIECUS at 212-819-9770. You can find them on the web at www.siecus.org.
- The Centers for Disease Control and Prevention have a lot of information available for free download, including:
    1. The latest results from the National Intimate Partner and Sexual Violence Survey (NISVS) at http://www.cdc.gov/violenceprevention/nisvs/infographic.html. This provides an excellent summary of current information about sexual violence, intimate partner violence, and stalking.
    2. A technical (but informative) resource about ways to prevent sexual victimization/violence at http://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf.
    3. A Facebook page devoted to sexual (and other forms of) violence prevention at https://www.facebook.com/VetoViolence/.
- Lalumière, M. L., et al. (2005). *The causes of rape: Understanding individual male propensity for sexual aggression.* Washington, DC: American Psychological Association. Discusses the factors implicated in sexual aggression. New and used copies are available on Amazon.com.
- Tewksbury, R. (2007). Effects of sexual assaults on men: Physical, mental and sexual consequences. *International Journal of Men's Health,* 6, 22–35. Interesting examination of the impact of sexual assault on male victims.

Sexual Consent

- Another interesting and informative discussion of sexual consent is provided by sex worker Nina Hartley in her YouTube video, "Consent Explained by a Porn Star," located at https://www.youtube.com/watch?v%3DJEAgXMtcJ0w.
- The Thames Valley Police Department (in the United Kingdom) released a much-viewed video in 2015 that illustrated the concept of sexual consent using an analogy to drinking tea. This video presents a difficult and serious topic in a lighthearted and accurate way. It can be located on YouTube at https://www.youtube.com/watch?v%3DpZwvrxVavnQ. (If this link does not work, search YouTube for "Thames Valley Police tea and consent" and a working link should come up.) Additional videos about issues of sexual harassment, victimization, and consent can be found on the Thames Valley Police Department's YouTube channel (https://www.youtube.com/user/thamesvalleypoliceuk).

Sexual Assault and Harassment in College

- Sexual assault continues to be a problem on university and college campuses. See the following link for a recent article on this issue: http://www.huffingtonpost.com/entry/schools-investigation-sexual-assault_us_55b19b43e4b0074ba5a40b77.
- Links to two articles detailing the ongoing sexual assault issues plaguing one particular college—Occidental College in Los Angeles, CA—can be found here: http://www.laweekly.com/news/rape-at-occidental-college-official-hush-up-shatters-trust-2614267.
- http://www.lamag.com/longform/trouble-oxy/
- Hill, C., & Silva, E. (2005). *Drawing the line: Sexual harassment on campus*. Washington, DC: AAUW Educational Foundation. This article presents facts and information about the types of sexual harassment faced by many college students. It is available at http://www.aauw.org/files/2013/02/drawing-the-line-sexual-harassment-on-campus.pdf.
- The Brock Turner case (in which ex–Stanford undergraduate Turner was convicted of felony sexual assault but released after serving only three months in prison) made national headlines and spurred calls for more rigorous prosecution and increased mandatory sentences for sexual assault. Here is the powerful letter that his victim, "Emily Doe," read in open court during sentencing and provided to BuzzFeed in its entirety: https://www.buzzfeed.com/katiejmbaker/heres-the-powerful-letter-the-stanford-victim-read-to-her-ra?utm_term%3D.jgXMelN9mP%23.kmrYzQd1XL.

Child Sexual Abuse

- The U.S. Department of Health and Human Services (Children's Bureau) has an information service called the Child Welfare Information Gateway. The link is https://www.childwelfare.gov/topics/preventing/preventionmonth/get-involved/publications/. This site provides information and material related to preventing child abuse, protecting children from the risk of abuse, and promoting healthy families.
- LaRosa, P. (2014, October 17). "48 Hours" investigates sex abuse by women teachers. *CBS News.* The following link provides access to a report about female teacher predators (including interviews with scientific experts): http://www.cbsnews.com/news/48-hours-investigates-sex-abuse-by-women-teachers/.
- Salter, A. (2003). *Predators: Pedophiles, rapists, & other sex offenders: Who they are, how they operate, and how we can protect ourselves and our children.* New York: Basic Books. Various editions of this book are available on Amazon.com.

Victim Services

- Childhelp is a national organization that provides information, crisis intervention, and referrals to local services. Located online at https://www.childhelp.org/. The National Child Abuse Hotline number (listed on that site) is 1(800) 4-A-CHILD or 1(800) 422-4453.

- Rape, Abuse, and Incest National Network (RAINN) is a national organization that also provides information and referrals to local services. Located online at https://www.rainn.org/index.php. They have a sexual assault hotline (National Sexual Assault Hotline)—that number is 1(800) 656-HOPE (4673).

- Maltz, W. (2012). *The sexual healing journey: A guide for survivors of sexual abuse.* (3rd ed.). William Morrow. One of the most frequently recommended books by members of the Society for Sex Therapy and Research. Copies of this and earlier editions are readily available on Amazon.com.

Chapter 16

- *Attorney General's Commission on Pornography: Final report*. (1986). Washington, DC: U.S. Department of Justice. The Meese Report is available in its entirety online at http://www.porn-report.com/attorney-generals-commission-pornography.htm. It makes for interesting reading, and many of the conclusions (and speculations) the commission provided have been supported by subsequent research.

- Bullough, V., & Bullough, B. (1988). *Women and prostitution: A social history*. Buffalo, NY: Prometheus Books. A comprehensive sociological, historical, and cross-cultural examination.

- Dines, G. (2010). *Pornland: How porn has hijacked our sexuality*. Boston, MA: Beacon Press. Fascinating and thought-provoking exploration of the ways in which pornography has shaped and distorted our sexual attitudes and expectations. Available on Amazon.com. Gail Dines is an engaging and passionate speaker, and some of her lectures are available on YouTube.

- Donnerstein, E. J., & Linz, D. G. (1986, December). The question of pornography. *Psychology Today*. In this article, two well-known researchers challenge the conclusions of the Attorney General's Commission and argue that we should be more concerned with violence in the media (as opposed to sexual explicitness per se).

- Heins, M. (1993). *Sex, sin, and blasphemy: A guide to America's censorship wars*. New York: New Press. Takes the view that sexually explicit material should be protected as a First Amendment right (see MacKinnon, below, for an alternative viewpoint).

- MacKinnon, C. (1996). *Only words*. Cambridge, MA: Harvard University Press. Takes the view that pornography should be banned as discriminatory against women under the Fourteenth Amendment (see Heins for an alternative viewpoint).

- Nichols, A. (2016). *Sex trafficking in the United States: Theory, research, policy, and practice*. New York: Columbia University Press. An up-to-date review about sex trafficking in the United States. Available at Amazon.com.

- Skinner, E. B. (2009). *A crime so monstrous: Face-to-face with modern-day slavery* (reprint edition). New York: Free Press. This is a compelling look into the global slave trade, providing insight into the lives of victims as well as the workings of the U.S. State Department and the complexities (and failings) of many abolitionists and anti-slavery organizations. Winner of the 2009 Dayton Literary Peace Prize. Available at Amazon.com in electronic and paper formats.

- Smith, L., & Coloma, C. (2013). *Renting Lacy: A story of America's prostituted children*. Vancouver, WA: Shared Hope International. This set of true stories, interviews, and commentary is based on research conducted for Shared Hope International's *National Report on Domestic Minor Sex Trafficking* (see web-based resources, below). Author Smith (a former member of the U.S. Congress) founded Shared Hope International to provide assistance to victims of sex trafficking. Available at Amazon.com in electronic and paper formats.

- There are a number of web-based resources available on prostitution, sex trafficking, and other forms of sexual (and nonsexual) exploitation, including the following:

    1. Prostitution Research and Education (www.prostitutionresearch.com). Established by Dr. Melissa Farley, this nonprofit organization "conducts research on prostitution, pornography and trafficking and offers education and consultation to researchers, survivors, the public and policymakers." The site is a great resource for information about trafficking and prostitution.

    2. End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Proposes (ECPAT International, online at www.ecpat.org/). This is a global network of individuals working to stop child exploitation. An offshoot of EPCAT-International, EPCAT-USA (www.ecpatusa.org/) is the "first American non-profit to work on the issue of commercial sexual exploitation of children." Both of these organizations provide informational pamphlets (designed for adults as well as children), research reports, and policy statements as well as a variety of ways to become involved in their work.

    3. Federal Bureau of Investigation (FBI) investigates trafficking under its Civil Rights and Violent Crimes Against Children programs. Information and helpful links can be found at www.fbi.gov/investigate/civil-rights/human-trafficking.

    4. Office on Trafficking in Persons (a division of the U.S. Department of Health and Human Services). Located online at www.acf.hhs.gov/otip, this site provides information about human trafficking, victim assistance, research and policy, and other resources.

    5. Shared Hope International's 2009 *National Report on Domestic Minor Sex Trafficking*. This report presents the results of field research, funded by a grant from the U.S. Department of Justice, that examined the sexual exploitation of children in the United States from 2006 to 2009. It is available at sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf.

    6. U.S. Department of State's *Trafficking in Persons (TIP) Reports*. These annual reports (which began in 2001) provide information on human trafficking around the world, including how well the governments in each world nation are doing in terms of prevention, prosecution, and victim assistance. Available at www.state.gov/j/tip/rls/tiprpt/.

Answers

Chapter 1

1. their friends
2. the media (e.g., TV)
3. 85
4. sexuality
5. the biblical Hebrews
6. Christians
7. Saint Augustine
8. Queen Victoria
9. penicillin
10. the birth control pill and IUD
11. socialization
12. the media
13. identification
14. Sigmund Freud
15. Henry Havelock Ellis
16. Alfred Kinsey
17. Masters and Johnson
18. true
19. false
20. false
21. false
22. false
23. false
24. false
25. true
26. true
27. false
28. false
29. false
30. true
31. true
32. true
33. true
34. false
35. false

36. e
37. m
38. f
39. g
40. c
41. l
42. a
43. i
44. n
45. Inis Baeg
46. leisure time, mobility, birth control, antibiotics
47. each possible sample of that size
48. body, soul
49. spermatorrhea
50. “Any mutually voluntary activity with another person that involves genital contact…”
51. television

Chapter 2

1. vulva
2. mons veneris
3. labia majora
4. labia minora
5. clitoris
6. vaginal opening
7. urethral opening
8. mons veneris
9. outer surfaces of the labia majora
10. clitoris
11. penis
12. labia minora
13. vestibular area
14. hymen
15. eight
16. vagina
17. uterus
18. Fallopian tubes
19. ovaries
20. vagina
21. vagina
22. Grafenberg (G) spot
23. ovary
24. Fallopian tube
25. uterus
26. endometrium
27. cancer of the cervix
28. scrotum
29. testicles
30. corpora cavernosa
31. corpus spongiosum
32. glans
33. foreskin
34. circumcision
35. testicles

36. testosterone
37. epididymis
38. vas deferens
39. ejaculatory ducts
40. urethra
41. prostate gland
42. seminal vesicles
43. semen
44. Cowper’s glands
45. testicles
46. prostate gland
47. true
48. true
49. true
50. false
51. false
52. true
53. false
54. true
55. false
56. true
57. false
58. false
59. false
60. false
61. false
62. b
63. e
64. c
65. a
66. f
67. l
68. h
69. i
70. j
71. k

72. d
73. g
74. m
75. n
76. prostate gland
77. labia majora
78. endometrium
79. blood
80. Cowper’s glands
81. amount of fatty tissue
82. just after menstruation
83. ejaculatory ducts
84. seminal vesicles
85. after a warm bath or shower
86. Bartholin’s glands
87. seminiferous tubules
88. clitoris
89. pubococcygeus (PC)
90. front
91. prolactin

Chapter 3

1. endocrine
2. testosterone
3. estrogen
4. progesterone
5. pituitary gland
6. 28
7. follicle-stimulating hormone (FSH)
8. follicle
9. follicular (or proliferative)
10. endometrium
11. FSH
12. luteinizing hormone (LH)
13. LH
14. ovulation
15. abdominal cavity
16. Fallopian tube
17. luteal (or secretory)
18. corpus luteum
19. endometrium
20. endometrium
21. menstruation
22. at least 7 days
23. estrous
24. estrus (ovulation)
25. sperm production
26. luteinizing hormone
27. male hormones (e.g., testosterone)
28. taboos
29. sloughed off endometrial tissue
30. cervical mucus
31. blood
32. amenorrhea
33. 3 to 14
34. premenstrual syndrome (PMS)
35. with the start of menstruation

36. dysmenorrhea
37. prostaglandins
38. endometrial tissue grows outside the uterus
39. toxic shock syndrome
40. testosterone
41. estrogen
42. progesterone (and oxytocin)
43. testosterone
44. high blood pressure; liver, prostate, and breast tumors; impaired reproductive function; masculinization in women; emotional or psychological problems
45. false
46. false
47. false
48. false (28 days is an average)
49. true
50. true
51. false (there is no strong evidence for this)
52. false
53. false
54. true
55. false
56. false
57. h
58. d
59. n
60. j
61. l
62. k
63. b
64. m
65. f
66. o
67. e
68. p
69. i
70. a
71. c

72. g
73. pituitary
74. pheromones
75. follicle
76. corpus luteum
77. menstruation
78. human chorionic gonadotropin (HCG)
79. gonadotropin-releasing hormone (GnRH)
80. progesterone
81. testosterone
82. inhibin
83. oxytocin
84. 5, 1, ovulation
85. the start of menstruation

Chapter 4

1. Sexual desire
2. Sexual arousal
3. sexual activity
4. sexual affect and cognitions
5. Masters and Johnson
6. excitement
7. plateau
8. orgasm
9. resolution
10. sexual response cycle
11. Helen Singer Kaplan
12. sexual desire
13. Rosemary Basson
14. circular
15. vasocongestion
16. penile erection
17. vaginal lubrication
18. subjective arousal
19. plateau
20. orgasmic platform
21. pulls back against the pubic bone and disappears beneath the clitoral hood
22. 50% to 75%
23. sex-tension flush or sex flush
24. rhythmic muscular contractions
25. the brain or the mind
26. similar
27. emission
28. expulsion
29. ejaculation
30. refractory period
31. multiple orgasms
32. resolution
33. 75%
34. 60% (technically 62%, according to national surveys)
35. clitoral

