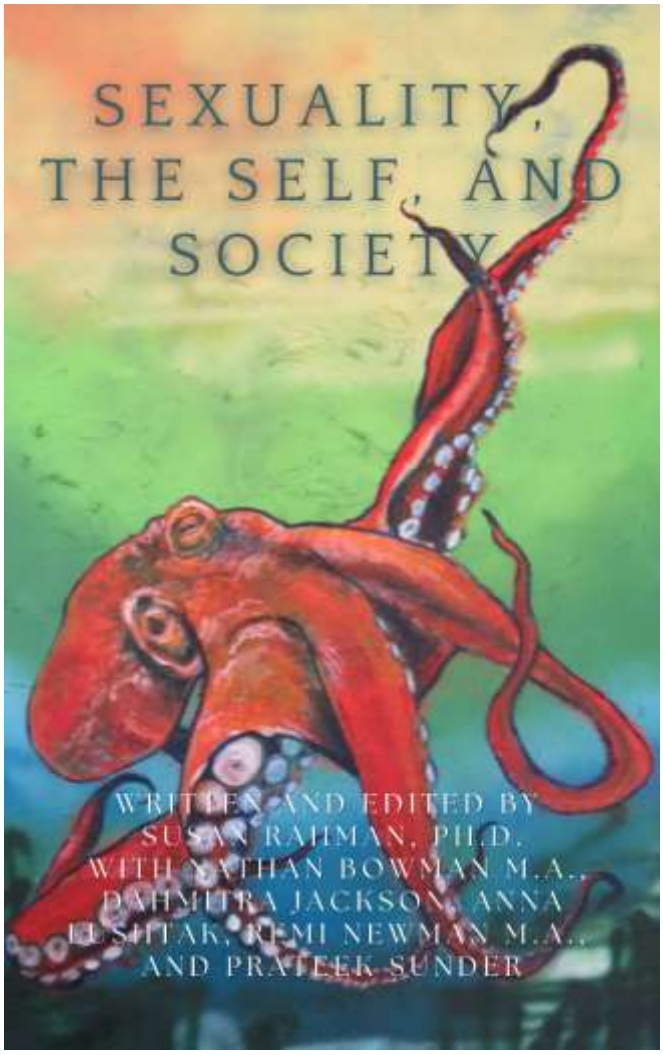
Sexuality, the Self, and Society



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The contents of this book were developed under an Open Textbooks Pilot grant from the Fund for the Improvement of Postsecondary Education (FIPSE), U.S. Department of Education. However, those contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government.

About the Authors

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Anna Lushtak was trained as an engineer and started her career in high-tech. She decided to pivot to a career in psychology and is currently working on her MS in Counseling Psychology. While raising two children into their young adulthood, she realized that relationship communication, including sexual communication, is a skill that can be learned and must be taught.

Remi Newman is a sexuality writer and educator with over 20 years of experience empowering people of diverse backgrounds to live healthy and fulfilling sex lives.

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Prateek Sunder is currently a student at the University of California, Berkeley, majoring in Psychology. He served as the editor for this book, and co-wrote "A People's History of Structural Racism in Academia" with Professor Rahman. He is a first generation student and community college transfer, as well as a son and brother.

Preface

This Open Educational Reader (OER) was created to fill a gap in existing OERs. Thanks to the generous grant from the Department of Education, we were able to fund this work. The text is a collaboration between faculty, students and others who work in the field of Human Sexuality.

Acknowledgements

A lot goes into writing a book. Some of the work is fulfilling and empowering and some is hard, depressing, and frustrating. So much of the work is done without anyone around noticing what you are doing. Some people wondered what I did all day, if I actually had a job, or if I just sat around goofing off. It was hard to share the process because it was mostly taking place in my head. In many ways writing is a very individual act but without the support of others, it is virtually impossible. Being in your head for months at a time can be very isolating so, for me, it was very

important to have connection. While I did have co-creators, and the ability to check in with them was important, there are also others in my life that, if I didn't have their love and support I do not think I would have been able to do this.

My daughter, Jordan. Everything I do in life is done with the hopes that you will see that anything is possible. You make me a better person and your love keeps me moving. My Mom for all she has taught me and her continued support of my work- she still edits my papers:). My Sister for always supporting me and offering her medical expertise to this project. My brilliant bestie Carmen, who reminds me how far we've come, knows me better than most, and loves me anyway. You, who is with me every step of the way, helps me see a way forward even when I can't, and who reminds me to appreciate what I have and be patient. Rosie, Phoebi, and Izzy who all blanket me in love and comfort, and make me laugh.

Future, current and former students, too many to name, who think big thoughts, feel powerful feelings, and strive to make the world a better place. I couldn't imagine a better way to make a living than to be in the classroom with you all.

My co-creators on this project. You each taught me something I needed to know about human sexuality and myself. Nathan, you came back, got me organized, and picked up the slack all while making me laugh. I couldn't ask for a better gift. Thank you Dahmitra, Anna and Remi for your expertise and willingness to work with me as I learned along the way, sometimes without enough clarity to be of much help. Elle, my friend, you have put up with my impatience and always been kind. There is always more to say. Prateek, how far we've come since we began this journey, I continue to be grateful for your kindness, strength, and wisdom. All of the named and unnamed guest authors throughout this textbook. You each brought another voice and viewpoint which gave this book more richness and variety.

A very special thanks to everyone in the community of Yogis I belong to. Being able to get out of my head on a daily basis provided life-saving self-care. My guides Defne and Dana, you both are incredible teachers, role models, and fabulous humans. My heart is full whenever I think of you and I am reminded of so many important intentions; to get over myself, that I have to do everything to do anything, that I fit myself perfectly, and to breathe! Katie, you have created a sanctuary for all of us to thrive, you brighten my day, and are always so welcoming. Mary and Juliana, thank you for your support on this project, your friendship, and for just being you.

With immense gratitude,

Susan

General Approach

Content included in *Sexuality, the Self, and Society* is aligned with the typical scope for an introductory, interdisciplinary Human Sexuality Textbook. It is written to be a complete text for a semester length course but could be used, in part, reorganized, or edited in true OER fashion. It is meant to be accessible, relevant, and inclusive. It also will not remain static meaning that the author will continue to update periodically and those who adopt may do so as they see fit.

A Note on Peer Review

The content here was reviewed for accuracy and usefulness as an introductory, interdisciplinary Human Sexuality Textbook by the following:

Yashica Crawford, Ph.D., College of Marin

Jamie Weinstein, M.D.

Kathleen Brumley, F.N.P.

Sexuality, the Self and Society Key Features

The text is designed as a collection of modules that can be used in parts or as a whole text embedded into course shells in whatever order best suits the needs of the user. That being said, in its original form, it does build on topics discussed earlier in the book as it progresses along.

- **Specific Learning Outcomes** that are stated at the beginning of the chapter and then covered throughout
- **Glossary** of key terms with definition for each chapter.
- **For Further Exploration Section** that offers the reader a deeper dive into content related to the chapter
- **Multiple Choice Questions** in each chapter
- **Discussion Questions** in each chapter
- **Guest Contributions** from experts in the field, people with lived experiences or relevant stories to share to make the content come alive

Supplemental Features

An Online Instructor Resource Guide Containing:

- Suggested talking points or ways to approach difficult topics based on the author's methods
- Presentation slides for each chapter
- Multiple Choice Questions with answers included
- Discussion Questions with intended responses included
- Suggested videos/clips/podcasts/talks to support each chapter's learning outcomes

Introduction

Welcome to this open educational reader covering the topic of Human Sexuality. The materials in this book are a co-creation of new and existing Open Educational Resources (OERs) put together by a group of authors to give the reader an introductory overview to the study of Human Sexuality. The field of Human Sexuality is multi-disciplinary, covering a broad spectrum of perspectives. **Human Sexuality** can be understood as the ways in which we experience and express ourselves as sexual beings. For the purposes of this reader and course associated with it, much of what we learn will relate directly to the human condition. The reader will examine their experience with their own sexuality, and perhaps delve a little deeper into a subject that often does not get the attention it deserves, particularly when taking a holistic approach to understanding the self. Taking the time to learn about the many ways in which human sexuality is expressed and understood will also demonstrate that there is no one right way to "do" sexuality. In general, and within the lifespan, sexual expression adjusts and changes. Hopefully these readings will be enlightening and empowering. Understanding our sexual selves goes a long way towards self-fulfillment. Taking the time to learn more about

one's individual sense of pleasure, to understand the diversity of bodies and differing ways of expressing sexuality, and the ways in which culture polices sexuality is a necessary piece of higher learning and achievement of self-actualization. Additionally, understanding the broad range of sexualities may allow greater insight into the humanity of others who diverge from the reader's perspective that they might not have previously had. The hope here is that the reader ends this course with a greater knowledge of that aspect of their humanity and recognizes and respects the large variety of ways in which humans express their sexuality.

A *sex positive* approach informs this reader. We use the term sex positive in this reader to imply an open and progressive approach to sexuality without judgement. For the good of the people, this is a space to embody and explore sexuality and discover our desires because it is important for us to feel good. There is entirely too much cultural shame around our bodies and sexuality that predominantly is based in misinformation or myth. We hope this reader will help you develop your sexual

literacy both personally in terms of what fulfills you, and through deeper understanding of the vast diversity present in human sexuality. As one continues through this book, please make note of how those myths have informed an understanding of sexuality and critically evaluate how that has affected an approach to sexuality.

This book will be centered around two main themes. The first will be a focus on the importance of open honest communication. Communication with ourselves, as we embark on understanding our knowledge of the world of human sexuality, our bodies, and what we like and don't like. Additionally we will stress the importance of honest open communication with those who we interact with regarding our sexuality. The only way to really know if another person wants to enter into a sexual encounter is to talk about it and make sure the feeling is mutual. As Salt-N-Pepa so eloquently put it way back in 1991, *let's talk about sex baby!* Salt-N-Pepa - Let's Talk About Sex

Talking freely and openly takes practice, and not everyone has been conditioned to talk about sex with intimate partners, family or really, anyone. But taking the step to add open ccommunication to one's sexual life goes a long way in terms of overall wellness and isn't that what it's all about?

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The second theme connects to the first theme of being open and honest with ourselves and others by way of an authentic acceptance of ourselves via embodiment and radical self-love. An objective of these course materials is for the reader to finish this semester with a deeper understanding of their body, how it feels and how amazing it is. We spend entirely too much time critiquing when we ought to be celebrating. Please commit to practicing radical self-love this semester. The human body is a wonderland in all of its iterations, no two bodies look alike, and it is about time to start reveling in its gorgeousness! So please be on the lookout for opportunities throughout this semester both in class and in life beyond the classroom, to develop your sexual literacy and practice both honest communication and radical self-love, whether related to human sexuality or in any other aspect of life. Because just imagine what the world would look like if everyone walked around telling people the truth (in a kind way), and truly loving themselves wholly and completely.

This reader is in no way meant to be the totality of the world of human sexuality. It is merely a sampling of readings based on selected topics within the study of

human sexuality. Because OERs are free and open to adaptation, this material is available to anyone wishing to teach or learn this content. The flexibility of OER also means others may pick and choose from this reader to create their own collection. This document is not static, it will change from year to year based on changing times and the vastly growing repositories of Open Educational Materials. A debt of gratitude is owed to the OER movement, and the authors are excited to be a part of it through this and other projects.

Whenever possible, the authors try to avoid the false binary trap–the assumption that there are only two possibilities when it comes to human bodies or genders. There are specific bodies that perform different functions and human sexuality is often concerned with these functions. Human Sexuality, biology and identity however, are more complicated than that, and whenever possible the authors seek to not fall back into a false binary or generalize based on themes like "what women want" or "how to be a man." That being said, there will be instances where we discuss things through binary lenses. It is our hope that we do this as accurately and in as non-stereotypical a way as possible. If we reference any classic works just as examples the likes of *Our Bodies Ourselves,* or *The Vagina Monologues*, we will be exploring them in context and so re-imagining language may not always take place. When we discuss issues like pregnancy or abortion, we are referring to bodies that can be impregnated so we will need to discuss them in those terms. When we use work that could be served from some non-binary language updates, and articulate this point, we are not suggesting the intent of the content is not valid, only that we see a way forward that can both provide the valuable information in a way that does not reinforce stereotypes of the gender binary or feel offensive to anyone.

Thank you and welcome to Sexuality, the Self and Society.

Susan Rahman, PhD.

Assignment:

Ready to develop your sexual literacy? Before we begin the course, there is one small assignment I need all of you to undertake. Please get yourself a small mirror and a quiet private place. You have one of three options to choose from.

Option 1: Please use the mirror to inspect your sex organs-however you define them. This may feel strange at first, as we do not spend a great deal of time looking at those parts of our bodies. Do not rush, take some time to look at the structure. Do you know what all the parts are? Pay attention to how this process feels to you.

Option 2: Using your largest sex organ, your brain (yes it is!), think about what you love about yourself. Look in the mirror and tell yourself what it is. Could be one thing directly related to your sexuality, could be a long list and maybe some of the things have to do with sexuality maybe they don't.

Option 3: Do both of these:)

Write 2-3 sentences about how it was doing this. You will not be turning this in. It is for you and only you to share with as you wish.

Chapter 1: What is Human Sexuality

"Finger heart illustration Free Vector" © freepik

Learning Objectives

- Understand how structural racism, homophobia, white supremacy and patriarchy have influenced the development of the field of human sexuality
- Understand different attitudes associated with sex and sexuality
- Define sexual inequality in various societies
- Discuss theoretical perspectives on sex and sexuality

What is Human Sexuality?

Human Sexuality as an academic field studies the ways in which humans express themselves as sexual beings. This epistemology is interdisciplinary in nature, utilizing biology, medical research, sociology and psychology. The science of human sexuality approaches understanding as multilayered. Pulling from these varying disciplines, the field is able to look at sexuality from multiple lenses. While there are many approaches to the study, its foundation lies in the heteronormative white male perspective using a default sexual script that normalizes certain types of sexuality and practices and pathologizes others. As exclusionary as its roots are, there is an ongoing demand from scholars in the field and much has been written about the need to be more expansive. Understanding Human Sexuality in its totality demands a wider lens. Whether it was biology or medical research, or any of the other disciplines that fall under the wide umbrella of an interdisciplinary approach to Human Sexuality, there is a tendency towards an explanation of human sexuality in terms of a false binary that informs the creation of knowledge in the field which is often scientifically inaccurate. Repercussions of this result in varying levels of invalidation of lived experiences of students in the field, to highly abusive practices in research and medicine. Historically, the field of Human Sexuality in the United States has been chronically underfunded due to the puritanical roots inherent in the White Anglo-Saxon Protestant (WASP) foundation. In particular, the study of female or non-binary bodied persons and research findings, stated conclusions of “normal” sexual behavior, and best practices about sexuality have often been determined with a white, misogynistic, heteronormative lens. This is of concern for those who seek to advance the field because any default sexual script inevitably alienates some people and potentially have unwanted or un-consensual sexual experiences.

For this text we will be examining sexuality from an intersectional lens that can be loosely termed **biopsychosocial** in that it systematically considers biological, psychological, and social factors and their complex interactions. We will observe biological aspects of our bodies and minds and see how that interacts with how we experience our bodies and others we relate to sexually, and put in all in context with culture. All of this will then be related to our specific ascribed or achieved aspects of selves that make us who we are. The resulting objective of looking at sexuality in this fashion is to remove specific sexual scripts or normalize certain things and pathologize others. “Sexuality is a multidimensional, biopsychosocial, intersectional, fluid, ever-changing set of reinforcing/resisting stories which enable and/or block the flow of embodied feelings like desire and shame” (Barker & Scheele, 2021 p. 132). For our purposes this text seeks to move the reader away from shame and towards pleasure.

Sidebar 1.1 Amazons and Angels

I don't know when I first knew that I would want to climb her but once I started, I couldn't stop.

Running across the top of her foot I leapt up her leg and started the ascent. The muscles of her strong calf offered support as I made my way around her knee and up the inside of her thigh. Her skin became softer, easier to grip. I rested on the fleshy ledge on the inside of her hip joint.

Excitement building, I squeezed my head, shoulders, torso, and finally legs and feet through the folds between her legs. It was so dark, but I didn't care. I knew where I was going. I'd been there before. I wiggled my way along her smooth softness until I arrived. Full of grief and deep appreciation, I laid where I had first found form. The walls of nurturing, feeding, keeping me sage were there. I never wanted to leave. We were together then. Same body. Same blood. No separation. I sobbed remembering the completeness. Knowing I could not stay. To see her face meant letting go of our oneness. My belly button ached. I wanted to go higher.

Scaling internal organs, I got lost in the twists and turns of her guts. The path was curvy. The pain of transformation meant discarding the rest.

Arriving in the stomach, with its crude methods of caring deeply, loving completely, I felt perseverance. She takes it all in, breaks it down with the truth of being. She knows the answers to the hardest questions.

Down in her lungs I felt the power of her breath and the fire of her heart. Huge. Bathing muscles in clean, compassionate blood. I screamed.

The vibration of my shrillness carried me up her throat and onto her tongue. I laughed at her gorgeous teeth and pulled on her succulent lips as I crawled over her nose. Kissing her eyelids and rubbing her brow, I finally came to rest in the intoxicating smell of her hair. The precious gift of being held washed over me.

Maybe tomorrow I'll climb up inside myself and admire the view? But I won't scream at the hugeness of my heart. I'll gaze in the awe of a passionate path, vast beauty and the honor of being seen. -Heidi McBride, April 1998.

A Picture of Sara Baartman

Sculpture of Sara Baartman on display at the University of Cape Town, South Africa

Another problematic arena in the field of human sexuality has been well documented examples of ethical violations that stem from both individual and structural racism, dating back to the development of the field up until present day. We begin with the case of enslaved woman, Sara Baartman. Today, she is seen by many as the epitome of colonial exploitation and racism, of the ridicule and commodification of Black bodies. Sarah Baartman was brought to Europe seemingly on false pretenses by a British doctor, stage-named the "Hottentot Venus." She was paraded around "freak shows" in London and Paris, with crowds invited to look at her large buttocks. Baartman died on 29 December 1815, but her exhibition continued. Her brain, skeleton and sexual organs remained on display in a Paris museum until 1974. Her remains weren't repatriated and buried until 2002 (Parkinson, 2016). A 2018 exhibition featuring a sculpture of Sarah Baartman at the

University of Cape Town, South Africa was created to facilitate dialogue about heritage and contemporary life.

A second example is Dr. J. Marion Sims, who has been heralded as the father of modern gynecology. It has long been asserted that Dr. Sims perfected the first consistently successful operation for the cure of “vesicovaginal fistula (VVF), a catastrophic complication of childbirth in which a hole develops between a woman's bladder and her vagina and leads to constant, unremitting, and uncontrollable urinary incontinence” (Wall, 2006). He did so by practicing on slave women without the use of anesthesia, which clearly raises questions regarding Dr. Sim’s medical ethics and his perceptions surrounding the human rights of enslaved persons. During Sim's tenure, women suffered horribly from this condition and a race for the cure was critical. Dr Sims' use of slave women was well documented historically. By the very nature of their enslavement, these women were unable to consent. He performed surgery on them as test cases, and then performed more surgeries later on some white women without anesthesia. The use of anesthesia was new during this time, and anesthesia did not become commonplace until he was routinely performing this procedure on white women (Wall, 2006). He later described white women complaining of pain while enslaved Black women did not, and used this anecdotal evidence to make assumptions about differing pain thresholds based on race, rather than other possible factors for their differing responses, such as enslaved women’s likely fear of punishment for expressing said pain. Some argue it is not because Dr. Sims was racist, but rather, that anesthesia was not widely used; however, whatever biases Simms had about pain thresholds and racial identity allowed him to make assumptions about how the women he worked on experienced the procedures.

There is much controversy surrounding the practices of Dr. Sims and the ethical considerations factoring in despite the invention's historical significance. A vesicovaginal fistula (VVF), rendered women greatly incapacitated during the time Dr. Sims was in practice. It was considered a fate worse than death for many. Prior to Dr. Sims's breakthrough, there had been no consistently effective procedure to repair the fistula, and there was not a field of gynecology at the time; in fact, examining women's organs was considered repugnant by male doctors. From 1845-1849, Dr. Sims performed experimental surgery on 7 enslaved Black women in his small backyard hospital (Ojanuga, 1993). He performed his experimental surgery on his first patient Lucy in front of 12 male doctors watching as she crouched on her hands and knees and endured the hour long procedure without anesthesia. The surgery was a failure and she almost died. Another patient, an enslaved woman named Anarcha endured 13 operations without anesthesia with limited success (Ojanuga, 1993). Dr. Sims attempted his procedure on white women but as previously mentioned, found that they could not endure the pain. In the minds of many who look at the history of this particular doctor and his practices, Dr. Sims was not merely a product of his time but rather his infliction of pain on Black women was unethical, cruel and callous.

Sadly, the pattern of white male doctors who callously practice unethical procedures on women and people of color does not end with Dr. Simms. Well into the 21st century, forced sterilization of women in California correctional institutions was a consistent practice (Jindia, 2020).

A state audit and prison records reveal nearly 1,400 sterilizations between 1997 and 2013. In addition to people sterilized during labor, an unknown number of cis

women and trans people were sterilized during other abdominal procedures (Jindia, 2020).

These sterilizations took place without consent or under coercive circumstances. Despite ethical mandates and procedural efforts to make sure research participants are protected, there remain recent examples of gross violations. As we take a look at these, we often find that marginalized populations are the ones most at risk. There seems to almost be permission to test on incarcerated people as if they are lab rats. From high risk cancer treatments, to testing skin cream and cosmetics, they have been used for non-consensual medical testing as if their human rights are not valid. These forced sterilizations of incarcerated women in California prisons are the topic of the 2021 documentary, Belly Of The Beast | Documentary Film | Official Trailer. This film highlights one of the ways in which the lives of incarcerated people are not their own, and basic human rights to choice and autonomy of their bodies were grossly disregarded. The 13th Amendment to the Constitution allows for involuntary servitude as a punishment for crime as a means to take away any free will incarcerated people have thus this is just another link in the chain of enslavement. But it is not just the incarcerated who have their free will disregarded. Those institutionalized in mental health facilities as well have been sterilized against their will. Many of these facilities were shut down when then President Ronald Reagan gutted much of the mental health services and facilities. While these facilities were not without problems, this forced many who needed support out on their own, often ending up in prison as they were incapable of getting what they needed to live independently. Facilities for the mentally ill in many ways were like prisons in that those housed there were not treated humanely. A recent expose highlighted the decades long practice of forced sterilization and castration of men and women who were living in one of these

facilities, the Sonoma home, one of the many homes for the mentally ill/disabled that practiced this type of forced medical intervention (Barber, 2021). The medical directors chose to undertake these sterilizations based solely on their prejudiced attitudes towards the people whose care they were charged with. The unfortunate truth is that white supremacy, sexism and ableism were deeply entrenched in the mindsets of the medical community that made these decisions without consent, and this influences the science and decision making practices of the medical community to this day.

Just as the enslaved women could not consent, incarcerated and institutionalized people face similar lack of rights, and are coerced via the threat of increased sentences if they fail to comply with authority. The legacy of structural racism, sexism and heteronormativity are part and parcel of the field of Human Sexuality. There is much more to explore about the ways in which what is otherwise a rich field has to reckon with its problematic past and present. Its value stretches far beyond the walls of the academy and has real world consequences that affect all of humanity. A deeper understanding of human sexuality will help us put all of this in context so let's now turn our attention to understanding the field at large.

Sexual Attitudes and Practices

In the area of sexuality, sociologists focus their attention on sexual attitudes and practices, not on physiology or anatomy. **Sexuality** is viewed as a person's capacity for sexual feelings. Studying sexual attitudes and practices is a particularly interesting field of study, because sexual behavior is a cultural universal. Throughout time and place, the vast majority of human beings have participated in

sexual relationships (Broude 2003). Each society, however, interprets sexuality and sexual activity in different ways. Many societies around the world have different attitudes about premarital sex, the age of sexual consent, homosexuality, masturbation, and other sexual behaviors that are not consistent with stated cultural norms (Widmer, Treas and Newcomb 1998). At the same time, sociologists have learned that certain norms (like disapproval of incest) are shared among most societies. Likewise, societies generally have norms that reinforce their accepted social system of sexuality.

What is considered “normal” in terms of sexual behavior is based on the mores and values of the society. Societies that value monogamy, for example, would likely oppose extramarital sex. Individuals are socialized to sexual attitudes by their family, education system, peers, media, and religion. Sexuality is not static, and cultural influences shape all parts of human sexuality. The culture shapes how sex acts are performed and perceived as normal or deviant, as well as what we find sexually appealing. Historically, religion has been the greatest influence on sexual behavior in most societies, but in more recent years, peers and the media have emerged as two of the strongest influences, particularly with American teens (Potard, Courtois, and Rusch 2008). Let us take a closer look at sexual attitudes in the United States and around the world.

Why is it Important to Study Sexuality?

International Citizen Service / *CC BY*

There are many reasons that an understanding of our sexuality is an important part of our overall wellness, mental, physical and emotional. As students in a class learning about sexuality, of course it is in part important so that you do well in the course, but beyond the classroom, we are all humans with bodies and our sexuality is encompassed as a part of this so to have some working knowledge of our own sexuality increases our quality of life. Imagine having a new smartphone with all sorts of features that you don't know how to use. For most, we would take the time to learn how to use those features. Our sexuality, learning about parts of our bodies, why we find certain things appealing or unappealing, and how culture shapes these notions will be valuable tools for you to possess.

For example:

- A deeper understanding of the structure and function of genitals will help you give and receive more pleasure from sexual activity.
- Learning that communication is paramount in healthy sexual relationships will help you create and maintain satisfying relationships.
- Understanding that there is a world of diversity when it comes to sexuality will help expand your sense of acceptance of those who differ from you.
- Educating yourself about sexually transmitted diseases (STIs) and contraception can help keep you safe as you explore your sexuality.
- A deeper understanding about sex, and how to communicate effectively will help you in will help you educate people in your life.

Sexuality Around the World

Cross-national research on sexual attitudes in industrial nations reveals that normative standards differ across the world. For example, several studies have shown that Scandinavian students are more tolerant of premarital sex than U.S. students are (Grose 2007). A study of 37 countries reported that non-Western societies—like China, Iran, and India—valued chastity highly in a potential mate, while Western European countries—such as France, the Netherlands, and Sweden—placed little value on prior sexual experiences (Buss 1989).

Country	**Males (Mean)**	**Females (Mean)**
China	2.54	2.61
India	2.44	2.17
Indonesia	2.06	1.98

Iran	2.67	2.23
Israel (Palestinian)	2.24	0.96
Sweden	0.25	0.28
Norway	0.31	0.30
Finland	0.27	0.29
The Netherlands	0.29	0.29

Table 12.1 Chastity in Terms of Potential Mates Source: Buss 1989

Even among Western cultures, attitudes can differ. For example, according to a 33,590-person survey across 24 countries, 89 percent of Swedes responded that there is nothing wrong with premarital sex, while only 42 percent of Irish responded this way. From the same study, 93 percent of Filipinos responded that sex before age 16 is always wrong or almost always wrong, while only 75 percent of Russians responded this way (Widmer, Treas, and Newcomb 1998). Sexual attitudes can also vary within a country. For instance, 45 percent of Spaniards responded that homosexuality is always wrong, while 42 percent responded that it is never wrong; only 13 percent responded somewhere in the middle (Widmer, Treas, and Newcomb 1998).

Of industrialized nations, Sweden is thought to be the most liberal when it comes to attitudes about sex, including sexual practices and sexual openness. The country has very few regulations on sexual images in the media, and sex education, which starts around age six, and is a compulsory part of Swedish school curricula. Sweden's permissive approach to sex has helped the country avoid some of the

major social problems associated with sex. For example, rates of teen pregnancy and sexually transmitted disease are among the world's lowest (Grose 2007). It would appear that Sweden is a model for the benefits of sexual freedom and frankness. However, implementing Swedish ideals and policies regarding sexuality in other, more politically conservative, nations would likely be met with resistance.

Sidebar 1.2: Culture and Attitudes around Sex

A note: As culture shapes our attitudes and beliefs, so does time and place. The following two scenarios were observed by anthropologists over 50 years ago so we imagine things look different presently.

This following information is based on studies undertaken in the 1960s and 1970s by Cultural Anthropologist John Cowan Messenger and anthropologist Donald S. Marshall.

Retrieved from https://en.wikiversity.org/wiki/Cultural_differences_in_sexuality

Inis Beag, a small island off the coast of Ireland, is among the most naive and sexually repressive societies in the world. The islands abhor nudity, with adults washing only the parts of the body that extend beyond their clothing.

Even marital partners keep underclothes on during sexual activity. Premarital sex is essentially unknown, as is female orgasm. The husband invariably initiates sex, foreplay is limited to kissing and rough fondling of the buttocks, and the male-on-top position is the only position used.

The male has orgasm quickly and immediately falls asleep. Men believe that intercourse is hard on their health and will not engage in sex the night before an energy-demanding task. Moreover, they do not approach their wives sexually during menstruation or for months after childbirth.

The island women fear both menstruation and menopause. It is commonly believed that the latter can produce mental disorders. Thus, some women have retired from life in their mid-forties and a few have even confined themselves to bed until death years later.

Sex education is virtually nonexistent. Parents merely trust that, after marriage, nature will take its course.

In sharp contrast, Mangaia, an island in the South Pacific ocean, stands in sharp contrast to Inis Beag. Sex exists for both pleasure and procreation and is a principal interest and activity.

The Mangaian boy hears of masturbation at about 7 and begins the practice at age 8 or 9. At age 13, he undergoes the super incision ritual (a slit is made on the top of the penis, along its entire length) and the expert who performs the surgery gives him explicit sexual instruction.

About two weeks after the operation, the boy has intercourse with an experienced woman who provides him with practice in various acts and positions. She specifically trains him in restraint so that he can have simultaneous orgasms with his partner.

The young girl receives similar expert instruction and will typically have three or four successive boyfriends between the ages of 13 and 20. Mangaian parents encourage their daughters to have sexual experiences with several men so that they can find a marriage partner who is congenial.

Boys aggressively seek out girls, typically having coitus every night. The average boy may have ten or more girlfriends before marriage.

At around age 18, the Mangaians typically have sex most nights of the week with about three orgasms per night. All women apparently learn to experience orgasm. Bringing his partner to orgasm is one of the man's primary sources of pleasure.

So as you can see from just this one example, attitudes about sexuality vary greatly worldwide and the culture we live in provides us with a sexual script we learn from a very young age. Individually we learn to follow or disregard these rules based on various factors but in either case, we are shaped by cultural norms and values.

Sexuality in the United States

Source Pixabay

The United States prides itself on being the "land of the free," but it is rather restrictive when it comes to its citizens' general attitudes about sex compared to other industrialized nations. In an international survey, 29 percent of Americans stated that premarital sex is always wrong, while the average among the 24 countries surveyed was 17 percent. Similar discrepancies were found in questions about the condemnation of sex before the age of 16, extramarital sex, and homosexuality, with American total disapproval of these each acts being 12, 13, and 11 percent higher, respectively, than the study's average (Widmer, Treas and Newcomb 1998).

American culture is particularly restrictive in its attitudes about sex when it comes to female bodied individuals. Perceived expectations and rules around sexuality fall

along gender lines, and while the U.S. often fails to consider gender beyond the binary, when it comes to values and normative practices, the binary model always disadvantages female gendered people when it comes to sexual freedom. It is widely believed that male gendered people are more sexual than are female gendered ones. In fact, there is a popular notion that male gendered people think about sex every seven seconds. Research, however, suggests that male gendered people think about sex an average of 19 times per day, compared to 10 times per day for female gendered people (Fisher, Moore, and Pittenger 2011).

Belief that male gendered people have—or have the right to—more sexual urges than female gendered people creates a double standard. Ira Reiss, a pioneer researcher in the field of sexual studies, defined the *double standard* as prohibiting premarital sexual intercourse for female gendered people but allowing it for male gendered people (Reiss 1960). This standard has evolved into allowing female gendered people to engage in premarital sex only within committed love relationships, but allowing male gendered people to engage in sexual relationships with as many partners as they wish without condition (Milhausen and Herold 1999). Due to this double standard, a female gendered person is likely to have fewer sexual partners in their life time than a male gendered person. According to a Centers for Disease Control and Prevention (CDC) survey, the average 35-year-old female gendered person has had three opposite-sex sexual partners, while the average 35-year-old male gendered person has had twice as many (Centers for Disease Control 2011).

The future of a society's sexual attitudes may be somewhat predicted by the values and beliefs that a country's youth expresses about sex and sexuality. Data from the 2008 National Survey of Family Growth reveals that 64 percent of boys and 71

percent of girls ages 15–19 said they “agree” or “strongly agree” that “it’s okay for an unmarried female to have a child.” In a separate survey, 65 percent of teens stated that they “strongly agreed” or “somewhat agreed” that although waiting until marriage for sex is a nice idea, it’s not realistic (NBC News 2005). This does not mean that today’s youth have given up traditional sexual values such as monogamy. Nearly all college students (99%), regardless of gender who participated in a 2002 study on sexual attitudes stated they wished to settle down with one mutually exclusive sexual partner at some point in their lives, ideally within the next five years (Pedersen et al. 2002).

Comprehensive sex education should begin in early childhood, continue through a lifespan and be developmentally appropriate. The programs should not only focus on prevention of STI and unintended pregnancy, but also teach about forms of sexual expression, healthy relationships, gender identity and sexual orientation, communication, preventing sexual violence and consent.

Sidebar 1.3: How the State of California Governs what must be included in Sex Education in the K-12 School System

California Department of Education: If schools provide comprehensive sex education, what must it include?

EC Section 51933. First drafted in 1976 and most recently updated in 2015, requires that comprehensive sexual health education shall be age appropriate; medically accurate and objective; available on an equal basis to English language learners; appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds; and appropriate for and accessible to pupils with disabilities. This education shall encourage students to communicate with their parents or guardians about human sexuality and shall also teach respect for marriage and committed relationships. It shall not teach or promote religious doctrine nor reflect or promote bias against any person on the basis of any category protected by the non-discrimination policy codified in *EC* Section 220.

In accordance with *EC* Section 51933, in grades seven through twelve sex education classes shall also teach about:

- Abstinence from sexual activity
- STDs, including their transmission, treatment, and prevention and information about the effectiveness and safety of all Food and Drug Administration (FDA) approved methods reducing the risk of contracting STDs
- The effectiveness and safety of all contraceptive methods approved by the FDA
- The California law allows parents to surrender newborn babies to hospitals or other designated sites without legal penalty.
- In grades seven through twelve, sex education classes shall also provide students with skills for making and implementing responsible decisions about sexuality. All of the above topics may also be included in classes taught prior to seventh grade.

Sex Education

One of the biggest controversies regarding sexual attitudes is sexual education in American classrooms. Unlike in Sweden, sex education is not required in all public school curricula in the United States and can be "opted out of" if parents do not agree. The heart of the controversy is not about whether sex education should be taught in school (studies have shown that only seven percent of Americans oppose sex education in schools), it is about the *type* of sex education that should be taught.

Much of the debate is over the issue of abstinence. In a 2005 survey, 15 percent of Americans believed that schools should teach abstinence exclusively, and should not provide contraceptives or information on how to obtain them. Forty-six percent believed that schools should institute an abstinence-plus approach, which teaches children that abstinence is best, but still gives information about protected sex. Thirty-six percent believed that teaching about abstinence is not important and that sex education should focus on sexual safety and responsibility (NPR 2010).

Research suggests that while government officials may still be debating about the content of sexual education in public schools, the majority of Americans are not. Those who advocated for abstinence-only programs may be the proverbial squeaky wheel when it comes to this controversy, as they represent only 15 percent of parents. Fifty-five percent of Americans feel that giving teens accurate information about sex, including how to obtain and use protection will not encourage them to have sexual relations earlier than they would under an abstinence program. Additionally, 77 percent think such a curriculum would make teens more likely to practice safe sex now and in the future (NPR 2004).

Sex Education in the United States can be hit or miss depending on the state or school district in question. In the US, it often takes a one and done approach in which it is offered to students somewhere in middle grades and then again in high school. Whether abstinence based or not these offerings often involve the use of fear in order to prevent young people from sexual exploration whether it be on their own bodies or with a partner. Fear based programs do little to prevent unwanted teen pregnancy or disease transmission, and instead result in shame around our bodies and finding pleasure in them.

Wellness as a holistic endeavor needs to include our sexuality. Teaching students to love all parts of their bodies and love feeling good is not taking place in most of the school-based curriculum. Rather than making sex education an optional extra that feels ultra cringe-worthy when presented by teachers who otherwise never cover this type of information, another approach could be to offer sexual health education across all grades using a developmental approach. Learning about all parts and functions of our bodies, how to care for and protect them, and rejoicing in the wonderful pleasure they can provide would be very empowering. Liberating sex education has the ability to open minds and bodies for pleasurable exploration without stigma. U.S. youth would benefit from this and can help them feel good about who they are and understand that when it comes to sexual preferences, types, activities etc., there is no such thing as normal.

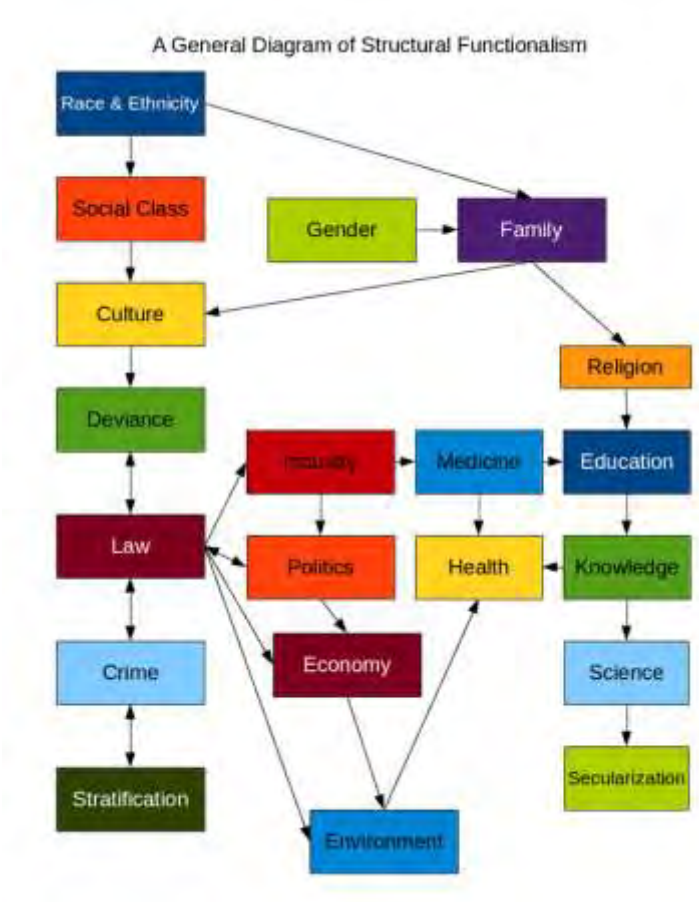
Sweden, which has a comprehensive sex education program in its public schools that educates participants about safe sex, can serve as a model for this approach. The teenage birth rate in Sweden is 7 per 1,000 births, compared with 49 per 1,000 births in the United States. Additionally, among 15- to 19-year-olds, reported cases

of gonorrhea in Sweden are nearly 600 times lower than in the United States (Grose 2007).

Sociological Perspectives on Sex and Sexuality

Sociologists representing all three major theoretical perspectives study the role that sexuality plays in social life today. Scholars recognize that sexuality continues to be an important and defining social location, and that the manner in which sexuality is constructed has a significant effect on perceptions, interactions, and outcomes.

Structural Functionalism



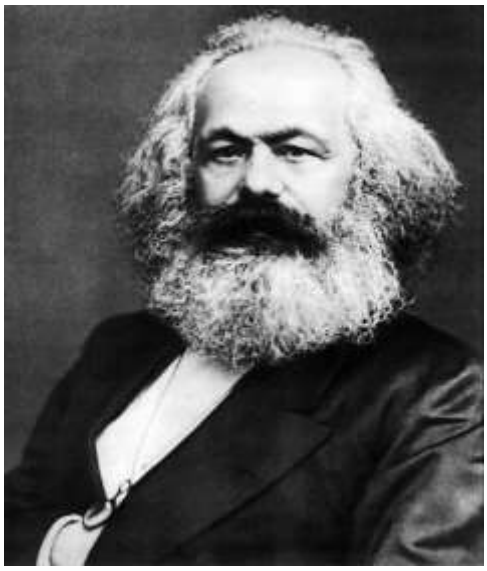
Rcragun 2011 Creative Commons Attribution-Share Alike 3.0

Structural Functionalism sees society as a structure with interrelated parts designed to meet the biological and social needs of the individuals in that society. When it comes to sexuality, functionalists stress the importance of regulating sexual behavior to ensure marital cohesion and family stability. Since functionalists identify the family unit as the most integral component in society, they maintain a strict focus on it at all times and argue in favor of social arrangements that promote and ensure family preservation.

Functionalists such as Talcott Parsons (1955) have long argued that the regulation of sexual activity is an important function of the family. Social norms surrounding family life have, traditionally, encouraged sexual activity within the family unit (marriage) and have discouraged activity outside of it (premarital and extramarital sex). From a functionalist point of view, the purpose of encouraging sexual activity in the confines of marriage is to intensify the bond between spouses, and to ensure that procreation occurs within a stable, legally recognized relationship. This structure gives offspring the best possible chance for appropriate socialization and the provision of basic resources.

From a functionalist standpoint, homosexuality cannot be promoted on a large-scale as an acceptable substitute for heterosexuality. If this occurred, procreation would eventually cease. Thus, homosexuality, if occurring predominantly within the population, is dysfunctional to society. This criticism does not take into account the increasing legal acceptance of same-sex marriage, or the rise in gay and lesbian couples who choose to bear and raise children through a variety of available resources.

Conflict Theory



Karl Marx 1875, Public Domain

Conflict theory looks at society as a competition for limited resources between those who have (bourgeoisie), and those who do not (proletariat). Karl Marx is considered the founder of Conflict theory. From a conflict theory perspective, sexuality is another area in which power differentials are present, and a space where dominant groups actively work to promote and impose their worldview, as well as serve their economic interests. Recently, we have seen the debate over the legalization of marriage equality for all intensify nationwide, and in 2015 The Marriage Equality Act became the law of the land, ensuring any two people wishing to enter into a marriage contract could do so. In protest of this many states have adopted statutes or constitutional provisions preventing same-sex marriage. One of these provisions, the Defense of Marriage Act, states that marriage between one man and one woman is the only domestic legal union that shall be valid or recognized; however the national law overrides these state policies. Unfortunately there have been many county officials refusing to issue marriage licenses for same

sex couples under violation of the federal law but nonetheless impeding couples rights, forcing them to seek legal recourse or go to another county.

For conflict theorists, there are two key dimensions to the debate over marriage equality—one ideological and the other economic. Dominant groups (in this instance, heterosexuals) wish for their worldview—which embraces traditional marriage and the nuclear family—to win out over what they see as the intrusion of a secular, individually driven worldview. On the other hand, many marriage equality activists argue that legal marriage is a fundamental right that cannot be denied based on sexual orientation and that, historically, there already exists a precedent for changes to marriage laws: the 1960s legalization of formerly forbidden interracial marriages is one example.

From an economic perspective, activists in favor of marriage equality point out that legal marriage brings with it certain entitlements, many of which are financial in nature, like Social Security benefits and medical insurance (Solmonese 2008). Denial of these benefits to same sex couples is wrong, they argue. Conflict theory suggests that as long as heterosexuals and homosexuals struggle over these social and financial resources, there will be some degree of conflict.

Symbolic Interactionism

G.dallorto 2010 cc Attribution

Symbolic Interactionism explores how we make meaning out of our interactions with one another in everyday life and how the specific roles we play affect these interactions. Interactionists may focus on the meanings associated with sexuality and with sexual orientation. Since femininity is devalued in American society, those who adopt such traits are subject to ridicule; this is especially true for male bodied people. Just as masculinity is the symbolic norm, so too has heterosexuality come to signify normalcy. Prior to 1973, the American Psychological Association (APA) defined homosexuality as an abnormal or deviant disorder. Interactionist labeling theory recognizes the impact this has made. Before 1973, the APA was powerful in shaping social attitudes toward homosexuality by defining it as pathological. Today, the APA cites no association between sexual orientation and psychopathology and sees homosexuality as a normal aspect of human sexuality (APA 2008).

Interactionists are also interested in how discussions of homosexuals often focus almost exclusively on the sex lives of gays and lesbians; homosexuals, especially male bodied, may be assumed to be hypersexual and, in some cases, deviant. Interactionism might also focus on the slurs used to describe homosexuals. Derogatory labels are often used to demean homosexual men by feminizing them. This subsequently affects how homosexuals perceive themselves. Recall Cooley's "looking-glass self," which suggests that self develops as a result of one's interpretation and evaluation of the responses of others (Cooley 1902). Constant exposure to derogatory labels, jokes, and pervasive homophobia would lead to a negative self-image, or worse, self-hate. The CDC reports that homosexual youths who experience high levels of social rejection are six times more likely to have high levels of depression and eight times more likely to have attempted suicide (CDC 2011).

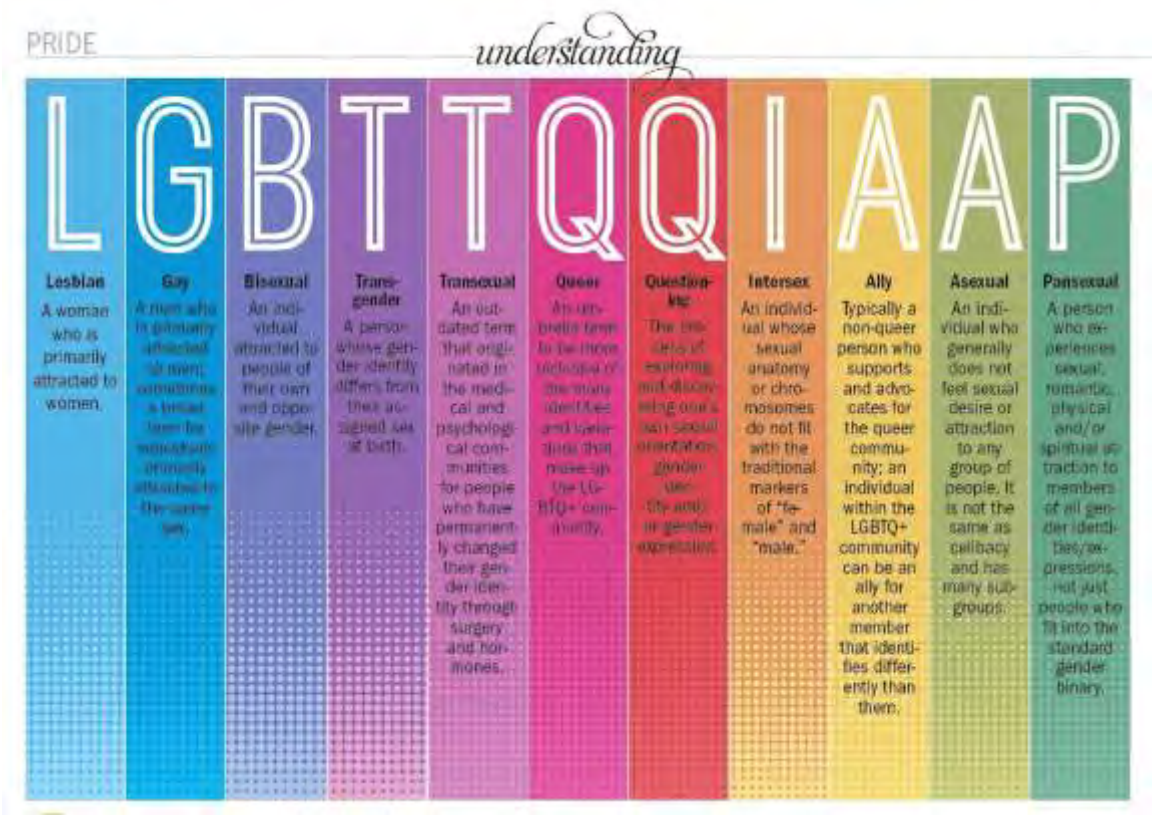
Sidebar 1.4: Reality is Socially Constructed

Read the following paragraph written in the United States in 1966:

In a collectivity (society) that has institutionalized military homosexuality, the stubbornly heterosexual individual is a sure candidate for therapy, not only because his sexual interests constitute an obvious threat to combat efficiency of his unit of warrior lovers, but also because his deviance is psychologically subversive to the others' spontaneous virility. After all, some of them, perhaps "subconsciously", might be tempted to follow his example. On a more fundamental level, the deviant's conduct challenges the societal reality as such, putting in question its taken for granted cognitive ("virile men by nature love one another") and normative ("virile men should love one another") operating procedures (Berger and Luckmann, 1966).

What did you understand about what is written? Is this statement representative of the reality of U.S. cultural values regarding sexuality? In 1966, Sociologists Peter L. Berger and Thomas Luckmann wrote *Conceptual Machineries of Universe Maintenance,* A chapter in their book, *The Social Construction of Reality.* In this chapter they were highlighting how social norms and values get affirmed through shared meaning and when people stray from those norms two "Conceptual Machineries" operate to keep people from deviating from these norms. This understanding of society being socially constructed also known as a **Social Constructionist** understanding is something we will learn more about in Chapter 7, *Bias and Discrimination in Human Sexuality.* The authors flipped the norm and you can imagine how their example could be the norm. When we think about social norms around sexuality, there are very narrow sexual scripts we are conditioned to follow but what we know is that these social constructions can change.

Queer Theory



Queer Theory is a perspective that problematizes the manner in which we have been taught to think about sexual orientation. By calling their discipline “queer,” these scholars are rejecting the effects of labeling; instead, they embrace the word “queer” and have reclaimed it for their own purposes. Queer theorists reject the dichotomization of sexual orientations into two binary and mutually exclusive outcomes, homosexual or heterosexual. Rather, the perspective highlights the need for a more flexible and fluid conceptualization of sexuality—one that allows for change, negotiation, and freedom. The current schema used to classify individuals as either “heterosexual” or “homosexual” pits one orientation against the other. This mirrors other oppressive schemas in our culture, especially those surrounding gender and race (black versus white, male versus female).

Queer theorist Eve Kosofsky Sedgwick argued against American society's monolithic definition of sexuality—against its reduction to a single factor: the sex of one's desired partner. Sedgwick identified dozens of other ways in which people's sexualities were different, such as:

- Even identical genital acts mean very different things to different people.
- Sexuality makes up a large share of the self-perceived identity of some people, a small share of others'. We all vary in our level of how much sexuality shapes our self-perception and focus.
- Some people spend a lot of time thinking about sex, others little.
- Some people like to have a lot of sex, others little or none.
- Many people have their richest mental/emotional involvement with sexual acts that they don't do, or don't even want to do.
- Some people like spontaneous sexual scenes, others like highly scripted ones, others like spontaneous-sounding ones that are nonetheless totally predictable.
- Some people, homo- hetero- and bisexual, experience their sexuality as deeply embedded in a matrix of gender meanings and gender differentials. Others of each sexuality do not (Sedgwick 1990).

In the end, queer theory strives to question the ways society perceives and experiences sex, gender, and sexuality, opening the door to new scholarly understanding.

Sidebar 1.5 Making Sense of it All

We will be looking at human sexuality from an interdisciplinary lens throughout this book. You will learn from a diverse amount of information and there will be competing narratives. When you start to think about how to figure out “what is right” in regard to your own sexuality, try instead to reflect on what makes sense and feels comfortable. There is not one way to be a human or express their sexuality. A sense of open mindedness is always a good tool in your toolbox when it comes to the world of human sexuality. Get ready to learn about things you don’t know much about and build your **sexual literacy,** a knowledge of your sexual health and well-being. Human Sexuality is as diverse as the world's population. So learn new things, maybe try something you’ve never done before, be safe, and don’t yuck my yum and I won’t yuck yours.

Conclusion

Throughout this chapter we have examined the complexities of gender, sex, and sexuality. Differentiating between sex, gender, and sexual orientation is an important first step to a deeper understanding and critical analysis of these issues. Understanding the sociology of sex, gender, and sexuality will help to build awareness of the inequalities experienced by subordinate groups such as people gendered female, homosexuals, and transgendered individuals.

The history of sexuality is fraught with the cultural biases of the times. Looking at this contextually helps set a foundation as one examines the academic study of sexuality. With this in mind, critical evaluation will take place of how the study operates in the present day. Looking cross-culturally also helps place social norms and values center in the social construction of sex. When studying sex and sexuality, sociologists focus their attention on sexual attitudes and practices, not on physiology or anatomy. Norms regarding gender and sexuality vary across cultures. In general, the United States tends to be fairly conservative in its sexual attitudes. As a result, most in the LGBTQIA+ community continue to face opposition and discrimination in most major social institutions, despite a whole host of new laws enacted in the 21st century.

Glossary

1. **Biopsychosocial Approach to Human Sexuality** systematically considers biological, psychological, and social factors and their complex interactions
2. **Conflict Theory** looks at society as a competition for limited resources between those who have (bourgeoisie), and those who do not (proletariat)
3. **Double standard** a rule or principle that is unfairly applied in different ways to different people or groups. For example, concept that prohibits premarital sexual intercourse for women but allows it for men
4. **queer theory** a scholarly discipline that questions fixed (normative) definitions of gender and sexuality. Queer theory problematizes the manner in which we have been taught to think about sexual orientation. By calling their discipline "queer," these scholars are rejecting the effects of labeling; instead, they embrace the word "queer" and have reclaimed it for their own purposes.
5. **Sex Education** high quality teaching and learning about a broad variety of topics related to sex and sexuality.
6. **Sexual Literacy** knowledge of sexual health and well-being
7. **sexuality** a person's capacity for sexual feelings
8. **Social Constructionism** is a theory of knowledge that holds that characteristics typically thought to be immutable and solely biological—such as gender, race, class, ability, and sexuality—are products of human definition and interpretation shaped by cultural and historical contexts.
9. **Structural Functionalism** sees society as a structure with interrelated parts designed to meet the biological and social needs of the individuals in that society.
10. **Symbolic Interactionism** explores how we make meaning out of our interactions with one another in everyday life and how the specific roles we play affect these interactions.

Discussion Questions

1. Describe the practices of the father of modern gynecology, Dr. Marian Simms and how structural racism played a role in his surgical decisions.
2. Identify three examples of how American society is heteronormative.
3. Consider the types of derogatory labeling that sociologists study and explain how these might apply to discrimination on the basis of sexual orientation.
4. How can Conflict theory be applied to the study of Human Sexuality?
5. How can Queer theory be applied to the study of Human Sexuality?

Multiple Choice Questions

1. What Western country is thought to be the most liberal in its attitudes toward sex?

    a. United States
    b. Sweden
    c. Mexico
    d. Ireland

2. Compared to most Western societies, American sexual attitudes are considered _____.
    a. Conservative
    b. Liberal
    c. Permissive
    d. Free

3. Sociologists associate sexuality with _____.
    a. Heterosexuality
    b. Homosexuality
    c. biological factors
    d. a person's capacity for sexual feelings

4. According to national surveys, most American parents support which type of sex education program in school?
    a. Abstinence only
    b. Abstinence plus sexual safety
    c. Sexual safety without promoting abstinence
    d. No sex education

5. What are three sociological perspectives on sex and sexuality discussed in this chapter?
    a. Structural Functionalism, Conflict Theory and Symbolic Interactionism
    b. Psychoanalysis, Symbolic Interactionism and Learning Theory
    c. Structural Functionalism, Psychoanalysis, and Symbolic Interactionism
    d. Conflict Theory, Symbolic Interactionism and Learning Theory

6. Which theoretical perspective stresses the importance of regulating sexual behavior to ensure marital cohesion and family stability?
    a. Functionalism
    b. Conflict theory
    c. Symbolic interactionism
    d. Queer theory

7. Queer Theory
    a. Questions fixed (normative) definitions of gender and sexuality
    b. Is focused on reptile behavior
    c. Is the first known theory of personality
    d. Is heteronormative in nature

8. What are the benefits of a liberating sex education approach?
    a. An open minded populace

b. People who take care of their sexual wellness
c. Less cultural shame around sexual preferences, thoughts or desires
d. All of the above

9. A Social Constructionist viewpoint understands that sexuality is:
    a. Made out of artificial materials
    b. a product of human definition and interpretation shaped by cultural and historical contexts.
    c. Shameful and horrible
    d. Innate, and binary

10. What is meant by *Sexual Literacy*?
    a. Knowing how to read
    b. A knowledge of one's sexual health and well-being
    c. Being able to explain what sex it
    d. Liberation

For Further Exploration

For more information about sexual attitudes and practices in countries around the world, see the entire "Attitudes Toward Nonmarital Sex in 24 Countries" article from the *Journal of Sex Research* at http://openstaxcollege.org/l/journal_of_sex_research

Sara Baartman Documentary

Queer Theory – Subcultures and Sociology

Symbolic interactionism (video) | Khan Academy

Functionalism

Conflict Theory

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Chapter 2: Research Methods and Ethics in Human Sexuality

Research by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

Learning Objectives

After completing this module, students have a working knowledge of the following:

- A Scientific Approach to Human Sexuality
- Some notable sex researchers and their contributions
- Populations and Samples: Representing the World of Diversity
- Methods of Observation
- Correlation
- Ethics in Sex Research
- Research Methods in Human Sexuality

Introduction

How does one go about research in Human Sexuality and who came up with the idea to study such things? This section will provide you with that overview. Studying sexuality has always been difficult, mainly due to lack of funding available for this scope of research.

All research is subject to ethical considerations. When we undertake the task of

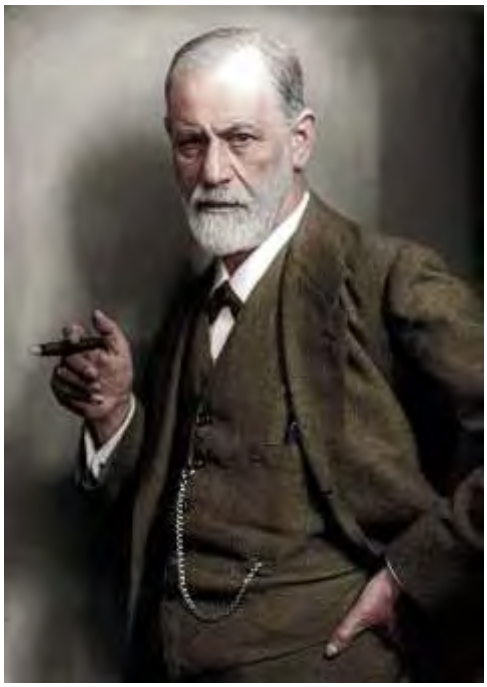
studying human behavior, we must first understand that the participants are human, and deserve to be treated ethically. Because this was not always the case, and people have been hurt or killed as a result, systems have been set in place to protect research participants.

History of Sexuality Research and Some Early Sex Researchers

Cover of January 1935 issue of magazine Sexology. Public Domain

As important as any other aspect of physical and mental health, our sexuality, how it operates biologically, and how we as social emotional creatures, approach sex, has been a topic of interest to various thinkers throughout time and location. As the scientific method became the way of knowing across academic fields, sexuality, which fell under multiple disciplines, was no exception. Let's turn our attention to some (certainly not all) notable contributors to the field.

Sigmund Freud (1856-1939)



Photocolorization. Circa 1921. Creative Commons Attribution-Share Alike 4.0

Sigmund Freud was born in Freiberg, Moravia on May 6, 1856. At a young age, Sigmund was considered to be very brilliant, and was given the best education his parents could afford. He eventually graduated from the University of Vienna in 1881. With a degree in medicine, he would find his interest in the realm of the mind, and would be greatly influenced by Charles Darwin and his work on the theory of evolution. He worked for a local psychiatric clinic, and from there he started up his research on human behavior. He then received a scholarship to study in France in order to solve the mystery behind the condition of *hysteria* in women (conversion disorder). He hypothesized that many of the women he treated were merely sexually frustrated, and later, postulated that most mental illnesses were caused by an underlying sexual problem (Haeberle, 1983). Today such notions have been proved wrong and Freud's legacy is a complicated one. There are many other causes of mental instability. Despite his narrow focus on sexuality as the root of all mental illness, his work in the field does begin the conversation of human sexuality in the academic world. Because of this, Freud is considered a pioneer in the study of human sexuality. Society is more open to the study of sexuality and sexuality itself due in part to Freud's work (Garcia, 1995).

Freud was the first to theorize that sexuality existed throughout a person's life beginning at infancy. In 1905, Freud published his work, Three Essays on the Theory of Sexuality. Freud's psychosexual development theory was the greatest major advancement in the study of sexuality of his time, and present day psychologists still consider Freud's theory when studying human sexuality. According to Freud, humans have libido, which is the notion of organically generated instinctual energy (Haeberle, 1983). Freud identified developmental stages of sexuality: the oral stage, anal stage, phallic stage, latency, and genital stage. The oral stage begins during infancy, and each stage is experienced until the child reaches adolescence, ending with the genital stage.

Not all Freud's theories were widely accepted during his life. Freud found that his theories on the sexuality of children caused some controversy and he became an outcast among other scientists. Freud wrote 4 major books: The Interpretation of Dreams (1900), Three Essays on the Theory of Sexuality (1905), Totem and Taboo (1913), and Beyond the Pleasure Principle (1919). These books based on the theories of Freud have earned him the title "the founder of psychoanalysis"(Haeberle, 1983).

Margaret Sanger (1879-1966)

Mike Alewitz. 2014. Creative Commons Attribution-Share Alike 4.0

An American Social activist who fought for the right of women to learn about and practice contraception. During her time, women were mostly relegated to a cycle of pregnancy and childbirth, and yet, the use of contraception was highly stigmatized.

Women of color, poor women and otherwise marginalized women were most at risk of suffering under a system that made it hard to access legal and safe contraception. While not a sex researcher, she introduced U.S. women to the diaphragm and went on to advocate for and promote research that aided in the development of the oral contraceptive known as “the pill”. Sanger was jailed for her activism and even taught her fellow incarcerated women about contraception. The organization she founded in pursuit of women’s rights later became Planned Parenthood.

Sidebar 2.1: Some Hard Truth

While Margaret Sanger was a successful American birth control activist, sex educator, writer, and nurse, the difficult truth is that the activist had alliances with Eugenicists (a debunked, discriminatory, evolutionary theory that seeks to eradicate "genetic defects" to improve the genetic makeup of a person through human breeding). Sanger's beliefs caused irreparable damage to Black, Indigenous, People of color, (BIPOC), people with disabilities, immigrants, and many others through her beliefs that were rooted in white supremacy. While Sanger is the founder of Planned Parenthood, the organization publicly acknowledges the legacy of anti-Blackness and racism as it relates to reproductive health as well as gynecology. Planned Parenthood is a well-known medical organization that specializes in reproductive health while also emphasizing the importance of people controlling their bodies, lives, self-determination and dignity. Planned Parenthood acknowledges Sanger's problematic beliefs and sees it as an opportunity to address the systemic issues within the organization and redefine its mission to uphold its values that strive to provide a variety of medical services to the communities that they exist in. For more on this, please watch Alexis McGill Johnson Remarks on Margaret Sanger | Planned Parenthood Video

Alfred Kinsey (1894-1956)

BORIS ARTZYBASHEFF. Dr. Alfred C. Kinsey on Time magazine cover, 1953. Public domain

Alfred Kinsey was an American researcher, who was most known for his research on sexual behavior. In particular, Kinsey's study and later book entitled, *Sexual Behavior in the Human Male* examined the sexual proclivities of males which led to his creation of the *Kinsey Scale* (Kinsey, 1948 p 636-649). This scale introduced the idea that sexuality is a spectrum rather than a binary set of categories, *either or.* Kinsey states that there are "patterns of sexual behavior and that the two types (homosexual and heterosexual) are represented in the sexual world, and that there is only a small number of "bisexuals" who occupy an intermediate position between the other groups"(More on this in Chapter 4). Kinsey made the assertion that most individuals were "exclusively either homosexual or heterosexual both in experience and in psychic reactions" by looking back to documented history (Kinsey, 1948 p 636-649). He also found that there were a very small group of individuals who experienced both types of behaviors, which led Kinsey to state that, "Males do not represent two discrete populations, heterosexual and homosexual" (Kinsey, 1948 p 636-649). Kinsey's work indicates that while an individual can be either homosexual or heterosexual, there are more than just two types of sexuality represented by the population.

Nettie Maria Stevens (1861-1912)

Nettie Maria Stevens. 1904 Bryn Mawr Special Collections Public Domain

Often overlooked in the literature, Nettie Stevens was one of the first female scientists to make a name for herself in the biological sciences. She was born in Cavendish, Vermont. Her family settled in Westford, Massachusetts. Stevens' father was a carpenter and handyman. He did well enough to own quite a bit of Westford property, and could afford to send his children to school.

Stevens was a brilliant student, consistently scoring the highest in her classes. In 1896, Stevens went to California to attend Leland Stanford University. She graduated with a Masters in Biology. Her thesis involved a lot of microscopic work and precise, careful detailing of new species of marine life. This training was a factor in her success with later investigations of chromosomal behavior.

After Stanford, Stevens went to Bryn Mawr College for more graduate work. Thomas Hunt Morgan was still teaching at Bryn Mawr, and was one of her professors. Stevens again did so well that she was awarded a fellowship to study abroad. She traveled to Europe and spent time in Theodor Boveri's lab at the Zoological Institute at Würzburg, Germany. Boveri was working on the problem of the role of chromosomes in heredity. Stevens likely developed an interest in the subject from her stay.

In 1903, Stevens got her Ph.D. from Bryn Mawr, and started looking for a research position. She was eventually given an assistantship by the Carnegie Institute after glowing recommendations from Thomas Hunt Morgan, Edmund Wilson and M. Carey Thomas, the president of Bryn Mawr. Her work on sex determination was published as a Carnegie Institute report in 1905. In this first study she looked at sex determination in meal worms. Later, she studied sex determination in many different species of insects.

Stevens' assistantship at Bryn Mawr still meant that she had to teach. She wanted a pure research position, and wrote to Charles Davenport to see if it was possible for her to work at his Station for Experimental Biology. Unfortunately, Stevens died of breast cancer in 1912 before she could occupy the research professorship created for her at Bryn Mawr, or work with Davenport at Cold Spring Harbor (Nettie Mae Stevens, 2011).

Margaret Mead (1901-1978)

Lynn Gilbert. 1977 Creative Commons Attribution-Share Alike 4.0

Mead, an American Anthropologist, sought to study sexuality outside of the Western lens. She traveled extensively abroad in pursuit of this. Her work in Samoa

led her to observe uninhibited sex that youth in Samoa engaged in. Sex among the youth was both condoned and encouraged by adult members of the community. Her work challenged the restrictive sexual ethics of her time. Beyond sexual practices differing relative to culture, she also wrote about gender roles differing from what were normative practices in the U.S. She spoke to the concept of sexuality as a social construction in terms of how culture was the shaping force in sexual attitudes and behaviors (Mead, 1928 p 61-76).

Richard von Krafft-Ebing (1840-1902)

Unknown Author. Public Domain circa 1900

Richard von Krafft-Ebing was a German sexologist who wrote the book Psychopathia Sexualis. According to the book, various forms of sexual behavior and arousal were considered disgusting. He believed that there existed numerous sexual behaviors and sexual practices which he called 'natural variations' and that all of them aroused the same cultural phenomenon of stigma. These sexual deviations were classified into four different groups: sadism, masochism, fetishism, and homosexuality. Krafft-Ebing emphasizes that the hand is one the most common fetishes and often joined by masochistic and sadistic behaviors (Bauer,

2003). He wrote that homosexuality was a natural occurrence and that it is not a chosen vice. Krafft-Ebing essentially brought to light the fact that homosexuality exists as part of the spectrum of human sexuality rather than pathologizing it (Bauer, 2003).

William Masters (1915-2001) and Virginia Johnson (1925-2013)

William Howell Masters and Virginia Eshelman Johnson

William Howell Masters and Virginia Eshelman Johnson pioneered research on human sexual behavior in the 1950s and 1960s. They worked together to disprove many of the long standing misconceptions about sexual behavior. In 1966 They released their most important, groundbreaking study, a four-stage model of human sexual response based on approximately 10,000 recordings of changes in participants' physiology during climax. From these data, they identified four successive stages: (1) excitement, (2) plateau, (3) orgasm, and (4) resolution. These findings would change how people viewed sexual responses and will be discussed further in Chapter 4. (Fuhrmann, & Buhi, 2009).

Sidebar 2.2: A Study on Parent/Child Communication About Sex

In 1995 a study was done on 1200 students at a Northern California University. Students were surveyed about their at home sex education. The hypothesis was that male students got vastly different messages about sexuality than female students did (note: the study demographics look only at gender asking only either male or female. If this study were to be replicated today, the gender question would be modified to include other gender options). The data gathered and resultant Master's Thesis obtained by this textbook's author gave support to the hypothesis that sex education falls down gendered lines. The sexual double standard is something we know exists, men are praised for being sexually experienced and women are taught to remain pure. This double standard in the United States dates back centuries and is rooted in Christianity, primarily White Anglo Saxon Protestant (WASP) religion and puritanical culture. The data suggested that this double standard was alive in well the sex education these students received at home. Overall parents were not teaching their children about sex much at all and when they were it was very different depending on the gender of the child. Students assigned male are told to go out, explore and become sexually experienced.

The philosophies that my father portrayed were: 1) Use a women to satisfy sexual desire, 2) Cast the woman aside when the sex act is finished, 3) Use any means possible, except for physical force, to have sex with any woman. To formally introduce me to manhood, my dad gave me a brief description of sexual intercourse which was followed by taking me to a hooker 2 months later. I reluctantly had sex with the hooker to save my pride F8401M

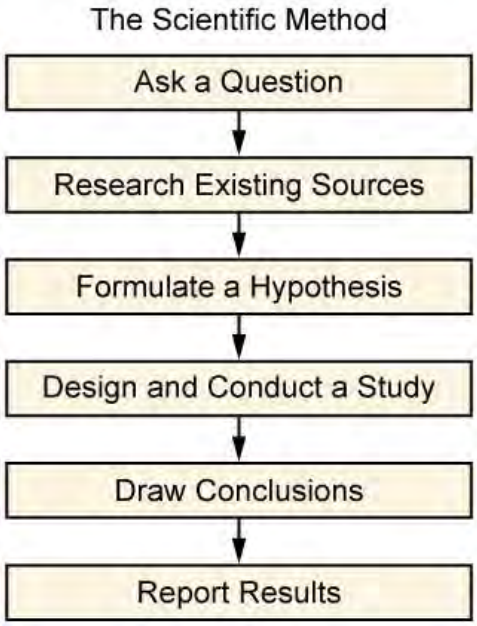
On the contrary, assigned females were taught to keep their bodies safe and not to have casual sex.

I am now very sad. Maybe I can ask my mom about sex. No! No way! They will kick me out of the family if they know I am not a virgin. I won't even tell them anything. I don't want my family to treat me like a monster. F9307F

The overall findings were that parents view their child's sexual rights very differently depending on whether they are assigned male or assigned female

(Rahman, 1995). So what this results in is two very different sexual scripts. How does this double standard play out in terms of coupling? If a significant number of people in society end up coupling with another person whose gender is not the same as theirs, how do we navigate sexuality, communication and consent when we have been given radically different messages?

The Scientific Method



Humans and their social interactions are so diverse that these interactions can seem impossible to chart or explain. However, this is exactly why scientific models can work for studying human behavior. A scientific process of research establishes parameters that help make sure results are objective and accurate. Scientific methods provide limitations and boundaries that focus a study and organize its results. The scientific method involves developing and testing theories about the world based on empirical evidence. It is defined by its commitment to systematic observation of the empirical world and strives to be objective, critical, skeptical, and logical as best as possible. No human study can be completely value free, but the scientific method includes acknowledging researcher bias or perspective as part of the findings report. It most often involves a series of prescribed steps (see chart above) that have been established over centuries of scholarship.

Problems and Issues in Sex Research Sample Methods

Sexuality is often considered a taboo subject in modern Western society, therefore, the field is among the most difficult to obtain reliable data. However, with the use of the survey method, information is easily obtained from large groups. Because of this, there is the potential for both representativeness and the size of the samples to be more adequate for generalizations to larger groups of people (Griffitt & Hatfield,1985). Using a voluntary large group to identify the traits and habits of the population can be both much more reliable, and not completely accurate. Focusing on a small case study or a small group in an experiment to draw a conclusion about the general population can be misleading, because the individuals who choose to participate in an experiment about sexuality are already likely more open to discussing sex than the general population. One of the most comprehensive sexuality studies in the U.S known as The Janus Report was largely criticized for not actually having information from a random sampling. The Americans in the study were willing to talk about and engage in wider varieties of sexual behaviors.

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Volunteer Bias

Volunteer bias can create major problems for any type of research. Some psychologists believe that people who volunteer for research have different

characteristics from those who don't volunteer. This is thought to be especially true in regards to sex research, with sex being a more taboo topic for some. The Volunteer Bias and Personality Traits in Sexual Standards research sought to see if there was stronger volunteer bias in sex surveys, versus a survey of a more general topic. The study surveyed 126 males and 128 females in an introductory Psychology course at a Midwestern Canadian university. The study began with the students completing the *Personality Research Form* developed in 1967 by Psychologist Douglas N. Jackson to assess the students' personalities. They were then assigned to be mailed either a sexual standard's questionnaire (experimental group) or parent-child relations questionnaire (control group). Returning these questionnaires was not required for the course. It was hypothesized that the volunteers who returned the sexual standards survey would stand out as an atypical group. However, when relating back to the personality research forms, personalities were about the same as those who returned the parent-child relations questionnaire.

Researcher Bias

Through the interdisciplinary study of human sexuality and corresponding research, we are able to obtain more information about the sexual aspects of human beings. As human beings, researchers are conducting research about topics that relate directly to them. Often, researchers will have ideas, values, or opinions based on their cultural or social status that may skew some data. While this is certainly to be expected, it is easily assuaged by full transparency surrounding the research. A section in any research report can include the researcher's hypothesis prior to undertaking the study, so that the reader can understand where the researcher is coming from. Clear description of methods and findings plus an analysis of the implications also helps validate research findings. While it is problematic if researchers do not recognize their own biases and include them in their findings, these simple steps can avoid this type of pitfall. Another type of bias can come from those who have a vested interest in keeping a certain narrative about whatever phenomena is a proposed topic of study. In some cases, intervention from lobbyists and conservative groups prevented major funding of certain research making discovery more difficult. Those special interest groups may argue that there is no value in the study and in fact would serve more harm than

good. This is a slippery slope, and sometimes, the research that can be life saving ends up being the most controversial.

Sidebar 2.3: The U.S. Public Health Service Syphilis Study at Tuskegee

The Tuskegee Syphilis Study was a clinical study conducted between 1932 and 1972. The study was intended to observe the natural history of untreated syphilis. As part of the study, researchers did not collect informed consent from participants and they did not offer treatment, even after it was widely available. The study ended in 1972 on the recommendation of an Ad Hoc Advisory Panel, convened by the Assistant Secretary for Health and Scientific Affairs, following publication of news articles about the study. In 1997, President Clinton issued a formal Presidential Apology, in which he announced an investment to establish what would become The National Center for Bioethics in Research and Health Care at Tuskegee University. Many records can be found in the National Archives. After the study, sweeping changes to standard research practices were made. Efforts to promote the highest ethical standards in research are ongoing today.

Content source: National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

Ethical Considerations in Sexuality Research

As discussed in the previous chapter, research done by the *Father of Modern Gynecology*, Dr. Marion Simms was tainted by his unethical approach to patient care, based on perceived racism and beliefs about the pain threshold of Black enslaved women. As research became something that aided in the pursuit of knowledge, many researchers who were laser focused on wanting to know chose to overlook ethical considerations, and their actions led to great harm in numerous cases. Ethics are taken very seriously in institutions of higher learning because of this shameful past, and we as present day practitioners are held to high standards when it comes to research on human subjects.

At a broader societal level, members of some groups have historically faced more than their fair share of the risks of scientific research, including people who are institutionalized, are disabled, or belong to a racial or ethnic minority or otherwise disadvantaged group. A particularly tragic example of this is the Tuskegee (Box 2.3 above) and Guatemala Syphilis studies both led by Dr. John Cutler. In Tuskegee, the study conducted for the Public Health Service took place from 1932 to 1972. These participants were poor African American men in the vicinity of Tuskegee, Alabama, who were told that they were being treated for *bad blood*. Although they were given free medical care, they were not treated for their syphilis. Instead, they were observed to see how the disease developed in untreated patients. Even after the use of penicillin became the standard treatment for syphilis in the 1940s, these men continued to be denied treatment without being given an opportunity to leave the study. The study was eventually discontinued only after details were made known to the general public by journalists and activists. It is now widely recognized that researchers need to consider issues of justice and fairness at the societal level.

Beginning in 1946, the United States government, under Dr. Cutler, immorally and unethically engaged in research experiments, in which more than 5000 uninformed and unconsenting Guatemalan people were intentionally infected with bacteria that cause sexually transmitted diseases. Many remain untreated to this day (Rodriguez, & García, 2013).

In 1997, 65 years after the Tuskegee Syphilis Study began, and 25 years after it ended, President Bill Clinton formally apologized on behalf of the government to those who were affected. The United States eventually provided treatment and compensation for victims, families, and heirs in Tuskegee, including funding to locate the victims and pay attorneys' fees. The ethical principle of equal justice strongly suggests that similar relief should be provided for the Guatemalan victims. While the U.S. now acknowledges this was an ethical failing, efforts to remediate the damage as in the case of Tuskegee, have not been undertaken, In a 2013 article entitled, *First, do no harm: the US sexually transmitted disease experiments in Guatemala*, The authors write, "Although US President Barack Obama apologized in 2010, and although the US Presidential Commission for the Study of Bioethical Issues found the Guatemalan experiments morally wrong, little if anything has been done to compensate the victims and their families." (Rodriguez, & García, 2013).

Researchers have an obligation to practice their research in an ethical manner, but what does that mean exactly? They must respect their participants' dignity and their autonomy, giving them the opportunity to act without coercion. Researchers must obtain informed consent, which essentially involves the participants' agreement and documentation of their agreement to participate in a study after having been informed of everything that might reasonably be expected of them as participants. Included in this is also a right to privacy so that those being studied have their identity kept confidential as well as the right to opt out. None of this was done in Guatemala nor in Tuskegee, and had they been informed, they most likely would not have agreed to participate in the first place.

Because of these and other heinous examples of ethical violations, measures have been put in place to offset this type of exploitation. One of the earliest ethics codes was the Nuremberg Code, a set of 10 principles written in 1947, in conjunction with the trials of Nazi physicians accused of shockingly cruel research on concentration camp prisoners during World War II. It provided a standard against which to compare the behavior of the men on trial, many of whom were eventually

convicted and either imprisoned or sentenced to death. The Nuremberg Code was particularly clear about the importance of carefully weighing risks against benefits and the need for informed consent. The Declaration of Helsinki is a similar ethics code that was created by the World Medical Council in 1964. Among the standards that it added to the Nuremberg Code was that research with human participants should be based on a written protocol, and it must include a detailed description of the research that is reviewed by an independent committee. The Declaration of Helsinki has been revised several times, most recently in 2004. In the U.S., concerns about the Tuskegee experiment and others led to the publication of federal guidelines known as the Belmont Report. The Belmont Report explicitly recognized the principle of seeking justice, including the importance of conducting research in a way that distributes risks and benefits fairly across different groups at the societal level. The Belmont Report became the basis of a set of laws the Federal Policy for the Protection of Human Subjects that apply to research conducted, supported, or regulated by the federal government. An extremely important part of these regulations is that universities, hospitals, and other institutions that receive support from the federal government must establish an Institutional Review Board (IRB), a committee that is responsible for reviewing research protocols for potential ethical problems. An IRB must consist of at least five people with varying backgrounds, including members of different professions, scientists and nonscientists, men and women, and at least one person not otherwise affiliated with the institution. The IRB helps to make sure that the risks of the proposed research are minimized, the benefits outweigh the risks, the research is carried out in a fair manner, and the informed consent procedure is adequate. The federal regulations also distinguish research that poses three levels of risk. Exempt research includes research on the effectiveness of normal educational activities, the use of standard psychological measures and surveys of a nonsensitive nature that are administered in a way that maintains confidentiality, and research using existing data from public sources. It is called exempt because the regulations do not apply to it. Minimal risk research exposes participants to risks that are no greater than those encountered by healthy people in daily life or during routine physical or psychological examinations. Minimal risk research can receive an expedited review by one member of the IRB, or by a separate committee under the authority of the IRB that can only approve minimal risk research. (Many departments of psychology have such separate committees.) Finally, at-risk research poses greater than minimal risk and must be reviewed by the entire IRB.

Specific to human sexuality research, The American Psychological Association (APA) is the governing body for much of the sex research undertaken. Ethical Principles of Psychologists and Code of Conduct (also known as the APA Ethics Code) was first published in 1953 and has been revised several times since then, most recently in 2002. It includes about 150 specific ethical standards that psychologists and their students are expected to follow. Much of the APA Ethics Code concerns the clinical practice of psychology advertising purposes, the most relevant part, is linked here: American Psychological Association Ethics Code.

Sidebar 2.4: Sex Research and Equity

Just as the medical field grew in the West out of predominately white, heteronormative, cisgender persons, so did the study of sexuality. Much of the body of research in the field is done on white, heterosexual cisgender people. Despite the world of human sexuality, being as vast and diverse as it is, research is slow to catch up. New spaces and opportunities for different research are opening up as the field of educators become more diverse but as we will learn throughout this book, there is much still to be done. One space that facilitates engaging with sexuality beyond those borders is afrosexology.com. Their mission to educate, explore and help people reclaim their sexual agency which then give them agency in their larger lives is one way in which current sex research is moving the needle towards equity.

Putting Ethics Into Practice

In this section, we look at some practical advice for conducting ethical research. Who knows, some of you may be undertaking sex research one day! Again, it is important to remember that ethical issues arise well before you begin to collect data and continue to arise through publication and beyond.

As the APA Ethics code notes in its introduction, “Lack of awareness or misunderstanding of an ethical standard is not itself a defense to a charge of unethical ethical responsibilities” (Ethical Principles of Psychologists and Code of Conduct, 2017). At a minimum, this means reading and understanding the relevant standards of the APA Ethics Code, distinguishing minimal risk from at-risk research, and knowing the specific policies and procedures of your institution including how to prepare and submit a research protocol for institutional review board (IRB) review. If you are conducting research as a course requirement, there may be specific course standards, policies, and procedures. If any standard, policy, or procedure is unclear, or you are unsure what to do about an ethical issue that arises, you must seek clarification. You can do this by reviewing the relevant ethics codes, reading about how similar issues have been resolved by others, or consulting with more experienced researchers, your IRB, or your course instructor. Ultimately, you as the researcher must take responsibility for the ethics of the research you conduct.

As you design your study, you must identify and minimize risks to participants via the informed consent procedure, which in parts states:

A researcher must inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (Ethical Principles of Psychologists and Code of Conduct, 2017).

Start by listing all the risks, including risks of physical and psychological harm and violations of confidentiality. Remember that some risks might apply only to some participants. For example, while many people would have no problem completing a survey about their fear of various sex crimes, this may be triggering for those who have been a victim of one of those crimes. This is why you should seek input from a variety of people, including your research collaborators, more experienced researchers, and even from nonresearchers who might be better able to take the perspective of a participant.

Once you have identified the risks, you can often reduce or eliminate many of them. One way is to modify the research design. For example, you might be able to shorten or simplify the procedure to prevent boredom and frustration. You might be able to replace upsetting or offensive stimulus materials (e.g., graphic photos) with less upsetting or offensive ones (e.g., milder photos of the sort people are likely to see in the newspaper).

A second way to minimize risks is to use a pre-screening procedure to identify and eliminate participants who are at high risk. You can do this in part through the informed consent process. For example, you can warn participants that a survey includes questions about their fear of sex crimes, and remind them that they are free to withdraw if they think this might upset them. Prescreening can also involve collecting data to identify and eliminate participants.

A third way to minimize risks is to take active steps to maintain confidentiality. You should keep signed consent forms separate from any data that you collect, and in such a way that no individual's name can be linked to their data. You should only collect information that you actually need to answer your research question. If a person’s sexual orientation or ethnicity is not clearly relevant to your research question, for example, then do not ask them about it. Be aware also that certain data collection procedures can lead to unintentional violations of confidentiality. When participants respond to an oral survey in a shopping mall or complete a questionnaire in a classroom setting, it is possible that their responses will be overheard or seen by others. If the responses are personal, it is better to administer the survey or questionnaire individually in private or to use other techniques to prevent the unintentional sharing of personal information.

Be sure to identify and minimize deception. The APA code of ethics standard 8.07 states that a researcher may:

(a) not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective non deceptive alternative procedures are not feasible.

(b) not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) must explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion

of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (Ethical Principles of Psychologists and Code of Conduct, 2017).

Remember that deception can take a variety of forms, not all of which involve actively misleading participants. It is also deceptive to allow participants to make incorrect assumptions or simply withhold information about the full design or purpose of the study. It is best to identify and minimize all forms of deception.

Remember that according to the APA Ethics Code, deception is ethically acceptable only if there is no way to answer your research question without it. Therefore, if your research design includes any form of active deception, you should consider whether it is truly necessary.

In general, it is considered acceptable to wait until debriefing before you reveal your research question as long as you describe the procedure, risk and benefits during the informed consent process.

Once the risks of the research have been identified and minimized, you need to weigh them against the benefits. This requires identifying all the benefits. Remember to consider benefits to the research participants, to science, and to society. If you are a student researcher, remember that one of the benefits is the knowledge you will gain about how to conduct scientific research, knowledge you can then use to complete your studies and succeed in graduate school or in your career.

If the research poses minimal risk, no more than in people's daily lives or in routine physical or psychological examinations, then even a small benefit to participants, science, or society is generally considered enough to justify it. If it poses more than minimal risk, then there should be more benefits. If the research has the potential to upset some participants, for example, then it becomes more important that the study be well designed and answer a scientifically interesting research question or have clear practical implications. It would be unethical to subject people to pain, fear, or embarrassment for minimal scientific gain. Research that has the potential to cause harm that is more than minor, or lasts for more than a short time, is rarely considered justified by its benefits.

Once you have settled on a research design, you need to create your informed consent and debriefing procedures. Start by deciding whether informed consent is necessary according to *APA Standard 8.05*. If informed consent is necessary, there

are several things you should do. First, when you recruit participants whether it is through word of mouth, posted advertisements, or a participant pool, provide them with as much information about the study as you can. This will allow those who might find the study objectionable to avoid it. Second, prepare a script or talking points to help you explain the study to your participants in simple everyday language. This should include a description of the procedure, the risks and benefits, and their right to withdraw at any time. Third, create an informed consent form that covers all the points in *APA Standard 8.02a* that participants can read and sign after you have described the study to them. Your university, department, or course instructor may have a sample consent form that you can adapt for your own study. If not, an Internet Search will turn up several samples. Remember that if appropriate, both the oral and written parts of the informed consent process should include the fact that you are keeping some information about the design or purpose of the study from them but that you will reveal it during debriefing.

Debriefing is similar to informed consent in that you cannot necessarily expect participants to read and understand written debriefing forms. So again, it is best to write a script or set of talking points, with the goal of being able to explain the study in simple everyday language. During debriefing, you should reveal the research question and full design of the study. For example, if participants are tested under only one condition, then you should explain what happened in the other conditions. If you deceived your participants, you should reveal this as soon as possible, apologize for the deception, explain why it was necessary, and correct any misconceptions that participants might have as a result. Debriefing is also a good time to provide additional benefits to research participants, by giving them relevant practical information or referrals to other sources of help. For example, in a study of attitudes toward domestic abuse, you could provide pamphlets about domestic abuse and referral information to the university counseling center for those who might want it.

Remember to schedule plenty of time for the informed consent and debriefing processes. They cannot be effective if you have to rush through them. The next step is to get institutional approval for your research, based on the specific policies and procedures at your institution or for your course. This will generally require writing a protocol that describes the purpose of the study, the research design and procedure, the risks and benefits, the steps taken to minimize risks, and the informed consent and debriefing procedures. Do not think of the institutional

approval process as merely an obstacle to overcome but as an opportunity to think through the ethics of your research and to consult with others who are likely to have more experience or different perspectives than you. If the IRB has questions or concerns about your research, address them promptly and in good faith. This might even mean making further modifications to your research design and procedure before resubmitting your protocol.

Your concern with ethics should not end when your study receives institutional approval. It now becomes important to stick to the protocol you submitted, or to seek additional approval for anything other than a minor change. During the research, you should monitor your participants for unanticipated reactions, and seek feedback from them during debriefing. Be alert also for potential violations of confidentiality. Keep the consent forms and the data safe and separate from each other and make sure that no one, intentionally or unintentionally, has access to participants personal information.

Finally, you must maintain your integrity through the publication process and beyond. Address publication credit; who will be authors on the research and the order of authors with your collaborators early and avoid plagiarism in your writing. Remember that our scientific goal is to learn about the way the world actually is and that your scientific duty is to report on your results honestly and accurately. So do not be tempted to fabricate data or alter your results in any way. Besides, unexpected results are often as interesting or more so than expected ones.

Sidebar 2.5: Hypocrisy is the Greatest Luxury

While these standards of ethics put forth by the APA are seen as a definitive guide in the pursuit of ethical research, even the organization itself, the APA has failed to abide by them in large scale research that has been widely published, cited and used as justification for policy and funding decisions nationwide. Many historically relevant psychological studies are clear violations of the current standards set by the American Psychological Association (APA) and were founded on the basis of systemic racism. Experiments like the aforementioned Tuskegee Syphilis Study, Jane Elliot's Blue/Brown Eyes Exercise examined in the film, A Class Divided (full film) | FRONTLINE, and The Doll Test Landmark Cases: Brown v Board Doll Test (C-SPAN) hold a variety of unethical practices in the way they were produced, but are still considered to be groundbreaking contributions to the current psychological landscape.

Additionally, many early thinkers including Ronald Fisher, a key player in the development of statistical science, also supported racism and eugenics. There is a laundry list of connections between systemic racism and psychology, which is why the APA's decision to apologize for its role in incorporating racism within the discipline of psychology is critical to the development of psychological practices to come, but not the only solution.

The APA cannot completely correct the wrongs of the racist practices put forth in the past, however, the Association has a responsibility to put forth more ethical practices that do not further marginalize and misdiagnose people of color. To this day, there is an overrepresentation of Black Americans who are admitted into psychiatric hospitals, suicide rates for Black Youth continue to rise, and Black Americans are more likely to be diagnosed with disorders like schizophrenia as compared to White Americans.

As American culture strives to become more centered around the emotional wellness of all people and seeks to condemn dehumanization, institutions must develop better practices for building spaces of healing.

Conclusion

Research is a building block of science, and without it, so many of our nation's innovations would have not been made. The early sex researchers discussed here paved the way for present day sex research. Learning how to undertake a research project is something most college students will experience during their time in college. The development of the process of research takes into consideration multiple variables with an important focus on ethics. The absolute need for ethical guidelines in research has been made vividly clear. Without policies and procedures that guide researchers (and sometimes even with them), violations that harm human subjects have taken place with grave consequences. Chapter 1: What is Human Sexuality describes multiple incidents of ethical violations throughout history and up until present day. In highlighting some of these, we see that in many cases, marginalized populations are the ones most at risk. It is important to remember both recent and distant past bad practices in order to do better. We must do better and need to both acknowledge and understand why ethical violations took place. Admitting that bias, racism and other forms of prejudice allowed for certain persons to be exploited when others remained protected by an ethical framework should trouble the reader and prompt them to learn from this shameful past.

Glossary

1. **APA Ethics Code**: “Lack of awareness or misunderstanding of an ethical standard is not itself a defense to a charge of unethical ethical responsibilities” (Ethical Principles of Psychologists and Code of Conduct, 2017)
2. **At-risk Research**: Poses greater than minimal risk and must be reviewed by the entire IRB
3. **Ethics**: moral principles that govern a person's behavior or the conducting of an activity
4. **Exempt Research**: Research on the effectiveness of normal educational activities, the use of standard psychological measures and surveys of a nonsensitive nature that are administered in a way that maintains confidentiality, and research using existing data from public sources

5. **Informed consent**: process of communication between you and your health care provider that often leads to agreement or permission for care, treatment, or services
6. **Minimal Risk Research**: exposes participants to risks that are no greater than those encountered by healthy people in daily life or during routine physical or psychological examination
7. **Researcher Bias**: ideas, values, or opinions held by researchers based on their cultural or social status that may skew some data
8. **Scientific Method**: A scientific process of research establishes parameters that help make sure results are objective and accurate
9. **Survey Method**: The collection of information from a sample of individuals through their responses to questions
10. **Volunteer Bias**: A bias people who volunteer for research have that differentiate them from those who don't volunteer

Discussion Questions

1. Who is Margaret Sanger and what was her impact on society?
2. What are the six steps in the scientific method?
3. What was the goal of the Tuskegee Syphilis Study and why is it widely known?
4. Why is the Kinsey Scale an important advancement in the research of sexual orientation?
5. What is one of the major issues associated with Volunteer Bias?

Multiple Choice Questions

1. Alfred Kinsey described patterns of sexual behavior as what two types?
    a. homosexual and heterosexual
    b. omnisexual and heterosexual
    c. male and female
    d. sexuality and sexual behavior

2. Von Krafft-Ebing is credited with understanding:

a. All of the answers are correct
b. homosexuality exists
c. homosexuality is not a disease
d. homosexuality is a natural occurring for those individuals who are homosexual

3. Master and Johnsons most important work helped to change how people viewed _____
    a. sexual responses
    b. sexual conflicts
    c. each other
    d. husbands and wives

4. In sexuality research, it is _____ to obtain reliable data
    a. Difficult
    b. Easy
    c. Worthwhile
    d. Important

5. According to the book, Psychopathia Sexualis, written by _____, various forms of sexual behavior and arousal were considered disgusting. The author believed that there existed numerous sexual behaviors and sexual practices which he called 'natural variations' and that all of them aroused the same cultural phenomenon of stigma.
    a. Margaret Sanger
    b. Richard von Krafft-Ebing
    c. Margaret Mead
    d. Nettie Maria Stevens

6. Researchers may be biased in their research based on their _____
    a. cultural or social status

b. cultural status only
c. social status only
d. research

7. Which of the following is not true about Freud?
    a. All of his theories were well received at first
    b. He caused controversy
    c. We wrote several major books that are consulted today
    d. He is called "the founder of psychoanalysis"

8. The Scientific Method is:

    a. Formulate a hypothesis, draw conclusions, ask a question, report results, design and conduct a study, research existing sources
    b. Design and conduct a study, report results, formulate a hypothesis, ask a question, research existing sources, draw conclusions
    c. Ask a question, research existing sources, formulate a hypothesis, design and conduct a study, draw conclusions, report results
    d. Ask a question, design and conduct a study, report results, formulate a hypothesis, report results, draw conclusions

9. Ethics are:

    a. Our familial nation of origin
    b. moral principles that govern a person's behavior
    c. Laws
    d. Silly

10. Researcher Bias can be defined as:

    a. Ideas, values, or opinions held by researchers based on their cultural or social status that may skew some data

b. Not choosing to participate because you dislike the scientist
c. Having too many choices in the data set
d. Being too involved with your participants

For Further Exploration

1. The Deadly Deception, Tuskegee Syphilis Experiment The Deadly Deception
2. The Tragic Life of "Hottentot Venus"| Sara Baartman The Tragic Life of "Hottentot Venus"| Sara Baartman
3. Podcast, Sex with Emily speaking with Gottman Institute for Sex Research on Compatibility, Conflict & Conversation,
4. BELLY OF THE BEAST | DOCUMENTARY FILM | OFFICIAL TRAILER
5. https://youtu.be/0Rnq1NpHdmw John Oliver on Scientific Research.

