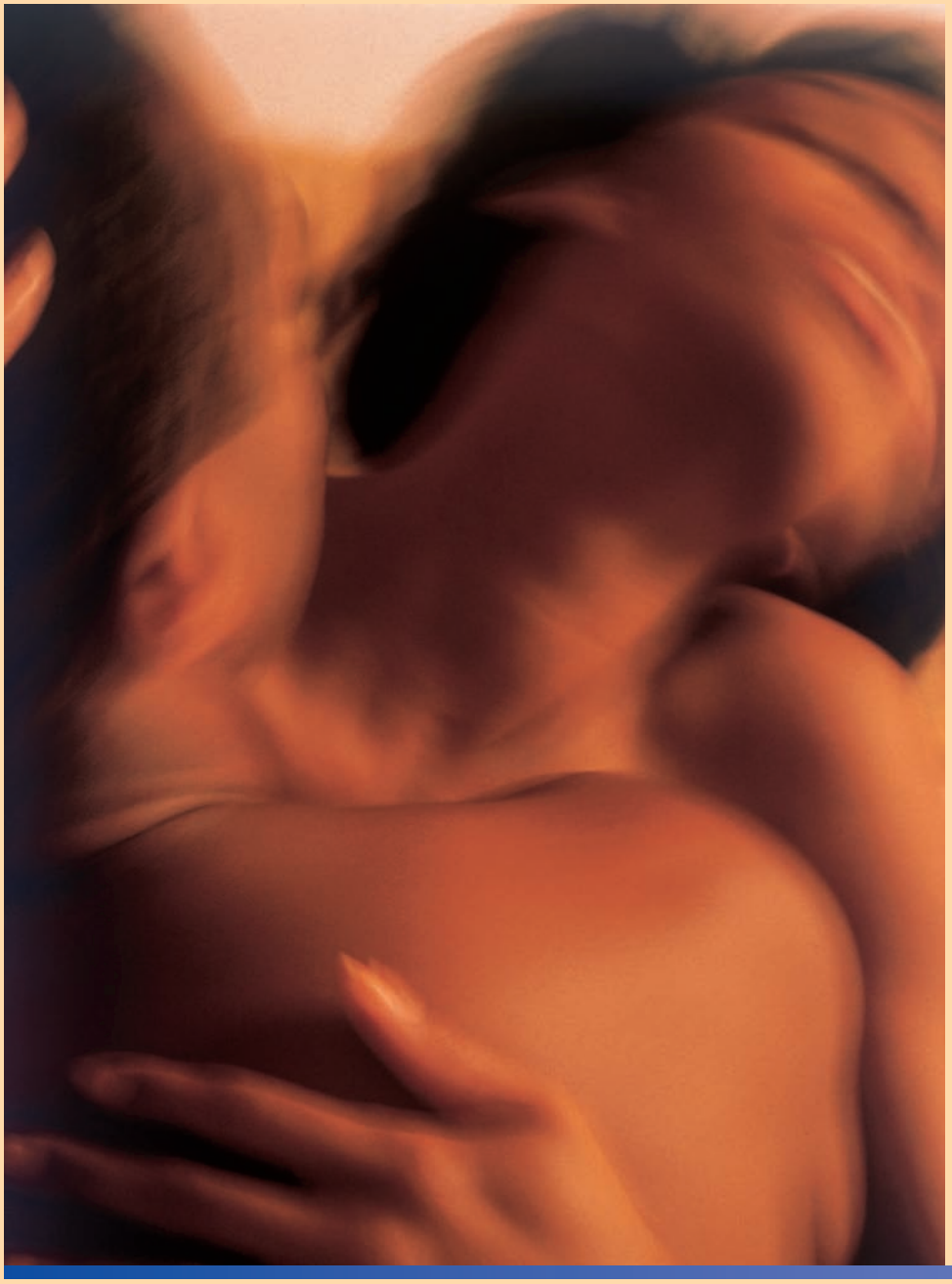
CHAPTER 6



Understanding Sex and Sexualities

Outline

What Do YOU Think?

Are the following statements TRUE or FALSE?
You may be surprised by the answers (see answer key on the bottom of this page).

T F 1 Unlike most human behavior, sexual behavior is instinctive.

T F 2 A significant number of women require manual or oral stimulation of the clitoris to experience orgasm.

T F 3 It is normal for children to engage in sexual experimentation with other children of both sexes.

T F 4 Kissing is the most common and most accepted sexual activity.

T F 5 A decline in the frequency of intercourse almost always indicates problems in the marital relationship.

T F 6 Most married women and men have had an extramarital sexual relationship.

T F 7 Bisexuality is more widely accepted than male homosexuality or lesbianism.

T F 8 Latinos are generally less permissive about sex than African Americans or Anglos.

T F 9 Because of their knowledge, college students rarely put themselves at risk for HIV and AIDS.

T F 10 Condoms are not very effective as contraceptive devices.

Answer Key for What Do You Think

1 False, see p. 190; 2 True, see p. 216; 3 True, see p. 198; 4 True, see p. 215; 5 False, see p. 220; 6 False, see p. 218; 7 False, see p. 209; 8 True, see p. 218; 9 False, see p. 226; 10 False, see p.218.

It is now time to consider sex. For many of you, that must seem like a silly statement. Quite apart from this book, we often consider, think about, or take steps to pursue—or avoid—sexual encounters. Our popular culture is heavily sexualized. Advertising, in particular, uses sexual innuendo and image to sell us any number of products. Furthermore, being sexual is an essential part of being human. Through our sexuality we are able to connect with others on the most intimate levels, revealing ourselves and creating deep bonds and relationships. Sexuality is a source of great pleasure and profound satisfaction. It is the typical means by which we reproduce, transforming ourselves into mothers and fathers. Paradoxically, sexuality also can be a source of guilt and confusion, a pathway to infection, and a means of exploitation and aggression. Examining the multiple aspects of sexuality helps us understand our sexuality and that of others. It provides the basis for enriching our relationships.

In this chapter, we offer an overview of sexuality and sexual issues, especially as they are interconnected with relationships, marriages, and family life. We begin by considering the sources of our sexual learning and proceed through sexual development and expression in young, middle, and later adulthood, including the gay, lesbian, or bisexual identity process. We consider the shifts in sexual scripts from traditional to modern and the social control of sexuality. When we examine sexual behavior, we cover the range of activities and relationships in which people engage. Ultimately, we look at nonconsensual sexual relations, sexual problems, and dysfunctions; birth control; sexually transmissible diseases, human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS); and sexual responsibility. We hope that this chapter will help you make sexuality a positive element in your life and relationships.

Gender, Sexuality, and Sexual Scripts

Linking Chapter 4 with the present one, our gender roles are critical in learning sexuality, telling us what sexual behavior is appropriate, legitimate, and acceptable for each gender. Organizing and directing our

sexual impulses are culturally shared sexual scripts, which we learn and act out. A **sexual script** consists of expectations of how to behave sexually as a female or male and as a heterosexual, lesbian, or gay male. Like a sexual road map or blueprint offering us general directions, a sexual script enables each individual to organize sexual situations and interpret emotions and sensations as sexually meaningful (Hynie et al. 1998). It may be more important than our own experiences in guiding our actions. Over time, we may modify or change our scripts, but we will not throw them away.

The scripts we are "given" for sexual behavior tend to be traditional. They are most powerful during adolescence, when we are first learning to be sexual. Gradually, as we gain experience, we modify and change our sexual scripts. As children and adolescents, we learn our sexual scripts primarily from our parents, peers, and the media. As we get older, interactions with our partners become increasingly important. In adolescence, both middle-class Caucasians and middle-class African Americans appear to share similar values and attitudes about sex and male–female relationships (Howard 1988).

Traditional Male Sexual Scripts

In traditional sexual scripts, men are perceived to be sexually aggressive and their sexual response, once set in motion, is thought to be difficult to control (Denov 2003). Traditional male sexual scripts also portray sex as "recreational," or pleasure centered for men (Hynie et al. 1998). Therapist Bernie Zilbergeld (1993) has identified the following assumptions in the male sexual script:

- *Men should not have (or at least should not express) certain feelings.* Men should be assertive, confident, and aggressive. Tenderness and compassion are not masculine feelings, and doubts should be kept to oneself.
- *A man always wants sex and is always ready for it.* It doesn't matter what else is going on; a man wants sex. He is always able to become erect.
- *Performance is the thing that counts.* Sex is something to be achieved, more about orgasm than intimacy.
- *The man is in charge.* As in other things, the man is the leader; he initiates sex and gives the woman her orgasm. A "real man" knows what women like, he doesn't need to be told.
- *All physical contact leads to sex.* Men are basically sexual "machines" any physical contact, including touching, is a sign for, or step toward, sex. There is no physical pleasure except sexual pleasure.
- *Sex equals intercourse.* All erotic contact leads to or is intended to lead to sexual intercourse. **Foreplay** is just that: warming up, getting your partner excited for penetration. Kissing, hugging, erotic touching, and oral sex are only preliminaries to intercourse.
- *Sexual intercourse always leads to orgasm.* The orgasm is the proof of the pudding; the more orgasms, the better the sex. If a woman does not have an orgasm, the male feels that he is a failure because he was not good enough to give her pleasure. If she requires clitoral stimulation to have an orgasm, she is considered to have a problem.

Researchers who study sexual stereotypes observe that men's sexual identity may depend heavily on a capricious physiological event: getting and maintaining an erection. They note that the following traits are associated with the traditional male role: (1) sexual competence, (2) ability to give partners orgasms, (3) sexual desire, (4) prolonged erection, (5) being a good lover, (6) fertility, (7) reliable erection, and (8) heterosexuality (Riseden and Hort 1992). Common to all these beliefs, sex is seen as a performance in which men are both the directors and the principal actors.

Traditional Female Sexual Scripts

Contrary to male sexual scripts, traditional female sexual scripts focus on feelings more than sex, on love more than passion. In the traditional female sexual script, sex is relational, a way of "expressing or achieving emotional and psychological intimacy *within certain prescribed relationships*" (Hynie et al. 1998, emphases added). It includes the following assumptions (Barbach 1982):

- *Sex is both good and bad.* What makes sex good or bad is whether it occurs in marriage or a committed relationship as opposed to a casual or uncommitted relationship. When not sanctioned by love or marriage, sexually active women risk their reputations.
- *Girls don't want to know about their bodies "down there."* Girls are taught not to look at, touch, and explore their genitals. As a result, women may know little about their genitals. They are often concerned

Exploring Diversity Asian American Sexuality

Although much of what we look at within this chapter can be generalized across boundaries of race or ethnicity, we need to recognize that ethnicity often shapes our sexual identities and experiences. Using the case of Asian Americans, we can illustrate ways in which culture can affect sexuality.

We recognize that "Asian American" actually encompasses as many as "thirty separate and distinct groups (Chan 2004)—such as Chinese, Japanese, Filipino, Vietnamese—the following sketch pertains mostly to East Asians.

Among Asians, sexuality in not as openly discussed as among Americans, even among one's closest friends. Among East Asian cultures, such as China and Japan, there is minimal open, public discussion. Asian cultures strongly emphasize modesty and sexual restraint. Sexual expression before or outside of marriage is mostly seen as inappropriate. It is especially expected that individuals will withhold expression of anything that might shame or embarrass their families. Occasionally (mis)construed as Asian *asexuality,* sexuality is a valued and normal but private part of life.

When their behavior or demeanor appears to be too sexual in nature, young Asians can expect to receive "strong and direct messages" from parents, including "expressions of disappointment and a strong sense of shame" (Chan 2004, 109).

Behaviorally Speaking

Asian American teens and young adults are significantly less sexually active than Caucasian, African American, or Hispanic young adults; 47% of a sample of single, heterosexual,18- to 25-year-old Asian American college students were sexually active compared to 72% of whites, 84% of blacks, and 59% of Hispanics (Chan 2004). A study of Los Angeles County high schoolers found that Asian Americans were far more likely to be virgins (73%) than Caucasian (50%), Latino (43%), and African American (28%) high school students. Among Canadians, Asian Canadians hold "more conservative sexual attitudes" and possess less knowledge about sex than their non-Asian peers.

Compared to other ethnic groups, Asian American high school and college students report the "oldest 'best' age" for first intercourse and have "significantly later normative and personal sexual timetables" for all sorts of sexual behavior (Okazaki 2004). Indeed, Asian American males had the highest median age at first sex (18.1) among a sample of Los Angeles–area young people. A study of Southern California college students found that more than 50% of the Asian men and 60% of the women were virgins. Among Caucasians, only 25% of men and less than 30% of women were virgins (Okazaki 2004).

Sexuality-Related Issues

Asian Americans, especially recent immigrants, are more likely to believe that Pap tests and gynecological care, more generally, should wait until after marriage and that they are too invasive and inappropriate beforehand (Okazaki 2004).

Consequences of such practices suggest that the greater sexual modesty of Asian Americans comes at a price. Compared to Caucasian women, Asian American women tend to be diagnosed with more advanced cases of breast and cervical cancer. Asian American men also show the same health service utilization pattern. A study by the National Asian Women's Health Organization of more than 800 Asian American men age 18–65 found that 89% had *never received reproductive or sexual health-care services* (Okazaki 2004). Other possible consequences of conservative sexual attitudes include Asian women's "extreme reluctance" to discuss or report sexual assault or abuse. Also, Asian American women are more likely than Caucasians to have been socialized to believe they have fewer sexual rights than their husbands, to believe rape myths, and to have negative attitudes toward rape victims. On the positive side, however, data indicate that Asian American women are less often victims of sexual assault and Asian American men are less often perpetrators of sexual assault (Okazaki 2004).

SOURCES: Okazaki 2004, 159–169; Chan 2004, 106–112.

about vaginal odors, which may make them uncomfortable about cunnilingus (oral sex).

- *Sex is for men.* Men are supposed to want sex; women are supposed to want love. Women are supposed to be sexually passive, waiting to be aroused. Sex is not supposed to be a pleasurable activity as an end in itself; it is something performed by women for men.
- *Men should know what women want.* Men are supposed to know what women want, even if women

don't tell them. To keep her image of sexual innocence, and remain pure, a woman does not tell a man what she wants.

- *Women shouldn't talk about sex.* Many women cannot talk about sex easily because they are not expected to have strong sexual feelings. Some women may know their partners "well enough" to have sex with them but not well enough to communicate their needs to them.
- *Women should look like beautiful models.* The ideal woman is unrealistically depicted with slender hips, firm, full breasts, and no fat; they are always young, have no pimples, wrinkles, or gray hair. Many women become self-conscious, worrying that they are too fat, too plain, or too old. They often feel awkward without clothes on to hide their imagined flaws.
- *Women are nurturers.* Women are supposed to give themselves, their bodies, their pleasures. Men are supposed to receive. His needs come first—his desire, his orgasm, his enjoyment.
- *There is only one right way to experience orgasm.* Women often "learn" that the only right way to experience orgasm is from penile stimulation during sexual intercourse. But there are many ways to reach orgasm: through oral sex; manual stimulation before, during, or after intercourse; masturbation; and so on. Women who rarely or never have an orgasm during heterosexual intercourse may be deprived by not sexually expressing themselves in other ways.

Sexual scripts can affect the ways in which we look at a range of sexual and sexually related behaviors. For example, by portraying males as active, sexually aggressive initiators whose sexual response cannot be easily controlled or constrained and females as sexually passive, innocent, and even nonsexual, traditional scripts ignore the possibilities of sexually reluctant males or sexually coercive females. This, in turn, obscures the phenomenon of female sexual offending, especially with male victims, and leaves police, victims, and helping professionals in the dark about what may be a more common phenomenon than is understood. Although rates of female sexual offending on male victims are quite low in the United States, Canada, and the United Kingdom, the 1%–8% of cases don't easily fit within the widely shared traditional male and female sexual scripts. In addition to the female sexual script, gender role norms suggest that females are nurturing and nonaggressive. As a consequence, authorities may not recognize and respond and victims are more reluctant to report victimization by a female out of fear that their claims may be met by disbelief, ridicule, or trivializing. Given the belief that women "don't do things like that" victims may decide to forego reporting altogether (Denov 2003).

Contemporary Sexual Scripts

As gender roles have changed, so have sexual scripts. To a degree, traditional sexual scripts have been replaced by more liberal and egalitarian ones. Sexual attitudes and behaviors have become increasingly liberal for both Caucasian and African American males and females, but African American attitudes and behaviors have been and continue to be somewhat more liberal than those of Caucasians (Wyatt et al. 1988). We know less about how Latino sexuality and Asian American sexuality have changed, as there is less research on the sexual scripts, values, and behaviors in those cultures.

Many women have explicitly rejected the more traditional scripts, especially the good girl–bad girl dichotomy and the belief that "nice" girls don't enjoy sex (Moffatt 1989). College-age women, as well as older, professional women who are single, are among those most likely to reject the old images (Davidson and Darling 1988).

Contemporary sexual scripts include the following elements for both sexes (Gagnon and Simon 1987; Rubin 1990):

- Sexual expression is positive.
- Sexual activities are a mutual exchange of erotic pleasure.
- Sexuality is equally involving of both partners, and the partners are equally responsible.
- Legitimate sexual activities are not limited to sexual intercourse but also include masturbation and oral–genital sex.
- Sexual activities may be initiated by either partner.
- Both partners have a right to experience orgasm, whether through intercourse, oral–genital sex, or manual stimulation.
- Nonmarital sex is acceptable within a relationship context.
- Gay, lesbian, and bisexual orientations and relationships are increasingly open and accepted or tolerated, especially on college campuses and in large cities.

Contemporary scripts both give greater recognition to female sexuality and are relationship-centered rather than male-centered. As we said earlier, traditional scripts have been replaced *to a degree*. Women who have several concurrent sexual partners or casual sexual relationships, for example, are still more likely to be regarded as more promiscuous than are men in similar circumstances (Williams and Jacoby 1989). The "suppression of female sexuality" is often carried out by women, whether through maternal influence or the judgments of female peer groups (Miracle, Miracle, and Baumeister 2003).

A 1999 study of 165 young, heterosexual women showed both the liberalization of attitudes and the continuation of a **sexual double standard.** On the liberalization side, 99% of the university sample "strongly agreed" or "agreed" that women can enjoy sex as much as men do. Of the women, 69% disagreed or strongly disagreed with the statement that "women are less interested in sex than men are." However, 95% of the women believed that there continues to be a double standard, wherein it is less accepted for a woman to have many sexual partners than it is for a man. In addition, 93% "probably" or "definitely agreed" that women who have many partners are more harshly judged than men with many partners, 49% indicated that women were labeled and penalized, but 48% stated that men were encouraged to have and rewarded for having many partners.

Robin Milhausen and Edward Herold (1999) concluded that women "overwhelmingly" perceive that there is still a double standard in society, even though they claim not to support it. Furthermore, women's own attitudes were influenced by their experiences; the more sexual partners a woman had had, the more accepting she was likely to be of men and women who have had many partners.