36. clitoral
37. vaginal
38. clitoris
39. front
40. Grafenberg (G) spot
41. emission of fluid (or ejaculation)
42. prostate gland
43. not important
44. aphrodisiacs
45. true
46. false
47. true
48. false
49. true
50. true
51. false (lubrication does not necessarily signify "readiness")
52. true
53. false
54. true
55. false
56. false
57. false
58. true
59. true
60. false
61. true
62. false
63. false
64. false
65. true
66. false
67. true
68. false (for men only)
69. d
70. b, g, j, k, l, n, s
71. a, c, f, i, q, r, t

72. e, p, u
73. h, m, o
74. b, c, g, i, k, q, t
75. vasocongestion, myotonia, and cardiopulmonary changes
76. vasocongestion
77. urethra (or Skene's glands)
78. sex-tension flush or sex flush
79. orgasmic platform
80. refractory period

Chapter 5

1. 2
2. bacteria
3. viruses
4. parasites
5. gonorrhea
6. chlamydia
7. syphilis
8. gonorrhea
9. chlamydia
10. pelvic inflammatory disease (PID)
11. syphilis
12. antibiotics
13. skin, skin
14. recurrent
15. liver
16. feces
17. blood and other body fluids
18. human papilloma
19. human immunodeficiency virus (HIV)
20. CD4+
21. immune
22. opportunistic
23. 11
24. intimate sexual activity
25. blood
26. casual contact
27. men and women
28. infestations of parasites
29. trichomoniasis
30. monilial
31. bacterial vaginosis
32. false
33. true
34. false
35. false

36. false
37. true
38. false
39. true
40. false
41. true
42. false
43. false
44. false
45. true
46. false
47. true
48. false
49. false
50. false
51. false
52. true
53. false
54. true
55. true
56. true
57. true
58. false
59. true
60. false
61. a
62. l
63. c
64. q
65. h
66. f
67. o
68. i
69. m
70. j
71. e

72. n
73. g
74. b
75. d
76. p
77. k
78. parasites
79. pelvic inflammatory disease
80. human papillomavirus infection
81. human immunodeficiency virus (HIV) infection
82. types of vaginal infections
83. hepatitis A and B
84. ectopic pregnancy, infertility
85. syphilis, human immunodeficiency virus, hepatitis
86. stress
87. mucous membranes
88. nongonococcal (or nonspecific) urethritis
89. yeast (monilial)
90. pinworms
91. chlamydia
92. CD4+
93. during the first 60 days and late in the infection (AIDS)
94. HIV antibodies
95. gonorrhea, chlamydia, syphilis (the chancre is often internal), HPV infection, HIV infection
96. HPV infection, HIV infection, trichomoniasis
97. to always use condoms, to abstain from sex until you are in a long-term monogamous relationship
98. HPV infection

Chapter 6

1. 9
2. 45%
3. abstaining from sex
4. calendar
5. Billings
6. symptothermal
7. ovulation
8. lactational amenorrhea
9. spermicides
10. the diaphragm
11. the cervical cap
12. condoms
13. the contraceptive sponge
14. vagina or uterus
15. offer some protection against sexually transmitted infections
16. estrogen
17. progesterone
18. patch
19. NuvaRing
20. Depo-Provera
21. 3-5 (depending on type)
22. the IUD
23. Nexplanon
24. vas deferens
25. tubal sterilization
26. true
27. true
28. false
29. true
30. false
31. false
32. true
33. true
34. false
35. false

36. false
37. false
38. false
39. false
40. true
41. true
42. true
43. false
44. false
45. true
46. true
47. true
48. true
49. true
50. true
51. true
52. false
53. n
54. i
55. k, d
56. d
57. primarily b, secondarily e
58. h
59. h
60. e
61. e
62. primarily e, secondarily b, g
63. j, a
64. c, j
65. a, m
66. c, j
67. c, j
68. l
69. f
70. c, j
71. c, j

72. many men fail to withdraw in time
73. he has had 20 ejaculations
74. 7, 20
75. rises slightly
76. clear and slippery
77. oil-based
78. male condom, female condom, contraceptive sponge
79. using emergency contraception
80. 5 days
81. to abstain from sex

Chapter 7

1. 5
2. ovulation
3. 1
4. Fallopian tube
5. endometrium
6. ectopic
7. chlamydia and/or gonorrhea
8. human chorionic gonadotropin (HCG)
9. trimesters
10. embryo
11. 2
12. fetus
13. 7
14. quickening
15. 4th or 5th
16. teratogens
17. amniocentesis
18. fear-tension-pain
19. midwife
20. contractions
21. dilation
22. start-up
23. amniotic sac
24. transition phase
25. fully dilated
26. head
27. umbilical cord
28. placenta
29. cesarean (C-section)
30. proteins
31. postpartum blues or depression
32. 4 to 6
33. 1 year
34. 40
35. 40

36. 20
37. a low sperm count
38. artificial insemination
39. Fallopian tubes
40. ovulate
41. in vitro fertilization
42. false
43. true
44. false
45. true
46. false
47. false
48. false
49. false
50. true
51. false
52. false
53. true
54. false
55. false
56. false
57. false
58. c
59. d
60. h
61. b
62. g
63. f
64. a
65. e
66. c
67. morula, blastocyst
68. umbilical cord
69. preeclampsia
70. lightening
71. whether contractions are coming 10 minutes apart (or sooner) on a regular basis; whether contractions are at least 30 seconds long on a regular basis; whether the cervix is dilated to at least 2 to 3 centimeters; whether the cervix is at least 70% effaced

72. first
73. tubal
74. 25 to 35
75. blastocyst
76. the head
77. 24 hours
78. amnion
79. episiotomies, cesarean sections
80. 22 to 23 weeks
81. year
82. at least 11 months

Chapter 8

1. gender identity
2. gender roles
3. XX
4. XY
5. Klinefelter's
6. Turner's
7. testosterone
8. girl
9. congenital adrenal hyperplasia
10. gender dysphoria
11. transgender
12. Freudian
13. social learning
14. gender constancy
15. 6 or 7
16. evolutionary (sociobiological)
17. sociocultural
18. independent
19. androgyny
20. schemas
21. sexual desire
22. sociosexuality
23. false
24. true
25. true
26. true
27. true
28. false
29. true
30. true
31. true
32. true
33. true
34. false
35. false

36. true
37. true
38. f, k
39. e
40. g
41. m, h
42. n
43. b, h
44. b, d, h
45. c
46. f, k, l
47. a, h
48. j
49. i, h
50. h
51. gender constancy
52. 1800s (when the United States and other countries became industrialized)
53. sociocultural
54. identification
55. socialization
56. stereotypes
57. undifferentiated
58. phallic
59. androgynous
60. testosterone
61. transvestites; transgender individuals
62. imitation
63. the social construction of masculinity and femininity
64. expressive
65. 2
66. gender schema
67. testosterone
68. two-spirit

Chapter 9

1. distinct preferences
2. 2.5% to 7%
3. 2, 3, or 4
4. gender identities
5. roles
6. Oedipus
7. social learning theory
8. Sambian
9. genetic
10. brains
11. hormones
12. interact
13. ancient Greeks
14. Romans
15. Thomas Aquinas
16. coming out
17. admitting to oneself that one has a homosexual orientation
18. sexual prejudice
19. should not attempt to change
20. true
21. false
22. false
23. false
24. false
25. false
26. false
27. true
28. true
29. false
30. false
31. false
32. false
33. false
34. false
35. false

36. true
37. false
38. a
39. b
40. e
41. d
42. b
43. e
44. c
45. a
46. e
47. d
48. b
49. adolescence
50. before or shortly after birth
51. predispose
52. admitting a homosexual orientation to oneself; getting to know other homosexuals; telling family and friends of one's sexual orientation; complete openness about one's homosexuality
53. Socrates, Leonardo da Vinci, Michelangelo, Gertrude Stein, Walt Whitman, many others

Chapter 10

1. 3 through 5
2. modesty (and inhibitions about exposing their bodies in public)
3. puberty
4. reproduction
5. hormone
6. self-identity
7. over half
8. peer pressure
9. monogamy
10. mid-20s to mid-30s
11. menopause
12. vaginal lubrication
13. testosterone
14. refractory
15. their attitudes about sex when they were younger
16. sexual learning
17. in early childhood (preschool years)
18. how you say it
19. scare tactics
20. askable
21. willingness to come to you when they have questions and problems
22. true
23. false
24. true
25. false
26. false
27. true
28. false
29. true
30. true
31. true
32. false
33. true
34. false
35. true

36. false
37. false
38. false
39. true
40. true
41. false
42. true
43. false
44. false
45. true
46. a
47. b
48. e (caused by b)
49. c
50. a
51. c
52. e
53. d
54. a
55. d (sometimes)
56. d
57. f, c (from DHEA)
58. lack of a partner
59. the climacteric
60. self-exploration
61. latency
62. secondary sex characteristics
63. emotional intimacy
64. opportunity, alienation
65. adrenarche, gonadarche

Chapter 11

1. range
2. Kinsey
3. 92
4. 62
5. increase
6. 70s
7. Latinos and African Americans
8. the clitoris, labia minora, and/or entire vulva
9. vibrator
10. homosexual or bisexual
11. sex (or intercourse)
12. sexual intimacy
13. replacement
14. romance, commitment, affection
15. dominance
16. submission
17. one to three
18. single people
19. 15 to 60
20. declines
21. man
22. missionary
23. woman-on-top (or man-from-behind)
24. fellatio
25. cunnilingus
26. African
27. higher
28. homosexual or gay
29. sexually healthy
30. oral
31. anal
32. false
33. true
34. false
35. false

36. true
37. false
38. true
39. false
40. false
41. true
42. true
43. false
44. true
45. true
46. false
47. false
48. true
49. true
50. true
51. (anorectal) bacteria
52. the replacement fantasy
53. variety
54. ritualized
55. vaginal intercourse, watching one's partner undress
56. a sexually active lifestyle
57. face-to-face
58. woman-on-top
59. feels comfortable with his or her sexuality; feels free to choose whether or not he or she wishes to try a variety of sexual behaviors
60. higher

Chapter 12

1. personal observation
2. Affection
3. number
4. psychometric approach
5. information/data
6. ongoing/actual relationships
7. liking
8. romantic love
9. companionate love
10. consummate love
11. Eros/erotic love
12. storge/storgic love
13. pragma/pragmatic love
14. mania/manic love
15. ludus/ludic love
16. agape/agapic love
17. matches
18. passionate love
19. emotions
20. idealize
21. affection/intimacy/commitment
22. emotionally volatile
23. moderate
24. similar
25. equity
26. self-acceptance
27. realistic idealism
28. habituation
29. attending to one's partner/sharing activities/openness/positive attitude/shared social network/trying new activities together
30. jealousy
31. false
32. false
33. true
34. false
35. true

36. false
37. true
38. true
39. true
40. false
41. true
42. true
43. true
44. false
45. true
46. false
47. false
48. true
49. true
50. true
51. e
52. l
53. k
54. f
55. a
56. d
57. i
58. h
59. g
60. j
61. n
62. b
63. m
64. o
65. c
66. eros/erotic love
67. storge/storgic love
68. mania/manic love (eros/erotic love is also an acceptable choice)
69. agape/agapic love
70. passionate, companionate
71. monogamy

72. companionate love
73. physical appearance
74. emotional indifference, cognitive disconnection, behavioral distancing
75. obsessive review, emotional and social loneliness

Chapter 13

1. at least half
2. couple’s
3. cognitive-behavioral
4. medical
5. biopsychosocial
6. medical
7. sexual
8. Educational
9. sensate focus exercises
10. couples
11. secondary
12. situational
13. hypoactive sexual desire
14. compulsiveness
15. dyspareunia
16. premature ejaculation
17. reasonable voluntary control (of ejaculation)
18. erectile disorder
19. performance anxiety
20. orgasmic disorder
21. headaches after orgasm
22. relationship problems
23. vaginismus
24. reaching orgasm
25. stereotypic gender roles, power
26. vocabulary
27. positive
28. negative
29. “you”
30. self-disclose
31. listener
32. eye contact, facial expressions, interpersonal distance, touch
33. true
34. false
35. true

36. false
37. false
38. true
39. false
40. false
41. true
42. true
43. true
44. true
45. false
46. false
47. false
48. false
49. true
50. false
51. clitoris
52. woman-on-top
53. spectatoring
54. nondemand mutual pleasuring
55. phimosis
56. hypoactive sexual desire
57. communication
58. verbal, nonverbal
59. disagreements
60. postcoital dysphoria

Chapter 14

1. statistical
2. sociological
3. psychological
4. place, context, culture (any of these)
5. mature
6. consenting any order
7. human
8. paraphilic disorder
9. sexual variants
10. men/males
11. courtship disorders
12. affiliative
13. tactile
14. voyeurs
15. exhibitionism
16. telephone scatologia
17. frotteurism
18. pedophilia
19. prepubescent
20. fetishism
21. transvestism
22. fetishism
23. urophilia
24. coprophilia
25. mysophilia
26. klismaphilia
27. zoophilia
28. criminal behavior, violence/violent behavior, sexual assault (any or all of these)
29. sadists
30. masochists
31. primary and preferred
32. BDSM
33. erotic, positive, pleasurable (any or all)
34. voluntary, consensual (either or both)
35. collaborative, scripted, mutually created (any) any order

36. playful, recreational (either or both)
37. necrophilia
38. men
39. antiandrogen
40. false
41. false
42. false
43. true
44. true
45. false
46. false
47. false
48. true
49. true
50. true
51. false
52. false
53. r
54. s
55. e
56. d
57. k
58. g
59. a
60. q
61. h
62. p
63. b
64. c
65. l
66. m
67. n
68. t
69. j
70. i
71. f