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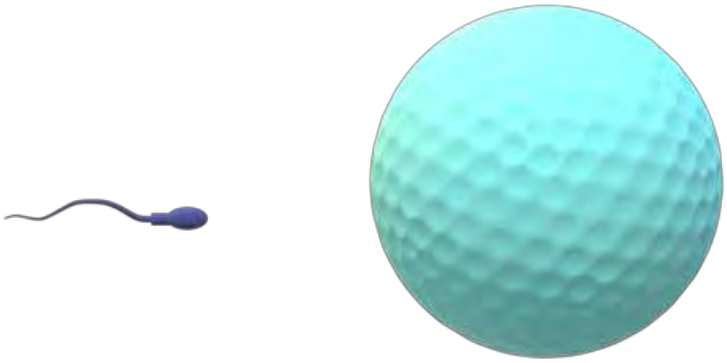
Chapter 3: Development and Structure of The Human Reproductive System



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Learning Objectives

By the end of this section, you will be able to:

- Explain how bipotential tissues are directed to develop into the differing sex organs
- Develop an understanding of Differentiated Sex Development which results in anatomical variations of sexual characteristics identified as Intersex
- Identify the rudimentary duct systems in the embryo that are precursors to internal sex organs
- Describe the hormonal changes that bring about puberty, and the secondary sex characteristics of assigned males and females

- Describe the structure and function of the organs of the assigned female reproductive system
- List the steps of oogenesis
- Describe the hormonal changes that occur during the ovarian and menstrual cycles
- Trace the path of an oocyte from ovary to fertilization
- Describe the structure and function of the organs of the assigned male reproductive system
- Describe the structure and function of the sperm cell
- Explain the events during spermatogenesis that produce haploid sperm from diploid cells
- Identify the importance of testosterone in assigned male reproductive function

Author's Note

The following chapter will be divided into three distinct sections in an effort to understand reproductive functions of human anatomy. The development of the reproductive systems begins soon after fertilization of the ovum, with primordial gonads beginning to develop approximately one month after conception which leads to assigned sex of the fetus. Reproductive development continues in utero, but there is little change in the reproductive system between infancy and puberty.

Section 1: Development of the Sexual Organs in the Embryo and Fetus

Assigned females at birth are considered the "fundamental" sex—that is, without much chemical prompting, all fertilized eggs would develop into assigned females at birth. To be assigned male at birth, an individual must be exposed to the cascade of factors initiated by a single gene on the male Y chromosome. This is called the SRY (*S*ex-determining *R*egion of the *Y* chromosome). Because females assigned at

birth do not have a Y chromosome, they do not have the *SRY* gene. Without a functional *SRY* gene, an individual will be assigned female at birth.

In all embryos, the same group of cells has the potential to develop into the primordial sex specific gonads; this tissue is considered bipotential. The *SRY* gene actively recruits other genes that begin to develop the testes, and suppresses genes that are important in anatomical female development. As part of this *SRY*-prompted cascade, germ cells in the bipotential gonads differentiate into spermatogonia. Without *SRY*, different genes are expressed, oogonia form, and primordial follicles develop in the primitive ovary.

Soon after the formation of the testes, the Leydig cells begin to secrete testosterone. Testosterone can influence tissues that are bipotential to become male assigned at birth reproductive structures. For example, with exposure to testosterone, cells that could become either the glans penis or the glans clitoris form the glans penis. Without testosterone, these same cells differentiate into the clitoris.

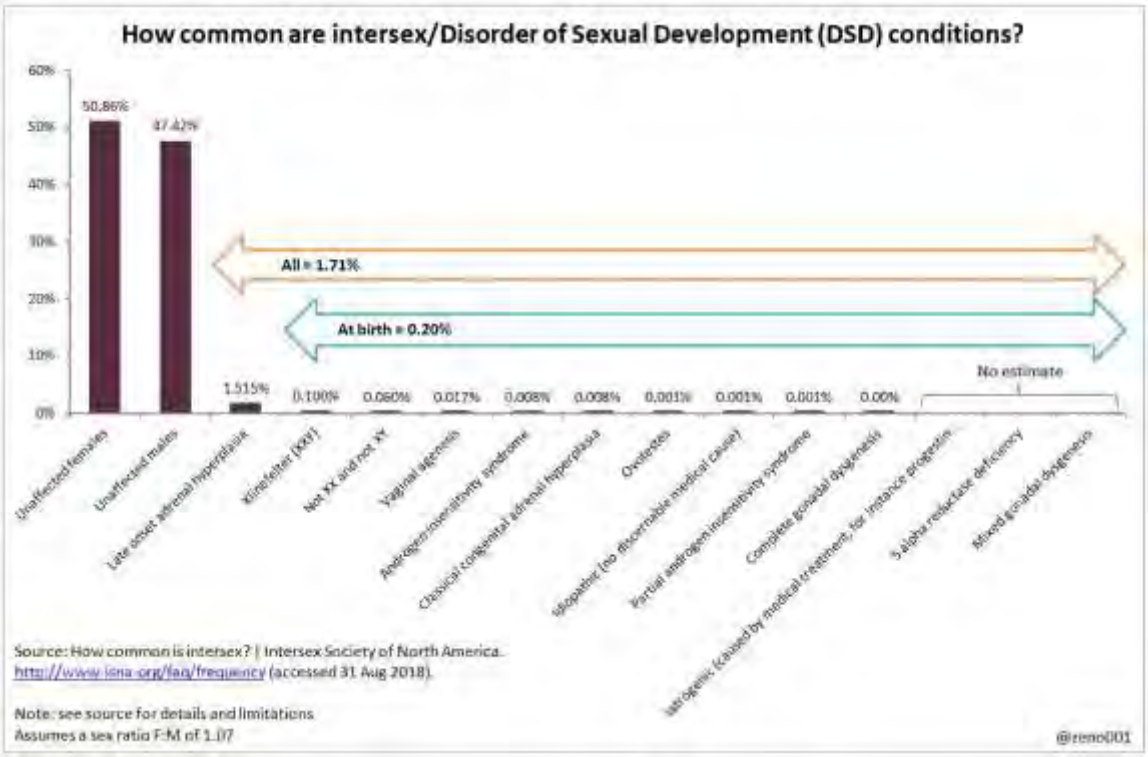
Not all tissues in the reproductive tract are bipotential. The internal reproductive structures (for example the uterus, fallopian tubes, and part of the vagina in people assigned female at birth; and the epididymis, ductus deferens, and seminal vesicles in people assigned male at birth form from one of two rudimentary duct systems in the embryo.

Sidebar 3.1: Disrupting the Binary-Understanding Intersex aka Differentiated Sex Development

From a medical perspective, differentiated sex development or DSD can occur in approximately 1 in 100 individuals. The general term for people born with DSD is **Intersex.** This umbrella term is used for a range of variations that can occur when a person does not have the specific anatomy or chromosomal markers that would typically assign them either male or female. This is roughly the same statistical variation for green eyes or red hair factoring in a margin of error of 2%. According to our current understanding there are approximately twenty-five genes that have an impact on anatomical sex development. Taken together as an umbrella category, an estimated forty types of DSD have been medically recorded with approximately eight of those being the typical determinants of DSD across a normalized population sample.

As with most complex systems including biological organisms, simple models are often necessary to provide a shortcut to understanding. However, the risk in using these models is that they lack nuance and they rarely show the larger picture in context to other connected systems. Looping back to the spectra of medical sex, most secondary and primary school textbooks as well as some introductory level college texts use a simplified XX/XY model to demonstrate reproductive characteristics within a lifecycle. The XX/XY model is incomplete and lacks a large amount of understanding in how all the biological systems reflect and inform one another. Models and shortcuts are useful; for example, this work has used the term 'assigned sex' here to differentiate itself from sex as a larger psycho-social categorization but even that lacks nuance to a medical clinician since 'assigned sex' can be further broken down into chromosomal, gonadal or anatomical specialties as well as how hormones impact primary and secondary sex characteristics. These differentiations are particularly important in healthcare decisions as these specialties might be in completely different hospital departments.

The spectrum of difference in DSD and intersexed individuals can be visualized below:



As new data and training is filtered down slowly through the medical establishment, medical sex is now thought of to be closer to polygenetic traits since it results in a variety of expressions. Consider that it is not, nor has it ever been a strictly binary category.

This chapter focuses primarily on human anatomy but it is important to understand that as humans we are much more than our body parts. As we unpack the intersectionality of self throughout the course of this textbook we will come back to shed more light on the Intersex community. The link below is a good place to start. [Intersex Community Q&A Series - YouTube]

Further Sexual Development Occurs at Puberty

Puberty is the stage of development at which individuals become sexually mature. Though the outcomes of puberty significantly differ depending on assigned sex at birth, the hormonal control of the process is very similar. In addition, though the timing of these events varies between individuals, the sequence of changes that occur is fairly predictable for adolescents. As shown in Figure 27.18, a concerted release of hormones from the hypothalamus **gonadotropin-releasing hormone** (GnRH), the **anterior pituitary-luteinizing hormone** (LH) and **follicle-stimulating hormone** (FSH), and the gonads (either testosterone or estrogen) is responsible for the maturation of the reproductive systems and the development of **secondary sex characteristics**, which are physical changes that serve auxiliary roles in reproduction.

In addition to age, multiple factors can affect the age of onset of puberty, including genetics, environment, and psychological stress. One of the more important influences may be nutrition; historical data demonstrate the effect of better and more consistent nutrition on the age of *menarche*, (first menstruation) in the United States, which decreased from an average age of approximately 17 years of age in 1860 to the current age of approximately 12.75 years in 1960, as it remains today. Some studies indicate a link between puberty onset and the amount of stored fat in an individual. This effect is more pronounced in people assigned female at birth, but has also been documented in people assigned male at birth. Body fat, corresponding with secretion of the hormone leptin by adipose cells, appears to have a strong role in determining menarche. This may reflect to some extent the high metabolic costs of gestation and lactation.

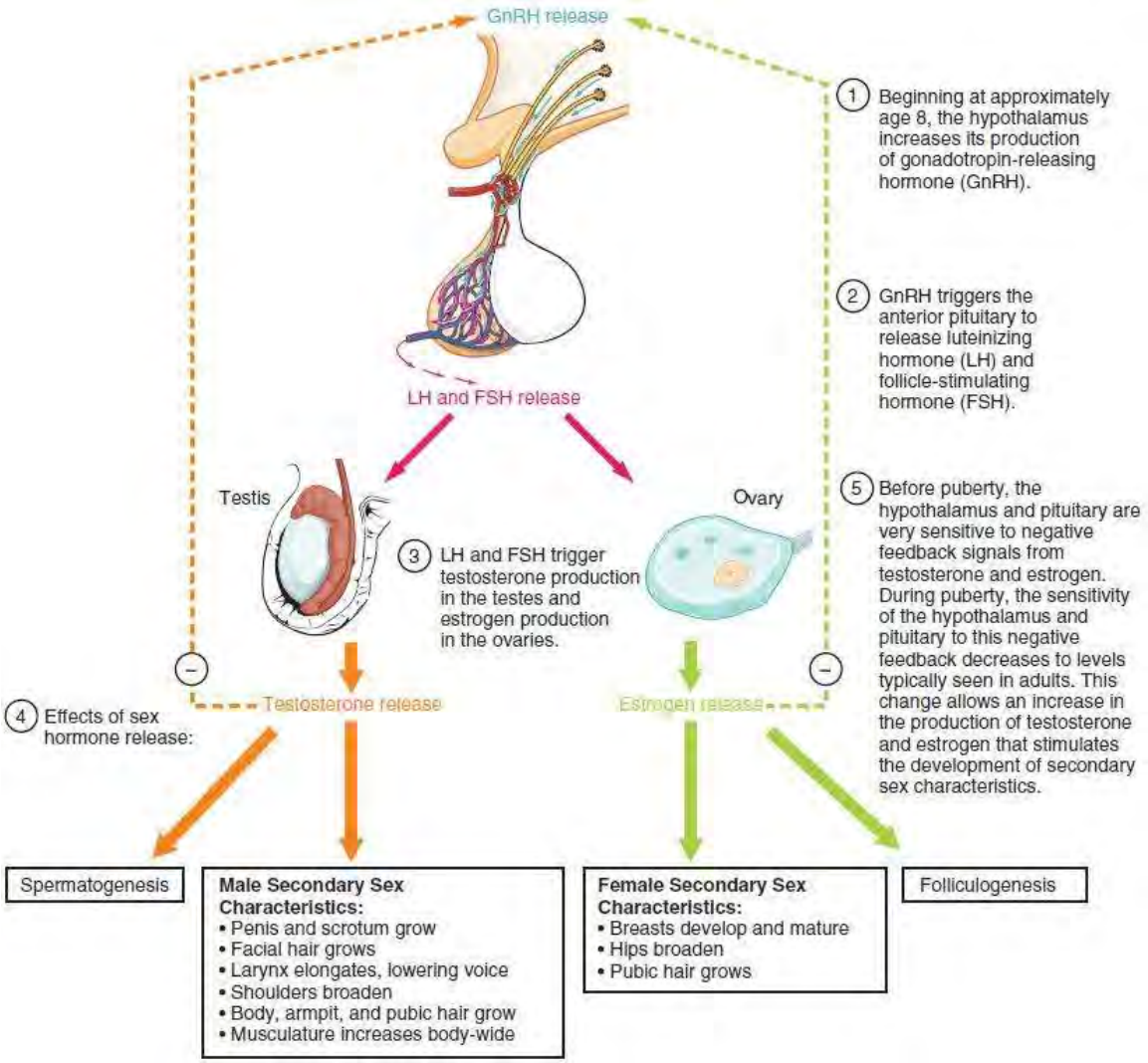


Figure 27.18 Hormones of Puberty *During puberty, the release of LH and FSH from the anterior pituitary stimulates the gonads to produce sex hormones in adolescents.*

Signs of Puberty

Different sex steroid hormone concentrations between the sexes also contribute to the development and function of secondary sexual characteristics. As assigned females at birth reach puberty, typically the first change that is visible is the development of the breast tissue. This is followed by the growth of axillary and pubic hair. A growth spurt normally starts at approximately age 9 to 11, and may last two years or more. During this time, their height can increase 3 inches a year. The next step in puberty is menarche, the start of menstruation.

For assigned males at birth, the growth of the testes is typically the first physical sign of the beginning of puberty, which is followed by growth and pigmentation of the scrotum and growth of the penis. The next step is the growth of hair, including armpit, pubic, chest, and facial hair. Testosterone stimulates the growth of the larynx and thickening and lengthening of the vocal folds, which causes the voice to drop in pitch. The first fertile ejaculations typically appear at approximately 15 years of age, but this age can vary widely. Unlike the early growth spurt observed in assigned females, assigned male's growth spurts occur toward the end of puberty, at approximately age 16 to 18, and their height can increase as much as 4 inches a year. In some, pubertal development can continue through the early 20s.

Sidebar 3.2: Interactive Link

A baby's assigned sex is determined at conception, and the different genitalia of all fetuses develop from the same tissues in the embryo. View this animation to see a comparison of the development of structures of the different reproductive systems in a growing fetus. Where are the testes located for most of gestational time?

Review of Development of the Sexual Organs in the Embryo and Fetus

Human reproductive systems begin to develop soon after conception. A gene on the assigned male's Y chromosome is called *SRY.* SRY is critical in stimulating a cascade of events that simultaneously stimulate testis development and repress the development of assigned female structures. Testosterone produced by Leydig cells in the embryonic testis stimulates the development of assigned male sexual organs. If testosterone is not present, female sexual organs will develop.

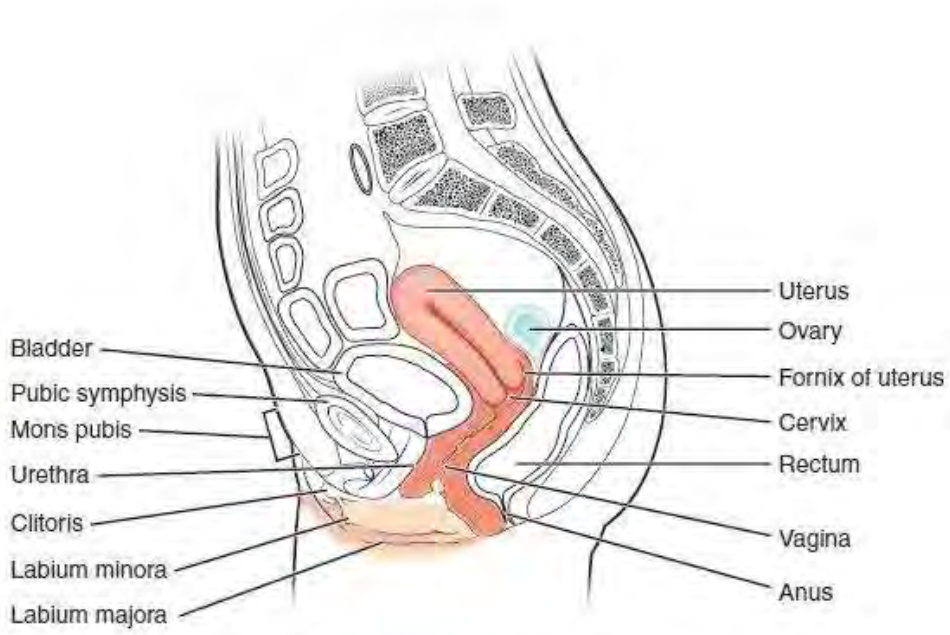
Whereas the gonads and some other reproductive tissues are considered bipotential, the tissue that forms the internal reproductive structures stems from ducts that will develop into only assigned male (Wolffian) or assigned female (Müllerian) structures. To be able to reproduce as an adult, one of these systems must develop properly and the other must degrade.

Further development of the reproductive systems occurs at puberty. The initiation of the changes that occur in puberty is the result of a decrease in sensitivity to negative feedback in the hypothalamus and pituitary gland, and an increase in sensitivity of the gonads to FSH and LH stimulation. These changes lead to increases in either estrogen or testosterone, in assigned female and male adolescents, respectively. The increase in sex steroid hormones leads to maturation of the gonads and other reproductive organs. The initiation of spermatogenesis begins in assigned males, and assigned females begin ovulating and menstruating. Increases in sex steroid hormones also lead to the development of secondary sex characteristics, such as breast development in assigned females and facial hair and larynx growth in assigned males.

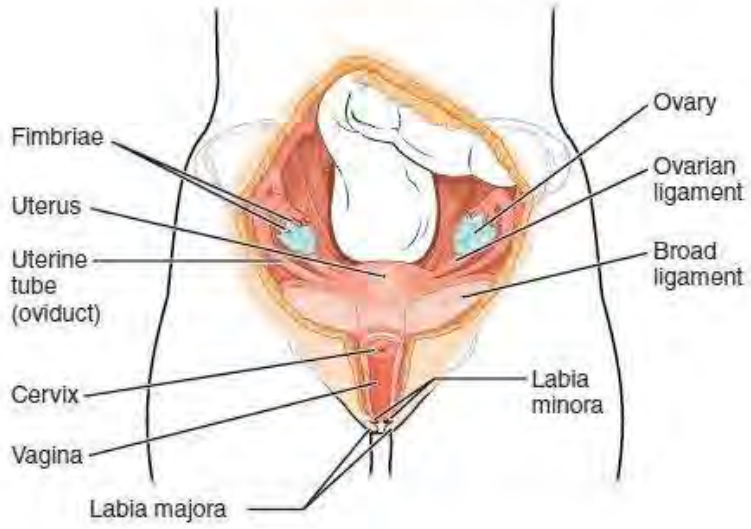
The previous section highlights the ways in which fetal sexual anatomical formation occurs. It covers both the dymorphism associated with those assigned female at birth, those assigned male at birth and includes intersex anatomical formation which is varied in type. Human sexual reproduction involves the fertilization of an ovum by a sperm, the remaining portion of this chapter will be divided, in order to explore anatomical systems within bodies assigned female at birth and bodies assigned male at birth.

Section 2: Assigned Female At Birth Sexual Reproductive Anatomy

The assigned female reproductive system functions to produce gametes and reproductive hormones and support the developing fetus and deliver it to the outside world. The assigned female reproductive system is located primarily inside the pelvic cavity (Figure 27.9). Recall that the ovaries are the assigned female gonads. The gamete they produce is called an **oocyte**. We'll discuss the production of oocytes in detail shortly. First, let's look at some of the structures of the reproductive system.



(a) Human female reproductive system: lateral view



(b) Human female reproductive system: anterior view

Figure 27.9 Assigned Female Reproductive System *The major organs of the female reproductive system are located inside the pelvic cavity.*

External Genitals

The external-assigned female reproductive structures are referred to collectively as the **vulva**. The **mons pubis** is a pad of fat that is located at the anterior, over the pubic bone. After puberty, it becomes covered in pubic hair. The **labia majora**

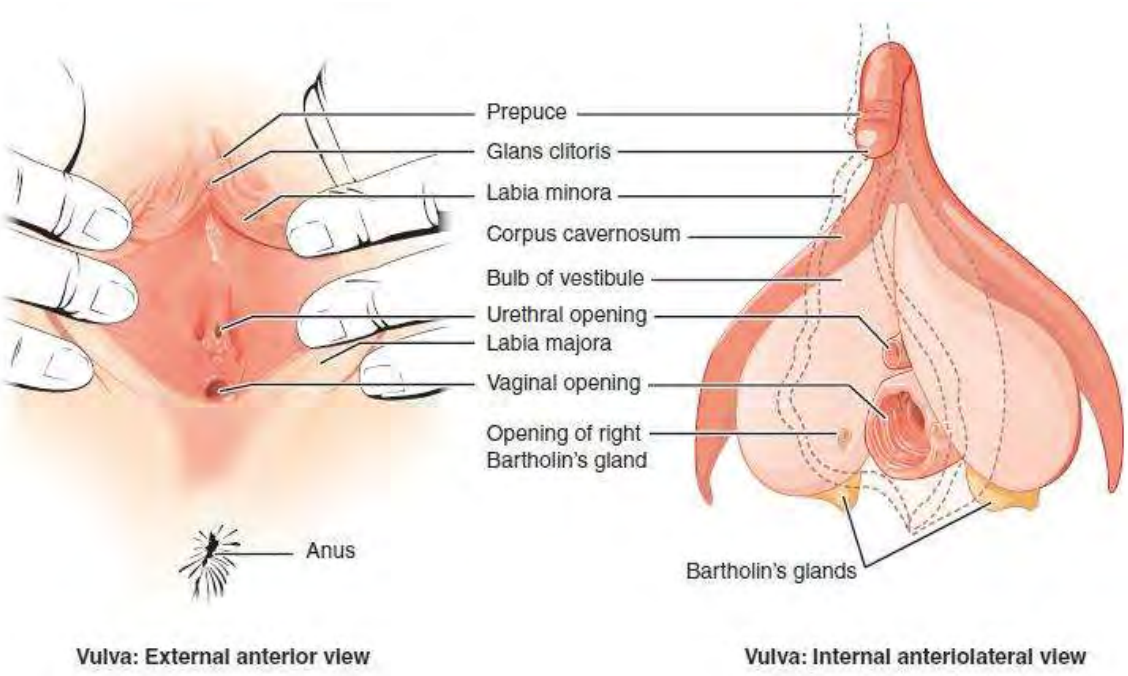
(labia = “lips”; majora = “larger”) are folds of hair-covered skin that begin just posterior to the mons pubis. The thinner and more pigmented **labia minora** (labia = “lips”; minora = “smaller”) extend medially to the labia majora. External genitalia naturally vary in shape and size; the labia minora serve to protect the urethra and the entrance to the reproductive tract.

Remi Newman

The superior, anterior portions of the labia minora come together to encircle the **clitoris** (or glans clitoris), an organ that originates from the same cells as the glans penis and has abundant nerves, which make it important in sexual sensation and orgasm. The **hymen** is a thin membrane that sometimes partially covers the

entrance to the vagina. An intact hymen cannot be used as an indication of "virginity;" even at birth, this is only a partial membrane, as menstrual fluid and other secretions must be able to exit the body, regardless of vaginal intercourse. The vaginal opening is located between the opening of the urethra and the anus. It is flanked by outlets to the **Bartholin's glands** (or greater vestibular glands).

The Vulva



The external female genitalia are referred to collectively as the vulva.

Vagina

The **vagina** is a muscular canal (approximately 10 cm long) that serves as the entrance to the reproductive tract. It also serves as the exit from the uterus during menses and childbirth. The outer walls of the anterior and posterior vagina are formed into longitudinal columns, or ridges, and the superior portion of the vagina—called the fornix—meets the protruding uterine cervix. The walls of the vagina are lined with an outer, fibrous adventitia, a middle layer of smooth muscle, and an inner mucous membrane with transverse folds called **rugae**. Together, the middle and inner layers allow the expansion of the vagina to accommodate intercourse and childbirth. The thin, perforated hymen can partially surround the

opening to the vaginal orifice. The Bartholin's glands and the lesser vestibular glands (located near the clitoris) secrete mucus, which keeps the vestibular area moist.

The vagina is home to a normal population of microorganisms that help to protect against infection by pathogenic bacteria, yeast, or other organisms that can enter the vagina. In a healthy vagina, the most predominant type of vaginal bacteria is from the genus *Lactobacillus*. This family of beneficial bacterial flora secretes lactic acid, and thus protects the vagina by maintaining an acidic pH (below 4.5). Potential pathogens are less likely to survive in these acidic conditions. Lactic acid, in combination with other vaginal secretions, makes the vagina a self-cleansing organ.

Ovaries

The **ovaries** are the female gonads. Paired ovals, they are each about 2 to 3 cm in length, about the size of an almond. The ovaries are located within the pelvic cavity, and are supported by the mesovarium, an extension of the peritoneum that connects the ovaries to the **broad ligament**. Extending from the mesovarium itself is the suspensory ligament, which contains the ovarian blood and lymph vessels. Finally, the ovary itself is attached to the uterus via the ovarian ligament.

The ovary comprises an outer covering of cuboidal epithelium called the ovarian surface epithelium that is superficial to a dense connective tissue covering called the tunica albuginea. Beneath the tunica albuginea is the cortex, or outer portion, of the organ. The cortex is composed of a tissue framework called the ovarian stroma that forms the bulk of the adult ovary. Oocytes develop within the outer layer of this stroma, each surrounded by supporting cells. This grouping of an oocyte and its supporting cells is called a **follicle**. Beneath the cortex lies the inner ovarian medulla, the site of blood vessels, lymph vessels, and the nerves of the ovary.

The Ovarian Cycle

The **ovarian cycle** is a set of predictable changes in the majority of assigned female's oocytes and ovarian follicles. During an assigned female's reproductive years, it is a roughly 28-day cycle that can be correlated with, but is not the same as, the menstrual cycle (discussed shortly). The cycle includes two interrelated

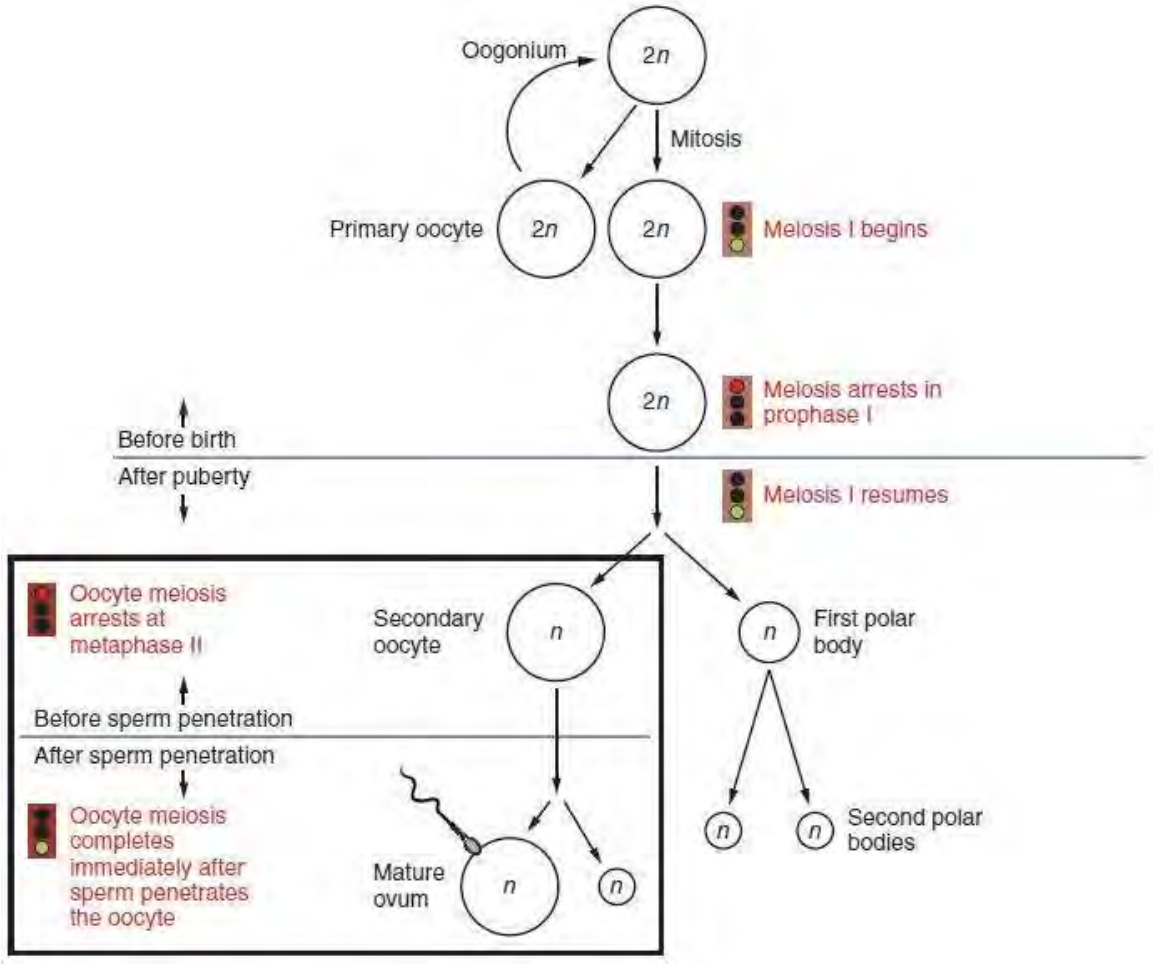
processes: oogenesis (the production of female gametes) and folliculogenesis (the growth and development of ovarian follicles).

Oogenesis

Gametogenesis in females is called **oogenesis**. The process begins with the ovarian stem cells, or **oogonia**. Oogonia are formed during fetal development, and divide via mitosis, much like spermatogonia in the testis. Unlike spermatogonia, however, oogonia form primary oocytes in the fetal ovary prior to birth. These primary oocytes are then arrested in this stage of meiosis I, only to resume it years later, beginning at puberty and continuing until the start of **menopause** (the cessation of reproductive functions). The number of primary oocytes present in the ovaries declines from one million to two million in an infant, to approximately 400,000 at puberty, to zero by the end of menopause.

The initiation of **ovulation**—the release of an oocyte from the ovary—marks the transition from puberty into reproductive maturity. From then on, throughout reproductive years, ovulation occurs approximately once every 28 days. Just prior to ovulation, a surge of luteinizing hormone triggers the resumption of meiosis in a primary oocyte. This initiates the transition from primary to secondary oocyte. However, as you can see, this cell division does not result in two identical cells. Instead, the cytoplasm is divided unequally, and one daughter cell is much larger than the other. This larger cell, the secondary oocyte, eventually leaves the ovary during ovulation. The smaller cell, called the first **polar body**, may or may not complete meiosis and produce second polar bodies; in either case, it eventually disintegrates. Therefore, even though oogenesis produces up to four cells, only one survives.

Oogenesis



The unequal cell division of oogenesis produces one to three polar bodies that later degrade, as well as a single haploid ovum, which is produced only if there is penetration of the secondary oocyte by a sperm cell.

How does the diploid secondary oocyte become an **ovum**—the haploid assigned female gamete? Meiosis of a secondary oocyte is completed only if a sperm succeeds in penetrating its barriers. Meiosis II then resumes, producing one haploid ovum that, at the instant of fertilization by a (haploid) sperm, becomes the first diploid cell of the new offspring (a zygote). Thus, the ovum can be thought of as a brief, transitional, haploid stage between the diploid oocyte and diploid zygote.

The larger amount of cytoplasm contained in the assigned female gamete is used to supply the developing zygote with nutrients during the period between

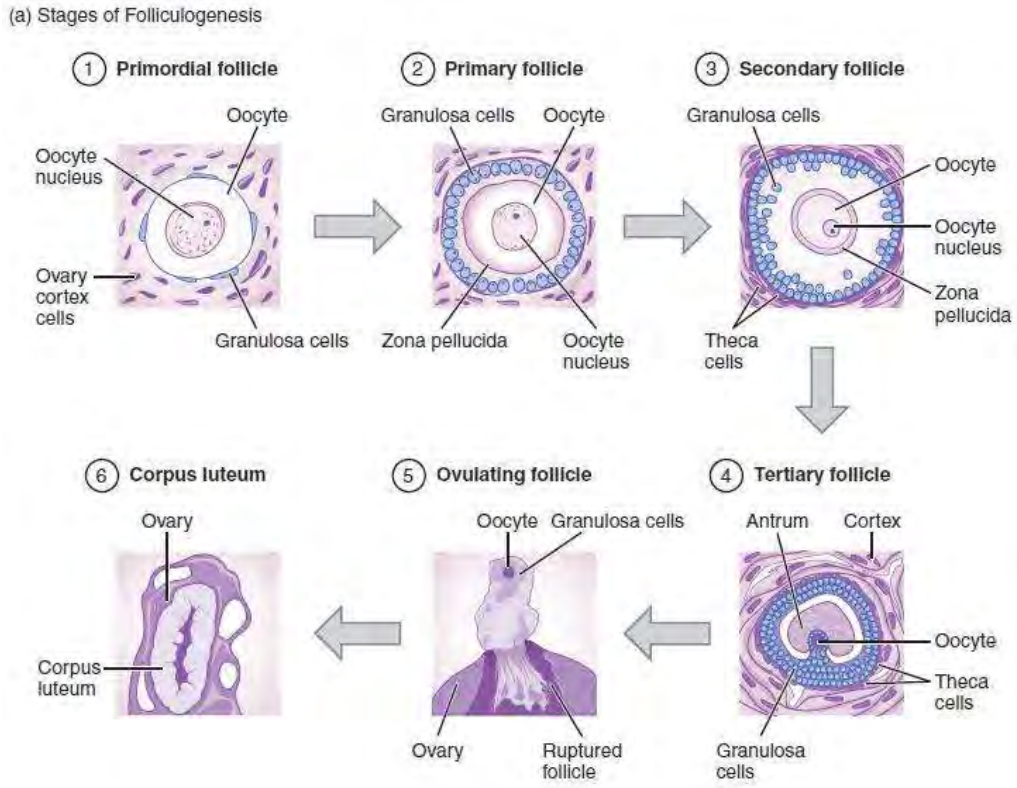
fertilization and implantation into the uterus. Interestingly, sperm contribute only DNA at fertilization —not cytoplasm. Therefore, the cytoplasm and all of the cytoplasmic organelles in the developing embryo are of maternal origin. This includes mitochondria, which contain their own DNA. Scientific research in the 1980s determined that mitochondrial DNA was maternally inherited, meaning that you can trace your mitochondrial DNA directly to your birth mother, their birth mother, and so on back through your matrilineal ancestors.

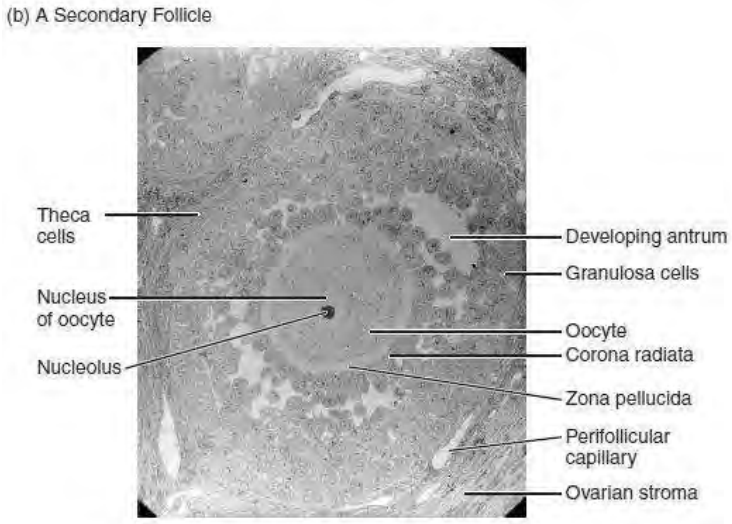
Folliculogenesis

Ovarian follicles are oocytes and their supporting cells. They grow and develop in a process called **folliculogenesis**, which typically leads to ovulation of one follicle approximately every 28 days, along with death to multiple other follicles. The death of ovarian follicles is called Atresia, and can occur at any point during follicular development. Recall that, assigned female infants at birth will have one million to two million oocytes within their ovarian follicles, and that this number declines throughout life until menopause, when no follicles remain. Follicles progress from primordial, to primary, to secondary and tertiary stages prior to ovulation—with the oocyte inside the follicle remaining as a primary oocyte until right before ovulation.

Folliculogenesis begins with follicles in a resting state. These small **primordial follicles** are present in newborns and are the prevailing follicle type in the adult ovary (Figure). Primordial follicles have only a single flat layer of support cells, called **granulosa cells**, that surround the oocyte, and they can stay in this resting state for years—some until right before menopause.

Keep in mind that most follicles don't grow and develop until ovulation. In fact, roughly 99 percent of the follicles in the ovary will undergo atresia (they die), which can occur at any stage of folliculogenesis.





(a) The maturation of a follicle is shown in a clockwise direction proceeding from the primordial follicles. FSH stimulates the growth of a tertiary follicle, and LH stimulates the production of estrogen by granulosa and theca cells. Once the follicle is mature, it ruptures and releases the oocyte. Cells remaining in the follicle then develop into the corpus luteum. (b) In this electron micrograph of a secondary follicle, the oocyte, theca cells (thecae folliculi), and developing antrum are clearly visible. EM × 1100. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

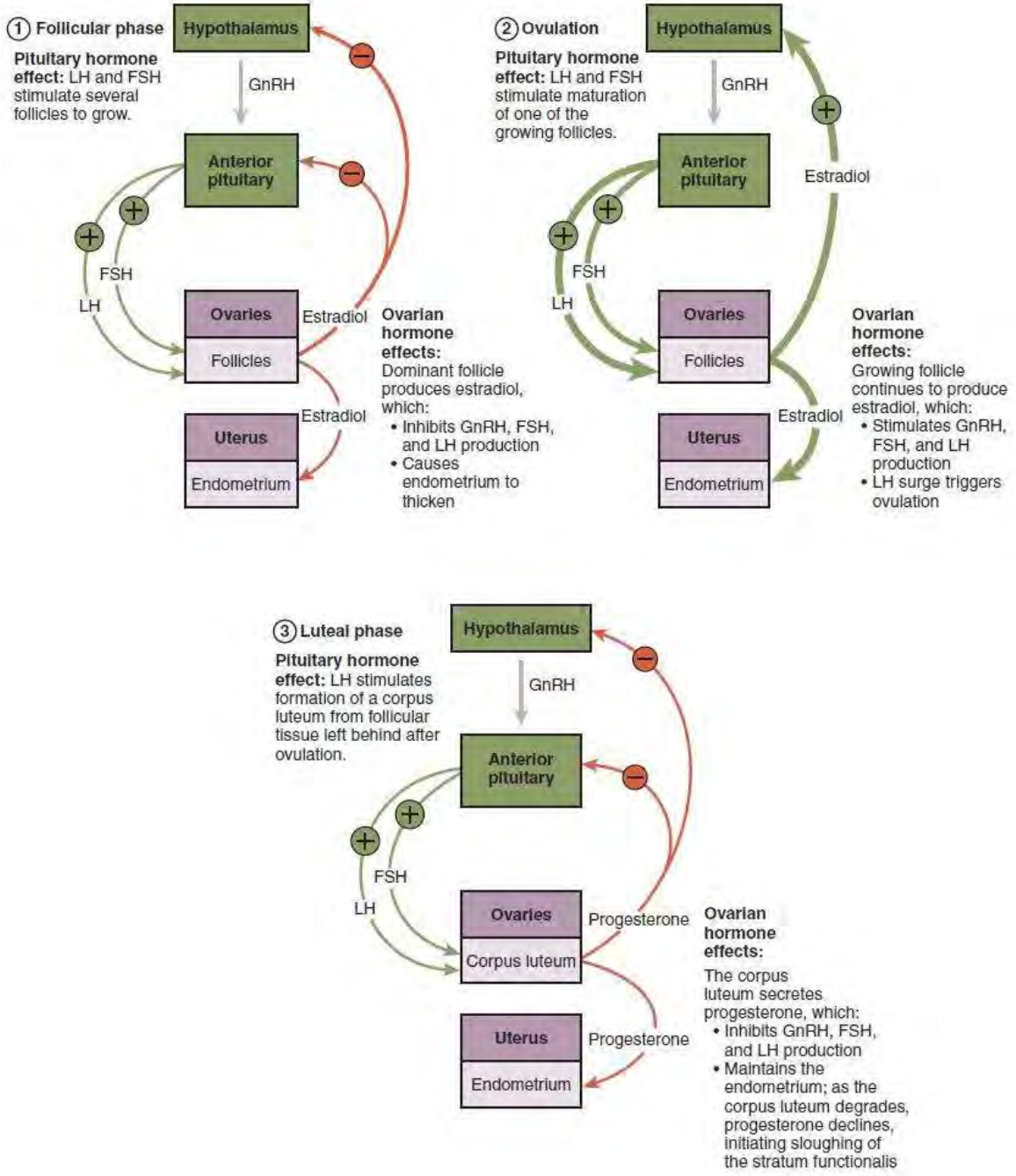
Hormonal Control of the Ovarian Cycle

The process of development that we have just described, from primordial follicle to early tertiary follicle, takes approximately two months in humans. The final stages of development of a small cohort of tertiary follicles, ending with ovulation of a secondary oocyte, occur over a course of approximately 28 days. These changes in the reproductive system are regulated by hormones including **gonadotropin-releasing hormone** (GnRH), **luteinizing hormone** (LH) and **follicle-stimulating hormone** (FSH).

The hypothalamus produces GnRH, a hormone that signals the anterior pituitary gland to produce the gonadotropins FSH and LH (Figure). These gonadotropins leave the pituitary and travel through the bloodstream to the ovaries, where they bind to receptors on the granulosa and theca cells of the follicles. FSH stimulates the follicles to grow (hence its name of follicle-stimulating hormone), and the five or six tertiary follicles expand in diameter. The release of LH also stimulates the granulosa and theca cells of the follicles to produce the sex steroid hormone estradiol, a type of estrogen. This phase of the ovarian cycle, when the tertiary follicles are growing and secreting estrogen, is known as the follicular phase.

The more granulosa and theca cells a follicle has (that is, the larger and more developed it is), the more estrogen it will produce in response to LH stimulation. As a result of these large follicles producing large amounts of estrogen, systemic plasma estrogen concentrations increase. Following a classic negative feedback loop, the high concentrations of estrogen will stimulate the hypothalamus and pituitary to reduce the production of GnRH, LH, and FSH. Because the large tertiary follicles require FSH to grow and survive at this point, this decline in FSH caused by negative feedback leads most of them to die (atresia). Typically only one follicle, now called the dominant follicle, will survive this reduction in FSH, and this follicle will be the one that releases an oocyte.

Hormonal Regulation of Ovulation



The hypothalamus and pituitary gland regulate the ovarian cycle and ovulation. GnRH activates the anterior pituitary to produce LH and FSH, which stimulate the production of estrogen and progesterone by the ovaries.

When only the one dominant follicle remains in the ovary, it again begins to secrete estrogen. It produces more estrogen than all of the developing follicles did together before the negative feedback occurred. It produces so much estrogen that the normal negative feedback doesn't occur. Instead, these extremely high concentrations of systemic plasma estrogen trigger a regulatory switch in the anterior pituitary that responds by secreting large amounts of LH and FSH into the bloodstream (see Figure). The positive feedback loop by which more estrogen triggers release of more LH and FSH only occurs at this point in the cycle.

It is this large burst of LH (called the LH surge) that leads to ovulation of the dominant follicle. The LH surge induces many changes in the dominant follicle, including stimulating the resumption of meiosis of the primary oocyte to a secondary oocyte. As noted earlier, the polar body that results from unequal cell division simply degrades. The LH surge also triggers proteases (enzymes that cleave proteins) to break down structural proteins in the ovary wall on the surface of the bulging dominant follicle. This degradation of the wall, combined with pressure from the large, fluid-filled antrum, results in the expulsion of the oocyte surrounded by granulosa cells into the peritoneal cavity. This release is ovulation.

The Fallopian Tubes

The **Fallopian Tubes** (also called uterine tubes or oviducts) serve as the conduit of the oocyte from the ovary to the uterus (Figure). Each of the two fallopian tubes is close to, but not directly connected to, the ovary and divided into sections. The **isthmus** is the narrow medial end of each uterine tube that is connected to the uterus. The wide distal **infundibulum** flares out with slender, finger-like projections called **fimbriae**. The middle region of the tube, called the **ampulla**, is where fertilization often occurs. The fallopian tubes also have three layers: an outer serosa, a middle smooth muscle layer, and an inner mucosal layer. In addition to its mucus-secreting cells, the inner mucosa contains ciliated cells (covered in microscopic projections that look like tiny hairs) that beat in the direction of the uterus, producing a current that will be critical to move the oocyte.

Following ovulation, the secondary oocyte surrounded by a few granulosa cells is released into the peritoneal cavity. The nearby uterine tube, either left or right, receives the oocyte. Unlike sperm, oocytes lack flagella (microscopic appendage that allows sperm to swim), and therefore cannot move on their own. So how do they travel into the uterine tube and toward the uterus? High concentrations of

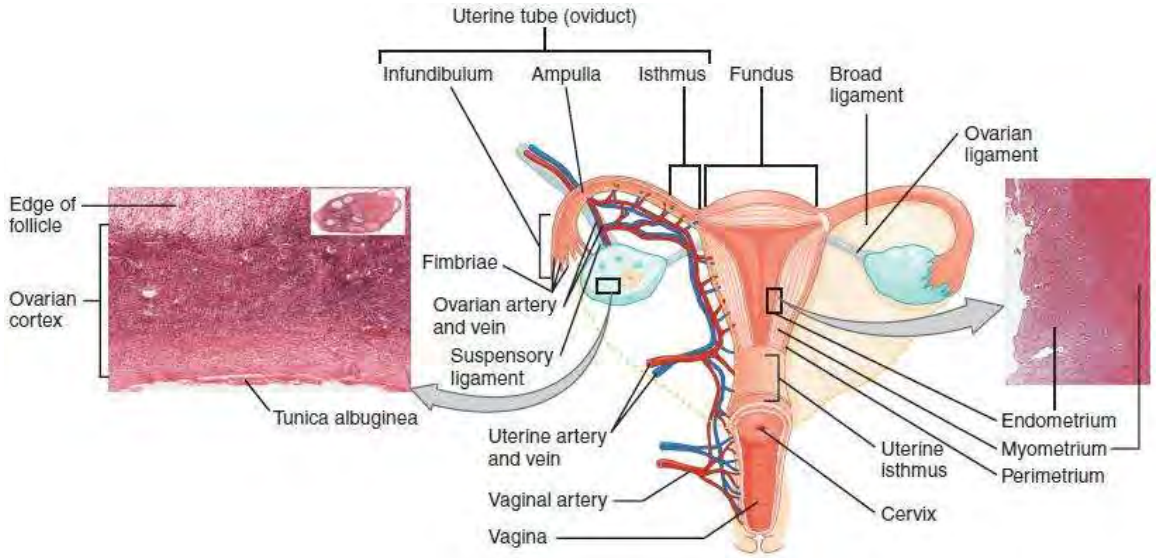
estrogen that occur around the time of ovulation induce contractions of the smooth muscle along the length of the uterine tube. These contractions occur every 4 to 8 seconds, and the result is a coordinated movement that sweeps the surface of the ovary and the pelvic cavity (some women can feel those contractions called Middleschmertz- meaning “middle pain” in German). Current flowing toward the uterus is generated by coordinated beating of the cilia that line the outside and lumen of the length of the uterine tube. These cilia beat more strongly in response to the high estrogen concentrations that occur around the time of ovulation. As a result of these mechanisms, the oocyte–granulosa cell complex is pulled into the interior of the tube. Once inside, the muscular contractions and beating cilia move the oocyte slowly toward the uterus. When fertilization does occur, sperm typically meet the ovum while it is still moving through the ampulla.

Sidebar 3.3: Interactive Link

Watch this video to observe ovulation and its initiation in response to the release of FSH and LH from the pituitary gland. What specialized structures help guide the oocyte from the ovary into the uterine tube?

If the oocyte is successfully fertilized, the resulting zygote will begin to divide into two cells, then four, and so on, as it makes its way through the uterine tube and into the uterus. There, it will implant and continue to grow. If the ovum is not fertilized, it will simply degrade—either in the uterine tube or in the uterus, where it may be shed with the next menstrual period.

Ovaries, Uterine Tubes, and Uterus



This anterior view shows the relationship of the ovaries, uterine tubes (oviducts), and uterus. Sperm enter through the vagina, and fertilization of an ovulated oocyte usually occurs in the distal uterine tube. From left to right, LM × 400, LM × 20. (Micrographs provided by the Regents of University of Michigan Medical School © 2012).

The Uterus and Cervix

The **uterus** is the muscular organ that nourishes and supports the growing embryo (see Figure). Its average size is approximately 5 cm wide by 7 cm long (approximately 2 in by 3 in) in a non-pregnant state. It has three sections. The portion of the uterus superior to the opening of the uterine tubes is called the **fundus**. The middle section of the uterus is called the **body of the uterus** (or corpus). The **cervix** is the narrow inferior portion of the uterus that projects into the vagina. The cervix produces mucus secretions that become thin and stringy under the influence of high systemic plasma estrogen concentrations, and these secretions can facilitate sperm movement through the reproductive tract.

Several ligaments maintain the position of the uterus within the abdominopelvic cavity. The broad ligament is a fold of peritoneum that serves as a primary support for the uterus, extending laterally from both sides of the uterus and attaching it to the pelvic wall. The round ligament attaches to the uterus near the uterine tubes, and extends to the labia majora. Finally, the uterosacral ligament stabilizes the uterus posteriorly, by its connection from the cervix to the pelvic wall.

The wall of the uterus is made up of three layers. The most superficial layer is the serous membrane, or **perimetrium**, which consists of epithelial tissue that covers

the exterior portion of the uterus. The middle layer, or **myometrium**, is a thick layer of smooth muscle responsible for uterine contractions. Most of the uterus is myometrial tissue, and the muscle fibers run horizontally, vertically, and diagonally, allowing the powerful contractions that occur during labor and the less powerful contractions (or cramps) that help to expel blood during menstruation. Anteriorly directed myometrial contractions also occur near the time of ovulation, and are thought to possibly facilitate the transport of sperm through the female reproductive tract.

The innermost layer of the uterus is called the **endometrium**. The endometrium contains a connective tissue lining, the lamina propria, which is covered by epithelial tissue that lines the lumen. Structurally, the endometrium consists of two layers: the stratum basalis and the stratum functionalis (the basal and functional layers). The stratum basalis layer is part of the lamina propria and is adjacent to the myometrium; this layer does not shed during menses. In contrast, the thicker stratum functionalis layer contains the glandular portion of the lamina propria and the endothelial tissue that lines the uterine lumen. It is the stratum functionalis that grows and thickens in response to increased levels of estrogen and progesterone. In the luteal phase of the menstrual cycle, special branches of the uterine artery, called spiral arteries, supply the thickened stratum functionalis. This inner functional layer provides the proper site of implantation for the fertilized ovum, and—should fertilization not occur—it is only the stratum functionalis layer of the endometrium that sheds during menstruation.

Recall that during the follicular phase of the ovarian cycle, the tertiary follicles are growing and secreting estrogen. At the same time, the stratum functionalis of the endometrium is thickening to prepare for a potential implantation. The post-ovulatory increase in progesterone, which characterizes the luteal phase, is key for maintaining a thick stratum functionalis. As long as a functional corpus luteum is present in the ovary, the endometrial lining is prepared for implantation. Indeed, if an embryo implants, signals are sent to the corpus luteum to continue secreting progesterone to maintain the endometrium, and thus maintain the pregnancy. If an embryo does not implant, no signal is sent to the corpus luteum and it degrades, ceasing progesterone production and ending the luteal phase. Without progesterone, the endometrium thins and, under the influence of prostaglandins, the spiral arteries of the endometrium constrict and rupture, preventing oxygenated blood from reaching the endometrial tissue. As a result, endometrial

tissue dies and blood, pieces of the endometrial tissue, and white blood cells are shed through the vagina during menstruation, or the **menses**. The first menses after puberty, called **menarche**, can occur either before or after the first ovulation.

The Menstrual Cycle

Now that we have discussed the maturation of the cohort of tertiary follicles in the ovary, the build-up and then shedding of the endometrial lining in the uterus, and the function of the uterine tubes and vagina, we can put everything together to talk about the three phases of the **menstrual cycle**—the series of changes in which the uterine lining is shed, rebuilds, and prepares for implantation.

The timing of the menstrual cycle starts with the first day of menses. Cycle length is determined by counting the days between the onset of bleeding in two subsequent cycles. Because the average length of a menstrual cycle is 28 days, this is the time period used to identify the timing of events in the cycle. However, the length of the menstrual cycle varies among individuals, and even in the same person from one cycle to the next, typically from 21 to 32 days.

Just as the hormones produced by the granulosa and theca cells of the ovary "drive" the follicular and luteal phases of the ovarian cycle, they also control the three distinct phases of the menstrual cycle. These phases are the menses phase, the proliferative phase, and the secretory phase.

Menses Phase

The **menses phase** of the menstrual cycle is the phase during which the lining is shed; that is, the days a person menstruates. Although it averages approximately five days, the menses phase can last from 2 to 7 days, or longer. As shown in Figure, the menses phase occurs during the early days of the follicular phase of the ovarian cycle, when progesterone, FSH, and LH levels are low.

Proliferative Phase

Once menstrual flow ceases, the endometrium begins to proliferate again, marking the beginning of the **proliferative phase** of the menstrual cycle (see Figure). It

occurs when the granulosa and theca cells of the tertiary follicles begin to produce increased amounts of estrogen. These rising estrogen concentrations stimulate the endometrial lining to rebuild.

The switch to positive feedback—which occurs with the elevated estrogen production from the dominant follicle—then stimulates the LH surge that will trigger ovulation. In a typical 28-day menstrual cycle, ovulation occurs on day 14. Ovulation marks the end of the proliferative phase as well as the end of the follicular phase.

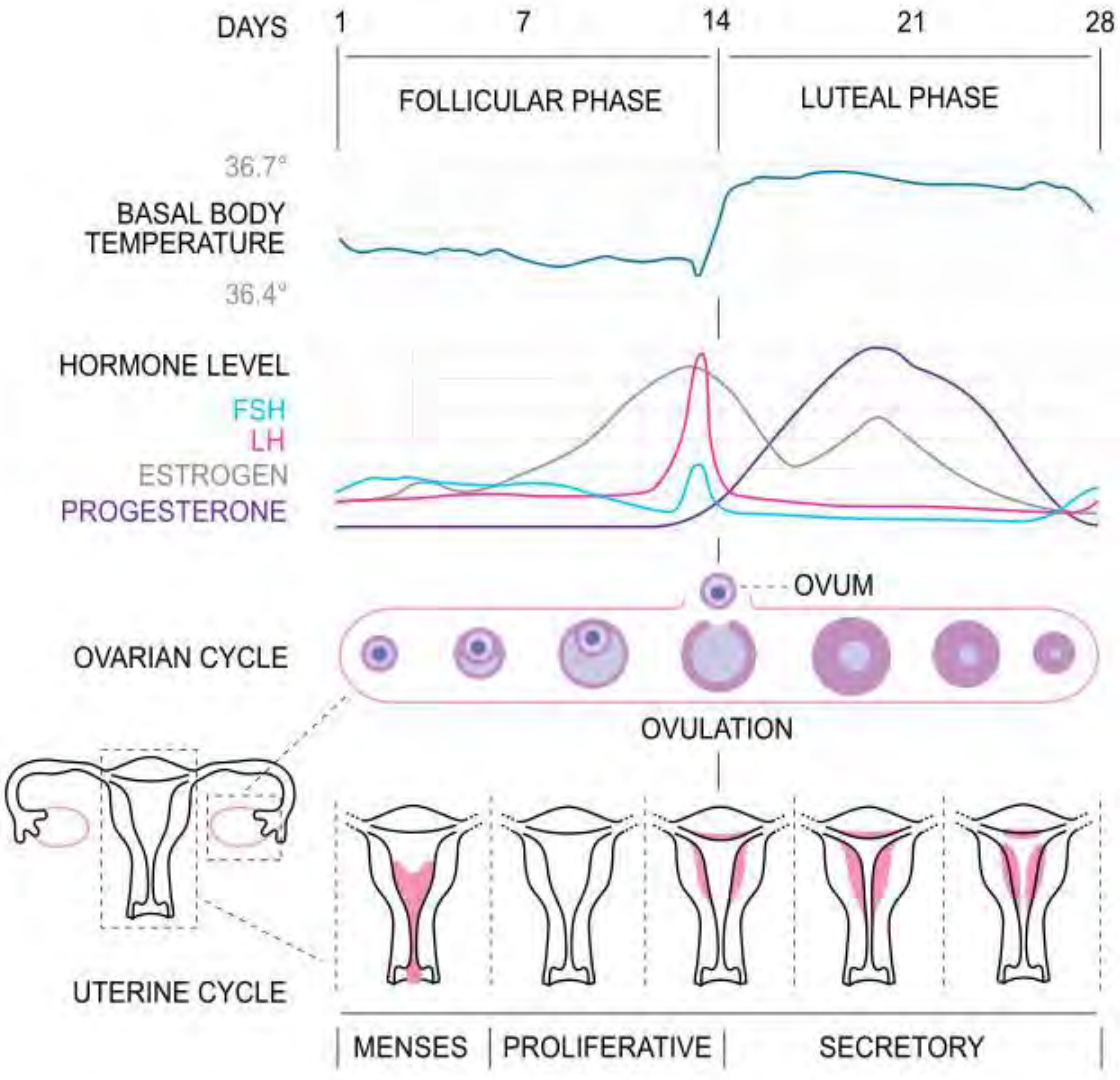


***Diagram of the menstrual cycle** Isometrik 2009 Creative Commons Attribution-Share Alike 3.0*

Secretory Phase

In addition to prompting the LH surge, high estrogen levels increase the uterine tube contractions that facilitate the pick-up and transfer of the ovulated oocyte. High estrogen levels also slightly decrease the acidity of the vagina, making it more hospitable to sperm. In the ovary, the luteinization of the granulosa cells of the collapsed follicle forms the progesterone-producing corpus luteum, marking the beginning of the luteal phase of the ovarian cycle. In the uterus, progesterone from the corpus luteum begins the **secretory phase** of the menstrual cycle, in which the endometrial lining prepares for implantation (see Figure). Over the next 10 to 12 days, the endometrial glands secrete a fluid rich in glycogen. If fertilization has occurred, this fluid will nourish the ball of cells now developing from the zygote. At the same time, the spiral arteries develop to provide blood to the thickened stratum functionalis.

If no pregnancy occurs within approximately 10 to 12 days, the corpus luteum will degrade into the corpus albicans. Levels of both estrogen and progesterone will fall, and the endometrium will grow thinner. Prostaglandins will be secreted that cause constriction of the spiral arteries, reducing oxygen supply. The endometrial tissue will die, resulting in menses—or the first day of the next cycle.

Sidebar 3.4: Interactive Link

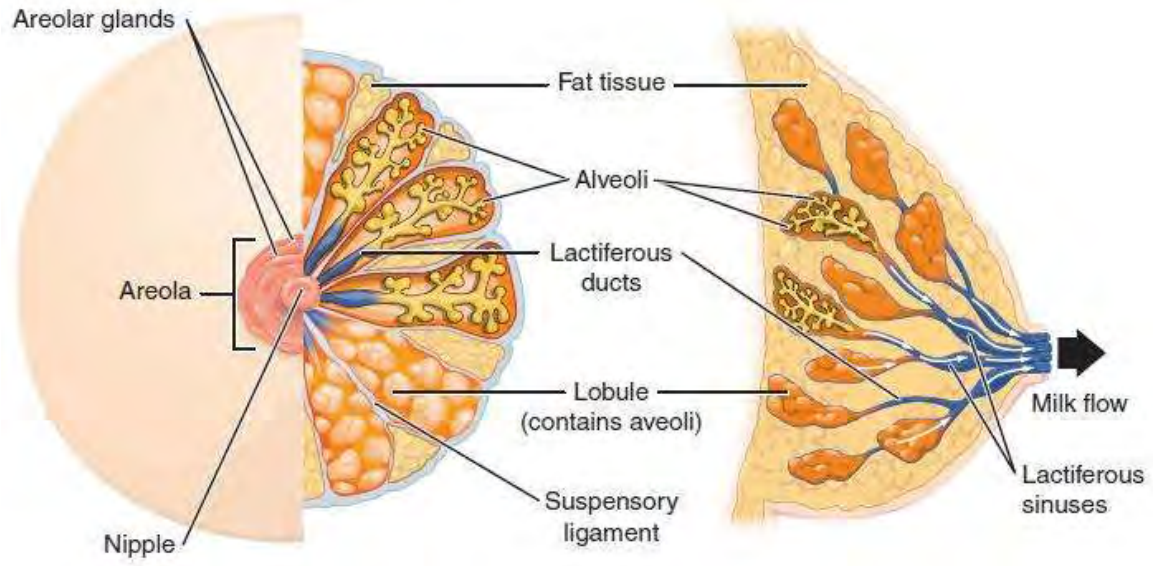
Watch this series of videos to look at the movement of the oocyte through the ovary. The cilia in the uterine tube promote movement of the oocyte. What would likely occur if the cilia were paralyzed at the time of ovulation?

The Breasts

Whereas the breasts are located far from the other reproductive organs, they are considered accessory organs of the reproductive system. The function of the breasts is to supply milk to an infant in a process called lactation. The external features of the breast include a nipple surrounded by a pigmented **areola** (Figure), whose coloration may deepen during pregnancy. The areola is typically circular and can vary in size from 25 to 100 mm in diameter. The areolar region is characterized by small, raised areolar glands that secrete lubricating fluid during lactation to protect the nipple from chafing. When a baby nurses, or draws milk from the breast, the entire areolar region is taken into the mouth.

Breast milk is produced by the **mammary glands**, which are modified sweat glands. The milk itself exits the breast through the nipple via 15 to 20 **lactiferous ducts** that open on the surface of the nipple. These lactiferous ducts each extend to a **lactiferous sinus** that connects to a glandular lobe within the breast itself that contains groups of milk-secreting cells in clusters called **alveoli** (see Figure). The clusters can change in size depending on the amount of milk in the alveolar lumen. Once milk is made in the alveoli, stimulated myoepithelial cells that surround the alveoli contract to push the milk to the lactiferous sinuses. From here, the baby can draw milk through the lactiferous ducts by suckling. The lobes themselves are surrounded by fat tissue, which determines the size of the breast; breast size differs between individuals and does not affect the amount of milk produced. Supporting the breasts are multiple bands of connective tissue called **suspensory ligaments,** which connect the breast tissue to the dermis of the overlying skin.

Anatomy of the Breast



During lactation, milk moves from the alveoli through the lactiferous ducts to the nipple.

During the hormonal fluctuations in the menstrual cycle, breast tissue responds to changing levels of estrogen and progesterone, which can lead to swelling and breast tenderness in some individuals, especially during the secretory phase. If pregnancy occurs, the increase in hormones leads to further development of the mammary tissue and enlargement of the breasts.

Review of Assigned Female Reproductive Anatomy

The external genitalia are collectively called the vulva. The vagina is the pathway into and out of the uterus. A penis is inserted into the vagina to deliver sperm, and the baby exits the uterus through the vagina during childbirth.

The ovaries produce oocytes, the female gametes, in a process called oogenesis. As with spermatogenesis, meiosis produces the haploid gamete (in this case, an ovum); however, it is completed only in an oocyte that has been penetrated by a sperm. In the ovary, an oocyte surrounded by supporting cells is called a follicle. In folliculogenesis, primordial follicles develop into primary, secondary, and tertiary follicles. Early tertiary follicles with their fluid-filled antrum will be stimulated by an

increase in FSH, a gonadotropin produced by the anterior pituitary, to grow in the 28-day ovarian cycle. Supporting granulosa and theca cells in the growing follicles produce estrogens, until the level of estrogen in the bloodstream is high enough that it triggers negative feedback at the hypothalamus and pituitary. This results in a reduction of FSH and LH, and most tertiary follicles in the ovary undergo atresia (they die). One follicle, usually the one with the most FSH receptors, survives this period and is now called the dominant follicle. The dominant follicle produces more estrogen, triggering positive feedback and the LH surge that will induce ovulation. Following ovulation, the granulosa cells of the empty follicle luteinize and transform into the progesterone-producing corpus luteum. The ovulated oocyte with its surrounding granulosa cells is picked up by the infundibulum of the uterine tube, and beating cilia help to transport it through the tube toward the uterus. Fertilization occurs within the uterine tube, and the final stage of meiosis is completed.

The uterus has three regions: the fundus, the body, and the cervix. It has three layers: the outer perimetrium, the muscular myometrium, and the inner endometrium. The endometrium responds to estrogen released by the follicles during the menstrual cycle, and grows thicker with an increase in blood vessels in preparation for pregnancy. If the egg is not fertilized, no signal is sent to extend the life of the corpus luteum, and it degrades, stopping progesterone production. This decline in progesterone results in the sloughing of the inner portion of the endometrium in a process called menses, or menstruation. The breasts are accessory sexual organs that are utilized after the birth of a child to produce milk in a process called lactation.

Section 3: Assigned Male At Birth Sexual Reproductive Anatomy

Unique for its role in human reproduction, a **gamete** is a specialized sex cell carrying 23 chromosomes—one half the number in body cells. At fertilization, the chromosomes in one assigned male gamete, called a **sperm** (or spermatozoon), combine with the chromosomes in one assigned female gamete, called an oocyte. The function of the assigned male reproductive system, see Figure 27.2 is to produce sperm and transfer them to the assigned female reproductive tract. The paired testes are a crucial component in this process, as they produce both sperm

and androgens, the hormones that support assigned male reproductive physiology. In humans, the most important assigned male androgen is testosterone. Several accessory organs and ducts aid the process of sperm maturation and transport the sperm and other seminal components to the penis, which delivers sperm to the assigned female reproductive tract. In this section, we examine each of these different structures, and discuss the process of sperm production and transport.

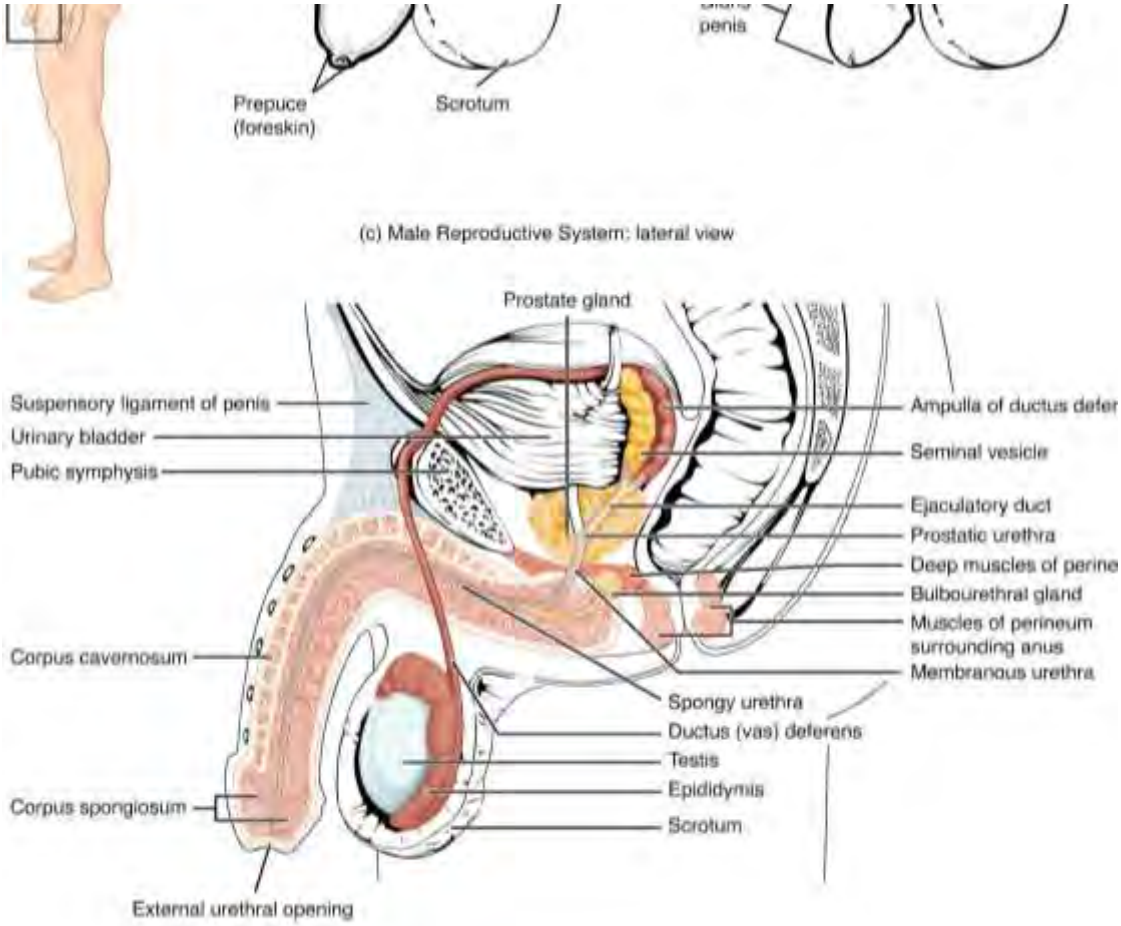


Figure 27.2 Assigned Male Reproductive System *The structures of the male reproductive system include the testes, the epididymides, the penis, and the ducts and glands that produce and carry semen. Sperm exit the scrotum*

through the ductus deferens, which is bundled in the spermatic cord. The seminal vesicles and prostate gland add fluids to the sperm to create semen.

Scrotum

The testes are located in a skin-covered, highly pigmented, muscular sack called the **scrotum** that extends from the body behind the penis see Figure 27.2. This location is important in sperm production, which occurs within the testes, and proceeds more efficiently when the testes are kept 2 to 4°C below core body temperature.

The dartos muscle makes up the subcutaneous muscle layer of the scrotum, Figure 27.3. It continues internally to make up the scrotal septum, a wall that divides the scrotum into two compartments, each housing one testis. Descending from the internal oblique muscle of the abdominal wall are the two cremaster muscles, which cover each testis like a muscular net. By contracting simultaneously, the dartos and cremaster muscles can elevate the testes in cold weather (or water), moving the testes closer to the body and decreasing the surface area of the scrotum to retain heat. Alternatively, as the environmental temperature increases, the scrotum relaxes, moving the testes farther from the body core and increasing scrotal surface area, which promotes heat loss. Externally, the scrotum has a raised medial thickening on the surface called the raphae.

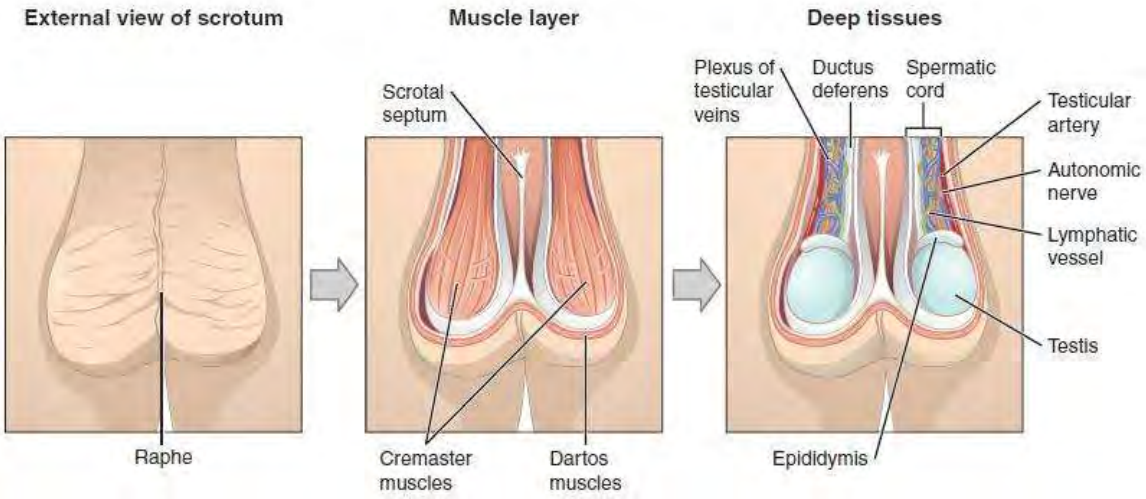


Figure 27.3 The Scrotum and Testes *This anterior view shows the structures of the scrotum and testes.*

Testes

The **testes** (singular = testis) are the assigned male **gonads**—that is, the assigned male at birth's reproductive organs. They produce both sperm and androgens, such as testosterone, and are active throughout the reproductive lifespan.

Paired ovals, the testes are each approximately 4 to 5 cm in length and are housed within the scrotum, see Figure 27.3. They are surrounded by two distinct layers of protective connective tissue (Figure 27.4). The outer tunica vaginalis is a serous membrane that has both a parietal and a thin visceral layer. Beneath the tunica vaginalis is the tunica albuginea, a tough, white, dense connective tissue layer covering the testis itself. Not only does the tunica albuginea cover the outside of the testis, it also invaginates (turns inside out or folds back on itself) to form septa that divide the testis into 300 to 400 structures called lobules. Within the lobules, sperm develop in structures called seminiferous tubules. During the seventh month of the developmental period of an assigned male fetus, each testis moves through the abdominal musculature to descend into the scrotal cavity. This is called the "descent of the testis." **Cryptorchidism** is the clinical term used when one or both of the testes does not descend into the scrotum prior to birth.

The tightly coiled **seminiferous tubules** form the bulk of each testis. They are composed of developing sperm cells surrounding a lumen, the hollow center of the tubule, where formed sperm are released into the duct system of the testis. Specifically, from the lumens of the seminiferous tubules, sperm move into the straight tubules (or tubuli recti), and from there into a fine meshwork of tubules called the **rete testes**. Sperm leave the rete testes, and the testis itself, through the 15 to 20 efferent ductules that cross the tunica albuginea.

Inside the seminiferous tubules are six different cell types. These include supporting cells called sustentacular cells, as well as five types of developing sperm cells called germ cells. Germ cell development progresses from the basement membrane—at the perimeter of the tubule—toward the lumen. Let's look more closely at these cell types.

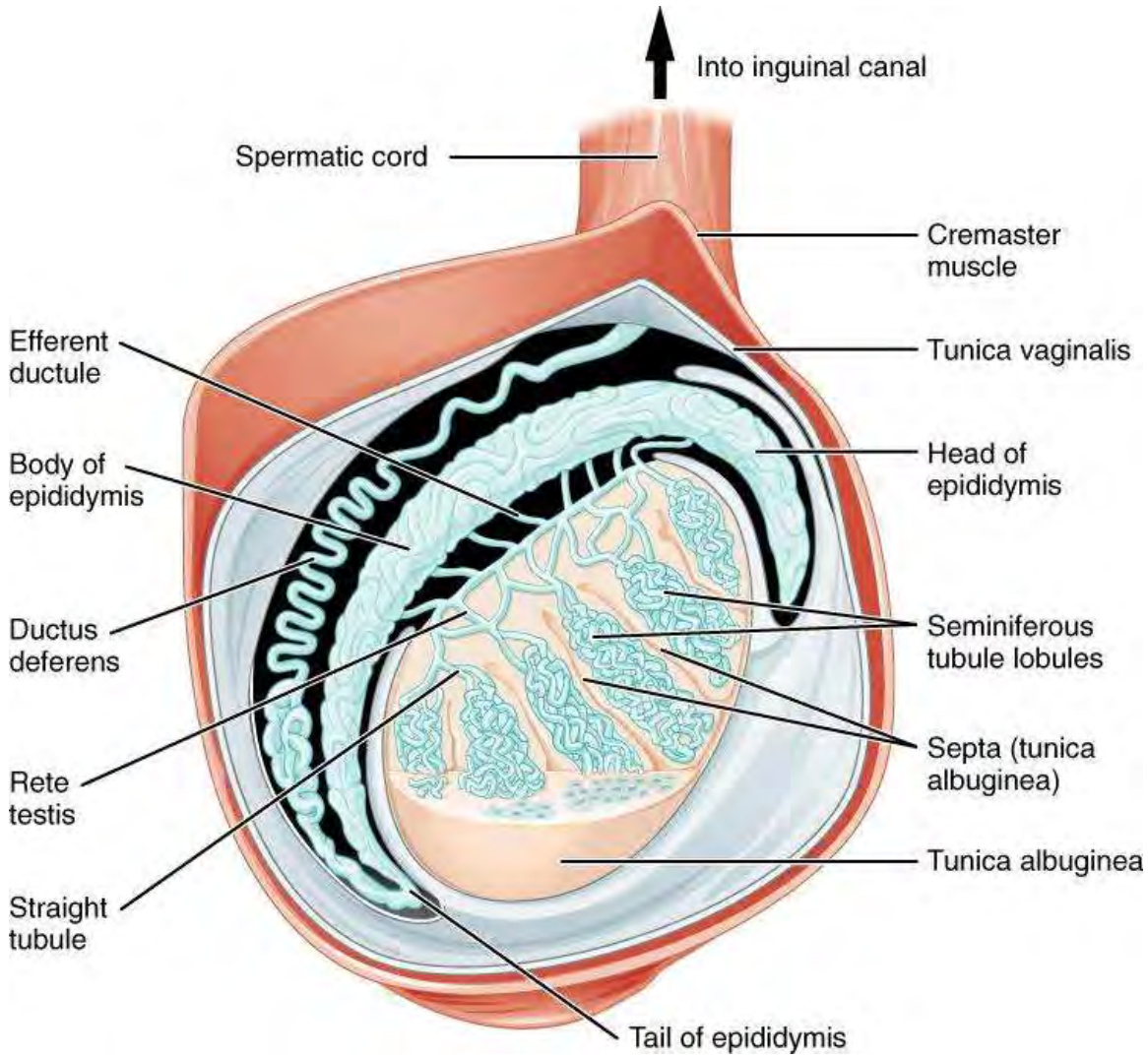


Figure 27.4 Anatomy of the Testis *This sagittal view shows the seminiferous tubules, the site of sperm production. Formed sperm are transferred to the epididymis, where they mature. They leave the epididymis during an ejaculation via the ductus deferens.*

Sertoli Cells

Surrounding all stages of the developing sperm cells are elongate, branching **Sertoli cells**. Sertoli cells are a type of supporting cell called a sustentacular cell, or sustentocyte, that are typically found in epithelial tissue. Sertoli cells secrete signaling molecules that promote sperm production, and can control whether germ cells live or die. Tight junctions between these sustentacular cells create the **blood–testis barrier**, which keeps bloodborne substances from reaching the germ cells and, at the same time, keeps surface antigens on developing germ cells from escaping into the bloodstream, prompting an autoimmune response.

Germ Cells

The least mature cells, the **spermatogonia** (singular = spermatogonium), line the basement membrane inside the tubule. Spermatogonia are the stem cells of the testis, which means that they are still able to differentiate into a variety of different cell types throughout adulthood. Spermatogonia divide to produce primary and secondary spermatocytes, then spermatids, which finally produce formed sperm. The process that begins with spermatogonia and concludes with the production of sperm is called **spermatogenesis**.

Spermatogenesis

As just noted, spermatogenesis occurs in the seminiferous tubules that form the bulk of each testis (see Figure 27.4). The process begins at puberty, after which time sperm is produced constantly throughout life. One production cycle, from spermatogonia through formed sperm, takes approximately 64 days. A new cycle starts approximately every 16 days, although this timing is not synchronous across the seminiferous tubules. Sperm counts—the total number of sperm produced—slowly decline after age 35, and some studies suggest that smoking can lower sperm counts irrespective of age.

Two identical diploid cells result from spermatogonia mitosis. One of these cells remains a spermatogonium, and the other becomes a primary **spermatocyte**, the next stage in the process of spermatogenesis. As in mitosis, DNA is replicated in a primary spermatocyte, before it undergoes a cell division called **meiosis I**. During meiosis I each of the 23 pairs of chromosomes separates. This results in two cells, called secondary spermatocytes, each with only half the number of chromosomes. Now a second round of cell division (**meiosis II**) occurs in both of the secondary spermatocytes. During meiosis II each of the 23 replicated chromosomes divides, similar to what happens during mitosis. Thus, meiosis results in separating the chromosome pairs. Eventually, the sperm are released into the lumen, and are moved along a series of ducts in the testis toward a structure called the epididymis for the next step of sperm maturation.

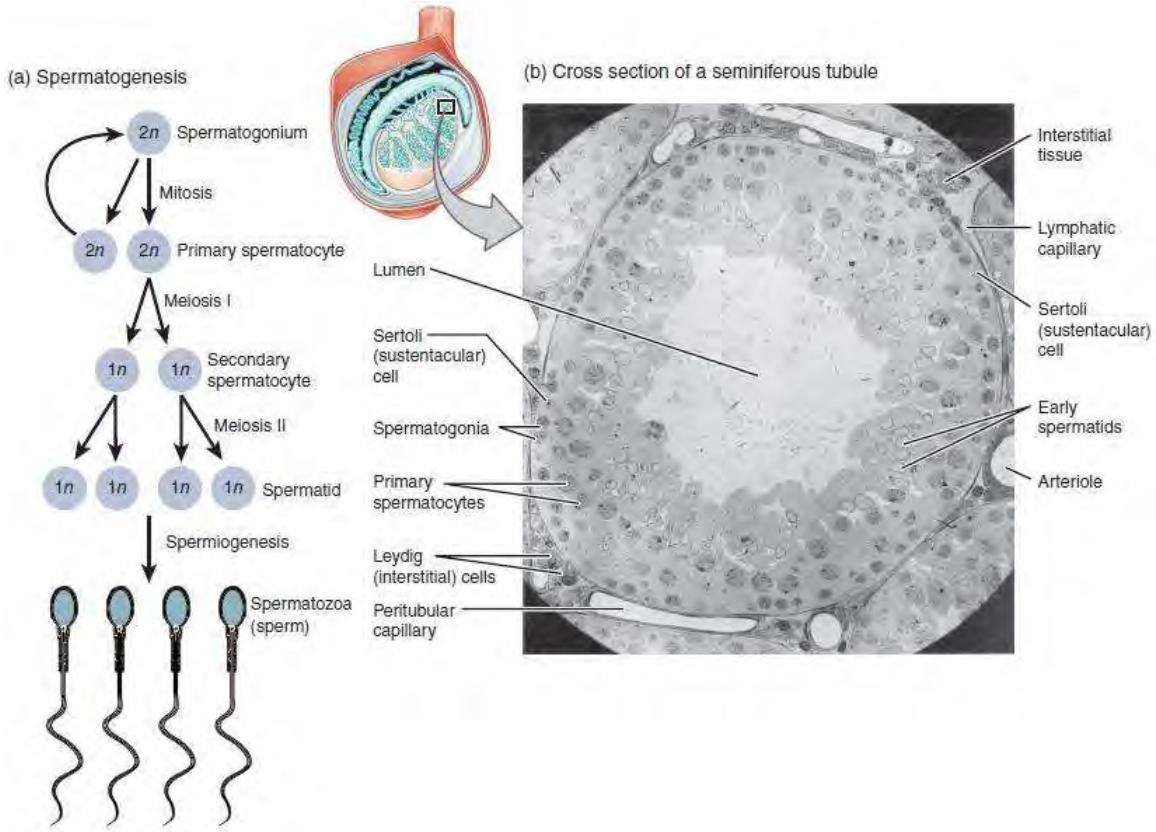


Figure 27.5 Spermatogenesis *(a) Mitosis of a spermatogonial stem cell involves a single cell division that results in two identical, diploid daughter cells (spermatogonia to primary spermatocyte). Meiosis has two rounds of cell division: primary spermatocyte to secondary spermatocyte, and then secondary spermatocyte to spermatid. This produces four haploid daughter cells (spermatids). (b) In this electron micrograph of a cross-section of a seminiferous tubule from a rat, the lumen is the light-shaded area in the center of the image. The location of the primary spermatocytes is near the basement membrane, and the early spermatids are approaching the lumen (tissue source: rat). EM × 900. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)*

Structure of Formed Sperm

Sperm are smaller than most cells in the body; in fact, the volume of a sperm cell is 85,000 times less than that of the ovum. Approximately 100 million to 300 million sperm are produced each day, whereas the ovary typically releases only one oocyte per month. As is true for most cells in the body, the structure of sperm cells speaks to their function. Sperm have a distinctive head, mid-piece, and tail region (Figure 27.6). The head of the sperm contains the extremely compact haploid nucleus with very little cytoplasm. These qualities contribute to the overall small size of the sperm (the head is only 5 μm long). A structure called the acrosome covers most of the head of the sperm cell as a “cap” that is filled with lysosomal enzymes important for preparing sperm to participate in fertilization. Tightly packed mitochondria fill the mid-piece of the sperm. ATP produced by these mitochondria

will power the flagellum, which extends from the neck and the mid-piece through the tail of the sperm, enabling it to move the entire sperm cell. The central strand of the flagellum, the axial filament, is formed from one centriole inside the maturing sperm cell during the final stages of spermatogenesis.

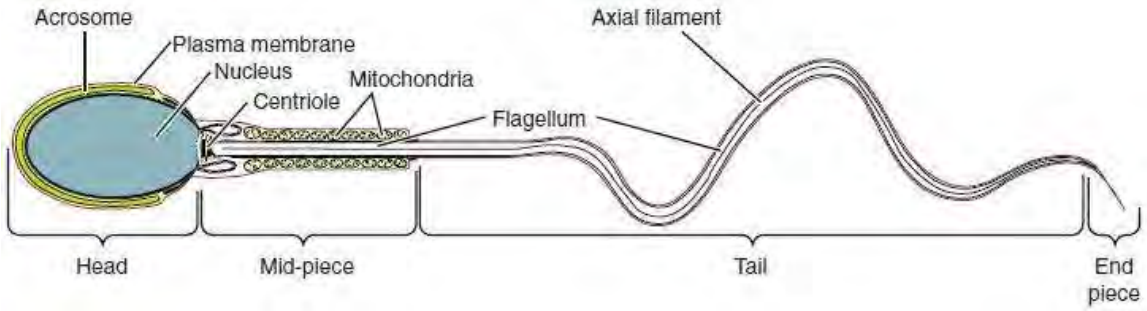


Figure 27.6 Structure of Sperm. *Sperm cells are divided into a head, containing DNA; a mid-piece, containing mitochondria; and a tail, providing motility. The acrosome is oval and somewhat flattened.*

Sperm Transport

To fertilize an ovum, sperm must be moved from the seminiferous tubules in the testes, through the epididymis, and—later during ejaculation—along the length of the penis and out into the assigned female reproductive tract.

Role of the Epididymis

From the lumen of the seminiferous tubules, the immotile sperm are surrounded by testicular fluid and moved to the **epididymis** (plural = epididymides), a coiled tube attached to the testis where newly formed sperm continue to mature (see Figure 27.4). Though the epididymis does not take up much room in its tightly coiled state, it would be approximately 6 m (20 feet) long if straightened. It takes an average of 12 days for sperm to move through the coils of the epididymis, with the shortest recorded transit time in humans being one day. Sperm enter the head of the epididymis and are moved along predominantly by the contraction of smooth muscles lining the epididymal tubes. As they are moved along the length of the epididymis, the sperm further mature and acquire the ability to move under their own power. Once inside the assigned female reproductive tract, they will use this ability to move independently toward the unfertilized ovum. The more mature sperm are then stored in the tail of the epididymis (the final section), until ejaculation occurs.

Duct System

During ejaculation, sperm exit the tail of the epididymis and are pushed by smooth muscle contraction to the **ductus deferens** (also called the vas deferens). The ductus deferens is a thick, muscular tube that is bundled together inside the scrotum with connective tissue, blood vessels, and nerves into a structure called the **spermatic cord** (see Figure 27.2 and Figure 27.3). Because the ductus deferens is physically accessible within the scrotum, surgical sterilization to interrupt sperm delivery can be performed by cutting and sealing a small section of the ductus (vas) deferens. This procedure is called a vasectomy, and it is an effective form of birth control. Although it may be possible to reverse a vasectomy, clinicians consider the procedure permanent, and advise individuals to undergo it only if they are certain they no longer wish to have children.

Sperm make up only 5 percent of the final volume of **semen**, the thick, milky fluid that the penis ejaculates. The bulk of semen is produced by three critical accessory glands of the reproductive system: the seminal vesicles, the prostate, and the bulbourethral glands.

Seminal Vesicles

As sperm pass through the ampulla of the ductus deferens at ejaculation, they mix with fluid from the associated **seminal vesicle** (see Figure 27.2). The paired seminal vesicles are glands that contribute approximately 60 percent of the semen volume. Seminal vesicle fluid contains large amounts of fructose, which is used by the sperm mitochondria to generate ATP to allow movement through the assigned female reproductive tract.

The fluid, now containing both sperm and seminal vesicle secretions, next moves into the associated **ejaculatory duct**, a short structure formed from the ampulla of the ductus deferens and the duct of the seminal vesicle. The paired ejaculatory ducts transport the seminal fluid into the next structure, the prostate gland.

Prostate Gland

As shown in Figure 27.2, the centrally located **prostate gland** sits anterior to the rectum at the base of the bladder surrounding the prostatic urethra (the portion of the urethra that runs within the prostate). About the size of a walnut, the prostate is formed of both muscular and glandular tissues. It secretes an alkaline, milky fluid to the passing seminal fluid—now called semen—that is critical to first coagulate and then decoagulate the semen following ejaculation. The temporary thickening of semen helps retain it within the assigned female reproductive tract, providing time for sperm to utilize the fructose provided by seminal vesicle secretions. When the semen regains its fluid state, sperm can then pass farther into the assigned female reproductive tract.

The prostate normally doubles in size during puberty. At approximately age 25, it gradually begins to enlarge again. Abnormal growth of the prostate, or benign prostatic hyperplasia (BPH), can cause constriction of the urethra as it passes through the middle of the prostate gland, leading to a number of lower urinary tract symptoms, such as a frequent and intense urge to urinate, a weak stream, and a sensation that the bladder has not emptied completely.

Bulbourethral Glands

The final addition to semen is made by two **bulbourethral glands** (or Cowper's glands) that release a thick, salty fluid that lubricates the end of the urethra and the vagina, and helps to clean urine residues from the penile urethra. The fluid from these accessory glands is released after the sexual arousal, and shortly before the release of the semen. It is therefore sometimes called pre-ejaculatory fluid . It is important to note that, in addition to the lubricating proteins, it is possible for bulbourethral fluid to pick up sperm already present in the urethra, and therefore it may be able to cause pregnancy.

Sidebar 3.5: Interactive Link

Watch this video to explore the structures of the assigned male reproductive system and the path of sperm, which starts in the testes and ends as the sperm leave the penis through the urethra. Where are sperm deposited after they leave the ejaculatory duct?

Remi Newman

The Penis

The **penis** is the organ of copulation (sexual intercourse). It is flaccid for non-sexual actions, such as urination, and turgid and rod-like with sexual arousal. When erect, the stiffness of the organ allows it to penetrate into the vagina and deposit semen into the assigned female reproductive tract.

The shaft of the penis surrounds the urethra (Figure 27.7). The shaft is composed of three column-like chambers of erectile tissue that span the length of the shaft. Each of the two larger lateral chambers is called a **corpus cavernosum** (plural = corpora

cavernosa). Together, these make up the bulk of the penis. The **corpus spongiosum**, which can be felt as a raised ridge on the erect penis, is a smaller chamber that surrounds the spongy, or penile, urethra. The end of the penis, called the **glans penis**, has a high concentration of nerve endings, resulting in very sensitive skin that influences the likelihood of ejaculation (see Figure 27.2). The skin from the shaft extends down over the glans and forms a collar called the **prepuce** (or foreskin). The foreskin also contains a dense concentration of nerve endings, and both lubricate and protect the sensitive skin of the glans penis. A surgical procedure called circumcision, often performed for religious or social reasons, removes the prepuce, typically within days of birth.

Both sexual arousal and REM sleep (during which dreaming occurs) can induce an erection. Penile erections are the result of vasocongestion, or engorgement of the tissues because of more arterial blood flowing into the penis than is leaving in the veins. During sexual arousal, nitric oxide (NO) is released from nerve endings near blood vessels within the corpora cavernosa and spongiosum. Release of NO activates a signaling pathway, which results in relaxation of the smooth muscles that surround the penile arteries, causing them to dilate. This dilation increases the amount of blood that can enter the penis and induces the endothelial cells in the penile arterial walls to also secrete NO and perpetuate the vasodilation. The rapid increase in blood volume fills the erectile chambers, and the increased pressure of the filled chambers compresses the thin-walled penile venules, preventing venous drainage of the penis. The result of this increased blood flow to the penis and reduced blood return from the penis is erection. Depending on the flaccid dimensions of a penis, it can increase in size slightly or greatly during erection, with the average length of an erect penis measuring approximately 15 cm or 5.9 inches.

A circumcision operation, Nupe, North Nigeria. 2014. *Creative Commons Attribution 4.0*

Sidebar 3.6: Circumcision: To snip or not to snip

Circumcision is a controversial procedure because it involves the mutilation of a penis. Many people view circumcision as a cosmetic procedure and argue that individuals should make their own decision regarding participating in the surgery once they reach their 18th birthday. Many cultures practice the ritual of circumcision, however, in recent decades; Australia, Canada, Ireland, New Zealand, and the United Kingdom have seen a decline in the ritual of circumcision.

Religion is typically a driving force in the decision to participate in circumcision, however, it is not always the case. While religion is a major driving force in the decision to circumcise a child, the decision to circumcise an individual can involve hygiene in addition to a way to express faith.

In recent decades, the potential risks associated with circumcision which include excessive bleeding, irritation to the head of the penis, the possibility of injury, or even a higher chance of meatitis (inflammation of the opening of the penis) have made many parents reconsider this elective surgical procedure.

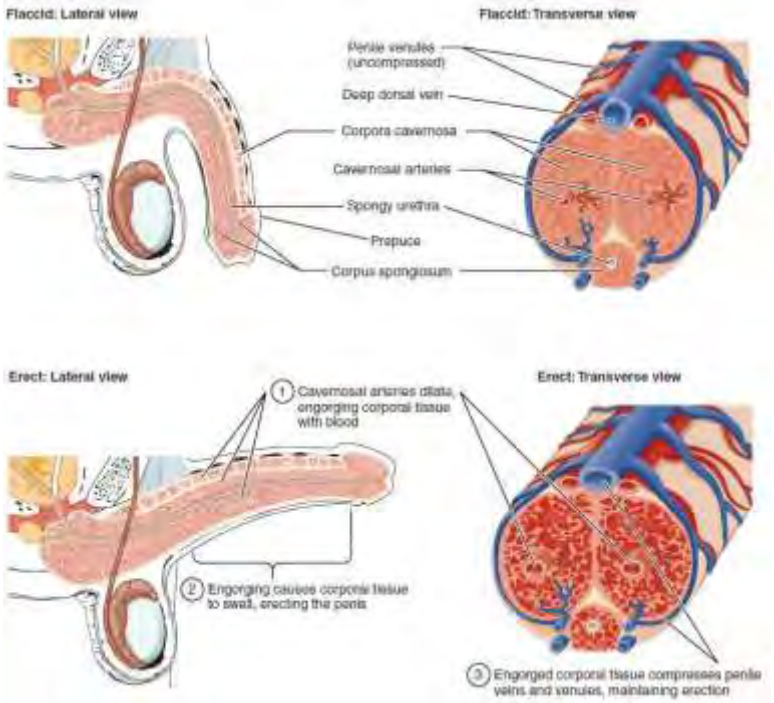


Figure 27.7 Cross-Sectional Anatomy of the Penis *Three columns of erectile tissue make up most of the volume of the penis.*

Testosterone

Testosterone, an androgen, is a steroid hormone produced by **Leydig cells**. The alternate term for Leydig cells, interstitial cells, reflects their location between the seminiferous tubules in the testes. In assigned male embryos, testosterone is secreted by Leydig cells by the seventh week of development, with peak concentrations reached in the second trimester. This early release of testosterone results in the anatomical differentiation of the sexual organs. In childhood, testosterone concentrations are low. They increase during puberty, activating characteristic physical changes and initiating spermatogenesis.

Functions of Testosterone

The continued presence of testosterone is necessary to keep the reproductive system working properly, and Leydig cells produce approximately 6 to 7 mg of testosterone per day. Testicular steroidogenesis (the manufacture of androgens, including testosterone) results in testosterone concentrations that are 100 times higher in the testes than in the circulation. Maintaining these normal concentrations of testosterone promotes spermatogenesis, whereas low levels of testosterone can lead to infertility. In addition to intratesticular secretion, testosterone is also released into the systemic circulation and plays an important role in muscle development, bone growth, the development of secondary sex characteristics, and maintaining libido in both assigned males and assigned females. In assigned females, the ovaries secrete small amounts of testosterone, although most is converted to estradiol. A small amount of testosterone is also secreted by the adrenal glands in both assigned sexes.