Psychosexual Development in Young Adulthood

At each period in our psychosexual development, we are presented with different challenges. In purely physical terms, adolescents are sexually mature (or close to it) but they are still learning their gender and social roles; they may also be struggling to understand the meaning of their sexual feelings for others and their sexual orientation. During young adulthood—from the late teens through mid-30s—many of the same tasks continue and new ones are added.

How Do We Know What We Know?

Before we examine the developmental tasks of young adulthood, let's look at some sources of our sexual learning. Children and adolescents are subjected to gender specific messages about sexuality, as well as both subtle and explicit socialization into heterosexuality (and away from homosexuality and bisexuality). Sources of influence include parents, peers, media, and school.

Parental Influence

Children learn a great deal about sexuality from their parents. Often, however, they learn not because their parents set out to teach them but because they are avid observers of their parents' behavior. Rather than openly and actively pursuing sexual topics, in many families sexuality remains "hidden" (Roberts 1983). When silence surrounds sexuality, it suggests that one of the most important dimensions of life is off limits, bad to talk about and dangerous to think about.

Parents convey sexual attitudes to their children in a number of ways. What parents say or do, for example, to children who touch their "private parts" or try

Ebby May/Getty Images/Taxi

Parents, especially mothers, are important sources of information and advice about sexuality. Although both sons and daughters speak more to mothers than to fathers about sexual issues, most parent–child sexual communication is really between mothers and daughters.

to touch either their mother's or some other woman's breasts conveys meanings about sex to a child. Parents who overreact to children's sexual curiosity may create a sense that sex is wrong. On the other hand, parents who acknowledge sexuality rather than ignoring or condemning it, help children develop positive body images, comfort with sexual matters, and higher self-esteem (Miracle, Miracle, and Baumeister 2003).

As young people enter adolescence, they are especially concerned about their own sexuality, but they may be too embarrassed or distrustful to ask their parents directly about these "secret" matters. Furthermore, many parents are ambivalent about their children's developing sexual nature. They are often fearful that their children (daughters especially) will become sexually active if they have too much information. They tend to indulge in wishful thinking: "I'm sure Jessica's not really interested in boys yet;" "I know Jason would never do anything like that." As a result, they may put off talking seriously with their children about sex, waiting for the "right time," or they may bring up the subject once, say their piece, breathe a sigh of relief, and never mention it again. Sociologist John Gagnon calls this the "inoculation" theory of sex education: "Once is enough" (cited in Roberts 1983). But children may need frequent "boosters" where sexual knowledge is concerned.

Because parents assume that their children are (or will be) heterosexual, they may avoid—intentionally or merely without thinking it relevant—discussion about sexual orientation. In so doing, they leave their children less aware of homosexuality, which, itself, becomes invisible. In addition, even simple comments such as "When you grow up and get married someday . . ." assumes that the child is or will become heterosexual (Shibley-Hyde and Jaffe 2000).

Research is somewhat mixed about the nature and consequences of parent–child communication about sexuality. Some research suggests that "early, clear communication" between parents and their teenage children leads to lower levels of teen sexual activity, and, for those who become sexually active, to greater understanding and use of safe-sex practices (Lehr, Demi, DiIorio, and Facteau 2005; Leland and Barth 1993; DiIorio, Kelly, and Hockenberry-Eaton 1999). In addition, research cited by Lehr and colleagues indicates that mothers who discuss sex-related issues influence their children's later protective sexual behaviors, including condom use (Dittus, Jaccard, and Gordon 1999; Miller, Levin, Whitaker, and Xu 1998). Other researchers report (Newcomer and Udry 1985; O'Sullivan et al. 1999) little to no effect of mother–child sexual communication on subsequent teen sexual behavior, and one study suggests that it is associated with greater involvement in sexual activity, although it may be as much a consequence as a cause (Paulson and Somers 2000). Existing research indicates that most parent–child discussion about sex is really mother–daughter discussion about sex, that sons receive much less parental insight and information than daughters do, and that what information sons do receive they tend to learn from their mothers not their fathers (Lehr, Demi, DiIorio and Facteau 2005).

Although parental norms and beliefs are generally influential, they do not always have the strong desired effect on an adolescent's decision to become sexually active, especially in comparison with peer influence. A lack of family rules and structure are related to more permissive sexual attitudes and premarital sex among adolescents (Forste and Heaton 1988; Hovell et al. 1994), whereas a strong bond with parents appears to lessen teens' dependence on the approval of their peers and to lessen the need for interpersonal bonding that may lead to sexual relationships (DiBlasio and Benda 1992).

Peer Influence

Adolescents garner a wealth of information, as well as much *misinformation,* from one another about sex. They often put pressure on one another to carry out traditional gender roles. Boys encourage other boys to become and be sexually active even if the others are unprepared or uninterested. Those who are pressured must camouflage their inexperience with bravado, which increases misinformation; they cannot reveal sexual ignorance. Even though many teenagers find their earliest sexual experiences less than satisfying, many still seem to feel a great deal of pressure to conform, which may mean becoming or continuing to be sexually active. For many young people, virginity may be experienced as a stigma, whereas virginity loss is seen either as a way to shed the stigma (more true for males) or merely as part of growing up (Carpenter 2002).

Encouragingly, four large national probability samples from the Youth Risk Behavior Survey indicate that the 1990s saw a shift in adolescent sexual activity toward greater responsibility and restraint. According to data collected between 1991 and 1997, there was an 11% increase in the "incidence of virgin adolescents." This shift occurred mostly among males and among

blacks and whites (but not Hispanics). Still, it represents a "significant reversal" from the 1970s and 1980s (Christopher and Sprecher 2000).

Other signs that adolescent sexual activity has declined can be seen in the findings of a Health and Human Services study, indicating that from 1995 to 2002 fewer teenage boys and younger teenage girls were sexually active. Among never-married females 15 to 17 years old, the percentage who ever had sexual intercourse declined from 38% in 1995 to 30% in 2002. For females 18 to19, there was virtually no change over this same time period. Among males there were more dramatic drops. From 1995 to 2002, the percentage of 15- to 17-year-olds reporting ever having had intercourse dropped from 43% to 31%. Among 18- to 19-year-old males, the decline was from 75% in 1995 to 64% in 2002. Clearly, more teens are delaying their initial experience of sexual intercourse, thus creating a somewhat different peer culture. We will look further at the trend in sexual involvement in a later section of this chapter.

Media Influence

The media profoundly affect our sexual attitudes (Wolf and Kielwasser 1991; McMahon 1990). Writing almost two decades ago, anthropologist Michael Moffatt noted that although about a third of the students he studied at Rutgers University mentioned the effect of college and college friends on their sexual development and another third mentioned their parents and religious values, the bigger and major influence on their sexuality was contemporary American pop culture, including "movies, popular music, advertising . . . TV . . . *Playboy, Penthouse, Cosmopolitan, Playgirl,* and so on; Harlequins and other pulp romances (females only); the occasional piece of real literature; sex education and popular psychology . . .; classic soft-core and hard-core pornographic movies, books, and (recently) videocassettes" (Moffatt, 1989). To these we can add DVDs, which now virtually have replaced videocassettes, and—even more significantly—the Internet, with its numerous sexually oriented websites and weblogs (see the "Popular Culture" box later in this chapter).

Whereas the effects of certain media—notably television—on attitudes about sex have received more scholarly attention, the effects of others, such as magazines, have received less (Kim and Ward 2004). Thus, even though women's magazines are "replete with sexual content," including "frank advice about sex," they remain somewhat understudied and therefore inadequately understood as a source of sexual learning.

Existing research suggests that the more "teen-focused magazines" expose young women to a contradictory message that encourages them be *sexually provocative* in their demeanor and dress but discourages them from being *sexually active.* Encouraged to devote much time and effort toward making themselves physically appealing to boys and to presenting themselves as sexual objects, at the same time girls are discouraged from and warned about pursuing sexual relationships. Males are negatively portrayed as "either emotionally inept . . . or as sexual predators" (Kim and Ward, 2004), neither of which are flattering to males or encouraging for females entering the world of heterosexual relationships.

More "adult-focused magazines," such as *Cosmopolitan,* convey a different message. Sexually aggressive women are portrayed positively, almost in the same way as a stereotypical male is portrayed. College-age women who more frequently read magazines such as *Cosmopolitan* were less likely to perceive sex as risky or dangerous and "more likely to view sex as a fun, casual activity and to be supportive of women taking charge in their sexual relationships" (Kim and Ward 2004).

SEX ON THE NET. From its inception in 1983 to the present, the Internet has revolutionized the way we live. By 2000, there were a reported 1 billion web pages. Just

©Scott Goodwin Photography

Popular magazines such as Seventeen *or* Cosmopolitan *are part of the sexual socialization that many young women in the United States experience. Although both are widely read, they convey different messages about sexuality.*

Popular Culture "Blogging" about Sex

One of the most popular innovations to emerge in our increasingly wired world is the **weblog,** or "blog." First appearing in the early 1990s, weblogs now number in the millions and have become resources for people with shared interests, people seeking specialized information, and people who wished to produce online journals. As defined by Blogger.com:

> A blog is a personal diary. A daily pulpit. A collaborative space. A political soapbox. A breaking-news outlet. A collection of links. Your own private thoughts. Memos to the world. Your blog is whatever you want it to be. There are millions of them, in all shapes and sizes, and there are no real rules.

Along with Blogger.com and its 1.1 million registered users, other popular blog sites include Blogwise.com, Globe of Blogs, Blogs.com (acquired by Yahoo), and even the popular but controversial Myspace.com. Describing itself as "a place for friends," Myspace.com also claims more than 61 million blog posts (not 61 million different bloggers) for bloggers to choose from.

Blogs can be accessed by people who are seeking others of similar backgrounds, interests, or points of view or by the less determined and more casual "surfer" on the net. In this way, blogs offer interested individuals a "place" where they can interact and yet retain a sense of anonymity.

Some sexually oriented blogs are really venues for posting, viewing, and/or sharing nude photos, sexually explicit videos, and/or pornographic images. Others are personal sexual "diaries," in which individuals share, either for a closed membership or for the anonymous public, their sexual fantasies, thoughts, and/or supposed exploits (anyone can claim to be or have done whatever they wish to have others think). They are a kind of "anonymous exhibitionism."

There are also more informational, sexually oriented blogs, where we can learn about various sexual issues. For young people, adolescents and young adults, the existence of the weblog community offers an expanded, although invisible and anonymous, network from whom they can learn about—and with whom they can talk about—sex and sexuality. For example, there are blogs by gay, lesbian, and bisexual bloggers (such as http://www.comingout.blogspot.com). There are blogs by "swingers" and "polyamorists" and blogs filled with more informational or educational resources.

There has been only limited research so far, and little "hard data" on the number of blogs with sexual content or themes or the number of users or readers. Clearly, however, the existence of blogs broadens the opportunities for online sexual communication and sexual learning. It also introduces a problem for parents of minors, because there are many blogs that are sexually explicit and quite graphic. Although parents can put "blocks" on their computers (to prevent children from accessing objectionable content), in the absence of such blocks, all children need do is claim to be 18 (or in some instances 21) and they can enter a world filled with explicit language, graphic images, and highly sexualized content. With the sense of "community" that sometimes surfaces among bloggers or within websites, these resources can act like peers do in the process of sexual learning yet at other times, and for other users, may be more like media content.

3 years later, a Google search reviewed more than 3 billion websites (Griffin-Shelley 2003). Beginning in the 1990s, researchers looked with increasingly critical eyes at "sex and the net." Topics such as "addiction" to pornography; exploitation and entrapment of children; sexual harassment; and deviant pornography are among the issues and concerns that emerged. A 1996 study of six patients in a sex offender program stirred much concern with assertions about the potential addictiveness of Internet sex.

Aside from the rare but disturbing victimization that occurs, such material significantly broadens young people's access to sexual knowledge and material and removes it further from parental control.

As we get older, parents, peers, and the media eventually become less important in our sexual learning. As we experience interpersonal sexuality, our sexual partners become the most important source of modifying traditional sexual scripts. In relationships, men and women learn that the sexual scripts and models they learned from parents, peers, and the media won't necessarily work in the real world. They adjust their attitudes and behaviors in everyday interactions. If they are married, sexual expectations

and interactions become important factors in their sexuality.

Sexuality in Adolescence and Young Adulthood

Sexual Developmental Tasks

Several tasks challenge young adults as they develop their sexuality:

- *Establishing a sexual orientation.* Children and adolescents may engage in sexual experimentation such as playing doctor, kissing, and fondling members of both sexes without such activities being associated with sexual orientation. By young adulthood a heterosexual, gay, or lesbian orientation emerges. Most young adults develop a heterosexual orientation. Others find themselves attracted to members of the same sex and begin to develop a gay, lesbian, or bisexual identity.
- *Integrating love and sex.* As we move into adulthood, we need to develop ways of uniting sex and love instead of polarizing them as opposites.
- *Forging intimacy and commitment.* Young adulthood is characterized by increasing sexual experience. Through dating, cohabitation, and courtship, we gain knowledge of ourselves and others as potential partners. As relationships become more meaningful and intimate, sexuality can be a means of enhancing intimacy and self-disclosure, as well as a means of obtaining physical pleasure.
- *Making fertility or childbearing decisions.* Childbearing is socially discouraged during adolescence, but fertility issues become critical, if unacknowledged, for single young adults. If sexually active, how important is it for them to prevent or defer pregnancy? What will they do if the woman unintentionally becomes pregnant?
- *Developing a sexual philosophy.* As we move from adolescence to adulthood, we reevaluate our moral standards, using our personal principles of right and wrong and of caring and responsibility. We develop a philosophical perspective to give coherence to our sexual attitudes, behaviors, beliefs, and values. Sexuality must be placed within the larger framework of our lives and relationships, integrating our personal, religious, spiritual, or humanistic values with our sexuality. (Gilligan 1982; Kohlberg 1969).

Adolescent Sexual Behavior

If we take a long view of changes in teenage sexual behavior, today's teenagers are more tolerant of premarital sex and more likely to engage in it than teenagers were, say, 30 or 50 years ago. Comparing members of the graduating classes of 1950, 1975, and 2000 from the same northeastern high school, Sandy Caron and Eilean Moskey found a steady decline in negative attitudes about premarital sex and an increase in the percentages who reported having had sexual intercourse while in their teens. Furthermore, graduates of the class of 1950 were not only much less likely to have had intercourse but also less likely to have had more than one sexual partner, used birth control, or even talked about sex with their parents. Of the respondents from the class of 1950, 25% were sexually active while in high school, compared with 65% of the class of 1975 and 69% of the class of 2000. Similarly, where 76% of sexually active members of the class of 2000 "always used birth control," 68% of the sexually active members of the class of 1950 *never* used birth control (Caron and Moskey 2002).

Yet, as noted earlier and revealed in what follows, teenage and young adult sexuality have undergone some pronounced changes in more recent years. For example, between 1993 and 2001, an estimated 2.5 million adolescents took public virginity pledges, promising to abstain from sexual intercourse until they married. As sponsored and organized by the Southern Baptist Church, such pledges did tend to delay first intercourse, often for a long time (Bearman and Bruckner 2001).

A more comprehensive picture of some recent trends can be seen in the following data on adolescent sexual behavior:

- Through the 1990s, the percentage of teenagers reporting having sexual intercourse dropped 5.7% and the teen pregnancy rate was down 14%. According to sociologists Pepper Schwartz and Barbara Risman, there were gender and race differences in the changes in sexual expression. The number of high school boys—but not girls—under 18 who remained virgins dramatically increased. The rate of sexual activity of black females was sharply reduced, and among Caucasian and Hispanic females it remained generally stable (http://www2.asanet.org/media/cntrisman.html).
- Cumulatively, looking at ninth- through twelfth-grade girls and boys, 47% report having had sexual intercourse, a decline of 6% since 1993.

- In 2003, 33% of ninth graders and 62% of twelfth graders reported that they had ever had sexual intercourse.
- The median age at first sexual intercourse was 16.9 for males and 17.4 for females.
- In 2003, 66% of teens were "sexually abstinent," meaning that they had refrained from sexual intercourse for at least 3 months.
- The percentage of teens who first had sexual intercourse before having turned 14 years of age declined from 8% of girls and 11% of boys in 1995 to 6% of girls and 8% of boys in 2002.
- In 2003, among those teens who were sexually active, 98% reported using at least some form of contraception, with condoms (94%) and birth control pills (61%) being the most commonly used methods (Kaiser Family Foundation 2005).

Nearly one in ten 15–17 year olds had been physically forced to have intercourse. Among those who were sexually active, 24% reported having done something sexually that they didn't really want to, and 21% had participated in oral sex to avoid sexual intercourse. Racial differences surface here; Leslie Houts reports that black females (at 13%) were most likely to report their first sexual intercourse as "unwanted," Hispanics were least likely to describe their initial experience of intercourse as forced (4%), with whites (6%) slightly more likely to respond that way (Houts 2005).

The earlier the age at which we first experience sexual intercourse, the less likely it is that the experience was wanted. The relationship context also makes a difference in desirability. The more committed the relationship in which it occurs (such as in engagement or going steady), the more likely the first sexual encounter is to have been "wanted" (Houts 2005).

Emily Impett and Letitia Peplau report that more than a third of college men and more than half of college women report having consented to unwanted sex, and between 21% and 32% of college women said they engaged in unwanted sex out of fear that their partners would leave them. They further link attachment style to whether and why some college women consent to unwanted sex and others don't. "Anxiously attached" women, because they feared their partners would leave them, were more willing to conceive of engaging in unwanted sex. They also expressed more of a desire to avoid conflict and a concern for preventing their partners from losing interest than more securely attached women reported (Impett and Peplau 2002).

Virginity and Its Loss

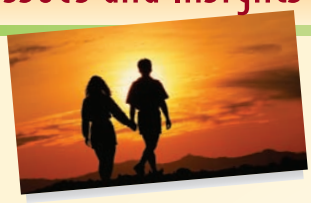
What makes one a virgin? This fairly simple and straightforward-sounding question is a little more complicated. Is virginity more broadly the preservation of "innocence" through the lack of sexual experience, or is it more narrowly the lack of sexual intercourse experience? Most people agree that we maintain **virginity** as long as we refrain from sexual intercourse. But occasionally we hear people speak of "technical virginity," to refer to people who have had a variety of sexual experiences but have not had sexual intercourse. Such individuals are hardly sexually naïve and lack some other connotations associated with the concept of virginity (innocence and purity, for example). Data indicate that a "very significant proportion of teens has had experience with oral sex, even if they haven't had sexual intercourse, *and may think of themselves as virgins*" (Lewin 2005, emphasis added). Research findings from the National Survey of Family Growth released by the National Center for Health Statistics reveal that "more than half of all teenagers aged 15 to 19 have engaged in oral sex—including nearly a quarter of those who have never had intercourse" (Lewin 2005).

The proportion of teenagers who have had oral sex was slightly higher than the proportion that has had intercourse: 55% of the boys and 54% of the girls reported having given or received oral sex, and 53% of the girls and 49% of the boys reported having had sexual intercourse. Other research, especially research looking into virginity loss, reports that 35% of virgins, defined as people who have never engaged in vaginal intercourse, have—nonetheless—engaged in one or more other forms of heterosexual sexual activity (for example, oral sex, anal sex, or mutual masturbation).