72. o
73. fetishism
74. exhibitionists
75. exhibitionism
76. 13
77. bodily discharges, fetishes
78. non-rejecting
79. hypersexual
80. long term

Chapter 15

1. physical force
2. coercion (manipulation or pressure)
3. consent or resist
4. forced penile-vaginal intercourse; “carnal knowledge of a female, forcibly and against her will”
5. oral, anal, or vaginal penetration by any body part or object, without consent or when the victim cannot give consent
6. crime reports
7. declined, decreased
8. underestimate
9. victimization surveys
10. higher
11. someone the victim knows
12. home
13. 12 and 34
14. rape or attempted rape
15. sexual coercion
16. physically coercive
17. verbally coercive
18. many of the cues and behaviors that happen on dates, each other’s intentions or behaviors
19. token resistance
20. compliance
21. marital rape
22. gang
23. statutory
24. men, someone they know
25. childhood
26. verbal
27. physical
28. hypergender
29. heteronormative
30. rape myths
31. deny or minimize
32. empathy
33. neglect and/or abuse
34. sexual violence
35. male violence

36. women who are raped usually provoke it by their dress and behavior
37. women subconsciously want to be raped
38. no woman can be raped if she truly does not want to be
39. post-rape posttraumatic stress disorder
40. controlled
41. long-term reorganization
42. rape-shield
43. social systems
44. sexual harassment
45. intentional and persistent contact or attempted contact by the stalker/pursuer that is unwanted by and psychologically aversive to the target
46. safety
47. someone they know
48. preference
49. situational
50. bisexual pedophile
51. 200
52. sexual and/or physical abuse
53. sibling
54. sexually violent predator/sexual predator
55. true
56. false
57. true
58. true
59. true
60. false
61. true
62. true
63. false
64. true
65. true
66. false
67. false
68. true
69. true
70. false
71. true

72. false
73. true
74. true
75. true
76. j
77. k
78. f
79. e
80. h
81. i
82. g
83. a
84. d
85. c
86. b
87. l
88. juveniles (persons under the legal "age of consent")
89. getting a partner intoxicated in order to have sex, having sex with someone who is asleep or unconscious, using guilt, anger, or pleading to get someone to comply, verbally threatening to end the relationship, continuing to persist over the other's objections (any four of these)
90. gang
91. opportunistic
92. period of long-term reorganization
93. Civil Rights Act
94. unequal power/power differential
95. traditional stereotypical gender roles
96. Romeo and Juliet

Chapter 16

1. human prehistory (Paleolithic period)
2. Kama Sutra
3. Production Code (Hays Code)
4. government regulation (oversight, interference, involvement)
5. one of these: nudity, suggestive dancing, lustful embraces, homosexuality (perversion), lustful kissing
6. one of these: nudity, suggestive dancing, lustful embraces, homosexuality (perversion), lustful kissing
7. one of these: nudity, suggestive dancing, lustful embraces, homosexuality (perversion), lustful kissing
8. Internet
9. multi-billion
10. webcam
11. men and boys (males)
12. women and girls (females)
13. Erotica
14. pornography
15. Miller Test (or Three-Part Obscenity Test)
16. contemporary community standards
17. offensive way
18. "serious literary, artistic, political, or scientific value"
19. twice
20. remained stable (been stable, stayed the same)
21. higher
22. positive
23. any one of these: curiosity, desire for information, interest in exploring sexual identity
24. any one of these: curiosity, desire for information, interest in exploring sexual identity
25. not associated with (not liked with, not related to)
26. nonviolent but degrading
27. violent
28. violent
29. sexual habituation
30. women
31. men
32. more positive
33. subjective sexual arousal
34. any one of these: greater number of sex partners overall, greater number of casual sex partners, younger age of first intercourse, prostitution, extramarital sex

35. see 34 (a second item from that list)
36. see 34 (a third item from that list)
37. casual hookup, with penetration, without a condom, while intoxicated
38. one of these: depression, anxiety, stress, poor overall quality of life
39. negative body image
40. own penis size
41. satisfaction
42. commitment
43. rape myth acceptance
44. less sympathetic
45. rape myths
46. commit rape
47. sexual coercion
48. one of these: physical force, threats of physical force, verbal coercion
49. physical aggression
50. violent (or demeaning)
51. demeaning (or violent)
52. physical, genital (one or both)
53. emotional, cognitive, interpersonal (any or all)
54. open communication
55. Nevada
56. limited legality
57. sells sex
58. 30 million
59. 1%
60. street prostitution or streetwalking
61. B-girls
62. brothel prostitution
63. escorts (or call girls)
64. call girls (or escorts)
65. hustlers/rent boys
66. female
67. economic hardship
68. substance use, abuse, or addiction
69. depression, anxiety, PTSD symptoms (one of these)
70. social support

71. a small percentage of
72. heterosexual
73. annual incomes
74. sex
75. the “girlfriend experience”
76. 27
77. 20%
78. legitimate business, commercial enterprise, industry, trade (one of these)
79. social context
80. public health, public welfare
81. true
82. false
83. true
84. false
85. true
86. true
87. false
88. true
89. true
90. false
91. false
92. true
93. true
94. false
95. true
96. true
97. false
98. false
99. true
100. false
101. b
102. a
103. d
104. c
105. g
106. f

107. e
108. j
109. h
110. i

This page contains the following errors:

```
error on line 951 at column 296: Expected '>' or '/', but got '.'.
```

Below is a rendering of the page up to the first error.

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A

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error on line 46 at column 333: Expected '>' or '/', but got '.'.
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Glossary

Abortion

Termination of pregnancy. Depending on how far the pregnancy has advanced, this can be done by taking a pill (RU 486), scraping the uterine lining (dilation and curettage), removing the uterine lining by suction (dilation and evacuation), or inducing labor (by injecting hypertonic saline or prostaglandins). (Ch. 6)

Accepting

Letting your child know that all questions are okay and will not be met with a negative attitude. (Ch. 10)

Acquaintance or date rape

A rape committed by someone who is known by and/or is dating the victim. (Ch. 15)

Acquired immunodeficiency syndrome (AIDS)

An often fatal infection caused by a virus (HIV) that destroys the immune system. It is spread by intimate sexual activity (the exchange of bodily fluids) or contaminated blood. (Ch. 5)

Adolescence

The time of life between puberty and adulthood. (Ch. 10)

Afterbirth

The expulsion of the placenta from the uterus after a baby is born. (Ch. 7)

Agape

A type of selfless, altruistic love that puts the interest of the loved person ahead of one's own, even if it means great sacrifice. (Ch. 12)

Alpha-fetoprotein (AFP) screening

Blood test used to detect neural abnormalities. (Ch. 7)

Amebiasis

Dysentery caused by infestation of amoebae, one-celled organisms. (Ch. 5)

Amenorrhea

The absence of menstruation for 3 months or longer. (Ch. 3)

Amniocentesis

A technique for detecting fetal problems, involving collection of amniotic fluid between the 14th and 18th weeks of pregnancy. (Ch. 7)

Amnion

A thick-skinned sac filled with water that surrounds the fetus. (Ch. 7)

Anabolic steroids

Synthetic steroid hormones that combine the growth (anabolic) effects of adrenal steroids with the masculinizing effects of androgenic steroids. (Ch. 3)

Anal intercourse

Penis in anus sex. (Ch. 11)

Anaphrodisiacs

Substances that suppress sexual functioning. (Ch. 4)

Androgen insensitivity syndrome

A condition in which the testicles secrete normal amounts of testosterone during male embryonic development but the tissues do not respond to it. As a result, a clitoris, labia, and a short vagina develop, but the internal female structures do not develop because the testicles still secrete Mullerian duct-inhibitory substances. (Ch. 8)

Androgyny

The ability of an individual to display a variety of personality characteristics, both masculine and feminine, depending on whether a trait or behavior is appropriate in a given situation. It is often viewed as a positive characteristic that gives an individual greater adaptability. (Ch. 8)

Anilingus

Oral stimulation of the anus. (Ch. 11)

Aphrodisiacs

Substances that enhance sexual desire or performance. (Ch. 4)

Artificial insemination

A method of treating infertility caused by a low sperm count in men. Sperm are collected during several ejaculations and then inserted into the partner's vagina at the time of ovulation. (Ch. 7)

Asexual

An individual with a lifelong lack of sexual attraction to men or women. (Ch. 9)

Askable

Being perceived as receptive, a good listener, and accepting. (Ch. 10)

Asphyxiophilia

A subtype of sexual masochism in which sexual arousal is achieved by restricting breathing. (Ch. 14)

Asymptomatic HIV infection

A stage of HIV infection in which infected individuals show no visible symptoms. (Ch. 5)

B-girls

Female prostitutes who work in bars, hotels, casinos, or clubs, generally with the approval of the ownership. (Ch. 16)

Bacteria

Small, single-celled organisms that lack a nuclear membrane but have all the genetic material (RNA and DNA) to reproduce themselves. (Ch. 5)

Bacterial vaginosis

A type of vaginitis caused by the interaction of several vaginal bacteria (particularly Gardnerella vaginalis). (Ch. 5)

Barrier (blockade) method

General term for contraceptive methods that block the passage of sperm. (Ch. 6)

Bartholin's glands

Glands located at the base of the labia minora in women that contribute a small amount of an alkaline fluid to their inner surfaces during sexual arousal. (Ch. 2)

BDSM

Practices involving bondage and discipline, dominance and submission, and/or sadomasochism. Also a subculture or community of people who regularly practice these activities, often with role playing and always in a mutual, consensual, and recreational manner. (Ch. 14)

Benign coital cephalalgia

Severe headaches that start during or slightly after orgasm, usually in men. (Ch. 13)

Bestiality

The act of having sexual contact with an animal. (Ch. 14)

Billings method

A fertility awareness method of birth control in which changes in the consistency and quantity of cervical mucus are used to tell when

ovulation has occurred. (Ch. 6)

Biopsychosocial therapy

Sexual therapy that recognizes that sexual problems are often caused by multiple factors and that effective treatments often must target a combination of biological, psychological, and interpersonal/social factors. (Ch. 13)

Bisexual

An individual with a sexual orientation toward both men and women. (Ch. 9)

Blastocyst

The fluid-filled sphere that reaches the uterus after fertilization and which was created by the transformation of the morula through continued, rapid cell division. (Ch. 7)

Braxton-Hicks contractions

Uterine contractions experienced during the last trimester of pregnancy that are often incorrectly interpreted as the beginning of labor; also called false labor. (Ch. 7)

Breasts

In women, glands that provide milk for infants; located at the front of the chest. (Ch. 2)

Breech birth

A birth in which the baby is born feet or buttocks first. (Ch. 7)

Bulbocavernosus muscle

A ring of sphincter muscles that surrounds the vaginal opening in women or the root of the penis in men. (Ch. 2)

Calendar method

A fertility awareness method of birth control that attempts to determine a woman's fertile period by use of a mathematical formula. (Ch. 6)

Call girls

Prostitutes who are usually self-employed but may use a broker or verification service, who provide sexual services only, and who often work out of their homes. (Ch. 16)

Capacitation

A process that sperm undergo while traveling through the woman's reproductive tract in which their membranes become thin enough so that an enzyme necessary for softening the ovum's membrane can be released. (Ch. 7)

Case study

An in-depth study of an individual. (Ch. 1)

Cervical cap

A contraceptive device that fits over the cervix by suction, thus blocking the passage of sperm into the uterus. (Ch. 6)

Cervical mucus

The slimy secretion of mucous membranes located inside the cervix. (Ch. 6)

Cesarean section (C-section)

The surgical removal of a fetus through the mother's abdomen. (Ch. 7)

Chancroid

A sexually transmitted infection, caused by the Hemophilus ducreyi bacterium, which is characterized by small, painful bumps that rupture into crater-like sores. (Ch. 5)

Chlamydia

A sexually transmitted infection caused by the Chlamydia trachomatis bacterium, which lives on mucous membranes. (Ch. 5)

Chorion

The fourth membrane of the trophoblast; it develops into the lining of the placenta. (Ch. 7)

Chorionic villus sampling

A technique used for detecting problems in a fetus during the 10th to 12th weeks of pregnancy. Hair-like projections (villi) of the chorion are collected and examined. (Ch. 7)

Chromosomes

Rod-shaped structures containing the genetic material that determines a person's inherited characteristics. (Ch. 8)

Circumcision

In men, the removal of all or part of the foreskin of the penis. In women, the removal of the clitoral hood. (Ch. 2)

Climacteric

The changes that occur in women in the few years that precede and the first year that follows menopause. (Ch. 10)

Clitoral hood

The part of the labia minora that covers the clitoris in women. (Ch. 2)

Clitoris

A small, elongated erectile structure in women that develops from the same embryonic tissue as the penis. It has no known function other than to focus sexual sensations. (Ch. 2)

Close relationship

A relationship in which the partners are highly interdependent. (Ch. 12)

Cognitive-behavioral therapy

Therapy that views problems as resulting from faulty learning and that focuses on specific sexual behaviors and how we think and feel about them. It does not focus on past events. (Ch. 13)

Coitus

Sexual intercourse. (Ch. 11)

Colostrum

A thick, sticky liquid produced by a mother's breasts before milk starts to flow. (Ch. 7)

Combination pill

An oral contraceptive that contains both synthetic estrogen and synthetic progesterone. (Ch. 6)

Coming out

Disclosing to others one's homosexual orientation, from the expression "coming out of the closet." (Ch. 9)

Communication

The exchange of information, thoughts, ideas, or feelings. (Ch. 13)

Companionate love

The state of loving another person; a sturdy, affectionate love that develops over time and is based on closeness, intimacy, and commitment. (Ch. 12)

Compliance

Agreeing to sexual activity when you do not really want to engage in it. (Ch. 15)

Conception

The union of an egg and a sperm. (Ch. 7)