Control of Testosterone

The regulation of testosterone concentrations throughout the body is critical for reproductive function. The intricate interplay between the endocrine system and the reproductive system is shown in Figure 27.8. The regulation of Leydig cell production of testosterone begins outside of the testes. The hypothalamus and the pituitary gland in the brain integrate external and internal signals to control testosterone synthesis and secretion. The regulation begins in the hypothalamus. Pulsatile release of a hormone called **gonadotropin-releasing hormone (GnRH)** from the hypothalamus stimulates the endocrine release of hormones from the

pituitary gland. Binding of GnRH to its receptors on the anterior pituitary gland stimulates release of the two gonadotropins: luteinizing hormone (LH) and follicle-stimulating hormone (FSH). These two hormones are critical for reproductive function in assigned males and assigned females. In assigned males, FSH binds predominantly to the Sertoli cells within the seminiferous tubules to promote spermatogenesis.

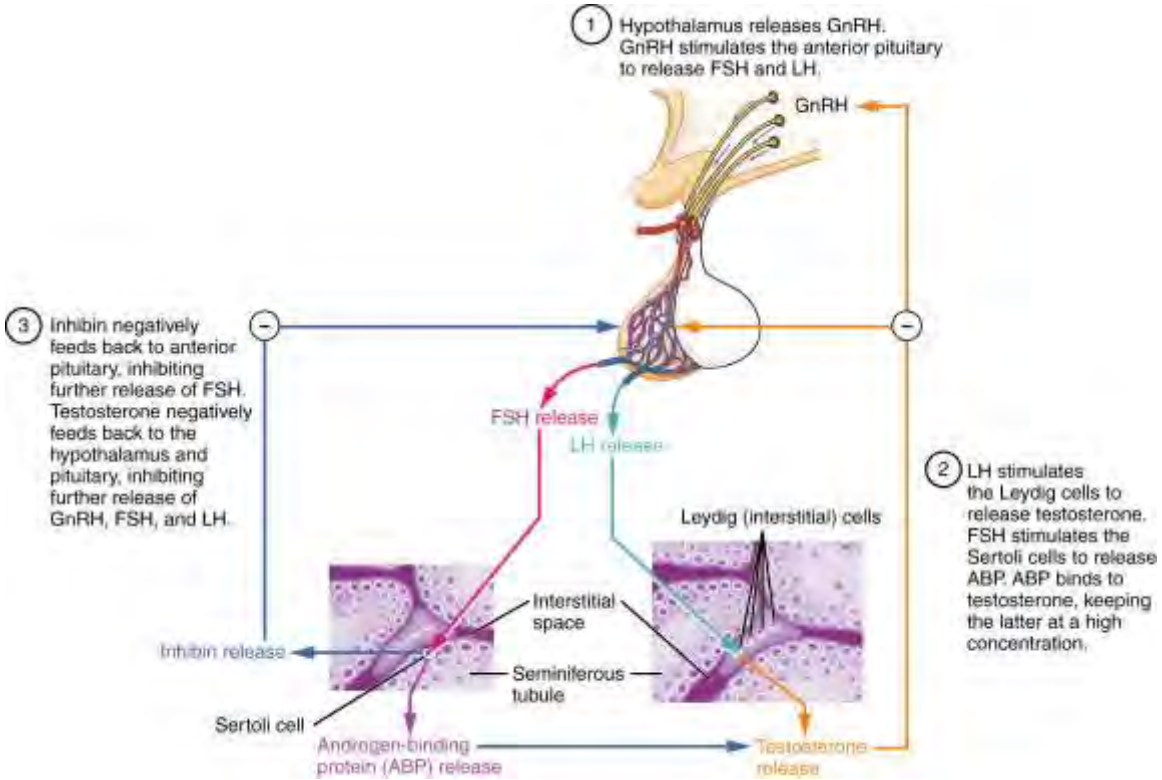


Figure 27.8 Regulation of Testosterone Production *The hypothalamus and pituitary gland regulate the production of testosterone and the cells that assist in spermatogenesis. GnRH activates the anterior pituitary to produce LH and FSH, which in turn stimulate Leydig cells and Sertoli cells, respectively. The system is a negative feedback loop because the end products of the pathway, testosterone and inhibin, interact with the activity of GnRH to inhibit their own production.*

When concentrations of testosterone in the blood reach a critical threshold, testosterone itself will bind to androgen receptors on both the hypothalamus and the anterior pituitary, inhibiting the synthesis and secretion of GnRH and LH, respectively. When the blood concentrations of testosterone once again decline, testosterone no longer interacts with the receptors to the same degree, and GnRH and LH are once again secreted, stimulating more testosterone production. This same process occurs with FSH and inhibin to control spermatogenesis.

Review of Assigned Male Reproductive Anatomy

Gametes are the reproductive cells that combine to form a zygote. Organs called gonads produce the gametes, along with the hormones that regulate human reproduction. The male gametes are called sperm. Spermatogenesis, the production of sperm, occurs within the seminiferous tubules that make up most of the testis. The scrotum is the muscular sac that holds the testes outside of the body cavity.

Spermatogenesis begins with mitotic division of spermatogonia (stem cells) to produce primary spermatocytes that undergo the two divisions of meiosis to become secondary spermatocytes, then the haploid spermatids. During spermiogenesis, spermatids are transformed into spermatozoa (formed sperm). Upon release from the seminiferous tubules, sperm are moved to the epididymis where they continue to mature. During ejaculation, sperm exit the epididymis through the ductus deferens, a duct in the spermatic cord that leaves the scrotum. The ampulla of the ductus deferens meets the seminal vesicle, a gland that contributes fructose and proteins, at the ejaculatory duct. The fluid continues through the prostatic urethra, where secretions from the prostate are added to form semen. These secretions help the sperm to travel through the urethra and into the assigned female reproductive tract. Secretions from the bulbourethral glands protect sperm and cleanse and lubricate the penile (spongy) urethra.

The penis is the assigned male organ of copulation. Columns of erectile tissue called the corpora cavernosa and corpus spongiosum fill with blood when sexual arousal activates vasodilatation in the blood vessels of the penis. Testosterone regulates and maintains the sex organs and libido, and induces the physical changes of puberty. Interplay between the testes and the endocrine system precisely controls the production of testosterone with a negative feedback loop.

Glossary

1. **Alveoli:** (of the breast) milk-secreting cells in the mammary gland
2. **Ampulla** (of the uterine tube) middle portion of the uterine tube in which fertilization often occurs
3. **Antrum** fluid-filled chamber that characterizes a mature tertiary (antral) follicle

4. **Areola** highly pigmented, circular area surrounding the raised nipple and containing areolar glands that secrete fluid important for lubrication during suckling
5. **Bartholin's glands** (also, greater vestibular glands) glands that produce a thick mucus that maintains moisture in the vulva area; also referred to as the greater vestibular glands
6. **Blood–testis barrier** tight junctions between Sertoli cells that prevent bloodborne pathogens from gaining access to later stages of spermatogenesis and prevent the potential for an autoimmune reaction to haploid sperm
7. **Body of uterus** middle section of the uterus
8. **Broad ligament** wide ligament that supports the uterus by attaching laterally to both sides of the uterus and pelvic wall
9. **Bulbourethral glands** (also, Cowper's glands) glands that secrete a lubricating mucus that cleans and lubricates the urethra prior to and during ejaculation
10. **Cervix** elongate inferior end of the uterus where it connects to the vagina
11. **Clitoris** (also, glans clitoris) nerve-rich area of the vulva that contributes to sexual sensation during intercourse
12. **Corpus albicans** nonfunctional structure remaining in the ovarian stroma following structural and functional regression of the corpus luteum
13. **Corpus cavernosum** either of two columns of erectile tissue in the penis that fill with blood during an erection
14. **Corpus luteum** transformed follicle after ovulation that secretes progesterone
15. **Corpus spongiosum** (plural = corpora cavernosa) column of erectile tissue in the penis that fills with blood during an erection and surrounds the penile urethra on the ventral portion of the penis
16. **Differentiated Sex Development** a range of variations that can occur when a person does not have the specific anatomy or chromosomal markers that would typically assign them either male or female

17. **Ductus deferens** (also, vas deferens) duct that transports sperm from the epididymis through the spermatic cord and into the ejaculatory duct; also referred as the vas deferens
18. **Ejaculatory duct** duct that connects the ampulla of the ductus deferens with the duct of the seminal vesicle at the prostatic urethra
19. **Endometrium** inner lining of the uterus, part of which builds up during the secretory phase of the menstrual cycle and then sheds with menses
20. **Epididymis** (plural = epididymides) coiled tubular structure in which sperm start to mature and are stored until ejaculation
21. **Fallopian tubes** (also, uterine tubes or oviducts) ducts that facilitate transport of an ovulated oocyte to the uterus
22. **Fimbriae** fingerlike projections on the distal uterine tubes
23. **Follicle** ovarian structure of one oocyte and surrounding granulosa (and later theca) cells
24. **Folliculogenesis** development of ovarian follicles from primordial to tertiary under the stimulation of gonadotropins
25. **Fundus** (of the uterus) domed portion of the uterus that is superior to the uterine tubes
26. **Gamete** haploid reproductive cell that contributes genetic material to form an offspring
27. **Glans penis** bulbous end of the penis that contains a large number of nerve endings
28. **Gonads** reproductive organs (testes in men and ovaries in women) that produce gametes and reproductive hormones
29. **Granulosa cells** supportive cells in the ovarian follicle that produce estrogen
30. **Hymen** membrane that covers part of the opening of the vagina
31. **Infundibulum** (of the uterine tube) wide, distal portion of the uterine tube terminating in fimbriae
32. **Inguinal canal** opening in abdominal wall that connects the testes to the abdominal cavity

33. **Intersex** an umbrella term that describes bodies that fall outside the strict male/female binary
34. **Isthmus** narrow, medial portion of the uterine tube that joins the uterus
35. **Labia majora** hair-covered folds of skin located behind the mons pubis
36. **Labia minora** thin, pigmented, hairless flaps of skin located medial and deep to the labia majora
37. **Lactiferous ducts** ducts that connect the mammary glands to the nipple and allow for the transport of milk
38. **Lactiferous sinus** area of milk collection between alveoli and lactiferous duct
39. **Leydig cells** cells between the seminiferous tubules of the testes that produce testosterone; a type of interstitial cell
40. **mammary glands** glands inside the breast that secrete milk
41. **Menarche** first menstruation in a pubertal female
42. **Menses** shedding of the inner portion of the endometrium out though the vagina; also referred to as menstruation
43. **Menses phase** phase of the menstrual cycle in which the endometrial lining is shed
44. **Menstrual cycle** approximately 28-day cycle of changes in the uterus consisting of a menses phase, a proliferative phase, and a secretory phase
45. **Mons pubis** mound of fatty tissue located at the front of the vulva
46. **Myometrium** smooth muscle layer of uterus that allows for uterine contractions during labor and expulsion of menstrual blood
47. **Oocyte** cell that results from the division of the oogonium and undergoes meiosis I at the LH surge and meiosis II at fertilization to become a haploid ovum
48. **Oogenesis** process by which oogonia divide by mitosis to primary oocytes, which undergo meiosis to produce the secondary oocyte and, upon fertilization, the ovum

49. **Oogonia** ovarian stem cells that undergo mitosis during female fetal development to form primary oocytes
50. **Ovarian cycle** approximately 28-day cycle of changes in the ovary consisting of a follicular phase and a luteal phase
51. **Ovaries** female gonads that produce oocytes and sex steroid hormones (notably estrogen and progesterone)
52. **Ovulation** release of a secondary oocyte and associated granulosa cells from an ovary
53. **Ovum** haploid female gamete resulting from completion of meiosis II at fertilization
54. **Penis** male organ of copulation
55. **Perimetrium** outer epithelial layer of uterine wall
56. **Polar body** smaller cell produced during the process of meiosis in oogenesis
57. **Prepuce** (also, foreskin) flap of skin that forms a collar around, and thus protects and lubricates, the glans penis; also referred as the foreskin
58. **Primary follicles** ovarian follicles with a primary oocyte and one layer of cuboidal granulosa cells
59. **Primordial follicles** least developed ovarian follicles that consist of a single oocyte and a single layer of flat (squamous) granulosa cells
60. **Proliferative phase** phase of the menstrual cycle in which the endometrium proliferates
61. **Prostate gland** doughnut-shaped gland at the base of the bladder surrounding the urethra and contributing fluid to semen during ejaculation
62. **Puberty** life stage during which a male or female adolescent becomes anatomically and physiologically capable of reproduction
63. **Rugae** (of the vagina) folds of skin in the vagina that allow it to stretch during intercourse and childbirth
64. **Scrotum** external pouch of skin and muscle that houses the testes

65. **Secondary follicles** ovarian follicles with a primary oocyte and multiple layers of granulosa cells
66. **Secondary sex characteristics** physical characteristics that are influenced by sex steroid hormones and have supporting roles in reproductive function
67. **Secretory phase** phase of the menstrual cycle in which the endometrium secretes a nutrient-rich fluid in preparation for implantation of an embryo
68. **Semen** ejaculatory fluid composed of sperm and secretions from the seminal vesicles, prostate, and bulbourethral glands
69. **Seminal vesicle** gland that produces seminal fluid, which contributes to semen
70. **Seminiferous tubules** tube structures within the testes where spermatogenesis occurs
71. **Sertoli cells** cells that support germ cells through the process of spermatogenesis; a type of sustentacular cell
72. **Sperm** (also, spermatozoon) male gamete
73. **spermatic cord** bundle of nerves and blood vessels that supplies the testes; contains ductus deferens
74. **Spermatid** immature sperm cells produced by meiosis II of secondary spermatocytes
75. **Spermatocyte** cell that results from the division of spermatogonium and undergoes meiosis I and meiosis II to form spermatids
76. **Spermatogenesis** formation of new sperm, occurs in the seminiferous tubules of the testes
77. **Spermatogonia** (singular = spermatogonium) diploid precursor cells that become sperm
78. **Spermiogenesis** transformation of spermatids to spermatozoa during spermatogenesis
79. **Suspensory ligaments** bands of connective tissue that suspend the breast onto the chest wall by attachment to the overlying dermis
80. **Testes** (singular = testis) male gonads

81. **Tertiary follicles** (also, antral follicles) ovarian follicles with a primary or secondary oocyte, multiple layers of granulosa cells, and a fully formed antrum
82. **Theca cells** estrogen-producing cells in a maturing ovarian follicle
83. **Uterus** muscular hollow organ in which a fertilized egg develops into a fetus
84. **Vagina** tunnel-like organ that provides access to the uterus for the insertion of semen and from the uterus for the birth of a baby
85. **Vulva** external female genitalia
86. **Wolffian duct** duct system present in the embryo that will eventually form the internal male reproductive structures

Discussion Questions

1. The different genitalia of fetuses develop from the same tissues in the embryo. View this **animation** that compares the development of structures of the female and male reproductive systems in a growing fetus. Where are the testes located for most of gestational time?
2. Watch this video to observe ovulation and its initiation in response to the release of FSH and LH from the pituitary gland. What specialized structures help guide the oocyte from the ovary into the uterine tube?
3. Watch this series of videos to look at the movement of the oocyte through the ovary. The cilia in the uterine tube promote movement of the oocyte. What would likely occur if the cilia were paralyzed at the time of ovulation?
4. Follow the path of ejaculated sperm from the vagina to the oocyte. Include all structures of the female reproductive tract that the sperm must swim through to reach the egg.
5. Explain the hormonal regulation of the phases of the menstrual cycle.

Multiple Choice Questions

1. What controls whether an embryo will develop testes or ovaries?

1. Y Chromosome
2. X chromosome
3. size of vulva
4. size of testes

2. What are the female gonads called?

1. oocytes
2. ova
3. oviducts
4. ovaries

3. When do the oogonia undergo mitosis?

1. before birth
2. at puberty
3. at the beginning of each menstrual cycle
4. during fertilization

4. From what structure does the corpus luteum originate?

1. uterine corpus
2. dominant follicle
3. fallopian tube
4. corpus albicans

5. Where does fertilization of the egg by the sperm typically occur?

1. vagina
2. uterus
3. fallopian tube
4. ovary

6. Why do estrogen levels fall after menopause?

1. The ovaries degrade.
2. There are no follicles left to produce estrogen.
3. The pituitary secretes a menopause-specific hormone.
4. The cells of the endometrium degenerate.

7. The vulva includes the _____.

1. lactiferous duct, rugae, and hymen
2. lactiferous duct, endometrium, and bulbourethral glands
3. mons pubis, endometrium, and hymen
4. mons pubis, labia majora, and Bartholin's glands

8. Sperm and ova are similar in terms of _____.

1. size
2. quantity produced per year
3. chromosome number
4. flagellar motility

9. Although the male ejaculate contains hundreds of millions of sperm, _____.

1. most do not reach the oocyte
2. most are destroyed by the alkaline environment of the uterus
3. it takes millions to penetrate the outer layers of the oocyte
4. most are destroyed by capacitation

10. Leydig cells _____.

1. secrete testosterone
2. secrete seminal fluid
3. have sperm-binding receptors
4. support spermatogenesis

11. What are the assigned male gametes called? _____.

1. sperm
2. testes
3. ova
4. placenta

For Further Exploration

Sex Redefined: The Idea of 2 Sexes Is Overly Simplistic - Scientific American

Ovum: Definition, Function & Structure - Video & Lesson Transcript | Study.com

Beyond The Shock - Chapter 2 - Breast Anatomy

How Sperm is Created

References

All material in this chapter has been modified from Chapter 27 The Reproductive System OpenStax Anatomy and Physiology.
https://openstax.org/details/books/anatomy-and-physiology

Chapter 4: Pleasure, Sexual Arousal and Response

Firegoddess by Amanda Ayala Instagram: @xicanaollin

Learning Objectives

After completing this module, students should have a working knowledge of:

- What pleasure is
- Stigma and pleasure seeking
- How culture shapes and constricts sexual pleasure
- How to tap into pleasurable things in life without regret
- The role of the brain in sexual arousal and response
- The sexual response cycle by William Masters and Virginia Johnson
- The importance of Alfred Kinsey's work and at the Kinsey Institute
- Current work on arousal done by sex researcher Emily Nagoski

Does my sexiness upset you? Does it come as a surprise? That I dance like I've got diamonds at the meeting of my thighs?

- Maya Angelou, Still I Rise

Maya Angelou at Elon University 2012 Creative Commons Attribution 2.0

Introduction

This chapter will explore the topic of pleasure and sexual arousal. More specifically, what turns you on or provides you pleasure of any kind. What do you desire, and how did you learn this was something you wanted? Is it the sight of an attractive person, a smell you find particularly appealing, or the taste of something silky and delicious? Is it being touched in just the right way or that particular song that gets you in the mood? Or is none of this something you find pleasurable? Whatever it is, our minds, influenced by our surroundings, hold the key to understanding our pleasure. The mind is our largest sex organ, and it can either accelerate our desires or bring them to a screeching halt.

How we become aroused and whether or not it involves physical embodiment is different for each and every one of us, but the pursuit of pleasure in various forms is intrinsic to the human condition. We are pleasure seekers and the sooner we acknowledge and embrace this, our lives become much fuller. Giving into pleasure is not a bad thing, it is part of radical self-love. In this chapter, we will unpack the notion of pleasure and some ways in which society constricts us from enjoying ourselves. Our goal is to eliminate those constraints and find our way to feeling joy. We will also explore some of the science behind sexual arousal and the mind-body connection. Specifically, the ways in which external factors, coupled with how our minds respond to those factors, either enhance or hinder our arousal.

Circe's House

Bodies entwined floating over water. Gurgling, is that my stomach or the waterbed where our bodies lay tangled in dirty sheets. Scents of cheap beer and marijuana wafting through the house into your roommates room. I feel special that you selected me. So much to learn and inhabit. I am outside of myself watching as we slosh around, your strawberry blond curls brushed against my trembling body. So unsure of what's to come and thankful that it is over.

- Anonymous

Pleasure

What does the term pleasure mean to you? It's a good thing right? Embracing embodied living and being present in our mind and bodies in order to tap into our senses. Pleasure, a feeling of happy satisfaction and enjoyment, heals. It is something we live for whether we know it or not. Every human seeks pleasure in one way or another, so why is so much of it taboo in our culture? Let's unpack this taboo a little bit and then put it away so we can get back to what's important, pleasure! As we discuss pleasure in general, it is important to note that while all people seek pleasure, we all have varying interest in sexual activity either with others or alone at different points throughout our lives. Sometimes the term *Asexual* can be used to describe a lack of interest in sexual activity and people who are asexual may self-identify as *Ace*. Just like gender and sexual orientation, sexual desire can also be viewed as being contained on a spectrum. All people also have

desires and seek pleasure; it just may be expressed in ways that differ from how you as an individual define what is pleasurable. The desire for pleasure is universal. Whether it be embodied or in our minds, a connection to our sensual selves helps us tap into this vital piece of our humanity. *Sensuality,* the notion of being highly tuned into your senses, is an important way to discover what it is you as an individual like. Paying attention to your senses rather than letting standards or norms guide our expressions of gender or sexuality will allow greater satisfaction. Pleasure is deeply connected, but not limited to our sexuality, and sexual health is an important part of overall well-being. The World Health Organization (WHO) considers our sexual health part of our overall quality of life (The World Health Organization Quality of Life (WHOQOL), 2012). Whether it be in the form of accessibility to sex education, reproductive rights and health care, or the right to openly express our sexual identity exactly as it is this very moment all add to our quality of life. Having desires and fulfilling them is part of our comprehensive wellness.

In terms of our sexual gratification, there is a spectrum of what people do to feel good. Whether it be *auto-erotic* (sexual pleasure with one's self), or with another person or persons, there is no right way to do it and what feels good to one person may not to another. As long as all parties consent to it, have fun. In many ways consent is complicated rather than a simple yes or no binary as many perceive. The ability to consent replicates the larger social structure. Think about how age, gender, cultural background, body type, race, experiences with trauma and social class afford us different levels of privilege. Consent becomes complicated by all of this. It is complicated by coercion, power, and privilege of those who may or may not consent to something authenticity as a result so a one size fits all definition of consent is difficult. The following clip describes consent in a humorous way. Tea Consent. If consent is to be authentically achieved, there must be open, honest communication and a sense of trust. Consent is ongoing and needs to be revisited. A yes now may be a no in 20 minutes so keep talking. The goal is for consent to be what is known as yes means yes or enthusiastic consent. Flipping this script helps add clarity to what people actually want. Remember, communication is lubrication so communicate about what you like, what you don't like, and what you want to try. Please also try to let go of societal messaging about how sexuality should look, sound or feel. Getting caught up in cultural standards of beauty or how the act of sex is supposed to look can make us feel like we don't get to enjoy ourselves until something changes (we lose 5lbs, or learn how to come in a certain position, etc.).

The work of Sex Educator, Emily Nagoski influences the ways in which we in this text hope to frame sexuality and self-acceptance. Her 2015 book, *Come As You Are,* debunks many of the societal messaging around sexuality, gender and offers an empowering alternative.

We all grew up hearing contradictory messages about sex, and so now many of us experience ambivalence about it. That's normal. The more aware you are of those contradictory messages, the more choice you have about whether to believe them (Nagoski, 2015, p 202).

You are deserving of pleasure right now! You get to define what that pleasure looks like and make choices that you want to make, instead of what you think society values. "When you embrace your sexuality precisely as it is right now, that's the context that creates the greatest potential for ecstatic pleasure" (Nagoski, 2015 p. 8).

Sidebar 4.1: Asexuality

A person who identifies as asexual might be commonly referred to as “Ace” or “Aces”. Asexuality is not defined as abstinence as a result of a bad relationship, celibacy, fear of intimacy, or other commonly referenced stereotypes. Rather, asexuality can be many things, but people who identify as asexual can still fall in love, choose to masturbate, choose to engage in sexual activities, have a spouse or partners(s)! It is important to note that love does not always equal sex, and that sexuality exists on a spectrum. Asexuality, or for that matter, any other sexual identity, is not fixed, nor is it expressed the same for every person who identifies as asexual (Chen, 2020). Asexuality as an orientation is not a single way of orienting towards sex, it is not a catch all, and it can be misinterpreted or misused, so it is best to not apply labels to others, and instead, allow expression and labels to be up to individuals if they chose. For a deeper dive into understanding Asexuality, here are three resources, Yasmin Benoit, Asexuals Need Media Representation, The Amazing Aces. and Season 8, Episode 15 of the *Gender Reveal Podcast*: Gender Reveal Podcast with Ev'Yan Whitney on the superpower of being an asexual sex educator, which offers first person insight from an asexual sex educator.

A Guide to Fulfillment: The Kama Sutra

None more famously referenced when talking about pleasure and sexuality is the ancient Sanskrit text, The *Kama Sutra*. While its actual date of publication is up for debate, it is likely somewhere between 200-400 BCE (Doniger, 2003 p. i). It is a guide to life, in which they include sections regarding sexuality, eroticism, and emotional fulfillment. The *Kama Sutra* is not exclusively a sex manual on sex positions, although the illustrations have been referenced throughout time as such. Its focus is broader, written as a spiritual manual to the art of living well, the nature of love, finding a life partner, maintaining one's love life, and other aspects pertaining to pleasure-oriented faculties of human life.

Author Unknown, 19th Century, Public Domain

The Erotic

"I want to live the rest of my life, however long or short, with as much sweetness as I can decently manage, loving all the people I love, and doing as much as I can of the work I still have to do. I am going to write fire until it comes out of my ears, my eyes, my nose holes--everywhere. Until it's every breath I breathe. I'm going to go out like a fucking meteor!" - Audre Lorde

Audre Lorde (1934-1992), represented many things to many people. Black, poet, womanist, feminist, writer and scholar, and activist whose work included pleasure. Her use of the term Erotic was meant to describe a state of being alive, a feeling one gets when they are tapping into something that provides pleasure. In some cases, the erotic has sexual connotations, but it can also refer to a really good feeling a person experiences when tapping into their joy, like feeling the warm sun

on their skin or indulging in something they really like. Lorde pointed out that if we were to really feel deeply and sensually, we would begin to understand what joy we are capable of feeling and live our lives in accordance. Can you imagine?

Stigma: How Culture Constrains Sexual Liberation

It is not hard to understand why we are socialized to not seek pleasure. Religion plays a role in decentering pleasure. Each nation worldwide has a religious foundation that shapes the values and beliefs held. This foundation is the basis for culture. Those raised with religion in their homes may be taught the notion of sin. From an early age, through various agents of socialization like, family, schools, the media and the church, we learn that there is a great deal of stigma surrounding sexual pleasure. As mentioned early on in this book, nations that offer comprehensive and sex-positive sex education from a young age, built intentionally into K-12 curriculum, have lower unintended pregnancy rates and overall comfort levels about communicating about sex. In the United States especially, where White Anglo-Saxon Protestant (WASP) ethics shape culture, this is not the case. Instead, the focus is more about denying pleasure and shaming sexuality. *Lust*, a strong passion or longing for something especially related to sexual desire, is one of the seven deadly sins written about in the Christian Bible. Masturbation is labeled a sinful act, and when young children are "caught" exploring their bodies, they are often shamed for it. Rather than seeing the moment as an opportunity to educate our kids about their bodies, parents usually mishandle the opportunity, and kids come away from the experience feeling like sexual pleasure is something they should hide and be ashamed of. This cultural message about sexual pleasure gets internalized at a very young age, and we quickly learn that sex is something that we are not supposed to talk about and depending on our gender identity, we are also not supposed to ask for it, desire it, or be in charge of it, unless we are trying to procreate. Those gendered female and non-binary are not usually allowed to initiate sex, want sex, or control the act of sex. Our bodies are seen as something to be ashamed of. Medieval anatomists called female external genitalia the *pudendum* which is derived from the Latin, pudere, meaning to *make ashamed* (Nagoski, 2015, p 18). *Hysteria*, another Latin term commonly used to describe exaggerated or uncontrollable emotion or excitement, literally translates to uterus. And then we have hedonism, the belief that pleasure is the most important thing in life which is derived from the Greek word, delight. Society often juxtaposes *hedonism*, the

pursuit of pleasure or sensual self-indulgence, with discipline and inhibiting one's desires, and devalues the notion that as humans we deserve the right to follow our desires.

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In U.S. culture hard work, material gain, and goal achievement are values that supersede personal desire. Pleasure is not quantifiable in the capitalist sense, and so it becomes more of an extra than something we espouse as a necessity. As a result, we receive mixed messages about sex, pleasure and fulfillment. Knowing that there is a cultural hang up with accessing pleasure can help us navigate the messy waters of sexuality and society and inform our decisions. Understanding this contradiction gives us the ability to question and debunk myths around pleasure, self-care and overall well-being. Hang-ups about our bodies or what we like sexually are entirely shaped by culture, and the sooner we move past self-criticism into self-love, the better. The ability to enjoy your sexuality in this very moment rests on what you are telling yourself about yourself.

You, too, are healthy and normal at the start of your sexual development, as you grow, and as you bear the fruits of living with confidence and joy inside your body. You are healthy when you need lots of sun, and you're healthy when you enjoy some shade. That's the true story. We are all the same. We are all different. We are all normal (Nagoski, 2015 pp. 7).

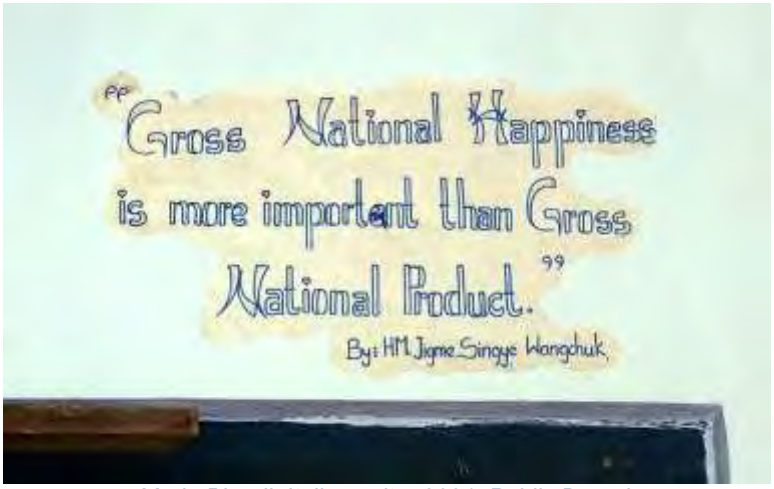
Sometimes the confines of culture clouds our ability to love ourselves exactly how we are. We may also experience trauma related to our sexuality that needs to be processed in order to get to a place of radical self-acceptance. In any case,

recognize the power to embrace yourself just as you are and enjoy life, whether that be through your sexuality or in any other realms that you derive pleasure from. We all deserve the right to feel good. Playwright Eve Ensler, in *The Vagina Monologues,* famously asks her audience what the world would look like with a bunch of "happy vaginas coming all the time" (Ensler, 1996). A world full of people who took care of their pleasure as a regular part of their overall wellness would look very different than the one we currently live in. Undoing all the cultural "no's" we've been told is not easy, and those "no's" may have prevented us from learning more about our amazing pleasure seeking selves. A really good resource for questions about sexuality and tapping into desire is, Meet Lindsey Doe! - Welcome to Sexplanations - 1. Check it out!

Sidebar 4.2: Take a Pause

As you read that last section, what is coming up for you? Are you buying it? Do you deserve to feel pleasure? If not, stop and ask yourself why. Quickly rule out that "why", and move along to what it is you desire. Tap into the Erotic. Make a list of 5 things that bring you joy. Any kind of joy. Put it somewhere you can see. Each day try to give yourself at least one of those things. More is always better so extra credit if you can give yourself all five.

Pleasure and Social Justice



Mario Biondi, Italian writer 2001, Public Domain

What does agency over one's body mean exactly? It seems pretty straightforward and is something we imagine all humans have a right to. Historical legacies of colonization, slavery, imprisonment, sexism and homophobia diminish agency for those impacted by these injustices. The impacts of these are still there for many, and so it begs the question, what does pleasure look like if you are navigating a world that constantly has a target on your back?

These impacts are felt more severely for already marginalized groups particularly because of this historical legacy. For Black women and girls in particular, their physical bodies have always been used as a way to maintain a racial hierarchy long after emancipation and the end of Jim Crow segregation. There is a highly racist stereotype that paints them as inherently sexual and innately promiscuous. A 2017 Georgetown University study found that,

Black girls as young as 5 years old are already seen as less innocent and in need of less support than white girls of the same age. This presumption leads teachers and other authority figures to treat Black girls as older than they actually are and more harshly than white female students, with the disparity being particularly wide for 10-to 14-year-olds (Epstein et al, 2017).

From a young age then, these types of inappropriate attributions leave Black women and girls at a disadvantage. Based on nothing more than ignorance, this myth removes agency and inappropriately sexualizes young children. As indicated in this study, a perception of an individual's sexuality is something that has farther

reaching consequences than access to pleasure. Sometimes, as in the case of Black women and girls, their bodies are weaponized against them, diminishing overall life satisfaction and opportunity.

Those who create these falsehoods and myths and present them as facts are unfortunately often the same experts we rely on to help guide us in our understanding of human sexuality. Prominent sex educators make assertions about sexuality, health, and normalcy from a very specific frame. Overwhelmingly, sex researchers tend to be cis gendered, white, heterosexual, and male, and may or may not have an understanding of the diversity inherent in human sexuality. Yet these are the people defining cultural standards of what are normative sexual attitudes or behavior. Not everyone identifies with these standards. Even as this book is being written, it is important to note that it is situated in a specific time and place. Although here we undertake a cultural critique of the narrow definition of "normal" sexuality, this too will shift as time passes. As the field of sex educators becomes more diverse and representative of the many demographics present in the culture, the understanding will widen to be more inclusive and more accurate.

Sidebar 4.3: A Personal Shift of Perspective on Intimacy and Hookup Culture

I've spent the majority of my adult life participating in hookup culture, and until recently, I did not experience any issues with regard to pleasure, sexual arousal and sexual responses. When I reached my mid-twenties, I developed a realization that I did not enjoy sex as much as I did in my early years as an adult, and it became more difficult to become aroused. Hookup apps like Grindr, Tinder, and other web-based services can allow users to experience sexual freedom, however, can be addictive, and (as it relates to me) might alter the user's ability to engage in intimacy due to the anonymous nature of sex apps.

I began using Grindr as a recently single twenty year old with limited sexual experiences and almost no dating history. As I became more familiar with Grindr, I began using the app for what most people believe to be its purpose, which is sex. After a few years, I began dating men and realized I was experiencing difficulties reaching orgasms with the people I dated. Once I would break up with my partner, I would quickly get back on the Grindr train and would be able to easily experience orgasms. After a few cycles of dating people, breaking up with them, and heading

back to the world of anonymous sex, I realized that the use of hookup apps distorted the ways in which I was able to experience sexual pleasure.

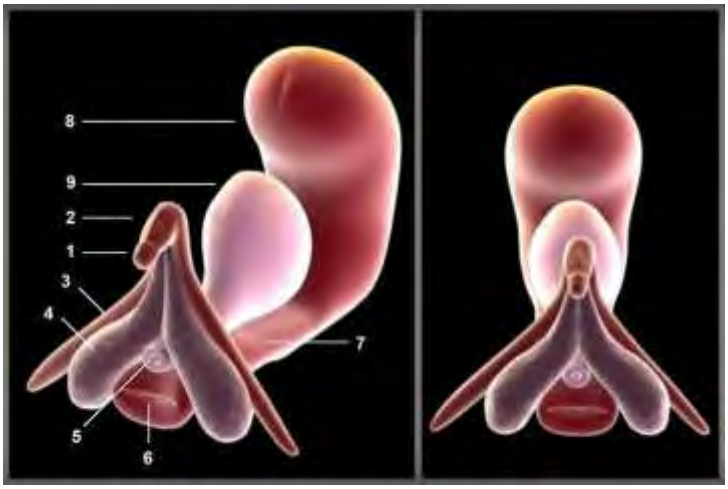
As an adult in my mid-twenties, I've become more intentional about my choices of sexual partners, because personally, I do not like to separate sexual pleasure and intimacy.

Get Cliterate!

The medical field in Western Society began by looking at white male bodies, and everything else became an object of study in relation to that. This automatically normalized male white bodies and made female, intersexed, and non-white bodies "others". In the case of sexual health, this is plainly clear in the lack of development in the study of the *Clitoris*, the pleasure center in the vulva, made up of the same erectile tissue as the penis.

When it comes to the wonderful feeling you get from an orgasm, erectile tissue rules (and we all have some)! As described in the earlier chapter on anatomy, when an infant in utero begins to develop, based on the genes and hormonal makeup of that fetus, then the erectile tissue takes shape. "We're all made of the same parts, but in each of us, those parts are organized in a unique way that may change over our life span" (Nagoski, 2015 p 7). The area known as the clitoris is highly sensitive to both the external nub, but also the inner parts, so the entire vulva is a site of great pleasure mostly due to that underlying erectile tissue.

Australia's first female urological surgeon and renowned sex researcher, Helen O'Connell, has done a great deal towards understanding erectile tissue on people with vulvas. Prior to her work, the deeper structures of the clitoris were not given much attention in medical journals, while its counterpart, the penis was. Her 2005 groundbreaking article, Anatomy of the Clitoris introduced many of us to the breadth and depth of the clitoris. Prior to her work, the clitoris was largely overlooked in medical studies and publications. Watch Dr. O'Connell discuss the clitoris and her work here: Get Cliterate | Professor Helen O'Connell | TEDxMacRobHS One of the most common misconceptions of the clitoris is that it is just the external nub visible at the top opening of the vulva. What is actually true is that the little nub that someone may see when they examine their vulva is just the tip of the metaphorical iceberg, and underneath the surface, it expands into a much larger organ worthy of its own notoriety. A debt of gratitude is owed to Dr. O'Connell for expanding the field. Better late than never!



Map of the clitoris Three-dimensional representation of the clitoris with its associated erectile tissue system. 1=Glans clitoridis; 2=Corpus clitoridis; 3=Corpus cavernosum clitoridis; 4=Bulbi clitoridis (Bulbi vestibuli); 5=Urethra; 6=Introitus vaginae; 7=Vagina; 8=Uterus; 9=Vesica urinaria.

Masturbation

Gustav Klimt 1913 Public Domain

From the time we are in utero, we do things to self-soothe and to feel good. Pleasure seeking is part of what makes us human. Our understanding of what we are doing to achieve pleasure changes as we develop, but it is inherent in who we are. Pleasure is well, pleasurable and why wouldn't that be something to strive for?

One of the things humans do to find pleasure is to masturbate. *Masturbation*, also known as *auto eroticism*, is often when a person touches, strokes or rubs their own genitals for sexual pleasure, but orgasm can also be achieved without touch. Our is mind is our largest sex organ and *orgasm*, a climax of sexual excitement, characterized by feelings of pleasure centered in the sex organs can also occur through mental stimulation. People masturbate in a variety of ways; sexual pleasure is different for everyone. Direct stimulation of erectile tissue is a common way to masturbate. People with clitorises may touch their clitoris, people with penises may touch their penis, with the goal of feeling pleasure through orgasm. Masturbation does not have to be a solo act. When two or more people masturbate together it's called *mutual masturbation*. This can help people explore what feels good with another person(s) and facilitate communication with their partner(s) about their bodies and what feels good. Masturbation is a safe way to experience pleasure, set our own comfort zones about our bodies, and learn what feels good. *Interoception* is the perception humans have of sensations inside the body. Masturbation can strengthen that sense which is helpful in overall wellness. People of all ages masturbate. People who are single and people in relationships masturbate. Some people don't ever masturbate, or very infrequently; others masturbate more. There is no right way; whatever you do, is ok. Masturbation is a healthy aspect of our sexuality and overall wellness. There have been various books and studies done on orgasm, and how to achieve and extend orgasm by various sex researchers. The two linked podcasts, Extended Massive Orgasm and Maximize Your Orgasm w/ Dolly Josette discuss some of the work in the field of orgasmic studies.

Sidebar 4.4: Sex Toys with Lola, Sexpert & Dildo Slinger

Sexpert Lola 2022

Sex toys are often written off by society as taboo novelties, but they have been around for centuries. They are part of our ancient history, and they have evolved alongside us. There was a time when sex toys were recognized as wellness products, and they are slowly but surely regaining that status.

The oldest known sex toy is a stone phallus found in a cave in Germany and dates back to 29,000BC. In 1300 AD, ben wah balls, c-rings, and double-ended dildos were all the rage in China. French sailors in the 16oo's created the first known sex dolls; back then, they were made of straw and referred to as "dames de voyage." During the 1800s in England, the short-lived medical term Hysteria was coined, and vibrators were the remedy. This medical diagnosis made sex toys respectable. They were considered wellness products by the medical community and became home necessities for a while. The vibrator was the fifth domestic appliance to be electrified before the iron and the vacuum, and prominent women's magazines featured vibrators for sale alongside makeup and home goods. Sex toys were seen as necessary as the iron until 1952 when The American Medical Association declared hysteria is not an ailment. With that decree, sex toys retreated to the back

rooms of seedy shops and the back pages of porn magazines, but their demonization did not stop their innovation.

Despite being frowned upon and seen as dirty and lewd, the sex toy industry continued to create products for those seeking pleasure.

Thanks to the tenacity of pleasure product makers, educators like Bettie Dodson, the rise of female-run and owned sex shops, and shows like Sex and The City, sex toys have become a multi-billion dollar market accessible from nearly anyplace, online or off.

Today, if you walk into a sex shop, you will find a vast collection of products designed to be pleasurable and gender-affirming, accessible, and medicinal. While many stores still group products based on gender, female toys, and male toys, there has been a movement toward grouping products based on their type and the body parts they're meant to be used on to move away from gendering products. Here are some examples of the types of products you'll find in your local sex shop.

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Vibrators: Vibrators can be used for vaginal, clitoral, g-spot, testicles, and penis stimulation

- Clitoral
- G-spot
- Dual Action (rabbit toys)

- Pleasure Air/Air Pulse

Dildos: Dildos can be used for vaginal and anal stimulation, and depending on the shape, they can also be used for g-spot and prostate stimulation.

- Strap-On Compatible
- Packers
- Double Ended
- Inflatable

Penis Toys: Penis toys can be used for shaft and testicle stimulation

- Strokers / Masturbaters
- Penis Sleeves
- Pumps
- Air Pulse
- Vibrating Strokers
- Cock Rings

Anal Toys: Anal toys can be used for general anal stimulation and prostate stimulation.

- Plugs
- Beads
- Prostate
- Inflatable Plugs

Sexcessories: Sexcessories enhance pleasure and create dual purposes for other sex toys.

- Strap-on Harnesses
- Penis Extenders
- Humping/Grinding Toys

- Pussy/Cock Pumps

Sexual Health Products: These products aid with various sexual health issues and can be used to enhance pleasure.

- Prostate Toys
- Kegel Exercisers
- Dilators
- Gender Affirming Products
- Penetration Buffers
- Lubes & Balms

The vast array of high-quality, technologically advanced sex toys on the market today has helped move these products out of the shadows and back into the realm of home necessities. As we further explore the connection between mental health and pleasure, sex toys will continue to evolve and aid in the journey towards discovery.

From Lola the sexpert . Find her at DirtyLola.Co

Sexual Arousal and Response

Genital sexual response for penises and vulvas 2001 Creative Commons Attribution-Share Alike 3.0

Understanding the biological responses to arousal studied by famous sex researchers, Kinsey and those at the Kinsey Institute, as well as Master's and Johnson, provide important information into the ways in which our bodies behave when sexually stimulated. While these observations help us in an overall understanding of human sexuality, left alone they do not answer some of the other questions that help us understand pleasure, and why it is we may all find pleasure very differently. As an interdisciplinary examination of the phenomena of human sexuality, this chapter seeks to connect these bodily responses with socio-cultural understandings. Gendered differences of sexual responses, differences in race, class, or orientation, all may play a part into why we find things pleasurable.

While the following section is mainly descriptive regarding the physiological changes the body undergoes when aroused, it is not meant to override the role good communication, consent, and desire play into how you are feeling about what you want and don't want.

Blood flow to the genitals is response to sex-related stimuli (*learning*), which is not the same thing as *liking* or *wanting*, much less consent. The best way to tell if someone is aroused is not to notice what their genitals are doing, but to *listen to their words (Nagoski, 2015,pp 236-237)*.

As Nagoski stated above, listening to what is being communicated is the best way to know what is arousing. Culture has constrained sexual enjoyment, especially for people who have vulvas and it is important to communicate openly about what you want to have happen in any sexual encounter both with yourself and with those who you engage with sexually. It is also important to point out that much of this research on arousal and response centers around Penis in Vagina (PIV) sex, with climax being the measurable outcome. While PIV sex to orgasm is one way to experience sexuality, it is important to note that sexual fulfillment and practices reach far beyond this one sex act. Despite this fact, much of our foundational data on sexual response and arousal has been based on PIV sex in pursuit of orgasm.

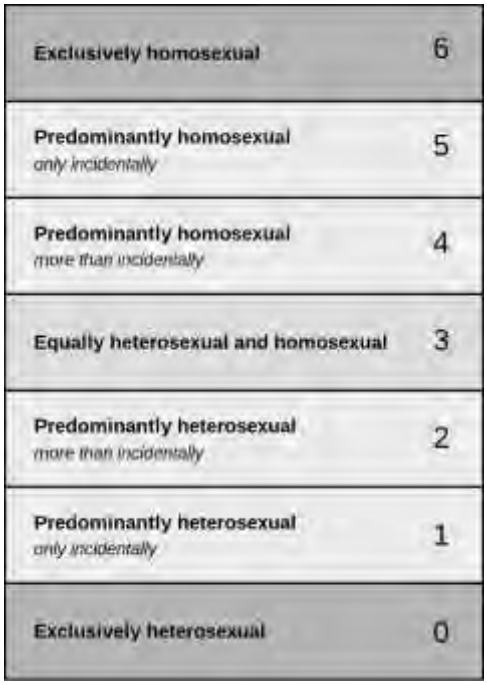
Alfred Kinsey's Research

Before the late 1940s, access to reliable, empirically-based information on sex was limited. Physicians were considered authorities on all issues related to sex, despite the fact that they had little to no training in these issues, and it is likely that most of what people knew about sex had been learned either through their own experiences, or by talking with their peers. Convinced that people would benefit from a more open dialogue on issues related to human sexuality, Dr. Alfred Kinsey of Indiana University initiated large-scale survey research on the topic . The results

of some of these efforts were published in two books—*Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*—which were published in 1948 and 1953, respectively (Bullough, 1998). At the time, the Kinsey reports were quite sensational. Never before had the American public seen its private sexual behavior become the focus of scientific scrutiny on such a large scale. The books, which were filled with statistics and scientific lingo, sold remarkably well to the general public, and people began to engage in open conversations about human sexuality. As you might imagine, not everyone was happy that this information was being published. In fact, these books were banned in some countries. Ultimately, the controversy resulted in Kinsey losing funding that he had secured from the Rockefeller Foundation to continue his research efforts (Bancroft, 2004).

Although Kinsey's research has been widely criticized as being riddled with sampling and statistical errors (Jenkins, 2010), there is little doubt that this research was very influential in shaping future research on human sexual behavior and motivation. Kinsey's life and his groundbreaking work were the subject of a 2004 feature film Kinsey (2004) - Movie Trailer. Kinsey described a remarkably diverse range of sexual behaviors and experiences reported by the volunteers participating in his research. Behaviors that had once been considered exceedingly rare or problematic were demonstrated to be much more common and innocuous than previously imagined (Bancroft, 2004; Bullough, 1998).

Among the results of Kinsey's research were the findings that people with vulvas are as interested and experienced in sex as their counterparts who have penises, that both masturbate without adverse health consequences, and that homosexual acts are fairly common (Bancroft, 2004). Kinsey also developed a continuum known as the Kinsey scale that is still commonly used today to categorize an individual's sexual orientation (Jenkins, 2010).



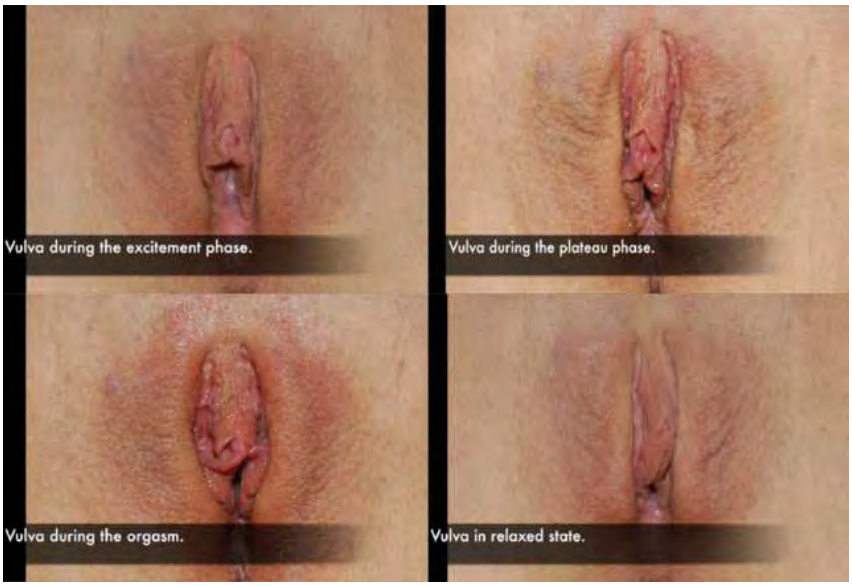
Kinsey-Scale in consideration of the bisexuality (3) as mentioned in the book 'Sexual Behavior In The Human Male' (1949), Page 656

Note that when Kinsey conducted his research, he based it on the definition of sexual orientation at the time which has since evolved. For Kinsey, sexual orientation is an individual's emotional and erotic attractions to same-sexed individuals (homosexual), opposite-sexed individuals (heterosexual), or both (bisexual).

Masters and Johnson's Research

In 1966, William Masters and Virginia Johnson published a book detailing the results of their observations of nearly 700 people who agreed to participate in their study of physiological responses during sexual behavior. Unlike Kinsey, who used personal interviews and surveys to collect data, Masters and Johnson observed people having intercourse in a variety of positions, and they observed people masturbating, manually or with the aid of a device. While this was occurring, researchers recorded measurements of physiological variables, such as blood pressure and respiration rate, as well as measurements of sexual arousal, such as vaginal lubrication and penile tumescence (swelling associated with an erection). In

total, Masters and Johnson observed nearly 10,000 sexual acts as a part of their research (Hock, 2008).



Female vulva in sexual response cycle: excitement phase; plateau phase; orgasm phase; resolution phase [*Creative Commons Attribution 3.0*]

Based on these observations, Masters and Johnson divided the sexual response cycle into four phases that are fairly similar regardless of biological sex: excitement, plateau, orgasm, and resolution. The excitement phase is the arousal phase of the sexual response cycle, and it is marked by erection of the penis or clitoris, and lubrication and expansion of the vaginal canal. During plateau, further swelling of the vulva and increased blood flow to the labia minora takes place, and full erection of the penis with possible excretion of pre-ejaculatory fluid. Everyone in the study experienced increases in muscle tone during this time. Orgasm is marked in people with vulvas by rhythmic contractions of the pelvis and uterus, along with increased muscle tension. In people with penises, pelvic contractions are accompanied by a buildup of seminal fluid near the urethra that is ultimately forced out by contractions of genital muscles, (i.e., ejaculation). Resolution is the relatively rapid return to an unaroused state accompanied by a decrease in blood pressure and muscular relaxation. While many people with vulvas can quickly repeat the sexual response cycle, people with penises must pass through a longer refractory period as part of resolution. The refractory period is a period of time that follows an orgasm during which an individual is incapable of experiencing another orgasm. In people with penises, the duration of the refractory period can vary dramatically

from individual to individual, with some refractory periods as short as several minutes and others as long as a day. As people with penises age, their refractory periods tend to span longer periods of time. In addition to the insights that their research provided with regards to the sexual response cycle and the multi-orgasmic potential of people with vulvas, Masters and Johnson also collected important information about reproductive anatomy. Their research demonstrated the oft-cited statistic of the average size of a flaccid and an erect penis (3 and 6 inches, respectively), as well as dispelling long-held beliefs about relationships between the size of an erect penis and the ability to provide sexual pleasure to a partner. Furthermore, they determined that the vulva is a very elastic structure that can conform to penises of various sizes (Hock, 2008).

The preceding two sections are adapted from *Psychology*. By: OpenStax College. Located at: http://cnx.org/contents/4abf04bf-93a0-45c3-9cbc-2cefd46e68cc@4.100:1/Psychology. *CC BY: Attribution*.

Sidebar 4.5: My Body is a Wonderland!

Mirror activity during arousal

Oh what amazing things our bodies do! Here's an activity to demonstrate just that and have some fun at the same time. Have you ever wondered what your genitals do as you orgasm? Maybe you know, maybe you don't. Probably what you've seen in porn isn't anatomically accurate so why not see for yourself. The mirror exercise we did at the beginning of the class is now being revisited but this time try watching yourself as you masturbate. This might be logistically harder based on what your hands are doing, but give it a try. Observe firsthand how you physically react during climax. Have fun!

Building Upon Classical Thought on Biological Sexual Response

Masters and Johnson's four-phase model of sexual response became the foundation for understanding human sexual response. As the first scientific description of the physiology of sexual response, it would become the basis for defining sexual health and also in the treatment of sexual problems (Nagoski, 2015 p 50). People who were unable to orgasm (*anorgasmic*) can learn to have orgasms, those with premature ejaculation can learn to control orgasm, those with

vaginismus (vaginal spasms) can learn to relax those muscles. But there's also a group of people who don't respond to therapy informed by the four-phase model.

In 1977 psychotherapist Helen Singer Kaplan published *Hypoactive Sexual Desire* in an effort to build upon this model and address a missing piece in the previous work done by Masters and Johnson, *desire.* Reviewing treatment failures among patients, she found that the clients with the least successful outcomes were those who lacked interest in sex. Kaplan realized something important was entirely missing from the four-phase model, *desire* (Kaplan, 1977 p. 3). The biological model put forth by Masters and Johnson removed how our brain connects us to the body and the reason it may not have come into play in the studies done in a lab might make sense.

It seems like a glaring oversight in retrospect, but of course it was missing, people who come to a laboratory to masturbate for science don't have to *want* sex before they begin; they just have to get aroused for the purpose of the experiment. Kaplan took the four-phase model out of the laboratory and adapted it to the lived experience of her clients. Her "triphasic" model of the sexual response cycle begins with desire, which she conceptualized as "interest in" or "appetite for" sex, much like hunger or thirst. The second phase is arousal, which combines excitement and plateau into one phase, and the third phase is orgasm (Nagoski 2015, p. 50).

Kaplan's model of sexual response has served as the foundation for diagnostic criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual*. Low desire and desire discrepancy between partners are the most common reasons people seek sex therapy. Some also seek help for "hypersexuality," where they feel their desire and behaviors are out of their control (Nagoski, 2015 p.51). This begs the question, how much desire is too little or too much? Circling back to the beginning of this chapter, the answer is there is not a right amount of desire, everybody is different. Understanding your individual sexual temperament can be useful in caring for your overall wellness. If there is something that concerns you about your level of desire, it is always good to talk with a sexual health educator.

The box below provides a way to understand your individual sexual temperament, and how certain stimuli can either excite or inhibit your sexual appetite. Because we are all different, our desires are as well. Bottom line, there is no “right” way to be sexual. It is time to let go of feeling the need to be a certain way, look a certain way, want sex in a certain way and focus on what you really want.

Sidebar 4.6: The Dual Control of Sexual Response Temperament Gauge and Adapted Quiz

Sara Paules describes the dual control of sexual response that is referenced by Emily Nagoski in her 2015 groundbreaking text that we have referred to throughout this chapter, *Come As You Are.* Nagoski asserts that we all develop these systems based on our lived experiences and we all vary. It can be broken into two parts that can be compared to a car:

1. Sexual Excitation System (SES). The system that responds to any sexually relevant stimuli in the environment-something we see, smell, remember etc. It is the accelerator.
2. Sexual Inhibition System (SIS). The system that responds to any sexually inhibiting stimuli-like your parent being in the next room. It is the brakes.

This system can be further broken down into two different SIS systems:

1. Responds to fear of performance failure (erectile dysfunction, premature ejaculation, etc.)
2. Responds to fear of performance consequences (STI transmission, unwanted pregnancy, social consequences).

Sexual arousal can be understood as two equally important processes:

1. Having gradually increasing stimulation for the SES
2. Removing anything that the SIS might respond to, whether it be physical or emotional

Sara Paules, MA, LPC from the Mindful Soul Center in Austin, TX has an adapted sexual temperament quiz based on the work of Emily Nagoski and other sex researcher studying sexual temperament. You can take the quiz here. These types of assessments are meant to inform, not judge your personal temperament. People vary in their responses and there is not a normal temperament type (Nagoski, 2015, Paules, n.d.).

Conclusion

The pursuit of pleasure has been a part of the human condition since time began. Desires are something we all have. Some embodied, some not. Culture shapes

what we learn to be pleasurable and constrains us from exploring what we might like. Embodied pleasure in the form of sexuality is part of an overall well-being. Sensuality allows us to tune into what we like. Our brain is our largest sex organ, holding the key to our arousal and response. Studies done on pleasure have mostly been framed around white, cis-gendered, heterosexual people with penises so there is a large gap in the field in order to represent totality of the human spectrum. The anatomy of the clitoris was not formally studied and included in the scientific literature until Helen O'Donnell wrote about it in 2005. Masturbation is a great way to stimulate your senses and learn about your body. Alfred Kinsey and work done at the Kinsey Institute brought sexuality studies into the scientific domain. Masters and Johnson's four phase model of sexual response became the tool for identifying issues in sexual health despite a missing piece. In 1977, Helen Kaplan updated this model to include desire which changed the way in which sexual health issues are treated. Understanding that we are all different and our levels of desire and what inhibits our desires are not fixed can help with self-acceptance. It is time to debunk cultural myths about the right way to be a sexual being and practice radical self-love.

Glossary

1. **Auto Eroticism** self-pleasuring using one's mind or touching, stroking or rubbing one's genitals for orgasm (also known as masturbation)
2. **Excitement Phase** the arousal phase of the sexual response cycle, and it is marked by erection of the penis or clitoris and lubrication and expansion of the vaginal canal
3. **Hedonism** the pursuit of pleasure or sensual self-indulgence
4. **Interoception** is the perception humans have of sensations inside the body
5. **Masturbation** self-pleasuring using one's mind or touching, stroking or rubbing one's genitals for orgasm (also known as Auto Eroticism)
6. **Orgasm Phase** a climax of sexual excitement, characterized by feelings of pleasure centered in the sex organs.
7. **Plateau Phase** swelling of the vagina and increased blood flow to the labia minora, and full erection of the penis and possible excretion of pre-ejaculatory fluid

8. **Pleasure** a feeling of happy satisfaction and enjoyment
9. **Resolution Phase** also known as the refractory period is a period of time that follows an orgasm during which an individual is incapable of experiencing another orgasm
10. **Sensuality** the notion of being highly tuned into your senses

Discussion Questions

1. What types of social controls affect how you experience pleasure? This about how social norms and messages you've received during your lifetime shape your pleasure seeking behavior.
2. What does pleasure without boundary mean to you? Where does pleasure fit in your life?
3. How does our environment and state of mind affect our feeling of desire? Think of some examples
4. What are your sexual brakes and your sexual accelerator?
5. How does researcher Helen Kaplan's addition of desire to the sexual arousal model by Masters and Johnson help us better understand sexual response?

Multiple Choice Questions

1. What is pleasure?

    a. a feeling of happy satisfaction and enjoyment
    b. Something to do to make others proud of us
    c. The root of all evil
    d. A feeling of disappointment

2. What is our largest sex organ?

    a. Our feet
    b. Our perineum
    c. Our lips
    d. Our minds

3. Hedonism means:

a. the pursuit of pleasure or sensual self-indulgence
b. To take heed, or be aware of something
c. The study of young angler fish
d. To be thankful

4. Lust is:

a. a strong passion or longing for something especially related to sexual desire
b. One of the seven deadly sins in the Christian bible
c. A normal part of the human condition
d. All of the above

5. The oversexualization of Black women and girls observed in a 2017 Georgetown University study:

a. Leads to larger hardships and marginalization due to stereotypical beliefs
b. Is without merit
c. Makes keeping Black women and girls safe from harm harder
d. All of the above

6. The Clitoris is:

a. Made up of erectile tissue
b. Goes far beyond the visible nub in the vulva with internal structures that branch out
c. Was researched in depth by urologist Helen O'Donnell
d. All of the above

7. Auto-eroticism, self-pleasuring using one's mind or touching, stroking or rubbing one's genitals for orgasm can also be called:

a. Masturbation
b. Surfing the internet
c. Inoculation
d. Intoxication

8. What is the best way to tell if someone is aroused?

a. Observe what changes are taking place in their genitals
b. Listen to their words
c. Look to see if their eyes have changed colors
d. None of the above

9. The four phases of the sexual response cycle described first by Masters and Johnson are:

a. excitement plateau, orgasm and resolution
b. desire, orgasm, arousal, sex flush
c. arousal, orgasm, resolution, satisfaction
d. Winter, Spring, Summer, Fall

10. Emily Nagoski describes the dual control of sexual response as:

a. Ketchup and Mustard
b. Accelerator and Brakes
c. Peanut Butter and Jelly
d. Lock and Key

For Further Exploration

The Asexuality Visibility and Resource Network

Sex With Emily Podcast

The Principles of Pleasure | Official Trailer | Netflix

books — Emily Nagoski, Ph.D.

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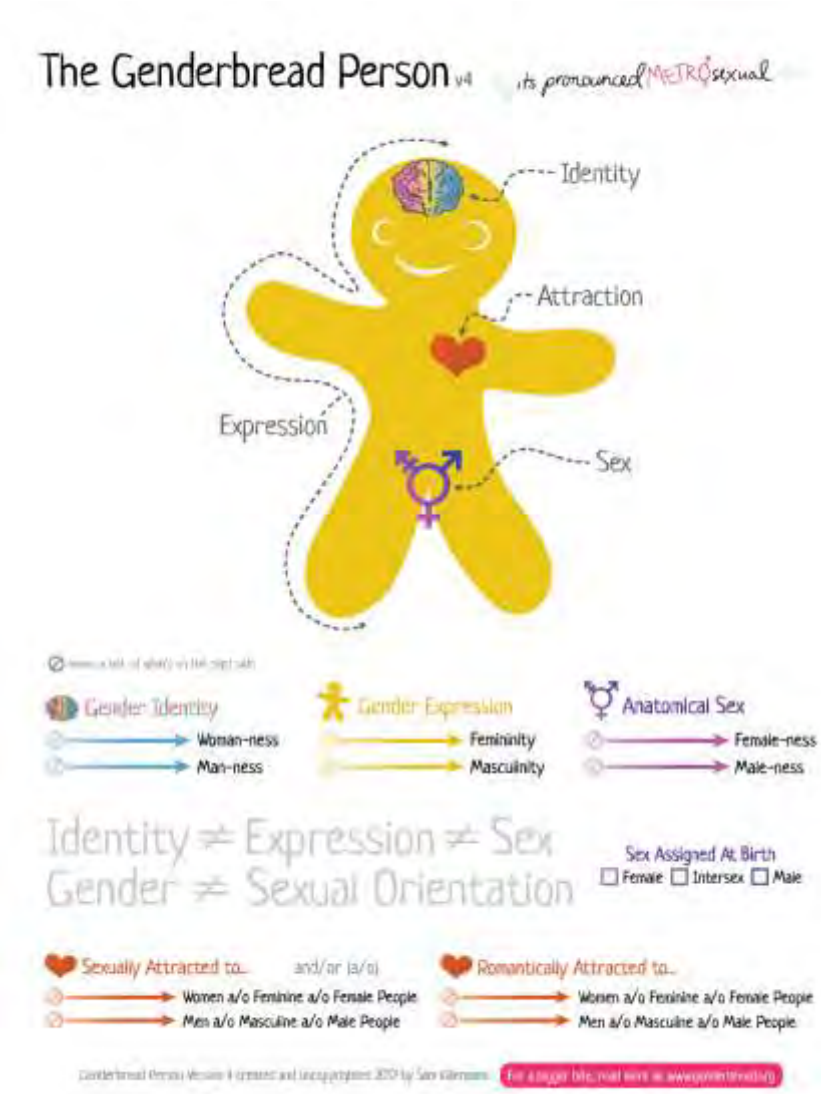
Chapter 5: Gender Identity, Gender Roles, and Gender Differences



Access to further explainers of "Genderbread person" ***Breaking through the Binary: Gender Explained Using Continuums*** *Sam Killerman 2018 Uncopyrighted*

Learning Objectives

After completing this module, students should have a working knowledge of:

- Dimensions of gender: the difference between sex, gender, identity, and sexuality
- The gender spectrum and gender binaries including transgender and non-binary
- The social construction of gender
- Gender Dysphoria
- Current State of the Transgender Community

Introduction

This chapter will examine the concepts of gender, sex, and sexuality. We will dive into the differences and then turn to the understanding of gender as a spectrum. The traditional binary understanding of male and female will be challenged, and we will explore the social construction of gender.

Dimensions of Gender

When filling out a document, such as a job application or school registration form, you are often asked to provide your name, address, phone number, birth date, and sex or gender. But have you ever been asked to provide your sex *and* your gender?

Like most people, you may not have realized that sex and gender are not the same. However, sociologists and most other social scientists view them as conceptually distinct. **Sex** refers to physical or physiological differences between male, female, and intersex bodies, including both primary sex characteristics (the reproductive system) and secondary sex characteristics (such as breasts and facial hair).

Gender is a term that refers to social or cultural distinctions associated with a given sex; it is generally considered to be a socially constructed concept. Sex and gender are important aspects of a person's identity; however, they do not inform us about a person's sexual orientation (Rule & Ambady, 2008). **Sexual orientation** refers to a person's sexual attraction (or lack thereof) to others and is the topic of the next chapter. Within the context of sexual orientation, sexual attraction refers to a person's capacity to arouse the sexual interest of another, or, conversely, the sexual interest one person feels toward another.

Sex, gender, and sexual orientation have always been a source of religious and political debate. As such, they have been policed in various ways. Some nations have laws against homosexuality, and enforce choosing from binary gender options on legal forms of identification, while others have laws protecting same-sex marriages. At a time when there seems to be little agreement among religious and political groups, one must wonder, what is acceptable and who decides?

The international scientific and medical communities (e.g., World Health Organization, World Medical Association, World Psychiatric Association, Association for Psychological Science) view variations of sex, gender, and sexual orientation as normal. Furthermore, variations of sex and the orientation of sexual behavior occur naturally throughout the animal kingdom. More than 65,000 animal species have intersex individuals, born with either an absence or some combination of male and female reproductive organs, sex hormones, or sex chromosomes (Jarne & Auld, 2006). More than 500 animal species engage in homosexual or bisexual behaviors (Lehrer, 2006). "The standard model of sexual and gender identification states that an individual's sex is solely determined by biological characteristics, as discussed above. Furthermore, gender is determined by the same model, existing on the same male-female binary. This leaves no room for gendered intersex people, instead viewing sex and gender as either male or female. The standard model is largely criticized for being dimorphic. The term intersex, which we first discussed in the chapter 3, defines those with a variation in sex characteristics, including chromosomes, gonads, or genitals that preclude an individual as distinctly assigned

as male or female. Being intersex is also more common than most people realize. Anywhere from 1.0 to 1.7% of children are born intersex, providing further evidence that assigned sex falls along a spectrum rather than a binary. Intersex can occur in a variety of ways. “We know today that not just the X and Y chromosomes, but at least 12 others across the human genome govern sex differentiation, and at least 30 genes are involved in sex development" (Giordano, n.d.).

A person may have both ovarian and testicular tissues, unique chromosomal combinations such as XXY, and some intersex individuals may outwardly present with a specific gender’s genitals but their internal hormones and organs do not match (What is intersex?: Definition of Intersexual, n.d.). Due to our culture’s engrained binary system, it is common practice that when intersex babies are born, the doctor and parents will determine the child’s gender, sometimes requiring a surgical procedure, and the possibility of future surgeries as they grow and develop further. There are occasions, however, when a person finds out they’re intersex at the onset of puberty. Others may go their whole life without realizing they are intersex (What is intersex?: Definition of Intersexual, n.d.). Our need to categorize and make “normal” in regard to the gender binary has been a cause of great harm to those intersexed individuals who were subjected to unnecessary medical intervention and forced gender assignment.

In a majority of societies worldwide, gender is categorized into two separate sides, being either masculine or feminine, is known as the **gender binary**. This inaccurate understanding completely excluding those who are intersex, transgender, androgynous, and so on. Modern scholars such as Anne Fausto-Sterling and Bonnie Spanier criticize the standard binaries of sex and gender, arguing that sex and gender are both fluid concepts that exist along a spectrum, rather than as binaries.

The gender binary, while specific to certain cultures, is not universal, but rather, a social construction. In some cultures, gender is viewed as fluid. In the past, some anthropologists used the term *berdache [also known as, two-spirit]* to refer to individuals who occasionally or permanently dressed and lived as a different gender. The practice has been noted among certain Native American tribes (Jacobs, Thomas, and Lang 1997). Samoan culture accepts what Samoans refer to as a “third gender.” *Fa’afafine*, which translates as “the way of the woman,” is a term used to describe individuals who are born biologically male but embody both masculine and feminine traits. Fa’afafines are considered an important part of Samoan culture. Individuals from other cultures may mislabel them as homosexuals

because fa'afafines have a varied sexual life that may include men and women (Poasa 1992). Among the Zapotec peoples of Oaxaca, Mexico, is a recognized third gender called The Muxes (Beyond gender: Indigenous perspectives, Muxe, n.d.). These cultures and many others acknowledge and accept the reality of a third gender; "the gender classification is not based on sexual identity [as in Western societies], but rather on gender identity and spirituality" (Beyond Gender: Indigenous perspectives, Muxe, n.d.).

Gender identity is a person's internal sense of self as a member of a particular gender. "Individuals who identify with a role that corresponds to the sex assigned to them at birth are cisgender. For example, someone who was born with assigned male sex characteristics, was assigned as a boy, and identify today as a boy or man are classified as **cisgender**, (or cis for short). Individuals who identify with a role that corresponds with a role that is different from their biological sex are often referred to as **transgender**. For example, they were born with assigned male characteristics, were assigned as a boy, but today identify as a girl, woman, or another gender are classified as transgender. Transgender people have a gender identity or expression that differs from what they are assigned at birth. The Latin prefix "cis" means "on the same side;" the prefix "trans"" means "across." The term "transgender" encompasses a wide range of possible identities (see glossary for definitions), including agender, genderfluid, genderqueer, two-spirit (for many indigenous people), androgynous, and many others. Some transgender individuals may undertake a process to change their outward, physical, or sexual characteristics in order for their physical being to better align with their gender identity. Not all transgender individuals choose to alter their bodies;: many will maintain their original anatomy, but may present themselves to society as another gender that aligns with who they are.

Scientific and Societal Understanding of Gender Variations

Hormones that masculinize the brain in chromosomally male (XY) individuals are distinct from those that lead to the development of a typically male body form. "Due to this branching of control factors for brain and body organization, it is quite possible for a male-type body to contain a female-type brain, and for a female-type body to contain a male-type brain" (Panksepp, 2004, page 225). These developmental deviations could influence an individual's ultimate sexual orientation and/or gender identity. An example of differing brain and body organization comes from a study that found that the bed nucleus of the stria terminalis (an area known to be important for sexual behavior located near the hypothalamus) was "female-like" in size (smaller than cisgender males and similar to cisgender females) in the brains of six male-to-female transsexuals. This difference was not correlated with either adult hormone levels or sexual orientation (Zhou et al., 1995). Given that studies requiring post-mortem brain tissue to examine tiny brain areas are very difficult to conduct, this type of information is scarce.

While studies of postmortem brains may help answer some questions surrounding gender identity, gender is ultimately a social construct, and those norms we learn to live by are shaped through our internalization of society. As society shifts, norms

change. An understanding of gender identity continues to evolve, and young people today have more opportunities to explore and openly express different ideas about what gender means than in previous generations. Recent studies indicate that a majority of millennials (birth years 1981-1996) regard gender as a spectrum, instead of a strict male/female binary, and that 12% identify as transgender or gender non-conforming. Additionally, more people know others who use gender-neutral pronouns, such as they/them (Kennedy, 2017). This change in language may indicate that millennials and Generation Z people (birth years 1997-2012) understand the experience of gender itself differently. This re-labeling and acknowledgement of gender as beyond the binary highlights how humans create and recreate reality rather than it being absolutely fixed. Just as gender can be viewed as a spectrum based on current knowledge and social agreements, we imagine there will be further shifts and understandings as culture changes. As young people lead this change, other changes are emerging in a range of spheres, from public bathroom policies to retail organizations. For example, some retailers are starting to change traditional gender-based marketing of products, such as removing pink and blue clothing and toy aisles. Despite these changes, those who exist outside of traditional gender norms face difficult challenges. Even people who vary slightly from traditional norms can be the target of discrimination and sometimes even violence.

Differentiation Between Sex and Gender

Gender is a complex subject, but could be better understood when we learn to differentiate biology from gender expression. Nevertheless, while gender may begin with the assignment of our sex, it doesn't end there. According to Understanding Gender, n.d., a person's gender is the complex interrelationship between three dimensions: body, identity, and social gender.

Body: Our body, our experience of our own body, how society genders bodies, and how others interact with us based on our body.

Identity: The name we use to convey our gender based on our deeply held, internal sense of self. Identities typically fall into binary (e.g. man, woman), nonbinary (e.g., genderqueer, genderfluid, etc.), or ungendered (e.g., agender, genderless) categories. The meaning associated with a particular identity can vary

among individuals using the same term. A person's gender identity can correspond to or differ from the sex they were assigned at birth.

Social gender: How we present our gender in the world and how individuals, society, culture, and community perceive, interact with, and try to shape our gender. Social gender includes roles and expectations and how society uses those to try to enforce conformity to current gender norms (Understanding gender, n.d.).

The connection between one's gender and physical appearance extends beyond reproductive functions. Gender experience is based on a broader scientific basis, according to research in Neurology, hormones, and Cellular Biology. Indeed, research is increasingly pointing to our brains as a crucial factor in how we uniquely experience gender (Understanding gender, n.d.). Given the fact that gender identity is separate from sex, not everyone identifies within the binary (male or female). For a broader analysis of gender beyond the binary, let's look at gender as a spectrum.

Gender is a Spectrum

A large number of people, including many transgender people, identify as either male or female. Others do not neatly fit into the categories of "man" or "woman," or "male" or "female." Some people have a gender that blends elements of being a man or a woman, or a gender that is different from either male or female. Others don't identify with any gender at all. Some people's gender changes over time.

People whose gender is not male or female use many different terms to describe themselves, with **non-binary** being one of the most common. Other terms include **genderqueer**, **agender**, **bigender**, and more. None of these terms mean exactly the same thing, and new terms are added occasionally, but all signify an experience of gender that is not simply male or female (Understanding non-binary people: How to be respectful and supportive, 2018).

A related aside: not all people who identify as transgender or outside the gender binary participate in hormone therapy or gender affirmation or confirmation surgery. Not only can hormone therapy and gender reassignment surgeries be

expensive, many gender non-conforming people, do not wish to subject themselves to traditional markers of masculinity or femininity.

Sidebar 5.1: Recognition

As is true for people in general, transgender women (TGW) have diverse levels of psychological androgyny (having both feminine and masculine characteristics). For example, five percent of the Samoan population are TGW referred to as fa'afafine, who range in androgyny from mostly masculine to mostly feminine (Tan, 2016); in Pakistan, India, Nepal, and Bangladesh, TGW are referred to as hijras (Figure 4.4), recognized by their governments as a third gender, and range in androgyny from only having a few masculine characteristics to being entirely feminine (Pasquesoone, 2014); and as many as six percent of biological males living in Oaxaca, Mexico are TGW referred to as muxes, who range in androgyny from mostly masculine to mostly feminine (Stephen, 2002).

Role of Sex Hormones in Transgender Treatment

Some transgender people do seek medical intervention to help align their bodies in a way that they feel represents who they are. One way this is done is through hormone therapy. Feminizing or masculinizing hormone therapy is the administration of exogenous endocrine agents to induce changes in physical appearance. Hormone therapy is inexpensive relative to surgery, and highly effective in the development of some secondary sex characteristics, such as facial and body hair in transgender men or breast development in transgender women. Thus, hormone therapy is often the first (and sometimes only) medical gender affirmation intervention accessed by transgender individuals looking to develop masculine or feminine characteristics consistent with their gender identity. In some cases, hormone therapy may be required before surgical interventions can be conducted. Transgender women are prescribed estrogen and testosterone blocking medication (such as cyproterone acetate and spironolactone). Transgender men are prescribed testosterone.

Sidebar 5.2: 2021 was one of the Deadliest Years for Transgender and Non-Binary People

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Violence and discrimination against people who exist within transgender and non-binary (NB) communities is at an all-time high. Even at a time when gender expression is becoming less of a taboo subject, and visibility and validation of identity is becoming more prevalent, the Human Rights Campaign reported that "2021 as one of the Deadliest Year on Record for Transgender and Non-Binary People". From social stigma and intolerance leading transgender and NB people to take their own lives, to the outright murders of trans women particularly of color, their lives are often at risk of harm for no other reason than a desire to be seen as who they are and society not accepting them.

Certain regions of the United States can be very unsafe for transgender or NB people. In parts of the U.S. anti-trans legislation is popping up and conservative politicians seem to be uniting around denying them basic rights. As this type of gender policing picks up momentum in states all over the US, we will likely see an increase violence amongst LGBTQ+ people (specifically transgender and non-binary people) as they become further marginalized.

Trans Day of Visibility is an annual awareness day celebrated around the world. The day is dedicated to celebrating the accomplishments of transgender and gender nonconforming people, while raising awareness of the work that still needs to be done to achieve trans justice.

Photo by Sharon McCutcheon on Unsplash

Gender Pronouns

Pronoun usage also plays a role in a person's gender identity. If you've ever been misgendered, you probably reacted in some way. Because language is a big part of how we make sense of ourselves, the pronouns we use when referring to ourselves represent who we are. Pronouns are used in place of proper nouns, such as a name, during daily conversations. In many languages, including English, pronouns are gendered. That is, pronouns are intended to identify the gender of the individual being referenced. English has traditionally been binary, providing only "he/him/his" for male subjects, and "she/her/hers" for female subjects.

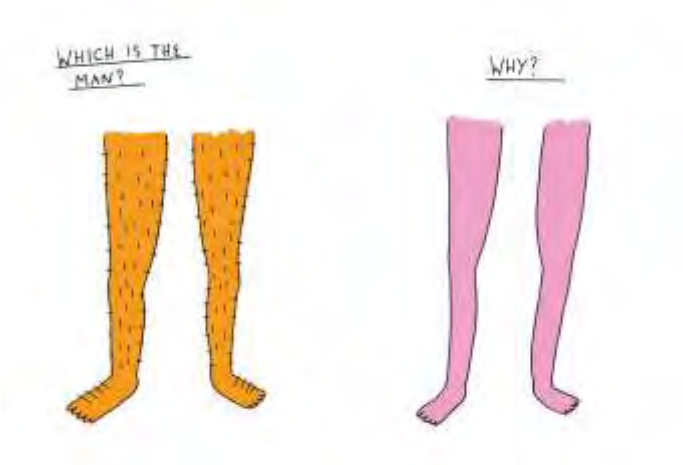
This binary system excludes those who identify as neither male nor female. The word "they," which was used for hundreds of years as a singular pronoun, is more inclusive. In 2019, Merriam Webster selected this use of "they" as Word of the Year.

"They" and other neopronouns [xe/xem/xry/xrys, ze/hir/hirs/hirself, etc.] are now used to reference those who align more closely to something other than he/him or she/her male or female. Making an assumption about someone's gender sends a potentially detrimental message: that people must appear and behave a certain way to demonstrate their gender identity. By using someone's correct pronouns, you are creating an inclusive environment and respecting them (What and Why,

n.d.). Today, there are many institutions normalizing the practice of gender pronoun neutrality and pronoun sharing in introductory settings, on email signatures and other spaces. For example, on the online school platform, *Canvas*, students and professors have a space to enter their pronouns that then appear next to their name. In the occupational field, sites like Zoom and LinkedIn offer a place to share one's pronouns.

Social Construction of Gender

While research has come a long way to help dismantle gender binaries, it is important to fully understand the binaries we currently still live in day to day, perhaps even without realizing it.



Scholars generally regard gender as a *social construct*—meaning that it does not exist naturally, but is instead a concept that is created by cultural and societal norms. Gender socialization begins at birth and occurs through major agents of socialization like family, education, peer groups, and mass media.

As soon as we are born, and even before birth, if we are from a country that views gender as specifically female or male, we have entered the socially constructed binary. At an early age, we begin learning cultural norms for what is considered masculine and feminine. For example, American children may associate long hair or dresses with femininity. Later in life, as adults, we often conform to these norms by

behaving in gender-specific ways: as men, we build houses; as women, we bake cookies (Marshall, 1989; Money et al., 1955; Weinraub et al., 1984).

Children are given traditional male or female names, nurseries decorated either in pink or blue, accessorized with dolls or trucks, and closets full of dresses or collared button-up shirts. As a young child were you ever told you could not use a certain colored pen or pencil? Pink is for girls, blue is for boys? Did you learn what you could and could not wear based on your predetermined gender?

Because cultures change over time, so too do ideas about gender. For example, European and American cultures today associate pink with femininity and blue with masculinity. However, less than a century ago, these same cultures were swaddling baby boys in pink, because of its masculine associations with "blood and war," and dressing little girls in blue, because of its feminine associations with the Virgin Mary (Kimmel, 1996).

Mack Male. 2014 Creative Commons Attribution-Share Alike 2.0

It is hard to scroll on social media, or even watch the news today without coming across a "gender-reveal" extravaganza. These gender reveals are planned events, meant to inform the parents' relatives, friends, and community what their child's biological sex is. There was a deep dive into finding out who created this trend as it has caused much controversy and catastrophe. In 2008, Jenna Karvunidis created a blog post sharing details of a party she threw in which she cut a cake to reveal pink icing, to share the gender of her first child (Langmuir, 2020). In an interview with The Guardian, she claims to regret having started the trend and believes the idea is

gender limiting (2020). Contrary to gender-reveal parties and what they over-emphasize, are some parents raising their children without gender, or "gender-neutral parenting." In the New Yorker Documentary, titled "Raising Baby Grey", two parents are raising their one-year-old child named Grey, with pronouns they/them, and offering clothing of all varieties (Long, 2020). Their hopes are to allow their child the freedom to choose their gender if and when they want, and prevent the harm that the gender binary can cause to children leading up to their adulthood (Long, 2020).

In a 1987 article by sociologists Candace West and Don Zimmerman, the phrase, "**doing gender**" was coined. They stated that "doing gender involves a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures'" (West & Zimmerman, 1987, p.126). Embedded into our everyday thoughts and actions, an example of doing gender could be that men are expected to open doors for women. This shows chivalry, a typically masculine trait, which reinforces the idea that women need to be taken care of, and are fragile.

These societal expectations and norms shape our understanding of gender from a very young age and we perform gender without questioning it. Think about how you sit, what you wear, and how much physical space you take up; how did you learn this performance? Through socialization and policing of boundaries over the life course, we learn to do gender as taken for granted reality. Even amongst children, if a peer were to veer off this binary course, they would experience ostracization and quickly learn to play along with the rules. Internalization of social rules and norms over time, causes us to forget that sometimes these rules we abide by, are not natural but rather a social construction.

Sidebar 5.3: Social Policy and Debate, the Legalese of Sex and Gender

The terms *sex* and *gender* have not always been differentiated in the English language. It was not until the 1950s that U.S. and British psychologists and other professionals working with intersex and transsexual patients formally began distinguishing between sex and gender. Since then, psychological and physiological professionals have increasingly used the term gender (Moi 2005). By the end of the twenty-first century, expanding the proper usage of the term *gender* to everyday language became more challenging—particularly where legal language is concerned. In an effort to clarify [the] usage of the terms *sex* and *gender*, U.S. Supreme Court Justice Antonin Scalia wrote in a 1994 briefing, "The word gender has acquired the new and useful connotation of cultural or attitudinal characteristics (as opposed to physical characteristics) distinctive to the sexes. That is to say, gender is to sex as feminine is to female and masculine is to male" (*J.E.B. v. Alabama*, 144 S. Ct. 1436 [1994]). The late great Supreme Court Justice Ruth Bader Ginsburg had a different take, however. Viewing the words as synonymous, she freely swapped them in her briefings to avoid having the word "sex" pop up too often. It is thought that her secretary supported this practice by [suggesting] to Ginsberg that "those nine men" (the other Supreme Court justices), "hear that word and their first association is not the way you want them to be thinking" (Case 1995). This anecdote reveals that both sex and gender are actually socially defined variables whose definitions change over time.

Gender Roles

Joe Hoover. 1995. Creative Commons Attribution-Share Alike 4.0

Gender roles are the broad cultural expectations of males and females which you probably have learned to follow. Those rules are made up of the norms, or standards created by society. Gender roles dictate how people should think, speak, act, dress and interact with society based on these social constructions. The attitudes and expectations surrounding gender roles are typically based not on any inherent or natural gender differences, but on *stereotypes* about the attitudes, traits, or behavior patterns of women or men. Gender stereotypes form the basis of *sexism*, the belief that males are superior to females, and create a gendered script we are taught to follow.

Gender schemas we make based on the script are deeply embedded our cognitive frameworks and play a role in defining what we perceive as correct male vs. female roles (note and an acknowledgement of a false binary: as of this writing we are unable to find stereotypical cultural expectations or scripts for non-binary people so the gender roles we are discussing are only M/F). Agents of socialization such as parents, teachers, television, music, or books work to reinforce what has been traditionally seen as 'male' or 'female' behavior. Oftentimes, adults perceive gender differently than children. This is due to the gender expectations they are taught as young children which shape their adult minds.

Focalphoto. (2021). Gender. Flickr. https://www.flickr.com/photos/192004829@N02/51016727727/ Attribution-NonCommercial 2.0 Generic (CC BY-NC 2.0)

The phrase “boys will be boys” is often used to justify behavior such as pushing, shoving, or other forms of aggression from young boys. The phrase implies that such behavior is unchangeable, and something that is part of a boy’s nature. Aggressive behavior, when it does not inflict significant harm, is often accepted from boys and men because it is congruent with the cultural script for masculinity. The “script” written by society is in some ways similar to a script written by a playwright. Just as a playwright expects actors to adhere to a prescribed script, society expects women and men to behave according to the expectations of their respective gender roles. Scripts are generally learned through a process known as socialization, which teaches people to behave according to social norms (Griffiths & Kierns, 2015).

Gender roles shape individual behavior, not only by dictating how people of each gender should behave, but also by giving rise to penalties for people who don’t conform to the norms. While it is somewhat acceptable for women to take on a narrow range of masculine characteristics without repercussions (such as dressing in traditionally male clothing), men are rarely able to take on more feminine characteristics (such as wearing skirts) without the risk of harassment or violence. This threat of punishment for stepping outside of gender norms is especially true for those who do not identify as male or female. Transgender, genderqueer, and other gender-nonconforming people face discrimination, oppression, and violence for not adhering to society’s traditional gender roles. People who identify as gay, lesbian, bisexual, or queer are also ostracized for breaking the traditional gender norm of who a person of a given sex “should” be attracted to. Even people who

identify as cisgender (identifying with the sex they were assigned at birth) and straight (attracted to the opposite sex) face repercussions if they step outside of their gender role in an obvious way.

Sidebar 5.4: We Asked an Expert

In creating this textbook, we sought out many experts to advise, consult and share wisdom. Dr. Jamie Weinstein, Family Physician, was kind enough to respond to specific questions posed here regarding her work with gender creative youth as a family practitioner. It begins with a little bit about her and the Q & A follows.

I see folks of all ages for routine preventive health care as well as any urgent illnesses that can be managed in an office. As a family doctor I try to focus on people in the whole context of their lives and relationships, not just as a collection of illnesses. I don't have special training in adolescent medicine, gender affirming care or human sexuality, though I have spent a lot of time talking/thinking/reading and educating myself and I have a very privileged perspective to be able to try out ideas and get feedback from my patients over the past 20 years.

What are the concerns of gender creative and nonbinary youth?

That's an interesting first question for me :)

How do you support the youth?

As a provider, parent, and friend I would say one of the overarching issues is being able to be 'seen' and accepted by others as who you are or are becoming... especially when you don't fit into the cis/hetero/binary categories and might not have supportive or knowledgeable friends and family.

There are so many ways to go with this question but I'm gonna start really general. I think one of the most important ways I can support is actually by changing my gendered language and my gendered world view across the board. Asking pronouns for everyone is a really simple way to start to do this. I want all my patients to be more comfortable in a less heteronormative, less gendered, less binary world. When I use non gendered language and ask about pronouns, folks that may want to share more hopefully see that they can, folks that don't know what I am talking about have an opportunity to learn (and I can use my power and privilege as a white, cis, hetero, old doctor to have those conversations). Then,

depending on how kids answer we can then go deeper if they want to. I would say in general for all things with teens, I like to start really simple and not overdo it - kind of like how you talk about sex with little kids - answer the question they are actually asking in a developmentally appropriate way, and then wait to see what else they want to know - in this case signal by asking pronouns, try to create an atmosphere of trust, and then give kids the opportunity and agency to ask more and go deeper if and when they want.

I think generally trans/NB folks (and everyone probably) want health care in a setting that feels comfortable to them, from providers they feel comfortable with *and* also don't have to have every visit and interaction always be about their gender identity - trans folks sprain their ankles too, and sometimes being gender affirming is not actually talking about gender, if that makes sense.

What are the concerns of their families? How do you support the families?

For some parents and loved ones I can help validate and contextualize. I can answer questions they can't (and shouldn't) be asking their kids, and give them a place to talk openly about their concerns. Sometimes, I need to be a fierce and supportive advocate, but a lot of times I have parents who are feeling really overwhelmed and confused, and are trying to do their best. Having a place where they can talk openly and mess up pronouns and say their deepest fears so that then they can be supportive and affirming is really valuable. Also in 2022 in Northern California, we have *a lot* of great resources - folks way more experienced and knowledgeable than me, and I can share that info.

What advice do you give other doctors working with gender creative youth?

Luckily, I think there is way more formal and informal education and understanding about sexual and gender identity and expression, so it's becoming more and more woven in. I really encourage folks to get comfortable asking and using pronouns and being more mindful of their language they use. For kids that don't have supportive families and friends or access to trans NB/queer communities, their

health care provider may be the only person/place they can talk about these issues and get correct information, so it's vital that providers are aware and create the space for kids to talk. If we don't, many kids who need info and support may not feel comfortable telling us, and getting the information and care they need. Unfortunately, as we know, trans/NB kids have much higher rates of depression and suicide, so their safety and lives are literally at stake. I think relatively soon there will be questions about gender identity in routine pediatric screening tools, which I think really needs to happen.

One piece of advice that is relevant here for docs who may be new and nervous about 'getting it right'... is how to acknowledge and apologize when you mess up without centering yourself and making the other person responsible for making you feel better. So, for example, when you mis gender or mis pronoun, which is inevitable, it's important to be able to correct, apologize and move on; I think too often trans/NB folks end up being made to feel responsible for other people's comfort.

What do you enjoy most about working with gender creative youth as their doctor?

Just in general I love taking care of kids and young adults; I love working with folks in different phases of development and seeing how their brains are processing and developing over time. I love challenging myself to try to get all my patients the information they need in a way they can absorb it, really take it in and integrate it into their lives and with kids it's particularly challenging and fun. Many kids (adults too) and especially trans/NB folks, don't have enough people in their lives that are validating them and loving them for who they are; it's such an honor and privilege when I get to do that. On top of that, many LGBTQIA+ folks have had really miserable experiences with health care (often meaning they have avoided getting care they need), so it feels really important to try to get it right.

What is most challenging for you in doing this work?

I wish I had more time and could do more of it (I'm a generalist family doctor with so many competing demands).

What are the terms that youth are embracing to name their gender?

Honestly I feel like terminology is often in flux and even in affirming communities there can be differences of opinion... Some folks use words for themselves that others might find insulting or offensive. I usually just try to use whatever words folks use for themselves.

I think we can always ask folks their pronouns but then consider if you really need to know their gender identity; is it really relevant for you to know at that moment? We don't generally ask congruent presenting cis folks to tell us “what they are”. One of my kids said early on when I asked what they wanted grown-ups to know about trans kids, something like *why are grown-ups so obsessed with what gender I am all the time - stop worrying about it and just relate to me*.. Worth thinking about.

Here is a great resource of examples of Gender Inclusive Language in health care. I also am a huge fan of not saying anything is normal; I don't think it's helpful as a concept when we are talking about bodies/people generally, so I just say that things look healthy instead. For example, I used to say kids have normal growth and development, whereas now I say healthy growth and development. The same occurs with genital exams/cervical cancer screening; there is no normal appearing vulva or cervix. I guess some folks might consider calling things “healthy” as ableist, but for the purpose of screening exams it works for now.

How do you approach negative emotions and reactions from family members (either towards you or gender creative youth) regarding gender identity?

I don't like or use the word ally, but I do really think that if I can be the person that has to address ignorant or rude questions or comments relating to gender identity and expression I am more than happy take that on (though it's hard not to roll my

eyes when folks want to talk about how grammar is just soooo important to them and they just can't handle using they/them for a singular person). My personal experience is that folks are much more likely to just avoid you then have a confrontation when they realize it's personal, or when I am the *doctor* telling them something. Honestly in places like Marin and Sonoma (Northern California), people are often more likely to be overdoing it to show you how accepting they are.

One of the things I have seen that I wish I could communicate to parents is unintentional harm. Many people say things about LGBTQIA+ folks generally or in passing that they would not say if they knew their own child was any of those identities, and a lot of kids are right now. Unfortunately for some folks, it doesn't matter and that's a different issue, but my experience is that many folks will dramatically change their views once someone they love and care for 'comes out,' and it can be hard to turn that around once your kid has heard you say it.

Original photo, circa 2022

Gender Dysphoria

Gender dysphoria is defined by the Mayo Clinic as discomfort or distress in a person whose gender identity differs from their assigned sex at birth. Some transgender and non-binary people feel at ease with their bodies and do not seek medical intervention; however, many transgender people experience gender dysphoria at some point in their lives, and may seek medical intervention.

Gender Dysphoria can be diagnosed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a manual published by the American Psychiatric Association. Questions around the use of the DSM in pathologizing gender dysphoria arise for many critical of this type of understanding, but for Trans folx seeking medical intervention, the diagnosis is often the only way to get the treatment they are seeking. Keep in mind that the term focuses on discomfort rather than identity itself.

Gender dysphoria can cause many complications that include, but are not limited to, a fear of being harassed or teased, pressure to dress in a certain way, or an inability to complete daily activities. People who experience gender dysphoria are likely to experience discrimination which would result in stress and/or an inability to receive quality health care as a result of stigmatization of gender. Additionally, many people who experience gender dysphoria fear the idea of seeking healthcare due to the stigmatization of gender.

Young people without gender-affirming treatment who experience gender dysphoria might also be at higher risk for self-harm and/or suicide.

Sidebar 5.5: Imagine If…

What if you had to live as a sex you were not biologically born to? If you identify as a man, imagine that you were forced to wear frilly dresses, dainty shoes, and makeup to special occasions, and you were expected to enjoy romantic comedies and daytime talk shows. If you identify as a woman, imagine that you were forced to wear shapeless clothing, put only minimal effort into your appearance, not show emotion, and watch countless hours of sporting events and sports-related commentary. It would be pretty uncomfortable, right? Well, maybe not. Many people enjoy participating in activities, whether they are associated with their assigned sex or not, and would not mind if some of the cultural expectations for men and women were loosened.

Now, imagine that when you look at your body in the mirror, you feel disconnected. You feel your genitals are shameful and dirty, and you feel as though you are trapped in someone else's body with no chance of escape. As you get older, you hate the way your body is changing, and, therefore, you hate yourself. These elements of disconnect and shame are important to understand when discussing dysphoria transgender individuals.

Policing of Gender in the United States

Sociologists who study gender are often interested in the factors that shape people's performance of gender based on social cues. As mentioned earlier, sociologists West and Zimmermman (1987) theorized this concept of "doing gender." "Doing gender" per the sexual scripts means that we fall into two distinct categories, and our behaviors must reflect what the culture defines as gender appropriate behavior. When the script is not followed, we are reminded that we are not staying in our gendered lane, and are sanctioned in some type of way. Gender policing is the enforcement of heteronormative gender ideals that force the gender binary onto people. "Masculinity" and "femininity" are often rewarded by people who reject the idea that gender is a social construct which lies on a spectrum. As a result, performances that differ from normative cis-gendered stereotypes are generally rejected from patriarchal, heteronormative society.

The ways that gender is 'policed' can range from microaggressions to macro-aggressions. Boys are policed at a young age for expressing stereotypical feminine traits. While young boys are generally policed more visibly than young girls early on, girls are asked to perform gender in ways that may be less visible, but are no less impactful. Being taught that their physical appearance is a basis for validation, or to defer to others' feelings, or take up less physical space, or be nice to people even when they don't feel like it teaches young girls to accept unwanted treatment or behavior. Repercussions of this type of role expectation can lead to young girls putting up with harassment or abuse, or being hypercritical of their bodies and starving themselves to fit into cultural standards of beauty because they have been socialized to put their wants and feelings aside to make others happy.