Sociologist Laura Carpenter, author of *Virginity Lost: An Intimate Portrait of First Sexual Experiences* (2005), acknowledges that losing virginity has different meaning for males and females (see the "Issue & Insights" box later in this chapter). For starters, at least a quarter of women, age 15–24, reported in the National Survey of Family Growth that, although "voluntary," their first experience of heterosexual intercourse was "not really wanted," rating it low (1 to 4) on a 10-point scale of "wantedness" (Houts 2005).

Young women and men not only attach different meaning but also experience virginity loss in different ways. Women are more likely to be worried about negative outcomes of their first experience of intercourse.

Issues and Insights The Meaning of Virginity Loss



Researchers looking into the meanings people attach to the loss of their virginity and how they negotiate the transition from virgin to nonvirgin find that virginity has different meanings for women of different ages (Carpenter 2002; Houts 2005). As Leslie Houts says, "the meaning of being a virgin at 14 is very different than at age 24, or at age 34" (2005, 1,097). At younger ages virginity may be culturally expected, at a somewhat later age it may be respected and celebrated, and at "too old an age" it may be viewed with curiosity or suspicion. In each of these scenarios, the meaning of virginity loss is different; in none of these scenarios is the physical pleasure of sexual intercourse manifest (Houts 2005).

Laura Carpenter's research with 61 women and men suggests that people draw upon three themes to make sense of their lost virginity: virginity as a gift, virginity as a stigma, and virginity loss as part of the transition to adulthood. Although many individuals indicated more than one of the following categories, the following pattern of response was revealed:

- *Virginity as a gift.* Half of Carpenter's informants recalled that at some point in their lives they had thought of virginity as a gift they were giving to someone, ideally to someone they loved, and to which the recipient would give enhanced love and commitment in return.
- *Virginity as stigma.* More than a third of Carpenter's sample saw their virginity as something to hide, and something they wished to shed as soon as possible ("at the first available opportunity, often with relatively casual partners, such as friends or strangers"). The sexual double standard of even contemporary sexual scripts made it easier for women both to hide, and to shed, their virgin status.
- *Virginity loss as part of growing up.* More than half of Carpenter's interviewees thought that the loss of virginity was inevitable and desirable, "just another experience" in the process of becoming an adult, with minimal gender differences in the interpretation of the experience. Where gender did surface prominently was in how much physical pleasure or enjoyment was experienced with the loss of virginity. For a majority in this group, including three-fourths of the women and three-fifths of the men, virginity loss was not physically enjoyable.

Sexual orientation also colored people's interpretations of their loss of virginity. Gay men and lesbians were more likely than heterosexuals to have seen the loss of virginity as a step in the process of growing up (73% versus 46%). Heterosexual women and men were more likely to have perceived virginity as a gift than were gays or lesbians (54% versus 31%). Interestingly, among gay men, lesbians, bisexuals, and heterosexuals who shared an interpretive framework, experience of virginity loss was quite similar.

In addition, women are more worried about pregnancy, more likely to be nervous, more likely to be in pain, and less likely to experience orgasm. They are also more likely to experience postcoital guilt and express with regret the wish that they had waited.

Converging Patterns for Women and Men

As recently as the 1980s, young women were more likely to value virginity and to contemplate its loss primarily within committed romantic relationships and men welcomed opportunities for casual sex and expressed disdain for virginity. Research in the 1990s revealed increasing similarities between women and men. More young men than before were expressing pride and happiness about being virgins. Growing numbers of young women were perceiving virginity in neither a positive nor a negative light, with a minority eagerly anticipating "getting it over with." By the 1990s, gender differences in the age at which one first engages in intercourse had all but disappeared. By 1999, age at first vaginal sex was between 16 and 17 for both females and males (Carpenter 2002).

Gay, Lesbian, and Bisexual Identities

In contemporary America, people are generally classified as **heterosexual** (sexually attracted to members of the other gender), **homosexual** (sexually attracted to members of the same gender), or **bisexual** (attracted to both genders). Although today we may automati-

cally accept these categories, such acceptance has not always been the case and the categories do not necessarily reflect reality. As late as the nineteenth century, there was no concept of "homosexuality." Both the label *homosexual* and the label *heterosexual* first appeared in print in the United States in a medical journal in 1892 (Katz 2004). At still other times, both *homosexual* and *heterosexual* were terms referring to sexual perversions, with heterosexuals being people with sexual inclinations toward both sexes and toward "abnormal methods of gratification" (Katz 2004).

The familiar threefold categorization of sexual orientation used today may not accurately depict the range that exists in our sexual orientations—who we are attracted to, who we have relations with, who we fantasize about, the type of lifestyle we live, and how we identify ourselves. On any of these items we may be *exclusively* oriented toward the other sex or our sex, *mostly* drawn to the other sex or our sex, or oriented to both sexes *about equally.* In addition, the interaction of numerous factors—social, biological, and personal—leads to the unconscious formation of sexual orientation. The two most important components of sexual orientation are the gender of our sexual partner and whether we label ourselves heterosexual, gay, lesbian, or bisexual. Finally, our sexual orientation may change over time. Thus, what was true of past relationships or attractions may not fit with the present or may differ from what we envision for our future (Klein 1990; Miracle, Miracle, and Baumeister 2003).

Because *homosexual* carries negative connotations and obscures the differences between what women and men experience, we refer to **gay men** and **lesbians.** In addition, replacing the term *homosexual* may help us see individuals as whole people; sexuality is not the only significant aspect of the lives of gay men, lesbians, bisexuals, or heterosexuals. Love, commitment, desire, caring, work, possibly children, religious devotion, passion, politics, loss, and hope are also, if not more, important.

At different times, especially in the past, those with lesbian or gay orientations have been called sinful, sick, perverse, or deviant, reflecting traditional religious, medical, and psychoanalytic approaches. Contemporary thinking in sociology and psychology has rejected these older approaches as biased and unscientific and has focused, instead, on how women and men come to identify themselves as lesbian or gay, how they interact among themselves, and what effect society has on them (Heyl 1989). As noted sociologist Howard Becker (1963) has pointed out, "Deviant behavior is behavior that people so label." Deviance is created by social groups that make rules whose violation results in violators being labeled deviant and treated as outsiders. Lesbian and gay behavior, then, is deviant only insofar as it is called deviant.

How does one "become" gay, lesbian, bisexual, or even heterosexual, for that matter? Such a question is neither easily answered nor inconsequential. If sexual orientation is biologically based, discrimination against gay men, lesbians, or bisexual women and men is especially unjustified. It becomes no different than discriminating against someone because of their age, their gender, or their race, all statuses over which we exercise no control.

Research on the self-identification process suggests that we can divide the gay, lesbian, and bisexual population into two groups of people: one group comprising men and women who say that they knew, from a much earlier age while growing up, that they were "different" from others. The second group grew up "never questioning the suitability of a heterosexual identity" until later in their lives, such as college age or middle age. Most men and many of the women in this latter group attribute this delayed identification to denial. However, many women (but not many men) reject the idea that they were driven by uncontrollable or irresistible desires, saying, instead, that they "chose" to become involved with a same-sex partner and that their choice was a political one, associated with their particular feminist politics. For others, it was a choice motivated out of the desire for more equal, more intimate relationships than they believed they could have with men (Butler 2005).

If sexual orientation is chosen, given the cultural, social, and legal changes that have occurred in recent decades, we might expect an increase in the percentage of the population that engages in same-sex sexual relationships. Indeed, data bear this out. Data from the General Social Survey indicate that between 1988–1990 and 1996–1998 the percentage of American men reporting having had a same-sex sexual partner the previous year more than doubled, from 1.7% to 3.9%. Among women a similar pattern held, as the percentage of women having had a same-sex sexual partner rose from 0.7% to 2.7%. Amy Butler (2005) extended the time frame for analysis and incorporated data through the 2002 General Social Survey. Her findings are shown in Table 6.1.

Butler reminds us that these increases may be interpreted in a few ways. Rather than an increase in the percentage of women and men who *have* same-sex

Table 6.1 ■ Sex of Sex Partner, 1988–2002 (in percentages)

	1988	1990	1992	1994	1996	1998	2000	2002
Males								
Same sex	2.4	2.0	2.5	2.6	3.7	4.1	3.8	2.9
Opposite sex only	82.3	88.4	84.1	83.6	82.9	80.6	80.5	82.5
No partner	10.9	6.6	10.9	10.9	8.6	11.3	11.7	12.5
No answer	4.4	3.0	2.4	2.8	4.9	4.0	4.0	2.1
Females								
Same sex	0.2	0.8	1.2	1.0	2.5	2.6	3.3	3.5
Opposite sex only	83.5	85.1	81.7	80.3	79.7	80	78.3	78.3
No partner	12.8	10.8	13.6	14.0	13.1	14.6	15.5	16.4
No answer	3.6	3.3	3.4	3.7	4.8	2.7	3.0	1.8

attractions or desires, they may reflect increases in the *willingness to act* on desires that otherwise would have been suppressed, ignored, or denied. Another alternative to consider is that the changing or liberalized climate may simply encourage people to report more honestly what they are doing sexually.

The actual percentage of the population that is lesbian, gay, or bisexual is not known. Among women, about 13% have had orgasms with other women, but only 1% to 3% identify themselves as lesbians (Fay et al. 1989; Kinsey, Pomeroy, and Martin 1948, Kinsey et al. 1953; Marmor 1980c). Among males, including adolescents, as many as 20% to 37% have had orgasms with other males, according to Alfred Kinsey's studies. Of these, 10% were predominantly gay for at least 3 years; 4% were exclusively gay throughout their entire lives (Kinsey et al. 1948). A review of studies on male same-sex behavior between 1970 and 1990 estimated that a minimum of 5% to 7% of adult men had had sexual contact with other men in adulthood. Based on their review, the researchers suggested that about 4.5% of men are exclusively gay (Rogers and Turner 1991). A large-scale study of 3,300 men age 20 to 39 reported that 2% had engaged in same-sex sexual activities and 1% considered themselves gay (Billy et al. 1993). In 1994, the National Health and Social Life Study found that, of the participants, 2.8% of men and 1.4% of women described themselves as homosexual or bisexual, although approximately 6% of men and 4% of women said they had had a sexual experience with someone of the same sex at least once since puberty (Laumann et al. 1994).

What can we make of the differences among studies? In part, the variances may be explained by different methodologies, interviewing techniques, sampling, or definitions of homosexuality. Furthermore, sexuality is more than simply sexual behaviors; it also includes attraction and desire. One can be a virgin or celibate and still be gay or heterosexual. Finally, sexuality is varied and changes over time; its expression at one time is not necessarily its expression at another.

Identifying Oneself as Gay or Lesbian

Many researchers believe that a person's sexual interest or direction as heterosexual, gay, or lesbian is established by age 4 or 5 (Marmor 1980a, 1980b). But identifying oneself as lesbian or gay takes considerable time and includes several phases, usually beginning in late childhood or early adolescence (Blumenfeld and Raymond 1989; Troiden 1988). **Homoeroticism**—erotic attraction to members of the same gender—almost always precedes gay or lesbian activity by several years.

We noted in Chapter 4 that people commonly, although incorrectly, assume that a person's masculinity or femininity reveals their sexual preference. Further complicating the connection, or lack thereof, between gender and sexual orientation are the retrospective accounts, more often revealed by gay men than by lesbians, of "being different" in childhood, of not fitting in with or desiring to conform to gender appropriate behavior. However, many heterosexuals remember their childhoods in similar ways; 60% or more of heterosexual women recall being tomboys, enjoying male activities and play, and engaging in gender nonconforming behavior (Gottshalk 2003). Research has shown that more heterosexual women than gay men enjoyed stereotypical masculine play and activities as children. Also, gay men and lesbians who piece together

Understanding Yourself

The Social Control of Sexuality and Your Sexual Scripts

Our discussion of sexual scripts illustrates some ways in which society influences our sexual attitudes and behavior. This is not unique to the United States; every society regulates and controls the who, what, when, where, and why of sexuality. Your script will change over time, depending on your age, sexual experience, and interaction with intimate partners and others. Examine some questions you are likely to encounter.

Who

Society tells you to have sex with people who are unrelated, around your age, and of the other sex (heterosexual). Less acceptable is having sex with yourself (masturbation), with members of the same sex (gay or lesbian sexuality), and with relatives (incest). In most societies, extramarital relationships are prohibited. Examine the "whos" in your sexual script, then think about the following questions:

- With whom do/would you engage in sexual behaviors?
- How do your choices reflect homogamy and heterogamy?
- What social factors influence your choice?
- Does your autoerotic behavior change if you are in a relationship? How? Why?

What

Society classifies sexual acts as good or bad, moral or immoral, and appropriate or inappropriate. Although these designations may seem absolute, they are culturally relative.

- What sexual acts are part of your sexual script?
- How are they regarded by society?
- How important is the level of commitment in a relationship in determining your sexual behaviors?
- What level of commitment do you need for kissing? Petting? Sexual intercourse?
- What occurs if you and your partner have different sexual scripts for engaging in various sexual behaviors?

When

You might make love when your parents are out of the house or, if a parent yourself, when your children are asleep. Usually, such timing is related to privacy, but it may also be related to the age at which sexual activity is expected to start and stop, how often people are expected to engage in sexual relations, and when in a relationship sex should begin. Finally, it may pertain to times when sex is considered appropriate or inappropriate. Some societies frown upon a woman engaging in sex during her menstrual flow, for a period after the birth of a child, or while nursing (Miracle, Miracle, and Baumeister 2003).

- When do you engage in sexual activities?
- Are the times related to privacy?
- When did you experience your first erotic kiss?
- At what age did you first have sexual intercourse? If you have not had intercourse, at what age do you think it would be appropriate?
- How was the timing for your first intercourse determined, or how will it be determined?
- What influences (friends, parents, religion) are brought to bear on the age-timing of sexual activities?

Where

Where do sexual activities occur with society's approval? In our society, they usually occur in the bedroom, where a closed door signifies privacy. For adolescents, automobiles, fields, beaches, and motels may be identified as locations for sex; churches, classrooms, and front yards usually are not. "Where" may also extend to where it might be considered appropriate or inappropriate to discuss sex or to expose parts of your body.

- Where do you think the acceptable places to be sexual are?
- What makes them acceptable for you?
- Have you ever had conflicts with partners about the "wheres" of sex? Why?

Why

There are many reasons for having sex: procreation, love, passion, revenge, intimacy, exploitation, fun, pleasure, relaxation, boredom, achievement, relief from loneliness, exertion of power, and on and on. Some of these reasons are approved by society; others are not. Some we conceal; others we do not.

- What are your reasons for sexual activities?
- Do you have different reasons for different activities, such as masturbation, oral sex, and sexual intercourse?
- Do the reasons change with different partners? With the same partner?
- Which reasons are approved by society, and which are disapproved?
- Which reasons do you make known, and which do you conceal? Why?

retrospective accounts do so from an adult vantage point *as gay or lesbian*. Thus, they may "read" their life story in such a way as to make it fit their adult sexuality (Gottshalk 2003).

Stages in Acquiring a Lesbian or Gay Identity

The first stage in acquiring a lesbian or gay identity is often marked by fear, confusion, and denial, and the perception that desires mark the person as different from others. The person may find it difficult to label the emotional and physical desires for the same sex. Adolescents especially fear their family's discovery of their homoerotic feelings. In the second stage, if these feelings recur often enough, the person recognizes the attraction, love, and desire as homoerotic. The third stage includes the person's self-definition as lesbian or gay. This may take a considerable struggle, because it entails accepting a label that society generally calls deviant. Questions then arise about whether to tell parents or friends, whether to hide the identity ("to be in the closet") or make the identity known ("to come out of the closet").

Some gay men and lesbians may go through two additional stages. One stage is to enter the gay subculture. A gay person may begin acquiring exclusively gay friends, going to gay bars and clubs, or joining gay activist groups. In the gay world, gay and lesbian identities incorporate a way of being in which sexual orientation is a major part of the identity as a person. Pat Califia (quoted in Weeks 1985) explains the process: "Knowing I was a lesbian transformed the way I saw, heard, perceived the whole world. I became aware of a network of sensations and reactions that I had ignored all my life."

The final stage begins with a person's first lesbian or gay affair. This marks the commitment to unifying sexuality and affection. Sex and love are no longer separated. Most lesbians and gay men have had such affairs, despite the stereotypes of anonymous gay sex.

Coming Out

Being lesbian or gay is often associated with a total lifestyle and way of thinking. In making the gay or lesbian orientation a lifestyle, **coming out**—publicly acknowledging one's gayness—has become especially important as an affirmation of sexuality. Coming out may jeopardize many relationships, but it is also an important means of self-validation. By publicly acknowledging a gay or lesbian orientation, a person begins to reject the stigma and condemnation associated with it. Generally, coming out occurs in stages, first involving family members, especially the mother and siblings and later the father. Coming out to the family often creates a crisis, but generally the family accepts the situation and gradually adjusts (Holtzen and Agresti 1990). Religious beliefs, prejudice, and misinformation about gay and lesbian sexuality, however, often interfere with a positive parental response, initially making adjustment difficult (Borhek 1988; Cramer and Roach 1987). After the family, friends may be told and, in fewer cases, employers and coworkers.

■ *Two significant factors in identifying sexual orientation are (1) the gender of one's partner, and (2) the label one gives oneself (lesbian, gay, bisexual, or heterosexual).*

Gay men and women are often "out" to varying degrees. Some may be out to no one, some to their lovers, others to close friends and lovers but not to their families, employers, associates, or fellow students. Still others may be out to everyone. Because of fear of reprisal, dismissal, or public reaction, lesbian and gay schoolteachers, police officers, members of the military, politicians, and members of other such professions are rarely out to their employers, coworkers, or the public.

Outing refers to the practice of publicly identifying "closeted" gays or lesbians. Some claim that outing is politically justified, rationalizing that if gays and lesbians stay quiet about their sexual orientation, neg-

ative stereotypes about homosexuals remain unchallenged. They reason that as heterosexuals discover that some of their friends and family members, or even public figures that they are familiar with and respect, are gay or lesbian, they may modify their attitudes about homosexuality in a more accepting direction (Miracle, Miracle, and Baumeister 2003).

Gay and Lesbian Relationships versus Heterosexual Relationships

In reviewing the existing research comparing same-sex and heterosexual relationships, the literature is mixed as to how similar or different they are from each other. In many ways, same-sex couples want, experience, and struggle with many of the same things as heterosexual couples. Comparative research has indicated that gay men, lesbians, and heterosexuals report the same levels of relationship satisfaction, attraction and love for their partners, and relationship adjustment. Following couples over an 18-month period, among couples who had been together 10 years or more, only modest differences have been found in their rate of breaking up: 6% among lesbians, 4% among gay couples, and 4% of married couples. Among those together 2 years or less there were some differences in that rate: 22% for lesbian couples, 16% for gay male couples, and 4% for married couples (over the same period, 17% of heterosexual cohabitants together less than 2 years broke up).