Condom

For men, a thin sheath made of latex rubber, lamb intestine, or polyurethane that fits over the penis. For women, an intravaginal pouch held in place by two flexible rings. Condoms are effective as contraception and for prevention of sexually transmitted infections. (Ch. 6)

Congenital adrenal hyperplasia (CAH)

A condition in girls in which the adrenal glands excrete too much testosterone during fetal development, causing masculinization. This includes enlargement of the clitoris and labia, so that at birth the genitals are sometimes mistaken for those of a boy. Also called adrenogenital syndrome. (Ch. 8)

Contraception

The prevention of conception. (Ch. 6)

Contraceptive sponge

A contraceptive device made of polyurethane sponge that contains enough spermicide to be effective for 24 hours after being inserted into the vagina. (Ch. 6)

Coprophilia

Repeated and persistent sexual arousal to feces or the act of defecation. (Ch. 14)

Corpus luteum

The follicular cells that remain in the ovary after the follicle expels the ovum during ovulation. They begin to secrete progesterone in large quantities in the postovulatory stage. (Ch. 3)

Correlation

A mathematical measure of the degree of relationship between two variables. (Ch. 1)

Couples therapy

Therapy that focuses on the overall relationship and communication skills between two people. (Ch. 13)

Courtship disorders

A group of paraphilias (voyeurism, exhibitionism, frotteurism, and telephone scatophilia) often seen together. (Ch. 14)

Couvade syndrome

The experiencing of pregnancy symptoms by male partners; sometimes called "sympathy pains." (Ch. 7)

Cowper's glands

Two pea-shaped structures located beneath the prostate gland in men that secrete a few drops of an alkaline fluid prior to orgasm. (Ch. 2)

Critical period

In relation to teratogens, the time during embryonic or fetal development during which a particular part of the body is most susceptible to damage. (Ch. 7)

Crowning

The appearance of the fetus' head at the vaginal opening during childbirth. (Ch. 7)

Cunnilingus

Oral stimulation of a woman's genitals. (Ch. 11)

Cystitis

A bacterial infection of the bladder (often caused by the bacterium Escherichia coli). (Ch. 5)

Decision/commitment

One of the three basic components in Sternberg's theory of love; the decision that one loves another person and the commitment to maintain that relationship over time. (Ch. 12)

Delayed puberty

A condition in which the appearance of secondary sex characteristics and physical growth do not begin until well after they have begun in most children. (Ch. 10)

Demand/withdraw

A problematic type of communication pattern commonly associated with relationship distress. One partner (typically the one who desires change and has less power) demands change while the other partner avoids the issue and disengages. (Ch. 13)

Depo-Provera

Market name for medroxyprogesterone acetate, a chemical that when injected suppresses ovulation for 3 months. (Ch. 6)

DHT deficiency syndrome

A type of androgen insensitivity syndrome in which, because testosterone is not converted into dihydrotestosterone, boys' external genitals do not develop properly. Development occurs at puberty with the rise in testosterone. (Ch. 8)

Diaphragm

A dome-shaped rubber cup with a flexible rim that fits over the cervix and thus acts as a contraceptive device by serving as a barrier to the passage of sperm into the uterus. (Ch. 6)

Dilation

Becoming wider or larger. (Ch. 7)

Direct observation

Observing and recording the activity of subjects as they conduct their activities. (Ch. 1)

Disengagement

Process in which partners become less involved in each other's lives and withdraw from the relationship. (Ch. 12)

Disorders of sex development

Individuals with a combination of male and female anatomical features or in which chromosomal sex is inconsistent with anatomical sex. (Ch. 8)

Doula

A woman who serves as a female companion during labor and childbirth. (Ch. 7)

Dualism

The belief that body and soul are separate and antagonistic. (Ch. 1)

Dysmenorrhea

Painful menstruation. (Ch. 3)

Dyspareunia (female)

A recurrent or persistent sexual problem in women in which pain is experienced (or fearfully anticipated) before or during vaginal intercourse; this occurs despite sufficient genital arousal (e.g., lubrication). (Ch. 13)

Dyspareunia (male)

Recurrent or persistent genital pain during intercourse. (Ch. 13)

Ectopic pregnancy

The implantation of a fertilized egg outside of the endometrium of the uterus. (Ch. 7)

Effacement

The thinning of the cervix during labor. (Ch. 7)

Ejaculation

The expulsion of semen from the body. (Ch. 4)

Ejaculatory ducts

One-inch-long paired tubes that pass through the prostate gland. The third part of the duct system that transports sperm out of a man's body. (Ch. 2)

Embryo

The term given to the blastocyst after it has implanted. (Ch. 7)

Emergency contraception

Methods that prevent conception when used in the first few days after sexual intercourse. (Ch. 6)

Emerging adulthood

A developmental stage of life; an extended period of being a single adult that occurs between adolescence and young adulthood. (Ch. 10)

Endocrine system

A network of ductless glands that secrete their chemical substances, called hormones, directly into the bloodstream, where they are carried to other parts of the body to exert their effects. (Ch. 3)

Endometriosis

The growth of endometrial tissue outside of the uterus. (Ch. 3)

Endometrium

The inner mucous membrane of the uterus where a fertilized egg implants. Its thickness varies with the phase of the menstrual cycle. (Ch. 2)

Epididymis

The elongated cord-like structure on the back of a testicle. It is the first part of the duct system that transports sperm out of a man's body. (Ch. 2)

Equitable relationship

Relationship in which partners have an equal ratio of positive-to-negative outcomes; a balanced relationship. (Ch. 12)

Erectile disorder

A sexual problem in which a man has persistent or recurrent difficulty getting and maintaining an erection. The problem must cause significant distress and not be attributable to some other readily identifiable nonsexual cause (e.g., mental disorder, medication, medical condition, severe life stressor). (Ch. 13)

Eros

Passionate love; a type of love characterized by immediate sexual attraction or physical ''chemistry,'' emotional intensity, and a sense of intimate connection. (Ch. 12)

Erotica

Art, literature, and other media that has an uplifting sexual theme. Designed to be artistic and celebratory of sexuality and the human body. (Ch. 16)

Escorts

Prostitutes who are usually under contract to an agency and who may provide social as well as sexual services. (Ch. 16)

Establishment-based prostitution

Prostitution associated with a particular establishment; customers are solicited in bars, hotel lobbies, casinos, clubs, massage parlors, or brothels. (Ch. 16)

Estrogen

A hormone that is produced by the ovaries (and in very small amounts by the testicles and adrenal glands). (Ch. 3)

Estrous cycle

The cycle of hormonal events that occurs in most non-human mammals. The females are sexually receptive ("in heat," or in estrus) to males only during ovulation. (Ch. 3)

Ethnocentric

The attitude that the behaviors and customs of one's own ethnic group or culture are superior to others. (Ch. 1)

Evolutionary (sociobiological) theory

In reference to sex differences in human behavior, states that the behavioral differences are due to the different reproductive pressures men and women faced over thousands of generations. (Ch. 8)

Excitement phase (men)

The second phase of the sexual response cycle proposed by Masters and Johnson. The first sign is vasocongestion of the penis, leading to erection. Other changes include increases in muscle tension and heart rate. (Ch. 4)

Excitement phase (women)

The second phase of Masters and Johnson's model of human sexual response. In all models of sexual response, physiological-genital excitement involves vasocongestion, myotonia, and increases in cardiopulmonary activity. (Ch. 4)

Exhibitionism

Repeatedly and persistently fantasizing about or actually exposing one's genitals to others in inappropriate settings in order to obtain sexual gratification. Becomes a disorder if the person acts on the urges, experiences distress, experiences impairment of normal functioning, and/or causes harm or risk of harm to others. (Ch. 14)

Experimental method

A study in which an investigator attempts to establish a cause-and-effect relationship by manipulating a variable of interest (the independent variable) while keeping all other factors the same. (Ch. 1)

Expressive

A personality characteristic; a cognitive focus on "an affective concern for the welfare of others." (Ch. 8)

Fallopian tubes

The passageways that eggs follow on their way to the uterus. (Ch. 2)

False labor

A set of temporary contractions of the uterus that resemble the start of labor. (Ch. 7)

Fear–tension–pain cycle

According to prepared childbirth advocates, the cycle of events that women experience during labor when they are not properly educated about labor and childbirth. (Ch. 7)

Fecundity

The ability of a couple to conceive within a certain period of time. (Ch. 7)

Fellatio

Oral stimulation of a man's genitals. (Ch. 11)

Female condom

An intravaginal pouch; a 7-inch-long bag that is held in place in the vagina by two flexible rings. (Ch. 6)

Female orgasmic disorder

A persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase, which causes significant personal distress, and which cannot be better explained by a nonsexual mental disorder, medication, or severe relationship or life stressor (e.g., partner violence). (Ch. 13)

Female sexual interest/arousal disorder

The persistent absence or reduction of interest in sexual activity, sexual thoughts/fantasies, initiation of or receptivity to sexual activity, and sexual excitement/pleasure and genital/nongenital sensations during sexual encounters. Symptoms must cause significant distress, not be due to an identifiable nonsexual cause (e.g., mental disorder, partner violence, medication, medical condition), and not simply reflect a desire discrepancy between partners. (Ch. 13)

FemCap

A version of the cervical cap; a barrier (or blockade) method of contraception. (Ch. 6)

Fertility awareness methods

Methods of birth control that attempt to prevent conception by having a couple abstain from sexual intercourse during the woman's ovulation. (Ch. 6)

Fertility drugs

Drugs that improve the chance of conception in women who are infertile owing to hormone deficiencies. The drugs either stimulate the pituitary gland to secrete FSH and LH or stimulate the ovaries directly. (Ch. 7)

Fetal alcohol syndrome (FAS)

A condition common to infants born to alcoholic mothers, involving physical and nervous system abnormalities. (Ch. 7)

Fetal surgery

A surgical operation on the fetus while it is still in the uterus. (Ch. 7)

Fetishism

A condition in which sexual arousal and gratification are dependent on using or fantasizing about an inanimate object or body part (if body part, often referred to as partialism). Becomes a disorder if the urges or behaviors cause harm to the individual or to others or impair normal functioning. (Ch. 14)

Fetus

The term given to the embryo after the 8th week of pregnancy. (Ch. 7)

Follicle

A sac in the ovary containing an ovum and surrounding follicular cells. (Ch. 3)

Follicle-stimulating hormone (FSH)

A gonadotropin hormone released by the pituitary gland that stimulates the development of a follicle in a woman's ovary and the production of sperm in a man's testicles. (Ch. 3)

Frotteurism

A condition in which sexual arousal and gratification are achieved repeatedly and primarily by rubbing one's genitals against others in public places (or fantasizing about doing so). This becomes a disorder if the urge to engage in these acts leads to illegal behavior, causes harm to others, produces psychological distress, and/or impairs normal functioning. (Ch. 14)

Gang rape

Rape in which a victim is assaulted by more than one attacker. (Ch. 15)

Gay

A term generally used to refer to male homosexuals, although in some places it is used to refer to homosexuals of either sex. (Ch. 9)

Gender

The social construction of femininity and masculinity. (Ch. 8)

Gender constancy

The knowledge that one's gender is constant and will not change. This knowledge is usually acquired by age 6 or 7. (Ch. 8)

Gender dysphoria

"A strong desire to be of the opposite gender or an insistence that he or she is of the other gender" that is accompanied by "clinically

significant distress" (DSM-V, 2013). (Ch. 8)

Gender identity

One's subjective sense of being a man (or boy) or a woman (or girl). This sense is usually acquired by the age of 3. (Ch. 8)

Gender role

A set of culturally specific norms concerning the expected behaviors and attitudes of men and women. (Ch. 8)

Gender schemas

Ideas about gender roles that children create from their interactions with their environment. (Ch. 8)

Gender-role stereotypes

Oversimplified, preconceived beliefs about the gender roles of men and women. (Ch. 8)

Genital (venereal) warts

Warts in the genital and anal regions caused by human papillomaviruses (mainly types 6 and 11). The warts are cauliflower-like growths. (Ch. 5)

Genital herpes

Herpes infection in the genital region. It can be caused by herpes simplex virus types 1 or 2. (Ch. 5)

Genitalia

The external reproductive organs of the man or woman. (Ch. 2)

Global moralities

Values that are supposed to apply to all people under all circumstances. (Ch. 10)

Gonadotropin-releasing hormone (GnRH)

A hormone released by the hypothalamus in the brain that causes the pituitary gland to release the hormones FSH and LH. (Ch. 3)

Gonorrhea

A sexually transmitted infection caused by the Neisseria gonorrhoeae bacterium (often referred to as the gonococcus), which lives on mucous membranes. (Ch. 5)

Graafian follicle

A mature follicle. (Ch. 7)

Grafenberg (G) spot

A small, sensitive area on the front wall of the vagina found in about 10% of all women. (Ch. 2) (Ch. 4)

Granuloma inguinale

A rare (in the United States) sexually transmitted infection that is characterized by ulceration of tissue. (Ch. 5)

Gynecomastia

Excessive development of the male breasts. (Ch. 10)

HAART

Highly active antiretroviral therapy for HIV infection. (Ch. 5)

Habituation

Responding less positively to a stimulus with repeated exposure to it. (Ch. 12)

Henry Havelock Ellis

English researcher who published seven volumes about the psychology of sex between 1896 and 1928. (Ch. 1)

Hepatitis A, B, and C

are liver infections caused by viruses. Type A is spread by direct or indirect contact with contaminated feces. Type B is transmitted by infected blood or body fluids, with about 50% of the cases contracted during sex. Type C is spread mainly by contaminated blood but may possibly be spread during sexual intercourse in some cases. (Ch. 5)

Heterosexual

An individual with a sexual orientation primarily to members of the opposite sex. (Ch. 9)

Homophobia

An irrational fear of homosexual individuals and homosexuality. (Ch. 9)

Homosexual

An individual with a sexual orientation primarily to members of the same sex. (Ch. 9)

Hooking up

Non-relationship sex without any commitment. (Ch. 10)