Gender policing into two distinct categories means that we learn very different cultural scripts (again, most policing takes place within the false binary so this is where we focus attention). As a result the definition of sexuality gets filtered through a gendered lens. Looking back to the author's own research on sex education and gender, we saw that parents have two very different expectations of their children sexuality, depending on their gender. When many of these humans come together in sexual or relational partnerships, they enter in with a completely different narrative of sexuality, consent, and communication. Right off the bat, this means in order to make things work, there is a lot of unlearning to do about sex and relationships.

Sociologists also note that gender policing exists at all periods of a person's life, and shows itself at the intersection between race and class. **Intersectionality**, allows for an understanding of how a person's social and political identities combine to create different modes of discrimination and privilege. The ways in which all of our different aspects of self-interact with our gender can affect the type, degree and severity of gender policing. An intersectional approach is important when looking at the impact of gender policing.

Sidebar 5.6 Doing Gender and Body Image

From a very early age I remember knowing that thin was good, fat was bad. My parents were immersed in society's idea that we were supposed to be thin and not take up too much space. Be thin. Look fit. My mom said to me once that when she was pregnant her doctor told her that she should only gain 20 lbs. So, she only gained 20lbs. Thinness wasn't about health, it was about acceptance. When I was a young child I never thought about how my body looked. It was just the vessel I used to run, play, go on adventures. When I was 11 I started to grow a lot. I became much taller than my friends. Soon after I began my period. I had no idea what to do or how to accept this. There was so much shame. We didn't talk about what menstruation was or why we go through it. It was just shameful. I remember a conversation with my friend one day when she recognized that I had grown so much. "How much do you weigh", she said. I didn't think anything about it. It was arbitrary, at least that's what I thought. "I weigh 80lbs". She was surprised. "I only weigh 50lbs". That was the first moment that I felt ashamed of my size. I was the big girl.

As my body continued to change into my teens, my hips grew, my boobs grew. I was being transformed into a sexual being. It was the most confusing time. As I was being told to remain a good girl, the world was treating me like a prize up for grabs. It was totally normal for people to comment on how your body looked. My body was no longer mine. It belonged to society, my parents, my boyfriend, random people. It's hard enough to embrace your body as it changes throughout your life, the last thing a person needs is scrutiny from others.

Thank God for my fifties. I no longer have to be sexy. I am no longer in a position to get pregnant. I don't need a partner. At first letting go was a challenge, but the more I let go the better I feel. I can love my body as it is. I can respect it for what it has given me and done for me. I love my soft saggy belly and my flappy "Hi Helen" arms. And I am very grateful for all the things I still get to do that bring me joy.

Conclusion

The international scientific and medical communities view variations of sex, gender, and sexual orientation as normal. It is important to note the difference between sex

and gender. Gender is a spectrum, and a person's biological makeup does not define one's gender identity. The term intersex is used to define individuals with a variation in sex characteristics, including chromosomes, gonads, or genitals, which highlights the false binary of two distinct sexes or genders. Transgender people have a gender identity or expression that differs from what they are assigned at birth. People who identify as transgender may participate in hormone therapy, which is an effective way to enhance secondary sex characteristics associated with a person's gender identity. Gender is a social construct, meaning that it is not developed naturally, but is instead a concept, created by cultural and societal norms. Gender socialization begins at birth, and occurs through a variety of major agents of socialization, including family, education, peer groups, and mass media. As a result of gender socialization beginning at birth, it is often difficult for people to 'come out' as transgender.

U.S. society continues to consider the gender binary as the 'norm', which causes many transgender and non-binary people to experience gender dysphoria. Gender dysphoria can negatively impact a person's quality of life, especially if a transgender person does not have resources to explore their gender identity. Prescribed gender roles can play a major role in gender dysphoria, and are based on a socially constructed idea of gender, which changes over time. Gender schemas are deeply embedded in a person's cognitive framework, which is why many transgender and non-binary people have to go through a process of un-learning. This process can be quite difficult, as a result of people being policed at a young age, causing a series of gendered expectations that define the ways people should act, dress, and interact with society, based on the gender that they are assumed to hold.

Glossary

1. **Agender:** a person who has an internal sense of being neither male nor female nor some combination of male and female
2. **Bigender:** a person whose gender identity is a combination of male and female or is sometimes male and sometimes female
3. **Cisgender:** a person whose gender identity corresponds with the sex the person had or was identified as having at birth

4. **Gender** is a term that refers to social or cultural distinctions associated with a given sex
5. **Gender Binary:** The word “binary” comes from a Latin word meaning "consisting of two.” When we refer to “gender binary” we are referring to the two common categories for gender, man and woman. Most of our world separates men and women using cultural stereotypes - from what we wear, how we smell, and the roles we are expected to play in the workplace and the home.
6. **Gender Expression:** Refers to the aspects of a person's behavior, mannerisms, interests, and appearance that are associated with gender in a particular cultural context, specifically with the categories of femininity or masculinity.
7. **Gender Identity:** a person’s sense of self as a member of a particular gender.
8. **Gender Spectrum:** If we imagine gender is a spectrum with male and female at either end, some people feel like they fit a different category than the gender they were given at birth, and move from one side to the other, and some people feel they are a mix and somewhere in between the ends of the spectrum.
9. **Genderqueer:** a person whose gender identity cannot be categorized as solely male or female
10. **Gender Neutral:** not referring to either sex but only to people in general
11. **Intersex:** those with a variation in sex characteristics, including chromosomes, gonads, or genitals that do not allow an individual to be distinctly identified as male or female
12. **Non-binary:** Some people don’t feel like they fit on the spectrum at all, and reject those terms altogether. Some people refer to their gender as “non-binary” to describe when their gender falls outside the gender binary system. These people can sometimes use gender-neutral pronouns such as “they” instead of “him” or “her”.

13. **Sexuality:** a person's capacity for sexual feelings
14. **Transgender:** a person whose gender identity differs from the sex the person had or was identified as having at birth
15. **Two-Spirit:** an umbrella term used by some Indigenous North Americans to describe Native people in their communities who fulfill a traditional third-gender (or other gender-variant) ceremonial and social role in their cultures.

Discussion Questions

1. Discuss your own experiences with gender stereotypes.
2. In your own words explain the idea that gender is a spectrum.
3. Why is the gender binary false?
4. Discuss different attitudes/stigmas/stereotypes associated with gender, either things you've heard or been taught.
5. How does gender dysphoria manifest itself in people? Think of some examples and offer suggestions for ways in which the culture could be more supportive.

Multiple Choice

1. True or False: someone can have both ovarian and testicular tissues, unique chromosomal combinations such as XXY?
    a. True
    b. False

2. What is the difference between sex and gender?

    a. Sex refers to sexual orientation, and gender refers to physical or physiological differences between males and females.
    b. Sex is the extent to which one identifies as being either masculine or feminine, gender is biological characterization of anatomy.

c. Sex refers to who a person is sexually attracted to, and gender refers to whom a person chooses to partner with.
d. Sex refers to physical or physiological differences between males and females, while gender is the extent to which one identifies as being either masculine or feminine.

3. Gender Dysphoria is:

a. A form of homophobia
b. A form of sexual dysfunction and paraphilia
c. A condition where transgender people choose to alter their bodies
d. A condition of people whose gender at birth is contrary to the one they identify with

4. The term “transgender” encompasses a wide range of possible identities, including what identities?

a. Agender
b. Genderqueer
c. Two-spirit
d. All of the above

5. Hormone therapy is a cheaper alternative to surgery can develop which of the secondary sex characteristics?

a. Breasts
b. Facial Hair
c. Body Hair
d. All of the above

6. What is an example of “doing gender” as proposed by Zimmerman and West?

a. Men opening doors for women

b. Boys playing with toy dolls
c. Women staying at home while their husband works
d. A and C

7. True or False: variations of sex and the orientation of sexual behavior occur naturally throughout the animal kingdom

a. True
b. False

8. The term doing gender can be defined as:

a. The refusal to participate in any tasks with gender-specific requirements.
b. When people perform tasks based upon the gender assigned to them by society and, in turn, themselves.
c. The prejudiced belief that one sex should be valued over another.
d. Dating a member of the same sex to make a political statement.

9. An example of gender policing would be:

a. Allowing kids to freely express themselves
b. Making fun of a male bodied person for crying
c. Arresting protesters
d. Wearing purple pants

10. What aspects of culture teach us to act in gendered ways?

a. Education
b. Family
c. Religion
d. All of the above

For Further Exploration

Online activity/game:

https://pronouns.minus18.org.au/ **Practicing with different pronouns + explanations.**

https://www.itspronouncedmetrosexual.com/2016/05/sexualitree-model-of-comprehensive-sexuality/ **Interactive activity, explores how we experience sexuality in different ways**

Film:

Straightlaced, How Gender's Got Us All Tied Up. 2009. Debra Chasnoff

YouTube:

https://www.youtube.com/watch?v=Ayi3OJbvePw "MAN or WOMAN!? | GENDER AND SEX"

https://www.youtube.com/watch?v=N_yBGQqg7kM "Why Pronouns Matter For Trans People"

https://www.youtube.com/watch?v=yu-2i8CJXY4 If Trans People Said The Stuff Cisgender People Say

https://youtu.be/q8bSIuyJHD8 Sam Killermann: Gender from boxes, to -ness.

Other:

https://everydayfeminism.com/2016/09/intersex%E2%80%8A-%E2%80%8Amore-than-a-diagnosis/ intersex pov.

http://www.intersexequality.com/wp-content/uploads/2012/10/Brief-Guidelines-for-Intersex-Allies.pdf "brief guidelines for intersex allies"

Vocab:

https://www.plannedparenthood.org/learn/gender-identity/transgender/transgender-identity-terms-and-labels glossary terms.

https://pflag.org/glossary glossary terms.

https://www.learningforjustice.org/magazine/publications/best-practices-for-serving-lgbtq-students/lgbtq-terms-definitions-the-acronym-and-beyond glossary terms

https://www.mypronouns.org/how how to use pronouns

https://rossieronline.usc.edu/blog/gender-identity-glossary/ glossary terms

Spahr Center https://thespahrcenter.org/

Gender Spectrum Institute https://genderspectrum.org/

Positive Images https://www.posimages.org/

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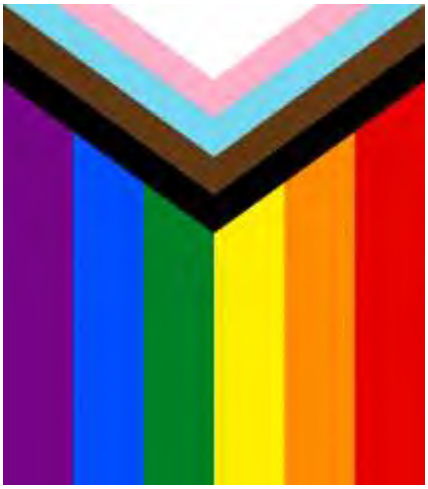
Chapter 6: Sexual Orientation



"I'm not missing a minute of this. It's the revolution!" – Sylvia Rivera

Learning Objectives

After completing this module, students should have a working knowledge of:

- What is sexual orientation?
- How sexual orientation develops and changes in individuals
- A variety of different types of sexual orientation
- Some history of LGBTQIA+ Social Movements
- How society differently treats people identifying as homosexual, heterosexual, bisexual, asexual, and queer
- Our sexuality; nature vs. nurture

Introduction

Who we are attracted to has a profound effect on our personal lives and how we are treated by others. In this chapter, we will examine sexual orientation, identity formation, and the fluid nature of human sexuality. We will provide definitions for a

variety of sexual orientations, give some historical context to LGBTQIA+ rights and formation as a marginalized group. We will look at the psychology behind sexual orientation, and the ways in which sexual orientation is policed in our political system, and through hetero and Cis normativity.

Sexual Orientation

Sexual orientation describes one's sexual attraction, and there are multiple labels that one can use in order to describe it. There are an infinite number of identities, and it should be noted that the meanings of these labels often change due to social or cultural shifts. Our sexuality is not fixed, but rather, it is fluid; people may identify with different labels at different points in their life. Some people will figure out what term they identify as, and identify that way their whole life, while for others, the labels they use to express their identity may shift. As new definitions and understanding emerge with regard to sexual orientation, people may then redefine themselves.

For individuals going through this discovery, there are many forums, groups, and organizations out there that support inquiry around one's sexual orientations. Many are organized around specific identities, such as groups that support lesbian, gay, bisexual, pansexual, queer, asexual, etc. In addition to sexual orientation, monogamy and polyqueer identities are other terms to consider in this conversation, as they relate to the expression of sexual orientation.

There is no question that progress has been made in the United States surrounding sexuality and gender equity; however, local, state, and federal governments continue to legislate policy that disadvantages LGBTQIA+ people, while hate crimes and other forms of discrimination persist. This is why LGBTQIA+ is still considered a protected category.

Charlie Marshall. 2017. Creative Commons Attribution 2.0

Identity Formation

How someone's sexual orientation develops and comes to be is up for debate. Within the LGBTQIA+ community and among those who study gender and sexual orientation, it is generally accepted that one's sexual orientation is not a choice, but something that is simply a part of a person. This is often challenged by those who argue that certain identities are simply a temporary "phase" or that queerness is unnatural. These arguments and views will be addressed in this chapter, as well as a section on terms that have been coined by scholars in queer theory and other academic fields that help us understand sexuality more.

Before we continue, an important thing to understand is that this information will likely change, and a certain definition may not be what everyone agrees on. People might share a label, but their experiences can vary in several ways, and some people choose to not label themselves at all when it comes to their attractions. The way these people present themselves can be drastically different, and their preferences in their partners can vary as well. The essence of this is to say an identity is not a "one size fits all" box, and rather than looking for external validation around a label, we hope this chapter helps you decide that you get to define yourself in whatever way you like.

When you think of a potential significant other (or if you already have one), what quality is most important to you? Your answer may differ from others or it may be similar. As we will learn later on in this book, attraction does fall down similar patterns but ultimately we all like who we like based on multiple factors that are

unique to who we are. While you may have some preferences when it comes to physical features, people generally want their partner to have similar values, and certain qualities are perceived to be more important than others.

Specific identities will have certain stereotypes and misconceptions associated with them. These stereotypes come from cultural labels surrounding differing sexual orientations often perpetuated in the media. In a 2010 study entitled *Fairy tales: Attraction and stereotypes in same-gender relationships*, Felmlee et al discuss common stereotypes surrounding same-gender relationships such as "exhibition of gender atypical traits, sexual promiscuity, and predatory sexual tendencies," and challenge these ideas with their data, which suggests that the reality is not as simple as previously believed, and that these stereotypes serve to create false beliefs surrounding same sex relationships. Just as heterosexual people have their own preferences when looking for a significant other, queer people have the same and the preferences are varied and multifaceted (Felmlee et al, 2010).

Sexual Fluidity

Sexual fluidity is a term that encompasses the many different ways that people experience desire. Contrary to the stereotypes associated with sexual orientation, bisexuality does in fact exist! In fact, there are many ways in which people express their sexual orientations (for a more detailed list, refer to the section entitled *Different Types of Sexuality*). Attention was drawn to the term "sexual fluidity" in 2008 by Lisa Diamond in a book titled, *Sexual Fluidity: Understanding Women's Love and Desire.* In the book, Diamond describes the idea of bisexuality, and that it does not completely identify the nature of many people's sexual identity. **Sexual fluidity,** one or more changes in a person's sexuality or sexual identity, describes the idea that an individual's sexual orientation can be 'fluid,' or something that can change over time. Prior to the idea of sexual fluidity, it was believed that our sexuality is fixed at birth, and incidents of people pursuing emotional or sexual relationships with genders other than their typical preference was considered 'experimenting.' In truth, human beings may develop relationships with individuals of different gender identifications through their lifetime, and people are not "tied" to one sexual orientation throughout the entirety of their life.

According to a study that looks at sexuality throughout the United States by the UCLA School of Law, the percentage of people who identify as lesbian, gay or bisexual is 3.5%, which translates to roughly 9 million people throughout the

country (LGBT Demographic Data Interactive, 2019). It can also be argued that if there were no social stigma attached to not being heterosexual, a lot more people would openly admit to a wider variety of sexualities. In the same study, it was found that women were significantly more likely to identify as bisexual as compared to men. As an example of sexual fluidity, a **pansexual** identifying person, or a person who is attracted to someone regardless of their gender identity, might pursue a relationship with a male or female identifying person, whereas someone who is sexually fluid might be seek female identifying people one day, but seek male identifying people another day.

A permanent, non-altering sexual orientation, whether it be heterosexuality, homosexuality, pansexuality or bisexuality is how some people live out their lifetimes, but it does not accurately define everyone, which is why the concept of sexual fluidity is important to add into a discussion of sexual orientation. It allows people to redefine their sexuality(ies) throughout their lives.

Sidebar 6.1: Oh, that's what I am!

I've always said, I like who I like. Sometimes I liked them romantically, sometimes I liked them physically, and sometimes I felt deep love for them. It was never exactly the same type of like I had for each of them, they were all different. For those of you lucky enough to be coming into your sexuality in the present era, there is a lot of room for discovery and flexibility. In my day, you were either hetero or gay and nothing else-super binary. It didn't make sense and it left me confused. The first time I heard the term pansexual I was blown away. That's a thing? Yes! That's me! I just like who I like, regardless of their label.

Heteronormativity and the Sexual Hierarchy

The LGBTQIA+ community has been a marginalized group, not unlike racial and ethnic groups. They face discrimination and hate and have been targets of violence. People have sought to deny their identity and pursued efforts to invalidate queer identities. The rights of this community have been debated by government officials, sometimes leading to laws that protect rights, and other times, to deny rights.

One of the reasons queer people have been seen as deviant and are marginalized is because of the idea of **heteronormativity**, the ways in which heterosexuality is normalized through myriad practices, so that it becomes naturalized as the only legitimate form of sexuality. Society has a socially constructed sexual hierarchy that classifies certain acts as morally superior and as the model that should be followed (Rubin 1984). Because of this hierarchy, there is what is considered a charmed circle

and the outer limits of what is culturally seen as acceptable sexual behavior. Heterosexuality gets privileged as the orientation that is every other orientation is viewed in relation to, and as a result, homosexuality and queerness are viewed as unnatural. Knowing what we know about homosexuality, we know it exists throughout the animal kingdom, including humans, it was historically not always stigmatized, and in fact, was part of what was regarded as normal sexual activity. As culture shifts, we see attitudes and rules around sexuality change, and at present depending on where you are geographically located, homosexuality is more widely accepted now than in the past (Rubin 1984).

Throughout this chapter "LGBTQIA+ community" and "queer community" will be used interchangeably; however, some argue that there is a major difference in these terms. The LGBTQIA+ community has a wide range of people who have different beliefs and practices. While some desire to not be viewed differently and fit in with the systems in place, others desire radical changes to these systems. Queer is often the word used to express a more radical approach.

Different Types of Sexualities

Observing sexuality worldwide throughout history is extremely helpful in understanding the way human beings perceive different sexualities. As we have alluded to previously, there is not a universal attitude about different sexual orientations, but rather, the way in which sexual orientation is socially constructed based on a given culture's attitudes and beliefs. Even within Western culture, attitudes have shifted over time. The early Greeks viewed same sex activity as just another sexual act, not linking it to any particular orientation. In the Medieval Period, sex that did not result in procreation was denounced, whereas the Enlightenment period created a shift that differentiated private from public life, making sex more acceptable. During the 19th century in the Victorian Period, people developed concerns regarding population growth, which led to governments and churches restructuring the narrative surrounding sex, in an attempt to reduce sexual desires throughout communities. Cultural perceptions of sexuality in Western societies were quite a bit more conservative in the 19th Century than they are now. The truth is that attitudes about sexuality are constantly changing. We might imagine that present day attitudes are very accepting and open of diversity, only to find that in the future, this era was seen as very restrictive.

With more than 200 sexuality scales developed by people to define sexual orientation, it is not possible to list each variant and again, these may change, become irrelevant or the names may be found offensive in the future, however; the list below defines 20 known sexual orientations in present day representative language (this information is also in the glossary):

- *Allosexual*

The term describes anyone who experiences any sort of sexual attraction. People who identify as Allosexual can be gay, pansexual, lesbian or any other sexual orientation because allosexuality is not connected to gender. Allosexuality opposes asexuality.

- *Androsexual*

Androsexual is a term that describes people who are attracted to people who present themselves as masculine. This type of orientation has little to do with biology, and more to do with the presentation of gender.

- *Asexual/Ace*

Asexual is a term that describes people who do not experience sexual attraction toward other people. People who identify as asexual are often able to feel romantic attraction towards people.

- *Autosexual*

Autosexual is a term that describes an individual's sexual attraction to oneself.

- *Bi-Curious*

Bi-curious is a term that refers to people who are looking to explore bisexuality.

- *Bisexual*

Bisexuality can often overlap with pansexuality, however; the term describes a person who may be romantically, sexually, or emotionally attracted to more than one gender.

- *Closeted*

Closeted, or "in the closet" refers to anyone who exists within the LGBTQIA+ community but does not publicly disclose the truth. Many people who identify as closeted seek to avoid persecution or discrimination, based on their sexual identity.

- *Demisexual*

Those who identify as demisexual feel sexual attraction to people only once they've established a romantic or emotional relationship with, and even after they've formed this bond, sexual attraction does not always occur.

- *Fluid*

A person who identifies as fluid experiences a shift in sexual identity over time, rather than someone who experiences a singular sexual orientation.

- *Gay*

The word *gay* is used to describe someone who is sexually or romantically attracted to a member of the same gender.

- *Greysexual*

People who identify as *greysexual* experience limited sexual attraction, meaning that sexual attraction is rare.

- *Gynesexual*

This term refers to people who are attracted to individuals with more feminine gender presentations rather than androsexual identifying people who are attracted to more masculine presenting people.

- *Heterosexual or Straight*

These two terms refer to people who are only romantically, sexually, or emotionally attracted to people of the opposite sex (i.e. men who are attracted to exclusively women, and women who are exclusively attracted to men).

- *Heteroflexible or homoflexible*

A *heteroflexible* person is mostly heterosexual (someone who is attracted to the same gender), but can occasionally be attracted to the same gender or other genders. Alternatively, a *Homoflexible* person is mostly attracted to people of the same gender, but is sometimes attracted to other genders.

- *Homosexual*

The term *homosexual* is a slightly outdated term; however, it refers to anyone who is attracted to people of the same (or similar) gender.

- *Lesbian*

A *lesbian* is a term that describes a female identifying person who is attracted to other women.

- *Pansexual*

This term refers to people who are attracted to someone regardless of their gender identity.

- *Queer*

Queer is an umbrella term that describes anyone within the LGBTQIA+ community. The dictionary defines the word as something that is "strange;" however, the term has been redefined and reclaimed.

- *Questioning*

This term refers to someone who is questioning their sexual preference or to describe someone who is curious about exploring their sexuality.

- *Sapiosexual*

Someone who identifies as *sapiosexual* is attracted to someone based on their intellect rather than the gender or sex of the other person.

Sidebar 6.2: A Deeper Dive into Asexuality

*"**Asexuality** is like any other identity – at its core it's just a word that people use to help figure themselves out, then communicate that part of themselves to others. If you find the word asexual useful to describe yourself, you may certainly identify as asexual. If you later experience things that indicate you're not asexual, that's fine as well." -AVEN*

Asexuality, or Ace (used interchangeably), is another sexual orientation and is known as an umbrella term. Specifically, however, asexuality refers to little to no sexual attraction towards others. Those who do experience sexual attraction to others are allosexual. Just as there is a spectrum with sexual attraction, asexuality has its own spectrum, with many different sub identities. Aces have different attitudes towards sex, with there being three different types: sex-repulsed, sex-indifferent, and sex-favorable. When one is sex-repulsed, they will not want to partake in sex at all. However, asexuality should not be confused with celibacy. Celibacy is seen as a choice to abstain from sex, whereas asexuality is simply a part of a person (AVEN). Additionally, one's asexuality does not influence or determine their romantic attraction toward others. Some Aces do desire romantic relationships, and those who do not are aromantic.

It is important to note that people who identify as Ace are just as likely to participate in masturbation as non-asexual people. Not all people who identify as asexual masturbate, however; many people who do identify as asexual find pleasure masturbating. Many people view masturbation as a sexual activity, however, masturbating has various functions (see Chapters 4 and 9 for more on masturbation).

The non-sexual gratifying reasons for masturbation given are the same for asexual and non-asexual people. Stress, boredom, help falling asleep, and more are all reasons as to why a person might masturbate. In fact, asexual individuals who masturbate may or may not think of masturbation as sexual at all. People who identify as asexual might view masturbation as an act of self-care, or even an enjoyable task that stimulates their mind, just like all other people.

Asexuality, is a sexual orientation, like other orientations listed above. People who identify as asexual are not participating in celibacy, which is a common

misconception. The lack of sexual attraction is not always associated with the lack of romantic attraction. Just like all sexualities, asexuality exists within a spectrum, and asexual people can develop emotional attraction towards people, and they can be attracted to one, two, or even multiple genders that exist within the gender spectrum. And as we have already stated, sexual fluidity alludes to the fact that someone who is asexual now, may or may not be asexual at a later time. Asexual people hold healthy and long-term monogamous, as well as non-monogamous relationships.

Ace activists have brought attention to being asexual and the representation of media characters has also been slowly growing. David Jay is a prominent figure in the asexual community and creator of the website, The Asexual Visibility and Education Network (AVEN). The website digs deeper into what being asexual means, and answers commonly asked questions. Aces also write their own accounts and stories under the "Asexual Perspectives" tab, and there are links to several forums and blogs that provide greater detail into the lives of asexual people.

Sexual Essentialism and Compulsory Sexuality

Observing sex as a natural force that precedes society and is an essential part of the human condition is also known as sexual essentialism. Sex, as defined by those in power, is what everybody wants, and there is a specific way to have it. This epistemology contrasts with a constructionist viewpoint of sexuality as being contextual based on lived experience; that sexuality is fluid in nature. Similar to sexual essentialism, **compulsory sexuality** speaks to the idea that sexuality and sexual attraction is something everyone experiences. As Kristina Gupta (2015) describes the term, it is "the assumption that all people are sexual and [describes] the social norms and practices that both marginalize various forms of non-sexuality". As we have already observed, archetypal sexuality is non-existent, and people's desires and choices are vast and varied. In a world that sees sex as natural and a biological drive, asexuality is viewed as a type of dysfunction. Phrases such as "it's just a phase" or "you just haven't found the right person" can be hurtful when one's sexuality is being challenged. (Przybylo 2016).

The Kinsey Scale

For generations, people have attempted to understand sexuality as something a person is born with, with the belief that a person's sexual preference can be changed through religion, therapy, torture, or other measures. Although sexual preference can change over time, it is not possible to alter an individual's sexual orientation with various forms of therapy. For example, those wishing to "pray away the gay" with types of "Conversion therapies" do irreparable harm to LBTQIA+ individuals. In Chapter 4, you were introduced to Alfred Kinsey's groundbreaking work, making him one of the classic theorists in the study of human sexuality. In 1949, he along with his colleagues published, *Sexual Behavior in the Human Male (1949)*. Based on their research, Doctors Alfred Kinsey, Wardell Pomeroy, and Clyde Martin created a scale that ranked a person's sexuality on a spectrum from homosexual to heterosexual. In 1949, this was seen as revolutionary. The *Kinsey Scale,* as it was later named, proved that not all people are inherently heterosexual or homosexual; in fact, sexuality exists on a wide spectrum. The Kinsey Scale set a standard for measuring sexuality as existing along a spectrum, rather than what was once thought of as bipolar (heterosexual or homosexual).

Dr. Kinsey's research uncovered that most people aren't absolutely straight or gay/lesbian. Instead of just asking "Do you prefer men or women?" he asked people to report their fantasies, dreams, thoughts, emotional investments in others, and frequency of sexual contact. Based on his findings, he broke sexuality down into a seven-point scale (see below), and reported that most people who identify as straight are actually somewhere between 1 and 3 on the scale, and most people who identify as lesbian/gay are between 3 and 5, meaning most of us are a little bisexual.

0—Exclusively Heterosexual

1—Predominantly heterosexual, incidentally homosexual

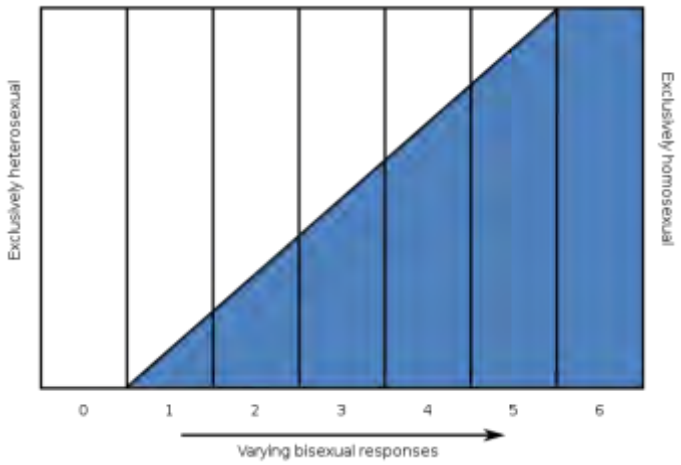
2—Predominantly heterosexual, but more than incidentally homosexual

3—Equally heterosexual and homosexual

4—Predominantly homosexual, but more than incidentally heterosexual

5—Predominantly homosexual, incidentally heterosexual

6—Exclusively Homosexual

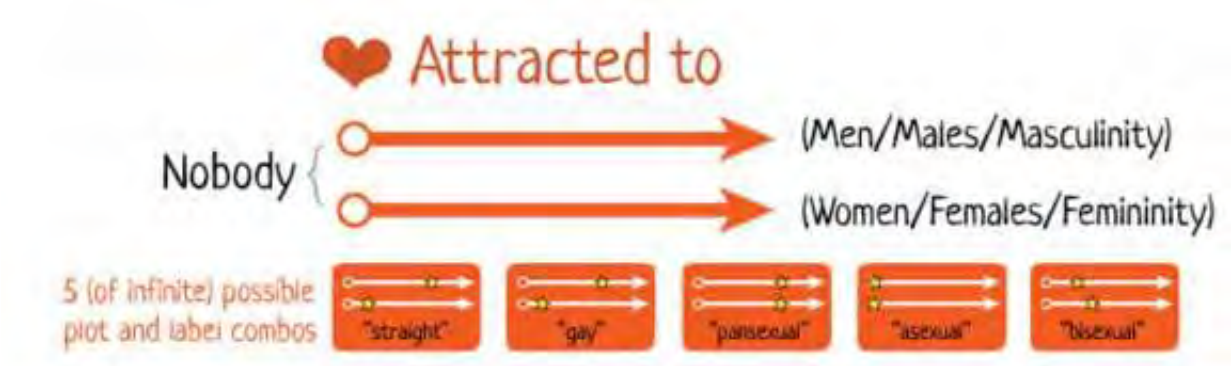


According to the Kinsey Institute, there is not an official Kinsey Test, and the team that developed the Kinsey Scale initially assigned a number to test subjects based on their sexual history. Ultimately, a person's sexuality cannot be fully measured through testing, and can only be defined by an individual's own expression.

The Kinsey Reports do not include all types of sexualities but have helped build a framework for other scales to dive deeper into the spectrum of sexuality. Two noted examples are the Klein Grid | Bi.org and the Storms Sexuality Axis. Over time, people have made adaptations to the Kinsey Scale by developing their own graphics, illustrations, and charts that showcase the fidelity of sexuality.

Decades of research has supported this idea that sexual orientation ranges along a continuum, from exclusive attraction to the opposite sex/gender to exclusive attraction to the same sex/gender (Carroll, 2016).

A more contemporary look at sexual orientation as infinite variations of attraction. A closer examination illustrates this:

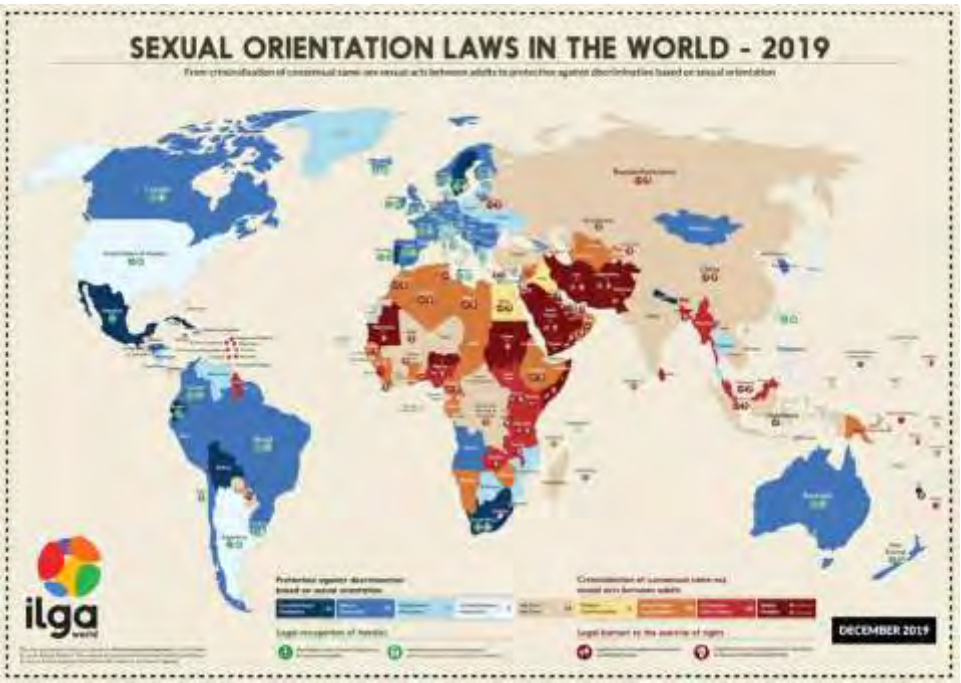


15.8.3: A spectrum of sexual orientation. (Image by it's pronounced METROsexual)

The Lavender Scare

During the 1950s, the United States was filled with fear that communism was seeping into the U.S., and the Federal Government began a public campaign to warn citizens that communism had infiltrated the United States. This time period is commonly referred to as the Red Scare. For queer people, this time period coincided with another moral panic, the Lavender Scare. The U.S. government and most notably, Senator Joe McCarthy began to assert that queer people would be more susceptible to blackmail from the enemy, and government employees who were known to be queer were fired from their jobs. During this time, society started to fear and focus on "the homosexual menace" more than prostitution and masturbation as "[they] were, along with communists, the objects of federal witch hunts and purges" (Rubin, 1984).

Around this time, several organizations were created by LGBTQIA+ people to protect their rights. The Library of Congress has a wonderful history on some of these groups in their LGBTQIA+ Studies Resource Guide. The Mattachine Society - LGBTQIA+ Studies: A Resource Guide and The Daughters of Bilitis - LGBTQIA+ Studies: A Resource Guide.



The data presented in this map is based on State-Sponsored Homophobia, an ILGA World report by Lucas Ramón Mendos. ILGA WORLD

Stonewall

On June 28, 1969, in one of history's first major protests on behalf of equal rights for LGBTQIA+ people, a police raid took place at the **Stonewall Inn**—a popular gay club in New York. This led to an uprising which soon became famously known as the Stonewall Riots. In the 1950's-1960's, homosexuality was not something people could safely be out about, and laws surrounding sodomy essentially made being gay a crime. During this time, legal punishments for homosexuality included large fines or even imprisonment. Members of the LGBTQIA+ community also faced high amounts of discrimination throughout the country, and many people faced physical and emotional abuse for their sexuality. As a way for many LGBTQIA+ people to avoid their displacement from society, many queer people would spend time at gay-friendly bars. Gay bars were known as "safe places" where people could express their sexuality without the fear of judgment, legal punishment, or violence. The Stonewall Inn was one of the gay bars that was a safe haven for many in the LGBTQIA+ community, and rumor has it that it owned by members of the Mafia. While places like the Stonewall Inn were seen as safe places to visit for LGBTQIA+ people, they were not completely free from police. Many times, police would raid Stonewall and charge people with acting upon homosexuality. Transgender and gender non-conforming people were also major targets of mistreatment, adding to the discrimination that existed during this time period.

On that famous June date in 1969, nine police officers raided the Stonewall Inn, but this time, people were not going to take the police violence lightly. Instead, it resulted in a major riot. While the police officers began to arrest patrons of the Stonewall Inn, fights began to break out inside the bar, people began resisting arrest, and people outside the bar began participating. As the riots continued, patrons made their way outside where the nine police officers locked themselves in the bar while they awaited for backup. During this time, rioters set the bar on fire while the mob became larger, attracting thousands of people. The riots continued for four days and ended on July 1, 1969.

The Stonewall Riots became famous, as they exposed the unjust treatment that members of the LGBTQIA+ received during this revolutionary era. While many people did not condone the acts of violence that occurred during the riots, the events of the Stonewall Riots created a long lasting legacy, which helped pave the way for LGBTQIA+ equity. Not only did the historic riots give voice to gay communities, they also opened opportunities around advocating for other marginalized people for their gender expression or sexual identity. Following the riots, the first Gay Pride event was organized. In 2016, President Obama made the site of the Stonewall Inn a historic site, marking the first National monument that celebrates LGBTQIA+ history. As a result of the Stonewall Riots, LGBTQIA+ communities began to be seen as more acceptable in society. Additionally, Pride events have become a yearly worldwide tradition, where the month of June is now known as Gay Pride Month.

Sidebar 6.3: More to know: Stonewall

The Stonewall Riots set the stage for LGBTQ+ equality across the United States, yet many people are unfamiliar with the relevance of the famous riots. Following the riots, gay rights began to be seen as more normalized; however, gay marriage was not federally legalized until 2015.

[The Stonewall riots - what happened and why | VideoScribe]

Homosexuality and Psychology

Psychology and sex have a long history. Another early thinker in the field of human sexuality, the controversial Sigmund Freud, was concerned with human sexuality as an indicator of mental wellness. Although he based his understanding from an essentialist viewpoint, and saw homosexuality as just a deviation of inborn unfocused sexual libido, he acted with empathy when parents of gay children would write to him and express their concern over their children's sexuality.

The field of Psychology writ large uses tools to help support and explain human conditions of the mind. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a psychological guide that is widely used in the United States. as a way to diagnose and treat mental disorders. The manual has a long history of identifying seemingly normal practices in the 21st century as mental illnesses. In the 1950's, the DSM identified homosexuality as a mental disorder. In addition to homosexuality being classified as a psychological disorder, older versions of the DSM have classified things like interracial relationships and gender dysphoria as a mental illness (all of which has been removed from the DSM), but it is still held as a resource for understanding and diagnosis. The 1960's was an important time in the history of Psychology because open homosexuality became more visible, which allowed for more research regarding homosexuality, gender, and other topics.

In the 1960's, Evelyn Hooker, an American Psychologist affiliated with UCLA, studied her homosexual neighbors, and by administering psychological tests (such as ink blot exams) discovered people who identified as homosexual were not mentally ill. In fact, Hooker noted that homosexual people do not have psychological differences from heterosexual people. Hooker's studies on homosexuality were given credence, and as a result, in 1973, homosexuality was no longer listed as a mental illness in the DSM, unless it bothered the individual, and in 1980, homosexuality was removed from the DSM completely.

Homosexuality being removed from the DSM was an important step for the American Psychological Association, because it played a major role in eliminating the stigma of homosexuality on a national level. Although homosexuality is not considered to be a mental illness now, homophobic hate crimes continue worldwide, and it is important to note that inequities within LGBTQIA+ communities still exist, even in the 21st century.

Sidebar 6.4: Cha-Cha-Cha Changes of a Gay Man's Life

I turned 23 in 1978, and had begun to accept that I am gay. I was close to graduating from an Art and Design College, and I lived in the charming 'German Village' district of Columbus, Ohio. Being gay in the late 70's and being young meant that life was exciting! I met guys at bars, sometimes involving sex afterwards, but often, just to have friendships develop. Disco was big, and you could lose yourself in the music, or watch others from the side of the crowded rooms. There was no big 'danger' from sex, and that was liberating. And clubs could be old music halls turned into magical clubs, with personalities like Grace Jones lighting up the stage.

Work was fine, and friends were plenty. I was part of a gay bowling league with 20 teams of 4 men each. It wasn't all about sex, it was about comradery, kidding with each other, and then perhaps an electric connection, who knew? In 1979, I moved to Houston, and the "volume" of life turned up loud. Bigger gay district, bigger clubs and leather bars, and more men to choose from. I met the man who became a sometimes lover the 3rd day I arrived in Houston. I think that set me up for a version of monogamy, at least the gay version, where you stayed with someone, broke up to go fool around with other guys, then got back together because you really loved the guy. That went on for a couple of years before I realized it wasn't going anywhere. And then I got a job offer to move to Dallas. A raise, more design opportunities, and a new start, how could I resist? So life began again, and I was happy being single, new in town, and had settled into the Texas gay mentality. You wore a western hat, boots of course, and either a tight T or a leather vest. At least, that was the young gay version of cool at the time. And life was fun, full of work challenges. I met and kind of fell for Richard, a tall hot guy who managed one of the gay Western bars. It was easy to hang out, and the relationship had no strings attached. Then I met Rand and fell in love for real! I was about 28 and we were everything to each other. We bought a house on the south neighborhood of Dallas where other gay couples were setting up households. There were 4 other gay couples on the street we lived on, and it was easy to find domestic bliss. But this was 1986, and the storm of AIDS was happening. All at once the bliss of young love was tested and we began to lose friends. It was nothing short of horrific. The first guy I knew who got sick, then died, was the hot manager Richard. It was brutal to see him wither away. So Rand and I got tested, and we both tested positive. Our

friendly gay neighbors and friends were all facing the same demon. We had weekly meetings to share any new information on how to stay safe, what sort of progress was developed to manage or cure the disease, and what we could do to help others.

And yet, despite all this desperation and misery, we were still able to enjoy life, have fun, and raise money for charity and relief efforts. We joined with others for the March on Washington, and got married in the group marriage ceremony. It wasn't legal, but we had a marriage certificate, so it was real enough for us. By 1989, Dallas had changed. The economy had tanked, Rand, who was an artist, wasn't finding much work. So I searched for a job and was offered one in San Francisco. It was the perfect move. San Francisco had the leading edge HIV/AIDS doctors, and we wanted to survive the devastation of our 'brothers.' And San Francisco, which I had visited in the thrill of the late 70's, was still the gay Mecca. The famous Castro neighborhood still had impromptu parties that shut down the corner of 18th at Castro, and holidays were still elaborately celebrated. It was fun until it wasn't. Rand started getting sick in 1991/92, and even though we fought the fight, I lost him in 1993. He was only 33, and that was crushing. Several months later, as I was wallowing in the loss, my downstairs neighbors invited me to join them for a weekend at the Russian River, about an hour north of San Francisco. We laughed, forgot the troubles of the moment, and once more, I found myself hopeful. I am, as you might have guessed, an eternal optimist. I met a guy there who changed my life again, J. J challenged me to a pinball game, and we chatted like we were old friends. He lived in the area, and invited me to come up some time. And that's how I discovered the real joys of Northern California and the healing of the redwoods. We got closer, had mutual friends, and I fell again. But it wasn't to be. J died two years later from complications from HIV/AIDS, and I was again left mourning what might have been.

About four months after J's death, life changed again. I lived part-time in Occidental in the Redwoods, in a house I rented with J, and was in a tough roommate situation in SF. A friend who had an extra room in the Castro asked if I wanted to move to his place. He had a friend help me move in and wanted us to meet. I would never have guessed that day would change my life! T was the friend who helped me move, and we connected instantly; it was like lightning in a bottle. My friend who invited me to move in recognized the attraction, and gracefully exited so that we could grab each

other. But, I was not ready for any relationship, and T had also lost a lover of 10 years to HIV/AIDS, and didn't want anything serious. We resisted any relationship, but kept seeing each other. I'd be over at his place in the city, then he would come up to Occidental and we would get lost in the joys of new lust. We were comparable, fit together, and despite the drama of life, kept seeing each other. We both had AIDS but were 'healthy,' in that relative term that is now used for asymptomatic. A year passed, we were still very much in love, and decided to take the leap of a relationship again. Neither of us wanted the other to have to see the other suffer from what could happen, but why resist? Yes, there were lots of dramatic events, health crises for each of us, but the joy of living again, and the new medications that allowed us to see another day, another year, why give up on love?

So, now 26 years have come and gone. We, who never expected to see 40, or 50, are now close to 70 and going strong! Sex is still good, we are still actively enjoying each other, but with a sense of contentment. Our commitment to not sweating the little stuff keeps us grounded, and our private jokes that only the other one understands are still worth a giggle. It's rather amazing to shift from passionate, uncontrollable sex to sensual, comfortable sex, and is actually really satisfying. I'd never have guessed that I could be content and still look to a future without cringing at the possible outcome. Life can all change in an instant, but isn't that true for everyone anyway? I say, why not enjoy the ride.

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The HIV/AIDS Pandemic

The HIV/AIDS pandemic (also discussed in Chapter 12) was devastating for the queer community. For quite some time, the public mistakenly assumed that the virus only affected gay people, particularly gay men, and was even labeled as a "gay cancer" (HIV.org n.d.). Worldwide HIV has taken over 36 million lives. Health officials in the United States first noticed the virus on June 5, 1981, when five gay men were hospitalized with notable infections and failing immune systems, but it wasn't until September 17, 1985, where President Ronald Reagan publicly spoke on the issue and claimed HIV then to be a priority of his (HIV.org n.d.).

Within that time frame, thousands were dying and desperate to do whatever possible to save the lives of themselves and their loved ones. Queer people and allies would look after their sick friends, and because of the slow reaction from the government, they would meet with others to organize for action. As a result of this organizing, one major coalition was formed, the AIDS Coalition to Unleash Power (ACT UP).

ACT UP would protest against misinformation and rally when they felt organizations were not acting with haste. They protested against New York City Hall, the Food and Drug Administration, Wall Street, St. Patrick's Cathedral, and more (United in Anger). Within ACT UP, there were affinity groups with different focuses, and people would use their knowledge and experiences to strategize. These affinity groups strengthened the sense of trust within the entire movement, and helped individual affinity groups feel a strong sense of support and belonging.

Sidebar 6.5: No longer a death sentence

Because of the painful history, HIV was stigmatized and labeled as a death sentence, even within the LGBTQ+ community. Just like COVID-19, when HIV first appeared, it was terrifying, and there was no treatment. In the 1980s, people were almost certain to die from it. Medical science has come a long way in the treatment of HIV, and now it is treatable with medication. HIV is also easily prevented with proper condom use. While HIV is not currently curable, HIV positive individuals can live long and healthy lives without transmitting the virus, if given the right medication, and can actually get to what is known as undetectable, meaning the virus is no longer showing up in your system. The following clip describes this. HIV: Journey to Undetectable

Marriage Equality and Current Social Movements

In 2015, marriage equality was legalized in the United States. Prior to this, certain states legalized marriage for same sex couples, but it was not a national right. Marriage as an institution has been policed by the government throughout the history of the U.S. Until the 1967 landmark case *Loving v. Virginia*, people of different ethnicities, specifically Black and White people, were not allowed to marry, which today seems absurd, but this is yet another example of how laws and policies serve as mechanisms of social control. The 2015 Marriage Equality Act allowed for same sex couples to access all rights and privilege of opposite sex couples receive as a result of getting married. Sanctioning marriage at the legal level for same sex couples was a major accomplishment that has benefitted the queer community. Currently, there are currently 31 countries that have legalized same-sex marriage (HRC.org).

While many view same-sex marriage as a major win within the LGBTQ+ community, many also agree that there is still a lot more work to be done to garner equal rights. Current LGBTQ+ movements take a variety of different approaches, which focus on multiple issues. The Human Rights Campaign remains a notable organization, and is often credited to be the largest advocacy group for the LGBTQ+ community. They keep track of current legislative issues that impact the community, and also keep track of where states stand on specific forms of legislation. These topics include employment, housing, anti-conversion therapy, education, hate crimes, discrimination in child welfare services, and more (HRC n.d.).

While big cities like San Francisco and New York are filled with a rich queer history, queer people are present all over the world, and often are not as fortunate to reside in those places. There are often local national organizations accessible via the Internet that one can visit to find support and solidarity. These organizations can provide support for several aspects of life and connect queer people to others. In Marin County, an area just north of San Francisco, where this textbook originated from, exists the Spahr Center. The Spahr Center is charged with "serving, supporting and empowering" the LGBT community present in the county, along with those who are living with HIV/AIDS, and provide a number of other social services.

There is usually some proposed legislation surrounding the rights of the queer community in motion as well, whether it be local, statewide, or nationwide. The

community is made up of a variety of people with differing skill sets, and their organizing has always been strong with fruitful results, despite always having to fight an uphill battle to seek change. While marriage equality did become the law of the land in 2015, speculation is brewing that since the Supreme Court may attempt to overturn Roe V Wade, that overturning marriage equality may be next on their agenda.

Don’t say Gay Bill in Florida

In a 22 to 17 vote, The Florida House and Senate passed the Parental Rights and Education bill, more commonly known as the ‘Don’t Say Gay’ bill, in 2022. The bill is designed to restrict and limit information that can be taught in Florida schools regarding sexual orientation and gender. The piece of legislation explicitly states that students cannot be taught about sexual orientation and gender from Kindergarten to Third grade, and the bill even allows for parents to sue schools and/or teachers that participate in the teaching of sexual orientation and/or gender. The recently passed piece of legislation is an example of revisionist history to serve a political agenda, and is extremely harmful to queer youth. Without equal representation within classrooms, the rights of LGBTQIA+ students are compromised. Instead of the Florida public schools acting as a safe place for LGBTQIA+ students, the state is playing a major role in perpetuating falsehoods about sexual orientation, alluding to the notion that heterosexuality is all they need to know. Unfortunately, the majority of House and Senate government officials in Florida believe that sexuality should not be discussed in schools, and that conversations regarding orientation should only be discussed at home.

Despite countless protests, Governor Ron DeSantis signed the bill into law in March of 2022. According to NPR, when referring to education surrounding LGBTQIA+ issues, Governor DeSantis said that "it's not something that's appropriate for any place, but especially not in Florida '' (Diaz, 2022). While the piece of legislation is incredibly discriminatory, the bill is dangerous because it creates a baseline for other states, cities and counties to introduce ‘copy cat’ legislation that will further marginalize LGBTQIA+ communities. LGBTQIA+ movements have made incredible advancements throughout the last 60 years, but bills like this cast a dark cloud over past significant advancements made within the United States. The bill follows the recent leaked draft of a possible Supreme Court ruling that could deny abortions to

millions of people throughout the county. Laws that protect the LGBTQIA+ community, along with reproductive rights have often been a target of conservative political agendas, despite a majority of the U.S. not supporting these agendas.

With Roe v. Wade being overturned by The Supreme Court in 2022, many people are asking if marriage equality will be next? History tells us that when social advancements occur within the United States, there is an even larger resistance that follows. It often feels like we take one step forward and then two steps back. Only time will tell the future of LGBTQIA+ representation in the United States, but vigilance on the part of equal rights advocates must remain. The resistance against equal rights is often steeped in discriminatory and false ideologies about gay people as a whole, and also claiming that liberals are grooming children to be gay. The Human Rights Campaign published an analysis of the US Census Bureau's reporting, which showed that over 20 million people identified as members of the LGBTQIA+ community, or nearly 10% of the American population. While the demographics of the United States are changing rapidly, and more people are feeling safe to be open about their sexual orientation, LGBTQIA+ people are still facing discrimination. According to the Department of Justice, approximately 20% of the incidents of hate crimes in the U. S. are based on sexual orientation. Sadly, as more legal rights and privileges are conferred to LGBTQIA+ community, backlash sometimes follows.

Unveiling the Truth: Heteronormativity & Cisnormativity

Sexual orientation and gender identity often fall under the same umbrella when it comes to understanding human sexuality, but as we covered in both this chapter and the previous one, they are two different aspects of the self. Sexual orientation describes a person's patterns of emotional, romantic, and/or sexual attraction to another person, while gender identity refers to an individual's own gender. Gender identity can be the same as someone's assigned sex, but it can also be different. Both gender identity and sexual orientation are larger than a binary, and may shift throughout a person's lifetime.

Heteronormativity is the assumption that all people are heterosexual, and that there are no other types of sexuality. (Cis)normativity has more to do with gender, in that it is the assumption that all individuals identify with a role that corresponds to the sex assigned to them at birth (cisgendered). Understanding human sexuality

through a Cisgendered, heteronormative lens automatically, labels LGBTQIA+ people as abnormal. These types of microaggressions are destructive whether intentional or unintentional, and discount the reality of entire groups of people. Microaggressions maintain heteronormativity and/or cisnormativity by invalidating non-hetero or trans folx lived experiences. An example of this could be is when a cisgendered, heterosexual female asks a cis-gendered lesbian female if they have a boyfriend. Another could be if a cisgendered male expresses hostility over a transgender male who uses a men's bathroom. The previous example is an act of a microaggression, but tragically, in some cases trans males have been assaulted while just trying to use the restroom.

Heteronormativity and cisnormativity are built into the fabric of American culture, which can cause many queer identifying people to hide their true selves from their friends and family. Unfortunately, sexual orientation and gender identity are stratified concepts in society. The hope is that one day in the near future, it'll be okay to be who you are without worry of backlash and discrimination, but until then, the need for solidarity is critical. There are solutions for overcoming the harmful effects of heteronormativity and cisnormativity. Speaking truth to power is one way to move the conversation forward. Allies are critical in the struggle. Here are a few organizations to check out: PFLAG |, About GLAAD,LGBTQ Youth Resources | Lesbian, Gay, Bisexual, and Transgender Health | CDC, LGBTQIA+ Resources - Positive Images

If you are a person who is questioning your sexual identity or gender identity, surrounding yourself with open minded people who are a part of the LGBTQIA+ community, or those who affirm your own identity will help you feel supported. Remember, one of the goals of this textbook is radical self-love so be sure to practice self-love now! If you are getting harmful rhetoric from friends or family members that make you feel ashamed of your sexual and/or gender identity, get help setting some boundaries, especially if it is negatively affecting your life. Sometimes, your chosen family can be who you need to turn to if your blood family is unable to accept you just exactly as you are. Just know that you are valued, and there is a community out there ready to invite you in.

Sidebar 6.6: A Brief History of Bad Sex Ed

Why does the United States do such a dismal job regarding sexual education? Was it always this bad? Is it worse now? What is the history of Sex Ed in the U.S.? Watch and see: Sex Education In America: A Brief History

Sex Education & LGBTQIA+ Young People

As we have discussed throughout this textbook, sexual education for children consists of teachers encouraging boys to wear condoms and girls to use birth control. While condoms are helpful in preventing unwanted pregnancies and STIs, it is not a comprehensive form of sexual education. A healthy sexual education will provide a knowledge of sex, work to develop equitable values associated with sex, and it will teach young people the importance of consent. Sex education prepares people for a pleasurable sex life, and it also teaches young people how to prevent problems associated with sex. A well designed sexual education program will promote healthy behavior. It will also instruct children on a wide variety of sexual practices as a way to promote inclusivity and sexual wellness. This shift will benefit all students, not just students that identify as cisgendered and/or heterosexual.

Comprehensive and affirming sex education courses must be designed to promote LGBTQIA+ inclusive material, so that all children learn about all aspects of Human Sexuality. Because queer people are disproportionately affected by negative sexual outcomes associated with sex education, it is especially important for their safety and well-being. According to Hannah Slater in their 2013 article entitled, *LGBT-Inclusive Sex Education Means Healthier Youth and Safer Schools,* "Young men who have sex with men, who may identify as gay or bisexual, account for more than two-thirds of new HIV infections among people ages 13 to 29." Additionally, young women who identify as lesbian or bisexual are more likely to contract an STI, compared to young heterosexual women (Slater, 2013). A major problem associated with current educational models that focus on sexual health and wellness is that gender identity and sexual orientation is typically excluded from the conversation.

Not only does non-inclusive sex education marginalize LGBTQIA+ youth from the perceived social norms associated with their sexuality, it can also play a role in the negative stereotypes about non-heterosexual relationships, and can create hostile academic and social environments for queer youth. Non-inclusive sex education may also play a role in developing unsafe sex practices for queer youth when they are ready to have sex.

Conclusion

Our sexual orientation is the direction of our sexual feelings. Contrary to previous definitions, it is not a simple binary, but actually exists on a spectrum. Sexuality is not fixed in all people, but rather, is fluid, and may change over time. As definitions of varying sexual orientations shift, more terms may be added, but to date there are at least 20 recognized types of sexual orientations. In 1949, sex researcher Alfred Kinsey developed a 7 point scale to identify sexual orientation, and found based on interview data that most people were not exclusively heterosexual or homosexual, but in fact fell somewhere in the middle of scale. Aside from who we are attracted to, studies of gay and straight individuals found no other difference in the overall psychological assessment of those studied. This prompted the removal of homosexuality as a mental illness in the DSM.

The HIV pandemic in the 1980s was especially detrimental to the gay community in the United States and over 36 million people have dies of the disease worldwide. New medical advances have made the virus less deadly, and many HIV+ people live relatively normal lives with the help of medical intervention. Policies around LGBTQIA+ rights are often being challenged by conservative politicians, and hate crimes still remain prevalent based on sexual orientation. Switching the script of heteronormativity in sex education to inclusive content will help everyone learn more about the variety of sexual orientations. By doing so, a more accepting climate for queer and questioning youth is possible.

Glossary (Most of these are also listed in the text)

1. **Allosexual** This term describes anyone who experiences any sort of sexual attraction. People who identify as Allosexual can be gay, pansexual, lesbian or any other sexual orientation because allosexuality is not connected to gender. Allosexuality opposes asexuality.
2. **Androsexual** Androsexual is a term that describes people who are attracted to people who present themselves as masculine. This type of orientation has little to do with biology and more to do with the presentation of gender.
3. **Asexual** Asexual is a term that describes people who do not experience sexual attraction toward other people. People who identify as asexual are often able to feel romantic attraction towards people.
4. **Autosexual** Autosexual is a term that describes an individual's sexual attraction to oneself.
5. **Bi-Curious** Bi-curious is a term that refers to people who are looking to explore bisexuality.
6. **Bisexual** Bisexuality can often overlap with pansexuality, however; the term describes a person who may be romantically, sexually, or emotionally attracted to more than one gender.
7. **Closeted** or "in the closet" refers to anyone who exists within the LGBTQIA+ community but does not publicly disclose the truth. Many people who identify as closeted seek to avoid persecution or discrimination based on their sexual identity.
8. **Demisexual** Similar to asexuality, those who identify as demisexual often feel sexual attraction to people they've established a romantic or emotional relationship with.

9. **Fluid** A person who identifies as fluid experiences a shift in sexual identity over time rather than someone how experiences a singular sexual orientation.

10. **Gay** The word *gay* is used to describe someone who is sexually or romantically attracted to a member of the same gender.

11. **Greysexual** People who identify as *greysexual* experience limited sexual attraction, meaning that sexual attraction is rare.

12. **Gynesexual** This term refers to people who are attracted to individuals with more feminine gender presentations rather than androsexual identifying people who are attracted to more masculine presenting people.

13. **Heteronormativity**, the ways in which heterosexuality is normalized through myriad practices, so that it becomes naturalized as the only legitimate form of sexuality.

14. **Heterosexual or Straight** These two terms refer to people who are only romantically, sexually, or emotionally attracted to people of the opposite sex (ie men who are attracted to exclusively women and women who are exclusively attracted to men).

15. **Heteroflexible or homoflexible** A *heteroflexible* person is mostly heterosexual (someone who is attracted to the same gender) but can occasionally be attracted to the same gender or other genders. Alternatively, a *Homoflexible* person is mostly attracted to people of the same gender, but is sometimes attracted to other genders.

16. **Homosexual** The term *homosexual* is a slightly outdated term, however; it refers to to anyone who is attracted to people of the same (or similar) gender.

17. **Lesbian** A *lesbian* is a term that describes a female identifying person who is attracted to other women.

18. **Pansexual** This term refers to people who are attracted to someone regardless of their gender identity.

19. **Queer** *Queer* is an umbrella term that describes anyone within the LGBTQIA+ community. The dictionary defines the word as something that is “strange”, however; the term has been redefined and reclaimed.
20. **Questioning** This term refers to someone who is questioning their sexual preference or to describe someone who is curious about exploring their sexuality.
21. **Sapiosexual** Someone who identifies as *sapiosexual* is attracted to someone based on their intellect rather than the gender or sex of the other person.
22. **Sexual fluidity** one or more changes in a person’s sexuality or sexual identity.

Discussion Questions

1. What are some of the characteristics of pansexuality? How might it differ from bisexuality?
2. What happened at the Stonewall Inn on June 28, 1969 and why is it significant?
3. What is the Kinsey Scale?
4. How does sexual orientation intersect with other aspects of self like gender, race or age?
5. What if sexual orientation was not looked at in terms of heteronormativity? People just were who they were? What would be different, individually and culturally?

Multiple Choice

1. The term sexual orientation can be defined as:

    a. A term that refers to individuals who identify with the behaviors and characteristics that are opposite of their biological sex.

b. A phase which a person outgrows before entering heterosexuality.
c. A person's emotional and sexual attraction to a particular sex.
d. A person's biological gender.

2.. There is not a finite number of sexual identities and it should be noted that the meanings of these labels often change due to social or cultural settings.

a. True
b. False

3. Sexual fluidity is not a term that encompasses the many different ways that people experience desire.

a. True
b. False

4. Which of the following terms could define a person's sexuality?

a. Gay
b. Queer
c. Fluid
d. All of the above

5. People who do not feel romantic attraction towards someone but could feel sexually attracted to the same person could identify as:

a. Aromantic
b. Asexual
c. Fluid
d. A and C

6. People who identify as asexual are just as likely to masturbate as any other people.

a. True
b. False

7. There is ____ scientific consensus regarding the exact reasons why an individual holds a particular sexual orientation

a. no
b. some
c. great
d. limited

8. A society is called _____ when it supports heterosexuality as the norm

a. heteronormative
b. puberty
c. sexuality
d. sexual normative

9. What year did the American Psychiatric Association remove homosexuality as an "illness" classification in its diagnostic manual, the DSM?

a. 1973
b. 1999
c. 1951
d. 1955

10. Throughout the 1980's the _____ contributed to the demands for compassion, medical funding, and renewed coalitions

a. HIV/AIDS epidemic
b. military

c. political action
d. publishing houses

For Further Exploration

- Asexuality: A Brief Introduction
    - http://www.asexualityarchive.com/wp-content/uploads/2012/05/AsexualityABriefIntroduction.pdf
- GLBT Historical Society - Museums and Archives
    - https://www.glbthistory.org/online-resources
- Human Rights Campaign
    - https://www.hrc.org/
    - https://www.hrc.org/resources/state-maps
- The Asexual Visibility and Education Network (AVEN)
    - http://www.asexuality.org/
- The Spahr Center
    - https://thespahrcenter.org/
- Terms and meanings
    - https://www.healthline.com/health/different-types-of-sexuality#d-l

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Chapter 7: Bias and Discrimination in Human Sexuality

Learning Objectives

After completing this module, students should have a working knowledge of:

- An Understanding of Bias and Discrimination
- Social Constructionism and how it relates to Bias and Discrimination
- An Overview of a Sample of Marginalized Groups
- A Shift in Sexual Freedom for All

Introduction

Society is made up of classifications and types, including people, professions, material objects, and political parties. This process serves to place people into categories that are easily identifiable. Understanding that we use these classifications or labels to create meaning is part of how humans operate. It is when these classifications are also assigned value where discrimination and bias take

place. Sometimes classifications leave those who do not fit a category we assign a positive value to be viewed in discriminatory ways or made invisible altogether. A social constructionist view allows us to see sexuality as created and defined by people, rather than an essential fixed way of being. Our media system shapes the ways in which we view our sexuality, in reference to the cultural norms we internalize by consuming media. When we are viewed as either invisible or as a negative in regard to sexuality, we experience discrimination. Chapter 4 introduced us to the notion of pleasure and the many ways people of all types enjoy pleasure. Here we will look at ways in bias and discrimination interfere with all people enjoying what is intrinsically their own expression of their sexuality, sensuality and the erotic. As an introductory example, our gender binary, those who do not identify as strictly, singularly, male or female, have been left out of the equation as though they do not exist, and their enjoyment of sexuality is not part of the normative sexual script we are taught to follow. Persons with disabilities are not perceived to have any sort of sexual self. We will also examine how grouping individuals into one box can be detrimental to their survival, as seen with African Americans who have a deep history in the U.S. as not being viewed as equal, rather as property, and have also been heavily stereotyped as hypersexual.

Author's note: Space and time for one chapter in a book do not afford us the opportunity to dive deep enough into the vast and varied examples of bias and discrimination. We hope this will serve as an introduction, and that the reader will take it upon themselves to further explore the ways in which bias and discrimination intersect with our sexuality. We will offer resources for further investigation and invite readers to share resources they find instructive to the topic. One resource for a continued conversation on bias is: Sociology Student Work | School of Interdisciplinary Arts and Sciences | University of Washington Tacoma

Bias and Identity

Fingerprint in Art. Adaiyaalam. 2011. Creative Commons Attribution-Share Alike 3.0

As society evolves and shifts in discourse happen, we are able to acknowledge that a lot of our biases and implicit biases are socially constructed and based in historical traumas built into patriarchal structures. **Bias** can be defined as, "Prejudice for or against one thing, person or group compared to another, usually in a way considered to be unfair" and **implicit bias** is defined as, "when we have attitudes towards people or groups of people or associate stereotypes with them without our conscious knowledge. A fairly commonplace example of this is seen in studies that show that white people will frequently associate criminality with black people without even realizing they are doing it" (New York Institute of Technology, 2020). In this chapter, we will discuss the social constructions we continue to hold in high regard, along with their negative outcomes, such as sexism, heteronormativity, racism, classism, ableism, ageism, and colorism.

Thanks to the important critiques of transnational, post-colonial, queer, trans and feminists of color, most contemporary WGSS [Women, Gender, Sexuality Studies] scholars strive to see the world through the lens of **intersectionality**. That is, they see systems of oppression working in concert, rather than separately and independently. For instance, the way sexism is experienced depends not only on a person's gender, but also on how the person experiences racism, economic inequality, ageism, and other forms of marginalization within particular historical and cultural contexts.

Feminism is not a single school of thought, but rather, encompasses diverse theories and analytical perspectives—such as socialist feminist theories, radical sex feminist theories, black feminist theories, queer feminist theories, transfeminist theories, feminist disability theories, and intersectional feminist theories. The common thread in all these feminist theories is the belief that knowledge is shaped by the political and social context in which it is made (Scott 1991). Acknowledging that all knowledge is constructed by individuals inhabiting particular social locations, feminist theorists argue that **reflexivity**—understanding how one's social position influences the ways that they understand the world—is of utmost necessity when creating theory and knowledge. As people occupy particular social locations in terms of race, class, ethnicity, gender, sexuality, age, and ability, these **multiple identities** act in combination at the same time to shape social experiences. At certain times, specific dimensions of their identities may be more salient than at others, but at no time is anyone without multiple identities. Thus, categories of identity are intersectional, influencing the experiences that individuals have and the ways they see and understand the world around them.

In the United States, we often are taught to think that people are self-activating, self-actualizing individuals. We repeatedly hear that everyone is unique, and that everyone has an equal chance to make something of themselves. Sociologists call a place where this would take place, a meritocracy. While feminists also believe that people have **agency**— the ability to influence the direction of their lives—they also argue that an individual's agency is limited or enhanced by their social position. A powerful way to understand oneself and one's multiple identities is to situate one's experiences within multiple **levels of analysis—micro –** (individual), **meso-** (group), **macro-** (structural), and **global**. These levels of analysis offer different analytical approaches to understanding a social phenomenon. Connecting personal experiences to larger, structural forces of race, gender, ethnicity, class, sexuality, and ability allows for a more powerful understanding of how our own lives are shaped by forces greater than ourselves, and how we might work to change these larger forces of inequality. Like a microscope that is initially set on a view of the most minute parts of a cell, moving back to see the whole of the cell, and then pulling one's eye away from the microscope to see the whole of the organism, these levels of analysis allow us to situate day-to-day experiences and phenomena within broader, structural processes that shape whole populations. The **micro** level is that which we, as individuals, live everyday—interacting with other people on the street, in the classroom, or while we are at a party or a social gathering. Therefore,

the micro-level is the level of analysis focused on individuals' experiences. The **meso** level of analysis moves the microscope back, seeing how groups, communities and organizations structure social life. A meso level-analysis might look at how churches shape gender expectations for women, how schools teach students to become girls and boys, or how workplace policies make gender transition and recognition either easier or harder for trans and gender nonconforming workers. The **macro** level consists of government policies, programs, and institutions, as well as ideologies and categories of identity. In this way, the macro level involves national power structures, as well as cultural ideas about different groups of people, based on race, class, gender, and sexuality spread through various national institutions, such as media, education and policy. Finally, the **global** level of analysis includes transnational production, trade, and migration, global capitalism, and transnational trade and legal bodies (such as the International Monetary Fund, the United Nations, the World Trade Organization). These larger transnational forces that affect our personal lives but that we often ignore or fail to see.

Recognizing how forces greater than ourselves operate in shaping the successes and failures we typically attribute to individual decisions allows us to see how inequalities are patterned by race, class, gender, and sexuality. Approaching these issues through multiple levels of analysis—at the micro, meso, and macro/global levels—gives a more integrative and complete understanding of both personal experience, and the ways in which macro structures affect the people who live within them. So if we look at sexuality or how someone is allowed to express their sexuality through multiple levels of analysis, we can connect what is experienced at the micro level as personal problems, like a person who's sexuality identity is questioned or shamed, to macro-economic, cultural, and social problems. For example, an entire demographic of people not able to access reproductive services or education. This not only gives us the ability to develop socially-lived theory, but also allows us to organize with other people who feel similar effects from the same economic, cultural, and social problems in order to challenge and change these problems.

Conceptualizing Structures of Power

i threw a guitar at him.2020.Creative Commons Attribution 2.0

A **social structure** is a set of long-lasting social relationships, practices and institutions that can be difficult to see at work in our daily lives. They are intangible social relations, but work much in the same way as structures we can see: buildings and skeletal systems are two examples. The human body is structured by bones; that is to say that the rest of our bodies' organs and vessels are where they are because bones provide the structure upon which these other things can reside. Structures limit possibility, but they are not fundamentally unchangeable. For instance, our bones may deteriorate over time, suffer acute injuries, or be affected by disease, but they never spontaneously change location or disappear into thin air. Such is the way with social structures.

The elements of a social structure, the parts of social life that direct possible actions, are the institutions of society. These will be addressed in more detail later, but for now **social institutions** may be understood to include: the government, work, education, family, law, media, and medicine, among others. To say these institutions direct, or structure, possible social action, means that within the confines of these spaces, there are rules, norms, and procedures that limit what actions are possible. For instance, family is a concept near and dear to most, but historically and culturally, family forms have been highly defined and structured. According to Dorothy Smith (1993), the standard North American family includes two married, heterosexual parents and one or more biologically-related children. It also includes a division of labor, in which the husband/father earns a larger income and the wife/mother takes responsibility for most of the care-taking and

childrearing. Although families vary in all sorts of ways, this is the norm to which they are most often compared. Thus, while we may consider our pets, friends, and lovers as family, the state, the legal system, and the media do not affirm these possibilities in the way they affirm the SNAF. In turn, when most people think of who is in their family, the normative notion of parents and children are the structures that they consider.

Overlaying these social structures are **structures of power**. By **power** we mean two things: 1) access to and through the various social institutions mentioned above, and 2) processes of privileging, normalizing, and valuing certain identities over others. This definition of power highlights the structural, institutional nature of power, while also highlighting the ways in which culture works in the creation and privileging of certain categories of people. Power in American society is organized along the axis of gender, race, class, sexuality, ability, age, nation, and religious identities. Some identities are more highly valued, or more normalized, than others—typically because they are contrasted to identities thought to be less valuable or less "normal." Thus, identities are not only descriptors of individuals, but grant a certain amount of collective access to the institutions of social life. This is not to say, for instance, that all white people are alike and wield the same amount of power over all people of color. It *does* mean that white, middle-class women as a group tend to hold more social power than middle-class women of color. This is where the concept of **intersectionality** is key. All individuals have multiple aspects of identity, and simultaneously experience some **privileges** due to their socially valued identity statuses, and disadvantages due to their devalued identity statuses. Thus a white, heterosexual middle-class woman may be disadvantaged compared to a white middle-class man, but she may experience advantages in different contexts in relation to a black, heterosexual middle-class woman, or a white, heterosexual working-class man, or a white lesbian upper-class woman.

At the higher level of social structure, we can see that some people have greater access to resources and institutionalized power across the board than others. **Sexism** is the term we use for discrimination and blocked access women face. **Genderism** describes discrimination and blocked access that transgender and other non-binary people face. **Racism** describes discrimination and blocked access on the basis of race, which is based on socially-constructed meanings rather than

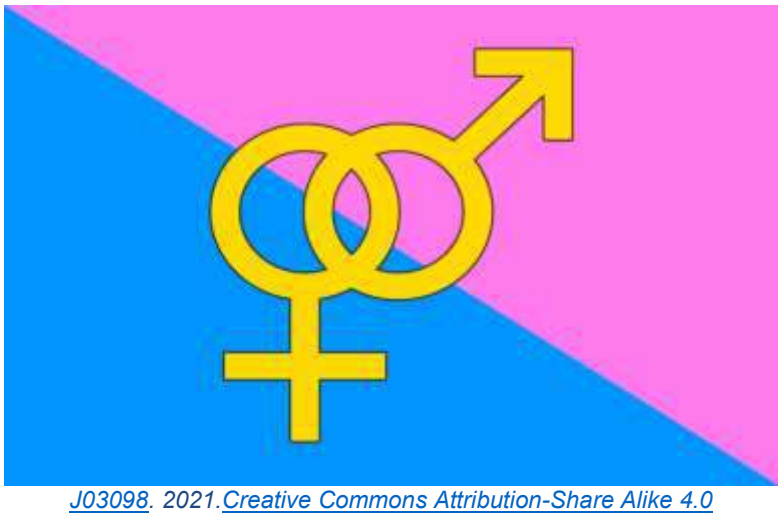
biological differences. **Classism** describes discrimination on the basis of social class, or blocked access to material wealth and social status. **Ableism** describes discrimination on the basis of physical, mental, or emotional impairment or blocked access to the fulfillment of needs and in particular, full participation in social life. These "-isms" reflect dominant cultural notions that women, trans people, people of color, poor people, and disabled people are inferior to men, non-trans people, white people, middle- and upper-class people, and non-disabled people. Yet, the "-isms" are greater than individuals' prejudice against women, trans people, people of color, the poor, and disabled people. For instance, in the founding of the United States the institutions of social life, including work, law, education, and the like, were built to benefit wealthy, white men since at the time these were, by law, the only real "citizens' ' of the country. Although these institutions have significantly changed over time in response to social movements and more progressive cultural shifts, their sexist, genderist, racist, classist, and ableist structures continue to persist in different forms today. Similar-sounding to "-isms," the language of "-ization," such as in "racialization," is used to highlight the formation or processes by which these forms of difference have been given meaning and power (Omi and Winant 1986).

Just like the human body's skeletal structure, social structures are not immutable, or completely resistant to change. Social movements mobilized on the basis of identities have fought for increased equality and changed the structures of society, in the US and abroad, over time. However, these struggles do not change society overnight; some struggles last decades, centuries, or remain infinitely unfinished. The structures and institutions of social life change slowly, but they can and do change based on the concerted efforts of individuals, social movements, and social institutions.

Social Constructionism

Social constructionism is a theory of knowledge that holds that characteristics typically thought to be immutable and solely biological—such as gender, race, class, ability, and sexuality—are products of human definition and interpretation shaped by cultural and historical contexts (Subramaniam 2010). As such, social constructionism highlights the ways in which cultural categories, such as "men," "women," "black," and "white" are concepts created, changed, and reproduced through historical processes within institutions and culture. We do not mean to say that bodily variation among individuals does not exist, but that we construct categories based on certain bodily features, we attach meanings to these categories, and then we place people into the categories by considering their bodies or bodily aspects. For example, by the **one-drop rule**, regardless of their appearance, individuals with any African ancestor are considered black. In contrast, racial conceptualization, and thus, racial categories, are different in Brazil, where many individuals with African ancestry are considered to be white. This shows how identity categories are not based on strict biological characteristics, but on the social perceptions and meanings that are assumed. Categories are not "natural" or fixed and the boundaries around them are always shifting—they are contested and redefined in different historical periods and across different societies. Therefore, the social constructionist perspective is concerned with the *meaning* created through defining and categorizing groups of people, experience, and reality in cultural contexts.

The Social Construction of Heterosexuality



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What does it mean to be "heterosexual" in contemporary US society? Did it mean the same thing in the late 19th century? As historian of human sexuality Jonathon Ned Katz shows in The Invention of Heterosexuality (1999), the word "heterosexual" was originally coined by Dr. James Kiernan in 1892, but its meaning and usage differed drastically from contemporary understandings of the term. Kiernan thought of "hetero-sexuals" as not defined by their attraction to the opposite sex, but by their "inclinations to both sexes." Furthermore, Kiernan thought of the heterosexual as someone who "betrayed inclinations to 'abnormal methods of gratification'" (Katz 1995). In other words, heterosexuals were those who were attracted to both sexes and engaged in sex for pleasure, not for reproduction. Katz further points out that this definition of the heterosexual lasted within middle-class cultures in the United States until the 1920s, and then went through various radical reformulations, up to the current usage.

Looking at this historical example makes visible the process of the social construction of heterosexuality. First of all, the example shows how social construction occurs within institutions—in this case, a medical doctor created a new category to describe a particular type of sexuality, based on existing medical knowledge at the time. "Hetero-sexuality" was initially a medical term that defined a deviant type of sexuality. Second, by seeing how Kiernan—and middle class culture, more broadly—defined "hetero-sexuality" in the 19th century, it is possible to see how drastically the meanings of the concept have changed over time. Typically, in the United States in contemporary usage, "heterosexuality" is thought to mean

"normal" or "good"—it is usually the invisible term defined by what is thought to be its opposite, homosexuality. However, in its initial usage, "hetero-sexuality" was thought to counter the norm of reproductive sexuality and be, therefore, deviant. This gets to the third aspect of social constructionism. That is, cultural and historical contexts shape our definition and understanding of concepts. In this case, the norm of reproductive sexuality—having sex not for pleasure, but to have children—defines what types of sexuality are regarded as "normal" or "deviant." Fourth, this case illustrates how categorization shapes human experience, behavior, and interpretation of reality. To be a "heterosexual" in middle class culture in the US in the early 1900s was not something desirable to be—it was not an identity that most people would have wanted to inhabit. The very definition of "hetero-sexual" as deviant, because it violated reproductive sexuality, and defined "proper" sexual behavior as that which was reproductive, and not pleasure-centered.

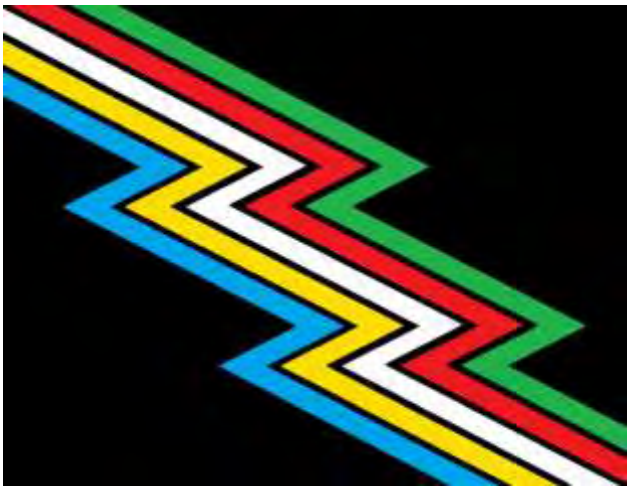
Social constructionist approaches to understanding the world challenge the essentialist or biological determinist understandings that typically underpin the "common sense" ways in which we think about race, gender, and sexuality. Essentialism is the idea that the characteristics of persons or groups are significantly influenced by biological factors, and are therefore largely similar in all human cultures and historical periods. A key assumption of essentialism is that "a given truth is a necessary natural part of the individual and object in question" (Gordon and Abbott 2002). In other words, an essentialist understanding of sexuality would argue that not only do all people have a sexual orientation, but that an individual's sexual orientation does not vary across time or place. In this example, "sexual orientation" is a given "truth" to individuals—it is thought to be inherent, biologically determined, and essential to their being.

Essentialism typically relies on a biological determinist theory of identity. **Biological determinism** can be defined as a general theory, which holds that a group's biological or genetic makeup shapes its social, political, and economic destiny (Subramaniam 2014). For example, "sex" is typically thought to be a biological "fact," where bodies are classified into two categories, male and female. Bodies in these categories are assumed to have "sex"-distinct chromosomes, reproductive systems, hormones, and sex characteristics. However, "sex" has been defined in many different ways, depending on the context within which it is defined. For example, feminist law professor Julie Greenberg (2002) writes that in the late 19th century and early 20th century, "when reproductive function was considered one of a

woman's essential characteristics, the medical community decided that the presence or absence of ovaries was the ultimate criterion of sex" (Greenberg 2002: 113). Thus, sexual difference was produced through the heteronormative assumption that women are defined by their ability to have children. Instead of assigning sex based on the presence or absence of ovaries, medical practitioners in the contemporary US typically assign sex based on the appearance of genitalia.

Differential definitions of sex point to two other primary aspects of the social construction of reality. First, it makes apparent how even the things commonly thought to be "natural" or "essential" in the world are socially constructed. Understandings of "nature" change through history and across place, according to systems of human knowledge. Second, the social construction of difference occurs within relations of power and privilege. Sociologist Abby Ferber (2009) argues that these two aspects of the social construction of difference cannot be separated, but must be understood together. Ferber argues that inequality and oppression actually produce ideas of essential racial difference. Therefore, racial categories that are thought to be "natural" or "essential" are created within the context of racialized power relations—in the case of African-Americans, that includes slavery, laws regulating interracial sexual relationships, lynching, and white supremacist discourse. Social constructionist analyses seek to better understand the processes through which racialized, gendered, or sexualized differentiations occur, in order to untangle the power relations within them.

Bias and Ability



Disability Pride Flag. Ann Magill. 2019. Public Domain

Notions of disability are similarly socially constructed within the context of ableist power relations. The **medical model of disability** frames body and mind differences and perceived challenges as flaws that need fixing at the individual level. The **social model of disability** shifts the focus to the disabling aspects of society for individuals with **impairments** (physical, sensory or mental differences), where the society disables those with impairments (Shakespeare 2006). **Disability,** then, refers to a form of oppression where individuals understood as having impairments are imagined to be inferior to those without impairments, and impairments are devalued and unwanted. This perspective manifests in structural arrangements that limit access for those with impairments. A **critical disability perspective** critiques the idea that **non-disability** is natural and normal—an ableist sentiment, which frames the person, rather than the society as the problem.

Sidebar 7.1: Disability and Pleasure Activism

"To me, disability is not a monolith, nor is it a clear-cut binary of disabled and nondisabled. Disability is mutable and ever evolving. Disability is both apparent and non-apparent. Disability is pain, struggle, brilliance, abundance and joy"

-Alice Wong, Founder of the Disability Visibility Project

One way to discriminate is erasure. With regard to sexuality, ableist bias leads to the decentering of people with disabilities as sexual beings. The sexual scripts we learn are very rarely open and inclusive to all people, and so we create ideas about sexuality that fall within a very narrow margin. Certain people have sex; they do it in a certain way, and that is the right way. Well, we know that is nonsense, but sometimes it is important to be reminded of this. The following web program is a joyful celebration of diversity in sexuality and pleasure. (Dancing at the end!)

Ballroom Dance Couple. Ar4en. 2014 Creative Commons Attribution-Share Alike 3.0

In this talk, Disability + Pleasure Activism Claudia Alick and adrienne maree brown explore the intersection of disability justice, pleasure and liberation. Come for the real talk on activism, pleasure and disability.

Hosted by Disability Visibility Project + Integrated Community Services.

Follow this link for a video description and transcript:
https://docs.google.com/document/d/1Q...

For more from these amazing thought leaders:

Claudia Alick: http://www.claudiaalick.com/

adrienne maree brown:http://adriennemareebrown.net/

Alice Wong: https://disabilityvisibilityproject.com/

Implications

What are the implications of a social constructionist approach to understanding the world? Because social constructionist analyses examine categories of difference as fluid, dynamic, and changing according to historical and geographical context, a social constructionist perspective suggests that existing inequalities are neither inevitable nor immutable. This perspective is especially useful for the activist and emancipatory aims of feminist movements and theories. By centering the processes through which inequality and power relations produce racialized, sexualized, and gendered differences, social constructionist analyses challenge the pathologization of minorities who have been thought to be essentially and inherently inferior to privileged groups. Additionally, social constructionist analyses destabilize the categories that organize people into hierarchically ordered groups through uncovering the historical, cultural, and/or institutional origins of the groups under study. In this way, social constructionist analyses challenge the categorical underpinnings of inequalities by revealing their production and reproduction through unequal systems of knowledge and power (Kang, et al., 2017).

As discussed in the section on social construction, heterosexuality is no more and no less "natural" than homosexuality or bisexuality. People—particularly sexologists and medical doctors—defined heterosexuality and its boundaries thus constructing an understanding we take for granted as real. This definition of the parameters of heterosexuality is an expression of power that constructs what types of sexuality are considered "normal" and which types of sexuality are considered "deviant." Situated cultural norms define what is considered "natural." Defining sexual desire and relations between women and men as acceptable and normal means defining all sexual desire and expression outside that parameter as deviant. However, even within sexual relations between men and women, gendered cultural norms associated with heterosexuality dictate what is "normal" or "deviant." As a quick thought exercise, think of some words for women who have many sexual partners, and then, do the same for men who have many sexual partners; the results will be quite different. So, within the field of sexuality we can see power in relations along lines of gender and sexual orientation (not to mention race, class, age, and ability).

Put Sexism, Racism and Homophobia in the trash. Kurt Löwenstein Educational Center International Team from Germany. 2005. Creative Commons Attribution 2.0

Feminist scholar, activist, and poet, Adrienne Rich (1980) called heterosexuality "compulsory," meaning that in our culture all people are assumed to be heterosexual, and society is full of both formal and informal enforcements that encourage heterosexuality and penalize sexual variation. Compulsory heterosexuality plays an important role in reproducing inequality in the lives of sexual minorities. Just look at laws; in a few states, such as Indiana, joint adoptions are illegal for gay men and lesbians (Lambda Legal). Gay men and lesbians have lost custody battles over children due to **homophobia**—the fear, hatred, or prejudice against gay people (Pershing, 1994). Media depictions of gay men and lesbians are few and often negatively stereotyped. There are few "out" gay athletes in the top three men's professional sports—basketball, baseball, and football—despite the fact that, statistically, there are very likely to be many (Zirin, 2010). Many religious groups openly exclude and discriminate against gay men and lesbians. Additionally, **heteronormativity** structures the everyday, taken-for-granted ways in which heterosexuality is privileged and normalized. For instance, sociologist Karen Martin studied what parents say to their children about sexuality and reproduction, and found that with children as young as three and five years old, parents routinely assumed their children were heterosexual, told them they would get (heterosexually) married, and interpreted cross-gender interactions between children as "signs" of heterosexuality (Martin 2009). In this kind of socialization is an additional element of normative sexuality—the idea of **compulsory monogamy**, where exclusive romantic and sexual relationships and marriage are expected and valued over other kinds of relationships (Willey 2016). Therefore, heteronormativity

surrounds us at a very young age, teaching us that there are only two genders, and that we should desire and partner with one person of the opposite gender, who we will marry.

Just like gender, sexuality is neither binary nor fixed. As discussed in chapter 6, there are straight people and gay people, but people are also asexual, bisexual, pansexual, omnisexual, queer, and heteroflexible, to name a few additional sexual identities. Also, sexual attraction, sexual relations and relationships, and sexual identity can shift over a person's lifetime. As there are more than two genders, there are more than two kinds of people to be attracted to, and individuals can be attracted to and can relate sexually to multiple people of different genders at once!

Another common misconception is that all transgender people are sexually queer. This belief may stem from the "LGBT" acronym that lists transgender people along with lesbians, gay men, and bisexuals. A trans man who previously identified as a lesbian may still be attracted to women and may identify as straight, or may identify as queer. Another trans man may be attracted to other men and identify as gay or queer. This multiplicity suggests that the culturally dominant binary model fails to accurately encapsulate the wide variety of sexual and gender lived experiences (Kang, et al., 2017).

Sidebar 7.2: My identity

No two people are the same, and it is important to view sexuality as a spectrum, in order to eliminate the potential for biases or generalizations. Growing up as a non-heterosexual person, I was forced to unlearn a series of generalizations that I grew to believe, like the idea that bisexuality is a fake sexuality.

For my entire childhood, I felt as if I could only be gay or straight and nothing in between. It wasn't until I was in my early twenties that I realized that I was genuinely attracted to more than one gender. I spent a great amount of time worrying about the way people perceived me, until I began understanding the spectrum of sexuality. I've also received a lot of criticism from people around me regarding the idea of bisexuality and monogamy. I prefer monogamy over polyamory, and the people close to me know this, however; many people continue to believe that monogamy and bisexuality cannot work together. While I believe bisexuality and monogamy can coexist, I've had to begin the process of unlearning the stereotypes associated with sexuality and learn to disregard the generalizations put forth by other people.

Biases in the field of Human Sexuality are ever present, and not everyone has the privilege of completing a human sexuality course, and developing their sexual literacy. It's important to understand and embrace your sexuality as you feel without regard to the opinions of other people!

Identity Terms

Bias and discrimination play out in varying ways. As we learned in Chapter 5, labels regarding how we want to be addressed can either constrain or free us. Choice of pronoun is now a more widely accepted practice in various social settings, which has allowed for individuals to create their identity in a way that feels authentic to who they are. Just like our pronouns, other aspects of our identity get named, and sometimes the naming is not done by the people who identify in a specific category, but instead by those in power. Language is political, hotly contested, always evolving, and deeply personal to each person who chooses the terms with which to identify themselves. To demonstrate respect and awareness of these complexities, it is important to be attentive to language, and to honor and use individuals' self-referential terms (Farinas and Farinas 2015). Below are some common identity terms and their meanings. This discussion is not meant to be definitive or prescriptive, but rather, aims to highlight the stakes of language and the debates and context surrounding these terms, and to assist in understanding terms that frequently come up in classroom discussions. While there are no strict rules about "correct" or "incorrect" language, these terms reflect much more than personal preferences. They reflect individual and collective histories, ongoing scholarly debates, and current politics. Let's look at two examples.

"Disabled people" vs. "People with disabilities"

Bandera Partido Accesibilidad sin Exclusión Costa Rica. Rogz. 2021.Creative Commons Attribution-Share Alike 4.0

Some people prefer person-first phrasing, while others prefer identity-first phrasing. **People-first language** linguistically puts the person before their

impairment (physical, sensory or mental difference). Example: “a *woman with* a vision impairment.” This terminology encourages **nondisabled** people to think of those with disabilities as people (Logsdon 2016). The acronym PWD stands for “people with disabilities.” Although it aims to humanize, people-first language has been critiqued for aiming to create distance from the impairment, which can be understood as devaluing the impairment. Those who prefer **identity-first language** often emphasize embracing their impairment as an integral, important, valued aspect of themselves, which they do not want to distance themselves from. Example: “a *disabled person*.” Using this language points to how society disables individuals (Liebowitz 2015). Many terms in common use have ableist meanings, such as evaluative expressions like “lame,” “retarded,” “crippled,” and “crazy.” It is important to avoid using these terms. Although in the case of disability, both people-first and disability-first phrasing are currently in use, as mentioned above, this is not the case when it comes to race (Kang, et al., 2017).

Just as we now are choosing to include pronouns into introductory phases of interpersonal relations and group events or situations, other parts of identity can also be added if those invited in wish to disclose. As nothing is static in the culture, these practices may shift too, but for now, if you are wondering how to implement something like this in a group you are facilitating, it is best to self-disclose and make space for others to share how they’d like to be referenced. If they do not share a part of their identity you think is important, be able to let that go and allow them to be seen and named how they wish.

Sidebar 7.3: Disability Relationship Bias

The effects of ableism are widespread, and profound and are often unacknowledged by the nondisabled public. Unlike other identities, anyone can become disabled at any time in their life, yet it is often the last one discussed by the general population, even though disabled people are the largest global minority group. Whether it's due to society's delayed collective awakening to ableism, it's avoidant fears of becoming part of the largest minority, or it's well practiced solution of sweeping it under the rug, the variations and degrees of disabilities and topics surrounding it require a more prompt attentiveness from us to begin unpacking and addressing it all.

There is not a monolithic disabled experience, there are countless spectrums, types, and ways that people experience disability, there are endless ways in how ableism shows up for each individual, sub-community, and intersection. The majority of accessibility advocacy work reflects the urgency of removing barriers in basic daily activities, meeting needs, and increasing visibility and overshadow the rest - often leaving sexuality and relationships as last or completely disregarded as topics under the umbrella of disability.

"Most everyone has felt those Unwelcome, crawling feelings - Unfavorable, Undesirable, Unwanted; the "doing them a favor" by preemptively rolling away on your cart of baggage. But being a human in a body that is neglected, mistreated, tokenized, infantilized (on top of it all) carries its own cruel irony."

In my essays in Where Shame Dies, a collection of work on disability and sexuality, I address these topics from the lens of my own experiences and observations, primarily about the effects of having obviously visible physical differences. Visibly disabled people face automatic discrimination whether it be abuse, aggressive harassment, micro aggressions, or "friendly" avoidance alongside harmful assumptions, which all run rampant. Others immediately assess your worth, function, desirability, or humanness as a whole.

"I know it's up to every individual to figure things out for themselves and how they relate to those around them - But how are we supposed to put ourselves in the conversation when we're left in the other room? How do we get/feel invited to the circle when we seem covered in red flags? How can we rectify the twisted connotation that disabled means

nonsexual when you perpetuate it? How can we process our layers of trauma when we're too busy putting you at ease? How do we put ourselves out there when people with disabilities are 3x more likely to be sexually assaulted than literally anyone else? How can we expect healthy relationships when you'll either love us or fuck us but rarely both?"

The more visibly different or disabled a person is, the more bias in romantic relationships will dominate interactions despite any relevance to potential further connection. Even for those who have done the work to address their own ableism, conscious efforts to move with more humanity cannot fully undo generations of programming in the subconscious. It shows up in loved ones behaving as if they cannot be honest with what they want or do not want from you, or romantic endeavors not being able to bring themselves to commit to exploring a committed relationship with you, or them unknowingly using you for more of their own ego-based benefit than a reciprocal connection.

"It's being too much and not enough; the ever-looming fog of burden. It's bubbles of grief that speak words of exhaustion of this corporal form. It's the culmination of patterns and sickly reminders making it feel like my insides are going to crawl out my mouth. It's the risks in being vulnerable, weighing like a punishment. It's being in a body with talents of opening others up just to further perfect the art of self-preservation. The dark magic of seeing and not being seen."

Due to both societal and internal ableism, people often view disability as an individual issue to navigate or overcome, but especially in sexuality and romance, the biggest challenge is rooted in other's perceptions and having to either educate others for them, or unlearn absorbed notions of shame and worth.

Assuming a disabled person is nonsexual or undesirable to any able-bodied or nondisabled person is suggesting that disabled people are automatically excluded from the full range of the human experience. It's a common misconception full of privilege and ignorance that can cause harm and create more barriers to connection and pleasure for both disabled and nondisabled people at large.

The George Floyd mural outside Cup Foods at Chicago Ave and E 38th St in Minneapolis, Minnesota. 2020. CC BY-SA 2.0

People of color vs. Colored people

People of color is a contemporary term used mainly in the United States to refer to all individuals who are non-white (Safire 1988). It is a political, coalitional term, as it encompasses common experiences of racism. People of color is abbreviated as **POC**. **Black** or **African American** are commonly the preferred terms for most individuals of African descent today. These are widely used terms, though sometimes they obscure the specificity of individuals' histories. Other preferred terms are African diasporic or African descent, to refer, for example, to people who trace their lineage to Africa but migrated through Latin America and the Caribbean. **Colored people** is an antiquated term used before the civil rights movement in the United States and the United Kingdom to refer pejoratively to individuals of African descent. The term is now taken as a slur, as it represents a time when many forms of institutional racism during the Jim Crow era were legal.