Gay, lesbian, and heterosexual couples struggle over the same sorts of issues: money, housework, power, and abuse. When relationships end—because of breakup or death—they suffer similarly. However, gay and lesbian couples often lack the supportiveness of family, friends, and others that married heterosexual couples can mostly take for granted. Thus, when relationship issues arise, conflict occurs, and losses result, gay men and lesbians may not receive the encouragement, support, advice, and sympathy that heterosexuals receive (Peplau, Veniegas, and Campbell 2004).

Major areas of difference have been identified in the importance attached to gender and gender role behavior (as expected, greater among heterosexuals than in gay or lesbian relationships), the presence or absence of role models for healthy relationships and for resolution of difficulties (scarcer for gay and lesbian couples), and in sexual behavior. Sexual exclusivity is lower among gay male couples than among heterosexual or lesbian couples. Sexual behavior is less frequent among lesbian couples than among gay male or heterosexual couples, although nongenital or nonsexual affection (for example, cuddling, kissing, and hugging) is reportedly more common. Monogamy and romantic love are more important to lesbians and to heterosexual women than to men in heterosexual or gay relationships (Spitalnik and McNair 2005). Lesbians and gay men also have fewer barriers than do heterosexuals to ending their relationships once troubles surface. This makes it unlikely that lesbians and gay men will live in long-term, dissatisfying, "miserable and deteriorating" relationships, but more gay and lesbian relationships than heterosexual relationships will end that could have been saved or improved with patience and effort. In addition, gay male and lesbian couples must deal with disagreements about how much they wish to disclose their sexuality to others. Such disagreements may lead a more open partner to pressure a less open partner with the threat of disclosure or leave the more open partner feeling as though the less open partner is less committed to the relationship (Peplau, Veniegas, and Campbell 2004).

Antigay Prejudice and Discrimination

Antigay prejudice is a strong dislike, fear, or hatred of lesbians and gay men because of their homosexuality. **Homophobia** is an irrational or phobic fear of gay men and lesbians. Not all antigay feelings are phobic in the clinical sense of being excessive and irrational. They may be unreasonable or biased. (Nevertheless, they may be within the norms of a biased culture.) Because prejudice may not be clinically phobic, the less clinical term, *antigay prejudice,* may be more appropriate (Haaga 1991).

Antigay prejudice justifies discrimination and violence based on sexual orientation. In his classic work on prejudice, Gordon Allport (1958) states that social prejudice is acted out in three stages: (1) offensive language, (2) discrimination, and (3) violence. Gay men and lesbians experience each stage. They are called *faggot, dyke, queer,* and *homo.* They are discriminated against in terms of housing, equal employment opportunities, insurance, adoption, parental rights, family acceptance, and so on, and they are the victims of violence known as *gay bashing* or *queer bashing.*

Such negative attitudes and hostile behaviors often exist among college students. One study of college freshmen found that 50% felt that homosexual behavior was wrong and that gay men were disgusting.

Real Families — Memoirs of a Sissy

The following autobiographical excerpts from writer Tommi Avicolli's longer essay "He Defies You Still: The Memoirs of a Sissy" describe treatment he received as a young boy and later teen in school and reveal the depth of painful consequences of the harassment he faced.

Scene One

A homeroom in a Catholic high school in South Philadelphia. The boy sits quietly in the first aisle, third desk, reading a book. He does not look up, not even for a moment. He is hoping no one will remember he is sitting there. He wishes he were invisible. The teacher is not yet in the classroom so the other boys are talking and laughing loudly.

Suddenly, a voice from beside him:

"Hey; you're a faggot, ain't you?"

The boy does not answer. He goes on reading his book, or rather pretending. . . . It is impossible to actually read the book now.

"Hey, I'm talking to you!"

The boy still does not look up. He is so scared his heart is thumping madly; it feels like it is leaping out of his chest and into his throat. But he can't look up.

"Faggot, I'm talking to you!"

. . . Suddenly, a sharpened pencil point is thrust into the boy's arm. He jolts, shaking off the pencil, aware that there is blood seeping from the wound.

"What did you do that for?" he asks timidly.

"Cause I hate faggots," the other boy says laughing. Some other boys begin to laugh, too. A symphony of laughter. The boy feels as if he's going to cry. But he must not cry. . . . So he holds back the tears and tries to read the book again. . . .

When the teacher arrives a few minutes later, the class quiets down. The boy does not tell the teacher what has happened. He spits on the wound to clean it, dabbing it with a tissue until the bleeding stops. For weeks he fears some dreadful infection from the lead in the pencil point.

Scene Two

The boy is walking home from school. A group of boys (two, maybe three, he is not certain) grab him from behind, drag him into an alley and beat him up. When he gets home, he races up to his room, refusing dinner ("I don't feel well," he tells his mother through the locked door) and spends the night alone in the dark wishing he would die. . . .

These are not fictitious accounts—I *was* that boy. Having been branded a sissy by neighborhood children because I preferred a jump rope to baseball and dolls to playing soldiers, I was often taunted with "hey sissy" or "hey faggot" or "yoo hoo, honey" (in a mocking voice) when I left the house.

To avoid harassment, I spent many summers alone in my room. I went out on rainy days when the street was empty.

. . . I came to like being alone. I didn't need anyone. . . . Contact with others meant pain. Alone, I was protected. I began writing poems, then short stories. There was no rea-

And 30% said they would prefer to not go to school with gays and lesbians (D'Augelli and Rose 1990). Antigay prejudice can even extend to heterosexuals who voluntarily choose to room with a lesbian or gay man. They are assumed to have "homosexual tendencies" and to have many of the negative stereotypical traits of gay men and lesbians, such as poor mental health (Sigelman et al. 1991).

Typically, males harbor more prejudice and express more negative attitudes toward gays and lesbians than women do. As they move through adolescence toward young adulthood, male prejudice increases where female prejudice diminishes. Antigay prejudice is experienced in many different ways. Nearly all (98%) first-year college students in Anthony D'Augelli and M. L. Rose's study (1990) reported hearing disparaging remarks on campus about gays and lesbians. In terms of victimization accounts, a nationwide survey of 15- to 21-year-old gay males, lesbians, and bisexuals revealed disturbing evidence pointing to wide ranging forms of mistreatment (see Figure 6.1).

Antigay prejudice adversely affects heterosexuals, too, by doing the following:

- Creating fear and hatred, aversive emotions that cause distress and anxiety
- Alienating heterosexuals from gay family members, friends, neighbors, and coworkers (Holtzen and Agresti 1990)
- Limiting expression of a range of behaviors and feelings, such as hugging or being emotionally intimate, with same-sex friends for fear that such in-

son to go outside anymore. I had a world of my own. . . .

Scene 4....

High school religion class. Someone has a copy of *Playboy.* Father N. is not in the room yet. . . . Someone taps the boy roughly on the shoulder. He turns. A finger points to the centerfold model, pink fleshy body, thin and sleek. . . . The other asks, mocking voice, "Hey, does she turn you on?"

The boy smiles, nodding meekly; turns away.

The other jabs him harder on the shoulder, "Hey, whatsamatter, don't you like girls?"

Laughter . . . unbearable din of laughter. . . . The laughter seems to go on forever. . . .

What did being a sissy really mean? It was a way of walking (from the hips rather than the shoulders); . . . of talking (often with a lisp or a high pitched voice); . . . of relating to others (gently, not wanting to fight, or hurt anyone's feelings). It was being intelligent . . . getting good grades. It means not being interested in sports, not playing football in the street after school; not discussing teams and scores and playoffs. And it involved not showing fervent interest in girls, not talking about scoring . . . not concealing naked women in your history books, or porno books in your locker.

On the other hand, anyone could be a "faggot." It was a catch-all. If you did something that didn't conform to what was acceptable behavior of the group . . . if you didn't get along with the "in" crowd, you were a faggot. It was the most commonly used put-down. It kept guys in line . . . The word had power. It toppled the male ego . . . violated the image he projected. He was tough. Without feeling. Faggot cut through all this. It made him vulnerable. Feminine. And feminine was the worst thing he could possibly be. Girls were fine for [sex], but no boy in his right mind wanted to be like them. A boy was the opposite of a girl. He was not feminine . . . not feeling . . . not weak.

Scene Five

. . . Realizing I was gay was not an easy task. Although I knew I was attracted to boys by the time I was about eleven, I didn't connect this attraction to homosexuality. I was not queer. Not I. I was merely appreciating a boy's good looks, his fine features, his proportions. It didn't matter that I didn't appreciate a girl's looks in the same way. There was no twitching in my thighs when I gazed upon a beautiful girl. But I wasn't queer.

I resisted that label—queer—for the longest time. Even when everything pointed to it, I refused to see it. I was certainly not queer. Not I.

Epilogue

The boy marching down the Parkway. Hundreds of queers. Signs proclaiming gay pride. Speakers. Tables with literature from gay groups. A miracle, he is thinking. Tears are coming loose now. Someone hugs him.

You could not control
The sissy in me
Nor could you exorcise him
Nor electrocute him
You declared him illegal illegitimate
Insane and immature
But he defies you still.

SOURCE: Avicolli 1985, 4–5.

timacy may be "homosexual" (Britton 1990; Garnets et al. 1990)

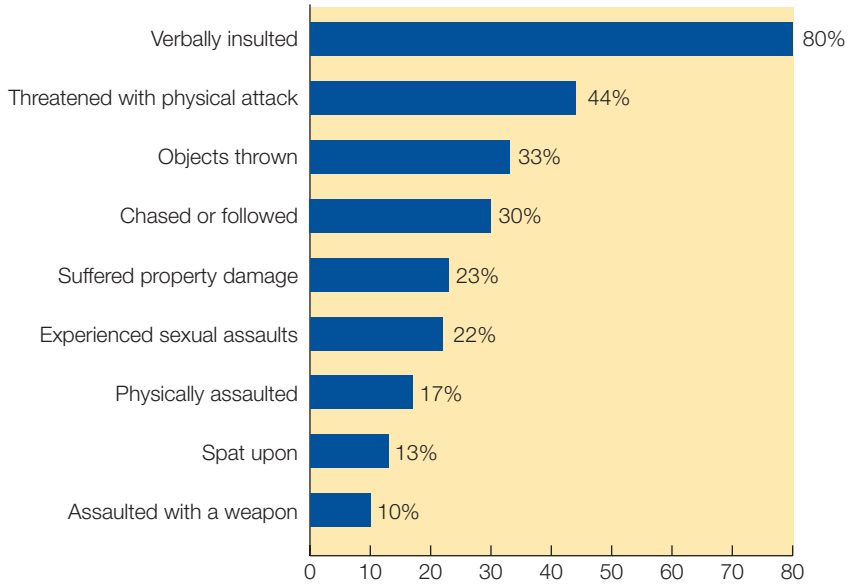
- Leading to exaggerated displays of masculinity by heterosexual men trying to prove they are not gay (Mosher and Tomkins 1988)

Education and positive social interactions appear to be important vehicles for changing attitudes and reducing hostility. Some research reveals increased tolerance following human sexuality courses (Stevenson 1990). Negative attitudes about homosexuality may also be reduced by arranging positive interactions between heterosexuals and gay men or lesbians, especially in settings of equal status, common goals, cooperation, and a moderate degree of intimacy. Such interactions may occur when family members or close friends come out. Other interactions may emphasize common group membership (religious, social, ethnic, or political, for example) on a one-to-one basis.

Bisexuality

As we noted earlier, bisexuals are individuals attracted to members of both genders. Asked what their bisexual identities meant to them, most of Paula Rust's respondents said it meant that they had "the potential to be sexually, emotionally and/or romantically attracted to members of both sexes or genders" (Rust 2004). For many it is the capacity or potential, not necessarily the actual experience that makes them identify themselves as bisexual. For some, bisexuality is

Figure 6.1 ■ Harassment and Mistreatment Experienced by Young Gay Males, Lesbians, and Bisexuals



SOURCE: Hershberger and D'Augelli 1995.

expressed in alternating relationships with women and men. Others have equal sexual relationships with women and men (for example, "I have a girlfriend, with whom I have sex often and am very attracted to, but am still attracted to men, with whom I also have sexual relations") (Rust 2004, 218). Still others base their self-definitions more on feelings than on any actual relationships, past or present (for example, "over 99% of my sexual interactions have been heterosexual. But I fantasize about women a great deal and enjoyed the one-on-one encounter I had") (Rust 2004).

■ *The hate-based killing of Matthew Shepherd inspired memorial demonstrations and raised awareness about the extent of homophobia in the United States.*

Becoming bisexual requires the rejection of two recognized categories of sexual identity: heterosexual and homosexual. In a nationwide study by Samuel and Cynthia Janus (1993), about 5% of men and 3% of women identified themselves as bisexual. Data from the comprehensive survey of sexual behavior in the United States, the National Health and Social Life Survey, reveal a smaller percentage (less than 1%) who self-identified themselves as bisexual. If we look at reports of "sexual attraction," 3.9% of men and 4.1% of women report themselves attracted to "mostly the opposite gender," both genders, or "mostly the same gender" (Laumann et al. 1994).

Because it is only since the 1980s that bisexuality has become more visible and bisexuals more politicized and organized, it shouldn't be surprising that research on the "bisexual experience" is less abundant than the similar literature on gays and lesbians (Herek 2002). What research we have indicates that, like gays and lesbians, bisexuals are often the targets of hostility and harassment. Herek, Gillis, and Cogan report that 15% of bisexual women and 27% of bisexual men in their sample had experienced a property or violent crime. These rates are similar to what was reported

by lesbians (19%) and gay men (28%). A Kaiser Family Foundation survey of 405 lesbians, gay men, and bisexuals found that among bisexuals, because of their sexual orientation, 60% had experienced some form of discrimination, 52% had suffered verbal abuse, and 26% felt that they were not accepted by their families. These percentages were lower than the comparable percentages for lesbians and gay men, suggesting that bisexuality may be somewhat less stigmatized than homosexuality (Herek 2002).

More negative attitudes toward bisexual men and women seem to be associated with certain individual characteristics, such as frequent attendance at religious services, a conservative political ideology, and having had minimal prior contact with bisexual men or women. These same factors are associated with heterosexual attitudes toward gay men and lesbians (Herek 2002).

Because they might be perceived as rejecting both heterosexuality and homosexuality, bisexuals can also be stigmatized by gay men and lesbians who might view bisexuals as "fence-sitters" not willing to admit their homosexuality or as people simply "playing" with their orientation (Herek 2002). Thus, bisexuality may not be taken seriously by either group. Loraine Hutchins and Lani Kaahumanu (1991) believe that bisexuality arouses hostility because it "challenges current assumptions about the immutability of people's orientations and society's supposed divisions into discrete groups."

Gregory Herek (2002) looked at the attitudes of heterosexuals toward bisexuals by having his sample of more than 1,270 men and women rate them on a "feeling thermometer." He asked them to rate on a scale of 0–100 a number of different groups, including religious groups (Protestants, Catholics, and Jews); gay men, lesbians, and bisexuals; racial, ethnic, and national groups (including blacks, Mexican Americans, Puerto Ricans, whites, and Haitians); pro-life and pro-choice groups; people with AIDS; and people who inject illegal drugs. Higher numbers reflect "warmer" feelings. If the respondents felt "neither warm nor cold," they were instructed to rate a group with a 50. His results are shown in Table 6.2.

Bisexual women and men received similar but lower ratings than the average "feeling scores" for lesbian and gay men. The only group to receive "colder" ratings than bisexual women (45.8) and men (43.4) was illegal drug users (21.0). More than 400 people rated illegal drug users with the "coldest" possible score of zero. The two groups who had the next highest number of zero ratings were gay men (134) and bisexual men (140). Ratings for lesbians were more favorable than ratings for gay men, and among bisexuals, women received "warmer" scores than did bisexual men (Herek 2002).

Table 6.2 ■ "Feeling Thermometer" Measuring Attitudes toward Gays, Lesbians, Bisexuals, and Other Groups

Thermometer Target	Average Rating	# of Extreme Scores	
		# Coldest (rating of 0)	# Warmest (rating of 100)
Whites	70.4	1	223
Catholics	67.7	2	230
Blacks	66.8	4	190
Protestants	66.5	3	210
Mexican Americans	64.9	5	167
Jews	64.8	3	167
Puerto Ricans	63.5	7	162
Haitians	60.5	8	143
Pro-lifers	56.3	54	146
People with AIDS	55.6	48	96
Pro-choice people	53.3	116	117
Lesbians	47.5	116	57
Gay men	46.1	134	63
Bisexual women	45.8	116	57
Bisexual men	43.4	140	54
People who inject illegal drugs	21.0	414	19

Becoming Bisexual

There is considerable HIV and AIDS research on bisexual behavior among men who identify themselves as heterosexual, but compared with research on gay men and lesbians there is much less research on bisexuality. In 1994, the first model of bisexual identity formation was developed (Weinberg, Williams, and Pryor 1994). According to this model, bisexual women and men go through four stages in developing their identity:

1. *Initial confusion.* This may last years. People may be distressed by being sexually attracted to both sexes, may believe that their attraction to the same sex means an end to their heterosexuality, or may be disturbed by their inability to categorize their feelings as either heterosexual or homosexual.
2. *Finding and applying the bisexual label.* For many, discovering there is such a thing as bisexuality is a turning point. Some find that their first heterosexual or same-sex experience permits them to view sex with both sexes as pleasurable; others learn of the term *bisexuality* from friends and are able to apply it to themselves.
3. *Settling into the identity.* At this stage, bisexuals begin to feel at home with and accept the bisexual label.
4. *Continued uncertainty.* Bisexuals don't have a community or social environment that reaffirms their identity. Despite being settled in, many feel persistent pressure from gay men and lesbians to relabel themselves as homosexual and to engage exclusively in same-sex activities.

Sexuality in Adulthood

Psychosexual development and change does not end in young adulthood. It continues throughout our lives. In middle age and old age, our lives, bodies, sexuality, relationships, and environment continue to change. New tasks and new satisfactions arise to replace or supplement older ones.

Developmental Tasks in Middle Adulthood

In the middle adult years, some tasks of psychosexual development begun, but only partly completed, or deferred in young adulthood (for example, issues surrounding intimacy or childbearing) may continue. Because of separation or divorce, we may find ourselves facing the same intimacy and commitment tasks at age 40 that we thought we completed 15 years earlier (Cate and Lloyd 1992). But life does not stand still; it moves steadily forward, whether we're ready or not. Other developmental issues appear, including the following:

- *Redefining sex in marital or other long-term relationships.* In new relationships, sex is often passionate, intense, and may be the central focus. But in long-term marital or cohabiting relationships, the passionate intensity associated with sex is often eroded by habituation, competing parental and work obligations, fatigue, and unresolved conflicts. Sex may need to be redefined as a form of intimacy and caring. Individuals may also need to decide how to deal with the possibility, reality, and meaning of extramarital or extrarelational affairs.
- *Reevaluating sexuality.* Single men and women may need to weigh the costs and benefits of sex in casual or lightly committed relationships. In long-term relationships, sexuality often becomes less central to relationship satisfaction. Nonsexual elements, such as communication, intimacy, and shared interests and activities, become increasingly important to relationships. Women who have deferred their childbearing begin to reappraise their decision: Should they remain childfree, "race" against their biological clocks, or adopt a child?
- *Accepting the biological aging process.* As we age, our skin wrinkles, our flesh sags, our hair grays (or falls out), our vision blurs—and we become in the eyes of society less attractive and less sexual. By our 40s, our physiological responses have begun to slow noticeably. By our 50s, society begins to "neuter" us, especially if we are women who have gone through menopause. The challenges of aging are to accept its biological mandate and to reject the stereotypes associated with it.