Hormones

Chemical substances that are secreted by ductless glands into the bloodstream. They are carried in the blood to other parts of the body, where they exert their effects on other glands or target organs. (Ch. 3)

Human chorionic gonadotropin (HCG)

A hormone secreted by the chorion that stimulates the ovaries during pregnancy. (Ch. 7)

Human immunodeficiency virus (HIV)

A virus that kills CD4+ cells, eventually resulting in AIDS. (Ch. 5)

Human papillomaviruses (HPV)

Viruses that cause abnormal growths in epithelial cells. There are over 100 types. A few (types 6 and 11) cause genital warts, while others (types 16, 18, 31, 33, and 45) can lead to cancer of the cervix. (Ch. 5)

Hustler

Streetwalker or rent boy; a male prostitute who works on the street and typically caters to men. (Ch. 16)

Hymen

The thin membrane that partially covers the vaginal opening in sexually inexperienced women. Its presence or absence, however, is really a very poor indicator of prior sexual experience. (Ch. 2)

Hypergender

Tendency to endorse and rigidly adhere to exaggerated and extreme sex role stereotypes; high levels are linked with likelihood to commit (among men) or to experience (among women) sexual coercion and assault. (Ch. 15)

Hypersexuality

A persistent, excessive, impulsive, and uncontrollable sexual appetite. Individuals with hypersexuality fantasize about and/or engage in sex compulsively, often to reduce anxiety, but experience little or no emotional satisfaction. Sometimes called sexual addiction or sexual compulsivity. (Ch. 13)

Hypoactive sexual desire

A sexual problem characterized by a persistent and pervasive absence of sexual interest, thoughts, and fantasies. The problem must cause significant distress and not be more readily attributable to some other nonsexual issue (e.g., mental disorder, partner violence, medication, medical condition). (Ch. 13)

Identification

Two meanings: (1) in advertising, to identify or relate to a product; (2) the adoption of the sex roles of the same-sex parent by a child (see (Ch. 8). (Ch. 1)

Identification

Two meanings: (1) the adoption of the sex roles of the same-sex parent by a child, and (2) in advertising, to identify or relate to a product. (Ch. 8)

"I" language

Communicating your desires to another person by beginning sentences with "I," followed by your feelings, desires, or thoughts. (Ch. 13)

Immune system

The bodily mechanisms involved in the production of antibodies in response to bacteria, viruses, and cancerous cells. (Ch. 5)

Implantation

The process by which the blastocyst attaches itself to the wall of the uterus. (Ch. 7)

In vitro fertilization (IVF)

A process in which a mature ovum is surgically removed from a woman's ovary, placed in a medium with sperm until fertilization occurs, and then placed in the woman's uterus. This is usually done in women who cannot conceive because of blocked Fallopian tubes. (Ch. 7)

Incest

Sexual contact between two closely related persons. (Ch. 15)

Infertility

The inability of a couple to conceive. (Ch. 7)

Inhibin

A hormone produced by the testicles and ovaries that inhibits release of follicle-stimulating hormone from the pituitary gland. (Ch. 3)

Instrumental

A personality characteristic; a cognitive focus on "getting the job done." (Ch. 8)

Intercourse

The word means communication. (Ch. 13)

Intimacy

One of the three basic components in Sternberg's theory of love; those feelings in a relationship that promote closeness or bondedness, warmth, and other positive emotional experiences. (Ch. 12)

Intracytoplasmic sperm injection (ICSI)

A procedure used to treat men who have a low sperm count; injection of a single sperm directly into an egg. (Ch. 7)

Intrauterine device (IUD)

A birth control device, usually made of plastic with either a copper or progesterone coating, that is placed in the uterus to prevent conception and implantation. (Ch. 6)

Jealousy

An emotional state that is aroused by a perceived threat to a valued relationship or position. (Ch. 12)

Kegel exercises

Exercises that are designed to strengthen the pubococcygeus muscle that surrounds the bladder and vagina. (Ch. 2)

Kinsey, Alfred C.

College professor whose surveys in 1948 of male sexual behaviors and in 1953 of female sexual behaviors marked the beginning of the modern era of sexuality research. (Ch. 1)

Klismaphilia

Repeated and persistent sexual arousal to enemas (receiving, giving, watching). (Ch. 14)

Labia majora

Two elongated folds of skin extending from the mons to the perineum in women. Its outer surfaces become covered with pubic hair during puberty. (Ch. 2)

Labia minora

Two hairless elongated folds of skin located between the labia majora in women. They meet above the clitoris to form the clitoral hood. (Ch. 2)

Lactational amenorrhea method (breast-feeding)

In reference to contraception, the sucking response by a baby on the mother's nipple inhibits release of follicle-stimulating hormone, thus preventing ovulation. (Ch. 6)

Lanugo

Light hair that covers a newborn baby. (Ch. 7)

Lesbian

A female homosexual. (Ch. 9)

Lightening

Rotation of the fetus prior to childbirth so that its head is downward, resulting in decreased pressure on the mother's abdomen. (Ch. 7)

Ludus

A self-centered type of love. Ludic lovers avoid commitment and treat love as a game, often viewing the chase as more pleasurable than the prize. (Ch. 12)

Luteinizing hormone (LH)

A gonadotropin hormone released by the pituitary gland that triggers ovulation in women and stimulates the production of male hormones in men. (Ch. 3)

Lymphogranuloma venereum (LGV)

A sexually transmitted infection common in tropical countries that is caused by chlamydia. If left untreated, it causes swelling of the inguinal lymph nodes, penis, labia, or clitoris. (Ch. 5)

Male escort (gigolo)

A prostitute who engages in out call sex; works for an agency or is self-employed (more common). May provide social as well as sexual services and typically charges more than street or establishment-based prostitutes. (Ch. 16)

Male orgasmic disorder

A condition in which a man has difficulty reaching orgasm and ejaculating (or is unable to do so at all) during partnered sexual activity. The problem must cause significant distress and not be the result of a readily identifiable nonsexual (e.g., medication, mental or physical disorder, severe life stressor) issue. (Ch. 13)

Male rape

Rape in which the victim is a man. (Ch. 15)

Mammary glands

Milk-producing glands of the breast. (Ch. 2)

Mammogram

Low-radiation X-rays used to detect breast tumors. (Ch. 2)

Mania

A type of jealous, obsessive love characterized by an intense emotional dependency on the attention and affection of one's lover. (Ch. 12)

Marital (intimate partner) rape

Nonconsensual sex in which the perpetrator is the victim's spouse (or other long-term partner). (Ch. 15)

Nonconsensual sex in which the perpetrator is the victim's spouse (or other long-term partner). (Ch. 13)

Masochism (Sexual)

A paraphilia in which individuals obtain sexual pleasure primarily from fantasizing about or actually having pain and/or humiliation inflicted on them. Becomes a disorder (sexual masochism disorder) when the individual experiences clinically significant distress or impaired functioning and/or acts on the urges with a nonconsenting person. (Ch. 14)

Masters and Johnson

Researchers whose studies of sexual physiological responses led to the development of modern-day sexual therapy techniques. (Ch. 1)

Masturbation

Self-stimulation of one's genitals. (Ch. 11)

Medical model

Attributing sexual problems to medical causes and treating them with medical techniques. (Ch. 13)

Menarche

The term for a girl's first menstrual period. (Ch. 3) (Ch. 10)

Menopause

The term for a woman's last menstrual period. (Ch. 10)

Menorrhagia

Heavy vaginal bleeding. (Ch. 3)

Menstrual cycle

The monthly cycle of hormonal events in a woman that leads to ovulation and menstruation. (Ch. 3)

Menstrual taboos

Incorrect negative attitudes about menstruating women. (Ch. 3)

Menstruation

The monthly discharge of endometrial tissue, blood, and other secretions from the uterus that occurs when an egg is not fertilized. (Ch. 3)

Microbicide

A cream or gel that is applied intravaginally or intrarectally before sex in order to kill, block, or inactivate bacteria and viruses that cause sexually transmitted infections. (Ch. 6)

Miscarriage

A spontaneous abortion. (Ch. 7)

Missionary position

A face-to-face position of sexual intercourse in which the woman lies on her back and the man lies on top with his legs between hers. It was called this because Christian missionaries instructed people that other positions were unnatural. (Ch. 1) (Ch. 11)

Molluscum contagiosum

A sexually transmitted virus with symptoms that look like small pimples filled with kernels of corn. (Ch. 5)

Moniliasis

Sometimes called candidiasis. A type of vaginitis caused by the overgrowth of a microorganism (Candida albicans) that is normally found in the vagina. Moniliasis is a fungus or yeast infection and usually is a sexually related, rather than a sexually transmitted, infection. (Ch. 5)

Mons veneris

The soft layer of fatty tissue that overlays the pubic bone in women. It becomes covered with pubic hair during puberty. (Ch. 2)

"Morning sickness"

A symptom of early pregnancy involving nausea. (Ch. 7)

Morula

The collection of cells formed when the zygote begins rapid cell division. (Ch. 7)

Mullerian duct system

A primitive duct system found in embryos that if allowed to develop becomes the female reproductive system. (Ch. 8)

Mullerian duct-inhibiting substance

A chemical secreted by the testicles during embryonic development that causes the Mullerian ducts to shrink and disappear. (Ch. 8)

Multiple orgasms

Having two or more successive orgasms without falling below the plateau level of physiological and genital arousal. (Ch. 4)

Myotonia

Muscular tension; experienced throughout the body and in the genital area. (Ch. 4)

Mysophilia

A condition in which sexual arousal is persistently and preferentially caused by filth or filthy surroundings or objects. (Ch. 14)

Necking

Erotic physical contact above the waist (kissing, touching breasts). (Ch. 10)

Necrophilia

Sexual arousal by a corpse. (Ch. 14)

Nexplanon

A hormone implant with a single progestin-releasing rod that is effective for 3 years. (Ch. 6)

Nocturnal emission

An ejaculation that occurs during sleep in teenaged boys and men; a "wet dream." (Ch. 10)

Non-coital sexual pain disorder

Recurrent or persistent genital pain caused by sexual stimulation other than intercourse. (Ch. 13)

Nongonococcal (nonspecific) urethritis (NGU)

Any inflammation of the urethra that is not caused by the Neisseria gonorrhoeae (gonococcus) bacterium. (Ch. 5)

Nurse-midwife

A registered nurse, trained in obstetrical techniques, who delivers babies, often at the expectant mother's home. (Ch. 7)

NuvaRing

A flexible ring containing the same hormones as the combination birth control pill that is inserted into the vagina and is effective for 3 weeks. (Ch. 6)

Obscenity

In legal terminology, material that by contemporary community standards depicts patently offensive sexual conduct, lacks serious value, and appeals to prurient interests. (Ch. 16)

Observer bias

The prejudicing of observations and conclusions by the observer's own belief system. (Ch. 1)

Open marriage

A marital relationship in which the couple agrees that it is permissible to have sexual relations outside of the marriage. (Ch. 10)

Open-ended questions

Questions asked in a manner that places no limitations on your partner's response. (Ch. 13)

Opportunistic rapists

Rapists motivated by a desire for sex who rape impulsively when there is an opportunity. (Ch. 15)

Oral herpes

A herpes infection in or around the mouth. It can be caused by herpes simplex virus types 1 or 2. (Ch. 5)

Orgasm

The brief but intense sensations (focused largely in the genitals but really a whole body response) experienced during sexual arousal at the release of genital and physiological tension. During orgasm, rhythmic muscular contractions occur in certain tissues in both the man and woman; this is generally accompanied by subjective feelings of relief, release, and/or pleasure. The fourth phase of the sexual response cycle proposed by Masters and Johnson. (Ch. 4)

OrthoEvra

A contraceptive patch (containing the same hormones as the combination birth control pill) that is applied to the skin and is effective for 1 week. (Ch. 6)

Outcall prostitution

Prostitution in which sexual services are advertised via an agency, broker, or personal ad and clients are met at designated indoor locations. (Ch. 16)

Ovary

The female gonad in which ova are produced. (Ch. 2)

Ovulation

The expulsion of an egg from one of the ovaries. (Ch. 3)

Ovum (ova, pl.)