Sidebar 7.4: Hyper-Sexualization of Black Women in the Media

Early example of hypersexualization of Black Woman, Sarah Baartman.1810.Public domain

"Black women have always been these vixens, these animalistic erotic women. Why can 't we just be the sexy American girl next door?" - Tyra Banks on being a sex symbol

Black women in the media are portrayed as sexual objects, and this is not an accident. Hollywood works hard at perpetuating dehumanizing stereotypes of people of color, and Black women are often subject to this. The media is a powerful outlet to the entire world, and has a significant impact on molding the general public to think a certain way. In the media, we see Black women portrayed as "sexually willing characters often inviting of sexual objectification. [These] transcend the confines of the media, and penetrate and manifest themselves in everyday society" (Ntinu 1).

Life and culture as we know it are greatly impacted by the media. So, when all we see is Black women playing that same old role of the hoochie mama, and we walk down the street and hear a man catcalling a Black woman with some sexualized slur, we know this to be learned behavior. We know that because of the media misrepresenting Black women in every way possible; there are people that are

going to live their day to day lives believing everything they hear in the media. There are people that will see what's on television, whether that be their favorite show, movie, music video to their favorite song, and believe every last bit of it. Black women are constantly portrayed as sexual beings. Their bodies and their innocence have been stripped away from them since adolescence, and not much is being done to save them. I say all of this to say that representation matters. The intersections of race and gender are things that a Black woman cannot escape. Those two things follow her wherever she goes.

Excerpts adapted from: Matthews, Annalycia D., "Hyper-Sexualization of Black Women in the Media"

(2018). *Sociology Student Work Collection*. 22. Full text available at:

https://digitalcommons.tacoma.uw.edu/gender_studies/22

Media

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Take a minute to think about how much media you are exposed to in one day—from watching television and movies, to cruising the Internet, reading newspapers, books, and magazines, listening to music and watching music videos, or playing video games. The majority of this media is produced by corporations, and infused and supplemented with advertisements.

According to the Nielsen Company—a marketing corporation that collects statistics on media usage—report, the average American "18-34 spent two hours and 45

minutes daily watching live TV in the 4th Quarter of 2015, and one hour and 23 minutes using TV-connected devices—a total of four hours and 8 minutes using a TV set for any purpose" (Nielsen Company, 2016, p 201). The pervasiveness of an ever present mass media begs a number of questions:

What are the effects of such an overwhelming amount of exposure to media that is often saturated with advertisements?

How do media construct or perpetuate gendered, sexualized, classed, ableist, and racialized differences and inequalities?

What is the relationship between media and consumers?

How do consumers interact with media?

Media expert and sociologist Michael Kimmel (2003) argues that the media are a primary institution of socialization that not only reflects, but creates culture. Media representation is a key domain for identity formation and the creation of gendered and sexualized differences. For example, think back to Disney movies you were probably shown as a child. The plots of these movies typically feature a dominant young man—a prince, a colonial ship captain, a soldier—who is romantically interested in a young woman—both are always assumed to be heterosexual—who at first resists the advances of the young man, but eventually falls in love with him and marries him. These Disney movies teach children a great deal about gender and sexuality; specifically, they teach children to value **hegemonic masculinity** and **emphasized femininity**. Hegemonic masculinity refers to a specific type of culturally-valued masculinity tied to marriage, heterosexuality, and patriarchal authority in the family and workplace, and maintains its privileged position through subordinating other less dominant forms of masculinity (i.e., dominance over men of lower socioeconomic classes or gay men). Emphasized femininity, meanwhile, refers to a compliance with the normative ideal of femininity, as it is oriented to serving the interests of men (Connell 1987).

Traveljunction. 2014 Creative Commons Attribution-Share Alike 2.0

What do Disney movies have to do with how people actually live their lives? It is *because* they are fictional and do not have to be verified by reality, and they are so pervasive in our culture and shown to us at such a young age, that they may shape our gendered and sexualized selves in ways that we do not even realize. How many times have you heard people say that they want a "fairy tale wedding," or heard the media refer to a celebrity wedding as a "fairy tale wedding?" This is one example of how the media reproduces dominant ideologies—the ideas, attitudes, and values of the dominant culture—about gender and sexuality.

Media also reproduce racialized and gendered normative standards in the form of **beauty ideals** for both women and men. As Jean Kilbourne's video series *Killing Us Softly* illustrates, representations of women in advertising, film, and magazines often rely on the **objectification** of women—cutting apart their bodies with the camera frame and re-crafting their bodies through digital manipulation, in order to create feminized bodies with characteristics that are largely unattainable by the majority of the population. Kilbourne shows how advertising often values the body types and features of white women—having petite figures and European facial features—while often exoticizing women of color by putting them in "nature" scenes and animal-print clothing that are intended to recall a pre-civilizational past. The effect of this is to cast women of color as animalistic, savage creatures—a practice that has historically been used in political cartoons and depictions of people of color, to legitimize their subjugation as less than human. In addition, media depicts the world from a masculine point of view, representing women as sex objects. This kind of framing, what Laura Mulvey called the **male gaze,**

encourages men viewers to see women as objects and encourages women to see themselves as objects of men's desire; the male gaze is thus a heterosexual male gaze. These are just a few examples of how media simultaneously reflect and construct differences in power between social groups in society through representing those groups.

Anonymous. 2020. Creative Commons Zero, Public Domain Dedication

Another way in which media reflect and simultaneously produce power differences between social groups is through **symbolic annihilation**. Symbolic annihilation refers to how social groups that lack power in society are rendered absent, condemned, or trivialized through mass media representations, which simultaneously reinforce dominant ideologies and the privilege of dominant groups. For example, as we argued earlier, gay and lesbian, as well as transgender and disabled characters in mass media are often few, and when they are present, they are typically stereotyped and misrepresented. Trans women characters portrayed through the cisgender heterosexual male gaze are often used as plot twists or objects of ridicule for comedic effect, and are often represented as "actually men" who deceive men in order to "trap" them into having sex with them; these representations function to justify and normalize portrayals of disgust in response to them and violence against them. These kinds of portrayals of trans

women as “evil deceivers” and “pretenders” have been used in court cases to pardon perpetrators who have murdered trans women (Bettcher 2007).

While Jean Kilbourne’s insights illustrate how beauty ideals produce damaging effects on women and girls, her model of how consumers relate to media constructs media consumers as passively accepting everything they see. As Michael Kimmel (2003) argues, “The question is never whether or not the media do such and such, but rather *how* the media and its consumers interact to create the varying meanings that derive from our interactions with those media” (Kimmel 2003: 238). No advertisement, movie, or any form of media has an inherent, intended meaning that passes directly from the producer of that media to the consumer of it, but consumers interact with, critique, and sometimes reject the intended messages of media. In this way, the meanings of media develop through the interaction between the media product and the consumers who are interacting with it. Furthermore, media consumers can blur the distinction between producer and consumer through creating their own media in the form of videos, music, pamphlets, ‘zines, and other forms of **cultural production**. Therefore, while media certainly often reproduce dominant ideologies and normative standards, media consumers from different standpoints can and do modify and reject the intended meanings of media (Kang, et al., 2017).

Heteronormativity, sexism, racism, ableism, classism, and genderism are some of the “isms” that divide us, and uphold social messages that define a good way to be a sexual being. This script lays out a false binary that privileges those who are superior (who follow the script) over those inferior (those who have a different script). This way of looking at sexuality is very limiting. Having a wider array of story and images that capture the diversity of identity, orientation, level of sexual desire, and lifestyle would allow for greater representation and help de-center the heteronormative sexual script so prevalent in much of the media we consume. Imagine how different a society in which all forms of sex and communication about sex were represented non-judgmentally in the media could be.

As we progress with our openness to gender and sexual orientation spectrums, along with body and sex positivity, we must grant the same freedom of expression to all. In a hypersexualized (yet sexually repressed) society, those who do not engage in sex (people who are asexual or ace), or have different preferences of intimacy not involving physical touch are not given a space to freely celebrate who they are. Without the growth of identity and folx expressing themselves as ace,

there was not a term for someone who did not find pleasure in sex or seek it out. Because of the sexual narrative told to us, people who identify as ace may even think something is wrong with them since everyone else around them is enjoying physical intimacy. There is not a right amount of sexual desire or a right way to enjoy sex or our bodies. Yet our culture is telling us through various ways that it is and can provide medical interventions in the form of pharmaceuticals to aid in making us "normal." Individuals who have a lower sexual desire are told that is a problem to be fixed. Varying levels of libido over the life course is typical but our culture tells us we should be wanting a specific amount of sexual gratification. For more on libido, please see Chapter 13 on Sexual Health.

Sidebar 7.5: Inconspicuous Consumption & The Concrete Eunuch

Two years ago, I was released from prison for a non-violent offense after serving a life sentence under California's three strikes law. For twenty-five years, prison regulations, jailhouse etiquette, and religion informed me that lust of the flesh and pre- or extra-marital sex amounted to sinful and despicable conduct.

Prisoners can lose time for engaging sexual activity in a visiting room, indecent exposure, consensual participation in sodomy or oral copulation, and sexual disorderly conduct. The rules of conduct for California prisoners are codified under Title 15 of the California Code of Regulations, and are enforceable by way of disciplinary forfeiture where time gets added to a prisoner's sentence for misconduct. Thus, if I got caught masturbating in the privacy of my cell, I could receive an infraction for sexual misconduct. Moreover, to obtain some semblance of privacy while satisfying a need, I also ran the risk of being disciplined for *obstructing* the view of the cell by installing a *modesty curtain*. Prisoners also receive disciplinary infractions for staring lustfully at female staff, for *sexual misconduct* unofficially defined as *reckless eyeballing*. Then, there are additional circumstances where prisoners get penalized for becoming too intimate with staff. I came perilously close to being written up and displaced from the general population via transfer to administrative segregation for being *overly familiar with staff*. And lastly, given the fact that rules violations are highly scrutinized by the Board of Parole Hearings, complying with prison regulations hugely impacted my ability as an indeterminately sentenced prisoner to cater to a carnal desire. Parole hearing Commissioners view rules violations as a harbinger of impending criminality—prisoners who choose to disobey the law in prison demonstrate the same propensity to disobey the law in society. Accordingly, he or she poses an unreasonable risk to society and must be found unsuitable for parole. Because of such an outcome, I trained my energies on remaining disciplinary free in order to facilitate my release on parole. Fortunately, for 25 years my response to the urge to procreate went undetected, and I was never penalized for sexual misconduct.

Prisoners assigned to clerical duties and office work positions requiring an extensive amount of staff/prisoner interaction are rotated to other positions within

the institution, for good reason. While working as a clerk for more than 18 years I had several encounters with female staff. Even though prison staff could be sanctioned for fraternizing or having sexual relations with incarcerated persons, there was nevertheless attraction between the sexes. In my case I never had sex, but several women and I became unmistakably intimate: a secret touch here, a special hello there, evocative body language, a nice compliment, and steamy conversations.

Women I came in contact with communicated their feelings by transmitting subtle gestures of concern. They seemed to sense my deprivation from having had any form of intimacy for a prolonged period. They knew I had been out of circulation, and it seemed to me that they wanted me to get back in touch with what it felt like to interact with and be cared for by a woman. For me it felt as if I was being seen for the first time in a long time.

In prison, there is no such thing as privacy, because prisoners are constantly being observed by staff or other prisoners. So, cops and civilians weren't the only ones demanding vigilance when it came to my desire to tend to a need. I had to keep an eye out for any of my brethren or other incarcerated people that could potentially cause me to become a source of shame and embarrassment should they inadvertently catch me in the throes of ecstasy during a momentary delivery of self-care. Nevertheless, to heed the advice to safeguard my soul, or evade peer-to-peer detection, I tried to quell the urge to engage in sexual gratification by treating it as a loathsome pastime. Masturbation, then, was no different than fornication, a sinful act that harms the soul. But no matter how hard I tried heeding the advice of chaplains or incarcerated acolytes, I couldn't stifle that instinctual urge. I reckon the longest I was able to ignore an incessant craving for sex was about two months. Sometimes relief from pent up sexual energy came in the form of a nocturnal emission, or I employed the more conventional method of taking matters into my own hand.

After I became a product of the Prison Industrial Complex, I concluded my existence was not unlike that of a eunuch. On the one hand I constantly felt like an inquisitive youngster whose parents wouldn't allow them to explore the taboo tugging at the fabric of their awakened sexuality. And on the other hand, after years of hiring myself out as a beast of burden I stuffed my libido so deeply inside myself

it seemed as though my genitals were grotesque, cancerous appendages that might as well have been severed from my body altogether. And that insidious supplanting of a *need* (to stifle a once robust sex drive) led me to believe any form of sexual gratification was an abomination. The thought of being with or admiring a woman's voice, shape, face, hair, or other such *whispers of provocation* served to remind me of the telltale signs of weakness of faith. But now and again, sporadic bouts of clarity intervene, as the jarring of truth and belief produce a new reality, where the in-dwelling soul aligns itself with my biological mind and body, and refuses to subscribe to contrived notions of celibacy and abstinence, or any plea of dissonance with the Will of its Creator that authored such desires.

Thus, when it came to sex and intimacy in the prison setting all these dynamics invariably came into play. And on the matter of sex in prison the inquiry for me was squarely focused on how I might train both mind and body to suppress an inherently intrinsic need: hence the question—how does one suppress nature? To curtail an innate craving or preserve the standards of decency I tried abstinence, celibacy, and even religion, but the result was always the same—no matter how long and how hard I fought I could not overthrow nature. I had no control over an irrepressibly unchaste gland. And just as stems sprout through pavement, any attempts to contain my monstrous libido amounted to an exercise in futility. It was through practice and vigilance that I managed to escape an elongated sentence while catering to an instinct that rises to the level of food and drink, that drives you just as mad when you don't attend to it. And as a returning citizen, I find myself being revisited by the rigors of incarceration through the subtle whisper of three unshakeable influences that constantly compel me to suppress or altogether deactivate my libido. In order to embrace my current reality in the aftermath of such a lengthy sentence, I find I must learn how to deconstruct a corrections-induced mentality that to this day counsels me to shun sex at all costs.

Our need for intimacy

We all felt the effects of minimal to no close-contact with our friends and family during the 2020 COVID-19 pandemic. Throughout this isolated period, the need for physical touch, or non-contact intimate face to face closeness was inaccessible to so

many. Many of us did not realize they would miss this as much as we did. Many felt a sort of deprivation that led to a whole host of mental health issues. The pandemic highlighted for us just how deprivation feels. Now imagine being incarcerated for years on end, where any sort of physical touch with another person or simple self-gratification is illegal. On top of this, strip searches are permissible, as well as access to your body at any time without consent by those who are imprisoning you because you are property of the state.

Sidebar 7.6: Why are the Incarcerated Treated Non-Consensually?

Rainerzufall1234. 2016. Creative Commons Attribution-Share Alike 4.0

When I first came into the prison system in the early 1990s, there was no such thing as personal privacy or body autonomy. Our dignity and humanity went out the window. The first thing you did was strip nude in front of god and everybody, spread your ass cheeks, squat, and cough. It was routine to be told by a jailer or a prison guard to lift up your nut sack and the bottom of your feet as they searched you for contraband. It was one of the most humiliating experiences I have ever had in my life. If I went around doing this to people, I'd be convicted of serious sex offenses but the state has carte blanche.

In the 1990s prison guards could feel or caress your body for any reason and simply call it a search. They could tell you to strip down to your boxers or strip nude and you could get a write up if you disobeyed. You had no human will of your own, no opportunity to not consent. Our bodies are property of the state, and being able to refuse was not an option. Force was permissible, and resistance only served to increase the level of violence enacted upon you. Guards could grab and squeeze your breast, buttocks, and crotch. This highly intrusive conduct is a sexual assault in the larger society but is considered the norm in prison.

Sexual assault happens often in prison. Any sexual encounter is always classified as an assault even when its consensual. California penal code section 289.6 prohibits inmates, prison volunteers, contractors, and employees from engaging in any type

of sexual activity. Yet condom dispensers sit in common areas of the prison, so people who choose to break the law can practice safe sex. A lot of men have sex with each other in prison and so do women. Everyone knows it's happening but it's difficult to police. Guards become uncomfortable. But some will sometimes pull people from cells who are obviously engaged in sexual activity. They are written up for violating the rules. No signs hang from any wall in prison saying practice safe sex. But HIV, aids, hepatitis, and other diseases are rampant. Condoms are the warning. A phone number is posted for you to call if raped by a guard or prisoner. It's a PREA hotline.

One Friday in December of 2021, I was called to a correctional lieutenant's office for a PREA interview. PREA is an acronym used to describe the federal Prison Rape Elimination Act, a law implemented in 2003. It requires that federal, state, and local correctional facilities maintain and enforce a zero-tolerance policy towards sexual assault for both inmates on inmate and staff on inmate sexual contact. The lieutenant asked me if I have ever been raped, or if I've raped someone else while in prison. He asked me if I felt like a victim or if I had a fear of being raped. He then asked me if I identified as male or female.

Sex is illegal in prison. The state controls our bodies, and at the same time, our sexuality is closely monitored. There are only two options for sex available to incarcerated people-masturbation or infrequent family visits with your spouse-which few people have access to. Masturbation is hard to police, but they do, getting caught in the act comes with a write up that can be used against you when attempting to parole. They'd outlaw it altogether if they could, because it's one of a few pleasures an incarcerated person can steal while in this hell. Ironically, they have condom dispensers bolted on walls throughout the prison full of brightly colored condoms. But sex is technically illegal. Two men can engage in consensual sexual activity while incarcerated, and they do all the time, but in the eyes of the law, they are raping each other.

Conclusion

Bias and discrimination in human sexuality shows itself through normalizing some behaviors and stigmatizing others. We learn sexual scripts as young people about

what it looks like to “do” sexuality. Our gender, race, ability, age, and sexual preferences are all pieces to the puzzle of whether or not our sexual expression is socially regarded as appropriate or not. Bodies have been labeled either “overly sexual” or not included as “sexy,” based on prejudice. The constructionist perspective helps us analyze this as something that was created by people to define what sexuality should be. Autonomy over one’s body is something taken for granted, when in fact, there are many in the world who do not have this. The world of humans and their unique sexualities is vast and is worthy of understanding and celebrating. Rather than excluding people from the full range of human possibility, expanding to include the endless possibilities could be transformative.

Glossary

1. **Ableism** Discrimination on the basis of physical, mental, or emotional impairment or blocked access to the fulfillment of needs and in particular, full participation in social life.
2. **Bias** Prejudice for or against one thing, person or group compared to another, usually in a way considered to be unfair.
3. **Biological determinism** can be defined as a general theory, which holds that a group’s biological or genetic makeup shapes its social, political, and economic destiny.
4. **Classism** Discrimination on the basis of social class, or blocked access to material wealth and social status.
5. **Feminism** is not a single school of thought, but rather, encompasses diverse theories and analytical perspectives—such as socialist feminist theories, radical sex feminist theories, black feminist theories, queer feminist theories, transfeminist theories, feminist disability theories, and intersectional feminist theories.
6. **Heteronormativity** The everyday, taken-for-granted ways in which heterosexuality is privileged and normalized.
7. **Homophobia**—the fear, hatred, or prejudice against gay people.

8. **Implicit bias** attitudes towards people or groups of people or associate stereotypes with them without our conscious knowledge.
9. **Intersectionality** Seeing systems of oppression working in concert, rather than separately and independently. Also, the complex, cumulative way in which the multiple forms of discrimination (e.g. racism, sexism, classism) combine, overlap or intersect the experiences of marginalized individuals or groups.
10. **Social constructionism** is a theory of knowledge that holds that characteristics typically thought to be immutable and solely biological—such as gender, race, class, ability, and sexuality—are products of human definition and interpretation shaped by cultural and historical contexts.

Discussion Questions

1. What types of implicit biases do you feel like you have? How do you think you learned them?
2. What are the intersecting aspects of yourself? Can you pick 3 that are the most visible to you?
3. What do you see as the main difference between biological determinism and social constructionism?
4. Incarcerated people have very little agency over their body. What types of harm do you think this can cause?
5. How does sexual literacy relate to eradicating bias and discrimination in human sexuality?

Multiple Choice

1. _____ is defined as, “when we have attitudes towards people or groups of people or associate stereotypes with them without our conscious knowledge

    a. Stereotype

b. Implicit Bias
c. Generalization
d. Yucky

2. Feminist theorists argue that reflexivity—understanding how one's social position influences the ways that they understand the world—is of utmost necessity when creating theory and knowledge.

    a. True
    b. False

3. Feminists also believe that people have _____—or the ability to influence the direction of their lives

    a. Level of Analysis
    b. Agency
    c. Multiple Identities
    d. Reflexivity

4. Homophobia is

    a. the fear, hatred, or prejudice against gay people
    b. Feeling cold without a sweater
    c. Fear of homeowners
    d. All of the above

5. What is a social structure?

    a. A set of long-lasting social relationships, practices and institutions that can be difficult to see at work in our daily lives
    b. The term we use for discrimination and blocked access women face
    c. Discrimination and blocked access on the basis of race, which is based on socially-constructed meanings rather than biological differences.

d. All of the above

6. _____ describes discrimination on the basis of physical, mental, or emotional impairment or blocked access to the fulfillment of needs and in particular, full participation in social life.

    a. Ableism
    b. Classism
    c. Genderism
    d. Sexism

7. A Social Constructionist viewpoint understands that sexuality is:

    a. Made out of artificial materials
    b. a product of human definition and interpretation shaped by cultural and historical contexts.
    c. Shameful and horrible
    d. Innate, and binary

8. Intersectionality observes

    a. Systems of oppression working in concert, rather than separately and independently.
    b. Where people should cross the street
    c. The way dogs look at each other when they meet for the first time
    d. All of the above

9. Feminism is not a single school of thought

    a. True
    b. False

10. Sex is illegal in Prison

    a. True
    b. False

For Further Exploration

Social Constructs | Philosophy Tube Social Constructs explained by a philosopher

"Erotic Revolutionaries: Black Women, Sexuality, and Popular Culture" book written by Shayne Lee

Implicit Association Test Implicit Bias test-Harvard University (Activity)

Podcast: What's from Ear Hustle Episode 5 April 27, 2022.

Atlantic article, The Limits of Sex Positivity

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Chapter 8: Attraction, Love and Relationship Formation

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Learning Objectives

After completing this module, students should have a working knowledge of:

- How initial attraction starts.
- What the variables are that lead us to perceive someone as physically attractive.
- Describe the ways that similarity and complementarity influence our liking for others.
- Define the concept of mere exposure, and explain how proximity influences liking.
- Explore the relationship between affect and attraction.
- Explain how initial attraction correlates with forming a romantic interest.
- Outline the factors that define close relationships.
- Distinguish between communal and exchange relationships.

- Sternberg's triangular theory of love.
- Some research on romantic love and attention to others.
- The role of attachment style in close relationships.
- The impact of Internet behaviors on intimate relationships.
- Some important factors that can help romantic relationships to be successful.
- Some key factors that contribute to the ending of close relationships.

Introduction

Why do we like who we like? What factors lead to our decision? Does having consistent access to a person help grow this bond? Are we attracted to someone who we perceive as our equal, or do we prefer a hierarchy in our intimate relationships? Do gender roles have anything to do with this choice? Can you be attracted to someone and not like them? Are the two mutually exclusive? Could the answers to these questions be in part due cultural conditioning? This chapter will explore these questions. We will also look at romantic love within a cultural context and explore the science of falling in love. While some of these findings come from an evolutionary perspective that describes the biological need to reproduce, we understand that humans are much more complex than this and that most of us are attracted to people for a variety of reasons. We will explore all of this and then move into an understanding of how close relationships are formed, introducing Steinberg's triangular theory of love. How do relationships form and thrive, and furthermore, what gets in the way?

Initial Attraction

When we say that we like or love someone, we are experiencing **interpersonal attraction** - the strength of our liking or loving for another person. Although interpersonal attraction occurs between friends, family members, and other people in general, and although our analysis can apply to these relationships as well, our primary focus in this chapter will be on romantic attraction between people. There is a large amount of literature on the variables that lead us to like others in our

initial interactions with them. We'll review some important findings here (Sprecher, Wenzel, & Harvey, 2008). Most of us are drawn to the same qualities in our partners; however, the research indicates that there are some differences based on sexual orientation and gender. We will discuss the differences and the theories around these differences later in the chapter, but we will start by reviewing the variables that lead to initial attraction between people.

Two Ways to Understand Gender and Attraction

Two very differing perspectives on perceived attractiveness are the **Evolutionary Theory** and the **Sociocultural Perspective**. As an interdisciplinary textbook, we are describing both ways of understanding attraction and expect the reader to consider these theories independently and perhaps in combination to make sense of the phenomena of attraction.

Evolutionary Theory

The main idea of **Evolutionary Theory** is that our behavior reflects evolved adaptations for the survival of our ancestors. So a man's best strategy for passing their genes is to have a lot of short-term sexual encounters with healthy and fertile woman. Youth, a low waist-to-hip ratio, facial and bodily symmetry and long shiny hair are indicators of health and fertility so it is species survival that explains preferences. According to evolutionary theory, men become focused on appearance because it is a useful cue for their potential future reproductive success. However, women have to deal with unequal **parental investment,** and need to have a reliable partner to raise their family, so more than physical appearance matters to them from an evolutionary standpoint.

Sociocultural Perspective

Sociocultural Perspective acknowledges that evolution plays some role in sex differences in attraction; however, the sex differences may be more to do with social and cultural factors. How we were socialized in combination with who we are as individuals shaped the way we form attractions and preferences. The role of media and cultural values regarding attractiveness standards cannot be

overlooked. We also consider the notion of free will and understand that while we are living in response to our society and the norms and values that come along with it we do have the power to choose what we are attracted to. Ultimately social forces do have a large influence on what we know to be attractive or what we should like but we have the ability to think past these influences and decide for ourselves. Research has found that in cultures where there is more gender equality, partner preferences are more similar between people (Zentner & Mitura, 2012).

Reasons for Attraction

Researchers in various fields have studied attraction. Findings suggest that many reasons account for our attraction to others, including physical attractiveness, affect, proximity, perceived gain, similarities and differences, and disclosure. We will discuss some of these findings with the caveat that, as mentioned above, there is always more to know.

Physical Attractiveness

Although it may seem shallow to admit it, and while it is certainly not the only determinant of liking, people are strongly influenced, at least in initial encounters, by the physical attractiveness of their partners (Swami, Greven, & Furnham, 2007). In day-to-day interactions, it has been shown that people are more likely to pay attention to someone they find attractive. Perhaps this finding doesn't surprise you too much, given the prevalence of physically attractive people in the media we consume. Movies and TV shows often feature unusually attractive people and we know that media shapes so much of how we understand the world around us. TV ads use attractive people to promote their products, and many people spend considerable amounts of money each year to make themselves look more attractive. (Langlois, Ritter, Roggman, & Vaughn, 1991).

While it is sometimes said that "beauty is in the eyes of the beholder," this may not be completely true. In studies like Ramsey, J, et al's 2004, *Origins of a stereotype: categorization of facial attractiveness by 6-month-old infants*, that expose participants of all ages to different facial images, there tends to be certain features that the participants found more pleasing to them. (Ramsey, Langlois, Hoss, Rubenstein, &

Griffin, 2004). This preference is in part due to shared norms within cultures about what is attractive, which varies among cultures.

Leslie Zebrowitz and her colleagues have extensively studied the tendency for humans to prefer facial features that have youthful characteristics (Zebrowitz, 1996). These features include large, round, and widely spaced eyes, a small nose and chin, prominent cheekbones, and a large forehead. Zebrowitz has found that individuals who have youthful-looking faces are more liked, are judged as warmer and more honest, and also receive other positive outcomes. We may like baby-faced people because they remind us of babies. Because we respond to baby-faced people positively, they may respond to our positivity in turn, and act more positively to us.

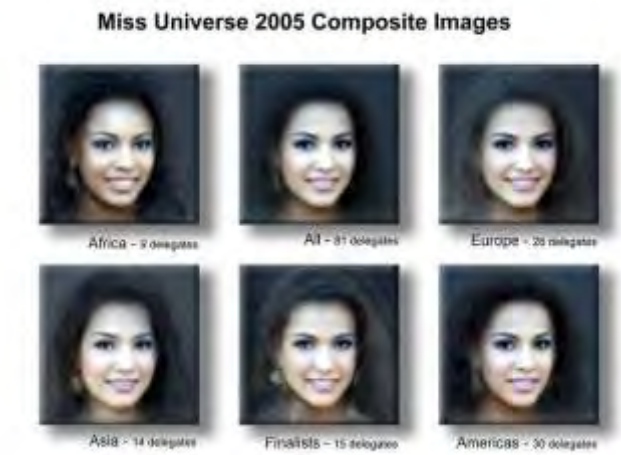
Some faces are more symmetrical than others. People studied preferred faces that are more symmetrical when compared to those that were less symmetrical. This may be in part because of the perception that people with symmetrical faces are more healthy, and thus make better reproductive mates (Rhodes, 2006). Another hypothesis is that symmetrical faces seem more familiar and thus less threatening to us (Winkielman & Cacioppo, 2001). The attraction to symmetry is not limited to facial features. In *Human Sexual Selection and Developmental Stability* Gangestad & Thornhill, 1997, posit that body symmetry, meaning a correspondence of body parts in size and shape may trigger in someone the perception that that person will reproduce well. So we may be drawn to symmetrical body types for that reason whether we are aware of this or not (Gangestad & Thornhill, 1997).

One might think that people prefer faces that are unusual or unique, but in fact the opposite is true (Langlois, Roggman, & Musselman, 1994). Langlois and Roggman (1990) showed college students the faces of men and women. The faces were composites made up of the average of 2, 4, 8, 16, or 32 faces. The researchers found that the more faces that were averaged into the image, the more attractive it was judged to be. As with the findings for facial symmetry, one possible explanation for our preference toward average faces is because they are more similar to the ones that we have frequently seen, and thus are more familiar to us (Grammer, Fink, Juette, Ronzal, & Thornhill, 2002).

Sidebar 8.1: The Science of Attraction

Romantic chemistry is all about warm, gooey feelings that gush from the deepest depths of the heart…right? Not quite. Actually, the real boss behind attraction is your brain, which runs through a very quick, very complex series of calculations when assessing a potential partner. Dawn Maslar explores how our five senses contribute to this mating game, citing some pretty wild studies along the way. Watch Dawn Maslar: The science of attraction | TED Talk

[Directed by TOGETHER, narrated by Addison Anderson].



Symmetry may have evolutionary significance—people with these characteristics probably appear to be healthy and would make good reproductive partners. Although the preferences for youth, symmetry, and averageness appear to be universal, at least some differences in perceived attractiveness are due to social factors. What is seen as attractive in one culture may not be seen as attractive in another, and what is attractive in a culture at one time may not be attractive at another time. Additionally, these preferences are perhaps what leads to initial attraction in some cases but there are many other factors beyond physical appearance that cause people to find someone attractive.

Sidebar 8.2: The Ideal Female Form throughout History

Watch a visually dynamic attempt to recreate this evolution, Women's Ideal Body Types Throughout History showcased a diverse cast of models to depict more than 3,000 years of women's ideal body types by each society's standard of beauty.

Gender Differences in Perceived Attractiveness

You might wonder if gender influences what we find attractive. The answer is yes, although as in most cases with gender differences, the differences are outweighed by overall similarities. Overall, most people value physical attractiveness, as well as certain personality characteristics, such as kindness, humor, dependability, intelligence, and sociability and this is true across different genders and cultures (Li, Bailey, Kenrick, & Linsenmeier, 2002). For people who identify as heterosexual men, the physical attractiveness of a mate is most important whereas people who identify as heterosexual women do value attractiveness in a mate, but are more interested in the social status of a potential partner. (Li, Bailey, Kenrick, & Linsenmeier, 2002).

Some Data on Attraction Preferences Among Lesbians and Gay Men

Many of the same factors that influence sexual attraction for heterosexual people also apply to lesbians and gays. Research by Bailey et al. found that homosexual

men showed similar preferences for physical attractiveness as heterosexual men, whereas homosexual women were similar to heterosexual women in ranking attractiveness relatively low (Bailey, Gaulin, Agyei, & Gladue, 1994). Studies on the topic of age preferences suggest that in homosexual individuals are also similar to those of heterosexual individuals. Like their heterosexual counterparts, homosexual men show a tendency to be sexually interested in young men, and homosexual women show a tendency to be interested in women in their own age range (Kenrick, Keefee, Bryan, Barr, & Brown, 1995). The **modularity hypothesis** (Symons, 1979) explains homosexuality as different from heterosexuality only with respect to the sex of the desired partner, and suggests that homosexual and heterosexual individuals show similar patterns regarding other aspects of sexual psychology. Thus, no differences in age preferences would be expected based on sexual orientation alone. Less research is available about age preferences in bisexuals. A study by Adam (2000) suggests, however, that both homosexual men and bisexual men display the same interest in young partners as heterosexual men do.

Sidebar 8.3: Wearing My Heart on My Sleeve - A Personal Reflection

Growing up, I specifically remember being sexually attracted to men and women, but I was unable to feel emotionally attracted to men until I was 20 years old. Despite being attracted to them, I was unable to feel love towards men, whereas I was able to feel love towards women. To this day, I am unsure as to why I was unable to feel emotional connections to men, but I'm sure a psychologist would blame my father! If I had to guess, I believe that sexual attraction differs from emotional attraction, and until I was 20 years old, I was unable to allow myself to be vulnerable around men.

Online dating apps have helped me express my sexuality and show vulnerability towards men, but it has also negatively impacted the ways that I perceive love due to the anonymity of the app. Due to this, I've begun to take more precautions before meeting up with anonymous people on the internet because I've noticed an unhealthy pattern of love bombing, or attempting to influence another person with an abundance of affection, in my intimate interactions with other men. Not only have I noticed myself quickly falling in love with Internet strangers, but I've noticed other people doing it as well!

In my early twenties, I worked in Arizona for a short period of time, and when I drove home, I spent the night in New Mexico, where I slept with a man I met on Grindr. The next day, I left New Mexico and drove to Minnesota, but I ended up returning to New Mexico after a week, with the intention of moving in with the man who I fell in love with way too quickly. The man and I dated for about a week before he cheated on me. After I found out the man cheated on me, I left New Mexico and vowed to never move across the country to begin a romantic relationship with someone unless I've spent more than 24 hours with the person! I've learned a lot about attraction and love throughout the last few years of my adulthood, and I've also experienced the consequences of wearing my heart on my sleeve!

Physical Proximity

When you ask some people how they met their significant other, you will often hear proximity is a factor in how they met. Perhaps, they were taking the same class, or their families went to the same grocery store. These common places create opportunities for others to meet and mingle. We are more likely to talk to people that we see frequently. Proximity allows people the opportunity to get to know one other and discover their similarities—all of which can result in a friendship or intimate relationship. Proximity is not just about geographic distance, but rather **functional distance,** or the frequency with which we cross paths with others. How does the notion of proximity apply in terms of online relationships? Deb Levine (2000) argues that in terms of developing online relationships and attraction, functional distance refers to being at the same place at the same time in a virtual world (i.e., a chat room or Internet forum)—crossing virtual paths.

Aditi Kulkarni. 2022.Creative Commons Attribution-Share Alike 4.0

Familiarity

One of the reasons why proximity matters to attraction is that it breeds familiarity; people are more attracted to that which is familiar. Just being around someone or being repeatedly exposed to them increases the likelihood that we will be attracted to them. We also tend to feel safe with familiar people, as it is likely we know what to expect from them. In 1968, Dr. Robert Zajonc labeled this phenomenon the **mere-exposure effect**. More specifically, he argued that the more often we are exposed to a stimulus (e.g., sound, person) the more likely we are to view that stimulus positively. In 1992, Moreland and Beach demonstrated this by exposing a

college class to four women (similar in appearance and age) who attended different numbers of classes, finding that the more classes a woman attended, the more familiar, similar, and attractive they were considered by the other students.

There is a certain comfort in knowing what to expect from others; consequently, research suggests that we like what is familiar. While this is often on a subconscious level, research has found this to be one of the most basic principles of attraction (Zajonc, 1980). We are attracted to familiar people because we consider them to be safe and unlikely to cause harm. This doesn't just apply to people we've actually seen before or to people who look familiar, but also to people who behave in ways that are familiar to us. For example, if you grew up with an alcoholic person, you may tend to be attracted to people who are alcoholics, because you find their behavior familiar. Even when someone's behavior or personality is hurtful, on a subconscious level, some part of you may find comfort in the familiarity of that behavior. Good or bad, the environment in which you grew up is the only home you have ever known. This is one reason that it may be difficult for people to leave hurtful relationships, if that is what they are used to.

Similarities and Differences

It feels comforting when someone who appears to like the same things you like also has other similarities to you. Thus, you don't have to explain yourself or give reasons for doing things a certain way. People with similar cultural, ethnic, or religious backgrounds are typically drawn to each other for this reason. This is also defined as a **similarity thesis**. The similarity thesis basically states that we are attracted to and tend to form relationships with others who are similar to us. There are three reasons why similarity thesis works: validation, predictability, and affiliation. First, it is validating to know that someone likes the same things that we do. It confirms and endorses what we believe. In turn, it increases support and affection. Second, when we are similar to another person, we can make predictions about what they will like and not like. We can make better estimations and expectations about what the person will do, and how they will behave. The third reason is due to the fact that we like others who are similar to us, and they may also like us because we are the same. Hence, it creates affiliation or connection with that other person.

However, there are some people who are attracted to someone completely opposite from who they are. This is where differences come into play. Differences can make a relationship stronger, especially when you have a relationship that is **complementary**. In complementary relationships, each person in the relationship can help satisfy the other person's needs. For instance, one person likes to talk, and the other person likes to listen. They get along great because they can be comfortable in their communication behaviors and roles. In addition, they don't have to argue over who will need to talk. One person may like to cook, and the other person likes to eat. Both people are getting things they like, and each other's talents are complementary. Usually, friction will occur when there are differences of opinion or control issues. For example, if you have someone who loves to spend money and another person who loves to save money, it might be difficult to decide how to handle financial issues.

Perceived Gain

This type of relationship might appear similar to an economic model, and can be explained by **exchange theory**. In other words, we will form relationships with people who can offer us rewards that outweigh the costs. Rewards are benefits we want to acquire. They could be tangible (e.g., food, money, clothes) or intangible (support, admiration, status). Costs are undesirable tasks that we don't want to expend a lot of energy to do. For instance, we don't want to have to constantly nag the other person to call us, or spend a lot of time arguing about past items. Ideally a relationship will have fewer costs and more rewards. Often, when people are deciding whether or not to end a relationship, they will consider the costs and rewards.

Disclosure

Sometimes, we form relationships with others after we have disclosed something personal about ourselves. Disclosure increases liking, because it creates support and trust between people. We typically don't disclose our most intimate thoughts to a stranger. We do this with people we are close to because it creates a bond with them. Disclosure does not automatically lead to forming a relationship. Disclosure needs to be appropriate and reciprocal. In other words, if you provide information, it must be mutual. If you reveal too much or too little, it might be regarded as

inappropriate and can create tension. Also, if you disclose information too early in the relationship, it can be problematic.

Physiological Arousal

If you meet a new person when already physiologically aroused, this may increase the likelihood of developing an attraction. The likely mechanism is a misattribution of physiological arousal. For this to happen, the true source of the arousal must be ambiguous and not clear to the person what is responsible for it. The ambiguity may lead for a person to incorrectly label the true source of arousal (fear of heights, exercise to bring the heart rate up, etc.). According to this body of research, dinner and a movie are not the best first date activities. Instead, skydiving is the way to go!

Love Styles

Attitudes toward love and perceptions of love may change throughout an individual's life. College students may perceive love very differently from their parents or guardians. College students are in a different stage of life and their decisions reflect this. College students are living among people their age who are more than likely single or unmarried. There are more prospects for dating, and experimentation. College students are at the time in their life when committed relationships and the work involved may not be their best option. Instead they may choose "hooking up". In contrast, individuals with children who are financially tied

may view romantic relationships as partnerships, in which goal achievement (pay off the house, send kids to college, pay off debt, etc.) is as important as romance. We can trace these differences in perception of love as far back as the classical age. The Greeks distinguished four concepts of love:

- *Storge*: loving attachment and non-sexual affection; the type that binds parents and children
- *Agape*: selfless love similar to generosity and charity
- *Philia*: friendship love, liking and respect rather than sexual desire
- *Eros*: passionate love similar to modern concept of passion

What concept of love is depicted on an image of the ancient Greek drinking cup?

An image on an ancient Greek drinking cup of two lovers kissing. ca. 480 BC [Image: Marie-Lan Nguyen, goo.gl/uCPpNy,Public Domain]

Color Wheel Theory of Love

The color wheel theory of love was conceptualized by Canadian psychologist John Alan Lee in 1973. Lee describes six love styles, using several Latin and Greek words for love. First introduced in his book, *Colours of Love: An Exploration of the Ways of Loving* (1973), Lee defines three primary, three secondary, and nine tertiary love styles, describing them in the traditional color wheel. The three primary types are Eros, Ludus and Storge, and the three secondary types are Mania, Pragma and Agape.

Eros is the Greek term for romantic, passionate, or sexual love, from which the term "erotic" is derived. Lee describes Eros as a passionate physical and emotional love feeling of wanting to satisfy, create sexual contentment, security, and aesthetic

enjoyment for each other, it also includes creating sexual security for the other by striving to forsake options of sharing one's intimate and sexual self with outsiders. It is a highly sensual, intense, passionate style of love. Erotic lovers choose their lovers by intuition or "chemistry". They are more likely to say they fell in love at first sight than those of other love styles.

Storge is the Greek term for familial love. Lee defines *Storge* as growing slowly out of friendship and based more on similar interests and a commitment to one another rather than on passion. However, he chooses *Storge*, rather than the term *Philia* (the usual term for friendship) to describe this kind of love.

Ludic means "game" or "school" in Latin. Lee uses the term to describe those who see love as a desire to want to have fun with each other, to do activities indoor and outdoor, tease, indulge, and play harmless pranks on each other. The acquisition of love and attention itself may be part of the game. Individuals with this love style have a low tolerance for commitment, jealousy, and strong emotional attachment.

In contrast, **agape** love involves altruism, giving, and other-centered love. This love style approaches relationships in a non-demanding style with gentle caring and tolerance for others. Lee describes agape as an altruistic love, given by the lover who sees it as his obligation without expecting reciprocity. According to Lee, Agapic lovers are usually older and more emotionally mature, thus a love guided by will and reason rather than emotion or attraction.

Pragma love is known as practical love involving logic and reason. Arranged marriages were often arranged for functional purposes. Kings and Queens of different countries often married to form alliances. This love style may seek out a romantic partner for financial stability, ability to parent, or simple companionship.

Mania is the final love style characterized by dependence, uncertainty, jealousy, and emotional upheaval. This type of love is insecure and needs constant reassurance.

THE COLOUR WHEEL OF LOVE

These love styles are not mutually independent. An individual may approach love from a pragmatic stance *and* have found love that provides financial stability. However, they still feel insecure (representative of mania) about whether their romantic partner will remain with them, thus ensuring continued financial stability. People engage in each of these love styles, and it is simply a matter of how much of each love style a person possesses.

Sternberg's Triangular Theory of Love

Is all love the same or are there different types of love? Examining these questions more closely, Robert Sternberg's (2004, 2007) work has focused on the notion that all types of love are comprised of three distinct areas: intimacy, passion, and commitment. Intimacy includes caring, closeness, and emotional support. The passion component of love is comprised of physiological and emotional arousal; these can include physical attraction, emotional responses that promote physiological changes, and sexual arousal. Lastly, commitment refers to the cognitive process and decision to commit to love another person and the willingness to work to keep that love over the course of your life. The elements involved in intimacy (caring, closeness, and emotional support) are generally found in all types of close relationships—for example, a mother's love for a child or the love that friends share. Interestingly, this is not true for passion. Passion is unique to romantic love, differentiating friends from lovers. In sum, depending on the type of love and the stage of the relationship (i.e., newly in love), different combinations of these elements are present.

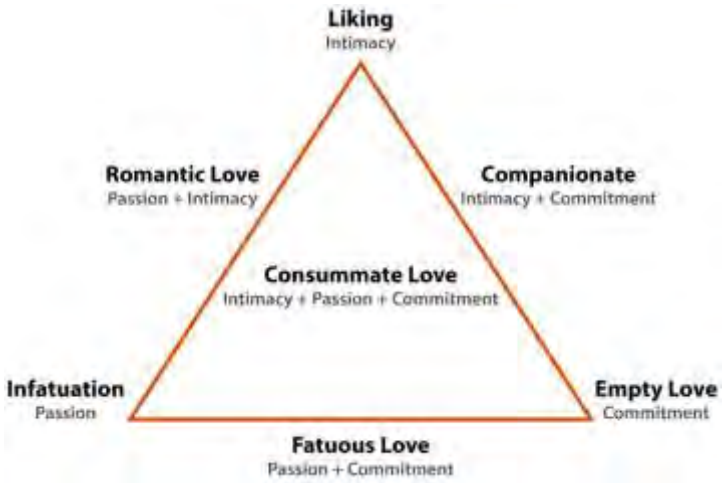


Figure 1: Triangular Theory of Love. Adapted from Wikipedia Creative Commons, 2013

1. **Liking** in this case is not used in a trivial sense. Sternberg says that this intimate liking characterizes true friendships, in which a person feels a bondedness, a warmth, and a closeness with another but not intense passion or long-term commitment.

2. **Infatuated love** is often what is felt as "love at first sight." But without the intimacy and the commitment components of love, infatuated love may disappear suddenly.

3. **Empty love:** Sometimes, a stronger love deteriorates into empty love, in which the commitment remains, but the intimacy and passion have died. In cultures in which arranged marriages are common, relationships often begin as empty love.

4. **Romantic love:** Romantic lovers are bonded emotionally (as in liking) and physically through passionate arousal.

5. **Companionate love** is often found in marriages in which the passion has gone out of the relationship, but a deep affection and commitment remain. Companionate love is generally a personal relation you build with somebody you share your life with, but with no sexual or physical desire. It is stronger than friendship because of the extra element of commitment.

6. **Fatuous love** can be exemplified by a whirlwind courtship and marriage in which a commitment is motivated largely by passion, without the stabilizing influence of intimacy.

7. **Consummate love** is the complete form of love, representing the ideal relationship toward which many people strive but which apparently few achieve. Sternberg cautions that maintaining a consummate love may be even harder than achieving it. He stresses the importance of translating the components of love into action. "Without expression," he warns, "even the greatest of loves can die" (Sternberg 1988, p.341). Consummate love may not be permanent. For example, if passion is lost over time, it may change into companionate love.

The balance among Sternberg's three aspects of love is likely to shift through the course of a relationship. A strong dose of all three components-found in consummate love-typifies, for many of us, an ideal relationship. However, time alone does not cause intimacy, passion, and commitment to occur and grow. Knowing about these components of love may help couples avoid pitfalls in their relationship, work on the areas that need improvement, or help them recognize when it might be time for a relationship to come to an end.

Taking this the study of love a step further, Anthropologist Helen Fisher studied fMRI brain scans of people who had just fallen in love and observed that their brain chemistry was "going crazy," similar to the brain of an addict on a drug high (Cohen, 2007). Specifically, serotonin production increased by as much as 40% in newly in-love individuals. Further, those newly in love tended to show obsessive-compulsive tendencies. Conversely, when a person experiences a breakup, the brain processes it in a similar way to quitting a heroin habit (Fisher, Brown, Aron, Strong, & Mashek, 2009). Thus, those who believe that breakups are physically painful are correct! Another interesting finding is that long-term love and sexual desire activate different areas of the brain. Sexual needs activate the part of the brain that is particularly sensitive to innately pleasurable things such as food, sex, and drugs (i.e., the striatum—a rather simplistic reward system), whereas love requires conditioning—it is more like a habit. When sexual needs are rewarded consistently, then love can develop. In other words, love grows out of positive rewards, expectancies, and habit (Cacioppo, Bianchi-Demicheli, Hatfield & Rapson, 2012).

Sidebar 8.4: Intense Romantic Love and Long Term Relationships

Dr. Helen Fisher, senior research fellow at the Kinsey Institute, discusses how intense romantic love affects our long-term goals here. They explain how to

maintain novelty, the fuel of romantic love, and how to be aware of the brain regions that affect satisfaction in a relationship.

Factors that Define Close Relationships

How do attraction and love emerge in sexual or romantic relationships? Some ways in which these types of relationships form and what holds them together is our next focus. In our next chapter, we will extend and expand this initial discussion of relationships, describing a broader assortment of styles, and some more tips on how to keep relationships thriving. We are just getting started!

Closeness and Intimacy

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Although it is safe to say that many of the variables that influence initial attraction remain important in longer-term relationships, other variables also come into play over time. One important change is that as a relationship progresses, the partners come to know each other more fully and care about each other to a greater degree. In thriving relationships, the partners feel increasingly close to each other over time. The closeness experienced in these relationships is marked in part by reciprocal **self-disclosure**—the tendency to communicate frequently, without fear of reprisal, and in an accepting and empathetic manner.

An **intimate relationship** can be defined as partners in a relationship that feel that they are close, and when they indicate that the relationship is based on caring, warmth, acceptance, and social support (Sternberg, 1986). Partners in intimate relationships are likely to think of the couple as "we" rather than as separate individuals. People who have a sense of closeness with their partner(s) are better

able to maintain positive feelings about the relationship, while at the same time are able to express negative feelings and to have accurate (although sometimes less than positive) judgments of the other (Neff & Karney, 2002). People may also use their close partner's positive characteristics to feel better about themselves (Lockwood, Dolderman, Sadler, & Gerchak, 2004).

Interdependence and Commitment

Another factor that makes long-term relationships different from short-term ones is that they are more complex. When a couple begins to take care of a household together, has children, and perhaps has to care for elderly parents, the requirements of the relationship become correspondingly bigger. As a result of this complexity, the partners in close relationships increasingly turn to each other, not only for social support, but also for help in coordinating activities, remembering dates and appointments, and accomplishing tasks (Wegner, Erber, & Raymond, 1991). The members of a close relationship are highly interdependent, relying to a great degree on each other to meet their goals.

It takes a long time for partners in a relationship to develop the ability to understand the other person's needs, and to form positive patterns of interdependence in which each person's needs are adequately met. The social investment of a significant other is a rich, complex, and detailed one, because we know and care so much about them and because we have spent so much time in their company (Andersen & Cole, 1990). Because a lot of energy has been invested in creating the relationship, particularly when the relationship includes children, breaking off the partnership becomes more and more costly with time. After spending a long time with one person, it may also become more and more difficult to imagine ourselves with anyone else.

In relationships in which a positive rapport between the partners is developed and maintained over a period of time, the partners are happy with the relationship and they become committed to it. **Commitment** refers to the feelings and actions that keep partners working together to maintain the relationship. In comparison with those who are less committed, partners who are more committed to the relationship see their mates as more attractive than others, are less able to imagine themselves with another partner, express less interest in other potential mates, are

less aggressive toward each other, and are less likely to break up (Simpson, 1987; Slotter et al., 2011).

Commitment may in some cases lead individuals to stay in relationships that they would otherwise leave, even though the costs of remaining in the relationship are very high. On the surface, this seems puzzling, because most people presumably attempt to maximize their rewards in relationships, and would leave them if they are not fulfilling. But in addition to evaluating the outcomes that one gains from a given relationship, the individual also evaluates the potential costs of moving to another relationship, or not having any relationship at all. We might stay in a romantic relationship, even if the benefits of that relationship are not high, because the costs of being in no relationship at all are perceived as even higher. We may also remain in relationships that have become dysfunctional in part because we recognize just how much time and effort we have invested in them over the years. When we choose to stay in situations largely because we feel we have put too much effort in to be able to leave them behind, this is known as the **sunk costs bias** (Eisenberg, Harvey, Moore, Gazelle, & Pandharipande, 2012). In short, when considering whether to stay or leave, it is advised to consider both the costs and benefits of the current relationship and the costs and benefits of the alternatives to it (Rusbult, Olsen, Davis, & Hannon, 2001).

Although the good news about interdependence and commitment is clear—they help relationships last longer—they also have a potential downside. Breaking up, should it happen, is more difficult in relationships that are interdependent and committed. The closer and more committed a relationship has been, the more devastating a breakup will be.

Sidebar 8.5: On Codependency and Ending the Relationship

"Sad couple" by Garik Lawson Asplund is licensed under CC BY-NC 2.0

Moving on after a relationship ends is often a painful and lengthy process, especially for people with codependent traits. Codependency is a group of traits or a way of relating to one's self and others. People-pleasing, caretaking as a source of self-esteem, fear of abandonment, difficulty setting boundaries, a need for external validation, wanting to feel in control and obsessive thoughts make it challenging for us to release our dependency on someone else. People develop these traits in childhood, generally as a result of family dynamics and trauma. Some people carry these traits with them into adult life, and they often negatively impact their romantic life and other adult relationships. Codependent people often have a particularly difficult time moving on after a break-up or the end of a relationship. Even when they know it was an unhealthy relationship, they have a very hard time moving forward with their life. However, it is possible to break the cycle of codependency. Below are some suggestions if you think you may be in a codependent relationship:

- Start focusing on you; one of the hardest things for someone with codependency to do is to focus on themselves in a positive, loving and supportive way. Taking small steps and working daily to learn about the real you and not the messages you have heard for years from emotionally abusive partners is an essential first step.

- Work with a therapist. By working with a therapist to uncover the trauma and dysfunction that often formed thoughts about self-worth and control by watching parents interact with each other in unhealthy and codependent ways.
- Become comfortable single. Learning to be a confident single person is a long-term goal in recovery from codependency. A person has to learn to be comfortable with themselves before trying a new relationship.

Attachment Styles

Attachment research suggests that the type of intimate relationship people form are due to the type of attachment formed as a child. Attachment theory examines the relationship between a person in their early years with at least one primary caregiver, and based on this(ese) relationship(s), we develop our attachment style. Hazan and Shaver (1987) applied attachment theory to adult romantic relationships. See below:

- Secure: I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't often worry about being abandoned or about someone getting too close to me.
- Avoidant: I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.
- Anxious/Ambivalent: I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't stay with me. I want to merge completely with another person, and this sometimes scares people away.

Adapted from Hazan, C., & Shaver, P. (1987) Romantic love conceptualized as an attachment process. Journal of Personality and Social Psychology, 52, 511-524. http://dx.doi.org/10.1037/0022-3514.52.3.511 Page 515

Bartholomew (1990) took this further and challenged the categorical view of attachment in adults and introduced two dimensions (avoidance and anxiety) for the four attachment styles (secure, dismissing, preoccupied, and fearful- avoidant (see Figure below). He suggested that adult attachments vary along two dimensions.

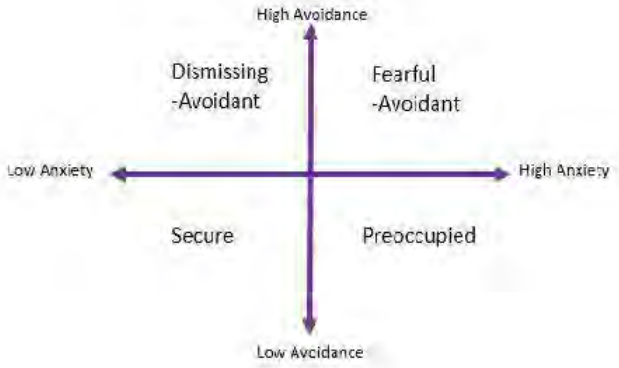

Figure 7.19 *Four-Category Model with the Two- Dimensions of Attachment Source: Adapted from Fraley, et al., 2015. p. 355*

Securely attached adults score lower on both dimensions. They are comfortable trusting their partners, and do not worry excessively about their partner's love for them. Adults with a dismissing style score low on attachment-related anxiety, but higher on attachment-related avoidance. Such adults dismiss the importance of relationships. They trust themselves, but do not trust others, thus do not share their dreams, goals, and fears with others. They do not depend on other people, and feel uncomfortable when they have to do so.

Those with a preoccupied attachment are low in attachment-related avoidance, but high in attachment-related anxiety. Such adults are often prone to jealousy and worry that their partner does not love them as much as they need to be loved. Adults whose attachment style is fearful- avoidant score high on both attachment-related avoidance and attachment-related anxiety. These adults want close relationships, but do not feel comfortable getting emotionally close to others. They have trust issues with others and often do not trust their own social skills in maintaining relationships.

Do people with certain attachment styles attract those with similar styles? When people are asked what kinds of psychological or behavioral qualities they are seeking in a romantic partner, a large majority of people indicate that they are seeking someone who is kind, caring, trustworthy, and understanding. These are the kinds of attributes that characterize a "secure" caregiver (Chappell & Davis, 1998). However, we know that people do not always end up with others who meet their ideals. Are secure people more likely to end up with secure partners, and, vice

versa, are insecure people more likely to end up with insecure partners? The majority of the research that has been conducted to date suggests that the answer is "yes." Frazier, Byer, Fischer, Wright, and DeBord (1996) studied the attachment patterns of more than 83 heterosexual couples and found that, if one partner was relatively secure, the other was also likely to be secure.

One important question is whether these findings exist because (a) secure people are more likely to be attracted to other secure people, (b) secure people are likely to create security in their partners over time, or (c) some combination of these possibilities. Existing empirical research strongly supports the first alternative. A 2010 study by McClure et. al. entitled, *A signal detection analysis of chronic attachment anxiety at speed dating: Being unpopular is only the first part of the problem,* found that when people have the opportunity to interact with individuals who vary in security in a speed-dating context, they express a greater interest in those who are higher in security than those who are more insecure (McClure, Lydon, Baccus, & Baldwin, 2010). However, there is also some evidence that people's attachment styles mutually shape one another in close relationships. For example, in a longitudinal study, Hudson, Fraley, Vicary, and Brumbaugh (2014) found that if one person in a relationship experienced a change in security, their partner was likely to experience a change in the same direction.

Research has found that the attachment styles affect people's sexual behaviors and levels of sexual functioning. A review of 15 studies by Stefanou and McGabe (2012) uncovered that the high level of anxious attachment leads to more frequent sex and pursuit of sex as a means of getting closer to the partner. On the other hand, high level of avoidant attachment is linked to less frequent sexual activity and pursuit of sex for non-romantic reasons, like to manipulate a partner or to enhance one's own status. Both anxious and avoidant attachment were linked to lower sexual satisfaction.

Communal vs Exchange Relationships

In intimate relationships, the partners can become highly attuned to each other's needs, such that the desires and goals of the other become as important as, or more important than, one's own needs. When people are attentive to the needs of others—for instance, parents' attentiveness to the needs of their children or the attentiveness of partners in a romantic relationship—and when they help the other

person meet his or her needs without explicitly keeping track of what they are giving or expecting to get in return, we say that the partners have a communal relationship. **Communal relationships** are close relationships in which partners suspend their need for equity and exchange, giving support to the partner in order to meet this partner needs, and without consideration of the costs to themselves. Communal relationships are contrasted with **exchange relationships**, relationships in which each of the partners keeps track of his or her contributions to the partnership.

Research suggests that communal relationships can be beneficial, with findings showing that happier couples are less likely to "keep score" of their respective contributions (Buunk, Van Yperen, Taylor, & Collins, 1991). And when people are reminded of the external benefits that their partners provide them, they may experience decreased feelings of love for them (Seligman, Fazio, & Zanna, 1980).

Although partners in long-term relationships are frequently willing and ready to help each other meet their needs, and although they will in some cases forgo the need for exchange and reciprocity, this does not mean that they always or continually give to the relationship without expecting anything in return. Partners often do keep track of their contributions and perceived benefits. If one or both of the partners feel that they are unfairly contributing more than their share, and if this inequity continues over a period of time, the relationship will suffer. Partners who feel that they are contributing more may become upset if they feel that they are being taken advantage of. Partners who feel that they are receiving more than they deserve might feel guilty about their lack of contribution to the partnership.

Members of long-term relationships focus to a large extent on maintaining equity, and are happiest when all members perceive that they contribute relatively equally (Van Yperen & Buunk, 1990). Interestingly, it is not just our perception of the equity of the ratio of rewards and costs we have in our relationships that is important. It also matters how we see this ratio in comparison to those that we perceive people in similar situations as us receiving in the relationships around us. Buunk and Van Yperen (1991), for example, found that people who saw themselves as getting a better deal than those around them were particularly satisfied with their relationships. When we contrast our own situation with that of similar others and we perceive ourselves as better off, we tend to feel better about ourselves and our lot in life. There are also some individual differences in the extent to which perceptions of equity are important. Buunk and Van Yperen, for example, found

that the relationship between perceptions of equity and relationship satisfaction only held for people who were high in exchange orientation. In contrast, those low in exchange orientation did not show an association between equity and satisfaction, and, perhaps even more tellingly, were more satisfied with their relationships than those high in exchange orientation.

In summary, people generally stay in relationships longer when they feel that they are being rewarded by them (Margolin & Wampold, 1981). In relationships that last, the partners are aware of the needs of the other person and attempt to meet them equitably. Partners in lasting relationships are also able to look beyond the rewards themselves, and to think of the relationship in a communal way.

So far, we have discussed the factors of interpersonal attraction, and what is important in close relationships. Now, let's discuss what it takes to keep the relationship. It is true that many relationships end, and this number is higher in individualistic cultures, where the focus is on the individual, rather than it is in collectivistic cultures, where the focus is on maintaining group togetherness. (Kreider & Fields, 2000). Successful relationships take work, but the work is worth it. According to Kiecolt-Glaser & Newton (2000) people who are happy with their partner are also happier overall and have better psychological and physical health.

Making Relationship Last

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Some relationships last for many years and others don't. In Western cultures, people tend to form relationships with more than one partner throughout their lives, and the majority of these relationships come to an end. As people spend time together, they learn if they are well-matched, and most people learn how to compromise to help build and sustain relationships, communicate better and resolve conflicts in a constructive way. Below are some tips for when conflict arises.

- **Be prepared for squabbles**. Every relationship has conflict. This is not unexpected or always bad. Working through minor conflicts can help you and your partner improve your social skills and make the relationship stronger (Pickett & Gardner, 2005).

- **Don't be negative**. Negative cognitions and emotions have an extremely harmful influence on relationships (Gottman, 1994). The research showed that the strongest predictor of whether a given relationship succeeded was the ratio of positive to negative comments during the interaction. Those couples that expressed at least five positive comments for every one negative comment were the most likely to survive. The couples who expressed negative comments more frequently often headed for a breakup.
- **Be fair in how you evaluate behaviors**. Many people in close relationships, as do most people in their everyday lives, tend to inflate their own self-worth. They rate their own positive behaviors as better than their partner's, and rate their partner's negative behaviors as worse than their own. Try to give your partner the benefit of the doubt—remember that you are not perfect either.
- **Do things that please your partner**. The principles of social exchange make it clear that being nice to others leads them to be nice in return. This can be looked as a willingness to indulge in one of your partner's sexual fantasies, even if it is not as exciting for you. This type of mutual compromise can help people in intimate relationships achieve sexual satisfaction, while learning the give and take that partnering with another person entails.
- **Have fun**. Relationships in which the partners have positive moods and in which the partners do not feel bored tend to last longer (Tsapelas, Aron, & Orbuch, 2009). Human beings have a fundamental need to grow the self over time and in high-functioning relationships both partners fulfill the need for self-expansion. This can be accomplished by sharing self-expansion

experiences and doing exciting, novel, and varied things. When romantic partners fall into a routine, they run the risk of the relationship going stale. According to research on couples in long-term relationships, those who engage in novel and exciting activities together continue having the most intense feelings of love for one another (O'Leary et as., 2012). Another research study has found that the difference between couples in long-term relationships whose passion endured is in sexual variety (Frederick et al., 2017). Novelty in sexual encounters helps to fend off habituated desire and we can keep passion alive through maintaining novel sex life.

Sidebar 8.6: Some Thoughts on Romantic Competence

Joanne Davila, is a professor of psychology and the director of clinical training at Stony Brook University in Stony Brook, New York. In this TED Talk, Professor Davila discusses the 3 core skills needed for romantic competence. Davilla defines romantic competence as "the ability to function adaptively across all areas or all aspects of the relationship process [including] … figuring out what you need, finding the right person, building a healthy relationship, [and] getting out of relationships that are unhealthy." More on this here: Skills for Healthy Romantic Relationships | Joanne Davila | TEDxSBU

Internet and Close Relationship

Many of us are spending more time than ever connecting with others electronically. Online close relationships are also becoming more popular. However, you might wonder whether meeting and interacting with others online can create the same sense of closeness and caring that we experience through face-to-face encounters. And you might wonder whether people who spend more time on the Internet might end up finding less time to engage in activities with the friends and loved ones who are physically close by (Kraut et al., 1998).

Despite these potential concerns, research shows that using the Internet can lead to positive outcomes in our close relationships (Bargh, 2002; Bargh & McKenna, 2004). In one study, Kraut et al. (2002) found that people who reported using the Internet more frequently also reported spending more time with their family and friends, and indicated having better psychological health.

The Internet also seems to be useful for helping people develop new relationships, and the quality of those relationships can be as good as or better than those formed face-to-face (Parks & Floyd, 1996). McKenna, Green, and Gleason (2002) found that many people who participated in news and user groups online reported having formed a close relationship with someone they had originally met on the Internet. Over half of the participants said that they had developed a real-life relationship with people they had first met online, and almost a quarter reported that they had married, had become engaged to, or were living with someone they initially met on the Internet.

McKenna, Green, and Gleason (2002) studied how relationships developed online using laboratory studies. In their research, a previously unacquainted male and female college student met each other for the first time, either in what they thought was an Internet chat room or face-to-face. Those who met first on the Internet reported liking each other more than those who met first face-to-face—even when it was the same partner that they had met both times. People also report being better able to express their own emotions and experiences to their partners online than in face-to-face meetings (Bargh, McKenna, & Fitzsimons, 2002).

There are probably a number of reasons why Internet relationships can be so successful. For one, relationships grow to the extent that the partners self-disclose by sharing personal information with each other, and the relative anonymity of Internet interactions may allow people to self-disclose more readily. Another characteristic of Internet relationships is the relative lack of physical cues to a person's attractiveness. When physical attractiveness is taken out of the picture, people may be more likely to form relationships on the basis of other more important characteristics, such as similarity in values and beliefs. Another advantage of the Internet is that it allows people to stay in touch with friends and family who are not nearby, and to maintain better long-distance relationships (Wellman, Quan Haase, Witte, & Hampton, 2001). The Internet also may be helpful in finding others with shared interests and values. Finally, the major purpose of many Internet activities is to make new friends. In contrast, most face-to-face interactions are less conducive to starting new conversations and friendships.

Online interactions can also help to strengthen offline relationships. A 2013 study by Fox, Warber, & Makstaller explored the effects of publicly posting one's relationship status to Facebook, or going "Facebook official" (FBO) on romantic relationships between college students. They found that offline discussions between partners often preceded going FBO, and that once couples had gone FBO, they reported more perceived relationship commitment and stability.

Overall, then, the evidence suggests that rather than being an isolating activity, interacting with others over the Internet helps us maintain close ties with our family and friends, and in many cases, helps us form intimate and rewarding relationships.

Sidebar 8.7: The Four Keys to Improving your Relationship - John M, Gotman, Ph.D.

Arguments do not mean that your relationship is in trouble. Disagreement is inevitable. What matters is how you discuss and solve your disagreements. Use four strategies to break patterns of negativity and take a positive approach to solving problems:

- "Calm down" - You can't resolve your differences productively if your heart is racing and you feel overwhelmed. When things start to get out of hand, ask for a "time out." Taking five to 20 minutes off will calm you enough to allow you to listen better and discuss the subject objectively, rather than emotionally. Soothe yourself by taking deep breaths, a short drive, a walk or even a bath. Halt the negative cycle of your thoughts by replacing "distress-maintaining thoughts" with positive ones such as, "They're frustrated at the moment, but are not always like this," or "They're not really mad at me. They just had a bad day at work."

- "Speak non defensively" - Listen and speak to your spouse in a way that does
  not engender defensiveness but, instead, fosters healthy discussion. Praise and admiration are the best weapons against defensiveness. Remind yourself of your spouse's wonderful qualities to help keep negative thoughts at bay. Empathize with them. Realize that your partner's anger might be an effort to get your attention. Limit yourself to a specific complaint, rather than a multitude of criticisms. Try these approaches: Remove the blame from your comments. State clearly how you feel. Don't criticize your partner's personality. Don't insult, mock or use sarcasm. Be direct. Don't attempt to mindread.

- "Validation"- Validate your spouse's emotions by looking at the situation from his or her viewpoint and perspective. Often, simply empathizing is enough. You don't have to solve the problem. Validation foils criticism,

contempt and defensiveness. Validate your partner and their perspective by taking responsibility for your words and actions, and by apologizing when you are at fault.

- "Overlearning"- Once you learn the techniques of fighting fair, practice them over and over until they become second nature. Your objective is to be able to use these techniques during the heat of a battle, instead of resorting to your old, ineffective ways. Try to rediscover your delight and other positive emotions for each other.

Conclusion

Our initial attraction to others is born out of a number of things. Physical attraction, which is based on cultural standards of attractiveness, proximity to the individual and feeling a connection either through shared meaning or interdependency. Moving from initial attraction to love for another person is a process that involves varied choices and processes. When forming intimate relationships, partners bring with them their own unique biopsychosocial make up, which then interacts in the partnership in ways that either foster a thriving partnership, or become difficult to maintain. As we have said throughout this book and will see in the next chapter, honest communication with oneself and each other is an important aspect of sexual and relational wellness.

Glossary

1. **Commitment:** feelings and actions that keep partners working together to maintain the relationship.
2. **Communal relationships:** close relationships in which partners suspend their need for equity and exchange, giving support to the partner in order to meet this partner needs, and without consideration of the costs to themselves.
3. **Complementary relationships:** each person in the relationship brings different personality attributes to the relationship which can help satisfy the other person's needs

4. **Evolutionary theory:** our behavior reflects evolved adaptations for the survival of our ancestors.
5. **Exchange relationships**, relationships in which each of the partners keeps track of his or her contributions to the partnership
6. **Functional distance** or the frequency with which we cross paths with others
7. **Interpersonal attraction** - the strength of our liking or loving for another person
8. **Mere-exposure effect**. the more often we are exposed to a stimulus (e.g., sound, person) the more likely we are to view that stimulus positively
9. **Modularity hypothesis** explains homosexuality as different from heterosexuality only with respect to the sex of the desired partner, and suggests that homosexual and heterosexual individuals show similar patterns regarding other aspects of sexual psychology.
10. **Self-disclosure**—the tendency to communicate frequently, without fear of reprisal, and in an accepting and empathetic manner
11. **Similarity thesis** we are attracted to and tend to form relationships with others who are similar to us.
12. **Sociocultural Perspective** acknowledges that evolution plays some role in sex differences in attraction; however, the sex differences may be more to do with social and cultural factors.
13. **Sunk cost bias** When we choose to stay in situations largely because we feel we have put too much effort in to be able to leave them behind.

Discussion Questions

1. What does the modularity hypothesis explain?
2. What are some things that have attracted you to another person?
3. How does initial attraction work for you? What draws you to someone?
4. How does (or does not) gender play a role in your attractions?
5. When you are forming a new relationship, do you create agreements or set ground rules? How? Do part relationships inform this?

Multiple Choice

1. When we say that we like or love someone, we are experiencing _____

a. Interpersonal attraction
b. Physical Attraction
c. Emotional Attraction
d. Sexual Attraction

2. There are several reasons researchers have found for our attraction to others, including physical attractiveness, affect, proximity, perceived gain, similarities and differences, and disclosure.

    a. True
    b. False

3. TV ads use attractive people to promote their products, and many people spend considerable amounts of money each year to make themselves look more attractive.

    a. True
    b. False

4. Overall, most people value physical attractiveness, as well as certain personality characteristics, such as:

    a. Kindness
    b. Humor
    c. Dependability
    d. All of the Above

5. _____acknowledges that evolution plays some role in sex differences in attraction; however, the sex differences may be more to do with social and cultural factors.

    a. Similarity Thesis
    b. Sunk Cost Basis

c. Sociocultural Perspective
d. Evolutionary Theory

6. Attraction and love follow similar patterns regardless of a person's sexual orientation. This is known as:
    a. Common sense
    b. Modularity Hypothesis
    c. Sunk Cost Bias
    d. Evolutionary Theory

7. The strength of our liking or loving for another person is known as:
    a. Sociocultural Perspective
    b. Interpersonal Attraction
    c. Mere-Exposure Effect
    d. Functional Distance

8. Evolutionary theory asserts that our behavior reflects evolved adaptations for the survival of our ancestors?
    a. True
    b. False

9. A relationship in which each person in the relationship brings different personality attributes to the relationship which can help satisfy the other person's needs is known as:
    a. Communal relationship
    b. Complementary relationship
    c. Exchange relationship
    d. Codependent relationship

10. Sometimes the mere fact that we are around another person a lot leads us to form an attraction based on the frequency with which we cross paths. This is known as:
    a. Functional Distance
    b. Interpersonal Attraction
    c. Sexual Attraction
    d. Any Port in the Storm

For Further Exploration

The Science of Love | John Gottman | TEDxVeniceBeach

Love, Actually: The science behind lust, attraction, and companionship

Attraction, lust, love: It seems magical but there's science to back it up - oregonlive.com

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Chapter 9: Relationship Styles, Communication, Sexual Behavior, and Fantasies

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Learning Objectives

After completing this module, students should have a working knowledge of:

- The wide variety of relationship styles
- Effective relationship tools
- The importance of honest communication
- Sexual Behaviors
- Sexual Fantasies

Introduction

While many people enter into fulfilling relationships that enhance their lives, relationships also take energy and work to flourish. Part of this work involves open communication, both with ourselves and those who we are partnering with. There are many relationship styles and types, but because of the standard sexual scripts

we've been taught to follow, we usually imagine cisgendered, heterosexual, monogamous couples when we think of a relationship. We hope to expand this understanding here. Our sexual behaviors and fantasies are also varied, and the possibilities are endless. In this chapter, we will dive into some of these different behaviors and fantasies, but know that there is so much more to the story, and you get to imagine your own fantasies and ideas of what feels good. It is important to note that while we may not all find pleasure in the same things, pleasure is something all humans seek. If a particular behavior or fantasy is not appealing to you, that's ok, but please try to keep from judging and open your mind to learning. To put it simply, don't yuck someone else's yum.

Intimate Relationships

Intimate relationships have the capacity to make us feel happy, healthy, and fulfilled. We experience higher self-efficacy, self-esteem, and positivity when we believe that our friends and partners are responding to us supportively, and with a concern for our needs and our own welfare. Our relationships with others help us buffer the negative effects of stress, avoid unhealthy behaviors, and cope with serious physical illness. And our close relationships allow us to express our fundamental desires to reach out and respond to other people.

Often, people point to a **monogamous** (having a sexual relationship with only one partner at a time), heterosexual, married couple to exemplify a loving and committed relationship. In most cultures around the world, heterosexuality, monogamy and marriage are perceived to be the standard type of relationship that all others are held in contrast to. However, there is far greater diversity in the types of loving and committed relationships. In this chapter, we will discuss a number of different relationships with differing views on monogamy, in terms of sexual orientation, and different views on whether to get married or to cohabit.

A recent film on the concept of monogamy explores the ways in which culture drives the types of relationships we consider. This film also delves into the ways in which we blame ourselves if we don't thrive in a monogamous relationship.
Monogamish | Official Trailer - Directed by Tao Ruspoli (Abramorama Films)

Many people consider romantic attachments one of the most significant relationships and invest them with time and resources. [Image: Ly Thien Hoang (Lee), https://goo.gl/JQbLVe, CC BY 2.0, https://goo.gl/BRvSA7]

Same Sex Relationships

Social acceptance of same-sex relationships varies substantially throughout cultures and societies. Over the last few decades, same-sex relationships have changed more than heterosexual relationships. Some cultures became more tolerant and legally recognize same-sex unions. In the US marriage equality (same-sex marriage) was recognized and legalized nationwide in 2015. Research shows that same-sex and different-sex relationships operate in similar ways (Kurdek, 2004), and these couples tend to be as committed to each other and contented as different-sex couples, and the quality of their relationship is similar too.

Some Relationships Styles

Polyamory Pride Flag Molly Colleen Bennett Wilvich. 2022. Creative Commons Attribution-Share Alike 4.0

Monogamous relationships are viewed positively in the modern Western world as relationships that promote strong commitment and health. Non-monogamy is often stigmatized and viewed as illegitimate. Half the states in the United States have laws against sex outside of marriage, although these laws are rarely enforced (Sex and the Law | Nolo). One study found that 75% of Americans believe that extramarital sex was unacceptable and should not be tolerated. However, the research on the incidence of extramarital affairs varies greatly. Many people think that sexual desire drives an extramarital affair; however, research has found that over 90% of extramarital affairs occur because the current relationship does not meet person's emotional needs. Men are approximately three times more likely than women to say that a partner's sexual intercourse with another person was more upsetting than a partner's emotional attachment to that person (Shackelford, et al.). Men also find it more difficult than women to forgive sexual vs. emotional infidelity, and are more likely to say they would break up in response to sexual vs. emotional infidelity (Shackelford, et al.).

Some couples in committed relationships open up their relationship, and encourage their partners to have an extra-relationship affairs or to bring other partners into their bed, believing that sexual variety and experience may enhance their own sexual life. In an online survey (Rubin et al., 2014), 5% of participants said that they have an explicit agreement with their partner that they accept sexual or romantic pursuit outside of their relationship, and are practicing some form of **consensual non-monogamy**. According to a national US survey, about 21% reported that they were in some kind of **open relationship** at some point in their life. Consensual non-monogamy is also called **ethical non-monogamy** when involved parties strongly advocate for being honest with each other. Some people believe that consensual non-monogamy is one way to fight the habituation of desire, because introducing new sexual partners helps to keep sex interesting.

Open relationships generally have a "home base," but partners are free to have other relationships at the same time. Some open relationships adopt a policy of non-disclosure, and some require full disclosure of their outside sexual experiences. **Co-marital sex** refers to the consenting of married couples to sexually exchange partners who are often referred to as **swinging** or **polyamory**. Polyamory is the idea that it is possible to love multiple people simultaneously. It is different from polygamy because a polyamorous person may or not be married,

but the emphasis is mostly on building intimate relationships and not on recreational sex. Most couples who engage in co-marital sex have strict rules to protect their "home base" relationship, and see sex as separate from their loving long-term relationship.

Polygamy is the practice of having more than one spouse at a time. There are two types of polygamy arrangements: **polygyny**, when one man has multiple wives and **polyandry**, when one woman has multiple husbands. Both polygyny and polyandry are believed to be adaptive practices. Polygyny is rarely practiced in the United States. There are some small Mormon fundamentalist groups that practice it; however, they are not officially recognized by the Mormon Church. Polygyny was believed to have been developed in order to increase fertility to increase a greater number of offspring carrying a man's gene. However, it is likely that polygyny developed as a strategy for men to gain prestige and power by having several wives, and for women to gain the protection of a wealthy and powerful man. Polyandry is a practice of having more than one husband at a time and it is less common that polygyny. It usually happens for a reason of keeping inheritance together, and to be protected from a scenario when just one partner may potentially have a gene defect.

Cohabitation and Marriage

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In recent years the institution of **marriage,** the legally or formally recognized union of two people as partners in a personal relationship**,** has declined worldwide, but

cohabitation has increased dramatically. (Cohn, Passel, Wang, & Livingston, 2011). **Cohabitation** is when a couple are living together in a sexual relationship when the partners are not legally married. Cohabitation has become so common that sociologists regard it as a stage of courtship. Cohabitation is sometimes, but not always, a precursor to marriage. It allows couples to learn more about each other's habits and practices without being legally tied together. Cohabitation allows couples to mature together and create a partnership, regardless of if they decide to marry. Research shows that different-sex couples who cohabit are less likely to subscribe to traditional gender roles, and tend to have more equality in their relationships. (Blackwell & Lichter, 2000). However, at this point society as a whole does not legally recognize the cohabitation union for the purpose of health care, taxes, inheritance, etc. If a legal relationship is desired by people in cohabiting relationships, they can become domestic partners. **Domestic Partnership**, a legal relationship between couples, allows them to obtain many of the same benefits as a marriage, formalizing cohabitation. In the US, thirteen states recognize **common-law marriage**, which means that if a couple lives together for a certain number of years, they are automatically considered as married in the eyes of the law.

The meaning and purpose of marriage, and the manner in which spouses are selected, varies across cultures. For instance, in some cultures, like India, Pakistan, Bangladesh, China, and South Korea, the practice of **arranged marriage,** a marriage planned and agreed upon by the families of the couple to be married, is common, although the details differ depending on the cultural practices so not all arranged marriages look alike. These cultures tend to be collectivistic, where the needs of the family and community are placed above the needs of the individual. In contrast, Western cultures are considered to be more individualistic, and marriage is viewed as a matter of individual choice. Although many cultures have a tradition of arranged marriage, Western researchers interested in marital dynamics generally have focused on love-based marriages. A 2012 study entitled *Relationship Outcomes in Indian-American Love-Based and Arranged Marriages* by Regan et. al. compared relationship outcomes in love-based and arranged marriages contracted in the U.S. A community sample of 58 Indian participants living in the U.S. (28 arranged marriages, 30 love-based marriages) completed measures of marital satisfaction, commitment, companionate love, and passionate love. Men reported greater amounts of commitment, passionate love, and companionate love than women. Unexpectedly, no differences were found between participants in arranged and love-based marriages; high ratings of love, satisfaction, and commitment were

observed in both marriage types. The overall affective experiences of partners in arranged and love marriages appear to be similar, at least among Indian adults living in contemporary U.S. society (Regan, Lakhanpal, Anguiano, 2012). According a 2012 study Reexamining the case for marriage: *Union Formation and Changes in Wellbeing by Relationship* by Musick, K. and Bampass, L. an advantage of a long-term relationship is better physical and psychological health than those who remain single, and these benefits extend to married and cohabitating partners as well (Musick & Bumpass, 2012). However, the study noted that being partnered provides more health benefits to men in heterosexual partnerships than women. The authors conclude that it is likely that those women studied tended to have more sources of social and emotional support outside of their primary relationships.

Research suggests that if you focus on the positive aspects of a relationship you are more likely to stay in that relationship. [Image: adwriter, https://goo.gl/Hz9BOJ, CC BY-NC 2.0, https://goo.gl/tgFydH]

Sidebar 9.1: What is a relationship? Questioning Assumed Truths

What is a relationship? As we learn, grow and inhabit (or discard) multiple intersectional identities, we have a variety of them throughout our lives. Relationships are important to most people as they help shape and determine both how we see and navigate through the world. How does bias and cultural norms dictate, implicitly and explicitly, the boundaries of these connections and roles. As individuals we can recognize that the types of relationships we might have are as fluid as other identities we are assigned or adopt through life; for example, spouse, partner, sibling, child, teenager, adult, parental guardian, friend, colleague, mentor, boss, teacher as well as gender and sexual identities. However, the most rigid normative relationship identity that is enforced through societal status is one of monogamy.

Monogamy in both heteronormative and queer relationships are often defined as a one-to-one partnership that is typically intimate and exclusionary of any other partner. This is the relationship style that is reinforced and held up as the only available option throughout most of western culture, society and media. To its credit, even considering the massive divorce rate, monogamy works great for a lot of people. Maybe it even works for you or someone you know but what about the folkx that it doesn't work for? Equally fulfilling relationship styles and formations do exist but they are not the default. Polyamory is one such relationship identity that provides for romantic fulfillment similar to monogamy.

As monogamy is the default in most relationships, we have absorbed and internalized most of the unwritten and codified rules and boundaries that define a monogamous relationship. However, misconceptions abound when defining polyamory due to the bias and stereotypes imposed on it as the non-dominant style. Polyamory with its fluid construction is often wrongly portrayed in modern media as a replacement or in competition to monogamy when in fact it operates in parallel with it. Imagine both types as railroad tracks headed in the same direction rather than greater than/less than signs angrily pointed at each other.

Let's talk about what a polyamorous relationship is and isn't. Two major misconceptions are that it is strictly physical and it is just an excuse to cheat. Poly is

often conflated with open relationships and/or swinging. These are not polyamorous relationships. Polyamorous relationships are defined by transparent communication and boundary setting as well as the consent of all parties. Considering that relationships types under the polygamous umbrella are mutually self-defined and fluid, it is challenging to strictly define all the variations that exist but in general they fall into a few loosely defined categories.

The most common types of polyamory are partner-plus; egalitarian network partnerships sometimes referred to as relationship anarchy (RA) and solo or centered polyamory. All of these might also have attributes and agreements that can include terms like ethical non-monogamy, poly-secure and poly-fidelity. Partner-plus is typically additive and hierarchical; for example, this is when two partners (who are typically married or in a long-term relationship) add a third or fourth individual partner but the activities that those additive partners engage in are well-defined and secondary. Imagine that Alex and Jaiden are the primary partners in a relationship, a third partner, Dylan who is dating Alex share some relationship characteristics and intimacy like going on dates and engaging in shared interests. However, Dylan isn't included in making large primary relationship decisions for Alex and Jaiden like where to live, career advancement and child-rearing. Egalitarian network partnerships or relationship anarchy polyamory, in contrast and as the name suggests operate in a non-hierarchical fashion. Imagine Billy, Dakota and Kai are in this type of poly relationship: No one partner is the primary partner, all partners have an equitable share in making long-term relationship decisions. This is perhaps the most common type of polyamorous relationship making up the majority of the twenty or so percent of folkx in the United States and Canada who are poly and is commonly called a thruple. Thruples are also often characterized as having poly-fidelity or being a closed intimate relationship between the three partners. Solo polyamory is less common but is growing in popularity especially among individuals who identify as asexual, aero or ace. Individuals who engage in these types of relationships often never marry or live with their partners and can be described colloquially as "living together, apart".

A common reaction to these types of relationships is one of, "I can never do that, I would get jealous." Jealousy is, of course, not unique to either monogamous or polyamorous relationships. Surprisingly, most long-term poly relationships have a

lower reporting rate of jealousy as the reason for breaking up and ending. The research suggests that this is due to the increased focus on transparent communication and consent, emotional literacy and the purposeful development of compersion within the relationship. **Compersion** -the joy of seeing others experience joy- isn't often an emotion that is explicitly discussed within monogamous relationships as it is intertwined with its opposites, namely jealousy and shame. Individuals who practice polyamory cultivate and recognize compersion for their partner by acknowledging that jealousy is inevitable in all relationships: Instead of burying those feelings of jealousy in shame and hurt, they celebrate the joys of their partners even if they aren't the direct source of that joy.

Obviously, successful long-term polyamorous relationships exist and these relationships often share the same goals as monogamous relationships using the definitions above. Why then are they impacted by bias and discrimination when viewed through a western lens. One answer might be found by examining both the historical and economic pressures of long-term relationships as well as the sociological construction of the individualistic family unit. Historically, many marriages were seen as transactional often for financial or political security. Highlighting and following this trend from the 18th and 19th century well into the explosive growth of corporate capitalism in 1940's and 50's America, it aligns with the most successful marketing campaign of the last century. The diamond is forever campaign by DeBeers is synonymous with equating monetary worth, winning and competitive success with values like monogamy, love and the normative family unit. It is also synonymous with conflict diamonds, monopolization of both the supply and demand side of a natural resource as well as the creation and perpetuation of what is today's exploitative wedding industry. These norms often work in concert with imagery found throughout media like the Disneyfication of relationship roles which infantize both parties as well as movies and music that capitalize on the idea that one (and only one) special partner should be able to fulfill all the needs in a relationship and that partner must be "won" and "possessed" forever. This seems to mirror and reinforce the idea that the only relationship of value and worth is one that holds the shape of monogamy. This stands in opposition with a more communal pooling of resources for duties like family planning or child rearing common in more non-western facing cultures.

Why is monogamy the default while long-term polyamorous relationships are frequently looked upon with bias and derision? Perhaps, it is only a coincidence that the type of monogamy that is continually reinforced via media, cultural norms and government practices often benefit those that sell the idea of the one and only relationship model often to the financial detriment of the individual couple.

Communication

No matter what type of relationship you are in, or if you are presently single, communication about what you want and need is a crucial part of being fulfilled, sexually or otherwise. Depending on messages you've received throughout your growing years, you may have been told it is your job to please a partner, and not ask for what you want. In reality, a happy thriving person who is able to meet their own needs is a better partner in whatever type of relationship they enter. Asking for what you want is radical self-love, and will make you that much more attractive.

In the U.S. the normative sexual script of a forever couple living happily ever after is a myth that we may hold dear but in most cases, relationships end and life goes on. Sometimes moving on is the best thing to do if the relationship is becoming difficult, unpleasant or toxic, and one or more of the partners are not choosing to work to salvage it. Beginning and ending relationships are a part of the human condition. Sometimes a consensus can be reached by partners that it is just time to move on, but in many cases, it is a hard decision and the period is filled with

unhealthy communication and hurt. Learning when to walk away is not always easy.

Sidebar 9.2: The Four Horsemen of the Apocalypse (Adapted)

Relationship researcher, John Gottman, PhD discusses some thoughts on what he has seen as patterns that may signify the end of a relationship. Troubled relationships follow a similar pattern, featuring four ruinous ways of interacting that undermine communication. One negative path leads to the next, wreaking increasing levels of harm to the relationship. These "Four Horsemen of the Apocalypse" are criticism, contempt, defensiveness and stonewalling.

Criticism, the first damaging process in a relationship, is defined as "attacking someone's personality or character - rather than a specific behavior - usually with blame." For instance, instead of saying, "Please rinse out your dirty coffee cup and put it in the dishwasher," you say, “You are such a slob! You can't even wash a cup properly." Do not confuse criticism with complaining. Some complaining is actually healthy for a relationship. You express dissatisfaction and hope your partner responds. However, when complaints go unanswered, bad feelings build up, and the result is criticism, a destructive behavior.

Contempt is the second horseman. Unresolved issues stealthily permeate other aspects of a relationship. The resulting anger creates a negative thought pattern. Soon, the spouses begin to forget what attracted them to each other in the first place. Contempt is the intention to insult and psychologically abuse your partner. Your words and actions are meant to hurt and create an emotional reaction. Signs of contempt include “insults and name-calling, hostile humor and mockery.” Body language that communicates disgust, such as eye-rolling or sneering, is also contemptuous.

The third destructive horseman is defensiveness. When one partner acts contemptuously, the other naturally becomes defensive. This victim mentality can harm the relationship. Defensiveness takes many forms. In its simplest, it is the act of making excuses for your actions or refusing to accept responsibility. Defensive people assume their partners are judging them.

Such “negative mind reading” might go something like this:
Chris - “You hate when I go out to dinner with my sister. You think I should stay home with the kids.”
Alex - “That's not true... Thursday is a problem because I have a business dinner.”

Some defensive couples fall into one-upmanship. They trade escalating complaints:
Tylor - “You never want to have people over for dinner. You're too lazy.”
Jordan - “If you would clean the house once in a while, we could have people over.”

The final horseman is stonewalling, which occurs when one partner withdraws completely from an interaction. Often, stonewallers say they are trying to be neutral and keep an argument from escalating. But the message they send to their partner is that they don't care enough to engage.

Do you and your romantic partner have similar hobbies? Research suggests that spending time in meaningful ways also positively contributes to your relationships. [Image: Lucky Sunny, https://goo.gl/IADzgz, CC BY-NC-ND 2.0, https://goo.gl/FuDJ6c]

The End of a Relationship

Some relationships last for a very long time, but some deteriorate and end. As mentioned earlier in this chapter, ending and beginning relationships happen for most people, and it is just part of the life cycle. Some factors that lead to deterioration involve unhealthy patterns and poor communication, and other times a relationship has just run its course. Relationships draw to a close when the partners find little satisfaction in the union, and have an opportunity to end a relationship based on cultural rules and norms.

Jealousy and Insecurity

Are you Jealous? Paul Gauguin. 1892. Public Domain

Jealousy can create a wide range of negative effects on our sexual and romantic relationships. Jealousy often contributes to conflict and breakup, but it also could be a contributing factor to relationship violence. Even if a partner is not unfaithful, their partner may still be jealous, and jealousy can harm relationships. Jealousy is a powerful emotion that has been evolutionarily selected to help maintain close relationships. All humans experience jealousy, although they experience it to different extents and in different ways. Culture, gender roles, and how we internalize social norms all contribute to our tendency to feel jealousy and what we feel jealousy about. A number of researchers (e.g., Buss, 2009; Sagarin et al., 2012, Shackelford et al., 2005) all found that when jealousy emerges, there is a gendered difference in how it is experienced and expressed. People who identified as men in the studies were more jealous than people who identified as women overall. And those men were more concerned than the women in the study about sexual infidelities of their partners. Women in the study were relatively more concerned about emotional infidelities of their partners. In further support for Buss' claim, sex differences are also found in the reactions to infidelity and forgiveness with regard to infidelity. Men find it harder to forgive their partner after sexual infidelity, and are more likely to break up with their partners after learning of sexual infidelity, when compared to women. Women find it harder to forgive their partner after emotional infidelity, and are more likely to break up with their partners after learning of emotional infidelity when compared to men (Shackelford, Buss & Bennett, 2002).

Historically, research has focused on interpersonal relationships between opposite-sex couples; only recently has research begun to examine the unique experiences of individuals in same-sex relationships. Differences emerge when studying sexuality in same-sex and opposite-sex relationships. There are differences reported between same-sex and opposite sex couples when examining the issue of sexual exclusiveness with a partner versus openness. There are general differences in attitudes related to monogamy. Thirty-six percent of men in same-sex relationships indicated that it was important to be sexually monogamous. This is compared to 71% of women in same-sex relationships, 84% of women in opposite sex relationships and 75% of men in opposite sex relationships (Bailey, 1994).

There are also differences in relation to actual behavior in the relationships (Bryant & Demian, 1994). The American Couples Study indicated that women in same-sex relationships (28%), wives (21%) and husbands (26%) in opposite-sex relationships reported engaging in sex outside of the primary relationship, compared to 82% of men in same-sex relationships. The final difference that was discussed was the fact that of those individuals who took part in the extradyadic sex, men in same-sex relationships reported engaging with more partners when compared to the other groups (Blumstein & Schwartz, 1983).

A study conducted by Frederick and Fales (2016) examined the experience of jealousy in relation to sexual and emotional infidelity. The researcher used Buss' method, but examined differences in gender and also an individual's sexual orientation. Gender was a strong predictor of upset over sexual versus emotional infidelity for heterosexual participants, with men being more likely to be more distressed over sexual infidelity. Generally speaking, heterosexual men stood out from all other groups in terms of being most upset with sexual infidelity (54 %), more so than heterosexual women (35 %), gay men (32 %), lesbian women (34 %), bisexual men (30 %), and bisexual women (27 %).

Individuals who reported higher levels of dependency on and insecurity in their relationship also reported high levels of distress over both sexual and emotional infidelity (Blatt & Zuroff, 1992; Rusbult & Van Lange, 2003). This finding is congruent in relation to what is understood about these constructs. The more dependent an individual is in their relationship, the more distressed they will become when something threatens the dynamic of the relationship. This has been shown in past research when examining dependency in relationships, and how an individual with

increased dependency will feel maladaptive emotions in relation to the potential loss of that relationship (Blatt & Zuroff, 1992; Rusbult & Van Lange, 2003).

Infidelity

Infidelity is the most frequent reason people breakup. Infidelity is a situation when a romantic partner breaks a spoken or unspoken agreement to be sexually or romantically exclusive. It is different from consensual non-monogamy, when the partners have an agreement about sexual contacts outside their relationship. Statistically, people who identify as men are more likely to report having done it compared to people who identify as women. In recent years, this difference in reporting infidelity has decreased.

Some people initiate affairs to break the routine of a confining relationship (Allen & Atkins, 2005; Markman, 2005). Others enter affairs as a way of expressing hostility toward a partner or retaliating for injustice. Partners who engage in affairs often report that they are not satisfied with or fulfilled by their relationships. Curiosity and desire for personal growth are often more prominent motives than dissatisfaction in the relationship.

Many times, the sexual motive is less pressing than the desire for emotional closeness. Because we are socialized down gendered lines and only given certain emotions to express based on how we are gendered, communication among different gendered partners can get complicated. Emotional expression is policed by gendered cultural norms, which can make understanding an opposite sex partner difficult. Being able to acknowledge this and talk about it can be helpful. Even infidelity, and whether or not a person can accept staying in a relationship afterwards fall down gendered lines. Findings suggest that some women say they were unfaithful because they were seeking someone whom they can talk to or communicate with (Lamanna & Riedmann, 2005). According to Janis Abrahms Spring, author of *After the Affair,* women are usually seeking "soul mates," whereas men are seeking "play-mates." Women tend to justify affairs when they are searching for love, but men do so when the affair is *not* for love.

In, *Gender Differences in Sexual Attitudes and Behaviors: A Review of Meta-Analytic Results and Large Datasets*, 2011, Petersen & Hyde observed that women studied tended to be less accepting of sex without emotional involvement (Petersen & Hyde, 2011). This same study found that men are more likely than women to distinguish between sex and love, whereas women see love and sex as going

together so that falling in love justifies sex (Petersen & Hyde, 2011). To be clear, these are general group differences based on the study participants. Some men are interested primarily in the extramarital relationship, rather than the sex, and some women are out for the sex and not the relationship.