Sexuality and Middle Age

Men and women view and experience aging differently. As men approach their 50s, they fear the loss of their sexual capacity but not their attractiveness; for women the reverse is true. As both age, purely psychological stimuli, such as fantasies, become less effective for arousal. Physical stimulation remains effective, however.

Among American women, sexual responsiveness continues to grow from adolescence until it reaches its peak in the late 30s or early 40s; it is usually maintained near the same level into the 60s and beyond. Data from both the United States and elsewhere have yielded inconsistent research findings on women's sexuality at midlife. Some studies suggest that rates of sexual intercourse, levels of sexual interest, frequency of orgasm, extent of sexual fantasizing, vaginal lubrication, and satisfaction with a partner all decline in midlife. Others show no decline in sexual interest, responsiveness, or "functioning." About the only thing that can be safely concluded is that considerable variability occurs in midlife women's sexuality.

Having emotional and psychological needs met (feeling attractive, appreciated, independent, understood, and productive) is related both to feeling attractive and to satisfaction with one's sex life. Frequency of intercourse and orgasm and finding sex pleasant, enjoyable, and satisfying are associated with higher levels of marital adjustment and contentment, although it is not clear whether marital quality causes or follows sexual satisfaction (Fraser, Maticka-Tyndale, and Smylie 2004).

Data from the United States, Great Britain, and France indicate age differences that may be the result of cohort differences (based on differences in sexual socialization and changing cultural attitudes) or possible effects of aging (Table 6.3).

In addition to age differences in whether and how often women report having engaged in sexual intercourse, data from the 1994 Sex in America survey reveal information about sexual problems or dysfunctions for women of different ages (see Table 6.4). We can see the effect of aging on women's sexuality in a number of reported dysfunctions.

As these data reveal, relative to other ages, high levels of orgasmic difficulty, lack of pleasure and interest, and trouble with vaginal lubrication are reported by 55- to 59-year-olds. Keep in mind that these data are from "sexually active women" and as such may even understate the effect of aging, as more women may become sexually inactive as they move through their 40s and into their 50s. Sexually inactive women and any problems they have that might cause them to refrain from sex are not represented in this data (Fraser, Maticka-Tyndale, and Smylie 2004).

Around the age of 50, the average American woman begins **menopause,** which is marked by a cessation of the menstrual cycle and an end to fertility. Menopause is not a sudden event. Usually, for several years preceding menopause, the menstrual cycle becomes increasingly irregular. Menopause does not end interest in sexual activities. The decrease in estrogen, however, may cause thinning and dryness of the vaginal walls, which makes intercourse painful. The use of vaginal lubricants will remedy much of the problem.

There is no male equivalent to menopause. Male fertility slowly declines, but men in their 80s are often fertile. Men's physical responsiveness is greatest in late adolescence or early adulthood; beginning in men's 20s, responsiveness begins to slow imperceptibly. Changes in male sexual responsiveness become apparent only when men are in their 40s and 50s. As a man ages, achieving erection requires more stimulation and time and the erection may not be as firm. In a subsequent section we examine some drugs used for erectile dysfunctions. For now, however, the point is that because of physical changes, "middle-aged couples may be misled into thinking that this change heralds a sexual decline as an accompaniment to aging" (Katchadourian 1987).

Table 6.3 ■ Women Reporting Intercourse in Past Year

	Percentage in Past Year			Mean Frequency in Past Month	
Age	U.S.	France	Great Britain	U.S.	France
35–44	87%	96%	92%	5.8	8.1
45–54	82%	90%	78%	5.0	6.1
55–59	59%	66%	NA	3.5	4.0

NA means data not available.
SOURCE: Fraser, Maticka-Tyndale, and Smylie, 2004.

Table 6.4 ■ Percentage of Sexually Active U.S. Women Reporting Various Sexual Dysfunctions

Age	Pain	Not Pleasurable	Unable to Orgasm	Lack of Interest	Trouble Lubricating
35–39	13.0	18.3	26.9	37.6	18.1
40–44	12.0	15.7	20.8	36.0	15.9
45–49	10.3	15.4	18.8	33.7	22.6
50–54	7.4	15.3	20.2	30.2	21.4
55–59	8.7	16.4	21.8	37.0	24.8

SOURCE: Laumann et al., 1994.

Table 6.5 ■ Age and Sexual Desire for Men and Women

	Women		Men	
Age	% Low Desire	% High Desire	% Low Desire	% High Desire
60–64	23.26	13.85	18.29	4.89
65–69	26.92	10.26	21.13	5.63
70–74	46.05	7.90	38.00	2.00
75–79	49.12	5.26	27.08	2.08
80–84	85.29	2.94	50.0	3.85
85–89	73.0	0.0	50.0	0.0
90–94	100.0	0.0	NA	NA

SOURCE: DeLamater and Sill 2005.
NA means data not available.

Psychosexual Development in Later Adulthood

As we leave middle age, new tasks confront us, especially dealing with the process of aging itself. Our health and the presence or absence of a partner are key aspects of this time in our lives.

Developmental Tasks in Later Adulthood

Many of the psychosexual tasks older Americans must undertake are directly related to the aging process:

- *Changing sexuality.* As physical abilities change with age, sexual responses change as well. A 70-year-old person, although still sexual, is not sexual in the same manner as an 18-year-old. Sexuality tends to be more diffuse, less genital, and less insistent. Chronic illness and increasing frailty understandably result in diminished sexual activity and desire (see Table 6.5). These considerations contribute to the ongoing evolution of the individual's sexual philosophy.
- *Loss of partner.* One of the most critical life events is the loss of a partner. After age 60, there is a significant increase in spousal deaths. As having a partner is the single most important factor determining an older person's sexual interactions, the death of a partner signals a dramatic change in the survivor's sexual interactions.

The developmental tasks of later adulthood are accomplished within the context of continuing aging. Their resolution helps prepare us for acceptance of our own eventual mortality.

Adult Sexual Behavior

In this section we examine various sexual behaviors. For a discussion of sexual structure and the sexual response cycle, see Appendix A on the book website.

Keri Pickett

■ *Sexuality among the aged tends to be sensual and affectionate. Older couples may experience an intimacy forged by years of shared joys and sorrows that is as intense as the passion of young love.*

Autoeroticism

Autoeroticism consists of sexual activities such as sexual fantasies, masturbation, and erotic dreams that involve only the self. Autoeroticism is one of our earliest and most universal, yet also less accepted, expressions of sexual stirrings. By condemning it, our culture sets the stage for the development of deeply negative inhibitory attitudes toward sexuality.

Sexual Fantasies

Erotic fantasizing is probably the most universal of all sexual behaviors, but because they may touch on feelings or desires considered personally or socially unacceptable, typically they are not widely discussed. Although fantasies are normal and serve certain functions (such as escape or rehearsal for later sexual behavior), they may also interfere with an individual's self-image, causing a loss of self-esteem, as well as confusion.

Various studies report that between 60% and 90% of respondents fantasize during sex—the percentage depending on gender, age, and ethnicity (Miracle, Miracle, and Baumeister 2003; Knafo and Jaffe 1984; Price and Miller 1984). A large-scale study (Michael et al. 1994) found that 54% of the men and 19% of the women thought about sex daily.

Women and men have sexual fantasies, although their fantasies often differ. Can you tell the gender of the individuals who supplied the following fantasies?

- "A tropical island. I've always dreamed about making love in a crystal blue sea, with a waterfall in the background, then moving on shore to a white, sandy beach."
- "It's eveningtime [sic], the sun is setting, I'm on a tropical island, a light breeze is blowing into my balcony doors and the curtains [white] are fluttering lightly in the wind. The room is spacious and there is white everywhere, even the bed. There are flowers of all kinds and the light fragrance fills the room."
- "Ménage à trois."
- "Have sex on the beach."

If you guessed that the first two fantasies are from women and the third and fourth are from men, you guessed correctly. These are real examples that Michael Kimmel and Rebecca Plante received from undergraduates at three New York colleges or universities.

Men's and women's fantasies contained similarities (for example, in the acts they described), but the differences were more striking: women's fantasies were longer and more vivid, using more emotional and sensual imagery, especially in describing the setting; men

more often fantasized about *doing something sexual to someone,* whereas women's fantasies were often more passive and gentler, of *having something sexual done to them;* and women's fantasies tended to have more emotional and romantic content (47% of women described their fantasy partners as boyfriends or husbands; only 15% of men depicted their fantasy partners as "significant others"). Women's fantasies were also often romantic stories of love and affection, men's had less romance and less emotional language or context.

Masturbation

Masturbation is the manual stimulation of one's genitals. Individuals masturbate by rubbing, caressing, or otherwise stimulating their genitals to bring themselves sexual pleasure. Masturbation is an important means of learning about our bodies. Girls, boys, women, and men may masturbate during particular periods or throughout their entire lives. An analysis of research articles on gender roles and sexual behavior found that the greatest male–female difference was in masturbation (Oliver and Hyde 1993). Males had significantly more masturbatory experience than females.

By the end of adolescence, virtually all males and about two-thirds of females have masturbated to orgasm (Knox and Schacht 1992; Lopresto, Sherman, and Sherman 1985). Masturbation continues after adolescence. Gender differences, however, continue to be significant (Atwood and Gagnon 1987; Leitenberg, Detzer, and Srebnik 1993).

Although the rate is significantly lower for those who are married, many people, especially men, continue to masturbate even after they marry. There are many reasons for continuing the activity during marriage: masturbation is a pleasurable form of sexual excitement; a spouse may be away or unwilling to engage in sex; sexual intercourse may not be satisfying; the partners may fear sexual inadequacy; one partner may want to act out fantasies. In marital conflict, masturbation may act as a distancing device, with the masturbating spouse choosing masturbation over sexual intercourse as a means of emotional protection (Betchen 1991).

Cohabitation has a different effect than marriage on frequency of masturbation. Many cohabiting men masturbate often, despite the presence or availability of a sexual partner. Thus, social factors other than the presence of a partner affect masturbation. In citing reasons for why they masturbate, only a third of women and men list an unavailable partner (Laumann et al. 1994).

Matter of Fact

A study of college students in a human sexuality class found that 87% of the men and 58% of the women had masturbated (Knox and Schacht 1992). In a larger study, among adults of all ages, 63% of the men and 42% of the women had masturbated in the previous year (Michael et al. 1994).

Interpersonal Sexuality

We often think that sex is sexual intercourse and that sexual interactions end with orgasm (usually the male's). But sex is not limited to sexual intercourse. Heterosexuals engage in a variety of sexual activities, which may include erotic touching, kissing, and oral and anal sex. Except for sexual intercourse, gay and lesbian couples engage in sexual activities similar to those experienced by heterosexuals.

Touching

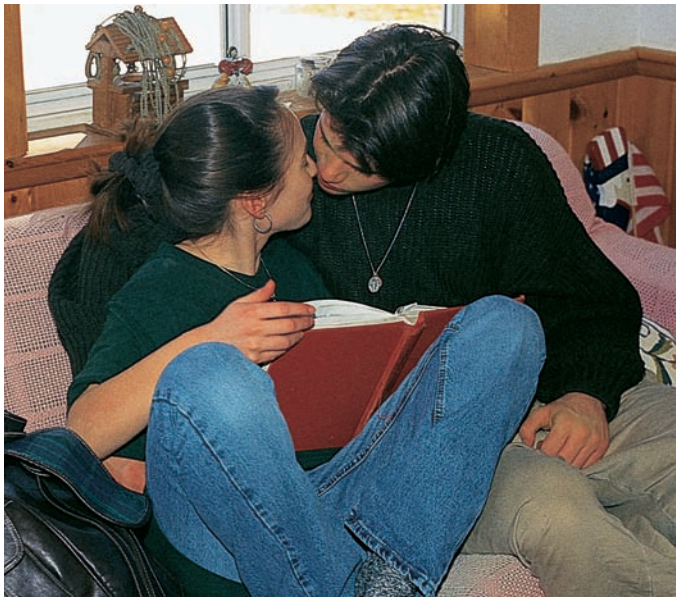
Because touching, like desire, does not in itself lead to orgasm, it has largely been ignored as a sexual behavior. Sex researchers William Masters and Virginia Johnson (1970) suggest a form of touching they call **pleasuring**—nongenital touching and caressing. Neither partner tries to stimulate the other sexually; the partners simply explore each other. Such pleasuring gives each a sense of his or her own responses; it also allows each to discover what the other likes or dislikes. We can't assume we know what any particular individual likes because there is too much variation among people. Pleasuring opens the door to communication; couples discover that the entire body is erogenous, rather than just the genitals.

As we enter old age, touching becomes increasingly significant as a primary form of erotic expression. Touching in all its myriad forms—ranging from holding hands to caressing, massaging to hugging, walking with arms around each other to fondling—becomes the touchstone of eroticism for the elderly. One study found touching to be the primary form of erotic expression for married couples more than 80 years old (Bretschneider and McCoy 1988).

Kissing

Kissing as a sexual activity is probably the most common and acceptable of all premarital sexual activities, occurring in more than 90% of all cultures (Jurich and Polson 1985; Fisher 1992, cited in Miracle, Miracle, and Baumeister 2003). The tender lover's kiss symbolizes love, and the erotic lover's kiss simultaneously represents passion. Both men and women in one study regarded kissing as a romantic act, a symbol of affection and attraction (Tucker, Marvin, and Vivian 1991). A cross-cultural study of jealousy found that kissing is also associated with a couple's boundary maintenance: In each culture studied, kissing a person other than the partner evoked jealousy (Buunk and Hupka 1987).

The lips and mouth are highly sensitive to touch. Kisses discover, explore, and excite the body. They also involve the senses of taste and smell, which are especially important because they activate unconscious memories and associations. Often we are aroused by familiar smells associated with particular sexual memories: a person's body smells, perhaps, or perfumes associated with erotic experiences. In some cultures—among the Borneans, for example—the word *kiss* literally translates as "smell." Among traditional Eskimos and Maoris there is no mouth kissing, only the nuzzling that facilitates smelling.



■ *Kissing is probably the most acceptable premarital sexual activity.*

Although kissing may appear innocent, it is in many ways the height of intimacy. The adolescent's first kiss is often regarded as a milestone, a rite of passage, the beginning of adult sexuality (Alapack 1991). Philip Blumstein and Pepper Schwartz (1983) report that many of their respondents found it unimaginable to engage in sexual intercourse without kissing. They found that those who have a minimal (or nonexistent) amount of kissing feel distant from their partners but engage in coitus nevertheless as a physical release.

The amount of kissing differs according to orientation. Lesbian couples tend to engage in more kissing than heterosexual couples, and gay male couples kiss less than heterosexual couples. As many as 95% of lesbian couples, 80% of heterosexual couples, and 71% of gay couples engage in kissing whenever they have sexual relations (Blumstein and Schwartz 1983).

Oral-Genital Sex

In recent years, oral sex has become part of our sexual scripts. It is engaged in by heterosexuals, gay men, and lesbians. The two types of oral–genital sex are cunnilingus and fellatio. **Cunnilingus** is the erotic stimulation of a woman's vulva by her partner's mouth and tongue. **Fellatio** is the oral stimulation of a man's penis by his partner's sucking and licking. Cunnilingus and fellatio may be performed singly or simultaneously. Oral sex is an increasingly common part of adolescent and young adult sexual development, as we noted earlier. It is also an important and healthy aspect of adults' sexual selves (Wilson and Medora 1990).

Although oral–genital sex is increasingly accepted by Caucasian middle-class Americans, it remains less permissible and less commonly practiced among certain ethnic groups. African Americans and Latinos, have lower rates of oral genital sex than do Caucasians (Wilson 1986; Wyatt and Lyons-Rowe 1990, Laumann et al. 1994). Although less is known about older Asian Americans and Asian immigrants, college-age Asian Americans appear to accept oral–genital sex to the same degree as middle-class Caucasians (Cochran, Mays, and Leung 1991).

Among both sexes, the same percentages report receiving and performing oral sex (Laumann et al. 1994). A study of university students of both sexes found that oral sex was regarded as an egalitarian, mutual practice (Moffatt

1989). Students felt less guilty about it than about sexual intercourse because oral sex was not "going all the way."

Sexual Intercourse

Sexual intercourse or **coitus**—the insertion of the penis into the vagina and subsequent stimulation—is a complex interaction. As with many other types of activities, the anticipation of reward triggers a pattern of behavior. The reward may not necessarily be orgasm, however, because the meaning of sexual intercourse varies considerably at different times for different people. There are many motivations for sexual intercourse; sexual pleasure is only one. Other motivations include showing love, having children, gaining power, ending an argument, demonstrating commitment, seeking revenge, proving masculinity or femininity, or degrading someone (including oneself).

Although sexual intercourse is important for most sexually involved couples, its significance is different for men and women. More than any other heterosexual sexual activity, sexual intercourse involves equal participation by both partners. Ideally, both partners equally and simultaneously give and receive. Many women report that this sense of sharing during intercourse is important to them.

Men tend to be more consistently orgasmic than women in sexual intercourse. Part of the reason may be that the clitoris often does not receive sufficient stimulation from penile thrusting alone to permit orgasm. Many women need manual stimulation during intercourse to be orgasmic. They may also need to be more assertive. A woman can manually stimulate herself or be stimulated by her partner before, during, or after intercourse. But to do so, she has to assert her own sexual needs and move from the idea that sex is centered around male orgasm.

Matter of Fact

According to a scientific, nationwide study of adults of all ages, about one-third of Americans have sexual intercourse twice a week, one-third a few times a month, and one-third a few times a year or not at all. Married couples are more likely to engage in coitus than singles; married women are more likely to be orgasmic. About 40% of married couples and 25% of singles report having coitus twice a week (Michael et al. 1994).

Anal Eroticism

Sexual activities involving the anus are known as **anal eroticism.** The male's insertion of his erect penis into his partner's anus is known as **anal intercourse.** Both heterosexuals and gay men may participate in this activity. For heterosexual couples who engage in it, anal intercourse is generally an experiment or occasional activity rather than a common mode of sexual expression. About 10% of men and 9% of women report engaging in anal sex in the previous year (Michael et al. 1994), and one in four men and one in five women reported having ever experienced anal sex (Laumann et al. 1994).

Anal intercourse is less common than oral sex but remains an important ingredient in the sexual satisfaction of many gay men (Blumstein and Schwartz 1983). From a health perspective, anal intercourse is the riskiest form of sexual interaction and the most prevalent sexual means of transmitting the HIV among both gay men and heterosexuals. Because the delicate rectal tissues are easily torn, HIV (carried within semen) can enter the bloodstream. (HIV will be discussed later in the chapter.)