An egg; the female reproductive cell. (Ch. 7)

Oxytocin

A pituitary hormone associated with milk release, labor and orgasmic contractions, and erotic attraction and touch. (Ch. 3) (Ch. 7)

Pap smear

A test for cancer of the cervix in women; named for Dr. Papanicolaou, who developed it. (Ch. 2)

Paraphilias

General term for a group of uncommon sexual preferences in which repeatedly fantasizing about and/or engaging in sexual activity with non-human, non-mature, and/or nonconsenting partners is the preferred way of obtaining sexual arousal and gratification. (Ch. 14)

Paraphilic disorder

A paraphilia that is accompanied by significant personal distress, that impairs normal functioning (social, occupational, etc.), and/or that has been acted on with a nonconsenting partner or causes harm or risk of harm to another. (Ch. 14)

Paraphrase

A rewording of the meaning expressed by someone else. (Ch. 13)

Passion

One of the three basic components in Sternberg's theory of love; the drives involved in physical attraction, sexual desire and activity, and romance. (Ch. 12)

Passionate love

The state of being in love with another person; a usually short-lived type of romantic love characterized by intense emotions, sexual

attraction, cognitive preoccupation, and idealization of the partner. (Ch. 12)

Pederasty

A same-sex sexual behavior between adult men and boys. (Ch. 9)

Pedophilia

A condition in which sexual arousal is achieved primarily and repeatedly through fantasizing about or engaging in sexual activity with children who have not reached puberty. Becomes a disorder if the individual acts on his or her urges (as children cannot legally give consent), if the urges cause distress, and/or if the urges impair normal functioning. Note that activity is not required to have pedophilia; thus, it is possible to have this paraphilia and not act on it (and therefore not be a child molester). (Ch. 14) (Ch. 15)

Peer pressure

Expectations by one's peer group about how one is supposed to behave. (Ch. 10)

Pelvic inflammatory disease (PID)

A bacterially caused inflammation of a woman's reproductive tract, particularly the Fallopian tubes, that can result in sterility. The most common (though not the only) cause is untreated gonorrhea and/or chlamydia. (Ch. 5)

Penis

The male organ for sexual intercourse and the passageway for sperm and urine. (Ch. 2)

Perfect-use pregnancy rate

For a particular birth control technique, the percentage of pregnancies during the first year of use by couples who use the technique properly and consistently. (Ch. 6)

Performance anxiety

A fear of failure during sexual relations that can lead to erectile dysfunction in men and inhibited orgasm in women (and other sexual problems). (Ch. 13)

Perineum

Technically, the entire pelvic floor, but more commonly used to refer to the hairless bit of skin between the anus and either the vaginal opening (in women) or the scrotum (in men). (Ch. 2)

Persistent genital arousal syndrome

Persistent, intrusive, and usually distressing genital arousal without subjective feelings of desire and in the absence of sexual stimulation. (Ch. 13)

Petting

Non-coital sexual contact below the waist. (Ch. 10)

Peyronie's disease

Curvature of the penis due to fibrous tissue deposits around the corpora cavernosa. (Ch. 13)

Pheromones

Chemical substances secreted externally by animals that convey information to, and produce specific responses in, members of the same species. (Ch. 3)

Phimosis

A condition in uncircumcised men in which the foreskin of the penis is too tight, causing pain during erection. (Ch. 13)

Pinworms

Small worms (Enterobius vermicularis)that live in the large intestine and are generally transmitted through non-sexual contact with the worms' eggs but that can be transmitted sexually by manual or oral contact with the anus of an infected person. (Ch. 5)

Placenta

An organ that serves as a connection or interface between the fetus' systems and those of the mother. (Ch. 7)

Placenta previa

A condition in which the placenta blocks the cervical opening. (Ch. 7)

Plateau

The third phase of the linear sexual response cycle proposed by Masters and Johnson. Physiologically and genitally, it represents a high state of arousal that sets the stage for orgasm. (Ch. 4)

Polyincestuous family

A family in which there are both multiple incestuous abusers and multiple victims, across generations and within the same generation. (Ch. 15)

Population

The complete set of observations about which a researcher wishes to draw conclusions. (Ch. 1)

Pornography

Entertainment media that is designed to cause sexual arousal and excitement and whose primary purpose is commercial (to generate revenue). Legal pornography is protected under the First Amendment; illegal pornography is not protected under the First Amendment. (Ch. 16)

Positive reinforcement

A stimulus that follows a response and increases the probability of the response occurring again. (Ch. 13)

Post-rape posttraumatic stress disorder

A group of clinical symptoms displayed by many victims of rape; previously called *rape trauma syndrome*. It includes an acute phase (involving initial physical and psychological recovery from the attack) and long-term psychological reorganization (involving attempts to deal with the long-term effects of the attack and to prevent a future rape). (Ch. 15)

Postcoital dysphoria

Negative affect (e.g., feelings of sadness, loneliness anxiety, and/or irritability) that is experienced after sexual intercourse that was otherwise physically satisfactory. (Ch. 13)

Postpartum blues

A mild, transient emotional letdown experienced by a majority of women after giving birth. (Ch. 7)

Postpartum depression

A deep depression experienced by about 10% of women in the first few months after giving birth. (Ch. 7)

Postpartum psychosis

A psychotic state experienced by about 1 in 1,000 women after giving birth. (Ch. 7)

Pragma

A rational or practical type of love. Pragmatic lovers actively look for a ‘‘good match.’’ (Ch. 12)

Precocious puberty

A condition in which puberty begins before the age of 8 in girls and 9 in boys. (Ch. 10)

Preeclampsia

A disease of pregnancy characterized by high blood pressure, weight gain, swollen joints, and protein in the urine. Unless it is corrected, it can lead to convulsions and coma. (Ch. 7)

Preference molesters (pedophiles)

Child molesters who have a primary sexual orientation to children and who are relatively uninterested in adult partners (they are pedophiles based on their sexual preference pattern, and molesters based on their actions). *The DSM-5* would classify these individuals as having pedophilic disorder. (Ch. 15)

Premature ejaculation (disorder)

A recurrent and persistent (at least 6 months) pattern of short time to ejaculation (within 1 minute) and absence of reasonable voluntary control of ejaculation during partnered sexual activity that is accompanied by distress (for the man and his partner) and that is not readily attributable to an existing nonsexual cause (e.g., medication, mental disorder, medical condition, severe life stressor). (Ch. 13)

Premenstrual dysphoric disorder (PMDD)

A severe form of PMS that markedly interferes with social relations, work, or education. (Ch. 3)

Premenstrual syndrome (PMS)

A group of physical and/or emotional changes that many women experience in the last 3 to 14 days before the start of a menstrual period. (Ch. 3)

Prenatal examination

A health checkup by a physician during pregnancy. (Ch. 7)

Prepared childbirth

Courses or techniques that prepare women for labor and childbirth, with the goal of making it a positive experience. (Ch. 7)

Preterm infant

An infant born before week 37 of pregnancy. (Ch. 7)

Priapism

A painful condition in which the penis remains erect for a prolonged period of time, sometimes days. (Ch. 13)

Primary follicle

An immature ovum enclosed by a single layer of cells. (Ch. 2) (Ch. 7)

Primary HIV infection

The first few weeks of HIV infection, during which HIV reaches enormous levels in the blood and 50% to 75% of infected individuals experience flu-like symptoms. (Ch. 5)

Progesterone

A hormone that is produced in large amounts by the ovaries after ovulation. It prepares the endometrium of the uterus to nourish a fertilized egg. (Ch. 3)

Progestin-only pill

An oral contraceptive that contains only progestins. (Ch. 6)

Prolactin

A hormone released from the pituitary gland that stimulates milk production in the breasts. (Ch. 3) (Ch. 7)

Prostate gland

A gland in men that surrounds the origins of the urethra and neck of the bladder and contributes many substances to the seminal fluid. (Ch. 2)

Prostitution

Sex for hire or the knowing exchange of sexual activity or contact for money or items of value. (Ch. 16)

Psychometric approach to love

Method for identifying types of love that exist; uses statistical methods to determine the types of love people experience by analyzing their love-related thoughts, behaviors, and events. (Ch. 12)

Puberty

The time in life when an individual first shows sexual attraction and becomes capable of reproduction. (Ch. 10)

Pubic lice

An infestation of the parasite Phthirus pubis, which attach themselves to pubic hair and feed on blood. Also known as "crabs." (Ch. 5)

An infestation of the parasite Phthirus pubis, which attach themselves to public hair and feed on blood. Also known as "crabs." (Ch. 3)

Pubococcygeus muscle

The major muscle in the pelvic region. In women, voluntary control over this muscle (to help prevent urinary incontinence or to enhance physical sensations during intercourse) is gained through Kegel exercises. (Ch. 2)

Quickening

The first time a pregnant woman experiences movement of the fetus, usually in the 5th month. (Ch. 7)

Random sample

A sample in which observations are drawn so that all other possible samples of the same size have an equal chance of being selected. (Ch. 1)

Rape

Oral, anal, or vaginal penetration without a person's consent or when a person is incapable of giving consent. (Ch. 15)

Rape myths

Widespread mistaken beliefs about rape. (Ch. 15)

Rape-shield laws

Laws that are designed to make the prosecution of rapists easier and to prevent the victims from feeling as if they are the ones on trial. (Ch. 15)

Realistic idealism

Accepting the partner's strengths and weaknesses while having an overly positive, idealized view of the relationship itself. (Ch. 12)

Refractory period

In men, the period of time after an orgasm in which their physiological responses fall below the plateau level, thus making it impossible for them to have another orgasm (until the responses build back up to plateau). (Ch. 4)

Replacement fantasy

Sexual fantasy in which one imagines oneself having sex with someone other than the current partner. (Ch. 11)

Resolution

The fifth and final phase of the sexual response cycle proposed by Masters and Johnson. It refers to the return of the body to its unaroused state. (Ch. 4)

Respiratory distress syndrome

An illness common in premature infants; caused by insufficient levels of surfactant. (Ch. 7)

Rh factor

A protein in the blood of most individuals. If a mother does not have it and the fetus she carries does, she can develop antibodies against the Rh factor. This is called an Rh incompatibility problem. (Ch. 7)

Romantic love

Type of love experienced for romantic partners; commonly divided into two subtypes called passionate love and companionate love. (Ch. 12)

Sadism (Sexual)

A paraphilia in which individuals repeatedly and intentionally inflict or desire to inflict pain on others in order to achieve sexual arousal and gratification. Becomes a disorder (sexual sadism disorder) when the individual experiences clinically significant distress or impaired functioning and/or acts on the urges with a nonconsenting person. (Ch. 14)

Sadomasochism (S&M)

A term used to indicate the linkage of sadism with masochism. (Ch. 14)

Safer sex

Sexual behaviors involving a low risk of contracting a sexually transmitted infection. These include consistent use of condoms and/or abstaining from sex until one enters a long-term monogamous relationship. (Ch. 5)

Saint Augustine

Person who was a major influence on Christian beliefs about sexuality. (Ch. 1)

Sample

A subset of a population of subjects. (Ch. 1)

Scabies

A contagious infestation of parasitic mites (Sarcoptes scabiei) that burrow under the skin to lay their eggs. (Ch. 5)

Scrotum

The pouch beneath the penis that contains the testicles. (Ch. 2)

Second stage of labor

The stage of labor that begins when the cervix is fully dilated and the fetus begins moving through the birth canal. It ends with birth. (Ch. 7)

Secondary sex characteristics

Bodily changes that occur during puberty and differentiate men and women. (Ch. 10)

Self-disclosure

Revealing self-relevant information (one's thoughts, feelings, and emotions) to another. (Ch. 12) (Ch. 13)

Seminal vesicles

Two structures in a man that contribute many substances to the seminal fluid. (Ch. 2)

Sensate focus exercises

Exercises designed to reduce anxiety and teach mutual pleasuring through non-genital touching in non-demanding situations. (Ch. 13)

Serial monogamy

The practice of having a series of monogamous sexual relationships. (Ch. 10)

Sex trafficking

A form of human trafficking or modern slavery in which a child or adult is coerced, forced, or deceived into prostitution or other types of sex work. (Ch. 16)

Sex work

Term commonly used to describe the exchange of sexual services for money or goods. (Ch. 16)

Sexual activity

Overt sexual behaviors, such as masturbation or intercourse; typically assessed via self-report. (Ch. 4)

Sexual affect and cognitions

Feelings and beliefs associated with sexual responses (e.g., satisfaction, pleasure, shame, guilt); typically assessed via self-report. (Ch. 4)

Sexual arousal

Also called sexual excitement. The genital component of human sexuality; contains both a physical and a psychological component. (Ch. 4)

Sexual assault

Unwanted or nonconsensual sexual contact that occurs as a result of force or the threatened use of force, as a result of coercion, or when the person is unable to consent or resist (e.g., intoxicated, asleep, unconscious, under the legal age of consent). (Ch. 15)

Sexual aversion

An extreme form of hypoactive sexual desire in which an individual's avoidance of sex becomes phobic. (Ch. 13)

Sexual coercion

The act of forcing another person into unwanted sexual activity by physical or verbal coercion (pressure, manipulation, use of drugs or alcohol). (Ch. 15)

Sexual desire

The motivational component of human sexuality; typically experienced as a need, craving, or wish for sexual contact. May be triggered by internal or external events or cues. (Ch. 4)

Sexual disorder

A sexual problem that produces significant distress, has been present for some minimum amount of time, and is not due to other readily identifiable nonsexual causes (e.g., medical condition, mental disorder, relationship distress, external stressors, medication, substance use). (Ch. 13)

Sexual harassment

Unwelcome sexual advances, requests for sexual favors, or verbal/physical conduct of a sexual nature that persist after the recipient has indicated that they are unwanted. See text for an expanded definition. (Ch. 15)

Sexual identity development

A term for disclosing one's homosexuality or bisexuality to others. (Ch. 9)

Sexual learning

Knowledge about sex that is received (usually informally) from family, friends, the media, and society in general. (Ch. 10)

Sexual orientation

A distinct preference for sexual partners of a particular sex in the presence of clear alternatives. (Ch. 9)

Sexual prejudice

Socially reinforced negative attitudes toward homosexuals, homosexual communities, and homosexual behaviors. (Ch. 9)

Sexual response cycle

A sequential model of sexual response that describes the physiological and genital responses that occur during sexual arousal; has subsequently been revised to include an initial sexual desire phase. (Ch. 4)

Sexual revolution

A period in U.S. history, beginning about 1960, of increased sexual permissiveness. (Ch. 1)

Sexual variant

Unusual sexual behaviors, urges, or fantasies that are engaged in infrequently, perhaps for the sake of variety, and are not the preferred manner of becoming sexually aroused. (Ch. 14)

Sexuality

All of the sexual attitudes, feelings, and behaviors associated with being human. The term does not refer specifically to a person's capacity for erotic response or to sexual acts, but rather to a dimension of one's personality. (Ch. 1) (Ch. 4)

Sexually explicit media

Drawings, paintings, sculpture, literature, and other forms of art or communication that depict or describe human sexual anatomy and behavior. (Ch. 16)

Sexually healthy person

Someone who feels positively about his or her sexuality and who feels free to choose whether or not to try a variety of sexual behaviors. (Ch. 11)

Sexually intrusive thoughts

Sudden, involuntary, unwanted sexual thoughts. (Ch. 11)

Sexually related diseases

Diseases of the reproductive system or genitals that are not contracted through sexual activity. Often involve overgrowths of bacteria, yeasts, viruses, or fungal organisms that are found naturally in sexual and reproductive organs. (Ch. 5)

Sexually transmitted infections (STIs)

Infections that can be, but are not necessarily always, transmitted by sexual contact. (Ch. 5)