Sidebar 9.3: Relationships, Infidelity and Forgiveness

What can you tell about your current relationship difficulties with your husband?

I am a gay man in my 50s who grew up and has been living all my life in San Francisco, the liberal city that has been always a center of advocacy for gay rights and gay pride. I have been in long-lasting relationships most of my adult life. My current partner/husband is in his 30s. We have been together for 12 years, but in the last year we had problems. About a year ago I discovered that my husband had been having an affair with a much younger man, a college-age man who was my nephew's best friend. This revelation came as a shock. My partner and I separated and were heading towards a divorce. For about six months, we were apart taking time to reassess. However, seven months ago we moved in together and we hadn't ever been happier.

How were you able to move past the infidelity and losing trust?

It took a great deal of work on both sides. My partner was able to express sincere remorse and handled the situation with a great deal of humility. He had to stand in front of my family and apologize, as he also harmed my family. In the twelve years that we were together, that was his first infidelity. He said that he was very attracted to the young man, dated him in secret for one year, but never stopped loving me. When he was faced with choosing between the two, he wanted to choose life with me and begin again. I was able to understand where he was coming from, his family history, and why he did what he did. On my end, I saw that our relationship leading to his affair was not perfect, and I am not perfect either. I was busy with moving my business, with setting it in a new place, and we were not spending as much time as a couple together. After all, I know he loves me because he chose me. We are both financially independent, so I could not think that his choosing me again was a matter of convenience.

In your experience, does monogamy work in gay relationships?

I think that only 1-3% gay couples are fully monogamous. I do not have real data, but it is my perception. Most gay couples last for about 2-3 years. Most couples, although not openly, endorse infidelity, but may nevertheless share an

understanding that discreet (and often anonymous) sexual liaisons with others can be forgiven. I call it the "Don't Ask, Don't Tell" policy of a relationship. If after such an encounter, there is an exchange of phone numbers, it may become an emotional involvement, and this scenario is perceived to be more problematic. Some couples agree to an open relationship. They are committed and supportive to each other as their main relationship; however, have several other sexual partners on a side with various degrees of emotional involvement. You may call it sexual freedom or promiscuity. I am not here to judge. I am not a therapist, but I think this pattern is because most gay men often felt marginalized growing up, and are still trying to prove their own sexuality to themselves.

Healthy Communication about Sexuality

Partners who communicate more about sex in general and during the act itself appear to be more sexually satisfied (Babin, 2013). People who are more comfortable talking about sex are better at discussing their sexual fantasies, asking about their partner's needs, giving their partners directions, and convey sexual likes and dislikes

Sidebar 9.4: Some Sexual Rules to Live by

Celeste Hirshman, MA and Danielle Harel, PhD are the Co-Founders of the Somatica Institute of Sex and Relationship Coaching, where they train coaches in their experiential method. You can find them at www.somaticainstitute.com

The following excerpt is a donated selection from *Making Love Real* by Danielle Harel PhD and Celeste Hirschman MA.

Sexual Rules to Live By

Rule #1: Don't judge

Most people are scared to share their desires and fantasies. After all, it's a big risk – few things are more private or make you feel more vulnerable. There are many judgments about what kind of sex is "good," "healthy," and "appropriate," yet almost all of us have some desires that lie outside those narrow bounds.

Your and your partner's desires are beautiful expressions of the deepest parts of who you are. Some of these desires will be realized in your life together and some will not. Some desires you will want to experience, while others you will want to keep in the realm of fantasy and may feel shameful about sharing. However, sharing them can create connection and intimacy between the two of you, regardless of how much you are willing to guest-star in each other's "movies."

People often judge their partner's desires and fantasies because they don't want to be a part of them. You might feel obligated to fulfill your partner's desires, or threatened by them because you can't or don't want to fulfill them. These fears may make you wish some of your partner's desires didn't exist. When sharing desires, it is essential to remember that desires do not necessarily have to happen – it is not your job to do anything you don't want to do. This brings us to the importance of boundaries.

Rule #2: You have a right to your boundaries

You and your partner both have a right to boundaries. As we discussed in the section on boundaries, it is essential that you keep your boundaries in sex to create trust and avoid building resentment. It is also important to remember that your boundaries may shift. A "no" right now doesn't shut the door forever. When you both feel permission to keep your boundaries, you will be able to relax and feel safer exploring. Each of you will also change and grow. What was a strong "no" at one point might become a "maybe" or "yes" later. A "yes" might also turn into a "no". If your sexual boundaries have been crossed in the past non-consensually (for example, if you have experienced sexual abuse or rape), or if you have let them be crossed in your current relationship, you may need to keep your boundaries quite

strong at first before you can let yourself trust again. Often when couples face boundary challenges, the person who needs strong boundaries feels guilty and the other feels rejected. As a result, the boundaries continue to get pushed and crossed over and over again. If this is your dynamic, you may need some support in learning how to negotiate boundaries, so that you will be able to open up together in the future. Long-term boundary challenges can result in resentment, shutdown, and sexual dysfunction.

Rule #3: Try something new

No matter how long you have been together, if you have not approached your sex life consciously with curiosity and open communication, there will be a learning curve. You can log many years of unsatisfying sex together without any improvement if you don't experiment. Trying something new can be scary, as it may bring up fears and inadequacies. But trying new things, exploring new ways of communicating around sex, and discussing needs and desires are essential to creating a good sex life.

Rule #4: Give each other the benefit of the doubt

Trust that each of you wants to please the other. If there is something you want from your partner, and you have asked for it but they have not given it to you, there are some likely explanations. They may not know exactly how to give it to you, they may be afraid to try for fear of doing it wrong, or they may be trying to learn under stressful circumstances. If you are asking for what you need from a place of frustration or criticism, your partner may be triggered and their ability to learn shut off. For this reason, you must be patient and forgiving with your partner as they learn. While you might have a precise picture in your mind of how you want to be touched, seduced, and talked to, it can be challenging for your partner to know exactly what you mean. Feedback and repetition are essential to the learning process. When you give your partner the benefit of the doubt, you will be more likely to approach them with a positive attitude and they will be more likely to learn what you need. If you've played sports or danced, you'll know that you don't learn complex athletic movements or dance routines on the first try, or even in the first week of practice. Sex is no different.

Rule #5: Trying it once doesn't mean you have to do it forever

In order to feel free while experimenting, it is essential to know that you always have a choice. You can try things out and see what is arousing and interesting for you, and what isn't. Not every sexual activity or attitude is right for every person, and you will need to accept your own and your partner's interests *and* boundaries. If you ask for something and then realize that it doesn't feel as good as you imagined it, or it only feels good when you're more aroused, feel free to say so. You can *always* change your mind. What works in your fantasy might not work in reality, and what works one time might not work for you forever.

Rule # 6: Ask for anything and everything you want

In order to get to the heights of your pleasure potential, you will need space in your relationship to ask for what you want. There are no right or wrong requests. When your partner asks what turns you on, you might think that the only appropriate answer is some sort of physical/touch technique, but that is just one of the many requests you can make. For many people, what turns them on has much more to do with psychological arousal than physiological, so just asking for how you want to be touched is not enough. For example, you might feel like it's okay to ask your partner for a lighter touch, but not okay to ask them to tell you what an amazing ass you have. We encourage you to ask for anything and everything you want.

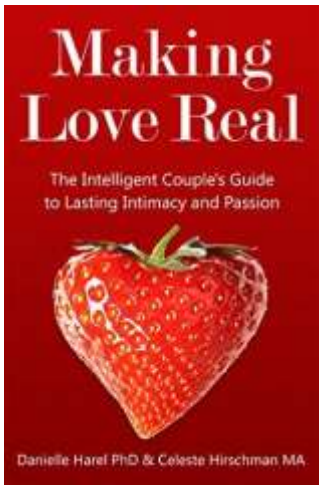
For example, it is helpful to let your partner know what kinds of experiences get you in the mood to have sex in the first place, whether it be a walk in nature together, a sensual massage, a solo bath, a sexy dance party in the living room, dressing up and going out somewhere, getting sexts from your partner, or being thrown against the wall. Also, your partner may be thinking all sorts of wonderful, loving, and desirous thoughts about you, but not know which ones will land well or how to say them best. If you help out by telling them, then they have a chance to do it right. The more specific you are, the more likely you are to get what you want. Try not to get frustrated when they don't get it right away or don't remember all the time.

Rule #7: Teach by showing

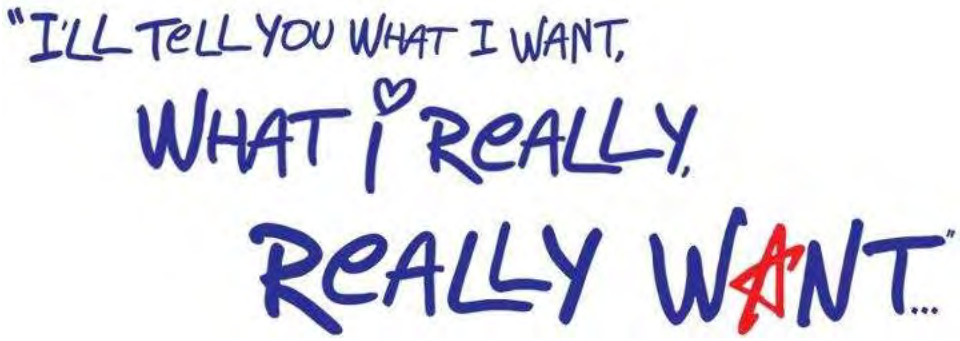
The ways you want to be touched, talked to, and looked at have to be taught through demonstration and practice. You will need to describe what you want, demonstrate it, and give gentle feedback. If you are teaching someone how you want to be talked to, then you will have to demonstrate the proper tone, inflection, and attitude.

Rule #8: Accept your partner's desires without feeling you have to fulfill them

When your partner shares their desires with you, you might feel pressure to give them what they want. It is important to understand the difference between accepting each other's desires and having to fulfill them. If you feel like you have to fulfill their desires but you don't want to or feel like you can't, you may get scared and lash out with judgment, trying to prove that their desires are bad or wrong so you won't have to deal with them. It is scary to let some of your partner's desires remain unfulfilled. Yet if you try to do things for your partner that are not in alignment with who you are, your partner will be able to tell and will not really be getting what they want. Additionally, you will probably feel bad about yourself or begin to shut down and resent your partner. Instead of giving your partner things you don't want to give, we suggest that you take two steps. The first is to hear and accept your partner's desire. The second is to see if the desire, or some part of it, is something that you feel comfortable fulfilling. For many people, having their desires heard and accepted is what makes them feel loved and connected. Others will want their desires to be met, but you might not be able to do that for them. If this is the case, and it is the case in many relationships, we recommend that you go back and reread the second section of this book, which discusses how to deal with disappointment in relationships.



Tell me what you want, what you really really want!



Relationships are hard. Being honest about our longings, fears and passions is hard. At the end of the day, if we cannot let ourselves be vulnerable about our wants, needs, fears and things that make us insecure, we cannot move past them. As mentioned in this chapter many relationship breakups have everything to do with communication. Remember back to the beginning of this book, we indicated that communication would be a big theme you'd find throughout these pages. Healthy individuals are better suited for healthy relationships. Being able to talk about what you want, what you need, and what you are scared of is a lifelong practice that can be hard. But we can do hard things. We do them all the time.

Communication and Fantasy

As they say, communication is lubrication but how does this translate to our sexual fantasies? Authentic communication about how we really feel, both with ourselves and with partners allows us to tap into our largest sex organ, our brains, and really think about what it is that we desire.

Sidebar 9.5: Open Source Erotica

Sometimes we need a little help imagining our sexual fantasies. Sometimes we know EXACTLY what we want. Either way, it's fun to hear other people's fantasies. Enjoy!

Violet Blue's Open Source Sex Podcast

Sexual Fantasies and Sexual Desire

A **sexual fantasy** is any mental picture or thoughts that come to mind while you are awake that generate sexual arousal. People may use sexual fantasies either when they are alone or to heighten sexual excitement with others. Some people find it sexually arousing to share fantasies or to enact them. Sexual fantasies may also be experienced without sexual behavior, as in erotic dreams or daydreams. Masturbation often requires some form of cognitive stimulation, such as fantasy or viewing erotica, to reach orgasm.

Research shows that many Americans have inaccurate perception about which sexual fantasies and desires are “normal” and the types of fantasies that “should” turn them on. This may cause them to “censor” and repress the majority of the urges and wants and try to carry on what they think “normal” is. The real problem in this approach is an internalized shame about sexuality, and a lack of sexual communication with the partner. The truth is that these fantasies are likely normal and healthy. Once a person understands how common their sexual fantasies are and the meaning of those fantasies, it will be easier to express them to partners and achieve greater sexual satisfaction and intimacy. When partners understand the diversity of human sexual desire, it helps to see the disclosure as an opportunity to strengthen mutual trust and intimacy, and to give new energy to their sex lives.

Dr. Justin Lehmiller conducted the largest survey of sexual fantasies in America, which is the subject of his 2018 book, *Tell Me What You Want: The Science of Sexual*

Desire and How It Can Help You Improve Your Sex Life. He surveyed more than four thousand Americans, including persons from all fifty states. The group included all sexual identities, political and religious affiliation, and relationship types, from singles to swingers. Below are a few of the many insights.

- 97% of respondents reported having sexual fantasies. The vast majority said they fantasize somewhere between several times per week and several times per day.
- Sex with multiple partners is the most common sexual fantasy among Americans. When asked whether they had ever fantasized about different forms of group sex, 89 % reported fantasizing about threesomes, 74 % about orgies, and 61 % about gangbangs. Men were more likely to have all of these multi-partner fantasies, but majority of women also reported having each of these sex fantasies.
- Sadomasochism, or the desire to link pleasure and pain during sex, is another extremely popular American fantasy. 60 % of participants reported having fantasized about inflicting physical pain on someone else during sex, while 65 % reported having fantasized about receiving physical pain during sex. Women were more likely than men to have fantasized about both giving and receiving pain.
- People mostly fantasize about real-life, everyday people and not about celebrities. 51 % said that they fantasize about their current partner often and just 7 % of participants said that they fantasize about celebrities often.
- Porn-viewing habits influence who and what people fantasize about. One in seven participants said that their biggest sexual fantasy of all time directly stems from something they saw in porn. Porn consumption is related to the size and shape of the bodies and genitals that appear in fantasies. For example, the more porn that heterosexual men watch, the bigger women's breasts are in their fantasies. Likewise, the more porn that heterosexual women watch, the bigger men's penis are in their fantasies.
- In fantasies people often change themselves in some way, whether it's having a different body shape, genital appearance, or personality. This

tendency to fantasize about changing one's physical or psychological characteristics sometimes reflects deep-seated insecurities.

- The more political and moral restrictions people place on their sexuality, the more intensely they fantasize about breaking free of them. For example, compared to Democrats, Republicans were more likely to fantasize about sexual activities that are typically considered immoral - like infidelity and orgies - or taboo - like voyeurism.
- Less than one-third of participants said they had previously acted out their biggest sexual fantasy. The remainder reported holding back for a range of reasons, but especially due to uncertainty about how to act on it, and fears that one's partner would disapprove of or be unwilling to participate in the activity (Lehmiller, 2018).

Dr. Lehmiller extracted seven broad themes that accounted for the vast majority of all fantasies. Here are the themes going from most to least common:

1. Multi-partner sex
2. Power, control, and rough sex
3. Novelty, adventure, and variety
4. Taboo and forbidden sex
5. Partner sharing and non-monogamous relationships
6. Passion and romance
7. Erotic flexibility - specifically, homoeroticism and gender-bending (Lehmiller, 2018)

Heavybondage.2018.Creative Commons Attribution-Share Alike 4.0

Sidebar 9.6: Fantasize!

As our largest sex organ, our brains can transport us away from all the noise that is real life. Have some fun here for a moment. Give yourself a full 5 minutes at a minimum to create a fantasy all your own. Does it involve role play? Does it involve other people? Does it feel naughty? Or is it completely G rated? Whatever it is, go with it. Allow it to entertain you for just a little while. Perhaps jot down some notes from it, and use it in the future for whatever purpose you like.

How to Tell What You Really Want?

Most of us have never been taught how to start a conversation with our partners about sexual desire. For many this conversation may seem awkward; however, there are many benefits of disclosing your sexual fantasies to a partner. First, if your fantasy revolves around a partnered activity, the disclosure may set the stage for you to act on your desire. Second, it may improve your relationship because self-disclosure has been shown to be the most powerful way of establishing intimacy (Laurenceau et al, 1998). When a person reveals a secret to us and we reciprocate, we build trust and feelings of closeness. Through mutual self-disclosure, we come to know someone the way other people do not, and this makes the bond all the more special, and there is potential to build a longer-lasting relationship. Dr. Lehmiller offers some tips that can help to make your conversation with partners about sexual desire more productive.

First, choose the timing of your sexual self-disclosures wisely, avoiding revealing everything at once. Self-disclosure is a careful process that unfolds gradually.

Second, be clear to your partner the reason why you are sharing these fantasies. Your partner would want to know whether you want to know more about each other or your goal is to act your fantasies out. When you tell your partner that you desire something different may lead to feelings of insecurity, so stress how you love and trust your partner, and this makes you want to reveal things you've never felt comfortable disclosing to anyone else.

Third, when your partner learns about you, you will be learning about your partner too. Self-disclosure is a transaction and goes both ways. You may discover that you and your partner do not share exact the same set of interests, but it does not mean that you are sexually incompatible. It is likely that almost every couple may have at least some shared interest given how common most fantasies are. If you do not share all the fantasies at the time of the disclosure, you may grow to desire the same things later.

Fourth, be mindful of how you will respond to your partner's disclosures. Think not just about what you say or do if your partner expresses a desire that seems strange to you, but what your body language and facial expressions can convey. The goal of communication with your partner is to express care and respect, both verbally and nonverbally (Lehmiller, 2018).

Sidebar 9.7: Sex with Emily Podcast

In this podcast, How to Initiate Sex Doctor of Human Sexuality, Emily Morse is helping you calm your nerves, recover from failed initiations, and walk into each sexual encounter with more confidence.

Sexual Behavior

Erotic carvings at the Jain temples of Kharjuraho in india. Graphic depiction of sexual intercourse. by denisbin is licensed under CC BY-ND 2.0

Autoeroticism

As we first discussed in Chapter 4, **Masturbation,** also known as *auto eroticism*, is often when a person touches, strokes or rubs their own genitals for sexual pleasure, but orgasm can also be achieved without touch by merely fantasizing, is one of the principal forms of one-person sexual expression. Other forms of individual sexual experience, such as sexual fantasy, may or may not be accompanied by genital stimulation. Masturbation techniques vary widely depending upon a person's body and preferences. For example, masturbation may be practiced by manual stimulation of the genitals, sometimes with the aid of artificial stimulation with a sex toy (see Chapter 4 for more on sex toys!). Before a person conceives of sexual experience with other people, they learn early in childhood that touching their genitals can produce pleasure. However, according to the findings of the 1992 National Health and Social Life Survey (NHSLS), there are other reasons that people masturbate (Laumann et al, 1992). The other reasons may include to relax, to relieve sexual tension, when partners are unavailable, when a partner does not want to engage in sexual activity, boredom, to help get to sleep, and fear to engage in sexual activity due to fear of HIV/AIDS and other STIs. Across individual of all sexes, masturbation habits vary in type of motion applied, speed, pressure applied and whether a person incorporates sexual imagery and sexual fantasies.

Masturbation Techniques

Most people with penises report that they masturbate by manual manipulation of their penis. Usually, they shift from a gentler rubbing action during the flaccid or semi-erect state of arousal to a more vigorous milking motion once full erection takes place. They are likely to stroke the glans and frenulum at the outset, but their grip tightens and the motions speed up as orgasm nears. At orgasm, the glans become sensitive and contact with it is usually avoided, but the penile shaft may be gripped tightly. Instead of using soap suds as a lubricant for masturbation during bath or showers, which may irritate the skin, it is more effective to use other lubricants, such as petroleum jelly, K-Y or other commercially available lubricants that are more effective at helping to reduce friction and simulate the moist conditions of coitus.

Vaginal/clitoral stimulation techniques also vary widely, but some general trends exist. Most people with vulvas masturbate by massaging the mons, labia minora and clitoral region with circular back-and-forth motions. Some straddle the clitoris with their fingers, stroking the shaft rather than the glans. Because of its exquisite sensitivity, the glans may be touched lightly only during early arousal. Clitoral stimulation is achieved by rubbing or stroking the clitoral shaft of pulling on the vaginal lips. In contrast to the myth that people with vulvas usually masturbate by simulating penile thrusting through the insertion of fingers or penis like objects into their vaginas, relatively few do, and most achieve orgasm through clitoral stimulation only. Still, some report erotic pleasure from deep vaginal penetration, but most precede or combine it with clitoral stimulation. Many people with vulvas masturbate by spraying their genitals with jets of water. During masturbation, some also massage other erogenous areas of the body, such as their breasts or nipples with the free hand.

Sidebar 9.8: Hysteria

Fun fact. *Female Hysteria* was a popular diagnosis in the Victorian days and doctors (who were all male) treated it by clitoral stimulation to achieve orgasm. At first they used their hands, but decided to invent a machine to do the work because their hands were getting tired, thus bringing about the birth of the vibrator. For more on this, watch: Hysteria - Trailer.

Historical Views of Masturbation

Historians suspect that people in ancient times condemned sex that did not lead to pregnancy because of the need for an increase in population. This need for progeny is also linked to the view that penis-in-vagina (PIV) intercourse within the context of a heterosexual marriage was the only morally acceptable avenue of sexual expression. Masturbation provides pleasure, but not procreation, so the attitudes of many world religions toward masturbation reflected the censure that was applied toward nonprocreative sex. Despite this history, there is no scientific evidence that masturbation is harmful, but rather, quite healthy. It does not cause psychological or physical harm, except for rare injuries to the genitals due to rough stimulation. Sex therapists have used masturbation as a treatment for individuals with low sexual desire and for those who have difficulty reaching orgasm. People who consider masturbation wrong or sinful may experience anxiety or guilt about it, but these negative reactions are due to their beliefs about masturbation, not the behavior itself.

Sex with others

Author Unknown. N.D. Public Domain

There is a great variety of partnered sexual behaviors, far too many to list here. We will discuss some better known activities and invite you to further research the wide world of sexual expression and maybe come up with something completely new. Some activities we will describe as “partnered,” which can include two or more people. We will discuss behavior for people with the same genitalia and different

genitalia. We will also address some of the misconceptions about same-sex sex lives.

The age of a first partnered sexual encounter varies based on the specific activities and cultural background. A study by Regan and colleagues, "*Gender, ethnicity, and the developmental timing of first sexual and romantic experiences*", investigated the age at which an ethnically diverse sample of young adults (N = 683) experienced their very first date, love, serious relationship, kiss, and act of intercourse (Regan et al, 2004). Most had experienced each event by the end of high school, with first dates and kisses occurring at earlier ages than falling in love or intercourse. Gender and ethnic differences were found. For example, young men began dating at earlier ages than did young women. Asian American participants were less sexually and romantically experienced, and had their very first sexual experiences at an older age, than African American, Latino/Hispanic, and Caucasian/non-Hispanic White participants. Interestingly, there were no differences in first romantic love experiences. Almost all men and women within each ethnic group had fallen in love at least once, typically around age 17; this suggests that romantic love is a common human life event, and that it first occurs during the developmental period spanning late adolescence and early adulthood. The below summarizes the findings of this research.

Age in years at which participants experienced romantic/sexual "firsts" by ethnicity:

	Latino(a)/Hispanic	White/Caucasian	African American	Asian American
Kiss	15.20	14.52	14.83	17.60
Date	15.75	14.53	17.53	16.12
Sexual Intercourse	17.33	16.97	16.31	18.85
In Love	17.48	17.62	17.25	17.40
Serious Relationship	17.91	17.56	18.00	19.05

Table 1. Adopted from Regan, Durvasula, Howell, Ureno, & Rea, 2004, "Gender, ethnicity, and the developmental timing of first sexual and romantic experiences"

After the first sexual debut, partnered sexual behavior often continues through the rest of people's lives. Good health, having a positive view of one's own sexuality and having a partner are all factors related to continued partnered sexual activity into

people's 60s, 70s and even into their 80s. Sex continues to be an important part of couple's life if one of a partner acquires a physical disability.

Kissing

Source: Creative Commons CC BY

In Western culture, kissing is common and almost universal, but it is unknown in some cultures. Kissing is least likely observed in Africa, Central and South America, and Oceania, but more frequently practiced in Europe, North America and Middle East. Kissing may take different forms, and there are many types of kissing, depending on whether partners part their lips, insert their tongues into each other's mouths, and how much pressure and force is applied. All people have their preference when it comes to what feels good, and it is important to respect your partner's preferences.

Foreplay

Traditionally, the word **foreplay** means a pre-coital partnered sexual activity and implies the kinds of methods that partners use to sexually arouse one another and themselves. However, most of these methods can also lead to orgasm or set the stage for orgasm when applying another technique. Many people prefer one or more of these methods to intercourse. For example, if both partners have female organs, they may choose to simulate intercourse manually, with the use of a sex toy or to forgo the idea of an intercourse all together in favor of clitoral stimulation. Foreplay can take various forms of noncoital sex, such as kissing, touching or caressing erogenous zones and oral-genital contact. Not all sexual contact must lead to coitus or orgasm, and many people enjoy kissing, genital touching, oral-genital contact as ends in themselves.

Touching

G.dallorto. 2007. Attribution

Touching is an integral part of sexual activity for many people, as touching or caressing primary or secondary erogenous zones with the hands or other parts of the body can be highly arousing. For people who are sexually attracted to each other, a simple holding hands can be sexually stimulating. With touching, sexual pleasure can be derived without direct stimulation of the genitals. Each individual has a personal preference on how they want to be touched, and this means that it is important to communicate with your partner. Masters and Johnson believed that touch is extremely important in sexual arousal and sexual communication a and they recommended it as part of almost every sex therapy technique (Masters & Johnson, 1966).

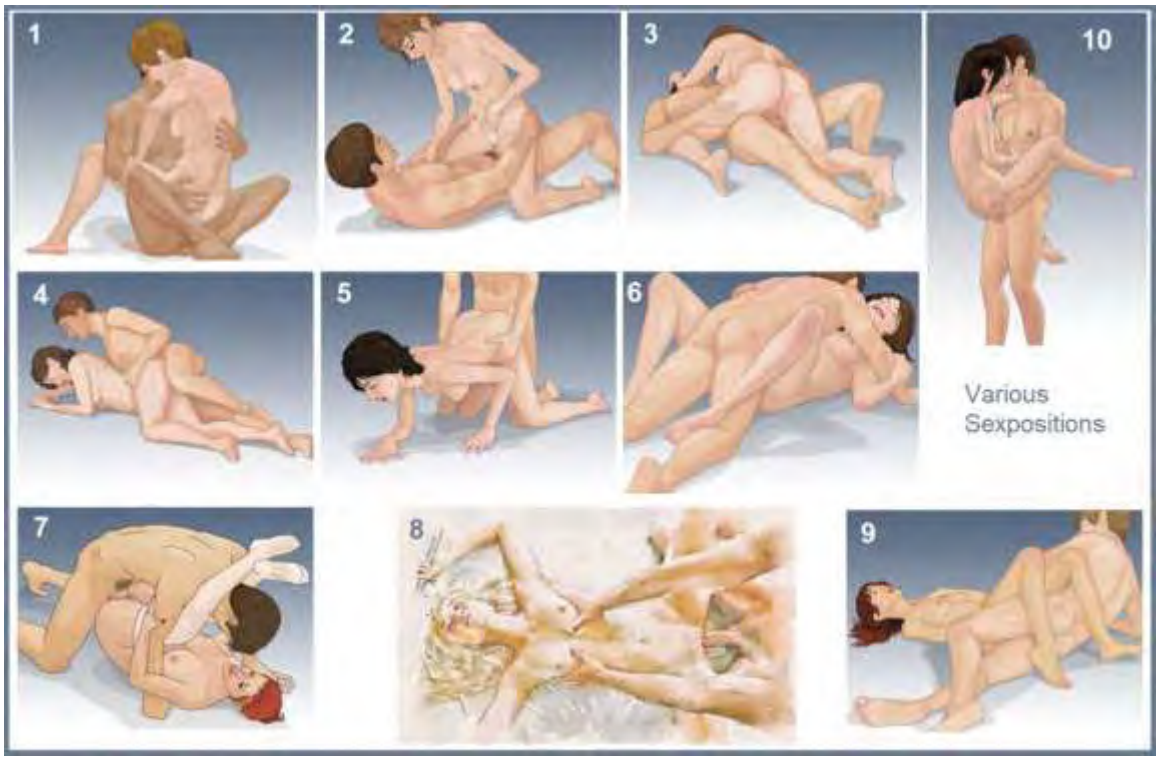
Touching or caressing erogenous zones can be highly arousing. People who identify as men prefer manual stroking of their genitals by their partner earlier than people who identify as women. Women do not necessarily enjoy when fingers or toys are inserted into vagina. If they do, it is usually after receiving stimulation to the whole body and external sexual organs.

Many people enjoy stimulation of their breasts. The breasts are a highly sensitive body part. The hands and mouth can be used to stimulate the breasts and nipples, but the type and intensity of stimulation varies from person to person. Gay males and lesbians tend to spend more time focusing on their partner's breasts and nipples than heterosexual partners.

Oral-Genital Stimulation

Oral stimulation of the male genitals is called **fellatio**, while oral stimulation of the female genitals is called **cunnilingus**. As with touching, oral sex could be used as a prelude to intercourse, or as a sexual activity on its own. Oral sex is practiced by people of all genders and sexual orientations. It could be performed individually or simultaneously, in what is known to be called the “sixty-nine” position. If orgasm is reached through oral sex, partners vary in ways they prefer to do about tasting or swallowing the male or female ejaculate. It is best to communicate with your partner early and often and ask them about their personal likes and dislikes. It is essential not to assume that you know what your partner may want, or that your partner will know what you enjoy the most. There is no evidence that swallowing ejaculate is harmful, unless a partner has an infection and can transmit it through oral contact. One of the misconceptions about oral sex is that oral sex does not transmit STIs. In fact, there are multiple infections that could be spread through oral sex, and it is important to take precautions as with other forms of sex.

Vaginal Intercourse



A common form of partnered sexual activity is vaginal intercourse, or **coitus**, known as sexual activity in which the penis is inserted into the vagina (PIV). Vaginal intercourse that can take many forms, but each position must allow the genitals to be aligned so that the penis is contained by the vagina. People may have preferences in their positions, depth and rate of thrusting, and availability of additional sexual stimulation during an intercourse. The number of possible coital positions is endless, but the four most used positions are the male superior ("missionary"), the female-superior (woman-on-top), the lateral entry (side-entry) and the rear-entry ("doggy style").

More than 90% of men usually experience orgasm during PIV intercourse; among women, this proportion is only around 50% (Darling, Haavio-Mannila & Kontula, 2001). This is a problematic observation from the perspective of both sexual rights and sexual health frameworks. Given the importance of orgasms to many people's sexual health and pleasure, an increased focus on and understanding of women's orgasm is valuable. The **coital alignment technique (CAT)** was developed and first

introduced by sex researcher Edward Eichel to help people who have difficulties climaxing from penetrative sex. The technique may also help curb premature ejaculation. CAT significantly increases the odds of both female orgasm and simultaneous orgasm during heterosexual intercourse (Pierce, 2000). That's because, unlike other penetrative positions, coital alignment isn't *really* about penetration. Taking the focus off of thrusting can help delay penile ejaculation so that both partners get more satisfaction, longer. Because this position uses both clitoral stimulation and penetration, it's often recognized as a technique for penile-vaginal intercourse. But that shouldn't keep you from practicing the technique if you want to try it. Coital alignment can just as easily be practiced and heightened with the use of a dildo for penetration between two partners with vaginas.

Anal Sex

Seedfeeder. 2011.Creative Commons Attribution-Share Alike 3.0

Anal intercourse is insertion of the penis into the rectum. It is practiced by male-male and male-female couples. Both partners may reach orgasm through anal sex, because the rectum is highly sensitive to sexual stimulation. When people mention "anal sex," they may they think about anal intercourse; however, there are more ways of how anus could be involved in sexual activity. Some people may want their partner's finger or sex toy in the anus at the height of passion or at the moment of orgasm. Many couples kiss or lick the anus in their foreplay, a practice known as **anilingus**.

One of the health concerns regarding anal stimulation is that rectum is a very delicate structure richly endowed with nerve endings, and it does not produce its own lubrication. To prevent an injury, a generous amount of a non-irritating lubricant is needed, and penetration should be slow. If a sex toy is used, it has to be significantly larger at the base than the top, so it would not accidentally travel all the way and become irretrievably lodged in the rectum. Additionally, anal sex carries a health risk because microorganisms causing intestinal diseases and many STIs can be spread through oral-anal contact. At the same time, naturally occurring intestinal microorganisms can reach inside the urinary tract and cause an infection.

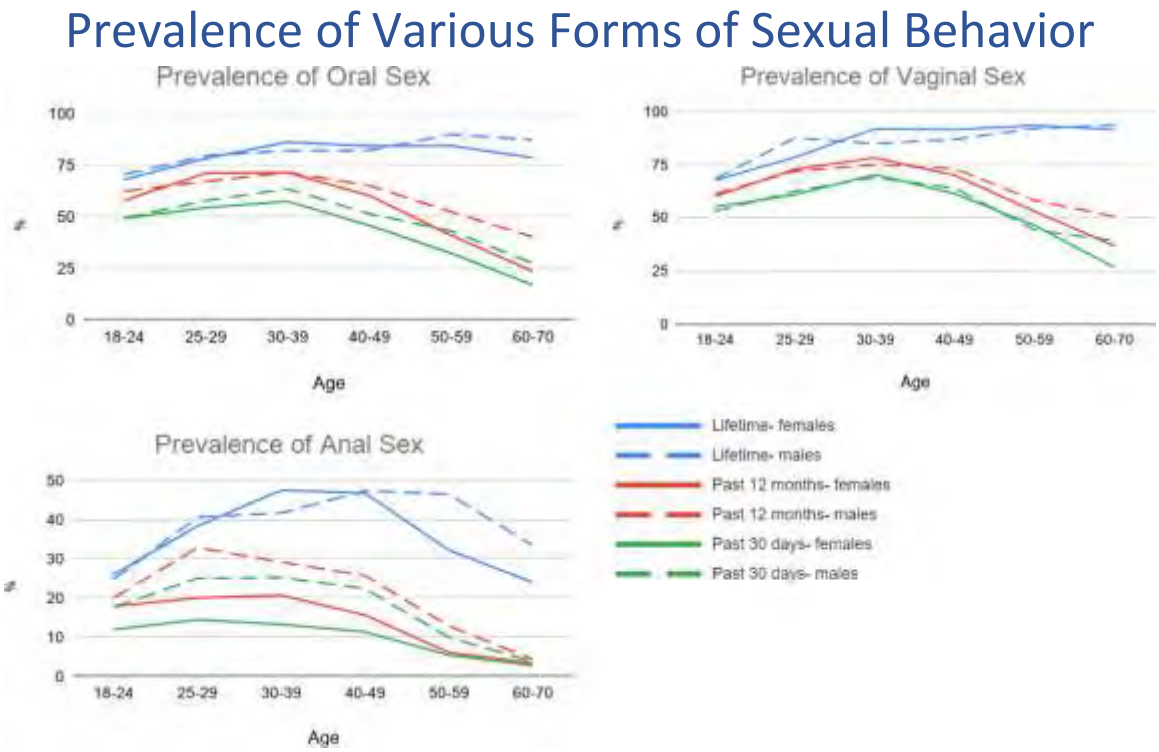


Fig 1. Age trends in the prevalence rates of oral, vaginal, and anal sex for lifetime, past 12 months, and past 30 days (N = 1,987; men n = 953, women n = 1015). https://doi.org/10.1371/journal.pone.0255371.g001

People engage in a diverse range of solo and partnered sexual behaviors throughout the life course. There exists a great variability and diversity in human sexual practices, and people use a great number of different combinations of sex acts during their sexual encounters. According to The study by Herbenick et al. "*Sexual Behavior in the United States: Results from a National Probability Sample of Men and Women Ages 14-94*" reported on the prevalence of specific sexual acts varied across sex, age, relationship status and other demographic trends. The study

revealed that masturbation was common throughout the lifespan and more common than partnered sexual activities during adolescence and older age (70+). Although uncommon among 14- to 15-year olds, in the past year 18.3% of 16- to 17-year-old males and 22.4% of 16- to 17-year-old females performed oral sex with an other-sex partner. Also in the past year, more than half of women and men ages 18 to 49 engaged in oral sex. The proportion of adults who reported vaginal sex in the past year was highest among men ages 25–39 and for women ages 20–29, then progressively declined among older age groups. More than 20% of men ages 25–49 and women ages 20–39 reported anal sex in the past year (Herbenick et al., 2010).

Historycurious. 1969. Creative Commons Zero, Public Domain Dedication

A research published in 2021 found that numerous aspects of sexual behavior varied by subgroups of relationship status, sexual orientation, race, and ethnicity. As oral, vaginal, or anal sex are all partnered behaviors, it follows that participating in ongoing romantic and sexual relationships facilitates access to potential sex partners, access that is more limited or at least not as readily available to people not participating in such relationships (Roberts, H. et al, 2021). This finding is in line with prior research, confirming that while single people may have greater opportunities for casual sex with a greater number of partners, people in a relationship have more frequent sex. Interestingly, people that reported being in a causal relationship(s) reported a higher frequency of sex and more sexual partners, though they constituted a small proportion of the sample.

Conclusion

Relationship styles are vast, and despite there being a large focus on monogamous heteronormative coupling in popular culture, the variety of ways in which relationships are formed tell us otherwise. Having an understanding of the variety of ways to engage with others in intimate relationships helps free us from what we are culturally taught is the "right way" to engage in relationships. Regardless of type or style, or if you prefer to not engage in intimate relationships, communication is critical for self-discovery and for maintaining healthy relationships. Often, we fall into patterns of miscommunication and feelings get hurt which takes away from the ability to deeply enjoy sexual intimacy. Humans engage in a wide repertoire of sexual behavior. The human body is sensitive to many forms of sexual stimulation and arousal, and knowing our bodies and what we like through masturbation helps inform sexual pleasure with others. Sometimes cultural expectations, personal values and individual experience shape our sexual behavior rather than our actual desires. There is a great diversity of sexual expression among different people, and exploring this is a part of radical self-love and fulfillment. What feels good for you and those you have sex with is worth striving for regardless of what cultural messages get in the way. Communication is lubrication, people who communicate about sex and during the sexual act tend to be more sexually happy. Getting comfortable talking about sex helps people learn about their own desires as well as their partner's and explore fantasies.

Glossary

1. **Arranged marriage,** a marriage planned and agreed upon by the families of the couple to be married
2. **Cohabitation** is when a couple are living together in a sexual relationship when the partners are not legally married
3. **Common-law marriage**, if a couple lives together for a certain number of years, they are automatically considered as married in the eyes of the law.
4. **Consensual non-monogamy** an explicit agreement between partners that they accept sexual or romantic pursuit outside of their primary relationship.
5. **Cunnilingus** oral stimulation of the female genitals

6. **Domestic Partnership**, a legal relationship between couples that allows them to obtain many of the same benefits as a marriage.
7. **Fellatio** Oral stimulation of the male genitals
8. **Foreplay** means a pre-coital partnered sexual activity
9. **Marriage** the legally or formally recognized union of two people as partners in a personal relationship
10. **Masturbation,** also known as *auto eroticism*, is often when a person touches, strokes or rubs their own genitals or fantasizes for sexual pleasure
11. **Monogamous** having a sexual relationship with only one partner at a time
12. **Polyamory** People who love multiple people simultaneously
13. **Polygamy** The practice of having more than one spouse at a time.
14. **Sexual fantasy** is any mental picture or thoughts that come to mind while you are awake that generate sexual arousal

Discussion Questions

1. What type of relationship do you think fits you best? Has this changed over time?
2. What is different in terms of the things you'd like from an intimate partner vs. a close friend?
3. How does communication relate to successful relationships?
4. How do you explore fantasy? What would you like to do that you don't?
5. Is it hard to talk about sex? Why? Would you like it to be more comfortable?

Multiple Choice:

1. Intimate relationships have the capacity to make us feel happy, healthy, and fulfilled.

    a. True
    b. False

2. Monogamy is not considered a standard relationship type in most cultures.
    a. True
    b. False

3. In the US marriage equality (same-sex marriage) was recognized and legalized nationwide in what year?
    a. 1995
    b. 2020
    c. 2015
    d. 2008

4. Polyamory is the idea that it is possible to love multiple people simultaneously
    a. True
    b. False

5. Non-monogamy is often stigmatized and viewed as illegitimate.
    a. True
    b. False

6. Co-marital sex refers to the consenting of married couples to sexually exchange partners who are often referred to as:
    a. Swinging
    b. Polyamory
    c. Both A and B

7. Cohabitation is
    a. when a couple are living together in a sexual relationship when the partners are not legally married
    b. Bad habits partners share
    c. When birds feed each other
    d. All of the above

8. A sexual fantasy is any mental picture or thoughts that come to mind while you are awake that generate sexual arousal.
    a. True
    b. False

9. Masturbation is:
    a. also known as *auto eroticism*
    b. is often when a person touches, strokes or rubs their own genitals for sexual pleasure
    c. fantasizes for sexual pleasure
    d. All of the above

10. People who communicate about sex and during the sexual act tend to be more sexually happy
    a. True
    b. False

For Further Exploration

Film, MONOGAMISH (full documentary)

Kama Sutra

Podcast Series , Sex with Emily, https://sexwithemily.com

The Society of Janus is a San Francisco-based support and education organization for people interested in the kink, fetish, and BDSM lifestyles. We provide opportunities to meet others with similar interests in a safe, relaxed atmosphere.

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Chapter 10 Conception, Pregnancy and Childbirth

Learning Objectives

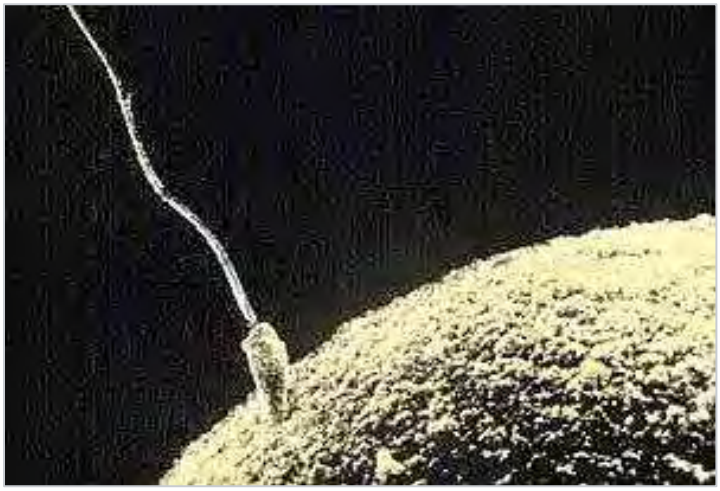
After completing this module, students should have a working knowledge of:

- Fertilization
- Implantation of the Zygote
- Pregnancy from the perspective of the fetus
- Pregnancy from the perspective of the mother
- Childbirth

Introduction

This chapter will cover pregnancy, from conception to birth. The chapter will include fertilization, implantation of the zygote, becoming a fetus, the three trimesters, and the progressive development of the fetus through the weeks of pregnancy. It will cover the topic of birth and different birthing methods.

Fertilization

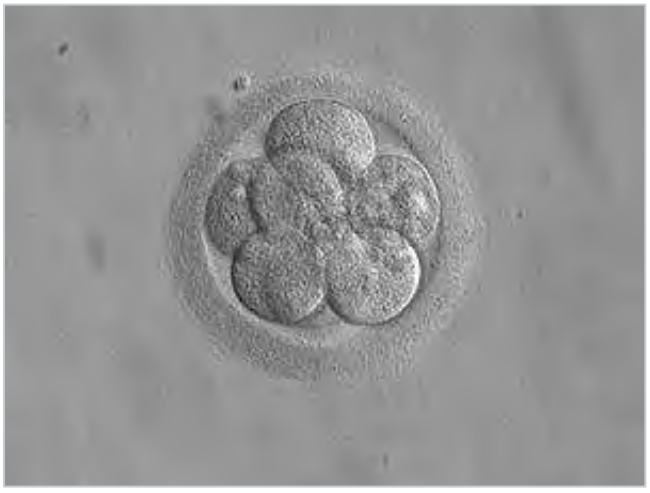


A sperm fertilizing an ovum

Fertilization is the process of the joining of a sperm and an ovum. A sperm is a male gamete that is released into the vagina of a female. In order for fertilization to occur, there must be a mature ovum present. Every month, one of the ovaries releases an ovum, which will meet one of the 4 million sperm the penis ejaculates into the vagina. The sperm swim through the cervix and into the uterus, which leads to the fallopian tubes. This is where fertilization is most likely to take place. The high amount of sperm in the ejaculate is needed, because only around 100 reach the fertilization site. In order to penetrate the egg, the sperm must first break through two barriers surrounding the ovum. Once a sperm reaches the plasma membrane of the ovum, it sets off a reaction that spreads across the membrane of the ovum, preventing other sperm from breaking through the ovum membrane. Once the sperm reaches the inside of the ovum, it sheds its tail, the two nuclei fuse, and now the 23 chromosomes from the ovum and the 23 chromosomes of the sperm join and they become a *zygote*. Chromosomes contain all the information needed to determine the genetic structure of the fetus. Typically(but not always), human beings have two chromosomes that determine sex (see chapter 3 on fetal reproductive development for more on this): A combination of X and Y will be assigned male or a combination of X and X will be assigned female. All ovum have X sex chromosomes whereas sperm have both X or Y sex chromosomes. Therefore, the male gametes determine the assigned sex of the baby.

Sidebar 10.1: Sperm in Action!

Watch some Variations of sperm swimming.



An 8-cell embryo in the process of cleavage.

Pre-Embryonic Period

After fertilization (around 24 hours after fertilization), the zygote begins a process of dividing by *mitosis* in a process called *cleavage*. It divides until it reaches 16 cells. It is now referred to as a *morula*. As the morula floats freely within the uterus, it starts to bring nutrients into the cells. The morula fills with fluid and the cells inside start to form two separate groups. At this stage it is now a *blastocyst*. The inner layer of cells is called the embryoblast, and will become the fetus. The outer layer is called a trophoblast, which will develop into part of the placenta.

Implantation

The blastocyst preserves itself by secreting Human chorionic gonadotropin (hCG) , a hormone that indirectly stops menstruation. The trophoblast cells secrete hCG hormones that help maintain the corpus luteum, which would normally regress. In turn, the corpus luteum continues to secrete progesterone, which maintains the endometrium, the mucous membrane lining of the uterus, in the secretory phase. This helps the blastocyst to continue to grow and stay embedded within the endometrium. The fetal life support system and the placenta begin to form, and eventually the placenta will take over the job of producing progesterone.

The embryoblast within the blastocyst forms 3 primary germ layers: the ectoderm, mesoderm, and endoderm, which make up the developing fetus.

Ectoderm

The ectoderm forms the nervous tissue and the epithelium covering the outer body surface. The ectoderm includes. The epidermis of skin, including hair and nails, glands of skin, linings of oral cavity, nasal cavity, anal canal, vagina, brain, spinal cord, sensory organs, lens of eye and epithelium of conjunctiva (a membrane that covers the sclera and lines the inside of the eyelids), pituitary gland, adrenal medulla, and enamel of teeth.

Mesoderm

The mesoderm forms all of the muscle tissue and the connective tissue of the body, as well as the kidneys and the epithelium of the serous membranes and blood vessels. The mesoderm includes all muscle tissue (skeletal, smooth, cardiac), all connective tissue (fibrous connective tissue, bone, blood, cartilage), dentin of teeth, adrenal cortex, kidneys and ureters, internal reproductive viscera, epithelium lining vessels, joint cavities, and the serous body cavities.

Endoderm

The endoderm forms the lining epithelium and glands of the visceral body systems. The endoderm include the lining epithelium and glands of digestive, respiratory, and parts of urogenital systems, thyroid and parathyroid glands, and thymus.

Formation of the Placenta

As changes to the endometrium occur, cellular growth and the accumulation of glycogen cause fetal and maternal tissue to come together. This formation creates the functional unit called the placenta. The placenta does not mix blood between mother and fetus, but allows nutrients and waste products to diffuse between the two blood systems. The placenta provides protection by filtering out many, but not all harmful substances that the mother comes in contact with. The placenta cannot protect against some teratogens including but not limited to:

- Thalidomide
- Heroin
- Cocaine
- Aspirin
- Alcohol
- Chemicals in cigarette smoke
- Propecia, also known as Finasteride, which can cause birth defects simply by handling a broken pill during pregnancy.

Amniotic Fluid

Attached to the placenta is the membranous sac which surrounds and protects the embryo. This sac is called the amnion. It grows and begins to fill, mainly with water, around two weeks after fertilization. This liquid is called **Amniotic fluid**, it allows the fetus to move freely, without the walls of the uterus being too tight against its body. Buoyancy is also provided here for comfort. After a further 10 weeks, the liquid contains proteins, carbohydrates, lipids and phospholipids, urea and electrolytes, all of which aid in the growth of the fetus. In the late stages of gestation much of the amniotic fluid consists of fetal urine. The fetus swallows the fluid and then voids it to prepare its digestive organs for use after birth. The fetus also "breathes" the fluid to aid in lung growth and development.

A small part of the placenta is shown at the bottom, while the fluid-filled amnion surrounds it.

Developing Fetus

The womb is expanding and the baby is growing while taking all needed nourishment from the mother. What started as a microscopic two-celled egg will be formed into a baby in just twelve weeks. The baby develops from conception to term, in a month-to-month progress.

Sidebar 10.2: Fetal Development

Watch Fetal Development Week by Week Overview.

Overview of Developmental Milestones

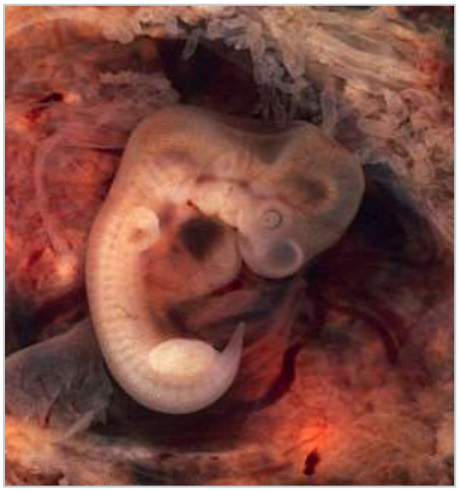
WEEK	CHANGES IN MOTHER	DEVELOPMENT OF BABY
		Pre-embryonic Development
1 week	Ovulation Occurs	Fertilization occurs, cell division begins and continues, chorion appears
		Embryonic Development
2 weeks	Symptoms of early pregnancy (nausea, breast swelling and tenderness, fatigue); blood pregnancy tests may show positive	Implantation occurs; amnion and yolk sac appear; embryo has tissue; placenta begins to form
3 weeks	First period missed; urine pregnancy test may show positive; early pregnancy symptoms continue	Nervous system begins to develop; allantois and blood vessels are present and placenta is well formed
4 weeks		Limb buds form; heart is beating; nervous system further develops; embryo has tail; other systems are forming
5 weeks	Uterus is the size of a hen's egg; mother may need to urinate frequently	Embryo is curved, head is large, limb buds are showing division, nose, ears and eyes are noticeable
6 weeks	Uterus is the size of an orange	Fingers and toes are present and skeleton is cartilaginous
8 weeks	Uterus can be felt above the pubic bone	Fetus begins to look human; limbs are developing and major organs forming; facial features are becoming refined
		Fetal Development

12 weeks	Uterus is the size of a grapefruit	Head grows faster than the rest of the body; facial features are apparent, but there is no layer of fat yet and the skin is translucent; gender can be distinguished via ultrasound; fingernails appear
16 weeks	Fetal movement can be felt	Fine hair (lanugo) grows over the body; fetus resembles a tiny human being; skeleton is visible
20-22 weeks	Uterus reaches up to the level of umbilicus and pregnancy is obvious	Vernix caseosa, the protective fatty coating, begins to be deposited; heartbeat can be heard
24 weeks	Doctor can tell where baby's head, back and limbs are; breasts have enlarged and nipples and areola are darker, colostrum is produced	Fully formed but still thin; much larger and very active, all major organs are working, the lungs and digestive system need more time to develop; body is covered in fine hair called lanugo
32 weeks	Uterus reaches halfway between umbilicus and rib cage	Most babies are in a head down position in the womb; head is more in proportion to the body; eyes are open; babies born at this stage have a good chance of living
36 weeks	Weight gain is averaging about a pound a week; standing and walking are becoming very difficult because the center of gravity is thrown forward	Body hair begins to disappear, fat is being deposited
40 weeks	Uterus is up to the rib cage, causing shortness of breath and heartburn; sleeping is very difficult	Not much room to move in the womb; fully mature, baby

		moves less, and the surrounding fluid reduces and the womb expands its limits

Embryonic Development at Specific Stages

First Trimester



An embryo this tiny shows very distinct anatomic features, including tail, limb buds, heart (which actually protrudes from the chest), eye cups, cornea/lens, brain, and prominent segmentation into somites. The gestational sac is surrounded by a myriad of chorionic villi resembling elongate party balloons. This embryo is about five weeks old (or seven weeks in the biologically misleading but eminently practical dating system used in obstetrics).

4 Weeks

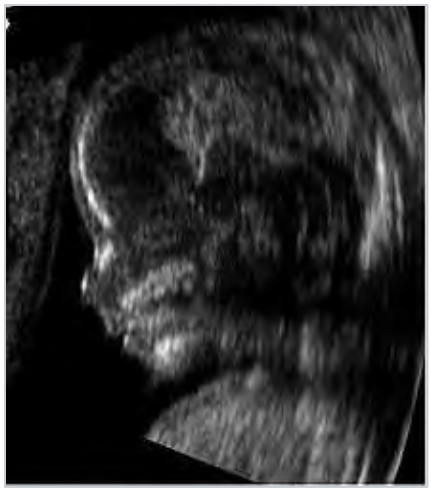
- There are only the beginnings of facial features. All the major organs are starting to form. Gill-like folds that develop into facial features, beginnings of the spinal cord, skin is translucent, and rudimentary (basic; minimal) heart develops.

6 Weeks

- The length from crown to rump is about the size of a fingertip, ¾ ". The beginnings of all the major organs will have formed.
- The embryo floats in a fluid filled bubble that will develop into the amniotic sac. The sac is covered by a protective layer of cells, called chorion. The yolk sac supplies the embryo with all its nutrients until the placenta is fully developed and takes over at around the twelfth week. During the first 12 weeks, the embryo will develop features and major organs of a human being. The embryo is susceptible to harmful environmental influences. This is a vital time for the embryo to develop healthily; taking supplements of folic acid, avoiding certain foods, and eliminating alcohol, cigarettes, and any unnecessary drugs or medicines.

9 Weeks

- The length from crown to rump is approximately 1 1/4". The facial features are becoming more distinct, and the “tail” has disappeared. The muscles are also developing. Eyes are formed but eyelids are still closed over them. Arms now bend at the elbow and rudimentary hands and fingers develop. Knees will have formed and developing feet with distinct toes.
- Heart- is now a four-chambered and fully formed organ; it beats about 160-180 times per minute.
- Brain and nervous system- is four times the size it was at 6 weeks. Special glial cells are being formed within the neural tube; they allow nerve cells to be joined so that messages can be transmitted from the brain to the body.
- Digestive system- the mouth, intestines, and stomach are developing very rapidly, but do not function yet.
- The fetal life-support system- the placental tissue that initially surrounds the fetus and the amniotic sac is becoming concentrated in one circular area on the womb wall to form the placenta.



Sonogram of a fetus at 14 weeks (Profile)

12 Weeks

- At twelve weeks the fetus looks like a tiny human. It is about 2 1/2" long and weighs 1/2 oz. Arms and legs are now beginning to move. Skin is red and translucent. Fingers and toes are more defined, and nails are starting to grow.
- Heart is complete and working, pumping blood to all parts of the body. Digestive system has formed and is linked to the mouth and intestines. Sexual organs have formed inside the body, but cannot yet establish the sex of the baby.

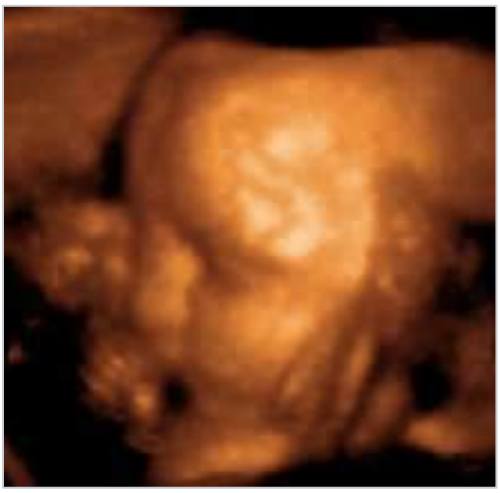
Second Trimester

20 Weeks

- By 20 weeks the fetus will be about 6 1/3" long and weighs 12 oz. Movements are more coordinated. The sexual organs are well developed and are usually visible on ultra sound.
- The fetus is growing very quickly. At this stage, the mother should feel the movements of the fetus. Movements are more noticeable as the fetus's leg bones achieve their final relative proportions in a process called *quickening*. Quickening is the process of muscles contracting that cause movement at the fetus's synovial joints. The joint movement enhances the nutrition of the

articular cartilage, and prevents the fusion of connective tissues within the joint. It also promotes bone hardening.

- From now on, the fully developed placenta will provide all the fetus' needs until birth: oxygen, nutrients and protective antibodies.



Fetus at 29 weeks gestation in 3D

Third Trimester

29 Weeks

- By 29 weeks the baby is about 10" long and weighs about 2 lbs. 7 oz.
- The brain grows much larger, and fatty protective sheath covers the nerve fibers; this important development allows brain impulses to travel faster, enhancing the ability to learn. The lungs have developed most of their airways and air sacs. The placenta is quite selective in what it allows to pass from the mother to the baby's blood, stopping some harmful substances, such as certain drugs, from crossing over.

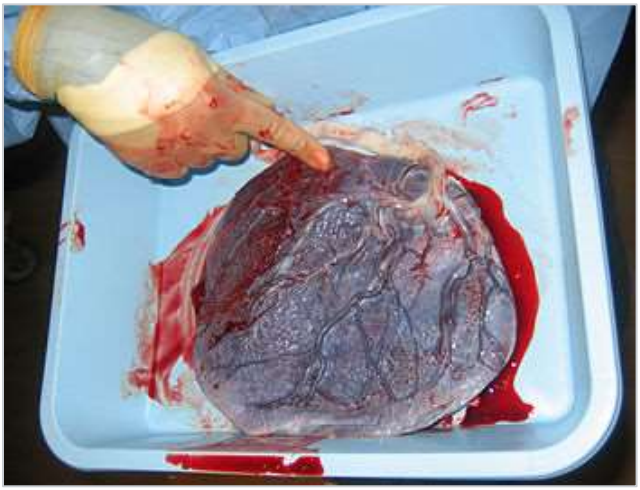
40 Weeks

- The baby is now ready to be born. When the head of the baby moves down from high in the mother's abdomen and settles deeper into her pelvis in preparation for birth, it is called engagement. This can happen any time between 36 weeks and labor.

- In the last four weeks of pregnancy the baby puts on a lot of weight and develops a thick layer of fat. All organs are completely formed and functioning.

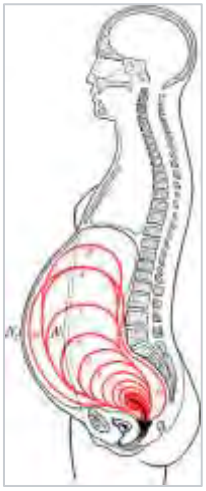
Umbilical Cord

This is the life support for a growing embryo. The umbilical cord stretches between the placenta and the fetus. This cord contains the umbilical arteries and vein. The umbilical cord begins to form 5 weeks after conception. The average cord is close to 22 inches long, and may have the appearance of a coil. The umbilical cord is very rich in stem cells, and is often used for parents who choose to store their stem cells in a blood bank or donate it to a blood bank. These stem cells can be used to treat over 45 disorders, and are an alternative from extracting the stem cells from a donor. This article highlights one example. Breakthrough treatment makes American woman 3rd person to be cured of HIV The woman underwent a new transplant procedure using donated umbilical cord blood.



Human placenta shown a few minutes after birth. The side shown faces the baby with the umbilical cord top right. The unseen side connects to the uterine wall. The white fringe surrounding the bottom is the remnants of the amniotic sac. You can see the differences in the umbilical vein and arteries.

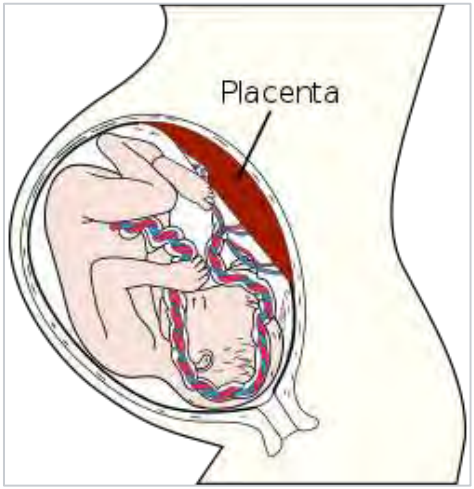
Pregnancy from the mother's perspective



Growth of the uterus in a pregnant female.

Human pregnancy lasts approximately 40 weeks from the time of the last menstrual cycle to childbirth (38 weeks from fertilization). In many societies' medical and legal definitions, human pregnancy is somewhat arbitrarily divided into three trimester periods, as a means to reference the different stages of fetal development. The first trimester period carries the highest risk of miscarriage (spontaneous death of embryo or fetus). During the second trimester, the development of the fetus can start to be monitored and diagnosed. The third trimester marks the beginning of viability, which means the fetus might survive if an early birth occurs.

Changing Body



(38 weeks) A fully developed fetus in the mothers abdomen

As soon as a woman becomes pregnant, her body begins to change so that it can support both herself and the unborn baby. All of the body functions start to work much harder. The heart has to pump more blood around the body, in particular to the womb, placenta, and the fetus. As well as physical demands, pregnancy also causes a range of emotional reactions.

First Trimester (1-12 weeks)

- Tiredness, nausea, constipation, frequent urination, food cravings, breast tenderness, change in size of breasts, fainting or dizziness, bloated stomach, and high emotions.

Second Trimester (13-27 weeks)

- More energy, constipation, heartburn, and indigestion. The breasts continue to grow, as does an increase in appetite. There is mild swelling in the feet, ankles, hands, and face. There is also more baby movement. There may be emotional ups and downs in the feeling of pregnancy, and short-term memory may be poor.
- The hormones estrogen, progesterone, human placental lactogen, oxytocin, and prolactin prepare the body for feeding the baby, and cause the breasts to enlarge, becoming painful and tender.
- The fetus, placenta, and amniotic fluid account for just over a third of the weight gain during pregnancy. The remaining weight comes from increased blood volume, fluid retention, and extra body fat. The suggested weight gain in most pregnancies is between 25-40 lbs.

Third Trimester (28-40 weeks)

- The body is changing to cope with the ever increasing size of the womb. The baby grows and pushes out the lower back of the mother. The breathing rate of the baby is growing very quickly. At this stage, the mother should feel the movements of the fetus. Other signs may be the nipples secreting colostrum,

Braxton-Hicks' contractions may begin, and blood flow to the womb has increased tenfold since conception.

Prenatal Care

Once pregnancy is confirmed, it is advised to seek prenatal care to assess the physical condition of the mother and what to expect in the coming months. It is typical to begin prenatal care at approximately 8-10 weeks gestation, and pregnancy care should continue until approximately 6 weeks postpartum. The main purpose of the prenatal visits is to perform preventative medicine. Most complications in pregnancy are best treated if they are caught early. A series of tests will be performed throughout the pregnancy to judge the mother and fetus' well-being including:

- Mother's history
- Urine tests for glucose, protein, blood cells and infection
- The mother's weight
- Blood tests such as a complete blood count, HIV test, or the triple screen which is the test used most commonly to look for neural tube defects and Down's Syndrome.
- Physical examination
- Blood pressure
- Fetal heart monitoring
- Ultrasound scans
- Non-stress tests

Continuous care is the best way to ensure a healthy mother and baby.

Labor and Birth

Labor is defined as contractions *and* cervical change, contractions alone are not labor.

Pre-Labor Signs: as your body is preparing for labor, there are a few things that should be expected to happen within four to six weeks of labor.

1. Pressure on the pelvic area
2. Occasional brownish discharge
3. Energy level is noticeably increasing or decreasing
4. Loss of the mucus plug (does not always exist)/increasing discharge
5. Braxton Hicks contractions (painless contraction of the uterus)
6. Movement of the baby into the pelvis

False Labor Signs: there are a few signs that indicate false labor.

1. Timing of the contractions are irregular and do not become more frequent or more intense
2. Contractions stop during rest, stopping what the mother is doing, walking, or changing position
3. Inconsistent in strength (strong one minute then weak the next)
4. Location of pain is in the front only

True Labor

1. Pain in the lower back, radiating towards the front abdomen, possibly also the legs
2. Contractions increase in strength and are closer together; coming now on a regular basis, 30 to 70 seconds apart
3. The mucous plug is detached, showing bloody discharge
4. The water breaks (often this does not break until the doctor or nurse midwife does it), when this happens, contractions become much stronger
5. Some women have the sudden need to go to the bathroom, diarrhea is common
6. Contractions continue despite movement
7. The cervix is thinning and dilating

When the contractions of labor begin, the walls of the uterus start to contract. They are stimulated by the release of the pituitary hormone *oxytocin*. The contractions cause the cervix to dilate (open) and efface (thin out) . As labor progresses the

amniotic sac can rupture causing a slow or a fast gush of fluids. Labor usually begins within a 24 hour period after the amniotic sac has ruptured. As contractions become closer and stronger the cervix will gradually start to dilate. The first stage of labor is broken into three parts:

- **Early Phase:** First is the early phase of labor, when the cervix dilates from 1-4 centimeters, this can be the longest and most exhausting part for the mother.
- **Active Phase:** The cervix dilates on average 1 cm per hour in the active phase of labor dilating from 4-7 centimeters. If an epidural is requested, it is usually given in this phase.
- **Transition:** This is often considered the most intense part of labor with contractions lasting longer and having shorter rest periods in between them. Dilation from 8-10 centimeters occurs during transition. Some women experience nausea and vomiting during this phase as well as rectal pressure and an urge to push.

At this point the labor enters the second stage, or the birth of the baby. The mother begins pushing to aid in the birth of the baby, this part of labor can last minutes, or even hours. A fetus is usually delivered head first. 'Crowning' is the term used when the fetus' head can be seen between the mothers labia as it emerges. At this point, the birth attendant may perform an episiotomy if necessary, which is a small surgical incision on the perineum. This procedure is usually done to deliver the baby more quickly, in response to fetal distress.

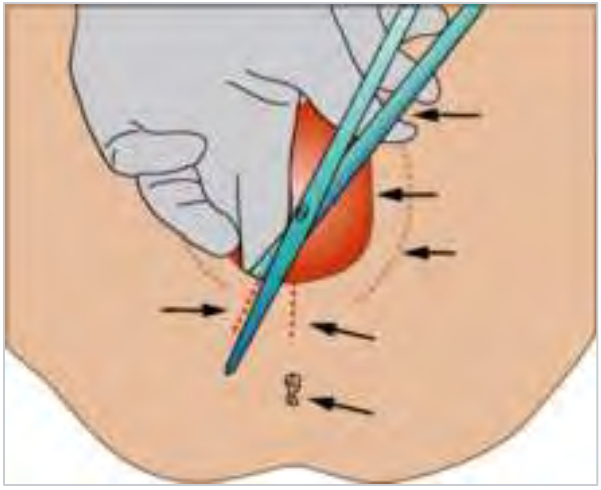
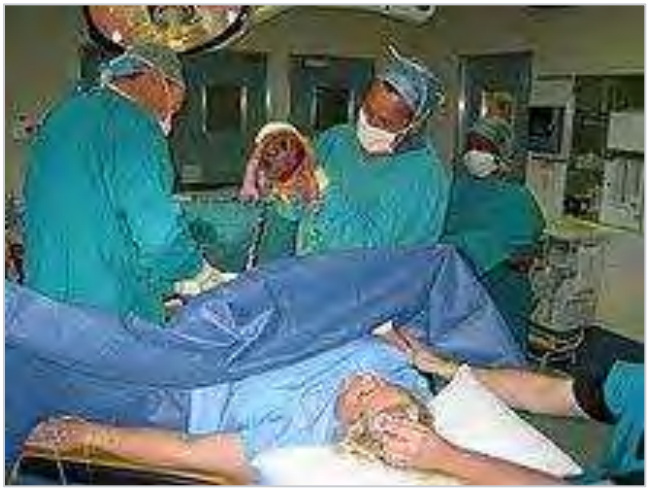


Diagram showing an episiotomie

The third stage of labor is the delivery of the afterbirth (placenta). Oxytocin continues to be released to shrink the size of the uterus and aid in the limiting of blood loss from the site of the placenta. As the uterus shrinks the attachment site blood vessels, some of which can be as large as an adult finger, shrink also. The average blood loss in a routine vaginal delivery is 400-500 cc.

There are times when a mother may need outside aid in the delivery of the baby, some of these methods include:

- Forceps, an instrument used to cradle the fetus' head and manipulate the head under the pubic bone to more easily pass through the birth canal.
- Vacuum Extraction, a suction cup is applied to the baby's head, and a plunger is used to suck any air from between the suction cup and the head to create a good seal. The baby's head is then manipulated through the birth canal. This usually leaves a baby's head bruised, but the mark fades within weeks after birth.



C-section Birth

- Cesarean section, also known as C-section, is the delivery of a baby through a surgical abdominal incision (Abdominal delivery - Abdominal birth - Cesarean section). A C-section delivery is performed when a vaginal birth is not possible or is not safe for the mother or child. Surgery is usually done while the woman is awake but anesthetized from the chest to the legs by epidural or spinal anesthesia. An incision is made across the abdomen just above the

pubic area. The uterus is opened, and often brought through the incision after delivery for better visualization. The amniotic fluid is drained, and the baby is delivered. The baby's mouth and nose are cleared of fluids, and the umbilical cord is clamped and cut.

After delivery, a Newborn Intensive Care Unit (NICU) nurse, nurse midwife, nurse practitioner, neonatologist or pediatrician checks to make sure that the baby is breathing and responding. Due to a variety of medical and social factors, C-sections have become fairly common; around 25% of births are performed by C-section. C-sections carry some risks to mother and baby. Compared to a vaginal birth, the risks to mother include increased risk of death, surgical injury, infection, postpartum depression, and hemorrhage, although these are rare. Babies born by c-section are more likely to be admitted to the NICU for breathing problems. Mothers are advised to carefully weigh the risks of C-section versus vaginal birth.

Newborn baby

Delivery Options

Hospital Births

The chances of having a natural, uncomplicated birth are optimized by carefully selecting your obstetrician and hospital. Doctors who work with midwives have lower Cesarean section rates because midwives handle less complicated pregnancies. Delivering babies by abdominal surgery has been steadily rising in America over the past two decades, so that now 22-30% of births in American

hospitals are by Cesarean section. The U.S., despite having the most advanced technology and highly trained medical personnel, ranks 23rd in infant mortality and 18th in perinatal mortality.

Medical interventions such as epidural anesthesia, pitocin augmentation of labor, vacuum extraction of the fetus, episiotomy and separation of newborn and mother are common in American hospitals. There are circumstances where medical procedures such as these are necessary, but many parents and professionals now question the routine use of such interventions. In some cases, the routine use of these procedures have led to further complications. For example, the epidural anesthetic, while providing pain relief, has shown to increase the operative vaginal delivery rate (i.e. forceps and vacuum extraction rates slightly), especially in first time mothers. Epidurals have not been shown to increase the cesarean section rate in recent well documented studies.

Freestanding Birth Centers & Water Birth

"Freestanding" Birth Centers are not inside of or affiliated with a hospital. They are run by a collaboration of midwives and/or physicians. This is an alternative choice for the woman who does not wish to give birth in a hospital environment, yet is not comfortable giving birth at home. Birth centers do not provide any additional measure of safety than most planned home births with qualified midwives; they may provide the expectant couple with the physiological comfort necessary to enable the mother to relax.

Out-of-hospital birth centers are designed for women having low-risk pregnancies, who want drug-free birth with minimal intervention in a home-like environment. Family members may participate in the birth. C-sections rates are lower than most hospitals because the pregnancies are low risk. Freestanding Birth Centers are an alternative choice for a woman who has had a previous cesarean and wishes to maximize her chances of a vaginal delivery. However, vaginal birth attempts after a prior cesarean section have a 1-2% risk of uterine rupture. Health insurance may cover costs. Many birth centers offer birthing tubs where one can give birth in water.

Homebirth

Birth at home provides parents with intimacy, privacy, comfort and family-centered experience. Childbirth at home may be a safe option for healthy women having normal pregnancies. It is for those who have a very strong desire for natural childbirth, and who are willing to take a high degree of responsibility for their health care and baby's birth. At home, the parents and midwife are in control of the birthing environment, and strict time perimeters for length of labor are not imposed, or routine medical interventions such as IVs done. In choosing the comfort of, home parents are also choosing to be further away from lifesaving measures, should complications arise.

Homebirth midwives provide complete prenatal care including monthly visits, laboratory tests, screening for infections. They provide nutritional counseling and support for psycho-social issues. There is a chance that a rare, but critical emergency might occur during the birth where hospital services may not be able to be obtained quick enough. Home birth midwives are trained to know when an emergency requires a medical interface, and can provide stabilizing measures until critical care can be obtained.

A newborn with umbilical cord still attached (3 minutes.)

Childbirth Disparities

Infant Mortality rates worldwide vary historically and present day. The availability of medical intervention has changed the likelihood of infants dying during childbirth. That being said, the medicalization of childbirth as a procedure carries with it

differing types of opportunities to treat the process as an ailment. In fact, childbirth is entirely different from most medical procedures that take place in hospitals.

Even in a highly industrialized nation with advanced technology, the United States faces a disparity issue in its infant mortality rates based on race. Historical and sociocultural explanations of this are discussed in this article. Why are black mothers and infants far more likely to die in U.S. from pregnancy-related causes?

Maternal Health in Developing Countries by United Nations Photo

Postpartum care

After the baby is born, the umbilical cord is clamped and cut and the baby is assessed by a doctor, nurse practitioner, nurse midwife or nurse. The baby is given an APGAR score (defined below) at one and five minutes after birth. The Apgar score measures five things to check a baby's health. Each is scored on a scale of 0 to 2, with 2 being the best score. Watch one being done here: APGAR Testing.

SCORE	0 points	1 point	2 points
Appearance (Skin color)	Cyanotic / Pale all over	Peripheral cyanosis only	Pink
Pulse (Heart rate)	0	<100	100-140
Grimace (Reflex irritability)	No response to stimulation	Grimace or weak cry when stimulated	Cry when stimulated
Activity (Tone)	Floppy	Some flexion	Well flexed and resisting extension
Respiration	Apneic	Slow, irregular breathing	Strong cry

Example APGAR Score Chart

For the mother, if vaginal or perineum tearing occurs, or an episiotomy occurs the wound is closed with absorbable sutures. The mother is closely watched for blood loss, infection, or any other possible complications. Breastfeeding should be initiated as soon as possible after delivery, as the stimulation of oxytocin in the mother aids in hemostasis.

Sidebar 10.3: I can feel that!

I gave birth in 2002. The process itself did not go as planned. I had a vision of what I perceived as the *right way* to give birth (silly me!). No drugs or intervention, a natural childbirth. I woke up the morning after my due date and made coffee (admittedly not that natural). I waddled to the sofa and sat my giant behind down. All of a sudden, I felt this wetness between my legs. I got up and noticed a pool of yellow water on the (white) sofa. I screamed for my sister in the other room and she told me to call the hospital. They said the baby had pooped inside me, and I needed to come to the hospital as my labor was beginning. I asked if I could finish my coffee first. Once there I was told it was dangerous to let the labor produce naturally because the poop could hurt the baby. They informed me they would need to induce me. They told me that it would be extra painful and so I needed an epidural. At the moment all I wanted was a healthy baby so I said ok. After the epidural, I couldn't pee or feel anything below my waist. Labor progressed, and within about 10 hours I was able to start pushing. That lasted about 45 minutes until my daughter popped out. The OBGYN was minimally involved, and left and came back during the whole process. I was high on adrenaline at that point and was just so happy to have my baby. Then came time to stitch me up. The OBGYN was visibly impatient trying to force the placenta out. When they started stitching me up, I screamed, "***I can feel that"***, but the OBGYN seemed unphased. While my family and hospital staff looked on, the doctor ignored me and kept stitching until they were done and then left abruptly.

Risks in Pregnancy

Pregnancies that warrant close attention usually come from an existing medical condition such as asthma, diabetes, epilepsy, or a condition developed because of pregnancy. Conditions that arise during pregnancy will require special treatment. The purpose of prenatal care is to detect these conditions, and to monitor and deal with them before they become serious.

- **Preeclampsia** is the medical term for high blood pressure during pregnancy. It is also characterized by edema, blurry vision, liver pain, and can progress into Eclampsia in which the mother can experience seizures, coma or even death.
- **Gestational Diabetes** is diabetes mellitus that develops during pregnancy. All women should be tested for the condition at about 28 weeks gestation. Gestational and pre-existing diabetes can cause large for gestational age babies, a sudden drop in a neonates blood sugar after birth, and has a high risk for stillbirth.

Other serious risks include:

- **Teratogens** (substances that cause birth defects including alcohol and certain prescription and recreational drugs)
- **Infection** (such as rubella or cytomegalovirus) An infection in the eleventh week is less likely to damage the heart, but the baby may be born deaf.
- **Genetics** (such as Factor V Leiden) Diabetes, blood conditions, etc.
- **Radiation** (ionizing radiation such as X-rays, radiation therapy, or accidental exposure to radiation)
- **Nutritional deficiencies** such as deficient in vitamins D, C, A, K, B-6, and E, as well as iron, folate, calcium, potassium, magnesium, and choline.
- **Fetal Alcohol Syndrome** or **FAS** exposure is the leading known cause of mental retardation in the Western world. It is a disorder of permanent birth defects that occurs in the offspring of women who drink alcohol during pregnancy, depending on the amount, frequency, and timing of alcohol consumption. Alcohol crosses the placental barrier and can stunt fetal growth or weight, create distinctive facial stigmata, damage neurons and brain structures, and cause other physical, mental, or behavioral problems. Drinking during pregnancy should be avoided. Women who drink more than

4 or 5 drinks per day may cause permanent damage to their fetus, including behavioral problems, sight and hearing loss, deformed organs and central nervous system dysfunction.

- **Smoking** can cause low birth weight, still birth, birth defects, preterm births and immature lung development. It can also contribute to addiction in the child's later teen years.
- **Illegal Drugs** can be the most devastating. Risks include SIDS (Sudden Infants Death Syndrome), learning disorders, birth defects, uncontrollable trembling, hyperactivity, and drug dependency. Most drugs can be tested by a simple urine or blood test.
- **Medications**. All medication use should be discussed with your doctor. Many over the counter and prescription drugs have warning labels. Follow these precautions to help avoid birth defects or other related problems.

Miscarriage

Miscarriage, or spontaneous abortion, is the natural or spontaneous end of a pregnancy at a stage where the embryo or the fetus is incapable of surviving, generally defined in humans at a gestation of prior to 20 weeks. Miscarriages are the most common complication of pregnancy. Basic Facts: 15-20% of pregnancies end in miscarriage, 70% of the time there is a chromosomal abnormality with the fetus, and one miscarriage does not increase your risk in the next pregnancy. Miscarriage is almost never the mother's fault.

If the products of conception are not completely expelled after fetal death, this is known as a missed abortion, and is usually treated surgically by a procedure known as a D&C or dilation and curettage.

Sidebar 10.4: Life on Life's Terms

Anonymous. 2022. Image donated from author

After two years of trying, I finally received a positive pregnancy test. I couldn't believe my eyes. Nothing about my journey had been easy. I identify as a lesbian, so my donor was a gay friend from San Francisco. I sent him a photo of the pregnancy test and my phone rang immediately. Neither of us could speak, we were so excited. Over the two years his mother was busy knitting outfits for the baby. I was overjoyed, but also slightly overwhelmed with the results.

The following morning I noticed light spotting. I didn't panic, hoping it was implantation bleeding. I was at work that day, working in a client's home. At lunchtime, I used the restroom. To my utter shock, I was gushing blood. I had the foresight to stick a tampon in my pocket. However, due to my confusion, I could not manage to use the tampon correctly. I was flustered in disbelief. I was also very conscious of how much time I spent in the restroom. I cleaned up as quickly as possible, returned down to face the client, while I got a second tampon from my purse.

I apologized to her saying, "I had a little surprise up there." She replied "Oh don't worry, it happened to me a million times." I climbed up the stairs again fighting off tears. I realized there was blood all over the bathroom, her floor, sink and countertops. Even more flustered, I cleaned myself up quickly, feeling the blood drying down my legs. I couldn't comprehend what was happening. How could I be

pregnant yesterday and gushing blood today? That beautiful little baby I pictured was gone. We were back at square one.

I returned to the client and attempted to eat my lunch. I had zero appetite. I was embarrassed, confused, anxious and overall devastated. Given the amount of time I spent in her bathroom, I felt I had to say something. I blurted out, “Yesterday I received a positive pregnancy test after two years of trying, so I’m absolutely in shock over what happened just now. I’m sorry I was gone so long, I was not expecting this and feel so uncomfortable.” The client looked up from her phone and said “Oh God, I had 14 miscarriages, so this couldn’t have happened at a better place. I know all about it.” Her reaction seemed quite casual to me. I could not imagine going through that experience 14 times.

I had fully expected her to say “Go home, you poor thing. You are in shock and need time to process this.” However, that did not happen. She expected me to carry on working, which I did. I was fighting the tears while also fighting the urge to walk out. Eventually we finished up. I cried the entire hour home. I was desperate for a shower and a long sleep.

Several days later, I was at work and suddenly started vomiting. Again, I was at a clients’ home. I couldn’t understand what was making me sick. I cleaned up and resumed working. About twenty minutes later, I was back in the bathroom, on my knees, violently shaking and vomiting into the toilet. This time I told the client. She was incredibly kind and concerned. She sent me home offering any help she could. I vomited one more time in her garden before attempting the hour drive home.

During my drive, it became obvious this was a serious situation. Instead of driving home, I went straight to the ER. I pulled up outside the hospital, quickly opened my door and vomited all over the street. I was admitted immediately. I couldn’t stop shaking. I was given IV fluids and nausea medicine to stop the vomiting. After seven long hours of extensive testing in ER, doctors determined my body was having a very unusual and violent reaction to the pregnancy. My blood type is positive, while my donor’s is negative. Once the egg was fertilized, my body fought it like an infection. The doctor assured me we could one day have a healthy baby. However, if I continued to miscarry, this would be my body’s normal reaction.

During these two years we had tried fertility clinics, acupuncture, a private out-of-pocket gynecologist, and we tried at home, turkey baster style. I even tried Clomid, a drug to help me ovulate. Clomid backfired on me, causing large painful cysts. Due to our circumstances, we also had to hire a lawyer to write a contract regarding parental rights once the baby was born. It was an emotional rollercoaster for everyone involved.

By the time I left the ER, I had decided I was done trying. I didn't have the mental or physical energy to continue this journey. It was a very painful decision. I had dedicated so much of my time to something that didn't seem meant to be. I always felt I would make such a great parent, but I needed to accept it may not be the way I imagined. For now, I needed to heal emotionally and mentally. If I am destined to be a parent, I believe that child will appear in another form. I was adopted as a baby and was given a beautiful life. Perhaps I will get the opportunity to return the favor. I have enough life experience to know my plan is not always the grand plan. Accepting life on life's terms is not always easy, but is often far more beautiful than I could have planned.

Bleeding During Pregnancy

Vaginal bleeding at any stage should be taken seriously. Severe bleeding in the early weeks may be a sign of miscarriage. However, 25% of pregnant patients bleed in the first trimester. After 24 weeks, the mother should seek medical advice immediately. Third trimester bleeding in pregnancy is often one of the first signs of placenta previa-placenta completely or partially covering the opening of the uterus (cervix). An ultrasound should be performed to establish the location. Other causes of late term bleeding include:

- **Preterm Labor** or labor that occurs before 38 weeks gestation that can have multiple causes
- **Placental Abruption** is a condition in which the placenta is torn away from the uterine wall causing loss of oxygen and nutrients to the baby, and hemorrhage of mother and baby from the large blood vessels in the placenta. Most women, but not all experience heavy bleeding and abdominal

pain. This is a life threatening emergency, as a fetus can only survive as long as 50% of the placenta is still attached.

Staying Healthy

Pregnancy and childbirth place great demands on a woman's body, it is important to keep healthy. The more healthy and relaxed the mother is, the better it will be to cope with the demands of pregnancy. A healthy lifestyle combines many factors:

Balanced Diet

A poor diet can cause a low birth weight. Excessive weight gain during pregnancy can cause back problems, varicose veins, or indicate preeclampsia. Advice on diet often includes eating foods that are high in nutritional content. Sufficient protein, vitamins, carbohydrates, fats, and minerals, as well as fiber. Limit intake of saturated fats and sugar, and salt. Drink plenty of fluids.

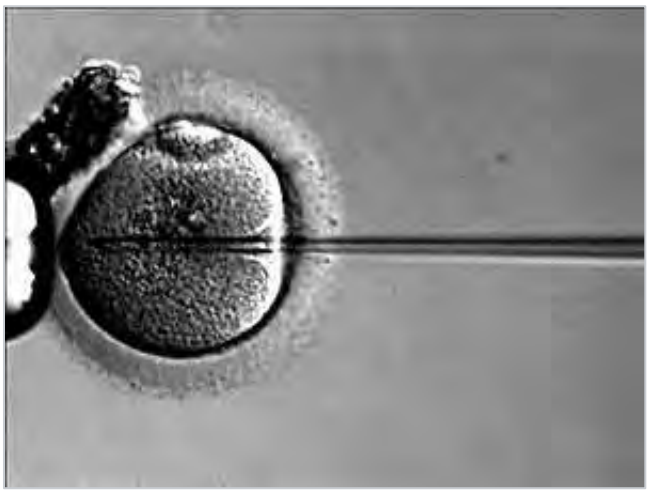
Regular Exercise

Mild exercise, such as walking or swimming, is beneficial and will help cope with the workload of pregnancy and the demands of labor. Mother's should listen to her body and stop exercising when it tells her to. Exercise should never be painful.

Baby's Health

Consumption of alcohol and cigarettes while pregnant are dangerous for your baby. Smoking reduces the oxygen and nutrients passing via the placenta to the baby. Avoid alcohol to avoid serious birth defects.

In Vitro Fertilization and Artificial Implantation



Oocyte injected with sperm outside of the womb.

In vitro fertilization (IVF) is a technique in which egg cells are fertilized by sperm outside the woman's womb. IVF is a major treatment in infertility when other methods of achieving conception have failed. The process involves hormonally controlling the ovulatory process, removing ova (eggs) from the woman's ovaries and letting sperm fertilize them in a fluid medium. The fertilized egg (zygote) is then transferred to the patient's uterus with the intent to establish a successful pregnancy.

The term in vitro, is used, because early biological experiments involving cultivation of tissues outside the living organism from which they came, were carried out in glass containers such as beakers, test tubes, or petri dishes.

While the overall live birth rate via IVF in the U.S. is about 27% per cycle (33% pregnancy rate), the chances of a successful pregnancy via IVF vary widely based on the age of the woman (or, more precisely, on the age of the eggs involved). Where the woman's own eggs are used as opposed to those of a donor, for women under 35, the pregnancy rate is commonly approximately 43% per cycle (37% live birth), while for women over 40, the rate falls drastically - to only 4% for women over 42. Other factors that determine success rates include the quality of the eggs and sperm, the duration of the infertility, the health of the uterus, and the medical expertise. It is a common practice for IVF programmes to boost the pregnancy rate by placing multiple embryos during embryo transfer. A flip side of this practice is a higher risk of multiple pregnancy, which is associated with obstetric complications.

Embryo cryopreservation If multiple embryos are generated, patients may choose to freeze embryos that are not transferred. Those embryos are placed in liquid nitrogen and can be preserved for a long time. There are currently 500,000 frozen embryos in the United States. The advantage is that patients who fail to conceive may become pregnant using such embryos without having to go through a full IVF cycle. Or, if pregnancy occurred, they could return later for another pregnancy.

Pregnancy and Lactation

A mother's milk is ideal because it meets the baby's specific needs. Lactation is a neuroendocrine response in *milk production*. Sucking stimulates the sensory nerve endings in the nipples and sends stimulus to the hypothalamus. The hypothalamus stimulates the anterior pituitary and prolactin is released. In *milk let-down,* the sucking stimulates sensory nerves in the nipples. This stimulates the hypothalamus which then stimulates the posterior pituitary and releases oxytocin. Sucking also stimulates contraction of the cells around the alveoli in the mammary cells. Milk then flows into the milk ducts causing milk let-down.

Breast milk provides all the nutrients required for the first 4-6 months. It contains carbohydrates (such as lactose), fats (such as linoleic acid), and easily digestible proteins (such as alpha-lactalbumin). Breast milk also contains an adequate supply of vitamins and minerals, digestive enzymes, hormones and immunological factors.

The first milk produced after birth is called *colostrum*. This is synthesized during the end of pregnancy and 3-5 days of postpartum. It is very high in protein and low in fat and carbohydrates, and contains immunoglobulins. This helps the baby have a first bowel movement and prevent jaundice. This bowel movement from the colostrum is a different color and consistency of bowel movements once the mother's milk comes in.

The composition varies in breast milk during feeding, and over time with development of the baby. When breastfeeding, there are three names for the composition of the milk: the fore milk, present during the beginning of breastfeeding; mid is the middle of feeding; and hind which is toward the end of the feeding and contains a composition high in fat.

When breastfeeding the mother should consider the types of food that will be consumed. If the mother is on a low fat diet, or if foods like garlic, broccoli, and

onions are eaten, it may affect the baby's preference for breastfeeding. Also, the mother should consider not breastfeeding after the consumption of alcohol, caffeine, smoking, and certain medications.

Some barriers to breastfeeding have been identified as lack of professional and social support, misinformation, embarrassment, early discharge from the hospital without instruction, and returning to work or school without adequate lactation rooms.

When breastfeeding, initiate as soon after delivery as possible, position the baby correctly, feed on demand from both breasts at each feeding and at least 10 minutes on each breast. Additionally, there should be a good educator in the case the infant is not latching on.

A common problem that may happen when breastfeeding is *mastitis*, which is an inflammation of one or both breasts, and is usually associated with the infection of a blocked milk duct during lactation. The symptoms include flu-like symptoms, red streaks on the breast, and hot skin. Antibiotics may be necessary to clear the infection. *Thrush,* a fungal yeast infection, may also happen, and could be passed between mom and baby. A symptom of thrush includes white flecks on the tongue; in this situation the baby and mother should be treated by a doctor.

Breast milk is recommended through the first 12 months. Supplementation of cow's milk is not recommended, due to the high amount of protein that would cause liver damage to the baby.

Why breastfeed?

- It is easily digested
- Composition changes with infant needs
- Changes during a feeding, high in fat at the end of feeding
- Antibodies in milk
- Breastfeeding moms miss less work because babies are sick less
- Fewer allergies
- Less spit-up
- Less constipation and diarrhea
- Better jaw development
- Decreased risk of SIDS (Sudden Infant Death Syndrome)
- Higher IQ

- Decreased risk of diabetes, Crohn's Disease, Celiac Sprue
- Bonding
- Convenient, always at the correct temperature and ready to go
- Less expensive
- Helps the uterus return to normal size more quickly
- Less incidence of postpartum “blues”
- Lower risk of breast cancer
- Lower risk of osteoporosis
- It is free!

Sidebar 10.5: On Reclaiming Myself

Before I had my son, I would have described myself as a woman who was very in touch with her sexuality. It was an integral part of my identity that I took pride in. Then, I became a mother. Overnight, my body was no longer my own. For 10 months, I had another life growing inside of me. After he was born, my breasts became my son's primary source of food and comfort, and my body was unrecognizable in the mirror. Every thought in my mind related to my son, who was physically on my body all day and much of the night for the first year of his life. I had zero sex drive. In addition to the transition I was undergoing internally, the way the world treated me felt different. The rules for how I was supposed to conduct myself publicly seemed to have shifted. I remember my first summer as a mother, getting my then 9 month old ready to go to the park. I tried on my favorite pre-baby denim short-shorts, but ultimately couldn't stomach the thought of wearing them in public while with my son. I remember feeling uncomfortable at the idea of baring myself in a way that might be perceived as sexual, when my body currently belonged to a being so pure and innocent. Now more than two and a half years into my motherhood journey, I am beginning to reconcile the woman I used to be with my identity as somebody's mother. I have exited the period of extreme enmeshment that comes with having a newborn and breastfeeding. I have also come to realize that I fundamentally reject the idea that a woman cannot be both a good mother and a sexual being. After all, I wouldn't be a mother if not for my sexuality. And as a mother to a young boy, I feel it is important to teach him that mothers are whole human beings (who can wear whatever they want!).

Juliana Garcia

Postpartum Depression

Having a baby is usually one of the happiest times in a woman's life, but for some women, it can include times of sadness and depression. More women actually suffer from postpartum depression than we really know. Women usually ignore the emotional and physical signs, dealing with their feelings on their own.

Postpartum depression affects approximately 10 to 15 percent of new mothers. It often causes anxiety and obsession about caring for the baby or the cleanliness of the home. It may cause changes in sleep patterns and affect relationships, including the ability to form a bond with the baby and other family members. Some mothers with postpartum depression have thoughts of wanting to die or of hurting the baby. If the symptoms are so severe that they keep the mother from being able to function, medical treatment is necessary.

Baby blues are common due to rapid hormonal changes but resolve after 1-2 weeks. Postpartum depression is characterized by persisting symptoms, and the mother should notify her provider immediately.

Conclusion

Conception is the union between a sperm and an ovum. The fetus develops from this union. During pregnancy, prenatal development is generally split into three trimesters in which the fetus develops. There are corresponding bodily changes in the mother during each of these phases of pregnancy. During pregnancy, the health of the mother is vital for the healthy development of the fetus. Good nutrition and health care are part of this. Childbirth begins with the onset of regular contractions of the uterus, which efface and dilate the cervix. Following this, during vaginal childbirth, the baby appears and the umbilical cord is clamped and cut. The placenta then is expelled. The postpartum period includes finding the best option for getting the baby the best nutrition possible often by breastfeeding or high quality infant formula. This period marks a large wave of emotions associated with hormonal and life changes, and sometimes, postpartum depression is associated with early motherhood, and most care providers are well-trained to support new mothers experiencing this.

Glossary

1. **Abruption**: Premature separation of the placenta from the wall of the womb
2. **Amnion**: An embryonic membrane that encircles a developing fetus and contains amniotic fluid.
3. **Amniocentesis**: A procedure in which a small sample of amniotic fluid is removed from around the fetus
4. **Amniotic fluid**: The fluid surrounding the fetus
5. **Amniotomy**: (artificial rupture of membranes, ARM) Breaking the membranes using a special plastic hook
6. **Anemia**: Lack of hemoglobin in red blood cells, due to iron deficiency or disease
7. **Antepartum Hemorrhage**: (APH) Vaginal bleeding that happens after 24 weeks of pregnancy and before delivery
8. **Breech**: The baby is lying bottom down in the womb
9. **Celiac sprue**: Nutrient absorption impairment which is improved when gluten is removed from the diet. Characteristic mucosal lesion of the small intestine.
10. **Cephalic**: The baby is lying head down in the womb
11. **Chorion**: The embryonic membrane that forms the outermost covering around the developing fetus.
12. **Chorionic Villus Sampling**: (CVS) A method for sampling placental tissue for genetic or chromosome studies.
13. **Colostrum:** the fluid that is made late in pregnancy and the first few days postpartum in the breast that contains immunologic substances and essential nutrients.
14. **Cleavage**: The early successive divisions of embryonic cells into smaller and smaller cells.
15. **Cilia**: The fine hairs that line the fallopian tubes
16. **Cordocentesis**: The procedure for taking blood from the fetal umbilical cord via a needle through the mother's abdomen
17. **Copulation**: (Coitus, sexual intercourse) is the procreative act of a man's erect penis is inserted into a woman's vagina. At climax, semen is ejaculated from the penis at the cervix of the uterus. Sperm then propel themselves into the fallopian tubes where fertilization may occur if an ovum is present.