Sexual Enhancement

Sexual behavior cannot be isolated from our personal feelings and relationships. Sometimes dissatisfaction arises because the relationship itself is unsatisfactory, other times the relationship itself is good but the erotic fire needs to be lit or rekindled. Such relationships may grow through **sexual enhancement**—improving the quality of a sexual relationship—which, according to noted sex therapist Bernie Zilbergeld (1992), consists of the following:

- Accurate information about sexuality, especially your own and your partner's.
- An orientation toward sex based on pleasure (including arousal, fun, love, and lust) rather than on performance and orgasm.
- Being involved in a relationship that allows each person's sexuality to flourish.
- An ability to communicate verbally and nonverbally about sex, feelings, and relationships.
- Being equally assertive and sensitive about your own sexual needs and those of your partner.
- Accepting, understanding, and appreciating differences between partners.

Being aware of our sexual needs is often critical to enhancing our sexuality. Gender-role stereotypes and negative learning about sexuality often cause us to lose sight of our sexual needs. Zilbergeld (1993) suggests that to fully enjoy our sexuality, we need to explore our "conditions for good sex," those things that make us "more relaxed, more comfortable, more confident, more excited, more open to your experience."

Different individuals report different conditions for good sex. More common conditions include the following:

- *Feeling intimate with your partner.* Emotional distance can take the heart out of sex.
- *Feeling sexually capable.* Generally this relates to an absence of anxieties about sexual performance
- *Feeling trust.* Both partners may need to know they are emotionally safe with the other and confident that they will not be judged, ridiculed, or talked about.
- *Feeling aroused.* A person does not need to be sexual unless he or she is sexually aroused or excited. Simply because your partner wants to be sexual does not mean that you have to be.
- *Feeling physically and mentally alert.* Both partners should not feel particularly tired, ill, stressed, preoccupied, or under the influence of excessive alcohol or drugs.
- *Feeling positive about the environment and situation.* A person may need privacy, to be in a place where he or she feels protected from intrusion.

Common conditions for a satisfying sexual relationship include feelings of intimacy, capability, trust, arousal, alertness, and positiveness about the environment and situation.

Sexual Expression and Relationships

Sexuality exists in various relationship contexts that may influence our feelings and activities. These include nonmarital, marital, and extramarital contexts.

Nonmarital Sexuality

Nonmarital sex encompasses sexual activities, especially sexual intercourse, that take place outside of marriage. We use the term *nonmarital sex* rather than *premarital sex* to describe sexual behavior among unmarried adults in general. When we use the term **premarital sex** we are referring to never-married adults under the age of 30. There are several reasons to make premarital sex a subcategory of nonmarital sex. First, because increasing numbers of never-married adults are over 30, "premarital sex" does not adequately describe the nature of their sexual activities. Second, at least 10% of adult Americans will never marry; it is misleading to describe their sexual activities as "premarital." Third, many adults are divorced, separated, or widowed; 30% of divorced women and men will never remarry. Fourth, between 3% and 10% of the population is lesbian or gay, and gay and lesbian sexual relationships cannot be categorized as "premarital" until gays and lesbians are given the right to marry.

Sexuality in Dating Relationships

Over the last several decades, there has been a remarkable increase in the acceptance of premarital sexual intercourse, a decline in the numbers of people who believe that premarital sex is "always wrong," and an increase in the percentages who feel it is "not wrong at all." This trend has been interpreted as a shift toward "moral neutrality" regarding intercourse before marriage (Christopher and Sprecher 2000).

For adolescents and young adults, the combination of effective birth control methods, changing gender roles that permit females to be sexual, and delayed marriages have played a major part in the rise of premarital sex. For middle-aged and older adults, increasing divorce rates and longer life expectancy have created an enormous pool of once-married men and women

who engage in nonmarital sex. Only **extramarital sex**—sexual interactions that take place outside the marital relationship—continues to be consistently frowned upon.

The increased legitimacy of sex outside of marriage has transformed both dating and marriage. Sexual intercourse has become an acceptable part of the dating process for many couples, whereas only petting was acceptable before. As a consequence, many people no longer feel that they need to marry to express their sexuality in a relationship (Scanzoni et al. 1989).

There appears to be a general expectation among students that they will engage in sexual intercourse sometime during their college careers. Although college students expect sexual involvement to occur within an emotional or loving relationship (Robinson et al. 1991), this emotional connection may be relatively transitory.

FACTORS LEADING TO PREMARITAL SEXUAL INVOLVEMENT. Examining the sexual decision making process closely, researcher Susan Sprecher (1989) identifies individual, relationship, and environmental factors affecting the decision to have premarital intercourse:

- *Individual factors.* Those with more premarital sexual experience, with more liberal sexual attitudes, and who do not feel high levels of guilt about sexuality are more likely to engage in sex, as are those who value erotic pleasure. Men tend to initiate sexual activity more than women, but both women and men use similar tactics to initiate sex (implying commitment, increasing attention, and displaying "status cues"). There is a gender difference in "compliance" with partner-initiated sex, such that women are more likely than men to comply, and they do it to maintain their relationships (Christopher and Sprecher 2000).
- *Relationship factors.* Two of the most important factors determining sexual activity in a relationship are the level of intimacy and the length of time the couple has been together. Even those with less permissive sexual attitudes accept sexual involvement if the relationship is emotionally intimate and long standing. Less committed individuals are less likely to make their relationships sexual. Finally, people in relationships in which power is shared equally are more likely to be sexually involved than those in inequitable relationships.
- *Environmental factors.* The opportunity for sex may be precluded by the presence of parents, friends, roommates, or children (Tanfer and Cubbins 1992). The cultural environment, too, affects premarital sex. The values of parents or peers may encourage or discourage sexual involvement. A person's ethnic group also affects premarital involvement. Generally, African Americans are more permissive than Caucasians, and Latinos are less permissive than non-Latinos (Baldwin, Whitely, and Baldwin 1992). Furthermore, a person's subculture—such as the university or church environment or the gay and lesbian community—influences sexual decision making.

INITIATING A SEXUAL RELATIONSHIP. After we meet someone, we weigh each other's attitudes, values, and philosophy to see if we are compatible. If the relationship continues in a romantic vein, we may include physical intimacy. To signal the transition from nonphysical to physical intimacy, one of us must make the first move, marking the transition from a potentially sexual relationship to an actual one.

According to traditional gender-role patterns, as described earlier, males make the first move to initiate sexual intimacy, whether it is kissing, petting, or engaging in sexual intercourse (O'Sullivan and Byers 1992). Initial sexual involvement can occur as early as the first meeting or much later as part of a well-established relationship. Some people become sexually involved immediately ("lust at first sight"), but most being their sexual involvement in the context of an ongoing relationship. Even in one-night stands or short-term affairs, more couples knew each other at least a year before engaging in sex than knew each other just for a couple or few days (Miracle, Miracle, and Baumeister 2003).

DIRECTING SEXUAL ACTIVITY. As we begin a sexual involvement, we have several tasks to accomplish:

1. *We need to practice safe sex.* Ideally, we need information about our partners' sexual history and whether he or she practices safe sex, including the use of condoms. Unlike much of our sexual communication, which is nonverbal or ambiguous, we need to use direct verbal discussion in practicing safe sex.
2. *Unless we are intending a pregnancy, we need to discuss birth control.* Condoms alone are only moderately effective as contraception, although they help prevent the spread of sexually transmitted diseases. To be more effective, they must be used with contraceptive foam or jellies or with other devices.

3. *We need to communicate about what we like and need sexually.* What kind of foreplay or afterplay do we like? Do we like to be orally or manually stimulated during intercourse? What does each partner need to be orgasmic? Many of our needs and desires can be communicated nonverbally by our movements or other physical cues. But if our partner does not pick up our nonverbal signals, we need to discuss them directly and clearly to avoid ambiguity.

Sexuality in Cohabiting Relationships

As shown in Chapter 8, cohabitation has become a widespread phenomenon in American culture. In contrast to married men and women, cohabitants have sexual intercourse more often, are more egalitarian in initiating sexual activities, and are more likely to be involved in sexual activities outside their relationship (Waite and Gallagher 2001; Blumstein and Schwartz 1983). The higher frequency of intercourse, however, may be because of the "honeymoon" effect: Cohabitants may be in the early stages of their relationship, the stages when sexual frequency is highest. The differences in frequency of extrarelational sex may result from a combination of two factors: Norms of sexual fidelity may be weaker in cohabiting relationships, and men and women who cohabit tend to conform less to conventional norms.

Sexuality in Gay and Lesbian Relationships

Because of their socialization as males, gay men are likely to initiate sexual activity earlier and more often in the relationship than are lesbians. This is largely because both partners are free to initiate sex and because men are not expected to refuse sex, as women are (Isensee 1990). Lesbians may feel uncomfortable initiating sex because women are not socialized to do so.

In both gay and lesbian relationships, the more emotionally expressive partner is likely to initiate sexual interaction. The partner who talks more about feelings and who spontaneously gives the partner hugs or kisses is the one who more often begins sexual activity.

One of the major differences between heterosexuals and gay men and lesbians is in how they handle extrarelational sex. In the gay and lesbian culture, sexual exclusivity is more negotiable and not necessarily equated with commitment or fidelity among gay men, although it often is among lesbians (Renzetti and Curran 1995). As a result of these differing norms, gay men and lesbians must decide early in the relationship whether they will be sexually exclusive (Isensee 1990). If they choose to have a nonexclusive relationship, they need to discuss how outside sexual interests will be handled. They need to decide whether to tell each other, whether to have affairs with friends, what degree of emotional involvement will be acceptable, and how to deal with jealousy.

Marital Sexuality

When people marry, they discover that their sexual life is different than it was before marriage. Sex is now morally and socially sanctioned. It is in marriage that most heterosexual interactions take place, yet as a culture we seem ambivalent about marital sex. On the one hand, marriage is the only relationship in which sexuality is fully legitimized. On the other hand, marital sex is an endless source of humor and ridicule: "Marital sex? What's that?" On television, more sexual encounters portrayed are between unmarried than married couples. An early 1990s study found four times as much extramarital sex depicted as marital sex (Hanson and Knopes 1993).

Sexual Interactions

A variety of large-scale studies report consistent findings in regard to how often married couples engage in sexual intercourse and in how sexual frequency changes over the course of a marriage. Married couples report engaging in sexual relations about once or twice a week, or about six to seven times a month (Christopher and Sprecher 2003).

Sexual intercourse tends to diminish in frequency the longer a couple is married. For newly married couples, the average rate of sexual intercourse is about three times a week. Data from more than 13,000 respondents in the National Survey of Families and Households reported that couples under the age of 24 had sex on average 11.7 times per month (or approximately three times per week). (Call, Sprecher, and Schwartz 1995, cited in Christopher and Sprecher 2000). As couples get older, sexual frequency drops. In early middle age, married couples make love an average of 1.5 to 2 times a week. After age 50, the rate is about once a week or less. Among couples 75 and older, the frequency is a little less than once a month (Christopher and Sprecher 2000).

This decreased frequency, however, does not necessarily mean that sex is no longer important or that the marriage is unsatisfactory. For dual-worker families and families with children, fatigue and lack of private time may be the most significant factors in the decline of frequency (Olds 1985). Couples also report "being accustomed" to each other. In addition, activities and interests other than sex engage them. The decline in interest and frequency of sex may begin within the first 2 years of marriage (Christopher and Sprecher 2000).

Bringing New Meanings to Sex

Sex within marriage is significantly different from premarital sex in at least three ways: it is expected to be monogamous; procreation is a legitimate goal; and such sex takes place in the everyday world. These differences present each person with important tasks.

MONOGAMY. One of the most significant factors shaping marital sexuality is the expectation of monogamy. Before marriage or following divorce a person may have various sexual partners, but within marriage all sexual interactions are expected to take place between the spouses. Approximately 90% of Americans believe extramarital sexual relations are "always" or "almost always" wrong (Miracle, Miracle, and Baumeister 2003; Christopher and Sprecher 2000). This expectation of monogamy lasts a lifetime; a person marrying at 20 commits to 40 to 60 years of sex with the same person. Within a monogamous relationship, each partner must decide how to handle fantasies, desires, and opportunities for extramarital sexuality. Do you tell your spouse that you have fantasies about other people? Do you have an extramarital relationship? If you do, do you tell your spouse? How do you handle sexual conflicts or difficulties with your partner?

SOCIALLY SANCTIONED REPRODUCTION. Sex also takes on a procreative meaning within marriage. In most segments of society, marriage remains the more socially approved setting for having children. In marriage, partners are confronted with one of the most crucial decisions they will make: the task of deciding whether and when to have children. Having children will profoundly alter a couple's relationship. If they decide to have a child, lovemaking may change from simply an erotic activity to an intentionally reproductive act as well.

CHANGED SEXUAL CONTEXT. The sexual context changes with marriage. Because married life takes place in a day-to-day living situation, sex must also be expressed in the day-to-day world. Sexual intercourse must be arranged around working hours and at times when the children are at school or asleep. One or the other partner may be tired, frustrated, or angry.

Two examples from interviews one of this book's authors did illustrate this quite vividly. In the first, a 33-year-old father of one contrasted where he and his wife prioritized sex:

> It's more important to me than to my wife . . . My wife always says, "I can't just have sex like you. Everything's gotta be . . . you know, the dishes gotta be washed, the place has gotta be cleaned. I got a thousand things on my mind." I say, "Yeah, well I got a thousand things on my mind too, but the first thing is sex!" They [women] can't do that.

However, in a second example, a 30-year-old husband describes life before and after marriage:

> You don't think of [this] when you're single. You go out with the guys, you work all day, then you go out and play basketball for a couple of hours, afterward you go out, have a couple of beers, come home exhausted, and just plop into bed. Nobody's there to complain. Do the same thing when you're married, and you come home and your wife says, "Hi sweetheart. How about tonight?" You say, "Aaaaahhhhh . . . I'm really exhausted, honey, please. . . ." And she says, "But that's what you said last night." . . . After we got married, the honeymoon came and went fine, but then you get into your routine. And I'm not one of those guys who can handle that every night. When I go to bed I like to go to sleep. (Cohen 1986)

In marriage, some emotions associated with premarital sex may disappear. For many, the passion of romantic love, especially as experienced in the earliest period of a relationship, eventually disappears as well, to be replaced with a love based on intimacy, caring, and commitment. The relationship rests more on qualities that we earlier identified as *companionate love.* Still, as humorist Garrison Keillor (1994) reminds us, even within the changed context marital sex can be intensely gratifying:

> Despite jobs and careers that eat away at their evenings and weekends and nasty whiny children who dog their footsteps and despite the need to fix meals and vacuum the carpet and pay bills, [married] couples still manage to encounter each other regularly in a lustful, inquisitive way and throw their

clothes in the corner and do thrilling things in the dark and cry out and breathe hard and afterward lie sweaty together feeling *extreme pleasure.*

Matter of Fact

Between 20% and 25% of American men and 10% to 15% of American women reported having extramarital affairs (Christopher and Sprecher 2000).

Relationship Infidelity and Extramarital Sexuality

As we noted, a fundamental assumption in our culture is that marriages are sexually and emotionally monogamous. This assumption is not unique to the United States. Eric Eric Widmer, Judith Treas, and Robert Newcomb (1998) undertook comparative research using a 24-country sample of more than 33,000 respondents and found strong and widespread disapproval of extramarital sex, although people in different countries varied some in their levels of disapproval, with some being more tolerant than the majority (for example, those in Russia, Bulgaria, and the Czech Republic). Within the United States, nearly 80% of Americans believe extramarital sex is "always wrong" (Blow and Hartnett 2005).

How Much Infidelity and Extramarital Sex Is There?

Although we sometimes overstate the amount of "cheating" that goes on, it is neither an isolated phenomenon nor restricted to married couples. As we reported previously, there is more nonmonogamy among cohabiting than among married couples and among gay male couples than among lesbians or heterosexual couples. There are widely varying estimates of how prevalent extramarital sex is in the United States. Adrian Blow and Kelley Hartnett (2005) cite a number of studies, with varying estimates:

- Of General Social Survey respondents in the 1991–1996 surveys, 13% admitted to having sex outside of their marriages.
- Of respondents, 1.5% acknowledged having had sex with someone other than their spouse or partner in the previous 12 months.
- In one survey, 25% of married men and 15% of married women said that at some point in their marriages they had sex with someone other than their spouses (Blow and Hartnett 2005).
- Findings from a study of 2,598 men and women ages 18–59 who had ever been married or lived with a partner suggested that 11% had been unfaithful; among those married only once, 16% acknowledged having had extramarital sex.
- Finally, when asked about behavior over the prior 12 months, 5% of the 2,010 respondents who had been married over that span of time admitted to infidelity (Olenick 2000).

Attempting to bring these disparate findings to some conclusion, Blow and Hartnett suggest the following (emphasis added)

> We can conclude that *over the course of married, heterosexual relationships* in the United States, [extramarital] sex occurs in less than 25% of committed relationships, and more men than women appear to be engaging in infidelity. . . . From studies of other countries, it appears that rates of infidelity are higher or lower in some places and that gender differences vary considerably.

Findings on extramarital sex from the widely hailed Sex in America survey are shown in Figure 6.2.

Types of Infidelity

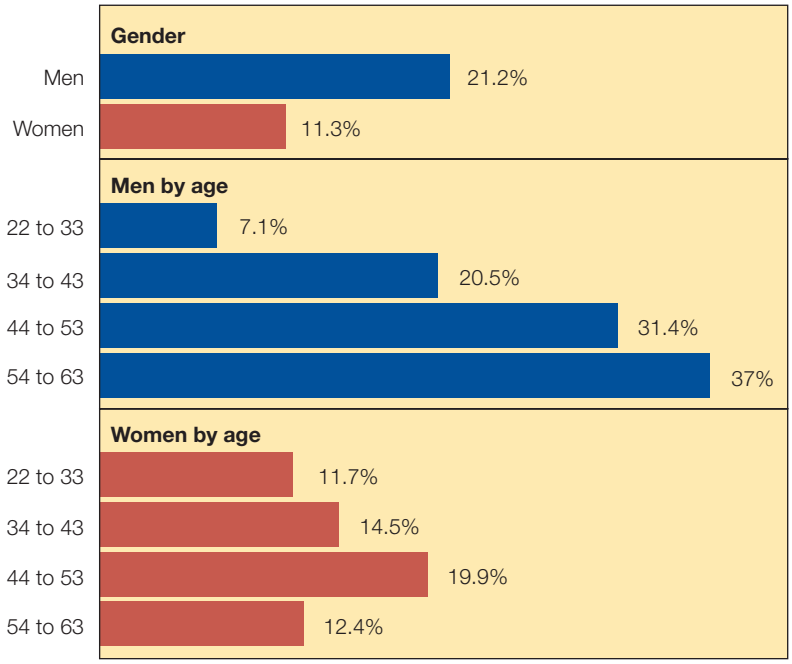
We tend to think of extramarital involvements as being sexual, but they may actually assume several forms (Moore-Hirschl et al. 1995; Thompson 1993). They may be (1) sexual but not emotional, (2) sexual and emotional, or (3) emotional but not sexual (Thompson 1984). Less is known about extramarital relationships in which the couple is emotionally but not sexually involved.