Sexually violent predator laws

Laws allowing for the civil commitment of convicted violent sex offenders after they have served their prison sentence if it can be shown that they pose a continued threat (that is, are likely to reoffend). (Ch. 15)

Shigellosis

An infection that can be contracted during sexual activity by exposure to feces containing the Shigella bacterium. (Ch. 5)

Sigmund Freud

Psychiatrist in the Victorian era who is responsible for emphasizing the importance of sexuality in human behavior and motivation. (Ch. 1)

Situational ethics

Values or ethics that emphasize the proper thing to do in particular situations. (Ch. 10)

Situational molesters

Child molesters who have a primary sexual orientation to adults (and, thus, are not pedophiles). They have sex with children impulsively and regard their behavior as abnormal. (Ch. 15)

Skene's glands

Glands located in the urethras of some women that are thought to develop from the same embryonic tissue as the man's prostate and that may be the source of a fluid emitted by some women during orgasm. (Ch. 4)

Smegma

The cheesy secretion of sebaceous glands that can cause the clitoris to stick to the clitoral hood or the foreskin of the penis to stick to the glans. (Ch. 2)

Socialization

The process of internalizing society's beliefs; the manner in which a society shapes individual behaviors and expectations of behaviors. (Ch. 1) (Ch. 8)

Socializing agent

The social influences (e.g., parents, peers, the media) that shape behaviors. (Ch. 1)

Sociocultural theory

States that the psychological differences between men and women are a social construction. (Ch. 8)

Sodomy laws

Laws that prohibit oral and/or anal sex. (Ch. 11)

Spectatoring

Observing and evaluating one's own sexual responses. This generally causes distraction, with subsequent erectile and/or orgasm problems. (Ch. 13)

Sperm

The germ cell of a man. (Ch. 7)

Spermicides

Chemicals that kill sperm. In most products, the chemical is nonoxynol-9. (Ch. 6)

Stalking

Repeated pursuit of another individual who does not want a relationship. (Ch. 15)

Repeated pursuit of another individual who does not want a relationship. (Ch. 15)

Standard Days Method

A fertility awareness method of birth control for women who typically have menstrual cycles of 26 to 32 days. (Ch. 6)

Start-up stage of labor

The stage of labor that begins with uterine contractions pushing the fetus downward toward the cervix and ends when the cervix is fully dilated. (Ch. 7)

Statutory rape

Sexual intercourse by an adult with a (consenting) partner who is not yet of the legal "age of consent." Sometimes called "carnal knowledge of a juvenile." (Ch. 15)

Sterilization

A general term for surgical techniques that render an individual infertile. (Ch. 6)

Storge

An affectionate type of love that grows from friendship. (Ch. 12)

Straight

A term used by homosexuals for a heterosexual. (Ch. 9)

Stranger rape

Rape (forcible sexual penetration) committed by someone who is not known by the victim. (Ch. 15)

Stratified random sample

A sample in which subgroups are randomly selected in the same proportion as they exist in the population. Thus the sample is representative of the target population. (Ch. 1)

Street prostitution (streetwalking)

Prostitution that occurs in public settings; customers are solicited on a street or road and sexual activity occurs in a car, outside a building, or in a hotel room or apartment. (Ch. 16)

Surrogate mother

A woman who carries a fetus to full term for another couple, agreeing to give the infant to the other couple after it is born. The infant generally represents a union of the sperm from the man and either his partner's ovum or the ovum of the surrogate mother. (Ch. 7)

Survey

A study of people's attitudes, opinions, or behaviors. Responses are usually obtained either in a face-to-face interview or on a paper-and-pencil questionnaire. (Ch. 1)

Swinging

A type of open marriage relationship in which a couple has extramarital relations together with other couples. (Ch. 10)

Symptomatic HIV infection

The early symptoms of HIV infection, which eventually lead to AIDS. (Ch. 5)

Symptothermal method

A combination of the basal body temperature and Billings fertility awareness methods. (Ch. 6)

Syphilis

A sexually transmitted infection caused by the Treponema pallidum bacterium (spirochete), which can also pass directly through any cut or scrape into the bloodstream. (Ch. 5)

Telephone scatologia

Sometimes called telephone scatophilia; a condition in which sexual arousal is achieved by repeatedly and persistently making (or fantasizing

about making) obscene telephone calls. Becomes a paraphilic disorder when the urges/actions cause harm to others or the individual and/or impair normal functioning. (Ch. 14)

Teratogens

Substances that can harm an embryo or fetus. (Ch. 7)

Testicles

The male gonads that produce sperm and male hormones. (Ch. 2)

Testosterone

A hormone that is produced by the testicles (and in very small amounts by the ovaries and adrenal glands). (Ch. 3)

Third stage of labor

Detachment and expulsion of the placenta from the uterus after childbirth. (Ch. 7)

Token resistance [to sex]

Saying "no" to sex when one means "yes." (Ch. 15)

Toxic shock syndrome (TSS)

A syndrome with symptoms of high fever, vomiting, diarrhea, and dizziness; caused by toxins produced by the Staphylococcus aureus bacterium. (Ch. 3)

Transgender

An individual whose gender identity and gender roles are opposite of those that society expects based on his or her anatomy. (Ch. 8)

Transition phase

The last part of the start-up stage of labor, during which the cervix dilates to 10 cm in order for the baby to be able to enter the birth canal. (Ch. 7)

Transsexual

Adults with gender dysphoria who desire to surgically change their anatomical sex. (Ch. 8)

Transvestic fetishism

Same meaning as transvestism. (Ch. 14)

Transvestism

A condition in which sexual arousal is achieved repeatedly by dressing as a member of the opposite sex (Ch. 14)

Trichomoniasis

A type of vaginitis caused by a one-celled protozoan that is usually transmitted during sexual intercourse. (Ch. 5)

Trimesters

Three-month periods of pregnancy (months 1–3, 4–6, and 7–9), so labeled for descriptive purposes. (Ch. 7)

Trophoblast

The outer four cell layers of the embryo. (Ch. 7)

Tubal sterilization

A general term for a variety of female sterilization techniques that prevent passage of an egg through the Fallopian tubes. (Ch. 6)

Typical-use pregnancy rate

For a particular birth control technique, the percentage of pregnancies during the first year of use by all couples who use the technique, regardless of whether they use it properly or consistently. (Ch. 6)

Ultrasound

A noninvasive technique for examining the internal organs of a fetus; it uses sound waves like a radar or sonar scan to create a picture. (Ch. 7)

Umbilical cord

The cord that connects an embryo or fetus to the mother's placenta. (Ch. 7)

Urethra

The passageway from the bladder to the exterior of the body. In men, it also serves as a passageway for semen during ejaculation. (Ch. 2)

Urophilia

Repeated and persistent sexual arousal caused by urine or the act of urination. (Ch. 14)

Uterus

The womb. The hollow, muscular organ in women where the fertilized egg normally implants. (Ch. 2)

Vagina

The sheath-like canal in a woman that extends from the vulva to the cervix and that receives the penis during intercourse. (Ch. 2)

Vaginismus

A recurrent or persistent sexual problem in women in which involuntary spasms of the muscles surrounding the vagina cause closure of the vaginal opening; this makes insertion of any object (penis, finger, tampon) difficult and/or painful, despite the woman's wish to do so. (Ch. 13)

Vas deferens

The second part of the duct system that transports sperm out of a man's body. (Ch. 2)

Vasectomy

The male sterilization technique in which the vas deferens is tied off and cut, thus preventing passage of sperm through the reproductive tract. (Ch. 6)

Vasocongestion

The engorgement (filling) of tissues with blood. (Ch. 4)

Vernix caseosa

A waxy bluish substance that covers a newborn baby. (Ch. 7)

Vestibular area

A term used to refer to the area between the two labia minora. (Ch. 2)

Vestibular bulbs

Structures surrounding the vaginal opening that fill with blood during sexual arousal, resulting in swelling of the tissues and a narrowing of the vaginal opening. (Ch. 2)

Victorian era

The period during the reign of Queen Victoria of England (1819-1901). With regard to sexuality, it was a time of great public prudery (the pleasurable aspects of sex were denied) and many incorrect medical beliefs. (Ch. 1)

Virus

A protein shell around a nucleic acid core. Viruses have either RNA or DNA, but not both, and thus cannot reproduce themselves. They invade host cells that provide the material to manufacture new virus particles. (Ch. 5)

Volunteer bias

A bias in research results that is caused by differences between people who agree to participate and others who refuse. (Ch. 1)

Voyeurism

Repeatedly seeking sexual arousal by observing people who are naked, getting undressed, or engaging in sexual activity without their

knowledge or consent. This becomes a disorder if it is accompanied by distress, impairment of normal functioning, and/or causes harm or risk of harm to others (in addition, the individual must be at least 18 years of age). (Ch. 14)

Vulva

A term for the external female genitalia, including the mons veneris, labia majora, labia minora, clitoris, vaginal opening, and urethral opening. (Ch. 2)

War rape

Rape that is committed by soldiers, combatants, or civilians during times of war, armed conflict, or military occupation. Used to destabilize, displace, and terrorize a targeted community. (Ch. 15)

Withdrawal (coitus interruptus)

Withdrawal of the man's penis from his partner's vagina before ejaculation in order to avoid conception. (Ch. 6)

Wolffian duct system

A primitive duct system found in embryos that if allowed to develop becomes the male reproductive system. (Ch. 8)

Yes-or-no questions

Questions that call for a simple one-word "yes" or "no" response. These should be avoided when striving for communication. (Ch. 13)

Zoophilia

Using sexual contact with animals as the primary means of achieving sexual gratification. (Ch. 14)

Zygote

The one-celled organism created from the fusion of a sperm and egg. (Ch. 7)

Credits

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sanctuary, Delos, monumental phallus with a relief of the phallus-bird, a symbol of the God, carried in procession or drawn on a chariot during Dionysian rites. Inscription says monuments were donated by Karystos, son of Asbelos. Around 300 BCE, Delos, Greece, Erich Lessing/Art Resource, New York; Red Figure Vase, Side A: Erotic Scene, 5th BCE. H. 41.5 cm. Cp9682. Photo: Christian Larrieu, Louvre, (Museum), Paris, France, Christian Larrieu/RMN-Grand Palais/Art Resource, New York; Lovers in extravagantly open posture, not mentioned in the 'Kama Sutra', Mankot, Punjab, mid-18th century (gouache on paper), Indian School, (18th century)/Private Collection/Bridgeman Images; ART Collection/Alamy Stock Photo; SuperStock; "Ledikant" or "Le Lit a la francaise". Etching, 1646. Inv. RvR 264 (B.186), The Pierpont Morgan Library, New York, NY, USA, The Morgan Library & Museum/Art Resource, New York; "The Origin of the World". 1866. Oil on canvas. 46 * 55 cm. RF 1995-10. Musee d'Orsay, Paris, France.Hervé Lewandowski/RMN-Grand Palais/Art Resource, New York; Ulrich Baumgarten/Getty Images; Isai Favela © 2017; Isai Favela © 2017; Joe Marquette/AP Images; Cynthia Johnson/The LIFE Images Collection/Getty Images; Ken Benner/CartoonStock Ltd.; Stephen Saks Photography/Alamy Stock Photo; Barry Lewis/Alamy Stock Photo; Victor W. Adams/Alamy Stock Photo; John van Hasselt/Sygma/Getty Images; Graham Prentice/Alamy Stock Photo; t-lorien/E+/Getty Images; Shady Lady/Splash News/Newscom; Jan Sochor/Alamy Stock Photo; Tim Gainey/Alamy Stock Photo; Jack Picone/Alamy Stock Photo; Aref Karimi/AFP/Getty Images; Jonathan Alpeyrie/Getty Images.

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A cartoon shows a close up of an older woman talking to a young woman, saying "No daughter of mine is gonna learn sex education in school. I'll explain to you all about the facts of life…" and then pans out to show the older woman finishing "As soon as you're ready" to the young girl, who is visibly pregnant, holding a little boy's hand, and has her other hand on a baby carriage.

A cartoon shows a young girl many times, sometimes close up or far away, with one of the following lines next to her: Sex in movies; Sex in rock lyrics; Sex on TV; Sex in advertising; Contraceptives in school-; To protect us from the sex education we get in the media.

A cartoon shows a woman holding a box of books and standing in the doorway of a teacher's room; "Ask your parents" is on the chalkboard and a book labeled Sex Ed in School is in the garbage. The woman is saying to the teacher "I was going to ask you if the school board had decided on a sex ed. policy, but never mind."

In the first diagram the breast is labeled with the nipple, the areola, and the milk ducts on the outside, and the second diagram shows the above plus the fatty tissue and mammary glands on the inside.

The illustration shows the following parts from top to bottom as follows: bladder, vas deferens, seminal vesicle, rectum, ejaculatory duct, prostate gland, Cowper's gland, anus, urethra, epididymis, penile glans, testicle, urethral opening.

The illustration shows the following parts from top to bottom as follows: bladder, penile shaft, urethra, corpora cavernosa, corpus spongiosum, corona, penile glans, urethral opening, scrotum.

The illustration shows the following parts from top to bottom as follows: corpus spongiosum, corpora cavernosa, urethra, penile glans, foreskin, urethral opening.

The illustration shows the following parts from top to bottom as follows: corpora cavernosa, urethra, and corpus spongiosum.

The figure shows a brain with the hypothalamus and pituitary gland with arrows pointing from them, through the estrogen progesterone (negative feedback) and FSH and LH, to the ovary and back again. The follicle, estrogen progesterone, and uterus are labeled.

The first section of the figure shows the brain and hypothalamus —> GnRH anterior pituitary —> FSH LH. The FSH slightly peaks and the LH surges (triggers ovulation) about halfway through the cycle.

The next section shows the uterus, with the endometrium of uterus and ovary pointed out. Then there are three graphs to go with it. The first shows the growth of a follicle in the first half of the cycle, then ovulation and corpus luteum. The second graph shows how estrogen peaks right before day 14 but that progesterone peaks later in the cycle, right in the middle of the second half of the cycle. The third graph shows the phases of the cycle, starting with the menstrual phase, then the proliferative phase, then the second half of the cycle is the secretory phase.