18. **Crohn's disease**: Skip lesions in the colon and is a malabsorptive disease.
19. **Cystitis**: Infection of the bladder
20. **Dizygous**: Not identical (fraternal) twins
21. **Doppler**: A form of ultrasound used specially to investigate blood flow in the placenta or in the fetus
22. **Down Syndrome**: (Trisomy 21) A disorder caused by the presence of an extra chromosome 21 in the cells
23. **Ectopic Pregnancy**: A pregnancy that develops outside of the womb
24. **Edema**: Swelling of the fingers, legs, toes, and face.
25. **Embryo**: The medical term for the baby from conception to about six weeks
26. **Engagement**: The process in which the head of the baby moves down from high in the mother's abdomen and settles deeper into her pelvis in preparation for birth. This can happen any time between 36 weeks and labor.
27. **Epidural Anesthesia**: A method of numbing the nerves of the lower spinal cord to ensure a pain-free labor
28. **Episiotomy**: A cut of the perineum and vagina performed to make the delivery easier
29. **External Fetal Monitor**: An electronic monitor used to record the fetal heartbeat and mother’s contractions
30. **Fallopian Tubes**: (uterine tubes) Two tubular structures (one on each side of the womb) leading from the ovaries to the uterus
31. **Fertilization**: The union of an egg cell and a sperm cell is present wherein 23 chromosomes from each parent come together to form a zygote. After sperm penetrates, the ovum undergoes a chemical change to prevent other sperm from entering. Multiple births can occur from complete division of the conceptus during early cleavage or from fertilization of multiple ova. Birth control techniques are designed to prevent ovulation or to prevent fertilization by barriers that keep sperm and ova separated.
32. **Fetus**: Medical term for the baby from six weeks after conception until birth
33. **Forceps**: Metal instruments that fit on either side of the baby's head and are used to help deliver the baby
34. **Fundus**: The top of the womb
35. **Germ layer**: Layers of cells within an embryo that form the body organs during development.

36. **Glial Cells** (neuroglia; glia): Non-neuronal cells that provide support and nutrition, maintain homeostasis, form myelin, and participate in signal transmission in the nervous system. In the human brain, glia are estimated to outnumber neurons by about 10 to 1. Glial cells provide support and protection for neurons, the other main type of cell in the central nervous system. They are thus known as the "glue" of the nervous system. The four main functions of glial cells are to surround neurons and hold them in place, to supply nutrients and oxygen to neurons, to insulate one neuron from another, and to destroy pathogens and remove dead neurons.
37. **Hemoglobin**: (Hb)The oxygen carrying constituent of red blood cells
38. **Induction of labor**: (IOL) the procedure for initiating labor artificially
39. **In utero death**: (IUD)the death of the unborn fetus after 24 weeks
40. **In vitro fertilization**: (IVF) a method of assisted conception in which fertilization occurs outside the mother's and the embryo is replaced in the womb
41. **Lanugo**: fine hair that covers the fetus in the womb
42. **Lochia**: blood loss after birth
43. **Mastitis** inflammation of the breast most frequently in lactation.
44. **Neonatal**: baby less than 28 days old
45. **Nuchal scan**: special ultrasound scan that gives an estimate of the risk of Down syndrome
46. **Oocyte**: one ovum that is released from the ovary at each ovulation
47. **Placenta**: The structure by which an unborn child is attached to its mother's uterine wall and through which it is nourished.
48. **Postnatal**: After birth
49. **Prenatal**: Before birth
50. **Quickening**: The process that occurs between the seventeenth and twentieth weeks of fetal development, the fetus's leg bones achieve their final relative proportions. In this process the muscles contract, causing movement at the fetus's synovial joints. The joint movement enhances the nutrition of the articular cartilage and prevents the fusion of connective tissues within the joint. It also promotes bone hardening. It is this stage, where the fetus's bones become more developed and harder, that the mother begins to notice fetal movement.

51. **Rudimentary**: Basic; minimal; with less than, or only the minimum, necessary
52. **Thrush**: Creamy white flakes on a red papillae on tongue and tongue may be enlarged.
53. **Umbilical cord**: The cord-like structure that connects the fetus to the placenta.
54. **Zygote**: A cell produced by the fusion of an egg and a sperm; a fertilized egg cell.

Discussion Questions

1. Discuss the initial process of becoming pregnant. What has to take place?
2. In the first trimester of pregnancy, what are some bodily changes the mother goes through?
3. What is the fetus doing during the second trimester?
4. How does access to resources facilitate a healthy pregnancy? Discuss factors related to this.
5. What does APGAR mean? What does this test measure?

Multiple Choice

1. Fertilization is the process of the joining of a sperm and an ovum

    a. True
    b. False

2. Which part of the embryoblast will become the central nervous system

    a. Ectoderm
    b. Mesoderm
    c. Endoderm
    d. Dermatology

3. This hormone is only produced in the human body when a woman is pregnant

a. Estrogen
b. HCG
c. Progesterone
d. FSH

4. Amniotic Fluid acts as a cushion for the fetus

a. True
b. False

5. The placenta provides oxygen and nutrients to a growing fetus

a. True
b. False

6. The cervix dilates on an average of _____ per hour in the active phase of labor

a. 2 mm
b. 2 cm
c. 1mm
d. 1 cm

7. The contractions of the uterus are stimulated by the release of

a. Oxytocin
b. FSH
c. LH
d. Prolactin

8. A sign of pre-labor is

a. irregular contractions
b. pain in the front only
c. loss of the mucus plug
d. contractions stop during rest

9. This is the most common complication of pregnancy

a. Preeclampsia
b. Miscarriage
c. Smoking
d. Rh factor

10. What is the first milk after birth called?

a. Thrush
b. Mastitis
c. Colostrum
d. milk let down

For Further Exploration

Conception to birth -- visualized | Alexander Tsiaras

Nurses Answer Most Commonly Searched Post-Birth Questions

Breast anatomy and lactation (video) | Khan Academy

Webinar: Confronting Racial Disparities in Maternal Health

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Chapter 11: Sexuality Through the Lifespan

Del Martin and Phyllis Lyon kiss. Olga Berrios. 2004. Creative Commons Attribution 2.0

Learning Objectives

After completing this module, students will have working knowledge of:

- Sexuality in Children
- Sexuality in Teens
- Sexuality in Mid-Adulthood
- Sexuality in Older Adults

Introduction

Our sexuality remains an important part of our overall wellness through our lifespan. However, our sexuality across the lifespan is not static, but rather dynamic and continually evolves as we go through our life cycle. In this chapter, we will look at human sexuality as a developmental process through various life stages and examine some of the biopsychosocial factors that contribute to the changes in sexual development.

Author caveat: much of the research on sexual development is gendered and we are reporting on this research while acknowledging taking a new critical view of gendering in this field is a direction we hope to see more of in future research. As this book is not a static document we hope to update and invite those who use this text to modify as new research surfaces.

Sexual Development in Early Childhood

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Historically, children have been thought of as innocent or incapable of sexual arousal (Aries, 1962). Yet, like all forms of human development, sexual development begins at birth in the form of physical sexual arousal. However, to associate this physical arousal with the elements of seduction, power, love, or lust that are part of the adult meanings of sexuality would be inappropriate. Sexuality begins in childhood as a response to physical states and sensation and cannot be interpreted as similar to that of adults in any way (Carroll, 2007). The physical changes continue to occur as children grow, and as they gain sexual knowledge and beliefs these later become associated with the physical sensations.

Infancy

Infants are capable of erections and vaginal lubrication even before birth (Martinson, 1981). In utero, infant self-stimulation has been observed too, but there is some debate about whether this behavior is purposeful.

As early as 16 weeks, erectile response in male fetuses has been viewed with ultrasound (Haffner, 1999; Martinson, 1994; Parrot, 1994). It is assumed it would be the same for female fetuses and that lubrication and clitoral erection would begin this early as well, although the technology for demonstrating it does not yet exist (Borneman, 1994; Martinson, 1994; Money, 1999). In newborn males, spontaneous erections continue to occur when awake and asleep, while female's vaginas lubricate and their clitorises swell (Money, 1999; Richardson & Schuster, 2003). Although the sexual response cycle is present at birth, many parents believe that infancy and childhood is a time of sexual innocence (meaning without sexuality) and that "sex is supposed to burst out full bloom at puberty or, hopefully, later" (Haroian, 2000; Martinson, 1973, p. 23, http://www.ejhs.org/volume11/Newman.htm).

Arousal can signal overall physical contentment and stimulation that accompanies feeding or warmth. Infants begin to explore their bodies and touch their genitals as soon as they have the sufficient motor skills. This stimulation is for comfort or to relieve tension rather than to reach orgasm (Carroll, 2007).

An element of sexually healthy development and developing a positive body image is feeling comfortable with and appreciating all body parts (Haffner, 1999). It is never too early to teach correct names for body parts (Richardson & Schuster, 2002). It is recommended that parents begin as soon as possible to use correct terms for the genitalia when speaking to their infants, because if they can't say the words "penis" or "vulva" to an infant who has no idea what they're saying, it's not going to get any easier when they get older and do know (Moglia, 2000). Starting early helps parents begin to feel comfortable using correct terminology. By not saying anything parents may be conveying uncomfortable feelings with genitalia and even a sense of shame about the genitalia. If the parent expresses disgust while diaper changing or cleaning their child’s genitalia, the child may internalize these reactions and begin to feel badly or shameful about their genitalia (Parrot, 1994). Although many parents don't display a negative attitude during diaper changes, few go as far as to show appreciation for the genitalia of their infants. How many parents go on about the cute little feeties, adorable belly, beautiful eyes, etc., but would never say what a wonderful penis or clitoris. An approving smile during diaper changes can make a difference in how children grow to feel about their bodies (Newman, 2008, Yates, 1978).

Early Childhood

Self-stimulation is common in early childhood for all children. Curiosity about the body and about others' bodies is a natural part of early childhood as well. As children grow, they are more likely to show their genitals to siblings or peers, and to take off their clothes and touch each other (Okami, Olmstead, & Abramson, 1997). Masturbation is common for both boys and girls. Boys are often shown by other boys how to masturbate, but girls tend to find out accidentally. Additionally, boys masturbate more often and touch themselves more openly than do girls (Schwartz, 1999). In 2009, The National Traumatic Stress Network published Sexual Development and Behavior in Children which offers information and advice.

Hopefully, parents respond to this without undue alarm and without making the child feel guilty about their bodies. Instead, messages about what is going on and the appropriate time and place for such activities help the child learn what is appropriate. Although parents often become concerned when a child shows sexual behavior, such as touching another child's private parts, these behaviors are not uncommon in developing children. Most sexual play is an expression of children's natural curiosity and should not be a cause for concern or alarm. In general, "typical" childhood sexual play and exploration:

- Occurs between children who play together regularly and know each other well
- Occurs between children of the same general age and physical size
- Is spontaneous and unplanned
- Is infrequent
- Is voluntary (the children agreed to the behavior, none of the involved children seem uncomfortable or upset)
- Is easily diverted when parents tell children to stop and explain privacy rules

Some childhood sexual behaviors indicate more than harmless curiosity, and are considered sexual behavior problems. Sexual behavior problems may pose a risk to the safety and well-being of the child and other children. (For more on this topic, see the National Child Traumatic Stress Network's factsheet, Understanding and Coping with Sexual Behavior Problems in Children: Information for Parents and Caregivers at http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf).

Sexual behavior problems include any act that:

- Is clearly beyond the child's developmental stage
- Involves threats, force, or aggression
- Involves children of widely different ages or abilities
- Provokes strong emotional reactions such as anger or anxiety in the child

Parents and/or guardians play a pivotal role in helping their children develop healthy attitudes and behaviors towards sexuality. Although talking with children about sex may feel outside the parental comfort zone, there are many resources available to help parents begin and continue the conversation about sexuality. When parents are reluctant to talk to children about sex and anatomy, children find alternative sources from their peers, internet and porn sites. These sources may lead to misinformation. Providing close supervision, and providing clear, positive messages about boundaries and privacy are crucial as children move through the stages of childhood. By talking openly with children about relationships, intimacy, and sexuality, parents and guardians can foster their healthy growth and development.

Sexual Abuse

Childhood **sexual abuse** *is defined as any sexual contact between a child and an adult or another child.* **Incest** *refers to sexual contact between a child and family members.* In each of these cases, the child is exploited by an older person without regard for the child's developmental immaturity and inability to understand the sexual behavior (Steele, 1986). Research estimates that 1 out of 4 girls and 1 out of 10 boys have been sexually abused (Valente, 2005). The median age for sexual abuse is 8 or 9 years for both boys and girls (Finkelhorn, Hotaling, Lewis, & Smith, 1990). Most children are sexually abused by a male. Although rates of sexual abuse are higher for girls than for boys, boys may be less likely to report abuse because of the cultural expectation that boys should be able to take care of themselves and because of the stigma attached to homosexual encounters (Finkelhorn et al., 1990). Girls are more likely to be abused by a family member and boys by strangers. Sexual abuse can create feelings of self-blame, betrayal, shame and guilt (Valente,

2005). Sexual abuse is particularly damaging when the perpetrator is someone the child trusts and may lead to depression, anxiety, problems with intimacy, and suicide (Valente, 2005).

Sexual Development in Adolescence

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Puberty

Puberty *is a period of rapid growth and sexual maturation*. These changes begin sometime between eight and fourteen. People assigned female at birth begin puberty at around ten years of age and people assigned male at birth begin approximately two years later. Pubertal changes take around three to four years to complete. Adolescents experience an overall physical growth spurt.

Typically, the growth spurt during adolescence is followed by the development of sexual maturity. Sexual changes are divided into two categories: Primary sexual characteristics and secondary sexual characteristics. **Primary sexual characteristics** *are changes in the reproductive organs*. For some, this includes growth of the testes, penis, scrotum, and **spermarche** *or first ejaculation of semen.* This occurs between 11 and 15 years of age. For others, primary characteristics include growth of the uterus and **menarche** *or the first menstrual period*. The female gametes, which are stored in the ovaries, are present at birth, but are immature. Each ovary contains about 400,000 gametes, but only 500 will become mature eggs (Crooks & Baur, 2007). Beginning at puberty, one ovum ripens and is

released about every 28 days during the menstrual cycle. Higher percentage of body fat can bring menstruation at younger ages.

Secondary sexual characteristics *are visible physical changes not directly linked to reproduction but signal sexual maturity*. For males this includes broader shoulders and a lower voice as the larynx grows. Hair becomes coarser and darker, and hair growth occurs in the pubic area, under the arms and on the face. For females, breast development occurs around age 10, although full development takes several years. Hips broaden, and pubic and underarm hair develops and also becomes darker and coarser.

Adolescent Sexual Activity

By about age ten or eleven, most children, regardless of sexual orientation, experience increased sexual attraction to others that affects social life, both in school and out (McClintock & Herdt, 1996). By the end of high school, more than half of boys and girls report having experienced sexual intercourse at least once, though it is hard to be certain of the proportion because of the sensitivity and privacy of the information (Center for Disease Control, 2004; Rosenbaum, 2006). Researchers identified many biopsychosocial influences that linked to early timing of **sexual debut** (first sexual intercourse). Among them are early puberty, anxious attachment style, sensation-seeking personality and positive beliefs and attitudes towards sex. In addition, several studies have found that there is a link between delayed sexual activity and receiving more parental support and parental supervision (Buhi and Goodson, 2007).

Masturbation

Masturbation is the most common sexual behavior among adolescents. Among American 14-17-year-olds, those reporting masturbation in the past year also report higher levels of several forms of partnered sex, including having given or received oral sex, penile-vaginal intercourse, and penile-anal intercourse (Robbins et al., 2011). Gender differences are evident in that women's masturbation prevalence increased from 34% among those reporting penile-vaginal sex occurring less frequently than four times in the last four weeks to 72% among those women reporting at least 16 occasions. In contrast, the prevalence of masturbation was

most frequent among men reporting fewer than four occasions of sex in the last four weeks (Gerressu et al., 2008).

Masturbation can provide a means of gaining familiarity and comfort with one's sexual responses and genitals (Hogarth & Ingham, 2009). Masturbation and non-coital orgasm among young women is associated with higher levels of sexual self-awareness, greater efficacy achieving pleasure, and more resistance to gendered double standards (Horne & Zimmer-Gembeck, 2005). Young men—but not young women—who report masturbation in the past year are substantially more likely to report condom use with penile-vaginal intercourse than young men who do not report masturbating (Robbins et al., 2011).

Sexual identity

According to Carroll (2016), by age 14 most adolescents become interested in intimate relationships, and they may begin sexual experimentation. Many adolescents feel pressure to express interest in opposite-sex relationships, even if they are not ready to do so. This pressure can be especially stressful for those adolescents who are gay, lesbian, bisexual or questioning their sexual identity. Many non-heterosexual adolescents struggle with negative peer and family reactions during their exploration. A lack of parental acceptance can adversely affect LGBTQ+ adolescents' emerging sexual identity and may result in feelings of depression. In contrast, adolescents whose families support their sexual identity have better health outcomes.

Adolescent Pregnancy

In 2018 females aged 15-19 years experienced a birth rate (live birth) of 17.4 per 1,000 women. The birth rate for teenagers has declined by 58% since 2007 and 72% since 1991, the most recent peak (Hamilton, Joyce, Martin, & Osterman, 2019). It appears that adolescents seem to be less sexually active than in previous years, and those who are sexually active seem to be using birth control (CDC, 2016).

After the child is born life can be difficult for a teenage mother. Only 40% of teenagers who have children before age 18 graduate from high school. Without a high school degree her job prospects are limited, and economic independence is difficult. Teen mothers are more likely to live in poverty, and more than 75% of all unmarried teen mothers live in poverty within 5 years of the birth of their first child. Approximately, 64% of children born to an unmarried teenage high-school dropout live in poverty. Further, a child born to a teenage mother is 50% more likely to repeat a grade in school and is more likely to perform poorly on standardized tests and drop out before finishing high school (March of Dimes, 2012).

Research analyzing the age that men father their first child and how far they complete their education have been summarized by the Pew Research Center (2015) and reflect the research for females. Among dads ages 22 to 44, 70% of those with less than a high school diploma say they fathered their first child before the age of 25. In comparison, less than half (45%) of fathers with some college experience became dads by that age. Additionally, becoming a young father occurs much less for those with a bachelor's degree or higher as just 14% had their first child prior to age 25. Like men, women with more education are likely to be older when they become mothers.

Romantic Relationships

Courtney Carmody from Trenton, Ohio, Us. 2010. Creative Commons Attribution-Share Alike 2.0

Adolescence is the developmental period during which romantic relationships typically first emerge. By the end of adolescence, most American teens have had at least one romantic relationship (Dolgin, 2011). Dating serves many purposes for teens, including having fun, companionship, status, socialization, sexual experimentation, intimacy, and partner selection for those in late adolescence (Dolgin, 2011).

There are several stages in the dating process beginning with engaging in mixed-sex group activities in early adolescence for heterosexual teens (Dolgin, 2011). The same-sex peer groups that were common during childhood expand into mixed-sex peer groups that are more characteristic of adolescence. Romantic relationships often form in the context of these mixed-sex peer groups (Connolly, Furman, & Konarski, 2000). Interacting in mixed-sex groups is easier for teens as they are among a supportive group of friends, can observe others interacting, and are kept safe from a too early intimate relationship. By middle adolescence teens are engaging in brief, casual dating or in group dating with established couples (Dolgin, 2011). Then in late adolescence dating involves exclusive, intense relationships.

These relationships tend to be long-lasting and continue for a year or longer, however, they may also interfere with friendships.

Although romantic relationships during adolescence are often short-lived rather than long-term committed partnerships, their importance should not be minimized. Adolescents spend a great deal of time focused on romantic relationships, and their positive and negative emotions are more tied to romantic relationships, or lack thereof, than to friendships, family relationships, or school (Furman & Shaffer, 2003). Romantic relationships contribute to adolescents' identity formation, changes in family and peer relationships, and emotional and behavioral adjustment.

Furthermore, romantic relationships are centrally connected to adolescents' emerging sexuality. Parents, policymakers, and researchers have devoted a great deal of attention to adolescents' sexuality, in large part because of concerns related to sexual intercourse, contraception, and preventing teen pregnancies. However, sexuality involves more than this narrow focus. For example, adolescence is often when individuals who are lesbian, gay, bisexual, or transgender come to perceive themselves as such (Russell, Clarke, & Clary, 2009). Thus, romantic relationships are a domain in which adolescents experiment with new behaviors and identities.

However, a negative dating relationship can adversely affect an adolescent's development. Soller (2014) explored the link between relationship inauthenticity and mental health. **Relationship inauthenticity** *refers to an incongruence between thoughts/feelings and actions within a relationship.* Desires to gain partner approval and demands in the relationship may negatively affect an adolescent's sense of authenticity. Soller found that relationship inauthenticity was positively correlated with poor mental health, including depression, suicidal ideation and suicide attempts, especially for females.

Sex Education

Many adolescents begin their sexual explorations with a lack of knowledge about sex and human anatomy. Many parents would like their kids to know about sex, but seldom talk to their kids about sex and expect the schools to provide sex education. Unfortunately, many school-based sex education is inadequate and, in some cases, provides incorrect information. With comprehensive school and community based

sex-ed programs, we can prevent unintended teen pregnancies and to keep back the spread of STI among young people (What do I need to know about STDs?, 2022).

Sexuality in Early Adulthood

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Sexual Responsiveness Peak

Men and women tend to reach their peak of sexual responsiveness at different ages and among men and women there is also variation so these milestones should serve as generalities. For men, sexual responsiveness tends to peak in the late teens and early twenties. Sexual arousal can easily occur in response to physical stimulation or fantasizing. Sexual responsiveness begins a slow decline in the late twenties and into the thirties. Through time, a man may require more intense stimulation in order to become aroused. Women often find that they become more sexually responsive throughout their 20s and 30s and may peak in the late 30s or early 40s. This may be due to greater self-confidence and reduced inhibitions about sexuality.

Hooking Up

United States demographic changes have significantly affected the romantic relationships among emerging and early adults. As previously described, the age for puberty has declined, while the times for one's first marriage and first child have

been pushed to older ages. This results in a "historically unprecedented time gap where young adults are physiologically able to reproduce, but not psychologically or socially ready to settle down and begin a family and child rearing," (Garcia, Reiber, Massey, & Merriwether, 2012, p. 172). Consequently, according to Bogle (2007, 2008) traditional forms of dating have shifted to more casual **hookups** *that involve uncommitted sexual encounters.* Even though most research on hooking up involves college students, 70% of sexually active 12- 21 year olds reported having had uncommitted sex during the past year (Grello, Welsh, Harper, & Dickson, 2003). A review of the literature suggests that these encounters are becoming increasingly normative among adolescents and young adults in North America, representing a marked shift in openness and acceptance of uncommitted sex. Additionally, Manning, Giordano and Longmore (2006) found that 61% of sexually active seventh, ninth, and eleventh graders reported being involved in a sexual encounter outside of a dating relationship.

Friends with Benefits: Hookups are different from the relationships that involve continued mutual exchange. These relationships are often referred to as **Friends with Benefits** (FWB) or "Booty Calls." *These relationships involve friends having casual sex without commitment.* Hookups do not need to include a friendship relationship but they may. Bisson and Levine (2009) found that 60% of 125 undergraduates reported a FWB relationship. Research also found that the common concern was that sex might complicate friendships by bringing forth unreciprocated desires for romantic commitment, and ironically that these relationships were desirable because they incorporated trust and comfort while avoiding romantic commitment. However, participants indicated that people in FWB relationships most often avoided explicit relational negotiation.

Making Out In Tehran by kamshots

Hooking up Gender Differences: When asked about their motivation for hooking up, both males and females indicated physical gratification, emotional gratification, and a desire to initiate a romantic relationship as reasons (Garcia & Reiber, 2008). Although people of different gender are more similar than different in their sexual behaviors, a consistent finding among the research is that males demonstrate a greater permissiveness to casual sex (Oliver & Hyde, 1993). In another study involving 16,288 individuals across 52 nations, males reported a greater desire of sexual partner variety than females, regardless of relationship status or sexual orientation (Schmitt et al., 2003). This difference can be attributed to gender role expectations for both males and females regarding sexual promiscuity. Additionally, the risks of sexual behavior are higher for females and include unplanned pregnancy, increased sexually transmitted diseases, and susceptibility to sexual violence (Garcia et al., 2012).

Although hooking up relationships have become normalized for emerging adults, some research indicates that the majority of people would prefer a more traditional romantic relationship (Garcia et al., 2012). Additionally, Owen and Fincham (2011) surveyed 500 college students with experience with hookups, and 65% of women and 45% of men reported that they hoped their hookup encounter would turn into a committed relationship. Further, 51% of women and 42% of men reported that they tried to discuss the possibility of starting a relationship with their hookup partner.

Online Dating

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The ways people are finding love has changed with the advent of the Internet. Nearly 50 million Americans have tried an online dating website or mobile app (Bryant & Sheldon, 2017). Online dating has also increased dramatically among those of 18 to 24. Today, one in five emerging adults report using a mobile dating app, while in 2013 only 5% did, and 27% report having used online dating, almost triple the rate in 2013 (Smith & Anderson, 2016).

According to a recent survey of couples who met online versus offline (Brown, 2019), those who met online tended to have slightly different levels of education, and political views from their partners, but, the biggest difference was that they were much more likely to come from different racial and ethnic backgrounds. This is not surprising as the average age of the couples who met online was 36, while the average age of a couple who met offline was 51. Young adults are more likely to be in a relationship with people who are different from them, regardless of how they met.

To evaluate what individuals are looking for online, Menkin, Robles, Wiley and Gonzaga (2015) reviewed data from an eHarmony.com relationship questionnaire completed by a cross-sectional representation of 5,434 new users. Their results indicated that users consistently valued communication and characteristics, such as personality and kindness over sexual attraction. Females valued communication over sexual attraction, even more when compared to males, and older users rated sexual attraction as less important than younger users. Alterovitz and Mendelsohn (2011) analyzed 600 Internet personal ads across the lifespan and found that men sought physical attractiveness and offered status related information more than women, while women were more selective than men and sought status more than men. These findings were consistent with previous research on gender differences regarding the importance of physical/sexual attraction.

Cohabitation

In American society, as well as in a number of other cultures, cohabitation has become increasingly commonplace (Gurrentz, 2018). For many emerging adults, cohabitation has become more commonplace than marriage. While marriage is still a more common living arrangement for those 25-34, cohabitation has increased, while marriage has declined. Gurrentz also found that cohabitation varies by

socioeconomic status. Those who are married tend to have higher levels of education, and thus higher earnings, or earning potential.

Three explanations have been given for the rise of cohabitation in Western cultures. The first notes that the increase in individualism and secularism, and the resulting decline in religious observance, has led to greater acceptance and adoption of cohabitation (Lesthaeghe & Surkyn, 1988). Moreover, the more people view cohabitating couples, the more normal this relationship becomes, and the more couples who will then cohabitate. Thus, cohabitation is both a cause and the effect of greater cohabitation. A second explanation focuses on economic changes. The growth of industry and the modernization of many cultures has improved women's social status, leading to greater gender equality and sexual freedom, with marriage no longer being the only long-term relationship option (Bumpass, 1990). A final explanation suggests that the change in employment requirements, with many jobs now requiring more advanced education, has led to a competition between marriage and pursuing post-secondary education (Yu & Xie, 2015). This might account for the increase in the age of first marriage in many nations. Taken together, the greater acceptance of premarital sex, and the economic and educational changes has led to a transition in relationships. Overall, cohabitation may become a step in the courtship process or may, for some, replace marriage altogether.

Similar increases in cohabitation have also occurred in other industrialized countries. For example, rates are high in Great Britain, Australia, Sweden, Denmark, and Finland. In fact, more children in Sweden are born to cohabiting couples than to married couples. The lowest rates of cohabitation in industrialized countries are in Ireland, Italy, and Japan (Benokraitis, 2005).

Sidebar 11.1: Cohabitation in Non-Western Cultures, The Philippines and China

Similar to other nations, young people in the Philippines are more likely to delay marriage, to cohabitate, and to engage in premarital sex as compared to previous generations (Williams, Kabamalan, & Ogena, 2007). Despite these changes, many young people are still not in favor of these practices. Moreover, there is still a persistence of traditional gender norms as there are stark differences in the acceptance of sexual behavior out of wedlock for men and women in Philippine society. Young men are given greater freedom. In China, young adults are cohabitating in higher numbers than in the past (Yu & Xie, 2015). Unlike many Western cultures, in China, adults with higher rather than lower levels of education are more likely to cohabitate. Yu and Xie (2015) suggest this may be due to seeing cohabitation as being a more "innovative" behavior and that those who are more highly educated may have had more exposure to Western culture.

Marriage

Marriage Worldwide: Cohen (2013) reviewed data assessing most of the world's countries and found that marriage has declined universally during the last several decades. This decline has occurred in most nations, however, the countries with the biggest drops in marriage were France, Italy, Germany, Japan and the U.S. Cohen states that the decline is not only due to individuals delaying marriage, but also because of high rates of non- marital cohabitation. Delayed or reduced marriage is associated with higher income and lower fertility rates that are reflected worldwide.

Marriage in the United States: In 1960, 72% of adults age 18 or older were married, in 2010 this had dropped to barely half (Wang & Taylor, 2011). At the same time, the age of first marriage has been increasing for both men and women. In 1960, the average age for first marriage was 20 for women and 23 for men. By 2010 this had increased to 26.5 for women and nearly 29 for men. Many of the explanations for increases in singlehood and cohabitation previously given can also account for the drop and delay in marriage.

Marriage Equality: On June 26, 2015, the United States Supreme Court ruled that the Constitution guarantees marriage equality. The decision indicated that limiting marriage to only heterosexual couples violated the 14th amendment's guarantee of equal protection under the law. This ruling occurred 11 years after same-sex marriage was first made legal in Massachusetts, and at the time of the high court decision, 36 states and the District of Columbia had legalized same sex marriage. Worldwide, 29 countries currently have national laws allowing gays and lesbians to

marry (Pew Research Center, 2019). These countries are located mostly in Europe and the Americas.

Cultural Influences on Marriage: Many cultures have both explicit and unstated rules that specify who is an appropriate mate. Consequently, mate selection is not completely left to the individual. Rules of **endogamy** *indicate the groups we should marry within and those we should not marry in* (Witt, 2009). For example, many cultures specify that people marry within their own race, social class, age group, or religion. Endogamy reinforces the cohesiveness of the group. Additionally, these rules encourage **homogamy** *or marriage between people who share social characteristics*. The majority of marriages in the U. S. are homogamous with respect to race, social class, age and to a lesser extent, religion. Homogamy is also seen in couples with similar personalities and interests.

Intimate Partner Abuse

Violence in romantic relationships is a significant concern for relationships throughout the lifespan. Statistically women aged 18 to 34 generally experience the highest rates of intimate partner violence. According to the most recent Violence Policy Center (2018) study, more than 1,800 women were murdered by men in 2016. The study found that nationwide, 93% of women killed by men were murdered by someone they knew, and guns were the most common weapon used. The national rate of women murdered by men in single victim/single offender incidents dropped 24%, from 1.57 per 100,000 in 1996 to 1.20 per 100,000 in 2016. However, since reaching a low of 1.08 per 100,000 women in 2014, the 2016 rate increased 11%.

Intimate partner violence is often divided into **situational couple violence**, *which is the violence that results when heated conflict escalates*, and **intimate terrorism**, *in which one partner consistently uses fear and violence to dominate the other* (Bosson, et al., 2019). Men and women equally use and experience situational couple violence, while men are more likely to use intimate terrorism than are women. Additionally, female victims of intimate partner violence experience different patterns of violence, such as rape, severe physical violence, and stalking than male victims, who most often experienced more slapping, shoving, and pushing.

If you need help: Call The National Domestic Violence Hotline 1-800-799-SAFE (7233) or go to The Hotline.org.

Sexuality in Middle Adulthood

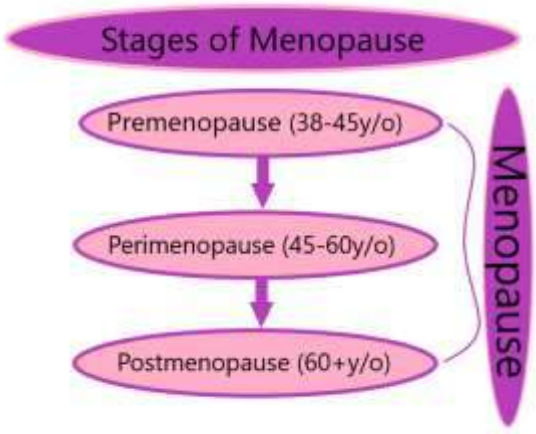
People in mid-adulthood continue to be sexually active. In fact, some find themselves leading some of the most sexually fulfilling years of their lives. Women in their 40s are more likely to reach orgasm than younger and older women because they have had more opportunities to learn about their sexuality and be more secure in their relationships. Relationship security promotes orgasmic consistency among women. The 1992 National Health and Social Life Survey, (NHSLS) data shows that married women are most likely to reach orgasm consistently, followed by cohabiting women, then single women regardless of racial or ethnic differences. The analysis of NHSLS data by Laura Carpenter (2009) found that among 1,053 heterosexual participants of study aged 40 to 59, women were less likely to be sexually satisfied than men were and there is a reversal of gender-role stereotype among people in midlife: women's emotional satisfaction was closely associated with bodily sexual practices, whereas men's physical pleasure was linked to relational factors. Midlife is the time when physical changes and changes in sexual response occur as the years pass; however, sexual activity among people in all age groups is influenced not only by physical changes but also by psychological well-being, feeling of intimacy, and cultural expectation.

Sidebar 11.2: OMG Menopause!

It sounds so daunting and downright sad. The truth is , even with its side effects, it is freedom. Even with the night sweats , and mood swings, I am all in. This is the first time I've had autonomy over my body. I do not get my period. I do not need to buy tampons or pads. I cannot get pregnant. People stop asking you dumb questions like "are you going to have more kids?" My body, myself is all mine now.

Your body is constantly changing. Moving with the change instead of fighting the change has allowed me to let go of crazy, unhealthy ideas of how a woman my age should be. I feel the most attractive and sexy when I'm doing what I love, which is yoga , working with my dogs, and gardening while a bit stoned. So my wardrobe is mainly yoga pants or jeans, tank top and a truckers cap. I have dirt under my nails, my hair is in a ponytail, and my make up consists of tinted sunscreen. I am attractive to myself. I feel sexy to me. This is an epic mind shift. If I feel good, then that is magic. I don't feel the urge to lure someone in with a false sense of being. I don't want to have bad sex with someone just to feel desired. I'd rather have good sex with myself. It's not that I wouldn't like having a partner, I would. But I am certainly not going to sacrifice anything to get there.

Midlife Transitions



Female Sexual and Reproductive Health: **Perimenopause** *refers to a period of transition in which a woman's ovaries stop releasing eggs and the level of estrogen and progesterone production decreases.* **Menopause** *is defined as 12 months without menstruation*. The average age of menopause is approximately 51, however, many women begin experiencing symptoms in their 40s. These symptoms occur during perimenopause, which can occur 2 to 8 years before menopause (Huang, 2007). A woman may first begin to notice that her periods are more or less frequent than before. After a year without menstruation, a woman is considered menopausal and no longer capable of reproduction.

Symptoms: The symptoms that occur during perimenopause and menopause are typically caused by the decreased production of estrogen and progesterone (North American Menopause Society, 2016). The shifting hormones can contribute to the inability to fall asleep. Additionally, the declining levels of estrogen may make a woman more susceptible to environmental factors and stressors which disrupt sleep. A **hot flash** *is a surge of adrenaline* that can awaken the brain from sleep. It often produces sweat and a change of temperature that can be disruptive to sleep and comfort levels. Unfortunately, it may take time for adrenaline to recede and allow sleep to occur again (National Sleep Foundation, 2016).

The loss of estrogen also affects vaginal lubrication which diminishes and becomes waterier and can contribute to pain during intercourse. The vaginal wall also becomes thinner, and less elastic. Estrogen is also important for bone formation

and growth, and decreased estrogen can cause osteoporosis resulting in decreased bone mass. Depression, irritability, and weight gain are often associated with menopause, but they are not menopausal (Avis, Stellato & Crawford, 2001; Rossi, 2004). Women vary greatly in the extent to which these symptoms are experienced. Most American women go through menopause with few problems (Carroll, 2016). Overall, menopause is not seen as universally distressing (Lachman, 2004).

Hormone Replacement Therapy: Concerns about the effects of hormone replacement have changed the frequency with which estrogen replacement and hormone replacement therapies have been prescribed for menopausal women. Estrogen replacement therapy was once commonly used to treat menopausal symptoms. However, more recently, hormone replacement therapy has been associated with breast cancer, stroke, and the development of blood clots (NIH, 2007). Most women do not have symptoms severe enough to warrant estrogen or hormone replacement therapy but for some it is very uncomfortable and unsettling. For those experiencing symptoms that are unmanageable they can be treated with lower doses of estrogen and monitored with more frequent breast and pelvic exams. Some natural ways to reduce symptoms are avoiding caffeine and alcohol, eating soy, remaining sexually active, practicing relaxation techniques, and using lubricants during intercourse.

Menopause and Ethnicity: In a review of studies that mentioned menopause, symptoms varied greatly across countries, geographic regions, and even across ethnic groups within the same region (Palacios, Henderson, & Siseles, 2010). For example, the Study of Women's Health across the Nation (SWAN) examined 14,906 white, African American, Hispanic, Japanese American, and Chinese American women's menopausal experiences (Avis et al., 2001). After controlling for age, educational level, general health status, and economic stressors, white women were more likely to disclose symptoms of depression, irritability, forgetfulness, and headaches compared to women in the other racial/ethnic groups. African American women experienced more night sweats, but this varied across research sites. Finally, Chinese American and Japanese American women reported fewer menopausal symptoms when compared to the women in the other groups. Overall, the Chinese and Japanese group reported the fewest symptoms, while white women reported more mental health symptoms and African American women reported more physical symptoms.

Cultural Differences: Cultural influences seem to also play a role in the way menopause is experienced. While some women focus on menopause as a loss of youth, womanhood, and physical attractiveness, career-oriented women tend to think of menopause as a liberating experience. In India, 94% of women said they welcome menopause. Aging women gain status and prestige and no longer have to go through self-imposed menstrual restrictions, which may contribute to Indian women's experiences (Kaur, Walia, & Singh, 2004). Overall, menopause signifies many different things to women around the world and there is no typical experience. Further, by normalizing rather than pathologizing menopause this life transition can shift the perspective of many who see it as a negative life change.

Sidebar 11.3 No more Periods? I say hooray!!

Many times in my life, the monthly “visit from Aunt Flo” was unwelcomed, whereas certain times it was a giant relief. Overall it was a big part of my identity and when it went away, I had to reimagine. For some menopause means loosing something, for others it means gaining. However you look at it, it is a time of change that can be marked with celebration or reflection. There are various celebrations worldwide to mark the occasion, often likening it as stepping into wisdom and many have written about the journey. Here’s a link to one I like: My Menopausal Ritual

Male Sexual and Reproductive Health

Males continue to produce sperm and can father children throughout middle adulthood. Changes that occur in middle adulthood include erectile dysfunction (ED). Erectile dysfunction refers to the inability to achieve an erection or an inconsistent ability to achieve an erection (Swierzewski, 2015). Intermittent ED affects as many as 50% of men between the ages of 40 and 70. About 30 million men in the United States experience chronic ED, and the percentages increase with age. Approximately 4% of men in their 40s, 17% of men in their 60s, and 47% of men older than 75 experience chronic ED.

Causes for ED are primarily due to medical conditions, including diabetes, kidney disease, alcoholism, and atherosclerosis (build-up of plaque in the arteries). Plaque is made up of fat, cholesterol, calcium and other substances found in the blood. Over time plaque builds up, hardens, and restricts the blood flow in the arteries (NIH, 2014d). This build-up limits the flow of oxygenated blood to organs and the penis. Overall, diseases account for 70% of chronic ED, while psychological factors, such as stress, depression and anxiety account for 10%-20% of all cases. Many of these causes are treatable, and ED is not an inevitable result of aging. For more on ED, see Chapter 13 on Sexual Health.

Men during middle adulthood may also experience prostate enlargement, which can interfere with urination, and deficient testosterone levels which decline throughout adulthood, but especially after age 50. *If testosterone levels decline significantly,* it is referred to as **andropause or late-onset hypogonadism.** Identifying whether testosterone levels are low is difficult because individual blood levels vary greatly. Low testosterone is not a concern unless it accompanied by negative symptoms such as low sex drive, ED, fatigue, loss of muscle, loss of body hair, or breast enlargement. Low testosterone is also associated with medical conditions, such as diabetes, obesity, high blood pressure, and testicular cancer. The effectiveness of supplemental testosterone is mixed, and long term testosterone replacement therapy for men can increase the risk of prostate cancer, blood clots, heart attack and stroke (WebMD, 2016). Most men with low testosterone do not have related problems (Berkeley Wellness, 2011).

The Midlife Transition and Sexuality

Sexuality is an important part of people's lives at any age, and many older adults are very interested in staying sexually active (Dimah & Dimah, 2004). According to the National Survey of Sexual Health and Behavior (NSSHB) , 74% of males and 70% of females aged 40-49 engaged in vaginal intercourse during the previous year, while 58% of males and 51% of females aged 50-59 did so (Center for Sexual Health Promotion, 2010).

Despite these percentages indicating that middle adults are sexually active, age-related physical changes can affect sexual functioning. For women, decreased sexual desire and pain during vaginal intercourse because of the hormonal changes have been identified (Schick et al., 2010). A woman may also notice less vaginal lubrication during arousal which can affect overall pleasure (Carroll, 2016). Men may require more direct stimulation for an erection and the erection may be delayed or less firm (Carroll, 2016). As previously discussed men may experience erectile dysfunction or experience medical conditions (such as diabetes or heart disease) that impact sexual functioning. Couples can continue to enjoy physical intimacy and may engage in more foreplay, oral sex, and other forms of sexual expression rather than focusing as much on sexual intercourse.

It is important to note that risk of pregnancy continues until a woman has been without menstruation for at least 12 months and couples where pregnancy is possible should continue to use contraception. People continue to be at risk of contracting sexually transmitted infections, such as genital herpes, chlamydia, and genital warts. In 2014, 16.7% of the country's new HIV diagnoses (7,391 of 44,071) were among people 50 and older, according to the Centers for Disease Control and Prevention (2014e). This was an increase from 15.4% in 2005. Hopefully, when partners understand how aging affects sexual expression, they will be less likely to misinterpret these changes as a lack of sexual interest or displeasure in the partner and more able to continue to have satisfying and safe sexual relationships. Practicing safe sex is important at any age, yet adults over the age of 40 have the lowest rates of condom use (Center for Sexual Health Promotion, 2010).

Sexuality in Late Adulthood

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According to Kane (2008), older adults are often viewed as genderless and asexual. There is a stereotype that elderly individuals no longer engage in sexual activity and when they do, they are perceived to have committed some kind of offense. These ageist myths can become internalized, and older people have a more difficult time accepting their sexuality (Gosney, 2011). In reality, many older couples find greater satisfaction in their sex life than they did when they were younger. They have fewer distractions, more time and privacy, no worries about getting pregnant, and greater intimacy with a lifelong partner (NIA, 2013). Results from the National Social Life Health, and Aging Project indicated that 72% of men and 45.5% of women aged 52 to 72 reported being sexually active (Karraker, DeLamater, & Schwarz, 2011). Additionally, the National Survey of Sexual Health data indicated that 20%-30% of individuals remain sexually active well into their 80s (Schick et al., 2010). However, there are issues that occur in older adults that can adversely affect their enjoyment of healthy sexual relationships.

Causes of Sexual Problems

According to the National Institute on Aging (2013), chronic illnesses such as arthritis, diabetes and heart disease can lead to sexual challenges such as join pain, erectile dysfunction or anorgasmia. Hormonal changes, physical disabilities, surgeries, and medicines can also affect a senior's ability to participate in and enjoy sex. How one feels about sex can also affect performance. For example, someone

who is unhappy about their appearance as they age may think their partner will no longer find them attractive. A cultural focus on youthful physical beauty especially for women may get in the way of them enjoying physical intimacy. Many people with penises have a problem with erectile dysfunction (ED) once in a while, and some may fear that ED will become a more common problem as they age. If there is a decline in sexual activity for a heterosexual couple, it is typically due to a decline in the male's physical health (Erber & Szuchman, 2015).

Overall, the best way to experience a healthy sex life in later life is to keep sexually active while aging and to not fall victim to negative cultural stereotypes about aging. However, the lack of an available partner can affect heterosexual women's participation in a sexual relationship. Beginning at age 40 there are more women than men in the population, and the ratio becomes 2 to 1 at age 85 (Karraker et al., 2011). Because older men tend to pair with younger women when they become widowed or divorced, this also decreases the pool of available men for older women (Erber & Szuchman, 2015). In fact, a change in marital status does not result in a decline in the sexual behavior of men aged 57 to 85 years-old, but it does result in a decline for similar aged women (Karraker et al., 2011).

Dating in Later Adulthood: Due to changing social norms and shifting cohort demographics, it has become more common for single older adults to be involved in dating and romantic relationships (Alterovitz & Mendelsohn, 2011). An analysis of widows and widowers ages 65 and older found that 18 months after the death of a spouse, 37% of men and 15% of women were interested in dating (Carr, 2004a). Unfortunately, opportunities to develop close relationships often diminish in later life as social networks decrease because of retirement, relocation, and the death of friends and loved ones (de Vries, 1996). Consequently, older adults, much like those younger, are increasing their social networks using technologies, including e-mail, chat rooms, and online dating sites (Fox, 2004; Wright & Query, 2004; Papernow, 2018).

Interestingly, older men and women parallel online dating information as those younger. Alterovitz and Mendelsohn (2011) analyzed 600 internet personal ads from different age groups, and across the life span, men sought physical attractiveness and offered status related information more than women. With advanced age, men desired women increasingly younger than themselves, whereas women desired older men until ages 75 and over, when they sought men younger than themselves. Research has previously shown that older women in romantic

relationships are not interested in becoming a caregiver or becoming widowed for a second time (Carr, 2004a). Additionally, older men are more eager to re-partner than are older women (Davidson, 2001; Erber & Szuchman, 2015). Concerns expressed by older women included not wanting to lose their autonomy, care for a potentially ill partner, or merge their finances with someone (Watson & Stelle, 2011).

Sidebar 11.4: My sexuality

These are responses to questions asked to an 84 year old widow regarding her sexuality:

1. What do you think people should know about the sexuality of senior adults?

It's still there! You never stop wanting the closeness of another person. The hormones are not surging as they did in your youth but they are still there. It's a myth and/or old wives tales that sexuality goes away after menopause, that you dry up and that's it. Not true! There is snow on the roof but there is a fire in the furnace!

2. Can a woman in older years have an orgasm? How important is your sexuality to you right now?

Older women can definitely have an orgasm, even multiple! My sexuality is very important to me. It makes me feel alive and youthful even though I am in my "twilight" years. It's a YES, I can still do it!

3. What was your stage in life when you felt most fulfilled sexually and why? What was special about that stage?

When I was in my twenties I felt most sexually fulfilled. I was 24 when I met my husband and there was immediately a sexual attraction on both sides. It was amazing, exciting and fulfilling. The passion lasted throughout most of our marriage, it just became more tender and loving.

4. If you are able to relive the stages of your sexuality through the lifespan and development, what would you like to change?

This is a tough one! I don't think I would change anything except possibly not having a relationship, lover etc. after my husband died as I was a young 60. With that being said, the thought of another man touching me was something I could not handle or wanted. I had more than one "relationship" when I was single before I married, but a sexual relationship after Marty scared the hell out of me! I just didn't want it. Not quite sure why.

Conclusion

Sexual development happens alongside overall maturing from in utero to death through different stages and phases throughout our life. In this chapter we examined sexual development from infancy through late adulthood looking at various factors including how culture and the socialization process contribute to attitudes and practices. We examined how sexuality develops and changes through the lifespan and saw how dynamic human sexuality can really be across various stages of the life cycle.

Glossary

1. **Andropause or late-onset hypogonadism**: Significant decline of testosterone levels
2. **Friends with Benefits**: Hookups different from the relationships that involve continued mutual exchange
3. **Hookups**: Uncommitted sexual encounters
4. **Hot Flash**: A surge of adrenaline associated with menopause
5. **Intimate partner violence** is often divided into **situational couple violence**, *which is the violence that results when heated conflict escalates*, and **intimate terrorism**, *in which one partner consistently uses fear and violence to dominate the other*
6. **Menarche**: The first menstrual period
7. **Menopause**: The end of the menstrual cycle typically diagnosed after 12 months without menstruation
8. **Primary sexual characteristics**: Reproductive organs present at birth compromising the external and internal genitalia
9. **Relationship inauthenticity**: refers to an incongruence between thoughts/feelings and actions within a relationship
10. **Secondary sexual characteristics**: Physical characteristic developing at puberty which distinguishes between the sexes but is not directly involved in reproduction
11. **Sexual debut:** First sexual intercourse
12. **Spermarche**: First ejaculation of semen

Discussion Questions

1. What are two purposes that dating serves for teenagers?
2. Discuss some of the cultural differences associated with the way menopause is viewed throughout the world.
3. What are your thoughts on hookups?
4. What are some of the issues associated with typical sexual education in the United States?
5. Did you have any stereotypes about older people and sexuality before you read this? What do you understand about sexuality into later adulthood?

Multiple Choice

1. As early as _____ weeks, erectile response in male fetuses has been viewed with ultrasound (Haffner, 1999; Martinson, 1994; Parrot, 1994)

    a. 16 Weeks
    b. 30 Weeks
    c. 10 Weeks
    d. 20 Weeks

2. Children participating in sexual behavior such as touching another child's private parts is general seen as abnormal.

    a. True
    b. False

3. _____refers to sexual contact between a child and family members.

    a. Sexual abuse
    b. Incest
    c. Sexual violence
    d. All of the above

4. Menarche is the first menstrual period

    a. True
    b. False

5. When is the developmental period during which romantic relationships typically first emerge?

    a. Adolescence
    b. Early-Adulthood
    c. Mid-Adulthood
    d. Late Adulthood

6. Nearly _____ Americans have tried an online dating website or mobile app.

    a. 10 million
    b. 50 million
    c. 70 million
    d. 100 million

7. What is a Sexual debut?

    a. First sexual intercourse
    b. Junior Prom
    c. Pizza
    d. All of the above

8. What is a Hot Flash?

    a. A surge of adrenaline associated with menopause
    b. Something you get at Bikram Yoga
    c. A counterculture superhero
    d. An unusual weather pattern

9. On June 26, 2015, the United States Supreme Court ruled that the Constitution guarantees marriage equality.

a. True
b. False

10. Andropause is

a. late-onset hypogonadism
b. Significant decline of testosterone levels
c. A pause in a relationship
d. Both a and b

For Further Exploration

Still Going Strong: Sexuality in Older Adults | Tuuli Kukkonen | TEDxGuelphU

Elevating Youth Voice to Inform Issues in Adolescent Sexual and Reproductive Health

Demystifying Sexual Health - JJ a middle age female swinger

Is it OK for Grandma to Have Sex? | Jane Fleishman, Ph.D. | TEDxEasthamptonWomen

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Chapter 12: Contraception, Abortion, and Sexually Transmitted Infections

Image of one of the world's oldest condoms made of pig intestine

Learning Objectives

After completing this module, students should have a working knowledge of the following:

- The various methods of birth control
- Reproductive rights and Abortion
- Sexually Transmitted Disease and Prevention

Introduction

From the dawn of time, people have sought sexual gratification without the desire to procreate. One of the first forms of birth control on record is a condom made of pig intestine which dates back to 1640. In this chapter we will explore the various methods of birth control also known as Contraception. We will understand abortion and the legal battle that continues to challenge the right to choose almost 50 years

since Roe v. Wade. We will look at some common Sexually Transmitted Infections (STIs aka STDs) and how to prevent and treat them. We will also explore how stigma plays a role in how we treat issues surrounding contraception, abortion and STIs.

Contraception

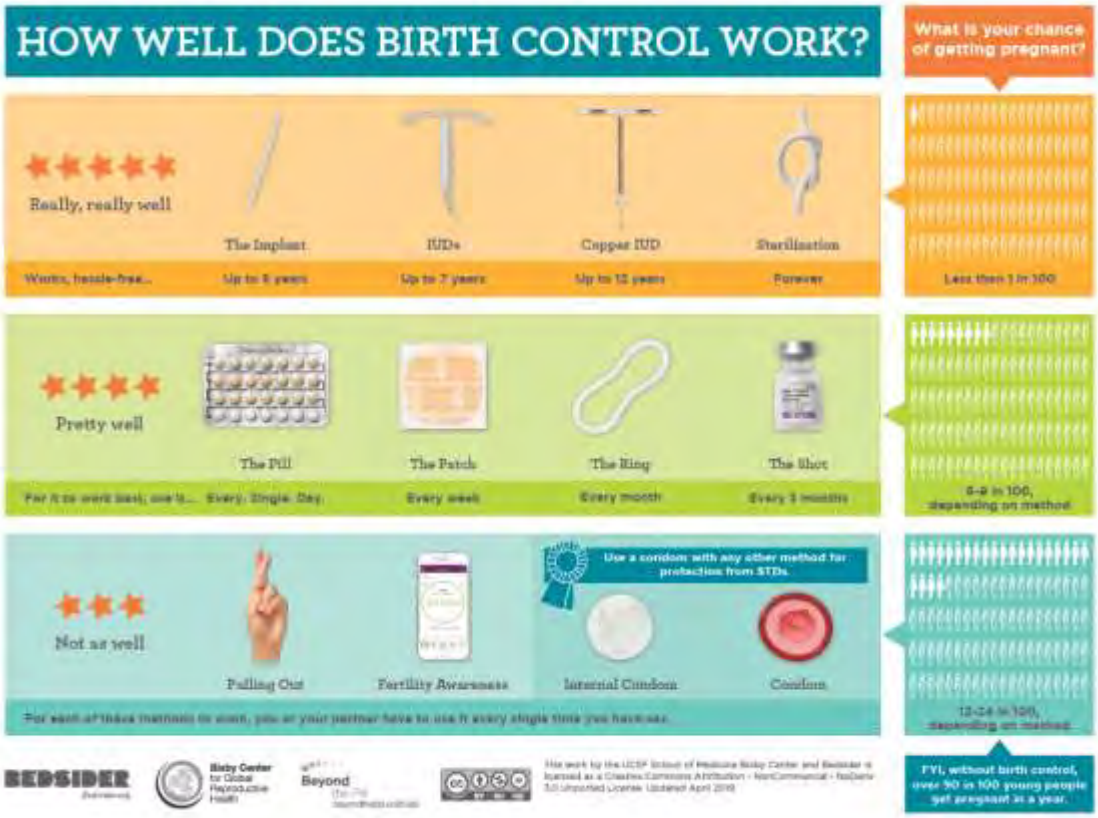
As we continue through our understanding of human sexuality, at this point it has become clear that sexual activity reaches far beyond the need to procreate. Humans throughout history have enjoyed the pleasure of sex without the purpose of procreation. *Contraception* is a technique that prevents a sperm cell and an ovum from uniting. Controlling fertility is something that is done to avoid pregnancy, and there are various options of birth control currently available. There are many birth control options: permanent, intrauterine devices (IUDs), hormonal, barrier, spermicidal and behavioral. It is important to note that when no birth control is used, 85 out of 100 sexually active women of childbearing age become pregnant in a year (Britton, et al, 2019). From very low maintenance options to ones that must be used every time a person has sex, the choices range and it is best to find the type of birth control that works for you and your lifestyle. Proper use of the choice of birth control is critical in preventing unwanted pregnancy. These methods vary in the ways in which they prevent pregnancy as well. Some, like condoms and cervical caps, can physically block sperm from reaching the eggs, while hormonal methods like the pill or birth control injections work with a woman's hormones to prevent ovulation. Other methods like fertility awareness, sometimes known as the rhythm method, require the person to know where their body is in its fertility cycle. There are also more permanent methods like vasectomy and tubal ligation which are surgical options. There are a variety of options to choose from and new options become available periodically, so be sure to double check with a healthcare provider to see what may be available. All people regardless of their ability to become pregnant are also at risk for Sexually Transmitted Infections (STIs aka STDs). Condoms are the only birth control method that also prevents infection transmission.

Planned Parenthood is one of the leading organizations in the United States that offers free or low cost birth control options. They offer support for various types of reproductive services. They have created an easily accessible site entitled: Birth Control Options and which is best for you which goes into greater detail about each

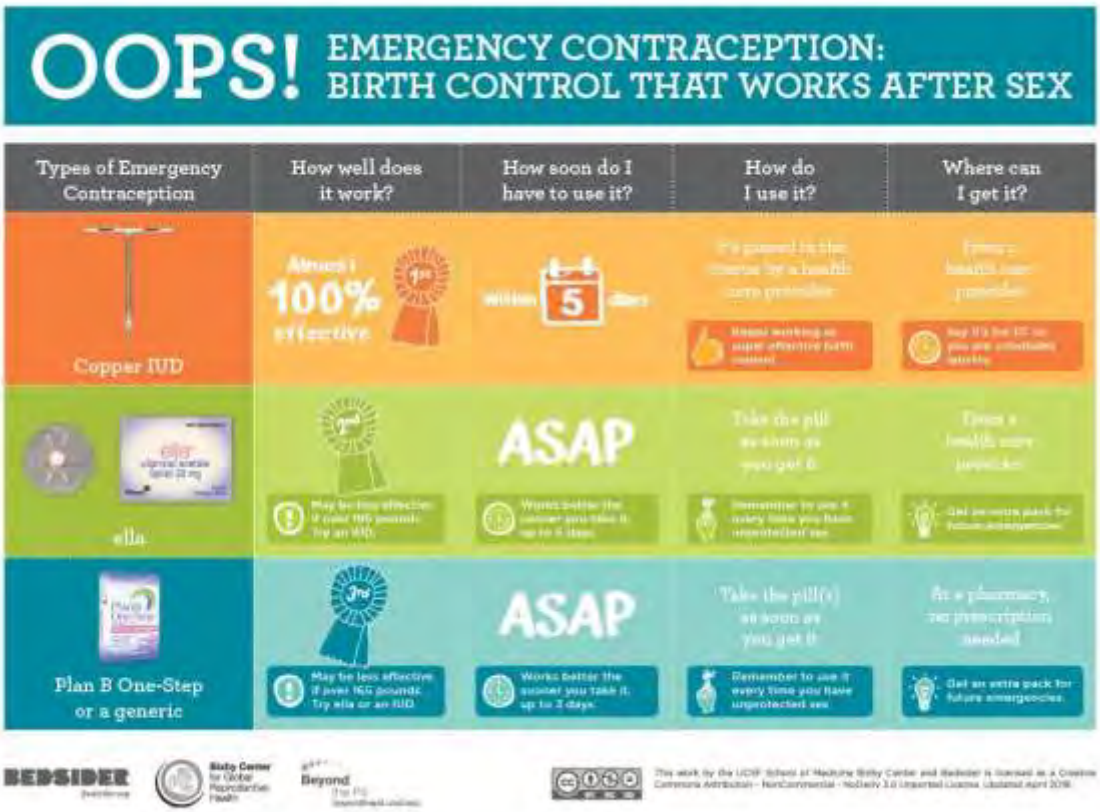
method. The infographic below highlights some of the more popular forms of birth control currently available and how well they work to prevent unwanted pregnancy.

Sidebar 12.1: Vasectomy

This short video describes a vasectomy. As described in this video, a vasectomy is a procedure in which a small section of the ductus (vas) deferens is removed from the scrotum. This interrupts the path taken by sperm through the ductus deferens. If sperm do not exit through the vas, either because the person has had a vasectomy or has not ejaculated, do you know what region of the testis they remain in?



Used consistently and effectively based on the individual methods and instructions, pregnancy can be prevented. Coupling hormonal methods (pill, patch, etc.) with barrier methods (condoms) increases the effectiveness rate AND prevents the spread of STIs, so doubling up is always a good option. When preventative birth control fails, there are also emergency contraceptive options sometimes referred to as *plan b* that are available.



A Brief History of *The Pill*

It is important to note that while humans sought to enjoy sex without a desire to procreate, for most of history there was not an option that gave women autonomy over their reproductive health in the way that the pill did. "The birth control pill separated sexual practice from conception, forcing re-assessment and reevaluation of social, political, and religious viewpoints" (Liao & Dollin, 2012, para 1). In essence, the pill changed the power dynamic which was part of women's liberation. After animal experiments in the 1930s demonstrated that high levels of progesterone could stop ovulation, Mexican Chemist Dr. Carl Djerassi synthesized progestin from Mexican Yam root. Dr. Djerassi did this work in the late 1940s, at a time when women's rights and reproductive freedom were not a cultural norm for most women in the U.S. and in most places worldwide. Despite this, the first birth control pill was approved by the United States Food and Drug Administration (FDA) in 1960 and control over reproductive rights became possible for women. Depending on the nation and its date of approval of the drug, worldwide dates of pill availability vary. More on the history of the pill here.

Sidebar 12.2: Someone you may not know but probably should: Percy Julian

A name to know in the development of hormonal birth control is Dr. Percy Julian. Dr Julian was the grandchild of slaves who went on to work on the chemical synthesis of medicinal drugs from plants. This work led to the synthetic chemicals used in hormonal birth control pills. His work to advance the birth control pill was just one area of contribution to the field yet his path was fraught with roadblocks because he was Black.

A Bit more on Hormonal Birth Control

Birth control pills take advantage of the negative feedback system that regulates the ovarian and menstrual cycles to stop ovulation and prevent pregnancy. Typically they work by providing a constant level of both estrogen and progesterone, which negatively feeds back onto the hypothalamus and pituitary, thus preventing the release of FSH and LH. Without FSH, the follicles do not mature, and without the LH surge, ovulation does not occur. Although the estrogen in birth control pills does stimulate some thickening of the endometrial wall, it is reduced compared with a normal cycle and is less likely to support implantation.

Some birth control pills contain 21 active pills containing hormones, and 7 inactive pills (placebos). The decline in hormones during the week that the woman takes the placebo pills triggers menses, although it is typically lighter than a normal menstrual flow because of the reduced endometrial thickening. Newer types of birth control pills have been developed that deliver low-dose estrogens and progesterone for the entire cycle (these are meant to be taken 365 days a year), and menses never occurs. While some women prefer to have the proof of a lack of pregnancy that a monthly period provides, menstruation every 28 days is not required for health reasons, and there are no reported adverse effects of not having a menstrual period in an otherwise healthy individual.

Because birth control pills function by providing constant estrogen and progesterone levels and disrupting negative feedback, skipping even just one or two pills at certain points of the cycle (or even being several hours late taking the pill) can lead to an increase in FSH and LH and result in ovulation. It is important, therefore, that the woman follow the directions on the birth control pill package to successfully prevent pregnancy.

Abortion

Moving towards choice in NI. actionsforchoice, *CC BY-NC-SA*

The previous section highlighted contraceptive options in order to prevent pregnancy. Once pregnant the option to end a pregnancy is available via abortion. An **Abortion** is the termination of a pregnancy by the removal or expulsion of the fetus. Millions of people decide to have abortions annually in the U.S., for varying reasons. Many health providers do abortions as a part of standard health care. Planned Parenthood, the organization that Margaret Sanger helped to found, has provided a variety of reproductive health services for women since Sanger's first clinic in 1916. Abortion services are part of what they provide.

There are two types of Abortion, The Abortion Pill and In-Clinic Abortion. The abortion pill works up to 11 weeks of pregnancy and can usually be taken at home. The combination of medications causes the uterus to cramp and bleed and expel it's content (Abortion, 2022). Depending on how far along the pregnancy is, it is anywhere between 87-98% effective. In-clinic abortions are safe, simple medical procedures provided by doctors and nurses at a health center. There are two methods used based on individual patient and clinic decisions. The first type uses gentle suction to empty the uterus. The second type can be used farther along during the pregnancy. Dilation and Evacuation (D & E) employs both suction and medical tools to evacuate the uterus. Both surgical methods are over 99% effective (Abortion, 2022).

As with most of the topics that surround human sexuality, there are often debates regarding value judgment and ethical considerations and few are more controversial than abortion. Legal access to abortion became the law of the land in the United States as a result of a couple of cases in the early 1970s, most famously

Roe V. Wade, when Jane Roe challenged a Texas law that prohibited abortion except in vary narrow circumstances. A long history of anti-choice or *pro-life* attempts to block a woman's right to choose has kept *Roe V. Wade* a tenuous legal decision. In May of 2022 the United States Supreme Court, led by male Justice Samuel Alito, leaked a draft opinion to vote on whether to strike it down after nearly half a century. On July 1, 2022 *Roe V. Wade* was officially struck down. Abortion is no longer a federally protected right for women. In effect, leaving the decision to individual states which drastically changes the landscape and makes access to safe and legal abortion a lot more difficult if not impossible nationally. Texas most famously continues to be a battleground for this issue, passing legislation that would limit a women's right to choose but less than half way through 2022 alone there have been over 500 bills in 39 states attempting to restrict legal access to abortion (Fallert, 2022).

Many health care providers, private doctors, clinics, and Planned Parenthood provide abortions. Although it is not the majority of Planned Parenthood's work, they are often targeted by those seeking to end the right to choice in the United States. Clinics and providers have been bombed, threatened and ostracized in their communities, and those seeking abortions have been harassed by anti-choice protesters. The right to choose is never secure, and as a result, Planned Parenthood is one of the strongest advocates for preserving this right. Planned Parenthood's policy and advocacy work does so with the goal of a world where all can make decisions about their own bodies, families and futures with dignity (Abortion, 2022).

Oklahoma and Texas are just some of the states currently overturning the right to abortion in their state. In 2022, 50 years after Roe became the law of the land, abortion rights are no longer guaranteed nationally and those seeking abortions in states where they are banned will have to travel across state lines to seek this medical treatment. Laws change based on lawmakers and voters thoughts around legal and safe abortion. The Guttmacher Institute, a research and policy organization committed to advancing sexual and reproductive health and rights (SRHR) worldwide has created an interactive abortion law by state infographic that breaks it all down. In the 50 years since the right to choose has been federally protected by law, there have been over 1300 legal attempts to overturn it and now that right has been revoked. As of this writing, the right to choose will be up to individual states to decide because it is no longer federally mandated.

Sidebar 12.3: Abortion story

"It was easy to spot that combination of defenselessness, eagerness to please and most of all a willingness to blame herself for the meanness of others"

-Toni Morrison. *A mercy*

I remember the first abortion I had. I was in college, it was a one night tryst and I had no intention of becoming pregnant. I blamed myself, and was unwilling to seek support from the person that contributed to the pregnancy. I was ashamed as I went into the clinic to get it done. The doctor was a parent at the preschool I taught at and as alone as I felt, I imagined she would comfort me in the same way as I comforted her child. The procedure did not go well. The doctor had punctured a hole in my uterus and the suctioning could not take place. She was annoyed with this and told me we had to redo the procedure in the hospital. It felt as if somehow this was my fault, my body was wrongly organized or something and she was profoundly unkind. The procedure was later done effectively in the hospital but the handling of the experience lingers in my own self-blame.

The others are a blur. Mostly hidden under a cloak of shame, sometimes telling the person who impregnated me, sometimes not. My last abortion occurred after I was already a mother, which created a different sense of pain. Working through the mixture of loss and gratitude for choice is complicated. For me, I know that if I were more empowered to act on my own behalf from early on and had better control of my fertility, I would have not needed to go through this. Keeping sexuality closeted in shame and the double standards surrounding it makes advocating for our bodies that much harder. We live in a culture that makes the shame of deciding to get an abortion something that must be kept secret. I share my complicated story because I am not alone, and telling the story is both cathartic for me and hopefully, will resonate with others who have a story. I am thankful that it was my right to have an abortion, however painful and complicated it was. Despite being almost 50 years since the landmark Roe V. Wade decision to allow the right to choose, the fight remains to preserve it.

There are many who share their stories in similar hopes. The American Civil Liberties Union (ACLU) highlights stories of others Abortion is Essential: Stories of Liberation.

We Testify is another organization dedicated to the leadership and representation of people who have abortions. *We Testify* unapologetically believes that people who have abortions deserves unconditional love and support. Read more at wetestify.org.

What if?

- Children had compulsory sex education that was age appropriate throughout their school years.
- Children and teens were taught about effective forms of birth control and STI prevention without fear or shame.
- Access to reproductive services from education to contraception and safe abortion was free and available to all.

Would these action steps lower the incidents of unwanted pregnancies and unsafe DIY abortions? Something to consider.

Sexually Transmitted Infections (STIs aka STDs)

Sexually transmitted infections (STIs) are passed via sexual activity from person to person. They can be passed with vaginal, anal or oral sex and in the case of oral herpes, via kissing. These infections can be caused by bacteria, viruses or parasites. Some are passed with bodily fluids and others by skin-to-skin contact. STIs are also referred to as sexually transmitted diseases or STDs.

According to the most recent compiled CDC data from 2018, almost half of all new STI's are in young people ages 15-24, so it is important to keep in mind that this age group is at higher risk (CDC, 2018).

Often, there are no symptoms, so the only way to know for sure if an STI is present is to do a test. Routine testing can be a good idea for all people who are sexually active. How often to test and what to test for depends on several factors. It is recommended to speak with a medical professional if you have questions about testing.

General testing guidelines:

- At a minimum, everyone should do at least one lifetime HIV test
- Everyone who is sexually active test at least once a year for HIV
- For MSM (men having sex with men or guys having sex with guys) testing is recommended every 3-6 months
- For people with multiple partners every 3-6 months
- People who are on PrEP (pre exposure prophylaxis) for HIV prevention testing every three months
- About three weeks post incident of concern, such as unprotected sex
- If having symptoms (such as burning with urination or genital discharge) test AND see a medical provider.

- If a partner or previous partner shares they have an STI. In this case, also seek treatment from a medical provider.

A Long History of Stigma

There has been stigma around STIs since there have been STIs. One good example is the case of syphilis.

Excerpt from Brief History of Syphilis:

From the very beginning, syphilis has been a stigmatized, disgraceful disease; each country whose population was affected by the infection blamed the neighboring (and sometimes enemy) countries for the outbreak. So, the inhabitants of today's Italy, Germany and United Kingdom named syphilis 'the French disease,' the French named it 'the Neapolitan disease,' the Russians assigned the name of 'Polish disease,' the Polish called it 'the German disease,' The Danish, the Portuguese and the inhabitants of Northern Africa named it 'the Spanish/Castilian disease' and the Turks coined the term 'Christian disease.' Moreover, in Northern India, the Muslims blamed the Hindu for the outbreak of the affliction. However, the Hindu blamed the Muslims and in the end, everyone blamed the Europeans (Tampa et al, 2014).

In the 16th and 17th centuries, syphilis was thought to be punishment for sin, and some felt people with the disease didn't deserve treatment.

Although there has been much medical advancement in the treatment of STIs, the stigma has not completely gone away. Many people report feeling dirty or ashamed

if they have an STI, primarily because this is what culture tells us. Rather than seeing it the way we see other contagious infections, such as colds, there is the added layer of shame because we still see sex as shameful in some contexts in our culture.

With HIV and AIDS, there was added stigma due to homophobia that already existed, because it was largely affecting the gay male community. HIV gave people a new reason to express hatred and fear of gay men, as they were now seen as vectors of disease.

One way to combat stigma around STIs is to normalize that when we touch bodies, when we are sexual, we may pass bacteria and viruses around. It's part of being sexual beings. Anyone can get an STI. It doesn't say anything about their moral character or who they are as a person.

Bacterial Infections

The most common **bacterial STIs** are chlamydia, gonorrhea and syphilis. Less common ones are chancroid and mycoplasma genitalium. Bacterial infections are curable with antibiotics.

Chlamydia:

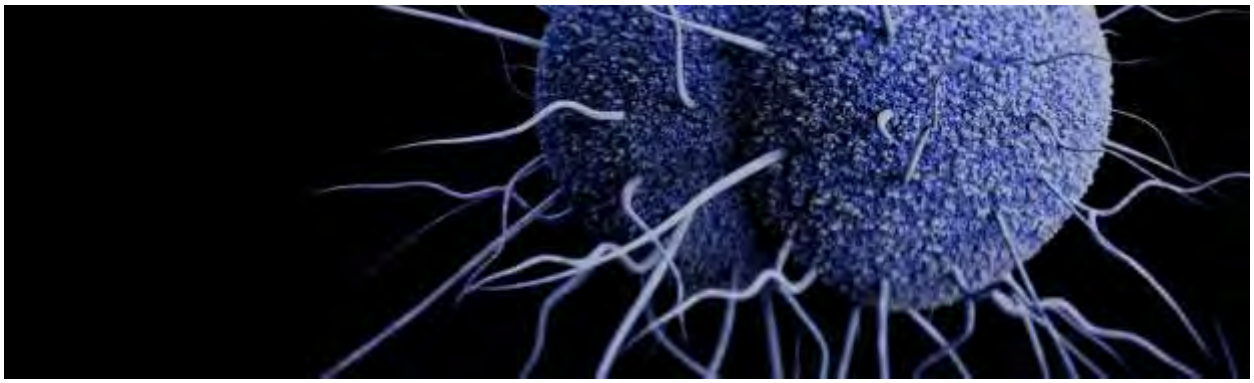
Chlamydia is caused by chlamydia trachomatis and is the most common bacterial STI in the United States, with highest rates among females under age 24. If left untreated for an extended period, it may result in urethritis, epididymitis, cervicitis, or acute salpingitis (inflammation of the fallopian tubes).

Symptoms for people with vulvas may include vaginal discharge, post-coital and intermenstrual bleeding, dysuria (painful or difficult urination), lower abdominal pain, and deep dyspareunia (vaginal pain before, during or after intercourse).

Symptoms for people with penises may include urethral discharge, dysuria, urethritis, and possible epididymitis.

Testing specimens may be obtained via a urine sample from patients of all genders. It is also possible to do endocervical or vulvovaginal swabs on vulvas and urethral swabs on penises. Rectal swabs are recommended for those who receive anal sex, and oropharyngeal (throat) swabs for those who have given oral sex. Self-swabbing may be available for throat, rectal and possibly for vaginal swabs.

Gonorrhea:



Gonorrhea is due to infection by the bacterium Neisseria gonorrhoeae. The most common symptoms are vaginal or penile discharge and dysuria. Other symptoms may include abdominal pain during intercourse, bleeding between menstrual periods, and post coitus or pain or swelling of testes.

It can affect the cervix, uterus, and fallopian tubes, and the urethra, mouth, throat, eyes, and anus and lead to inflammation including urethritis, cervicitis, proctitis, salpingitis, or pharyngitis.

Untreated infection is a cause of PID (pelvic inflammatory disease) and can result in tubal scarring that may lead to infertility or ectopic pregnancy. Mothers who acquire gonorrhea during pregnancy can pass the infection to the fetus, possibly causing blindness or life-threatening infections. The testing options are the same as chlamydia.

Syphilis:

Syphilis is caused by infection with Treponema pallidum, a spirochete bacterium. It has several potential stages- primary, secondary, latent and tertiary (late) and neurosyphilis. Transmission occurs through direct contact with an infectious chancre (lesion) via vaginal, anal or oral sex.

Congenital syphilis is passed during pregnancy or labor, and can result in abnormalities in the fetus. Syphilis infection in pregnant women increases the risk of miscarriage and stillbirth.

Treponema pallidum infection is diagnosed with an antibody blood test. If that test shows reactive (which means positive), then further testing is done. Rapid plasma reagin (RPR) testing is done to confirm positive treponemal testing.

Chancroid

Chancroid is not a common STI in the United States. In order to make a diagnosis of chancroid, four criteria must be met. 1) one or more painful genital ulcers; 2) swollen lymph nodes; 3) syphilis has been ruled out as a cause of the ulcers; 4) herpes has also been ruled out as a cause of the ulcers. Symptoms usually improve within 3-7 days post treatment.

Mycoplasma genitalium

M. genitalium causes symptomatic and asymptomatic urethritis (inflammation of the urethra) among men and is the cause of approximately 15%–20% of NGU (non gonococcal urethritis or urethritis that is not cause by gonorrhea), 20%–25% of nonchlamydial NGU, and 40% of persistent or recurrent urethritis.

M. genitalium is associated with cervicitis, PID (pelvic inflammatory disease), preterm delivery, spontaneous abortion, and infertility. *M. genitalium* infections among women are frequently asymptomatic, yet the consequences associated with asymptomatic infection are unknown.

Testing is not recommended if there are no symptoms. Only if there is recurrent urethritis, cervicitis or PID, then testing is recommended. There has been resistance to some antibiotics for treatment.

Parasitic infections

Parasitic STIs include trichomoniasis, pubic lice, and scabies. They are all curable with antibiotics and other medications.

Trichomoniasis (or “trich”) is very common but not routinely tested for. It is caused by infection with a protozoan parasite called Trichomonas vaginalis. Most people do not have any symptoms. If there are symptoms, they range from mild to severe, can come and go, and may include itching or irritation inside the penis, itching, redness or soreness of genitals, burning after urination or ejaculation, penile discharge, and increased vaginal discharge that can be clear, white, yellowish or greenish with a fishy odor. A test can be done with a sample of vaginal fluid or urine.

Pubic Lice are also called crabs or crab lice as they have a crab-like appearance. They are different from head and body lice. They are passed during sexual activity and diagnosed by finding a louse or eggs in the pubic area. Over the counter treatment lotion is available.

Scabies is a contagious skin condition caused by the human itch mite (*Sarcoptes scabiei* var. *hominis)*. It is spread via direct and prolonged skin-to-skin contact and therefore can be spread during sexual activity, but can also be spread through casual contact or transmitted via clothing or bedding. Symptoms include intense itching and a pimple-like skin rash. Treatment is a prescription medicine known as scabicide, as it kills scabies mites.

Viral infections

Viral STIs include HSV (herpes simplex virus), HPV (human papilloma virus) and HIV (human immunodeficiency virus), which can lead to AIDS (acquired immune deficiency syndrome). They are not curable, but they are treatable.

Herpes

Herpes is caused by HSV (herpes simplex virus) 1 or 2. Traditionally we have associated HSV 1 with oral herpes (cold sores on the lips) and HSV 2 with genital herpes. Either strain can be passed with oral sex, so it is possible to find HSV 1 in the genitals and vice versa. Herpes is spread with skin-to-skin contact. It is far more

likely to be passed with an active outbreak, but it is not impossible to pass otherwise. There can be viral shedding, when the virus is shedding at the surface of the skin, but the person is not aware. It can be passed with kissing, vaginal, anal or oral sex. It is manageable, but not curable. There is a lot of stigma around having herpes, but it is helpful to know that it is possible to have a happy, healthy sex life with herpes or with a partner who has herpes. In some ways, the stigma is actually worse than the infection itself. The best way to test for herpes is when there is an active outbreak. A medical professional can take a sample of a potential herpes sore to test for the virus itself. There is an antibody blood test available, but it is often not recommended as it is not considered reliable or helpful in most cases. For more on this, STIs aren't a consequence. They're inevitable. | Ella Dawson | TEDxConnecticutCollege

Human Papilloma Virus (HPV)

Gregory Barnell, Nurse Practitioner is credited for the following section.

Human papillomavirus (HPV) is a family of more than 140 viral strains, roughly 40 of which infect the mucosal skin of our bodies — mouth/throat, genitals and anus — and are sexually transmitted by skin-to-skin contact. Other HPV strains infect other types of skin, for example hands, feet or elbows. HPV is never a systemic infection; it can only live in the squamous cells of human skin.

Sexual transmission of HPV is very common. Almost all unvaccinated people who have sex with other people will acquire HPV. Most HPV infections clear on their own, without any obvious disease (change to the skin). There is no treatment for HPV itself, which means that screening for HPV is not clinically useful or recommended as a public health measure, except as part of cervical cancer screening programs. About 20% of people with HPV express disease. In these people, low-risk HPV strains cause warts (in mouth, anus or genitals) and high-risk strains cause pre-cancerous lesions in the same areas. Both warts and precancerous lesions can also clear (go away) on their own, without treatment; however, since anogenital warts are a risk factor for HIV infection, it is generally recommended to treat warts.

Long-term infection with high-risk HPV, particularly HPV-16 and -18, poses a higher risk for cancer. Cervical cancer can develop more quickly and is much more frequent than other sites where HPV infection occurs. Cervical cancer screening

(Pap screening and high-risk HPV testing) is very successful at preventing most cervical cancer. All people with a cervix should be periodically screened for cervical cancer, starting at age 25 and ending at age 65. Cancers of the anus, penis, vulva, vagina and mouth/throat are very rare in the general population. When they do occur, this is much more likely later in life. No specific recommendation exists to screen for these other HPV-associated cancers, although many experts recommend anal cancer screening for people with HIV (PWH), especially for older PWH who are men who have sex with men (MSM). Mouth and throat cancer is screened for during dental visits.

Available vaccines are very effective at preventing HPV infections and diseases caused by HPV. Most pediatricians recommend HPV vaccination at age 11-13, although the vaccine is FDA (Federal Drug Administration) approved up to age 45. The CDC recommends “catch up” vaccination up to age 26, for all people who were not vaccinated as a pre-teen.

-Gregory Barnell, NP

Human Immunodeficiency Virus (HIV)

Human Immunodeficiency Virus (HIV) is the virus that may cause AIDS. AIDS is acquired immunodeficiency syndrome. Not everyone with HIV gets AIDS. HIV attacks the immune system, and if it is not treated, can lead to illness and death. There is no cure for HIV, but there is treatment. Today people who are HIV positive (have the HIV virus) can live long healthy lives if they are receiving good medical care. This often means taking HIV medicines and having one’s viral load (the amount of HIV in the blood) tested routinely.

The only way to know for sure if someone has HIV is to get tested. Testing can be done with a blood sample in a laboratory or at some testing sites, rapid preliminary testing can be done with a mouth swab or a finger prick. This testing is considered preliminary because it is not as accurate as giving a blood sample. If a rapid oral or finger prick test is positive, a follow up blood test is recommended to confirm a diagnosis of HIV.

Getting to Zero:

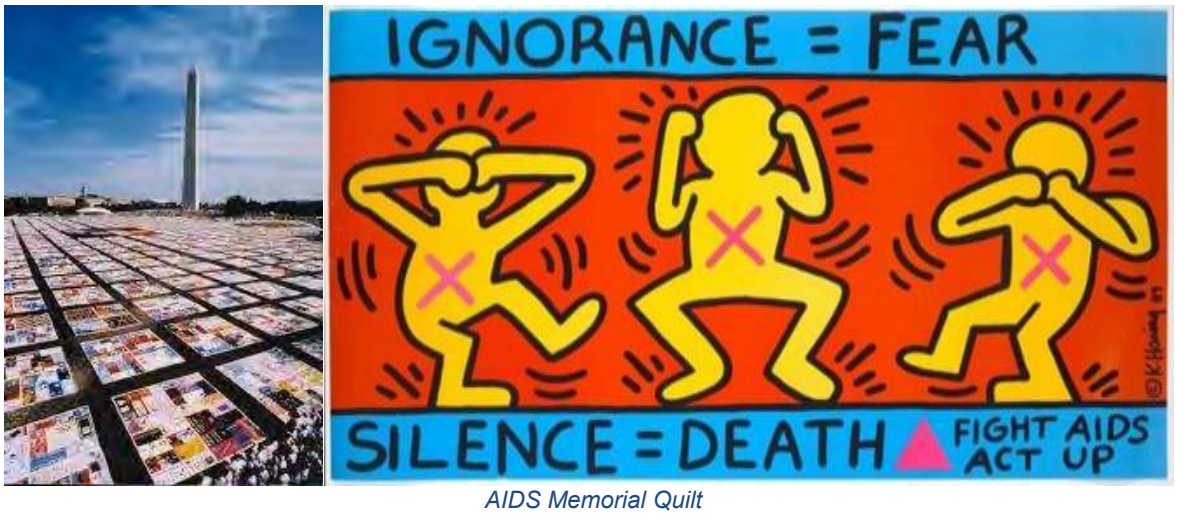
Getting to zero is a campaign that was started by UNAIDS in 2010 and has been adopted around the world as a vision for ending the HIV/AIDS epidemic. It refers to zero new HIV infections, zero deaths from AIDS and zero stigma around HIV/AIDS. We now have several tools to help with this vision.

There is a medication that can be taken daily to prevent HIV known as **PrEP** which stands for **pre-exposure prophylaxis**. People can also take it as needed which is referred to as on-demand PrEP or PrEP 2:1:1. That works for people whose sexual activity is not that frequent and always planned ahead because in order for the medicine to work the first two pills must be taken 2-24 hours prior to sexual activity. For people who don't fit this profile, taking daily PrEP makes more sense. People who are on PrEP are usually required to do lab tests every 3 months including HIV and full STI testing.

PEP stands for **post-exposure prophylaxis** and refers to medicine taken after a possible HIV exposure. This medicine must be taken within 72 hours after the potential exposure in order for it to work.

U=U means **undetectable equals untransmittable** and refers to people who are HIV positive who cannot transmit the virus. If someone is positive but their viral load (the amount of HIV in their system) is well controlled and low, also known as undetectable, they cannot give someone else HIV. These are all powerful tools in the fight to end the HIV/AIDS epidemic.

A History of AIDS Activism in the United States



AIDS Memorial Quilt

ACT UP (AIDS Coalition to Unleash Power) was a non-violent activist group started in New York City in 1987. It was a response to the U.S. government's severe mishandling of the HIV/AIDS crisis. ACT UP used direct action to pressure government agencies and pharmaceutical companies to pay attention to the AIDS crisis. It was mostly affecting MSM and IV drug users, and was being largely ignored.

In 1988, ACT UP staged a sit-in of over 1000 activists and successfully shut down the FDA (Food and Drug Administration) headquarters for a day, protesting the slow process of drug approval for HIV medications. It was one of their most successful protests as it resulted in the FDA agreeing to speed up the process.

The Names Project AIDS Memorial Quilt is another example of early AIDS activism. Cleve Jones, an activist in San Francisco, had people make signs with the names of loved ones they had lost to AIDS complications and the signs were hung on the old San Francisco Federal Building, as part of a candlelight march in 1985. Jones reports that when he saw the signs posted there, they looked like a patchwork quilt to him and he was inspired with the idea of creating an actual quilt to memorialize the lives lost to the AIDS crisis. The quilt became both a place for lovers, families and friends to honor their loved ones, but also a powerful political statement as it continued to grow in size and panels from all over the country were added.

"Today, the AIDS Memorial Quilt is an epic 54-ton tapestry that includes nearly 50,000 panels dedicated to more than 105,000 individuals. It is the premiere symbol of the AIDS pandemic, a living memorial to a generation lost to AIDS and an important HIV prevention education tool. With hundreds of thousands of people

contributing their talents to making the memorial panels, and tens of thousands of volunteers to help display it, the Quilt is considered the largest community arts project in history" (The History of the Quilt, n.d.).

Sidebar 12.4: Recent Breakthroughs in the fight against HIV/AIDS

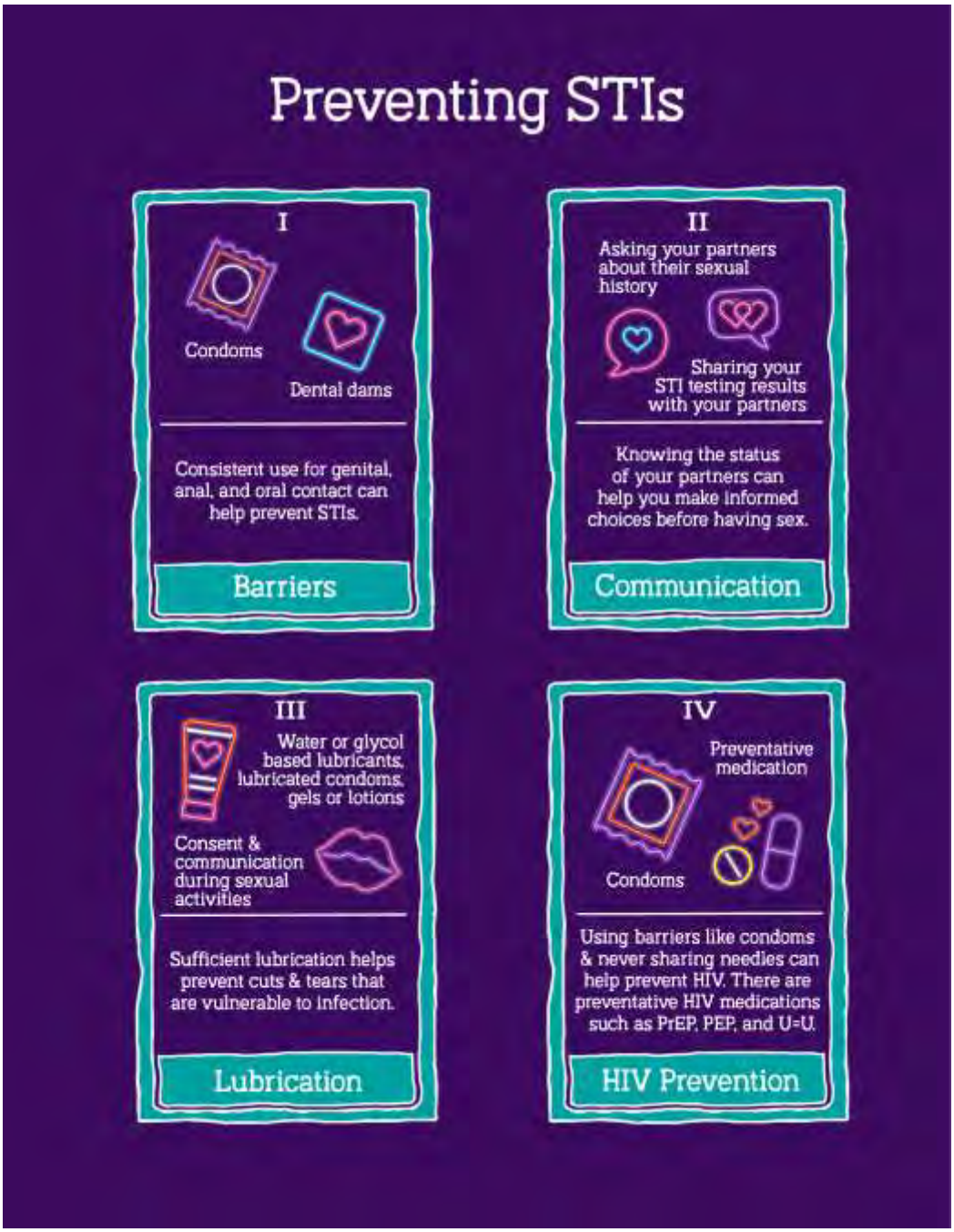
Watch: Woman cured of HIV using novel treatment | Latest World English News | WION

STI Prevention

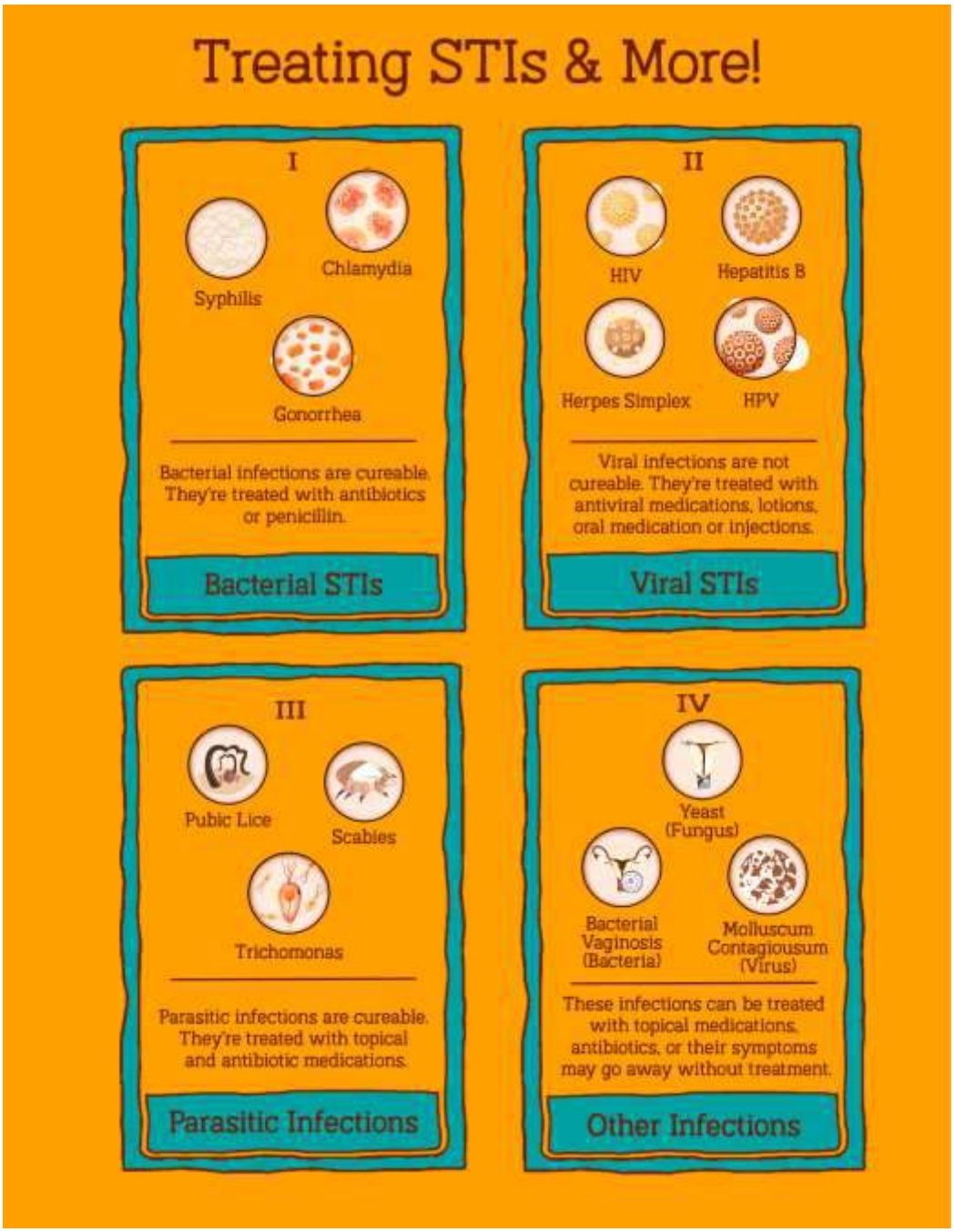
Stigma will not stop the spread of STIs. Testing, treatment and education will.

- Condoms and other barriers, used consistently and correctly, for genital, anal and oral contact can help prevent the spread of STIs.
- Talk to partners about testing, Know the status of your partners.
- Sufficient lubrication for vaginal and anal penetration can help prevent cuts and tears that can allow infections to get in. Be generous when using lube and be sure the lubricant is compatible with condoms if you are using them.
- For HIV prevention, PrEP, PEP and U=U are other powerful tools.

For more on this watch: Planned Parenthood on Getting Tested



Izzy Snow 2022



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Pubic Hair: Consider Keeping It

Pubic hair provides some protection from STIs, especially those that are passed via skin-to-skin contact. With hair removal (shaving, waxing or tweezing) tiny wounds can be created that create a place for bacteria, parasites and viruses to enter. Also, the hair itself provides a protective layer against skin abrasions and injury that can

come with friction during sexual activity. With hair removal, people sometimes end up with bumps and skin irritation they then mistake for an STI, so often it causes more stress than it's worth. The only upside of pubic hair removal as far as STIs is that pubic lice are rarely seen these days as they have lost their bushy habitat.

Partner notification

Notifying partners of a possible STI exposure is key in stopping transmission. Some public health departments will do anonymous partner notification as needed. This would usually be for HIV or syphilis. There are apps available to do anonymous notification. Partners should be treated as recommended by the CDC.

Expedited Partner Treatment (EPT)

When someone tests positive for chlamydia and receives treatment, it is recommended that all partners be treated with antibiotics in order to prevent re-infection. Often, a medical provider can prescribe partner packs of antibiotics to a patient to give to their partner(s) as needed. This is known as **expedited partner treatment**. Unfortunately, this is not as easily done for gonorrhea and syphilis, since the preferred treatment for those infections includes an injection. In that case partners are advised to seek medical treatment at a clinic.

A Shameful Legacy of Racism in Medicine: The Tuskegee Study of Untreated Syphilis in the Negro Male

The Tuskegee experiment, first discussed in Chapter 2 serves as an important lesson on multiple fronts. In 1932, the Public Health Service (which later became the CDC) of the United States, along with the Tuskegee Institute, began a syphilis study in Macon County, Alabama. The participants included 600 Black men– 399 with syphilis and 201 without. The men were not told they had syphilis nor that the study had anything to do with syphilis. They were told they were being treated for "bad blood." The study was based on the racist hypothesis that Black people had deficient cranial capacity and higher sex drive than whites. Even when penicillin was discovered to be highly effective treatment for syphilis in the mid-1940s, the

researchers did not offer it to subjects, nor were subjects given the choice to quit the study. They were kept off draft lists for World War II, since syphilis testing was done when one entered the armed forces, and the researchers did not want the men to find out they had syphilis and receive treatment. The researchers had decided they wanted to study the progression of the disease without treatment. They made it clear the idea was to follow the men until death so they could study the cadavers for disease progression.