People who engage in extramarital affairs have a number of different motivations, and these affairs satisfy a number of different needs (Adler 1996; Moultrup 1990).

Characteristics of Extramarital Sex

Most extramarital sexual involvements are sporadic. Most extramarital sex is not a love affair; it is generally more sexual than emotional. Affairs that are both emotional and sexual appear to detract more from the marital relationship than do affairs that are only sexual or only emotional (Thompson 1984). More women than men consider their affairs emotional; almost twice as many men as women consider their affairs only

Figure 6.2 ■ Lifetime Incidence of Infidelity by Gender and Age



SOURCE: National Opinion Research Center, 1994.

sexual. About equal percentages of men and women are involved in affairs that they view as both sexual and emotional. Research suggests that men are more bothered by the sexual nature of a partner's infidelity where women are disturbed more by the emotional aspect (Christopher and Sprecher 2000).

An emotionally significant extramarital affair creates a complex system of relationships among the three individuals (Moultrup 1990). Long-lasting affairs can form a second but secret "marriage." In some ways, these relationships resemble polygamy, in which the outside person is a "junior" partner with limited access to the other. The involved partners, who know their system is triadic, must try to meet each other's needs for time, affection, intimacy, and sex while taking the uninvolved partner into consideration. Such extramarital systems are stressful and demanding. Most people find great difficulty in sustaining them. If both people involved in the affair are married, the dynamics become even more complex.

Are Gay Male Relationships Sexually Open?

Although the outbreak of the AIDS crisis in the 1980s and 1990s affected behavior and changed how accepting of nonmonogamy gay men were, research conducted both before and after the onset of the epidemic show that a proportion of gay men maintain relationships in which both partners agree to be nonexclusive (LaSala 2004). Among heterosexual couples, lesbian couples, and gay male couples, gay male couples have been and continue to be more likely to accept and experience sexual nonmonogamy. Furthermore, in comparing monogamous and nonmonogamous (that is, "faithful" and "unfaithful") gay male couples, research often finds no differences in relationship adjustment or satisfaction (LaSala 2004). Some clinicians have gone as far as to deem those who condemn nonmonogamy as dysfunctional "heterocentrist," meaning that they are applying standards that may pertain to heterosexual relationships too broadly. Given that males think about and act differently regarding sexual relationships, we might assume that gay male couples would display these tendencies even more than heterosexual couples (each of whom has a female partner) and certainly more than lesbian couples (who obviously have no male partners). Michael LaSala reminds us that research has established that, compared to women, men are more likely to separate sex and love; to engage in sexual relationships in the absence of emotional involvement; to en-

gage in sexual relations within even "casual relationships;" and to consider having sex with strangers.

Just as a portion of gay men maintain nonexclusive relationships, many gay couples construct relationship boundaries that proscribe (prohibit) sex with others. Like heterosexual and lesbian couples, such men come to see infidelity as a breach of trust. In LaSala's sample of 121 gay male couples, 60% described their "relationship agreements" as assuming monogamy (40% were in sexually open relationships). However, among these 73 couples, 33 had breached this expectation and broken their monogamous agreement. It was this latter group that had the lowest scores on satisfaction, expression of affection toward one's partner, and relationship adjustment. Interestingly, however, when those who engaged in nonmonogamous sex in the prior 12 months were removed from the analysis, there appeared to be no real difference between those whose monogamous expectations had been upheld and those whose expectations had been violated.

Sexual Problems and Dysfunctions

Many of us who are sexually active may experience sexual difficulties or problems. Recurring problems that cause distress to the individual or his or her partner are known as **sexual dysfunctions.** Although some sexual dysfunctions are physical in origin, many are psychological. Some dysfunctions have immediate causes, others originate in conflict within the self, and still others are rooted in a particular sexual relationship.

Both men and women may suffer from hypoactive (low or inhibited) sexual desire (Hawton, Catalan, and Fagg 1991). Other dysfunctions experienced by women are orgasmic dysfunction (the inability to attain orgasm), arousal difficulties (the inability to become erotically stimulated), and **dyspareunia** (painful intercourse). The most common dysfunctions among men include **erectile dysfunction** (the inability to achieve or maintain an erection), **premature ejaculation** (the inability to delay ejaculation after penetration), and delayed orgasm (difficulty in ejaculating) (Spector and Carey 1990). Figure 6.3 shows the percentage of heterosexual adults in the general U.S. population who reported experiencing sexual problems during the previous year in response to a recent survey (Laumann et al. 1994).

Origins of Sexual Problems

Physical Causes

It is generally believed that between 10% and 20% of sexual dysfunctions are structural in nature. Physical problems may be *partial* causes in another 10% or 15% (Kaplan 1983; LoPiccolo 1991). Various illnesses may have an adverse effect on a person's sexuality (Wise, Epstein, and Ross 1992). Alcohol and some prescription drugs, such as medication for hypertension, may affect sexual responsiveness (Buffum 1992; "Drugs" 1992).

Among women, diabetes, hormone deficiencies, and neurological disorders, as well as alcohol and alcoholism, can cause orgasmic difficulties. Painful intercourse may be caused by an obstructed or thick hymen, clitoral adhesions, a constrictive clitoral hood, or a weak pubococcygeus muscle. Coital pain caused by inadequate lubrication and thinning vaginal walls often occurs as a result of decreased estrogen associated with menopause. Lubricants or hormone replacement therapy often resolve the difficulties.

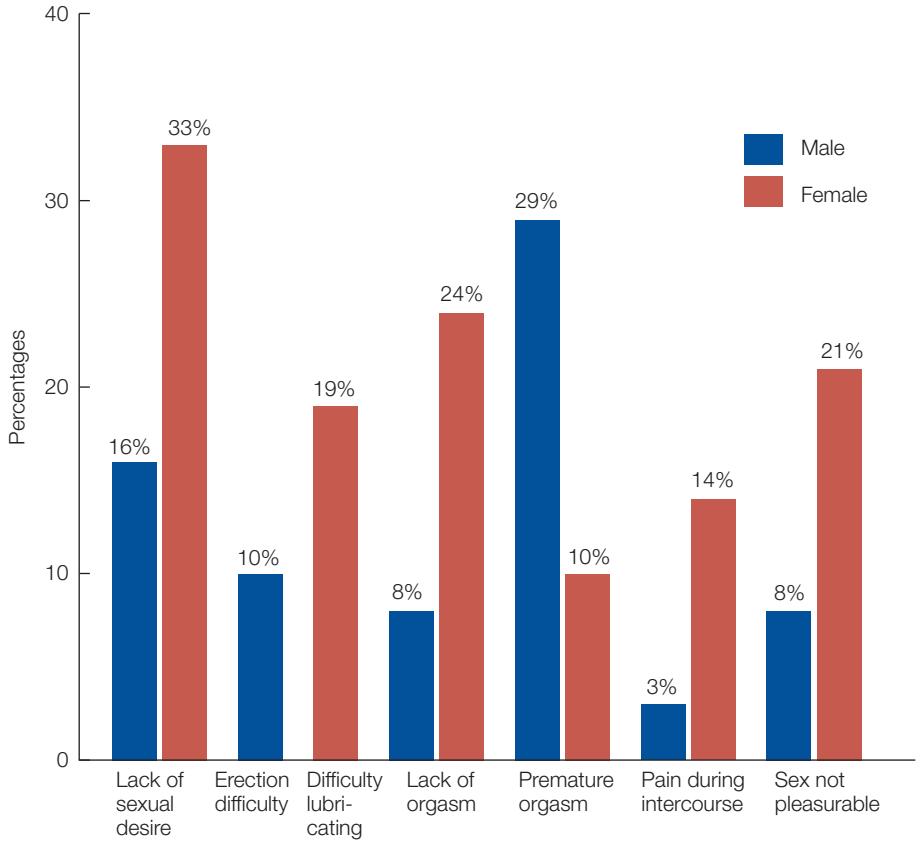
Among males, diabetes and alcoholism are the two leading physical causes of erectile dysfunctions; atherosclerosis is another important factor (LoPiccolo 1991; Roenrich and Kinder 1991). Smoking may also contribute to sexual difficulties (Rosen et al. 1991).

Psychological or Relationship Causes

Two of the most prominent causes of sexual dysfunctions are performance anxiety and conflicts within the self. **Performance anxiety**—the fear of failure—is probably the most important immediate cause of erectile dysfunctions and, to a lesser extent, of orgasmic dysfunctions in women (H. Kaplan 1979). If a man does not become erect, anxiety is a fairly common response. Some men experience their first erectile problem when a partner initiates or demands sexual intercourse. Women are permitted to say no, but many men have not learned that they too may say no to sex. Women suffer similar anxieties, but they tend to center around orgasmic abilities rather than the ability to have intercourse. If a woman is unable to experience orgasm, a cycle of fear may arise, preventing future orgasms. A related source of anxiety is an excessive need to please one's partner.

Conflicts within the self are guilt feelings about one's sexuality or sexual relationships. Guilt and emotional

Figure 6.3 ■ Heterosexual Sexual Dysfunctions in a Nonclinical Sample



SOURCE: Adapted from Laumann et al. 1994, 370–371.

conflict do not usually eliminate a person's sexual drive; rather, they inhibit the drive and alienate the person from his or her sexuality. Such inner conflicts often are deeply rooted. Among gay men and lesbians, concerns about sexual orientation may be an important cause of such conflicts (George and Behrendt 1987). The relationship itself, rather than either individual, sometimes can be the source of sexual problems. Disappointment, anger, or hostility may become integral parts of a deteriorating or unhappy relationship. Such factors affect sexual interactions, because sex can become a barometer for the whole relationship.

Relationship discord can affect our sexuality in several ways, such as through poor communication that inhibits our ability to express our needs and desires; power struggles in which sexuality becomes a tool in struggles for control; and sexual sabotage where partners ask for sex at the wrong time, put pressure on each other, and frustrate or criticize each other's sexual desires and fantasies. People most often do this unconsciously (Kaplan 1979).

Sex between Unequals, Sex between Equals

Sociologist Pepper Schwartz (1994) identified a number of sexual problems that plague traditional marriages because of the gender hierarchy and absence of empathy that characterize such marriages. Partners are "too distant, too different, and too inequitable" to enjoy complete sexual fulfillment. Sexual problems among traditional couples include the following:

- *Failure of timing.* This results when one person is more in charge of the couple's sexual relationship

and his or her needs define when the couple has sexual relations.

- *Failure of intimacy.* If traditional couples lack the same depth of intimacy (that is, sharing and communication) that Schwartz contends more egalitarian relationships possess, it is apparent in their sexual relationship. According to Schwartz, this can prevent them from finding complete fulfillment in their sexual relationship.
- *Failure of sexual empathy.* Some couples fail to realize that what one finds pleasing the other may not. This is particularly true in the most traditional marriages, where "men and women have little experience of each other's lives." They may show little respect for each other's sexual needs and refuse to make the effort to learn what each other wants (Schwartz 1994).
- *Failure of reciprocity.* Inequality outside the bedroom can spill into the bedroom. Often the woman, but potentially either partner, feels as if she gives more than she receives. There is less mutual massage than desired, or she feels that she is touched less or receives less oral sex than she gives or performs.
- *Failure of overromanticization.* Women in more traditional relationships may possess overly romanticized expectations of sexual relations. These are often beyond what most "ordinary" men can live up to.

Schwartz notes that peer marriages, relationships built on deep friendship and commitments to fairness, sharing, and equality, avoid these particular sexual problems. What they may suffer from, instead, is a decline in sexual intensity. Some of this results just from habituation. More specific to peer couples are other problems that can diminish sexual excitement, most notably an inability to transform themselves from their everyday identities based on sameness and openness to erotic identities based on "principles of opposites and mystery" (Schwartz 1994). Thus, the same things that differentiate peer relationships from their more common and less equal counterparts may make it hard for peer couples to sustain sexual energy. These problems are not insurmountable, but they do require special effort on the part of peer couples to create a separate and special sexual environment removed from more mundane life matters.

Resolving Sexual Problems

Sexual problems can be embarrassing and emotionally upsetting. Perhaps the first step in dealing with a sexual problem is to turn to immediate resources. Talking about the problem with one's partner, finding out what he or she thinks, discussing specific strategies that might be useful, and simply communicating feelings and thoughts can sometimes resolve the difficulty. One can also go outside the relationship, seeking friends with whom to safely share feelings and anxieties, asking whether they have had similar experiences, and learning how they handled them. Sexual problems can become self-fulfilling, because couples may focus so much on the difficulties that they are having that additional pressure is placed on sexual performance. Thus, keeping perspective—and often a sense of humor—may be quite helpful.

Aside from one's circle of friends and intimates, there are ever-increasing, additional resources on which one can draw. A growing number of self-help books dealing with sexuality and relationship issues line the shelves in bookstores and libraries. There are also numerous websites one can access and consult. For example, Yahoo searches for sites dealing with erectile dysfunction, premature ejaculation, and female sexual dysfunction, generated 9,680,000, 4,890,000, and 3,130,000 hits, respectively. Not all of these will be sites offering help or advice. Some may be pornographic, and others may carry exaggerated claims designed to sell products, but many websites offer information compiled or overseen by medical, psychiatric, psychological, nursing, or educational specialists.

Cumulatively, partners, friends, websites, and books may provide information and grant individuals needed "permission" to engage in sexual exploration and discovery by making such inquiries normal. From these sources we may learn that our sexual issues, problems, fantasies, and behaviors are not unique. Such methods are most effective when the dysfunctions arise from a lack of knowledge or mild sexual anxieties.

If, despite conversation with one's partner, consultation with friends, and/or reading books, magazines, or other resources one remains unable to resolve his or her sexual difficulties, seeking professional assistance is the logical next step. It is important to realize that seeking such assistance does not signal personal weakness or failure. Rather, it demonstrates

an ability to reach out and a willingness to change. It is a sign of caring for one's partner, one's relationship, and oneself.

For those whose problems stem mostly from psychological or relationship causes, therapists can help deal with sexual problems on several levels. Some focus directly on the problem, such as lack of orgasm, and suggest behavioral exercises, such as pleasuring and masturbation, to develop an orgasmic response. Others focus on the couple relationship as the source of difficulty. If the relationship improves, they believe that sexual responsiveness will also improve. Still others work with the individual to help develop insight into the origins of the problem to overcome it. Therapy can also take place in a group setting. Group therapy may be particularly valuable for providing partners with an open, safe forum in which they can discuss their sexual feelings and experience and discover commonalities with others.

A relatively new development for men who suffer from sexual problems is medication. In March 1998, the Food and Drug Administration approved **Viagra,** the first oral treatment for male impotence. With as many as 50% of men, 40 and older, suffering from at least occasional and mild impotence, Viagra quickly became an economic and cultural phenomenon. In just its first year of availability, Viagra had sales of $1 billion, propelling its manufacturer, Pfizer, to the second spot among the world's largest drug companies. In 2002, Viagra had sales in excess of $1.7 billion. Optimistic forecasts predicting continued growth and sales success turned out to be exaggerated, but Viagra definitely has made its mark on the economy, society, and culture.

There is still no equivalently successful prescription drug for women suffering from orgasmic difficulties or other sexual dysfunctions.

Issues Resulting from Sexual Involvement

Birth Control

Most of us think of sexuality in terms of love, passionate embraces, and entwined bodies. Sex involves all of these, but what we so often forget (unless we are worried) is that sex is also a means of reproduction. Whether we like to think about it or not, many of us (or our partners) are vulnerable to unintended pregnancies. Not thinking about pregnancy does not prevent it; indeed, not thinking about it may increase the likelihood of its occurring. Unless we practice **abstinence,** refraining from sexual intercourse, we need to think about unintended pregnancies and then take the necessary steps to prevent them.

Sexually Transmitted Diseases, HIV, and AIDS

Americans are in the middle of the worst epidemic of sexually transmitted diseases (STDs) in our history. There are an estimated 15 million new cases of sexually transmitted infections in the United States each year, the highest rate of infection of any industrialized nation in the world (Miracle, Miracle, and Baumeister 2003). College students are as vulnerable as anyone else. Untreated, chlamydia and gonorrhea can lead to pelvic inflammatory disease (PID) in women, a major cause of infertility.

Still, most of us would wince if asked on a first date, "Do you have chlamydia, gonorrhea, herpes, syphilis, HIV, or any other sexually transmissible disease that I should know about?" However, given the risks of contracting an STD and the consequences associated with infection, it is a question whose answers you should know before you become sexually involved. Just because a person is "nice" or good looking, or available and willing, is no guarantee that he or she does not have one of the STDs discussed later in this chapter. You could be infected through such sexual contact as sexual intercourse, oral sex, or anal sex. Unfortunately, no one can tell by a person's looks, intelligence, or demeanor whether he or she has contracted an STD. The costs of becoming sexually involved with a person without knowing about the presence of any of these diseases are potentially steep.

Principal STDs

The most prevalent STDs in the United States are chlamydia, gonorrhea, genital warts, genital herpes, syphilis, hepatitis, and HIV and AIDS. Conditions that may be sexually transmitted include urethritis (in both women and men) and vaginitis and PID (in women). Table 6.6 briefly describes the symptoms, exposure intervals, treatments, and other information regarding the principal STDs.

HIV and AIDS

The **human immunodeficiency virus (HIV)** is the virus that causes **acquired immunodeficiency syndrome (AIDS).** The disease is so termed because of its characteristics:

acquired—because people are not born with it

immunodeficiency—because the disease relates to the body's immune system, which is lacking in immunity

syndrome—because the symptoms occur as a group

Overall, the effects of HIV have been devastating, with the worst effects happening not in the United States but in other parts of the world. According to a report from the U.S. Department of Health and Human Services, National Institutes of Health, and National Institute of Allergies and Infectious Diseases, nearly 25 million people have died from HIV or AIDS worldwide, including nearly 0.5 million Americans. Furthermore, an estimated 40 million people worldwide are living with the disease, including 1 million or more Americans. Each year there are an estimated 40,000 new infections, with men representing 70% of the cases (National Institute of Allergies and Infectious Diseases 2005). The Centers for Disease Control (2003) estimates that approximately 56% of the infections in the United States were transmitted through male–male or heterosexual sexual contact.

HIV and AIDS cases have hit African Americans and Latinos especially hard, with each group infected at disproportionate rates. Despite being just 12% of the population of the United States, blacks make up more than half of all new HIV infections. Perhaps even more striking, AIDS is *the No. 1 cause of death* among African American men of all ages (National Institute of Allergies and Infectious Diseases 2005).

Although AIDS was initially discovered in gay men and was thought of early on as a "gay disease" or the "gay plague," sexually transmitted cases among heterosexuals increased at a rate at least comparable to that among gay men. This was partly because of how successful the gay community was in incorporating safer-sex practices, especially during the 1980s and 1990s. Unfortunately, there are some troubling signs that HIV and AIDS infections are again increasing among gay men, and not just among young men and/or minority men, at rates that Spencer Cox, of the AIDS Community Research Initiative of America, calls "alarming." Citing "dramatic increases in risky sex (and other kinds of risky behavior) among older, white, and relatively affluent gay men in major cities—traditionally the group for whom prevention efforts were most effective," Cox asserts that this new wave of infections will be difficult to combat, especially since it appears to be tied in with other lifestyle choices, such as crystal methamphetamine use. Crystal methamphetamine is a highly addictive drug and associated with more sexual risk taking, such as engaging in unprotected anal intercourse and having numerous casual partners. Evidence from cities such as Chicago, New York, and San Francisco reveal that between 15% and 20% of gay men report using methamphetamines (Cox 2006).