The uterus is labeled with the oviduct, ovary, uterus, and vagina. Then, an image shows how follicles change, beginning and ending in this order: Immature follicle (primary oocte and granolas cells are labeled); Zona pellucid develops around the primary oocyte; Fluid filled antrum develops; Follicle matures (Polar body, secondary oocyte, and ovarian connective tissue are labeled); Ovulation (Follicle ruptures, releasing the secondary oocyte with its polar body and granolas cells); Corpus luteum forms from ruptured follicle; corpus luteum degenerates if pregnancy does not occur.

The figure shows a brain with the pituitary gland labeled and arrows pointing from it to inhibit (negative feedback) and testosterone (negative feedback) to the testicle: FSH (sperm production) and LH (testosterone production).

A table describes various sexual responses and how they are measured.

The table describes the following sexual responses:

Sexual desire--Motivational component of sexuality; sexual urge, wish, craving, or interest; How is it measured? Self-report

Sexual arousal--What is it?: Genital component of sexuality; sexual excitement

- Physiological: genital arousal; Physiological and genital excitation (involving vasocongestion, myotonia, and cardiopulmonary changes); How is it measured?: Observation
- Subjective sexual arousal; Subjective awareness of physiological and genital excitation; How is it measured?: Self-report

Sexual activity: Overt sexual behaviors; How is it measured? Self-report

Sexual affect and cognitions; What is it?:Feelings and thoughts about sexuality and sexual responses; How is it measured? Self-report.

Two photos: A circular metal piece with wires coming off of it; a penile strain gauge and a plastic cylinder instrument with wires inside; a Barlow gauge.

A linear model with four stages of sexual response: Excitement —> Plateau —> Orgasm —> Plateau

A linear model with three stages of sexual response (Kaplan): Sexual

Desire —> Excitement —> Orgasm

A circular, nonlinear model with multiple stages of sexual response (Basson):

[START] Sexual neutrality

[seeks/is receptive to] Sexual stimuli

Sexual arousal

Sexual desire and arousal

Emotional and physical satisfaction

Emotional intimacy

Masers and Johnson's Model:

The line goes from unaroused, gradually to excitement, plateau, orgasm, and resolution. A second set is shown with a line connecting the two areas of orgasm that says Refractory period.

Helen Kaplan's Model:

The line moves upward through desire, excitement, orgasm, and then declines.

Figure with arrows pointing left to right in order:

Phase 1 Sexual desire

Phase 2 Excitement

Phase 3 Plateau

Phase 4 Orgasm

Phase 5 Resolution

The brain, spinal cord, and penis are shown. In the brain is the Psychogenic stimulation (Sights, Sounds, Touch, Taste, Smell, Fantasy), then at the spinal cord is: Erotic stimulation from the brain, and at the T11, T12, L1 and L2: Thoracolumbar erection center, and then from S2-S4 is the Sacral erection center. It reaches the penis and then goes back as sensory stimuli to the brain.

Excitement: Penis becomes erect; Scrotal skin tightens; Testicles enlarge and elevate

Plateau: Cowper's gland secretion; Corona becomes further engorged; Cowper's glands become active; Testicles become completely engorged and elevated; Loss of erection less likely; Scrotum maintains its thickened and tensed state

Orgasm and ejaculation: Contractions of penile urethra; Contractions force semen out through urethra; Semen builds up in urethral bulb; Contractions of muscles around base of penis

Masers and Johnson's Model:

The line goes from unaroused, gradually to excitement, plateau, orgasm, and resolution. A second set shows that plateau can last longer before resolution, and a third option shows that resolution can be more gradual.

Bassoon's model:

A circular, nonlinear model with multiple stages of sexual response (Basson):

[START] Sexual neutrality

[seeks/is receptive to] Sexual stimuli

Sexual arousal

Sexual desire and arousal

Emotional and physical satisfaction

Emotional intimacy

Excitement: clitoral glans and shaft increase in size; labia minor increase in size

Plateau: clitoral glans retracts under clitoral hood; labia minora darken in color

Orgasm: clitoris remains retracted under hood; uterus and pelvic muscles contract

Excitement: Vaginal walls lubricate; Inner vagina expands; Clitoris swells

Plateau: Inner vagina expands fully; Outer vaginal wall swells

Orgasm: Uterus contracts; Outer vagina contracts

Table showing the types of female genital mutilation.

A Table listing STIs in the United States depicting the estimated new cases per year and total new and existing cases. Stats are for HPV, Chlamydia, Trichomoniasis, Gonorrhea, Genital Herpes, Syphilis, HIV, Hepatitis B.

Two photos, one of a penis and one of a vagina each showing primary stage syphilis.

Two photos of people with secondary stage syphilis, one photo shows a rash on the palms and the other shows the rash on the body.

Three photos depicting herpes on the mouth, penis and ulcerated herpes on the penis.

Two photos show herpes infection on an eyelid and on an eye itself.

Two photos show early and late stage genital warts on a penis.

New HIV cases: Began around 2,000,000 in 1990 and peaked at around 3,250,000 in 1995, then slowly decreased to almost 2,000,000 again in 2015.

Deaths: Began around 300,000 in 1990, and increased until it peaked at around 2,000,000 in 2005, then decreased to almost 1,000,000 in 2015.

Women: Heterosexual sex, 87%; IV drug use, 13%. Men: Sex with other men, 83%; Heterosexual sex, 9.2%; IV drug use and sex with other men, 3.3%; IV drug use, 4.5%.

Photos show crab lice as well as a gravid female mite.

It begins at around 0.1 and remains there until it begins dramatically increasing at around year 1500, reaching around 1 in 1800, around 4 in 1974, and around 7 in 2011. It is projected to reach 9 in 2045.

Table outlining Teenaged (15 to 19 years old) Pregnancy and Birth Rates in Developed Nations.

Table 6.2 shows the Number of pregnancies per 100 women during the first year of continuous use for methods of birth control.

In the brain, the hypothalamus and pituitary gland is labeled, with an arrow pointing from (Estrogen Progesterone, negative feedback) and to (FSH and LH) the follicle in the ovary, and an arrow pointing from there to Estrogen progesterone in the uterus. Inhibition of pituitary hormones — inhibited development of endometrium.

Male condom 15.3%

Implant 1.3%

IUD 10.3%

Male sterilization 8.2%

Withdrawal 4.8%

Injectable 4.5%

Contraceptive ring or patch 2.6%

Pill 25.9%

Female sterilization 25.1%

Other 2%

A uterus is shown with follicles starting in the ovary and going down the fallopian tube: the follicle is labeled with the zygote, diploid nucleus, and zona pellucida. Each follicle has another diploid nucleus as it progresses, reaching morula then to the phase where the zone pellucida regresses, and then to the blastocyst (inner cell mass, hollow cavity, trophoblast).

Weeks 1-2: Embryonic stage. Period of dividing zygote, implantation, and embryo. Usually not susceptible to teratogens. Prenatal death.

Week 3: Embryonic stage. Greatest period of vulnerability for central nervous system and heart. Central nervous system. Heart. Major structural abnormalities.

Weeks 4-5: Embryonic stage. Greatest period of vulnerability for central nervous system, heart, arms, eyes, ear, and legs. Eye, heart, arm, leg. Major structural abnormalities. Indicates common site of action of teratogen.

Week 6: Embryonic stage. Greatest period of vulnerability for central nervous system, heart, arms, eyes, legs, teeth, ear, and palate. Ear. Teeth. Indicates common site of action of teratogen. Major structural abnormalities.

Week 7: Embryonic stage. Greatest period of vulnerability for arms, eyes, legs, teeth, palate, ear and external genitalia. Palate. Major structural abnormalities.

Week 8: Fetal stage. Greatest period of vulnerability for eyes, teeth, palate, ear and external genitalia. Palate. Ear. External genitalia. Major structural abnormalities.

Week 12: Fetal stage. Greatest period of vulnerability for ear and external genitalia. External genitalia. Physiological defects—minor structural abnormalities

Week 16: Fetal stage. Physiological defects—minor structural abnormalities

Week 20-36: Fetal stage. Brain. Physiological defects—minor structural abnormalities.

Week 38: Full term. Physiological defects—minor structural abnormalities.

Age 12 1/2: average onset of puberty — Egg reserve 400,000

25: monthly live birthrate starts to decline — 130,000

30: 12% of eggs remain — 70,000

35: considered “advanced maternal age” — 30,000

40: 3% of eggs remain — 13,000

45: 1% monthly chance of live birth — 5,000

49-51: average onset of menopause, 50 — 1,000

Undifferentiated: shows the wolffian duct, primitive gonad, mullerian duct, origin of Cowper's or Bartholin's glands and Origin of prostate or Sene's glands.

Arrows point from origin of Cowper's or Bartholin's glands to female, and from Origin of prostate or Sene's glands to male. The female's says: wolffian ducts degenerate and the male's says: mullerian duct degenerates. Both say: differentiation in progress. The final images show differentiation completed, with the females labeled: fallopian tube, ovary, uterus, vagina, Skene's duct and Bartholin's gland. The males labeled: Seminal vesicle, prostate gland, Cowper's gland, vas deferens, epididymis, and testicle.

A table defining Bern's Sex-Role Classifications.

A Table defining Kinsey and colleagues' rating scale for sexual gratification.

Black, non Hispanic: Begins around 80% in 1991 and slowly decreases to around 50% in 2015.

Hispanic: stays relatively consistent, from around 52% in 1991 to around 42% in 2015.

White, non Hispanic: begins around 50% in 1991 and ends around 40% in 2015.

No union: 28% (1995); 27% (2002); 29% (2006-2010).

Cohabitation: 34% (1995); 43% (2002); 48% (2006-2010).

Marriage: 39% (1995); 30% (2002); 23% (2006-2010).

Prepubertal: LH and FSH low, around 0-15.

Puberty: relatively stable around 10-15.

Reproductive: LH spikes several times (6) during this phase, from around 15 to 80. FSH spikes at the same times, from 10-20.

Menopause: slight increases over this period from around 10 to 20.

Postmenopausal: spikes occur during this phase, with LH increasing from around 15 to 80 and then decreasing to 50. FSH increases from around 15 to about 90 before decreasing to 50.

A table depicts the number of different things people do during sex.

14-19: Men, 75%; Women, 50%

20-29: Men, 93%; Women, 82%

30-39: Men, 93%; Women, 80%

40-49: Men, 92%; Women, 78%

50-59: Men, 89%; Women, 77%

60-69: Men, 90%; Women, 72%

70+: Men, 80%; Women, 58%

A table defining incidence of sexual behaviors among ethnic groups and educational groups in the U.S.

A table defining when people have sexual fantasies.

16-24: 25 minutes

25-34: 22 minutes

35-44: 21 minutes

45-54: 17 minutes

55-65: 15 minutes

A table detailing the percentages of men, defined by Homosexual, Bisexual and Heterosexual, and how often they had anal intercourse.

A table defining the historical views of love.

The middle of the triangle says: Consummate Love (Intimacy + Passion + Commitment). Clockwise from top of triange: The top point say Liking (intimacy alone), the space between that point and the next says Companionate Love (intimacy + commitment), the next point says Empty Love (decision/commitment alone), the space between that point and the next says Fatuous Love (Passion + Commitment), the next point says Infatuation (Passion alone), and between that point and the first point say Romantic Love (Intimacy + Passion).

A table 12-2 defines the different styles of loving.

A triangle is inside a circle. The top point of the triangle says Eros, the right side of the triangle says Mania, and the circle around that area says Ludic Eros. The next point say Ludus, the bottom side of the triangle says Pragma, and the circle around that area says Storgic Ludus. The final point says Storge, the left side of the triangle between that point and Eros says Agape, and the circle around that area says Storgic Eros.

A table defining the percentage of American women who have experienced sexual problem lasting several months.

A table outlining the three goals of sexual therapy.

A table that lists sexual disorders.

A table showing the prevalence of sexual disorders.

A table defining paraphilias, paraphilic disorders and sexual variants.

A table listing paraphilias in order of chapter presentation.

The line begins around 45 in 1970, then steadily increases to a peak of around 95 in 1990, then decreases steadily, to around 30 in 2015.

A table outlining where sexual assaults happen.

A table outlining items that measure the sexual beliefs associated with hypergender.

A table outlining the variables associated with sexual assault.

A cartoon shows a man saying "It's time for 'You asked for it!'-- the game show that wants to know 'when is rape the woman's fault?'" The woman says "Ok, I'm walking down the street. Tacky rain coat. Housedress. Sneakers." A man replies, "Makeup?" The woman responds, "No makeup." The man, "Good or bad neighborhood?" The woman, "Shopping mall. 11:30 AM." The man, "Sexy or not?" The woman, "Like a middle-aged frump." The man, "That turns me on!" The game show host, "Bzzz! You asked for it!"

A table outlining the relationship between child molesters and their victims.

Women: Begins around 17% in 2000, decreases slightly over the years to around 15% in 2004, and increases slightly, back to 17% in 2010.

Men: Begins around 33% in 2000, increases to around 37% in 2004, decreases to around 31% in 2006, and then increases to around 36% in 2010.

A table outlining the typology of Prostitution.

A table outlines common risk factors and outcomes of Prostitution.

A green “Go” Sign: Legal

- Prostitution is permitted
- Selling, buying, and facilitating are not crimes

A yellow triangle with an exclamation point: Legal on limited basis

- Individual adults may sell or buy sex (prostitute and client exempt from criminal prosecution)
- Other forms of selling, buying, and facilitating are crimes

A red outlined triangle with an exclamation point: Decriminalized

- Individual adults may sell sex (prostitutes exempt from criminal prosecution)
- Buying and facilitating are crimes

A red stop sign: Illegal

- No forms of prostitution (sexual commerce) are permitted
- Selling, buying, and facilitating are crimes