Without discounting or diminishing the devastation that the gay community suffered from AIDS and HIV, or signs of resurging rates of infection, it is important to keep in mind that heterosexuals and bisexuals are also at risk and become infected. Virtually all adults in the United States are or will soon be related to, personally know, work with, or go to school with people infected with HIV or will know others whose friends, relatives, or associates test HIV-positive.

As of April 2006, there is still no surefire vaccine to prevent HIV, nor is there a cure for those who are or become infected. Significant strides have been made in fighting the disease, suppressing its symptoms, and prolonging life for those who are infected. In addition, between 1996 and 2001, AIDS death rates were reduced by 80% and postdiagnosis survival had doubled in length. Those diagnosed after 1998 could expect to live 9 to 10 years longer than those who were diagnosed during the mid-1980s (Fallon 2005).

In addition to new treatments that can lengthen the life span of an AIDS-infected person as much as 15 years (Fallon 2005), we have considerable knowledge about the nature of the virus and how to reduce the likelihood of infection:

- *HIV attacks the body's immune system.* HIV is carried in the blood, semen, and vaginal secretions of infected people. A person may be HIV-positive (infected with HIV) for years before developing AIDS symptoms.
- *HIV is transmitted only in certain clearly defined circumstances.* It is transmitted through the exchange of blood (as by shared needles or transfusions of contaminated blood), through sexual contact involving semen or vaginal secretions, and from an infected woman to her fetus through the placenta. Infected mothers may also transmit the infection during delivery or by nursing (Miracle, Miracle, and Baumeister 2003).

Table 6.6 ■ Principal Sexually Transmitted Diseases

STD and Infecting Organism	Time from Exposure to Occurrence	Symptoms	Medical Treatment	Comments
Chlamydia *(Chlamydia trachomatis)*	7–21 days	Women: 80% asymptomatic; others may have vaginal discharge or pain with urination. Men: 30%–50% asymptomatic; others may have discharge from penis, burning urination, pain and swelling in testicles, or persistent low fever.	Doxycycline, tetracycline, erythromycin	If untreated, may lead to pelvic inflammatory disease (PID) and subsequent infertility in women.
Gonorrhea *(Neisseria gonorrhoeae)*	2–21 days	Women: 50%–80% asymptomatic; others may have symptoms similar to chlamydia. Men: itching, burning, or pain with urination; discharge from penis ("drip").	Penicillin, tetracycline, or other antibiotics	If untreated, may lead to PID and subsequent infertility in women.
Genital warts *(Human papilloma virus)*	1–6 months (usually within 3 months)	Variously appearing bumps (smooth, flat, round, clustered, fingerlike, white, pink, brown, and so on) on genitals, usually penis, anus, vulva, vagina, or cervix.	Surgical removal by freezing, cutting, or laser therapy. Chemical treatment with podophyllin (80% of warts eventually reappear)	Virus remains in the body after warts are removed.
Genital herpes *(Herpes simplex virus)*	3–20 days	Small, itchy bumps on genitals, becoming blisters that may rupture, forming painful sores; possibly swollen lymph nodes; flulike symptoms with first outbreak.	No cure although acyclovir may relieve symptoms. Nonmedical treatments may help relieve symptoms.	Virus remains in the body, and outbreaks of contagious sores may recur. Many people have no symptoms after the first outbreak.
Syphilis *(Treponema pallidum)*	Stage 1: 1–12 weeks Stage 2: 6 weeks to 6 months after chancre appears	Stage 1: Red, painless sore (chancre) at bacteria's point of entry. Stage 2: Skin rash over body, including palms of hands and soles of feet.	Penicillin or other antibiotics	Easily cured, but untreated syphilis can lead to ulcers of internal organs and eyes, heart disease, neurological disorders, and insanity.

SOURCE: Strong and DeVault 1997.

- *All those with HIV (whether or not they have AIDS symptoms) are HIV carriers.* They may infect others through unsafe sexual activity or by sharing needles; if they are pregnant, they may infect the fetus.
- *Heterosexuals, bisexuals, gay men, and lesbians are all susceptible to the sexual transmission of HIV.* Sexual transmission accounts for 68% of AIDS and 57% of HIV infections among men through 2002. Male–male sexual contact is attributed to 55% of all AIDS cases and 47% of all non-AIDS HIV infections among men. The rate of heterosexual HIV transmission is rising faster than the rate of gay transmission. Among women, heterosexual contact accounts for 42% of HIV and AIDS cases.
- *There is a definable progression of HIV infection and a range of illnesses associated with AIDS.* HIV attacks the immune system. AIDS symptoms occur as opportunistic diseases—diseases that the body normally resists—infect the individual. The most common opportunistic diseases are pneumocystis carinii pneumonia and Kaposi's sarcoma, a skin cancer. It is an opportunistic disease rather than HIV that kills the person with AIDS.
- *The presence of HIV can be detected through various kinds of antibody testing.*

Anonymous testing is available at many college health centers and community health agencies. HIV antibodies develop between 1 and 6 months after infection. Antibody testing should take place 1 month after possible exposure to the virus and, if the results are negative, again 6 months later. If the antibody is

Table 6.6 ■ Continued

STD and Infecting Organism	Time from Exposure to Occurrence	Symptoms	Medical Treatment	Comments
Hepatitis *(hepatitis A or B virus)*	1–4 months	Fatigue, diarrhea, nausea, abdominal pain, jaundice, and darkened urine due to impaired liver function.	No medical treatment available; rest and fluids are prescribed until the disease runs its course.	Hepatitis B is more commonly spread through sexual contact and can be prevented by vaccination.
Urethritis *(various organisms)*	1–3 weeks	Painful and/or frequent urination; discharge from penis. Women may be asymptomatic.	Penicillin, tetracycline, or erythromycin, depending on organism	Laboratory testing is important to determine appropriate treatment.
Vaginitis *(Gardnerella vaginalis, Trichomonas vaginalis, or Candida albicans)* (women only)	2–21 days	Intense itching of vagina and/or vulva; unusual discharge with foul or fishy odor; painful intercourse. Men who carry organisms may be asymptomatic.	Depends on organism; oral medications include metronidazole and clindamycin, and vaginal medications include clotrimazole and miconazole	Not always acquired sexually. Other causes include stress, oral contraceptives, pregnancy, tight pants or underwear, antibiotics, douching, and dietary imbalance.
HIV infection and AIDS *(human immunodeficiency virus)*	Several months to several years	Possible flulike symptoms but often no symptoms during early phase. Variety of later symptoms including weight loss, persistent fever, night sweats, diarrhea, swollen lymph nodes, bruiselike rash, and persistent cough.	No cure available, although many symptoms can be treated with medications and antiviral drugs may strengthen the immune system. Good health practices can delay or reduce the severity of symptoms.	Cannot be self-diagnosed; a blood test must be performed to determine the presence of the virus.
Pelvic inflammatory disease (PID) *(women only)*	Several weeks or months after exposure to chlamydia or gonorrhea (if untreated)	Low abdominal pain; bleeding between menstrual periods; persistent low fever.	Penicillin or other antibiotics; surgery	Caused by untreated chlamydia or gonorrhea; may lead to chronic problems such as arthritis and infertility.

present, the test will be positive. That means that the person has been infected with HIV and an active virus is present. The presence of HIV does not mean, however, that the person necessarily will develop AIDS symptoms in the near future; symptoms generally occur 7 to 10 years after the initial infection.

Protecting Yourself and Others

As with avoiding unintended pregnancies, the safest practice to avoid STDs is *abstinence,* foregoing sexual relations. There is no chance of contracting STDs, although HIV infection can and does occur through nonsexual transmission (for example, intravenous drug use with shared needles). If you are sexually active, however, the key to protecting yourself and others is to talk with your partner about STDs in an open, nonjudgmental way and to use condoms. The best way of finding out whether your partner has an STD is by asking. If you feel nervous about broaching the subject, you can rehearse talking about it. It may be sufficient to ask in a lighthearted manner, "Are you as healthy as you look?" or because many people are uncomfortable asking about STDs, you can open the topic by revealing your anxiety: "This is a little difficult for me to talk about because I like you and I'm embarrassed, but I'd like to know whether you have herpes, or HIV, or whatever." If *you* have an STD, you can say, "Look, I like you, but we can't make love right now because I have a chlamydial infection and I don't want you to get it."

Remember, however, that not every person with an STD knows she or he is infected. Women with chlamydia and gonorrhea, for example, generally don't exhibit symptoms. Both men and women infected with HIV may not show any symptoms for years, although they are capable of spreading the infection through sexual contact. If you are or are planning to be sexually active but don't know whether your partner has an STD, use a condom. Even if you don't discuss STDs, condoms are simple and easy to use without much discussion. Both men and women can carry them. A woman can take a condom from her purse and give it to her partner. If he doesn't want to use it, she can say, "No condom, no sex."

Sexual Responsibility

Because we have so many sexual choices today, we need to be sexually responsible. Sexual responsibility includes the following:

- *Disclosure of intentions.* Each person needs to reveal to the other whether a sexual involvement indicates love, commitment, recreation, and so on.
- *Freely and mutually agreed-upon sexual activities.* Each individual has the right to refuse any or all sexual activities without the need to justify his or her feelings. There can be no physical or emotional coercion.
- *Use of mutually agreed-upon contraception in sexual intercourse if pregnancy is not intended.* Sexual partners are equally responsible for preventing an unintended pregnancy in a mutually agreed-upon manner.
- *Use of "safer sex" practices.* Each person is responsible for practicing safer sex unless both have been monogamous with each other for at least 5 years or have recently tested negative for HIV. Safer sex practices do not transmit semen, vaginal secretions, or blood during sexual activities and guard against STDs, especially HIV and AIDS.
- *Disclosure of infection from or exposure to STDs.* Each person must inform his or her partner about personal exposure to an STD because of the serious health consequences, such as infertility or AIDS, that may follow untreated infections. Infected individuals must refrain from behaviors—such as sexual intercourse, oral–genital sex, and anal intercourse—that may infect their partner. To help ensure that STDs are not transmitted, a condom should be used.
- *Acceptance of the consequences of sexual behavior.* Each person needs to be aware of and accept the possible consequences of his or her sexual activities. These consequences can include emotional changes, pregnancy, abortion, and STDs.

Responsibility in many of these areas is facilitated when sex takes place within the context of an ongoing relationship. In that sense, sexual responsibility is a matter of values. Is responsible sex possible outside an established relationship? Are you able to act in a sexually responsible way? Sexual responsibility also leads to the question of the purpose of sex in your life. Is it for intimacy, erotic pleasure, reproduction, or other purposes?

As we consider the human life cycle from birth to death, we cannot help but be struck by how profoundly sexuality weaves its way through our lives. From the moment we are born, we are rich in sexual and erotic potential, which begins to take shape in our sexual experimentations of childhood. As children, we are still unformed, but the world around us haphazardly helps give shape to our sexuality. In adolescence, our education continues as a mixture of learning and yearning. But as we enter adulthood, with greater experience and understanding, we undertake to develop a mature sexuality: we establish our sexual orientation as heterosexual, gay, lesbian, or bisexual; we integrate love and sexuality; we forge intimate connections and make commitments; we make decisions regarding our fertility and sexual health; we develop a coherent sexual philosophy. Then, in our middle years, we redefine sex in our intimate relationships, accept our aging, and reevaluate our sexual philosophy. Finally, as we become elderly, we reinterpret the meaning of sexuality in accordance with the erotic capabilities of our bodies. We come to terms with the possible loss of our partner and our own end. In all these stages, sexuality weaves its bright and dark threads through our lives.

Summary

- Our sexual behavior is influenced by *sexual scripts:* the acts, rules, stereotyped interaction patterns, and expectations associated with male and female sexual expression. These provide general guidelines of what is expected from or accepted of us.
- Traditional female sexual scripts include the following ideas: Sex is both good and bad (depending on the context); men should know what women want; and there is only one right way to experience an orgasm.
- Traditional male sexual scripts include the following: Men should not have (or at least should not express) certain feelings; the man is in charge; and all physical contact leads to sex.
- Contemporary sexual scripts are more egalitarian, consisting of the following beliefs: Sexual expression is positive; sexuality involves both partners equally and both partners are equally responsible; and legitimate sexual activities include masturbation and oral–genital sex.
- Even with the emergence of the contemporary sexual script, evidence suggests that there is a *sexual double standard,* in which different sexual behaviors are accepted and expected of men and women.
- There are several tasks that we must undertake in developing our sexuality as young adults, including (1) integrating love and sex, (2) forging intimacy and commitment, (3) making fertility or childbearing decisions, (4) establishing a sexual orientation, and (5) developing a sexual philosophy.
- We learn about sexuality from multiple sources: parents, peers, the mass media, and increasingly the Internet. Most sexual socialization by parents is from mothers, and daughters have more sexual communication with mothers than sons do.
- Even amid a longer-term trend toward more open acceptance of nonmarital sexual behavior, a recent trend seems to point toward a decline in sexual activity among teenagers.
- Between 1% and 10% of American men are *gay,* and between 1% and 3% of American women are *lesbian* at one time or another in their lives. Identifying oneself as gay or lesbian occurs in stages. Although some gay men and lesbians assert that they "always knew" they were different from their heterosexual counterparts, some—especially among lesbians—report that their sexuality was partly a political choice.
- Gay men and lesbians maintain intimate relationships that have much in common with heterosexual relationships though they lack comparable social support, and legal rights and protections.
- Lesbian, gay, and bisexual individuals may be subject to prejudice or hostility, including verbal abuse, discrimination, or violence. Attitudes toward bisexuals may be even harsher than attitudes toward gay men and lesbians.
- *Bisexuals* are attracted to members of both genders. In developing a bisexual identity, men and women go through several stages: (1) initial confusion, (2) finding and applying the bisexual label, (3) settling into the identity, and (4) continued uncertainty. Bisexuals don't have a community or social environment that reaffirms their identity.
- Developmental tasks in middle adulthood include (1) redefining sex in marital or other long-term relationships, (2) reevaluating one's sexuality, and (3) accepting the biological aging process.
- The main determinants of sexual activity in old age are health and the availability of a partner.
- Chronic illnesses; medications; declining levels of testosterone in men and estrogens in women; negative attitudes and cultural stereotypes; and loss of, absence of, or monotony with a partner all contribute to the reduction in sexual desire for aging women and men.
- *Autoeroticism* consists of sexual activities that involve only the self. It includes sexual fantasies, masturbation, and erotic dreams.
- Gender and race differences in masturbation have been identified. More men than women masturbate, and men masturbate more often. In marriage, men masturbate to supplement their sexual activities, whereas women tend to masturbate as a substitute for such activities. European American women report higher rates of masturbation than either African American or Hispanic women.
- The most common and acceptable of all premarital sexual activities is kissing, which occurs in more than 90% of all cultures.

- *Oral–genital sex,* which includes *cunnilingus* and *fellatio,* is practiced by heterosexuals, gay men, and lesbians. Data indicate increasing rates of oral sex among teenagers and young adults.
- *Sexual intercourse (coitus)* is the insertion of the penis into the vagina and the stimulation that follows.
- *Anal eroticism* is practiced by both heterosexuals and gay men. From a health perspective, *anal intercourse* is dangerous because it is the most common means of sexually transmitting HIV.
- *Sexual enhancement* is based on accurate information about sexuality, developing communication skills, fostering positive attitudes, and increasing self-awareness.
- *Nonmarital sex* includes all sexual activities, especially sexual intercourse, that take place outside of marriage. *Premarital sex* has gained in acceptability.
- Marital sex tends to decline in frequency over time, but this does not necessarily signify marital deterioration.
- *Extramarital sex* is widely condemned, although people in some countries are more tolerant than those in others. Race, residential location, gender, and frequency of thinking about sex are associated with rates of infidelity.
- Extrarelational sex occurs among heterosexual cohabitants, gay male couples, and lesbian couples at higher rates than among married couples.
- ***Nonconsensual sexual behaviors*** range from exhibitionism and voyeurism to rape, sexual harassment, and child sexual abuse.
- *Sexual dysfunctions* (such as orgasmic or arousal difficulties in women or erectile dysfunction or premature ejaculation in men) are recurring problems in giving and receiving erotic satisfaction that may be physiological or psychological in origin.
- Therapeutic and medicinal assistance is available for people experiencing sexual dysfunctions.
- *Sexually transmitted diseases (STDs),* especially chlamydia and gonorrhea, are epidemic. *Acquired immunodeficiency syndrome (AIDS)* is caused by the *human immunodeficiency virus (HIV),* which attacks the body's immune system. HIV is carried in the blood, semen, and vaginal fluid of infected people.
- The rate of infection and death because of HIV is far greater in other parts of the world (for example, Africa and Asia) than in the United States, where. most HIV infections are the result of either heterosexual or male–male sexual contact, and where Hispanics and African Americans have been particularly hard hit.
- If someone is sexually active, the keys to protection against STDs, including HIV and AIDS, are communication and condom use.
- Anyone sexually active should practice sexual responsibility: disclose any STD infections, engage only in mutually agreed upon activities, use mutually agreed upon methods of contraception, and engage in safer sex.

Key Terms

abstinence 226
acquired immunodeficiency syndrome (AIDS) 227
anal eroticism 216
anal intercourse 216
antigay prejudice 205
autoeroticism 213
bisexual 200
coitus 216
coming out 204
cunnilingus 215
dyspareunia 223
erectile dysfunction 223
extramarital sex 218
fellatio 215
foreplay 191
gay men 201
heterosexual 200
homoeroticism 202
homophobia 205
homosexual 200
human immunodeficiency virus (HIV) 227
lesbians 201
masturbation 214
menopause 211
nonconsensual sexual behavior 232
nonmarital sex 217
outing 204
performance anxiety 223
pleasuring 214
premarital sex 217
premature ejaculation 223
sexual double standard 194
sexual dysfunctions 223
sexual enhancement 216
sexual intercourse 216
sexual script 191
Viagra 226
virginity 199
weblog 197

RESOURCES ON THE INTERNET

Companion Website for This Book

http://www.thomsonedu.com/sociology/strong

Gain an even better understanding of this chapter by going to the companion website for additional study resources. Take advantage of the Pre- and Post-Test quizzing tool, which is designed to help you grasp difficult concepts by referring you back to review specific pages in the chapter for questions you answer incorrectly. Use the flash cards to master key terms and check out the many other study aids you'll find there. Visit the Marriage and Family Resource Center on the site. You'll also find special features such as access to InfoTrac(c) College Edition (a database that allows you access to more than 18 million full-length articles from 5,000 periodicals and journals), as well as GSS Data and Census information to help you with your research projects and papers.