Originally, the study was projected to last 6 months, yet it went on for 40 years, finally ending in 1972, when it was leaked to the press what was happening. There were several whistleblowers inside the CDC who attempted to stop the study for many years before that date, but the CDC chose to continue. By 1972, 28 of the patients had died directly from syphilis, 100 had died from complications related to syphilis. Forty of the patient's wives had syphilis and 19 of their children had been born with congenital syphilis. This study was an incredible violation of ethical standards. The harm done to the men and their families was egregious. It has also left a legacy of mistrust between the Black community and U.S. public health. It wasn't until 1997 that the United States gave a formal apology to the few men who had been in the study who were still alive at that time and to their families. There is a Memorial Legacy Museum at Tuskegee University.

The Voices for Our Fathers Legacy Foundation, President Lillie Tyson Head, pictured above (daughter of Freddie Lee Tyson) was started by the families of the men to preserve the legacies and history of the 623 men victimized in the

United States Public Health Service Syphilis Study, foster social justice, education and public health.

Sidebar 12.5: Tips from an STI Educator:

Talk to partners about testing. If you've tested, that can be a conversation starter. You can say "I just did my routine STI testing. When was the last time you tested?" I talk to people sometimes who say "well, he says he doesn't need to test" or "she looks clean" or "I don't think I have anything."

The only way to know for sure is to test. If you test negative, it doesn't mean your partner is necessarily negative for everything. It's possible to have an STI and not give it to someone right away. Asking someone to test is not about accusing them of something. It's about being mature and responsible for your health and the health of your partner(s).

Consider throat and rectal swabs for chlamydia and gonorrhea when testing. They are often only offered to gay men or men having sex with men, but we all have throats and anuses. So, if you've given oral sex, ask for a throat swab and if you've received anal, ask for a rectal swab. Often you can do them yourself in the restroom at the testing lab.

Avoid language such as someone being "clean" when referring to someone who doesn't have an STI. This implies that someone with an STI is dirty. This adds to stigma which ultimately makes people less likely to talk about STIs and to test. Instead, one could use the phrase "STI-free" as it is accurate and nonjudgmental.

If you're having symptoms or a partner has told you they have an STI, and you are going for testing, let the medical provider know your reason for testing. If you have symptoms or have been exposed, they will likely prescribe you medicine right away, even before testing. It is still important to test, but this way you are not waiting for results to come back to get treatment, if needed.

One of the most challenging situations in dealing with STI testing is when there has been infidelity (often referred to as cheating) in a relationship. I talk to people on both sides of this issue. There can be lots of emotions involved from guilt, to shame to anger, resentment and sadness. I affirm that no matter the circumstances, testing is a good idea, for all parties involved. Even if the person who went outside the relationship says they are sure they didn't get anything, I suggest that testing can be a way to start to rebuild trust in the relationship, if that is the goal.

Routine testing often includes HIV (if the person is HIV negative), syphilis, chlamydia and gonorrhea. If you have questions about herpes, HPV or other STIs, talk to a medical provider.

Just about every STI can be passed easily with oral sex, except HIV. It is highly unlikely that HIV could be passed that way, but chlamydia, gonorrhea, syphilis, HPV and herpes can all be passed with oral sex. Most people don't use barriers for oral sex, but barriers are an option. Harm reduction for oral sex on a penis includes ejaculating outside of the mouth, as this can minimize risk for some STIs.

Conclusion

Contraception helps prevent pregnancy and there are various options available for use. In order to determine the best method for you, make sure to speak with a clinician. Abortion can be used to terminate unwanted pregnancy. Since the legalization of abortion in 1973, abortion rights have been challenged and with the 2022 overturning of Roe v. Wade, access to free, safe, and legal abortion is no longer available in some states. It is important to know what the laws are in your state and neighboring states. There are multiple sexually transmitted infections (STIs) that have differing symptoms which require various treatment. Condoms used properly protect both against pregnancy and STIs. Unfortunately, open communication is sometimes hindered because of the stigma around contraception, abortion and STI's. Communicating with your sexual partners about contraception and sexual history is an important part of safer sex.

Glossary

1. **Abortion**: The termination of a pregnancy by the removal or expulsion of the fetus
2. **Bacterial STIs**: are chlamydia, gonorrhea and syphilis- less common ones are chancroid and mycoplasma genitalium
3. **Birth Control/Contraception**: is a technique that prevents a sperm cell and an ovum from uniting. There are various types of birth control options including, barrier, surgical, and hormonal methods

4. **Expedited partner treatment:** a medical provider can prescribe partner packs of antibiotics to a patient to give to their partner(s) as needed
5. **Parasitic STIs:** include trichomoniasis, pubic lice, and scabies. They are all curable with antibiotics and other medications
6. **Plan B** Emergency contraception that can be used after sex to prevent pregnancy
7. **Pubic hair**: the hair that appears on the lower part of the hypogastric region at puberty
8. **Sexually transmitted infections (STIs)**: If you have sex — oral, anal or vaginal intercourse and skin to skin contact — you can get an STD , also called a sexually transmitted infection (STI)
9. **Vasectomy**: a procedure in which a small section of the ductus (vas) deferens is removed from the scrotum
10. **Viral STIs:** include HSV (herpes simplex virus), HPV (human papillomavirus) and HIV (human immunodeficiency virus), which can lead to AIDS (acquired immune deficiency syndrome)

Discussion Questions

1. What has the Supreme Court's 2022 overturning of Roe V. Wade changed about reproductive rights in the United States?
2. Higher rates of STIs are seen in communities of people of color, particularly highest in the Black population in the United States (Park, 2021). How might racism contribute to this? What can be done to reduce this disparity?
3. How might we reduce shame and stigma around STIs? If we were able to reduce stigma, how might this affect STI rates?
4. Have you ever talked with a medical professional about STI testing? If so, how do you feel it was handled? How might we help medical professionals feel more comfortable and be more competent at addressing STI concerns?
5. STI testing is offered more to people with vulvas since they may be receiving routine gynecological care, as opposed to people with penises.

Why do you think this is and does it make sense or should we be doing this differently? Explain your reasoning.

Multiple Choice

1. *Contraception* is:
    a. A technique that prevents a sperm cell and an ovum from uniting.
    b. The theory that understanding is learned from others
    c. An alternative to caffeine
    d. A video gamer

2. Experiments conducted on animals in the 1930s found that high levels of progesterone could stop _____?
    a. Ovulation
    b. Contraception
    c. Cancer
    d. STD's

3. A vasectomy is a procedure in which a small section of the ductus (vas) deferens is removed from the scrotum
    a. True
    b. False

4. Who helped found a variety of reproductive health services for women in 1916 that led to what is now known as Planned Parenthood?
    a. Ruth Westheimer
    b. Margaret Sanger
    c. Sigmund Freud
    d. Dr. Phil

5. What are the ways in which an STI can be transmitted?
    a. Oral sex
    b. Anal Sex
    c. Vaginal Sex
    d. All of the above

6. Although there has been much medical advancement in the treatment of syphilis, the stigma has not completely gone away
    a. True
    b. False

7. Which of these are bacterial STI's?
    a. Chlamydia
    b. Gonorrhea
    c. Herpes
    d. Both A and B

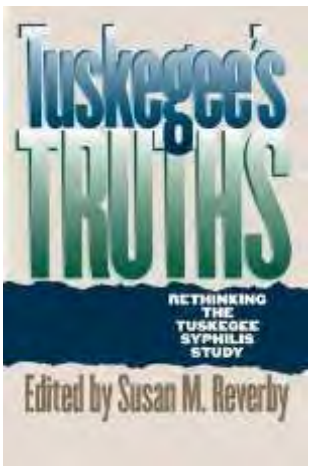
8. A medical provider can prescribe partner packs of antibiotics to a patient to give to their partner(s) as needed to treat a bacterial STI.
    a. True
    b. False

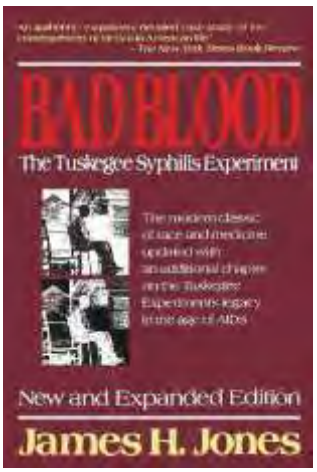
9. Keeping pubic hair rather than shaving it is a protective measure against STIs
    a. True
    b. False

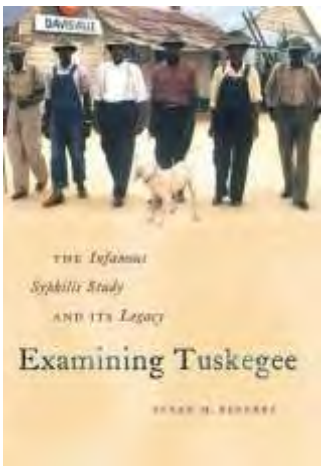
10. The only way to know for certain if you have an STI is to get tested
    a. True
    b. False

For Further Exploration

- Thebody.com
- CDC.gov
- The STD project.com
- Scarleteen.com
- Ashasexualhealth.org
- https://www.kinkly.com/we-pass-things-around-things-to-know-about-stis-in-2021/2/19445
- https://www.kinkly.com/cold-juice-old-phones-the-tale-of-my-first-herpes-outbreak/2/19716
- WHO fact sheet on success rate of types birth control
- HIV/AIDS at 40: What have we learned? | The Stream
- https://www.npr.org/2021/06/16/1007361916/act-up-a-history-of-aids-hiv-activism
- ACT UP: A history of AIDS HIV Activism, an NPR podcast







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What are the chances of getting pregnant if we're not using condoms or birth control?. (2011, October 6). In *Planned Parenthood.org*. Retrieved from

https://www.plannedparenthood.org/learn/ask-experts/is-it-possible-for-a-girl-to-spread-aids-to-someone-2.

Chapter 13: Sexual Health

Petty Officer 2nd Class Nathaniel Moger 2008. Public domain

Learning Objectives

After completing this module, students should have a working knowledge of:

- What sexual health is
- How sexual health relates to overall health
- Ways to maintain sexual health
- Some common sexual health concerns or issues that interfere with a healthy sex life
- How to get support

Introduction

We often think of sexual health as the absence of sexually transmitted infections and avoiding unwanted pregnancies, but it's much more than that. This chapter will provide you with an overview of what sexual health is and how it relates to our overall well-being. We will overview some suggested practices for maintaining our sexual health. We will also provide information on how to get help for issues that interfere with sexual gratification. We will conclude with a few thoughts on sexual health from some experts in the field.

Some Definitions on Sexual Health

Definitions by governing bodies, while never perfect or all encompassing, give us an idea of the cultural value of any topic. **The World Health Organization (WHO)** offers this comprehensive definition of sexual health:

Sexual health is fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries.

Sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

The ability of men and women to achieve sexual health and well-being depends on their:

- *access to comprehensive, good-quality information about sex and sexuality*
- *knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity*
- *ability to access sexual health care*
- *living in an environment that affirms and promotes sexual health (World Health Organization, 2022)*

The **World Association for Sexual Health (WAS)** took this definition further by elevating the importance of sex positivity and pleasure, and declaring sexual pleasure as integral to sexual health and overall well-being (World Association for Sexual Health, 2019).

The **American Association for Sexuality Educators Counselors and Therapists (AASECT)** "affirms the fundamental value of sexuality as an inherent, essential, and beneficial dimension of being human" (AASECT, 2022 para. 1). Additionally, AASECT believes that all individuals are entitled to enjoy:

- *Freedom of their sexual thoughts, feelings and fantasies.*
- *Freedom to engage in healthy modes of sexual activity, including both self-pleasuring and consensually shared-pleasuring.*
- *Freedom to exercise behavioral, emotional, economic, and social responsibility for their bodily functioning, their sexual liaisons, and their chosen mode of loving, working, and playing.*

AASECT believes that these rights pertain to all peoples whatever their age, family structure, backgrounds, beliefs, and circumstances, including those who are disadvantaged, specially challenged, ill or impaired (AASECT, 2022, para. 5).

Sidebar 13.1: What Does Sexual Health Look Like?

Some Sexually Healthy People Retrieved From https://www.rainbowhealthontario.ca/pap-campaigns

Just as governing bodies defining what sexual health is, here we are providing what many practitioners in the field regard as a sexually healthy person. No two people are alike, so there may be additions or deletions to this list depending on you.

Sexually healthy people:

- Embrace their personal expression of their sexuality
- Express love and intimacy in appropriate ways
- Communicate effectively with partners
- Avoid abusive sexual relationships
- Can enjoy sexual feelings without acting on them
- Use birth control and STI prevention methods effectively, as needed
- Practice health prevention—pap smears, medical checkups, etc.

Take a minute to ask yourself, do you feel confident doing all of these things? Why or why not?

What other aspects do you see to sexual health?

Our Sexuality Includes:

In order to understand sexual health, it is helpful to understand what we mean by sexuality. Sexuality is more than just the act of sex. Our sexuality is an integral part of our personality throughout our lifetime. It also changes as we grow and age (see Sexuality Over the Lifespan Chapter 11 for more info on this). Some components of sexuality are:

- Anatomy and physiology/ physical and reproductive development
- Gender
- Sexual orientation
- Sexual behavior/experiences
- Values and beliefs
- Spirituality
- Dreams and fantasies
- Intimate relationships
- Body image
- Sexual self-image

Word art by Remi

Sexual health: Why does it matter?

Sexual health is associated with happiness, longevity and well-being. Frequency and enjoyment of sexual intercourse are significant predictors of longevity. Challenges with sexual functioning may be an indicator of organic or psychiatric disease. For example, taking a sexual history in a doctor visit could help in early diagnosis of diabetes or depression. Sexual abuse (current or past) that is not addressed can lead to depression, PTSD, obesity, substance abuse, suicide attempts, relationship issues, and challenges with sexual functioning. Taking care of one's sexual health involves taking care of our bodies.

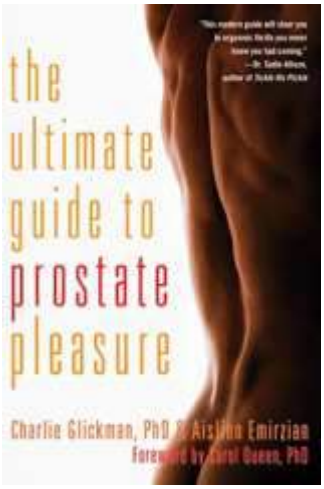
Some tips on taking care of the vulva:

- The vagina is self-cleaning- No douching or special wipes necessary
- Warm water and a washcloth or your hand is sufficient
- It is best to avoid scented products
- If you are experiencing painful vaginal intercourse, speak to a healthcare professional. Don't push through or ignore the pain.

The Prostate

The prostate gland is part of sexual anatomy, and produces the fluid that nourishes and helps to transport semen. The prostate normally doubles in size during puberty. At approximately age 25, it gradually begins to enlarge again. This enlargement does not usually cause problems; however, abnormal growth of the prostate, or benign prostatic hyperplasia (BPH), can cause constriction of the urethra as it passes through the middle of the prostate gland, leading to a number of lower urinary tract symptoms, such as a frequent and intense urge to urinate, a weak stream, and a sensation that the bladder has not emptied completely. By age 60, approximately 40 percent of men have some degree of BPH. By age 80, the number of affected individuals has jumped to as many as 80 percent. Treatments for BPH attempt to relieve the pressure on the urethra so that urine can flow more normally. Mild to moderate symptoms are treated with medication, whereas severe enlargement of the prostate is treated by surgery, in which a portion of the prostate tissue is removed.

The prostate gland can be a source of great sexual pleasure, and a direct route to orgasm and ejaculation. During arousal, the prostate gland swells and this is when prostate stimulation can feel most pleasurable. One can stimulate one's own prostate or a partner can do it, by inserting a finger in the anus and stroking towards the front of the body. Prostate massage is sometimes referred to as "milking the prostate" when it results in ejaculation or fluid coming out of the penis. When heterosexual couples do prostate massage and stimulation, it is sometimes referred to as pegging. *The Ultimate Guide to Prostate Pleasure* is a great resource for more information on how to safely enjoy sexual pleasure with prostate play.



Sometimes, surgery is recommended in order to treat prostate cancer. Removal of part or most of the prostate can cause the inability to achieve an erection. Working with a pelvic floor physical therapist prior to and after surgery can sometimes prevent this. Before having a prostate surgery, it can be helpful to speak to a healthcare provider regarding how it might affect erections.

We Asked! Answers to Some Questions from Jamie Weinstein, MD, Family Physician

As a family doctor, I see folks of all ages. I focus on people in the whole context of their lives and relationships, not just as a collection of illnesses. I have spent a lot of time talking/thinking/reading and educating myself on adolescent medicine, gender affirming care and human sexuality. I have a privileged perspective to be able to learn from my patients over the past 20 years.

What are common sexual health concerns that patients bring to you?

Many people come for contraception counseling or concerns about STIs or genital symptoms or pain. I also see a lot of women, between the ages of 20-40, who are raising kids, working and trying to partner. They report feeling overwhelmed, often not in a great place with their body, and sex becomes a point of tension or conflict. Typically, they are experiencing more lack of interest than lack of enjoyment, but sometimes, they do experience a combination of both. Many women have super supportive partners and just need reassurance and support to navigate this new phase of their relationships. I don't have time/permission in my practice to really delve into women's sexual history like a therapist might. I would also wonder if some of them may not have had a lot of great sex before and this phase of life is not always super conducive to figuring it out. If you have only ever really had male orgasm driven sex, and now you have 30 other competing demands that your

partner may or may not be stepping up for, it's not surprising that sex might not feel like your priority.

A lot of women want me to 'check their hormones" which is not really a thing. Like so many things, people really just want me to find a 'medical reason' which there rarely is... I usually try to do what I can to reassure and rule out, and then I want everyone to read Come As You Are by Emily Nagoski, or subscribe to OMGYES.

I see peri and post-menopausal women often for a combination of lack of interest/enjoyment Which may be due to decreased lubrication and also sometimes compounded by male partner with erectile challenges. In many cases they just need validation and support to adjust to what is their 'new normal,' but there are also medical interventions that can help.

I also see men of many ages who are struggling with ED and interested in medication. I try to talk about social/emotional/cultural factors, but often I just give them the prescription. I recommend they listen to the episodes on Viagra and ED especially #3 : death sex and money

Occasionally I see younger men with premature ejaculation. SSRIs (antidepressant medications) can help, as a side effect of them is delayed ejaculation.

I also see people who have been sexually assaulted, or had nonconsensual sex or sexual experiences they are regretting. I also see patients with a history of trauma, who struggle with body image issues, and sometimes eating disorders.

I also have seen a fair number of mostly older adults in my practice who are really hung up about 'intercourse' aka penis and vagina sex, patients who seem to be really unable to regroup and recover from not being able to have penis and vagina sex in the way they used to. It speaks to how male orgasm 'centric' we are as a culture about what defines "good sex." I think many folks could benefit from exploring the idea of sex as a journey, rather than a transactional destination. The lack of eye contact, blushing and obvious discomfort when I suggest to people there are other ways to have intimacy and pleasure or ask them to consider that millions of folks have amazing sex that doesn't involve a penis and a vagina speaks volumes. I wish sex therapy was more widely available for everyone!

More and more in my work, I really try to think about what is the purpose of my questions, especially as it relates to sex and gender. For example, when I was in

training, I was taught that the most appropriate way to take a nonjudgmental sexual history was:

“Do you have sex with men or women or both?” Now I realize that question is ridiculous...

What do I actually need to know?

For a person with a uterus, I usually want to know if they are having any type of sex that could lead to a pregnancy. For everyone, I want to know if they are at risk of sexually transmitted infections and this is much more about behaviors than the gender of their partners. If someone wants to talk about issues related to the gender of their partner or feelings about sexuality, I am more than happy to but it's not actually relevant a lot of the time. For someone who thinks she is good at this, I have had a surprising number of encounters where I asked a woman about contraception in a mindless hetero-centric way that forced her to have to tell me she has female partners. That did not feel like good care. I am always refining and trying out different ways of asking questions that feel open and respectful of different identities, that also get me the info I need to know.

Even when folks have actual questions about their bodies, especially genitals and if it relates to sex, they are often hesitant to talk about it. They are coming to me for a problem and concern and sometimes they can barely form the words or ask the questions, and then get really squirrelly when I try to get even the most basic supporting info to try to help them. Yes, if you come to me with concerns about your penis, I am actually going to have to ask you questions about your penis.

I also think sometimes for things related to sex I don't actually need to know all the details. In some cases making folks talk about it when that's not what they are looking for may actually be a barrier.

For example, we have transitioned to offering 3 site testing for gonorrhea and chlamydia (urine, throat and rectum) because of data suggesting you miss a lot of infections if you just did urine tests in specific populations (see STI chapter for more info). It didn't take long to realize that lots of folks use different parts of their body for sex, and now most of us offer all 3 tests to everyone as part of the STI screen, along with blood tests. Folks just go to the bathroom in the lab - pee and do the self-swabs and turn them in. This is one area when I have been thinking a lot about universal education/patient autonomy. Is asking folks to tell us their individual behaviors or experiences always the best tool for patient health? Do I actually have

to ask folks to tell me about their sexual practices if they don't want to? Or can I just educate them about the fact that many folks use lots of parts of their bodies for sex and you can get STIs in your throat or rectum and let them know that they can choose to do those tests if it's relevant for them. I don't have the ability to do a randomized trial on this, but anecdotally, it seems like the majority of my patients who want STI screening do all three tests. Is that because they automatically do whatever tests the lab gives them and they don't really need it? Is that because they realize they are at risk and are glad for the screening? Maybe it's a combination of both. And would they be less likely to do it if I asked them specifically, "do you have oral or anal sex?," and made them talk about it to get the test done?

How do you help patients feel comfortable coming to you with their concerns?

When I first started learning to be a doctor, I realized right away that I was never going to entirely fit in the "doctor box." I'm a little spazzy and casual. I like to dress differently. At some point I realized that could be a strength for me. When I worked more with teens (my previous job), it was a really great way to get kids to let me in a bit. I think one of the biggest things about being a good primary care provider is being observant, and then trying to mirror/match your patients, not to be fake, but rather, to help them be more comfortable. It's also interesting to note that I think many doctors focus way too much on what they are telling their patients, rather than making sure that their patients feel listened to.

Then the other part is being able and willing to talk comfortably with folks about personal things. Also signaling to people in verbal and nonverbal ways that you are a safe nonjudgmental person and their concern is something you are willing and able to help with. I had to actually practice saying certain things to not blush. It's kind of stereotypical and seems obvious, but actually saying "some of my patients say/do/feel..." can work as a signal and a way of getting the conversation where you think it might want/need to go.

What do you think doctors can do to improve the sexual health of their patients? How do you define sexual health?

I think sexual health is part of overall personal health and well-being and it means different things to different people. I don't want to impose my ideas on other

people, but sometimes I do interrupt/interrogate if I think their ideas are unsafe or not serving them well. I think a lot of the reasons folks struggle is more about social and cultural norms, so how much I can impact that in the exam room really depends.

I want folks to know they CAN talk to me about questions. There are a lot of competing demands in a primary care visits, and questions about sex and sexuality are not likely going to be brought up unless the patient initiates. Consider how weird/hostile Americans can be about discussions of sex and sexuality, and add in power/gender/age discrepancies between doctor and patient. I am always happy to answer questions about most anything. I am interested in sexuality, so I weave it in more than most other doctors I suspect. We got zero training in anything resembling sex positivity. I'm guessing it's slightly more now maybe, and doctors are just people so they may also just generally be uncomfortable talking about sex outside of the purely medical aspects.

There is no one right way to be or look or feel in regards to sex and sexuality. I support my patients to feel good about themselves and their bodies in whatever way works for them. I think many folks are in a challenging place navigating current ideas about sex positivity/sexual freedom and their own feelings and boundaries. I highly recommend this interview, and this one for starters.

For little kids, I think sexual health starts with using correct names for body parts, encouraging parents to support their children's body autonomy (often very challenging when you are literally in charge of their body functions), and giving kids information about reproduction and bodies and sex in developmentally appropriate ways. Sex ed in schools is generally lame - in my experience it barely gives even the most basic info kids need. I wish we had a system for everyone to get basic developmentally appropriate education about their bodies and sex that included safety (STI, consent, social media/body shaming/porn literacy, etc.), understood sex/gender/identity/expression, AND talked about pleasure.

Acknowledging this is gendered and stereotyped I'll say this-- For young assigned female at birth people, I want them to learn about their own bodies and feel okay prioritizing their own pleasure, not just their partners. I want young people, especially anyone who was or is a woman, to have sexual agency AND know that it's always more important to be safe than polite. For young cisgender/heterosexual men, I want them to also learn about how other bodies experience pleasure, and disrupt some very common cultural misconceptions in porn. I want some men

generally to think about their privilege and what they think they deserve from women. Everyone might benefit from thinking more about how their bodies feel during sex, and less about how they look. I want everyone to feel comfortable with the idea that it's okay to want and expect emotional intimacy before and in addition to physical intimacy. Or even to be able to distinguish that those might be different things. I want folks to feel safe and empowered to try things out, ask for what they want and also to be able to say “no thank you” without feeling like they are being sex-negative. I'm not sure sexual freedom today is actually that liberatory.

For adults, especially those struggling with changes in their bodies, I think about what someone said in the *Death Sex and Money Podcast*, about being lucky enough to live in an aging body. A lot of my job is helping folks come to terms with where they are now. This is part of the reason I think a lot about child development and supporting teens and young adults. So many things in adulthood, including sexual health, might feel better if we weren’t trying to reeducate and heal a lot of damage from when we were young.

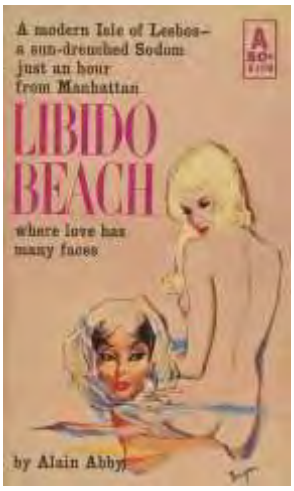
Sexual Desire and Functioning

Many people end up consulting with a medical professional when they feel their sexual desire or ability to perform has changed in a way they are unhappy with. Causes for this vary, but sometimes it may be related to common medications people take. There are many medications that have been shown to affect sexual desire and functioning including:

- Antidepressants and antipsychotics
- Blood pressure meds
- Incontinence meds
- Birth control pills
- Antihistamines
- Anticonvulsants
- Steroids
- Sedatives

Sometimes people take “drug holidays” or plan sexual activity around times when the effect of the medication is at its lowest, in order to manage this. Be sure to speak with a healthcare professional before changing or skipping medication.

What About Libido?



Libido Beach by Alain Abby. Cover art Charles Binger. 1962 Public Domain

Libido, or our desire for sex, is complex and not easily defined. Yet people tend to know if they have it or not. There can be changes in libido throughout one's lifetime. Libido is somewhat hormone driven, but can also be affected by many other factors, which is why it is so complex and sometimes elusive.

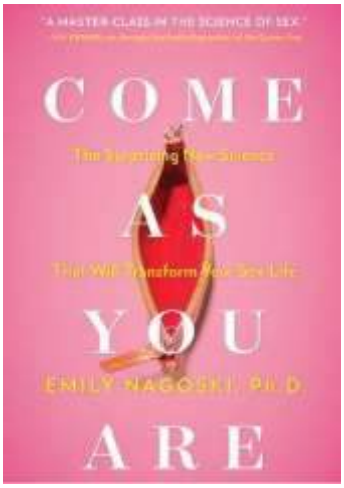
There is responsive and spontaneous libido. Often when people complain of low to no libido, they are referring to what they once felt as spontaneous libido or desire. That feeling when you see someone or think of someone, and instantly feel desire for sexual contact. Many people don't realize that although they may no longer have that spontaneous feeling they once had, they still have the possibility to experience responsive libido.

Responsive libido is dependent on context. Context includes external circumstances and internal brain state. Desire is arousal in the right context. For example, how we feel about our partner in the moment is part of the context. If we had a fight and are feeling hurt by them, that could affect our level of desire in that moment, most likely making it go down. On the other hand, if we had a fight and have now made up and are feeling extra close to them, that could also affect our level of desire, most likely making it increase.

As a sexuality educator, in order to help people assess if they have responsive libido, I recommend creating the right context for themselves with a partner and then being willing to be playful, not necessarily having a particular goal regarding

sexual activity. Engage in sexual playtime, and see if their body starts to wake up and become aroused. If it does, then sometimes they will see they begin to experience a feeling of desire that was eluding them. So rather than waiting for that spontaneous feeling of desire, plan sexy time together and see what happens. Often people are pleasantly surprised that they still feel something. This is not the case with everyone. There are some people who struggle to find responsive libido as well. And there are some people who don't desire to find it, who define themselves as asexual and are not looking to find that elusive libido. There is incredible variety in how we experience ourselves as sexual beings or asexual beings and no reason why we would all be the same.

For those people who are looking to find their lost libido or to increase libido, it can be helpful to understand that there are two processes going on when it comes to physical and mental arousal. Emily Nagoski explains this in her book *Come As You Are*, as activating the accelerator and deactivating the brakes, to use a car analogy.



Often people focus on how to activate the accelerator. What can one do to add to the situation to increase arousal level? For example, wearing a sexy outfit, or having the right lighting or music. It is also important to consider what might be putting the brakes on for someone. For example, if the house being a mess, dishes not done, laundry not put away, is a distraction for someone, then all of the sexy lingerie and music in the world isn't going to fix that. What would work better for that person would be planning sexual activity when all that is done. That way the person can relax and let their mind focus on pleasure and not dirty dishes sitting in

the sink. This is why people sometimes report better sex when on vacation. They aren't distracted by all of the chores they associate with being in their own home.

Why don't I desire sex and if I want to change that what are some options?

There are many things that can put the brakes on. Here is a partial list:

- Busy schedule/ Fatigue
- Depression/ Stress
- Negative effects of hormonal changes
- Sexual abuse (history or current)
- Painful intercourse
- Childcare issues
- Medications/ health problems
- Negative messages about sex/sexuality
- Relationship tension

For each one of these, there can be an antidote. It is often a matter of finding the right answer. For example, for people with busy schedules, scheduling sex is often an answer and if people are tired, then sometimes scheduling morning or afternoon sex is helpful. Addressing issues around depression and stress can be important. If it is hormonally related (as in menopause or andropause or postpartum or with breast feeding), then talking to a healthcare professional and seeing what medical options may be available can be helpful. Also, if hormone levels are low, adding hormones isn't the only answer. Sometimes, someone just needs more stimulation than they needed in the past, so getting creative with toys or simply taking more time to let arousal happen can be key.

If there is a history of sexual abuse, letting a partner know about this and finding ways to communicate as needed during sexual activity can be helpful, to help achieve a feeling of safety. If someone is having flashbacks and feeling unsafe or disassociating in order to continue, it is helpful if this can be communicated in some way, and sexual activity can be paused and the couple can work together to bring the person to the present moment and help them feel safe enough to stay there. Tenderness and compassion are key here.

If intercourse is painful, then it makes sense that someone may not desire it. Addressing what is causing the pain is important. Speak to a healthcare professional and have an exam. Let partners know that while this is being addressed, enveloping or penetrative sex is not on the menu. It is not a good idea to push through the pain which is what some people do. The body has a memory and if someone continues to push through pain, often the body will try to protect itself by making envelopment (penetration) even more challenging. In that case, for people with vaginas, the issue can go from dyspareunia (painful sex) to vaginismus (when the vaginal muscles tighten up) making penetration more difficult and painful. Again, if this is happening, having an assessment by a healthcare professional who is knowledgeable and sensitive to this issue is important. For some people with vaginismus, having a pap smear is painful, as it requires inserting a speculum. Finding a provider who will be patient and understanding about this is key. Meanwhile, if sexual activity is still desired, there are many other ways to give and receive pleasure that do not require vaginal penetration.

When there are childcare issues, it can be helpful to work with a partner to address them and come up with a plan for some private time that works for the whole family.

There are a variety of health issues that can affect sexual functioning. Diabetes is a good example, as it affects blood flow, so it is most often noticed by people with penises who are having erection issues. It can also lead to yeast infections for people with vaginas. Often addressing the health issue, in this case, regulating one's blood sugar, can help resolve the sexual functioning issues.

Smoking also affects blood flow, so certainly not smoking is good for one's overall health as well as one's ability to achieve and maintain erections. Blood flow is also important to functioning for people with vulvas, although it may not be as obvious as with penile erections. Clitorises also have erections, and in general, bringing blood flow to the genitals is part of the arousal process for people of all genders.

We all receive messages about sex and sexuality as children, whether it was spoken about or not. If it was unspoken, then the message the child internalizes is that there is something secret about sex and sexuality, and often, this becomes tied to shame. We learn that if sex is so bad that we can't even speak of it, then it must be shameful. Some people receive direct messages saying sex is bad or wrong. Others receive more positive messages. As discussed at length throughout this book, messages about sex and sexuality may come from family, peers, media, school,

community and religious organizations. Whether they were positive, negative, or neutral, these messages often stay with us through adulthood. Even if we grow up and develop different values than the ones we were raised with, these messages run deep in our psyche, and sometimes play out in unexpected ways in our sexual feelings and sexual self-esteem. Being aware of how we are continuing to hold these feelings. Are they serving us well or doing us a disservice? This is a first step in addressing them.

If there is a problem in a relationship, then addressing that can be important. Every couple is different. Some people find that if they are upset with their partner, the last thing they want to do is be sexual with them. For others, being sexual together can be part of the process of resolving differences, coming together, and feeling closer.

For some people, romance is important. For others, it is more about feeling emotionally close to a partner, and others want pure eroticism. For many people, we want a combination of these things from our sex life. There isn't one answer that will work for everyone all of the time. It is a matter of seeing what is missing and what could be added.

Overall, having the ability to communicate one's desires and to be open to hearing those of our partners is critical. In this sense, we can learn a lot from the BDSM and Kink community, where communication is considered absolutely critical for play, as emotional and physical safety can be a factor. Of course, our emotional and physical safety can be a factor in any sexual activity, but it is the BDSM and Kink community that make safety explicit.

In the world of BDSM and Kink, people will often negotiate terms of play ahead of time, expressing to a partner what they are willing to do, what they are not willing to do, and what things they may be willing to do under some circumstances. People in the community take these negotiations seriously. Sometimes, participants may have these agreements in writing in the form of a contract. This way, there are no surprises and people can then enjoy their playtime (sometimes referred to as a scene), working within the boundaries that have been set. For more information on BDSM and Kink, see Chapter 9, which covers types of sexual behavior.

A big part of what makes a great lover is simply being present. What better gift can one give to a lover than the feeling that they are in the moment with their partner, and wanting to be there.

For folks into BDSM and Kink

Icey at English Wikipedia. 2006. Public Domain

Dr. Charles Moser has written a great handbook for kinky people and their healthcare providers. This is something that rarely gets addressed in healthcare; however, is important. Finding a healthcare provider who is knowledgeable on the kink community is not always easy. Often, people are unsure about coming out to their doctors or therapists about their lifestyle or behavior, for fear that they will be shamed or even accused of letting themselves be abused or abusing someone else. It can be important information for a doctor or medical professional who is providing care to know; for example, if a patient has marks on their body from consensual spanking that is being done safely. That way, the medical professional who is often a mandated reporter is not suspecting abuse. It is also helpful if healthcare providers are knowledgeable of their patients' lifestyle and sexual choices, so they can have conversations to help patients engage in activities safely.

Sidebar 13.2: Some tips

Here are some tips on activities and practices to do **with a partner** to improve one's sex life.

- Take time for relaxing and fun activities aside from sex
- Schedule sex if your lives are busy
- Communicate— let each other know what you like and don't like and what you might want to try
- Share fantasy—this doesn't work for all people, but some find it to be sexually arousing to hear their partner's fantasies or share their own. Check with a partner first before sharing.
- Role play
- Use sex toys and lubricants as desired/needed
- Engage all of your senses—incorporate sexy music, silky sheets or lingerie, yummy foods, etc.
- Consider using arousing materials- this can be anything from an erotic story to sexual imagery you and a partner both enjoy and find arousing. Check with a partner first before introducing erotic material.

Sex Toys, personal photo

What you can do **on your own** to increase sexual pleasure and sexual health:

- Eat healthy
- Exercise
- Manage stress
- Get good sleep
- Use vaginal moisturizers & lubricants as needed (talk to a doctor if you are experiencing vaginal dryness)
- Experiment or play with sex toys, including vibrators and dildos (see Chapter 4 on Pleasure for more info on toys)
- Masturbate - get to know your body

Challenges with Erections AKA when Penises Misbehave:

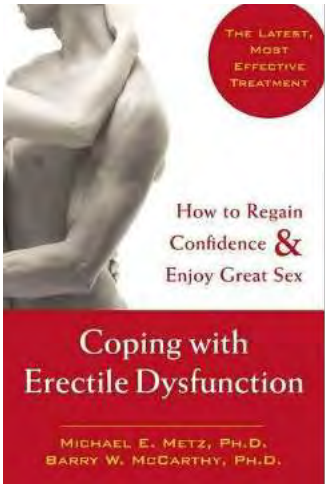
Sometimes, people have trouble achieving and/or maintaining an erection. In the medical world, this is referred to as erectile dysfunction or ED for short. There can be many explanations for this. It is not always clear if the issue is psychological, physiological or both. In order to diagnose, a medical provider might ask if the problem has been lifelong or recently acquired. Does it happen all of the time or only with a partner? Does it happen with masturbation as well? Answering these questions can help a healthcare provider determine the reason. For example, if it doesn't happen with masturbation but only with partners, then it is not physiological. It may be related to performance anxiety- when someone feels pressure to perform during sexual activity, and they get so nervous that they are

unable to relax enough to let their natural body processes happen. Their brain instead gets fixated on managing the stress the person is experiencing. This can create a negative cycle. The more nervous someone is about performing and getting an erection, the less likely they are to achieve or maintain one.

A healthcare provider may also ask if the person has morning erections. If they have morning erections, even sometimes, that means the body can still achieve an erection on its own. There are some cases where a person is no longer capable of achieving an erection on their own. This could be because of removal of the prostate due to prostate cancer or other health issues. In this case, the medical options are penile pumps, implants or injections. These methods can be discussed with a urologist or primary care doctor.

If the person is able to achieve an erection, but not able to maintain it, then a medication such as Viagra or Cialis can be prescribed. These medications do not create erections, but they help maintain blood flow once an erection has been achieved.

If the issue is clearly psychological and more related to performance anxiety or other stressors, then looking at addressing the anxiety or stress is the key. For some people, working with a sexuality educator, counselor or therapist can help with this. There are a variety of exercises one can do to learn to relax during sexual activity and improve erections (see Metz and McCarthy book *Coping with Erectile Dysfunction*, for examples). If the person has a willing partner, they can involve their partner in the exercises as well. Sometimes, it is necessary to reassure a partner that the erection challenges are not their fault.



As a sexuality educator, I encourage people who are having erection challenges, to be kind and patient with their penises. Sometimes penises “misbehave” for good reasons. Rather than thinking of themselves as dysfunctional or as having a dysfunction, I encourage them to consider why their penis may not be cooperating with their plan for dependable erections. Sometimes, there are factors such as relationship issues, stress, exhaustion, or insecurity regarding sexual performance, or the influence of past negative experiences and other factors which could be at play.

It is also important to note that a soft penis can enjoy being touched and appreciated as much as an erect one. There is a myth that penises should show up erect for sexual activity, and remain erect for as long as the penis owner or partner(s) demand, in order for sexual activity to be worthy. This is not true. There is much pleasure that can be had by all involved parties, regardless of whether a penis is erect. So be kind to your soft penis and encourage your partner to do the same. Who knows, maybe then an erection will show up.

Of course, the one thing you can’t do so easily with a soft penis is penetrative vaginal or anal sex, particularly if you are using condoms, as putting a condom on a soft penis is not effective prevention as it can easily slip off. If you are not using condoms, then the “stuff it” method could be an option, simply stuffing the soft penis inside the anus or vagina. Sometimes once inside, the penis may become erect, but this method does not work for everyone. One could consider taking intercourse off the menu temporarily, as this relieves the pressure that the person feels to achieve an erection.

If the partner feels that receiving an object in their vagina or anus is an important part of their sexual pleasure, then fingers or toys such as dildos (see Chapter 4 on Pleasure for more info on sex toys) can be used to achieve that.

Most importantly, I recommend that we take the stigma and shame out of erection challenges. Many men in our culture are raised to think that having an erection for sexual activity is what makes them a man, and is what defines their masculinity. As a society, we can come up with new inclusive definitions of masculinity and femininity when it comes to sexuality and sexual expression that don’t shame anyone for their bodies shape, size, or ability.

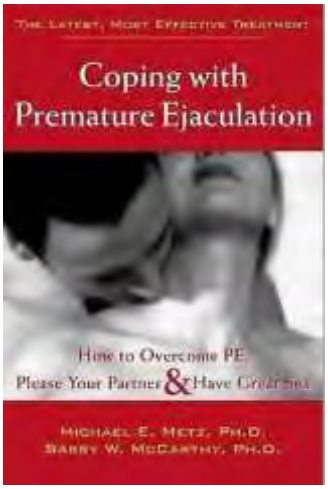
Premature Ejaculation

Premature Ejaculation is another common issue that people with penises experience. There is debate about the exact definition of premature ejaculation in the medical and psychological communities. How soon is considered premature? Too soon for what? There are definitions based on IELT (intravaginal ejaculation latency time) which is the amount of time it takes to ejaculate once a penis is inside a vagina (Waldinger & Schweitzer, 2019). This definition is hetero-centric, assuming the partner has a vagina.

As a sexuality educator, what I find most helpful is to ask the client what they are experiencing and go from there. It is often helpful to assess for realistic expectations. For example, if someone says I can only last 10 minutes and I used to be able to last 20, one could affirm how this change may feel upsetting, but also affirm that 10 minutes is not an unusual amount of time.

We would also assess to see whether this issue has been lifelong or is recently acquired. Just like with ED discussions, we would want to know if it happens when the person is masturbating as well or only with partners. Many people unknowingly train themselves to be premature ejaculators. As many young people masturbate in secret and are afraid of being caught by parents or other family members, they often train their bodies to come quickly. Unfortunately for some, this training can be challenging to undo when they are with a partner, even though they would like to last longer. This is a good reason to not rush through masturbation just to get to the goal of ejaculation and orgasm quickly, but to take one's time to feel pleasure and be present in and enjoy one's body.

Learning to last longer is often a matter of learning to be tuned into one's body, specifically, the feeling in one's genitals. Some medical professionals or lay people may recommend numbing creams as a way to last longer by reducing sensation in the genitals. Yet, many sexuality professionals see tuning in, rather than numbing out, as the answer. Learning to recognize when one has reached the point of ejaculatory inevitability and be able to tune into one's body based on this, is key. There are exercises one can do, either alone or with a willing partner, to practice, as outlined in *Coping with Premature Ejaculation* by McCarthy and Metz. Also being patient with oneself or one's partner if they are dealing with this is helpful. As with ED, the more one stresses over PE, the less likely they are to be able to easily overcome it.



Natural Physiological Changes with Aging

Our bodies and our sexuality changes as we age. For more on this, see Chapter 11 on Sexuality Through the Lifespan. Here is a general list of some of the natural changes that occur with age related to sexual health.

- Decrease in hormones such as testosterone and estrogen
- Decrease in morning erections
- Decreased libido
- Decreased penile sensitivity
- Direct penile stimulation often required for erection
- Delayed ejaculation/orgasm, anorgasmia
- Less firm erection, some older men full rigidity seconds before ejaculation
- Ejaculatory urgency may be reduced
- Post orgasm/ejaculation, detumescence and testicular descent more rapid
- Less semen, less viable sperm
- Bladder control issues
- Longer refractory period
- Vaginal atrophy
- Thinning of vaginal tissue
- Lack of lubrication leading to vaginal dryness
- Pain with vaginal intercourse
- More time/stimulation needed to reach orgasm

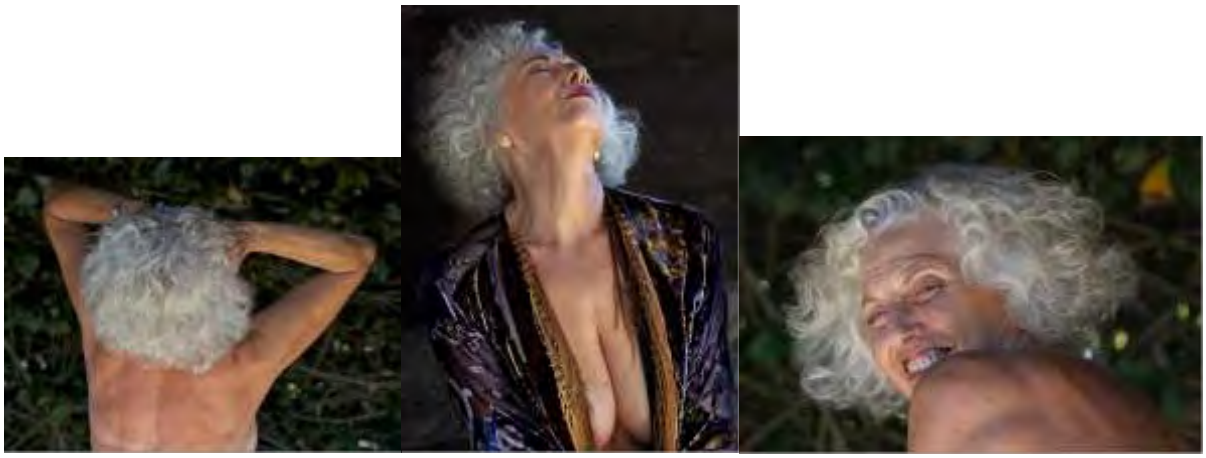
Many of these physiological changes can present challenges, but there is also good news about aging and our sexual health. For some, the wisdom that comes with age, the knowing of one's body, of a partner's body, and less self-consciousness, can leave more room for pure sexual joy and freedom. In some cases, these physiological changes can present an opportunity for creativity that can lead to some of the best sex people have ever experienced. If erections are not always dependable for example or vaginas not always open to enveloping sex (aka penetrative) but people still want intimate connection, they become open to the many ways they can experience sensual and erotic pleasure in their bodies, ways that are less focused on one kind of sex, but open to many new ways of giving and receiving sexual pleasure.

Sidebar 13.3: Sexual Health and Aging:

It is empowering to be seen by a camera eye that is appreciative of older women's beauty and experienced expression of sexuality. It is important, though, to understand that my feeling sensual/sexual does not depend on the male gaze. I must love and appreciate myself.

When I look in the mirror, or stretch and exercise, it is my challenge to get past notions of what constitutes a perfect body. The body that is sensitive, alert, alive, open, curious, willing, generous and relaxed is the body that has the most fun, whether hiking or playing pickleball or making love.

The woman who feels ageless is ageless. Jennie Orvino, born 1946



Adrian Mendoza Photography http://www.186282mps.com/

What are some health benefits of sexual activity?

- Increased happiness and sense of well-being
- Reduces stress and anxiety
- Raises self-esteem
- Builds trust and bonding, stronger more intimate relationships
- Enhances heart health, lower risk heart attack and stroke
- Improves immunity
- May reduce the risk of certain cancers
- More energy and better sleep
- Burns calories
- Lowers risk of cognitive impairment including dementia

- Improved bladder control
- Longer life
- Increased libido
-

So ask yourself, can you think of any other health benefits to sexual activity? Do you think the benefits may be different for masturbation and partner sex? Why or why not?

Sidebar 13.4: Ask the Expert: Jose Trejo, LCSW

As a sex therapist, how are you able to help people navigate challenges with their sexuality? What are some common issues people come to you with?

The first thing I want to do is rule out any medical conditions. Following that, a big part is normalizing the challenges people come in with related to their sexual struggles. We are in 2022, and yet there remains so much stigma surrounding sexuality/sexual health. A lot of people do not reach out due to shame, guilt, embarrassment or simply not realizing how common sexual health issues are. While some issues may take much longer to work on, many issues related to sexual health can be successfully treated in a short time. Oftentimes, normalizing and providing an open non-judgmental and curious forum for the people I see in my practice to work in is one of the first steps I take. The biggest step prior to that is actually reaching out for help, which I encourage all people to do, even if you may think a potential or possible issue is minor or embarrassing. I've noted once people start to have that sense of normalcy and safety, the walls start to come down, which allows us to explore the roots of their struggles. Next, we then focus on possible interventions, skills, or strategies. Sometimes, normalizing/general education may be the only thing necessary (for example: your penis is actually within the normal size range; most sex is not what you see in porn, etc.).

Some common issues people come in with include desire disorders (lack of sexual desire or interest in sex), arousal disorders (difficulty becoming physically aroused or excited), orgasm and pain disorders. Ultimately, mental health such as anxiety, depression or relationship/life stress may be contributing factors as well. Finally, it is always important to assess or take note of any possible sexual trauma one comes in with as well. I cannot stress how important that may be to one's overall sexual health or things that may be impacting it.

What do you think it means to be sexually healthy?

Sexual health is engaging in sexual activity you choose, that brings pleasure while free of exploitation, coercion, violence, or discrimination. Taking care of ourselves physically and mentally are significant.

Regarding physical health, I always want to rule out medical conditions first, such as conditions like diabetes, cholesterol and high blood pressure, which are known to impact proper blood flow, thus contributing to or directly causing some sexual dysfunction(s). Injuries related to the back, hip, spine and neurological or gynecological conditions, etc. can be significant, among other physical injuries. Managing medical conditions that improve blood flow can help address ED (erectile dysfunction) and PE (premature ejaculation), for example. Importantly, strengthening the pelvic floor can help several sexual dysfunctions as well. Overall health is a big part of our sexual health.

Taking care of our mental health also helps prevent sexual dysfunctions like erectile dysfunction, premature ejaculation and pain disorders. We also know symptoms of anxiety, depression and trauma can include those related to sexual functioning. For example, managing depression helps improve our mood and overall functioning, while also decreasing social isolation (i.e., our social well-being).

I believe if your sexual life/activities are pleasurable choices you made/feel fine with, are overall physically and mentally healthy and living a life with good connections, then you probably have good sexual health. If you struggle in areas related to sexual health, seek help. Start by checking in with your doctor to rule out medical conditions. In working with a sex therapist, one may discover certain diagnoses or conditions that are contributing, possibly causing sexual challenges

and can then address them. Keeping up a generally active and social lifestyle, combined with being physically/mentally healthy are what I would consider being sexually healthy.

Do you see identities such as race, class, gender and sexual orientation affect people's sexuality and if so, how?

No doubt! A lot of our sexuality is learned throughout our lifetime and certainly in our earlier years. What were the messages we received about sexuality? Thinking culturally for example, as a Latino male, the traditional message with regards to men is having to be "manly, macho" while females are to be "submissive, servants to the man." What if that Latino male identifies as being gay? Where does that play in the traditional culture? It often does not. That can then lead to shame and guilt, depression, or anxiety, which can impact one's sexuality. It may not be the person has a "problem," rather the cultural messages received instilled this "problem." What if they are then shunned by the family? What is the message? "This is wrong, I am wrong, I shouldn't be this way, there's something wrong with me." So now, we have an individual who may be struggling with orientation/identity issues and conflicts with what their sexuality entails.

Learning who they are and developing new scripts is one strategy that can assist in living their lives rather than the lives they were taught as "right." In that case gender, race/culture and orientation are present. In considering class, there continues to be a big gap in many areas, including education, resources, and upbringing. A lower socio-economic class pregnant teen is likely to have limited resources. This lack of resources/education not only may affect that teen's future, but also those of the generation(s) that follows. It's a continuing cycle based on a lack of resources. Someone from a higher socioeconomic class is likely to have more options, support and the financial backing to continue to be set up for success.

The messages we receive, our experiences related to sexuality, and the education and resources we are afforded can play a significant role in how our sexuality is defined and in the way we live our sexual lives.

Jose E Trejo, LCSW

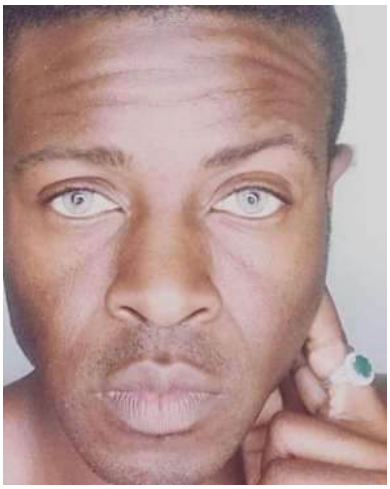
Sidebar 13.5: Ask the Expert: Markias D. Littlejohn LCSW, LISW-CP, MFSW

Strange Bedfellows: The Afro Diaspora and Sexuality & Sexual Expression

As a sex therapist who specializes in promoting healthy sexuality in the Afro Diaspora, I find there are common themes that seem to permeate all level of socioeconomic status and other intersectionalities regarding Black sexuality. The consistent and resounding theme is the "strange bedfellow" relationship that exists between the Afro Diaspora and sexuality and sexual expression.

To understand this relationship, it is vital to look at the historical context of colonialism and how it reshaped Black sexuality forever. During colonialism and slavery, sexuality was weaponized against Black bodies for capitalistic gain, nonconsensual personal pleasure, at times for sadistic experimentation, as seen in the creation of the field of gynecology, and to assert dominance as in buck breaking- the act of sexually assaulting Black male slaves publicly. Though many will profess that slavery was an event of long ago, I will counter with the fact that my great grandmother, whom I was reared with, was one generation removed from American chattel slavery. The implications of the effects of colonialism have been passed down through adaptive coping mechanisms, which now present as barriers to healthy sexuality/expression, epigenetics (as we know via science, trauma can be passed through our very DNA to our offspring), and through behaviors towards sexual expressions (for example religion and homophobia in the Black community).

As a sex therapist, my passion and purpose are to give name to the dysfunctional relationship between Afro Disapora descended persons and sexuality and sexual expression. I am a firm believer that if you do not name trauma, you can never address it. By naming a trauma and dysfunctional cycles, you imbue a person with the desire to understand the cycle, take back their power, and create a safe environment for them to cultivate and have the ideal sexual health and vision they want and deserve.



Markias D. Littlejohn LCSW, LISW-CP, MFSW

CEO, Kairos Therapeutic Alliance LLC.

https://www.psychologytoday.com/us/therapists/markias-kaiyan-littlejohn-sex-mental-health-therapist-san-francisco-ca/387891

Conclusion

A person's sexual health is connected to their overall wellness. Taking care of our bodies includes maintaining our sexual health. Regular checkups and preventative treatments, along with getting support from a knowledgeable practitioner when issues arise is important. Quality sex education that is inclusive and empowering of our bodies exactly how they are is a part of sexual wellness. There are ways our bodies change over time and sexual desire or libido does fluctuate. Sometimes desire is hindered by things that have nothing to do with our physical bodies so being attuned to how we are feeling emotionally is a big part of sexual health.

Glossary

1. **Sexual health**: fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries

2. **Prostate gland**: A gland located below the bladder that produces the fluid that nourishes and helps to transport sperm.
3. **Libido**: our desire for sex
4. **Premature ejaculatio**n: There are a variety of definitions. The consensus is that ejaculation is premature if it is sooner than desired.
5. **BDSM**: an umbrella term that refers to a variety of erotic practices that may involve bondage and discipline, dominance and submission, sadism and masochism
6. **Drug holidays**: plan sexual activity around times when the effect of the medication is at its lowest
7. **Erectile dysfunction**: challenges with obtaining and/or maintaining penile erection.
8. **Sex therapist**: therapist who specializes in sexuality.
9. **Vaginal dryness**: happens when estrogen levels drop and vaginal tissue thins and becomes more delicate.
10. **American Association of Sexuality Educators Counselors & Therapists (AASECT)**: a professional organization devoted to the promotion of sexual health. AASECT provides training and certification for sex therapists, counselors and educators.

Discussion Questions

1. Were you taught sex education in high school or middle school? If so, what did you learn? What, if anything, did you feel was missing?
2. Would you feel comfortable talking to a doctor about sexual health concerns? Why or why not?
3. What messages did you receive as a child about sex and sexuality? How do you feel these messages have affected you?
4. If you currently or someday have a child in your life, you are helping to raise, what messages would you want them to receive about sex and sexuality?
5. What are some other ways (other than those listed) one can improve their sexual health?
6. How do you see identities such as race, class, gender and sexual orientation affect people's sexuality?

Multiple Choice

1. Sexual health is associated with happiness, longevity and well-being.

    a. True
    b. False

2. Sexually healthy people:

    a. Embrace their personal expression of their sexuality
    b. Express love and intimacy in appropriate ways
    c. Communicate effectively with partners
    d. All of the above

3. The prostate normally doubles in size during puberty. The prostate gradually begins to enlarge again at what age?

    a. 18
    b. 25
    c. 30
    d. 40

4. Which types medications are shown to affect sexual desire and functioning?

    a. Blood pressure medications
    b. Incontinence medications
    c. Birth control pills
    d. All of the above

5. Libido, our desire for sex, is complex and not easily defined.

    a. True
    b. False

6. What are issues that could limit sexual desire?
    a. Busy schedule/ Fatigue
    b. Happiness
    c. Negative effects of hormonal changes
    d. Both A and C

7. Sexual Health can be improved by:
    a. Eating healthy
    b. Exercising
    c. Getting adequate rest
    d. All of the above

8. The vagina is self-cleaning- No douching or special wipes necessary
    a. True
    b. False

9. Sometimes, people have trouble achieving and/or maintaining an erection. In the medical world, this is referred to as:
    a. Upsetting
    b. Erectile Dysfunction(ED)
    c. COVID 19
    d. The Flu

10. Sexual Activity has a number of health benefits including
    a. Better sleep
    b. Bladder control
    c. Longer life

d. All of the above

For Further Exploration

- Middlesexmd.com- sex ed peri and post menopause
- Scarleteen.com- sex ed for teens & young adults
- Joanprice.com– sex ed for seniors
- Kinkly.com– sex ed for adults
- Kimbritive.com- Sexual Wellness for Black women and girls
- Goodvibes.com – sex ed & shopping
- Spicesensuality.com- local shop Rohnert Park, CA
- ASHASexualhealth.org (American Sexual health Assoc.)

Recommended book: The Black Body in Ecstasy, by Jennifer Nash, https://www.dukeupress.edu/the-black-body-in-ecstasy

Professional Associations for Sexual Health

- *AASECT (American Association of Sexuality Educators Counselors & Therapists) www.aasect.org*
- *SSSS (Society for the Scientific Study of Sexuality) www.sexscience.org*
- *SSTAR (Society for Sex Therapy and Research) www.sstarnet.org*
- *AACAST (American Association of Couples and Sex Therapists) www.aacast.net*
- *WAS (World Association for Sexual Health) www.worldsexology.org*
- *WPATH (World Professional Association of Transgender Health) www. wpath.org*
- *WoCSHN (Women of Color Sexual Health Network) www.wocshn.org*
- *IPSA (International Professional Surrogates Association) www.surrogatetherapy.org*
- *GLMA (Gay Lesbian Medical Association) www.glma.org*
- *ISTI (Integrative Sex Therapy Institute) www.integrativesextherapyinstitute.com*
- *TASHRA (The Alternative Sexualities Health Research Alliance) www.tashra.org*
- *CARAS (Community Academic Consortium for Research on Alternative Sexualities) www.carasresearch.org*

- *ISEE (Institute for Sexuality Education & Enlightenment) instituteforsexuality.com*
- *ISSWSH (International Society for the Study of Women's Sexual Health) www.isswsh.org*
- *APA (American Psychological Association) www.apa.org/topics/sexuality*

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Chapter 14: Consent, Coercion, and Sexual Violence

Photo by Markus Spiske on Unsplash

Learning Objectives

After completing this module, students should have a working knowledge of:

- Consent
- Sexual coercion in its many forms
- Preventing sexual assault through cultural shifts on gendered behavior
- Current events
- Sexual violence support services

Introduction

Chapter content warning. Possible trigger. The following chapter will examine consent, sexual coercion, and different sexual assaults including, rape, incest, human trafficking, and forced prostitution. We will discuss current events and propose solutions to end sexual violence. This chapter will cover some material that

the reader may find upsetting. Proceed with caution, and be sure to practice self-care, however that looks for you.

Consent

We've touched on consent throughout this book and the ways it gets complicated by power and privilege. Being communicative about what is ok and not ok throughout an intimate encounter is necessary for consent to authentically occur. Often, this is not adequately addressed, and then the encounter becomes coercive in some form. This chapter will be discussing some ways in which this coercion plays out. It is important to understand and distinguish between consent and non-consent, in any relationship between individuals who wish to participate in any sexual act. An introduction to understanding consent can be seen in this video previously mentioned in Chapter 4, Tea Consent. **Consent** can be defined as "an agreement between participants to engage in sexual activity… [and] should be clearly and freely communicated" (What Consent Looks Like, n.d.).

Consent in Relationships

In relationships, it is mandatory to ask for consent, regardless of the duration or status of the relationship. It is expected that you get your partner's consent *every time* you initiate a sexual act. People have the right to change their minds at any time, even during a sexual act, and even if they agreed to something once before, does not mean they will feel the same in the future; consent to one sexual activity does not guarantee consent to every sexual activity [thereafter] (Secretary of State for the Home Department, n.d.).

In healthy relationships, partners are able to communicate comfortably, continuously, and honestly, and inform one another of their desired levels of physical activity, from hand holding to touching, and/or having intercourse (What is Sexual Coercion, n.d). When getting physical with a crush, romantic partner, significant other, or a hookup, you absolutely have a voice and control over how far you wish to take things, if at all (What is Sexual Coercion, n.d).

Sidebar 14.1: Teaching Consent from a Mother's Point of View

The women in my life who are mothers to young girls often talk about what a scary time it is to have daughters. As a woman, I understand why. But as a mother to a young boy, I feel equally as fearful of the potential future he faces being raised in a society that normalizes and dismisses sexual violence against women. The first time I became aware that I would need to start teaching my son about consent occurred much earlier than I anticipated. When he was about a year and a half old, I was still breast feeding him, and he had gotten into the habit of walking up to me and pulling my shirt down when he wanted to nurse. He was a full blown toddler with a hearty appetite for solid food, meaning breastmilk was no longer his primary source of nutrition, and I no longer needed to nurse on demand. I decided it was time to create some boundaries around when and where I would allow him to nurse. He did not like being told no, and although it was heartbreaking for me to hold these boundaries at first, the more I did it, the more I felt that it was the perfect first opportunity to lovingly teach him about consent and bodily autonomy. As he grows, I make sure to offer plenty of opportunities for him to assert his own bodily autonomy. He knows that if we're playing and he says "no" or "stop", that his words will be honored immediately. He has also never been forced to give kisses or hugs to any family member, including me. I can't know if what I'm doing is "enough" to counterbalance everything he will inevitably be exposed to out in the world. What I do know is that introducing these concepts from a very early age is becoming more and more mainstream, and this gives me great hope for a generation of children who will have a healthy and clear understanding of consent from the start.

-Juliana Garcia, mom of Wylder

Consent in Law

There are legal contexts to be aware of when giving and/or receiving consent. According to the free public resource site, AgeofConsent.net, the legal age of consent in the U.S. varies from 16-18 years old between states, and any sexual relations with someone under the age of consent is illegal and considered **statutory rape**. In California, the legal age of consent is 18 years old and there is no "close in age exemption," a law that decriminalizes consensual sex between those who are underage (AgeofConsent.net, n.d.). Other factors to be taken into consideration with consent include developmental disabilities, intoxication [by alcohol and/or illegal/prescribed drugs], physical disabilities, unconsciousness, vulnerable adults, and the relationship of the victim and perpetrator (Legal Role of Consent, n.d.). Based on all of the above factors, it is understandable that there is confusion with the term consent; therefore, the need for a concrete legal definition is necessary for our judicial system.

There is no single legal definition of consent. RAINN or Rape, Abuse, & Incest National Network, the largest anti-sexual violence organization breaks down the complexities of consent. Each state sets its own definition, either in law or through court cases. In general, there are three main ways that states analyze consent in relation to sexual acts:

- **Affirmative consent:** Did the person express overt actions or words indicating agreement for sexual acts?
- **Freely given consent:** Was the consent offered of the person's own free will, without being induced by fraud, coercion, violence, or threat of violence?
- **Capacity to consent:** Did the individual have the capacity, or legal ability, to consent?

Source: *Legal role of consent*. RAINN. (n.d.). Retrieved February 28, 2022, from https://www.rainn.org/articles/legal-role-consent

In the legal field, one prominent issue is that the definition of consent also varies between states or is altogether lacking, which can be detrimental in prosecuting sexual assault cases. Joyce Short, CEO of Consent Awareness Network (CAN), proposes a legal definition of consent as, "freely given, knowledgeable, and

informed agreement" [**#FGKIA**] and stresses that consent is more complex than yes or no (McCrystal, 2021).

Planned Parenthood also offers an acronym to help define consent, stating "consent is as easy as FRIES":

- **Freely given.** Consenting is a choice you make without pressure, manipulation, or under the influence of drugs or alcohol.
- **Reversible.** Anyone can change their mind about what they feel like doing, anytime. Even if you've done it before, and even if you're both naked in bed.
- **Informed.** You can only consent to something if you have the full story. For example, if someone says they'll use a condom and then they don't, there isn't full consent.
- **Enthusiastic.** When it comes to sex, you should only do stuff you WANT to do, not things that you feel you're expected to do.
- **Specific.** Saying yes to one thing (like going to the bedroom to make out) doesn't mean you've said yes to others (like having sex) (Sexual Consent, n.d.).

yes means yes, no means no by louisa_catlover

Communication is key. Yes means yes.

In an effort to combat sexual assault in college and how they are handled, the affirmative consent campaign, or "Yes Means Yes" (SB-967) was proposed to the senate. Our society has a deep history of protecting perpetrators, and silencing and

blaming survivors. In 2014, California was the first state to sign the bill SB-967 into law. The law requires all colleges receiving state funding to have policies that "adopt an affirmative consent standard to be used when investigating sexual assault complaints and proceeding through the disciplinary process" (Emba, 2015). **Affirmative consent** is defined as:

a knowing, voluntary, and mutual decision among *all* participants to engage in sexual activity. Consent can be given by words or actions, as long as those words or actions create clear permission regarding willingness to engage in the sexual activity. Silence or a lack of resistance does not demonstrate consent. The definition of consent does not vary based upon a participant's sex, sexual orientation, gender identity, or gender expression (SUNY, n.d.).

This further breakdown of consent is a necessary step to protect all survivors of assault, and teach sexually active individuals what consent looks and sounds like, compared to when they are not. While there is progress among state and local governments in adopting policies such as these to end sexual violence, it is imperative that our society as a whole understands the boundaries of consent and when it has been breached, therefore, ending victim-blaming and establishing a new standard for solutions.

#METOO

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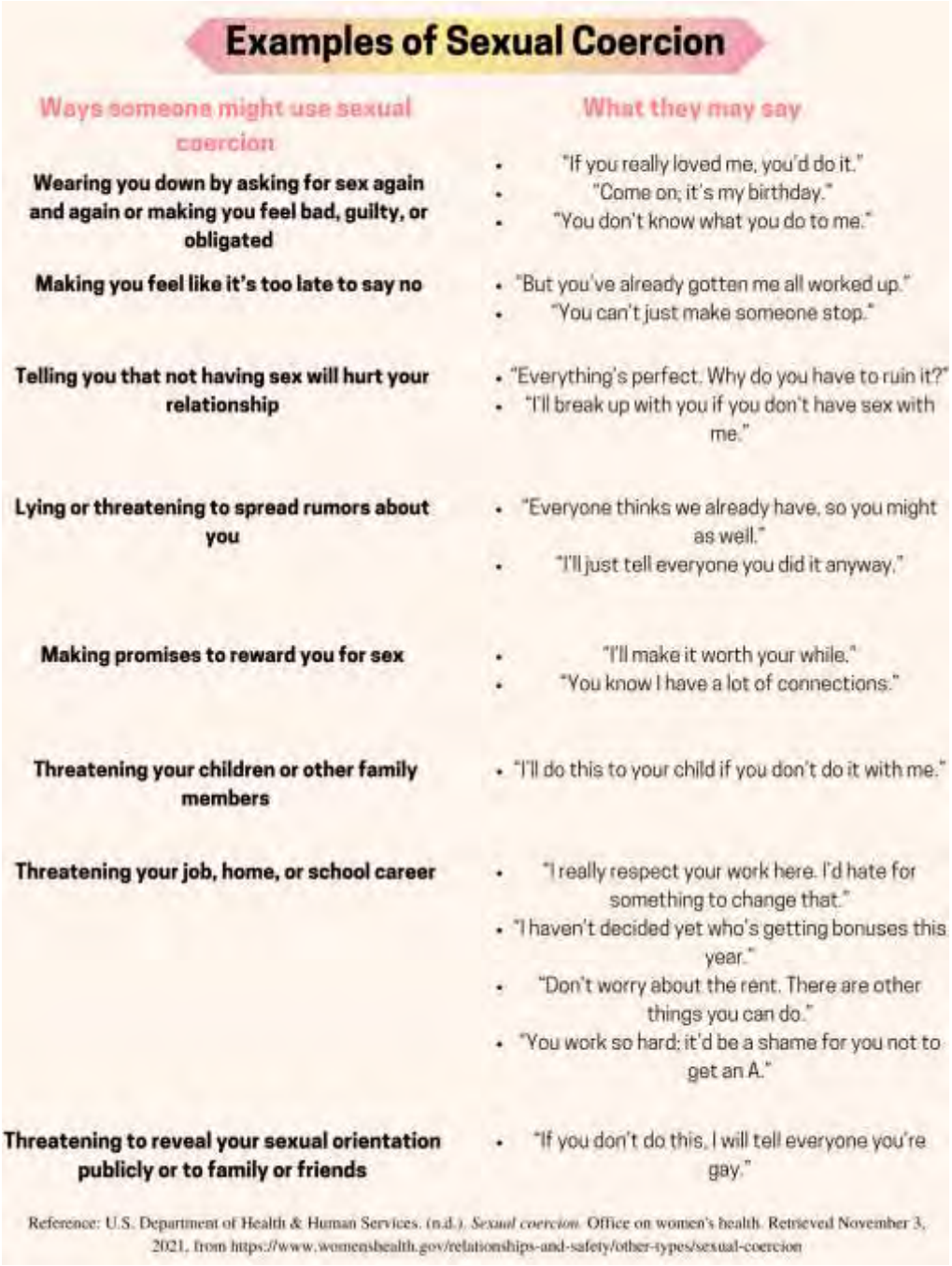
#MeToo is a social movement against sexual abuse, sexual harassment, and rape culture, in which people publicize their experiences of sexual abuse or sexual harassment. The phrase "Me Too" was initially used in this context on social media in 2006, on Myspace, by sexual assault survivor and activist Tarana Burke. Burke highlighted the fact that sexual violence knows no race, class, or gender, but the response to sexual violence does. The #metoo movement has brought voice to sexual assault survivors and served as a support for those who have been negatively impacted by sexual assault. As with all other aspects of social stratification, those who carry greater privilege have always received better treatment under the eyes of the law. Women of color experience lesser support and belief by others that it took place when reporting sexual assault or harassment than white women. Structural racism and misogyny are often to blame for these differing responses. Because of white privilege and an expectation of the law being there to protect them, studies have found that white women are more likely to report incidents than women of color. These discrepancies disadvantage women of color, and make getting support harder (Berdahl and Moore, 2006). The #metoo movement recognizes that these cultural hierarchies stand in the way of true progress for all of us who have experienced sexual assault. While this movement was started to support those often unheard voices of the marginalized, it is embedded within larger cultural scripts around who is a legitimate victim and who is an abuser, which is inherently problematic. Shifting the focus from specific individuals who were hurt or who hurt someone to an examination of the social structure that maintains rape culture can help move in a direction where sexual violence is less prevalent. In that regard, #METOO has helped to push legislation forward in terms of workplace harassment policies, and has opened the door for more people to share their stories.

Sexual Coercion

You should now have a clearer understanding of healthy relationships and that consent must be prevalent within them. We will now examine sexual coercion and how it can present in relationships and environments you may be in. **Sexual coercion** is, "'the act of using pressure, alcohol or drugs, or force to have sexual contact with someone against their will" and includes "persistent attempts to have sexual contact with someone who has already refused"' (What is Sexual Coercion, n.d.).

Sexual coercion can range from someone wearing you down verbally into consent, using actual force, to using guilt or shame tactics in order to have sexual contact with them (What is Sexual Coercion, n.d.). Those who attempt to coerce can be a spouse, employer, or friend for example.



Examples of Sexual Coercion

Ways someone might use sexual coercion	What they may say
Wearing you down by asking for sex again and again or making you feel bad, guilty, or obligated	• "If you really loved me, you'd do it." • "Come on; it's my birthday." • "You don't know what you do to me."
Making you feel like it's too late to say no	• "But you've already gotten me all worked up." • "You can't just make someone stop."
Telling you that not having sex will hurt your relationship	• "Everything's perfect. Why do you have to ruin it?" • "I'll break up with you if you don't have sex with me."
Lying or threatening to spread rumors about you	• "Everyone thinks we already have, so you might as well." • "I'll just tell everyone you did it anyway."
Making promises to reward you for sex	• "I'll make it worth your while." • "You know I have a lot of connections."
Threatening your children or other family members	• "I'll do this to your child if you don't do it with me."
Threatening your job, home, or school career	• "I really respect your work here. I'd hate for something to change that." • "I haven't decided yet who's getting bonuses this year." • "Don't worry about the rent. There are other things you can do." • "You work so hard; it'd be a shame for you not to get an A."
Threatening to reveal your sexual orientation publicly or to family or friends	• "If you don't do this, I will tell everyone you're gay."

Reference: U.S. Department of Health & Human Services. (n.d.). *Sexual coercion*. Office on women's health. Retrieved November 3, 2021, from https://www.womenshealth.gov/relationships-and-safety/other-types/sexual-coercion

There can be instances of coercion within relationships, such as **reproductive coercion** along with sexual coercion. This can be defined as, “pressuring someone to have sex or messing with their birth control to cause a pregnancy” (What is sexual and reproductive control, n.d.). Examples of reproductive coercion can include: breaking condoms, lying about using birth control, forcing a partner to have an abortion, or carrying a pregnancy to term (What is sexual and reproductive control, n.d.). If you are in a relationship, that does not mean you have to partake in sexual activities out of duty or because you are in love [that is coercion]; if you are forced to have sex, it is rape **(**What is sexual and reproductive control, n.d.). **Rape** is a form of sexual assault, that can be defined as, sexual penetration without consent (Sexual Assault, n.d.).

When consent is not granted or forced upon an individual, a physical boundary has been breached, and a sexual assault has been committed.

There is a huge cultural difference in terms of which acts are criminalized and punished. The word “rape” is defined differently in different cultures. In some cultures, spousal rape does not exist from a legal standpoint.

Sidebar 14.2: There's No Escaping It

I've lived a long life in this body, and have experienced many different coercive situations in which I have had a sexual encounter that was unwanted. Whatever the coercive factors may be, being pressured into doing something you don't want to do is traumatizing. At this point in my life, there are too many to count, but as I reflect back on a recent encounter, I am filled with sadness. He was one of my best friends. The loss of our friendship is one of the things I still grieve.

We were colleagues of over 10 years, and shared a passion for social justice. We were presenting together at a conference and had a shared room with two beds in a hotel. I was having a great time hanging out with my buddy and talking late into the night. On the first night he asked if we could have sex. He went into this long fantasy he'd been having about being with me sexually and that he wanted to tell his wife that he wanted an open relationship and that I could be his regular hookup when he was in town. I said no. He persisted. I said no. On the second night after our presentation a group went out and had dinner and drinks and when we got back to the room he asked again. I said no. He persisted, and persisted. I was pretty drunk and tired of him persisting. I said yes. We began, and part way through I said no. He stopped but continued to bring it up. I finally fell asleep, but when I woke up in the morning, he seemed to feel entitled to a more intimate friendship than I was comfortable with. He was seriously envisioning a continued hookup. It became clear that I could not retain what I thought was a solid friendship, and that much of our past work collaborations and connections was based in his desire to have a sexual relationship. Not only do I feel sad about losing a friend, I feel duped. I thought that for all these years, he viewed me as a valuable colleague, but in reality, he was just waiting to hook up.

Coercive encounters are often enhanced by gender scripts that we feel the need to follow. For me, I didn't want to hurt his feelings because I am supposed to be nice. Additionally, my work is within a predominantly cis-white male field, and my validity as a scholar gets called into question regularly, which feeds into my imposter syndrome. So when I realized that that was his objective all along, and that he did not see me as a respected colleague, it reinforced the notion that I don't belong.

Sexual Violence (SV)

"Sexual violence disproportionally affects the most vulnerable in society: children, women, and lesbian, gay, bisexual, transgender, and queer or questioning individuals" (Waechter, 2021).

Sexual violence (SV) is defined as, "any sexual contact or behavior occurring without the explicit consent of the victim" (Sexual Assault, n.d.). In other words, any unwanted sexual contact is sexual violence.

The National Sexual Violence Resource Center (NSVRC), which is founded by the Pennsylvania Coalition Against Rape, offers many resources about SV ."Social norms that condone violence, use power over others, traditional constructs of masculinity, the subjugation of women, and silence about violence and abuse contribute to the occurrence of sexual violence" (About Sexual Assault, n.d.). It is widely recognized that SV can occur in every community and affect anyone of any age, and SV has a deep cultural and social context surrounding it.

The NSVRC also offers an extensive list of types of SV that can occur, such as:

- Rape or sexual assault
- Child sexual assault and incest
- Sexual assault by a person's spouse or partner
- Unwanted sexual contact/touching
- Sexual harassment
- Sexual exploitation and trafficking
- Exposing one's genitals or naked body to others without consent
- Masturbating in public
- Watching someone engage in private acts without their knowledge or permission
- Nonconsensual image sharing (About Sexual Assault, n.d.).

When we consider interpersonal violence of all kinds—homicide, assault, robbery, rape, and sexual assault—men are more likely than women to be victims of violence. While true, this fact obscures another fact: women are far more likely than men to be raped and sexually assaulted. They are also much more likely to be portrayed as victims of pornographic violence across mediums, including on the

Internet, in videos, magazines, and other outlets. Finally, women are more likely than men to be victims of *domestic violence,* or violence between spouses and others with intimate relationships. The gendered nature of these acts against women distinguish them from the violence men suffer. Violence is directed against men not because they are men *per se*, but because of anger, jealousy, and the sociological reasons [stemming from] deviance and crime. But rape and sexual assault, domestic violence, and pornographic portrayals of violence are more frequently directed against women precisely *because* they are women. These acts are thus an extreme extension of the gender inequality that women face in other areas of life.

Domestic Violence (DV)

The effects of intimate partner abuse know no boundaries of race, class, orientation etc. It affects a wide array of people, regardless of socioeconomic backgrounds, gender, race, religion, profession, and education levels; however, DV is the leading source of injury amongst women (What is Domestic Violence, 2017). DV is a crime. The Center for Domestic Peace, an organization in Northern California that mobilizes individuals and communities to transform our world, so that domestic violence no longer exists, creating greater safety, justice and equality, has a Checklist to understand the signs of an abusive relationship

Sidebar 14.3: Stories of Harassment from a Cisgender Male

From employers to landlords, I've experienced a fair amount people who have attempted to use power to coerce me into sexual acts or situations. To my surprise, sexual coercion is a common occurrence in my life, even while existing as a cisgender male. I work in the field of politics, more specifically, I manage progressive and democratic campaigns where workplace protection from human resource departments is not always an option.

In 2020, I rented a house in Michigan, where my landlord made constant attempts to have sex with me, taking advantage of the fact that I lived next door, and that he recognized me from Grindr. More recently, I worked with a manager from a voter contact program, who consistently and unapologetically discussed sex acts, commented on my physical appearance, as well as the appearances of other staff members. One memorable morning, I received an apology from the manager for his sexually exploitative comments, which was short-lived, as the apology was immediately followed by a comment that expressed his sexual admiration for one of the consultants who worked with the campaign.

Admittedly, I've experienced sexual harassment far less than many of the women and gender non-conforming people in my life, and the persistent level of sexual persuasion and intimidation experienced by all genders is sickening and tiring.

Maybe it is my chronic idealism and male privilege that allows me to hope for a future without sexual exploitation, but I believe that newer generations will be far more inclusive and socially responsible than the typically older generations who incorporate sexual harassment in their daily activities.

Sexual Harassment

Sexual harassment as defined by federal guidelines and legal rulings and statutes, consists of unwelcome sexual advances, requests for sexual favors, or physical conduct of a sexual nature used as a condition of employment or promotion, or that interferes with an individual's job performance and creates an intimidating or hostile environment (National Sexual Violence Resource Center, n.d.).

Sexual harassment can be of one of two forms:

1. Quid pro quo (a person in a position of power offers rewards in exchange for sex
2. Hostile environment (other people's words/actions of sexual nature create an abusive situation for the victim)

Although anyone can be, and are, sexually harassed, women are more often the targets of sexual harassment, which is often considered a form of violence against women. This gender difference exists for at least two reasons, one cultural and one structural. The cultural reason centers on the depiction of women, as depicted in mass media, and the [gendered] socialization of men. Women are still depicted in our culture as sexual objects who exist for men's pleasure. At the same time, our culture socializes men to be sexually assertive. These two cultural beliefs combine to make men believe that they have the right to make verbal and physical advances to women in the workplace. When these advances fall into the guidelines listed here, they become sexual harassment (National Sexual Violence Resource Center, n.d.).

The second reason most targets of sexual harassment are women is more structural. Reflecting the gendered nature of the workplace and of the educational system, typically the men doing the harassment are in a position of power over the women they harass. A male boss harasses a female employee, or a male professor harasses a female student or employee. These men realize that subordinate women may find it difficult to resist their advances for fear of reprisal; a female employee may be fired or not promoted, and a female student may receive a bad grade.

How common is sexual harassment?

This is difficult to determine, as the men who do the sexual harassment are not about to shout it from the rooftops, and the women who suffer it often keep quiet because of the repercussions just listed. But anonymous surveys of women employees in corporate and other settings commonly find that 40%–65% of the respondents report being sexually harassed (Rospenda, et al., 2009). In a survey of 4,501 women physicians, 36.9% reported being sexually harassed either in medical school or in their practice as physicians (Frank, et al., 1998).

Sidebar 14.4: Understanding Rape in a Cultural Context

Susan Griffin (1971, p. 26)Griffin, S. (1971, September). Rape: The all-American crime. *Ramparts, 10*, 26–35. began a classic essay on rape in 1971 with this startling statement:

> "I have never been free of the fear of rape. From a very early age I, like most women, have thought of rape as a part of my natural environment—something to be feared and prayed against like fire or lightning. I never asked why men raped; I simply thought it one of the many mysteries of human nature."

Rape

Rape is a type of sexual assault, usually involving sexual intercourse or other forms of sexual penetration carried out without that person's consent. Information here about the extent and nature of rape and reasons for it comes from three sources: the FBI Uniform Crime Reports and the National Crime Victimization Survey (NCVS), and surveys of and interviews with women and men conducted by academic researchers. From these sources, we will provide information about how much rape occurs, the context in which it occurs, and the reasons for it.

What do we know about rape?

About 20%–30% of women college students in anonymous surveys report being raped or sexually assaulted (including attempts), usually by a male student they knew beforehand (Fisher, et al, 2000; Gross, et al, 2006). Thus, at a campus of 10,000 students, of whom 5,000 are women, about 1,000–1,500 will be raped or sexually assaulted over a period of 4 years, or about 10 per week in a 4-year academic calendar.

The public image of rape is of the proverbial stranger attacking someone in an alleyway. While such rapes do occur, most rapes actually happen between people who know each other. A wide body of research finds that 60%–80% of all rapes and sexual assaults are committed by someone the person knows, including ex-spouses and only 20%–35% by strangers (Barkan, 2012). Barkan, S. E. (2012). *Criminology: A sociological understanding* (5th ed.). Upper Saddle River, NJ: Prentice Hall. A person is

thus two to four times more likely to be raped by someone they knows than by a stranger.

Sociological explanations of rape fall into cultural and structural categories. Various "rape myths" in our culture support the absurd notion that women somehow enjoy being raped, want to be raped, or are "asking for it" (Franiuk, et al., 2008). One of the most famous scenes in movie history occurs in the classic film *Gone with the Wind*, when Rhett Butler carries a struggling Scarlett O'Hara up the stairs. She is struggling because she does not want to have sex with him. The next scene shows Scarlett waking up the next morning with a satisfied, loving look on her face. The not-so-subtle message is that she enjoyed being raped or that she changed her mind and therefore women may need a little coercion to be convinced..

A related cultural belief is that women somehow ask or deserve to be raped by the way they dress or behave. If she dresses attractively or walks into a bar by herself, she wants to have sex, and if a rape occurs, well, then, what did she expect? In the award-winning film *The Accused*, based on a true story, actress Jodie Foster plays a woman who was raped by several men on top of a pool table in a bar. The film recounts how members of the public questioned why she was in the bar by herself if she did not want to have sex. They ultimately blamed her for being raped.

A third cultural belief is that a man who is sexually active with a lot of women is a stud. Although this belief is less common presently, it is still with us. A man with multiple sex partners continues to be the source of envy among many of his peers. At a minimum, men are still the ones who have to "make the first move," and then continue making more moves. There is a thin line between being sexually assertive and sexually aggressive (Kassing et al, 2005). Gender role conflict, homophobia, age, and education are seen as predictors of male rape myth acceptance. *Journal of Mental Health Counseling, 27*(4), 311–328.

These three cultural beliefs—that women enjoy being forced to have sex, that they ask or deserve to be raped, and that men should be sexually assertive or even aggressive—combine to produce a cultural recipe for rape. Although most men do not rape, the cultural beliefs and myths just described help account for the rapes that do occur. Recognizing this, the contemporary women's movement began attacking these myths back in the 1970s, and the public is much more conscious of the true nature of rape than a generation ago. That said, much of the public still accepts these cultural beliefs and myths, and prosecutors continue to find it difficult to win jury convictions in rape trials unless the woman who was raped had

suffered visible injuries, had not known the man who raped her, and/or was not dressed attractively (Levine, 2006). Racism also factors into rape trial outcomes. For instance, when the victim is white and the accused is Black, the chance of conviction is much higher than in the reverse situation, or if both were either white or Back. This speaks to the larger issue of racism in our criminal justice system.

Structural explanations for rape emphasize the power differences between women and men. In societies that are male-dominated, rape and other violence against women is a likely outcome, as they allow men to demonstrate and maintain their power over women. Supporting this view, studies of preindustrial societies and of the 50 states of the United States find that rape is more common in societies where women have less economic and political power (Baron & Straus, 1989; Sanday, 1981). Poverty is also a predictor of rape: although rape in the United States transcends social class boundaries, it does seem more common among poorer segments of the population than among wealthier segments, as is true for other types of violence (Rand, 2009). Some scholars have postulated that the higher rape rates among the poor stem from poor men who have been emasculated by the capitalist system trying to prove their "masculinity" by taking out their economic frustration on women (Martin, Vieraitis, & Britto, 2006).Approximately 4 out of 5 rapes are committed by someone known to the survivor.

- 82 percent of sexual assaults are perpetrated by a non-stranger.
- 47 percent of rapists are a friend or an acquaintance.
- 25 percent are an intimate partner.
- 5 percent are a relative.

Sidebar 14.5: More From RAINN on Sexual Violence Statistics

Below are some devastating statistics that speak to the magnitude of sexual violence:

- Every 68 seconds an American is sexually assaulted
- The majority of victims are under 30 years old
- 1 out of every 6 American women have been the victim of an attempted or completed rape in her lifetime
- About 3% of American men—or 1 in 33—have experienced an attempted or completed rape in their lifetime
- 1 out of every 10 rape victims are male
- 21% of TGQN (transgender, genderqueer, nonconforming) college students have been sexually assaulted, compared to 18% of non-TGQN females, and 4% of non-TGQN males
- American Indians are twice as likely to experience a rape/sexual assault compared to all races.
- 6,053 military members reported experiencing sexual assault during military service in FY 2018. DoD estimates about 20,500 service members experienced sexual assault that year (Victims of Sexual Violence, n.d.).

For further in-depth statistics, please visit Victims of Sexual Violence: Statistics | RAINN

Rape Culture

Ranger Cervix & Jaime Chandra of 11th Principle: Consent! 2016. Creative Commons Attribution-Share Alike 4.0

Gender role stereotyping often conflates being a man with being violent. The myth of heterosexual sex as a conquest or an adversarial interaction sets the stage for coercion and lack of consent. An acceptance of violence in interpersonal relationships help create a climate that encourages many types of violence, including rape. By following a social script that asks males to be tough and dominant, young men learn that it's okay to control women. Rape culture normalizes, trivializes, and denies rape and blames, slut-shames, and dismisses the pain of survivors. As a result of this, survivors are often hesitant to come forward. It is estimated that anywhere from 60-80% of rapes go unreported, making it the most under-reported crime (National Sexual Violence Resource Center, 2018). When survivors come forward, they risk social and psychological consequences such as re-traumatization and victim blaming. In *The Opposite of Rape Culture is Nurturance Culture* published in 2016 Nora Samaran writes "Survivors are punished from all sides. People cut ties with them, shame them, and force them to

relive the experience over and over while doubting and questioning them on every point" (Samaran, 2016).

Responses to rape culture have involved decriminalizing assaults, since many see the criminal justice system as non-consensual, racially biased and ineffective. An eye for an eye has done so much collateral damage. People who are hurt may want those who hurt them to take accountability for what they did, and restorative justice can be an alternative that allows for such accountability.

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In other efforts to call out rape culture and slut shaming, slut walks have been marches designed to combat the stigma surrounding women and sexuality. The first slut walk took place in 2011 in Toronto, Canada. The marches are usually made up of young women, often wearing clothes considered to be "slutty." Slutwalks around the world take a variety of forms; sometimes there are speaker meetings and workshops, live music, sign-making sessions, leafleting, open microphones, chanting, dances, martial arts, and receptions or after-parties. Oftentimes, survivors speak of their assaults for the first time at events such as these.

"Date Rape Drugs"

One of the great things about being in college is having the chance to meet and get to know so many new people. Sadly, through this process many students are sexually assaulted. The National Crime Victimization Survey (NCVS) found that

approximately 1 in 4 college women will be sexually assaulted while in school. One very real risk on college campuses—and elsewhere—is the use of date rape drugs in order to commit sexual assaults. Date rape drugs are powerful and dangerous drugs that can be slipped into your drink when you are not looking. The drugs often have no color, smell, or taste, so you can't tell if you are being drugged. The drugs can make you become weak and confused—or even pass out—so that you are unable to refuse sex or defend yourself. If you are drugged, you might not remember what happened while you were drugged. Date rape drugs are used on anyone regardless of gender. There are now a variety of test strip products on the market that can identify their presence. Some colleges have begun offering these products free to students, along with suggested practices to keep yourself safe.

The three most common date rape drugs are Rohypnol, GHB, and Ketamine:

- Rohypnol comes as a pill that dissolves in liquids. Some are small, round, and white. Newer pills are oval and green-gray in color. When slipped into a drink, a dye in these new pills makes clear liquids turn bright blue and dark drinks turn cloudy. But this color change might be hard to see in a dark drink, like cola or dark beer, or in a dark room. Also, the pills with no dye are still available. The pills may be ground up into a powder.
- GHB has a few forms: a liquid with no odor or color, white powder, and pill. It might give your drink a slightly salty taste. Mixing it with a sweet drink, such as fruit juice, can mask the salty taste.
- Ketamine comes as a liquid and a white powder.

These drugs also are known as "club drugs" because they tend to be used at dance clubs, concerts, and "raves." The term "date rape" is widely used to describe sexual crimes involving these drugs, but most experts prefer the term "drug-facilitated sexual assault." These drugs are also used to help people commit other crimes, like robbery and physical assault. The term "date rape" can be misleading, because the person who commits the crime might not be dating the victim. Rather, it could be an acquaintance or stranger.

Alcohol and Other Drugs

Alcohol is also a drug that's commonly used to help commit sexual assault. Be aware of the risks you take by drinking alcohol at parties or in other social situations. When a person drinks too much alcohol:

- It's harder to think clearly.
- It's harder to set limits and make the same choices you would if you were sober.
- It's harder to tell when a situation could be dangerous.
- It's harder to say "no" to sexual advances.
- It's harder to fight back if a sexual assault occurs.
- It's possible to blackout and have memory loss.

The club drug "ecstasy" (MDMA) has been used to commit sexual assault. It can be slipped into someone's drink without the person's knowledge. Also, a person who willingly takes ecstasy is at greater risk of sexual assault. Ecstasy can make a person feel "lovey-dovey" toward others. As with alcohol, it also can lower a person's ability to give consent. Once under the drug's influence, a person is less able to sense danger, or to resist a sexual assault.

Even if a survivor of sexual assault drank alcohol or willingly took drugs, that person is **not** at fault for being assaulted. You cannot "ask for it" or cause it to happen. Still,

it's important to be vigilant and take precautionary steps to avoid putting yourself at risk. Some ways to protect yourself:

- Don't accept drinks from other people.
- Open containers yourself.
- Keep your drink with you at all times, even when you go to the bathroom.
- Don't share drinks.
- Don't drink from punch bowls or other common, open containers. They may already have drugs in them.
- If someone offers to get you a drink from a bar or at a party, go with the person to order your drink. Watch the drink being poured and carry it yourself.
- Don't drink anything that tastes or smells strange. Remember, GHB sometimes tastes salty.
- Have a non-drinking friend with you to make sure nothing happens.
- If you realize you left your drink unattended, pour it out.
- If you feel drunk and haven't drunk any alcohol—or, if you feel like the effects of drinking alcohol are stronger than usual—get help right away.

How and Where to Get Help

If you or someone you know has been assaulted, it's important to get help immediately. No one should suffer in silence and if you are planning to take legal action, time is of the essence in terms of gathering evidence. Take the following steps if you or someone you know has been raped, or you think you might have been drugged and raped:

- Get medical care right away. Call 911 or have a trusted friend take you to a hospital emergency room. Don't urinate, douche, bathe, brush your teeth, wash your hands, change clothes, or eat or drink before you go. These things may give evidence of the rape. The hospital will use a "rape kit" to collect evidence.
- Call the police from the hospital. Tell the police exactly what you remember. Be honest about all your activities. Remember, nothing you did—including drinking alcohol or doing drugs—can justify rape.

- Ask the hospital to take a urine (pee) sample that can be used to test for date rape drugs. The drugs leave your system quickly. Rohypnol stays in the body for several hours and can be detected in the urine up to 72 hours after taking it. GHB leaves the body in 12 hours. Don't urinate before going to the hospital.
- Don't pick up or clean up where you think the assault might have occurred. There could be evidence left behind—such as on a drinking glass or bed sheets.
- Get counseling and treatment. Feelings of shame, guilt, fear, and shock are normal. A counselor can help you work through these emotions and begin the healing process. Calling a crisis center or a hotline is a good place to start. One national hotline is the **National Sexual Assault Hotline at 800-656-HOPE**. (Sexual Assault, 2020).

Incest

Incest is defined as sexual relations between people classed as family members or close relatives. Typically, this includes sexual activity between people who are blood related, or by marriage in the case of step-families. Most cultures have some taboo against incestuous relationships, although they vary between present day and historically. Of concern primarily would be the coercive potential of a family member asserting dominance over another family member in order to engage in a sexual encounter. This would be sexual assault and in the case of a minor child, **child molestation** which is a crime of any sexual act with a minor. Laws against incest likely arose after people observed the consequences of the ways in which certain health problems tended to run in families. Procreating with people who are in the same gene pool reduces the amount of genetic variation.

Incest between siblings is the most common form, with father-daughter being second most (Finkelhor, 1990). Children learn by experimenting and exploring in other realms of their lives, so sexual exploration, alone or with peers, is part of that. A parent's role is to scaffold their child's learning by providing healthy sex education that includes specific social and personal boundaries. This type of sex education can empower children to have agency over their bodies. Incest between siblings is the most common form; it may result out of natural curiosity and be non-coercive, and is seen as more innocuous than parent child (Finkelhor, 1990).

It may also be a form of abuse. Sibling sexual abuse (SSA) has been defined as sexual behavior between siblings that is not age appropriate, not motivated by natural mutual curiosity and usually happens more than once (Bertele & Talmon, 2021; Tener et al., 2021; Watts, 2020). It does not necessarily include physical force, but often involves coercion (Bertele & Talmon, 2021). In the context of SSA, sibling can refer to children that are raised together in a household. They could be biological siblings, step or half siblings, cousins, foster siblings or other children who live together (Watts, 2020).

According to Bertele and Talmon (2021) there is not one clear definition of SSA. It is sometimes confused with mutual consensual sibling sexual behavior that is part of healthy sexual development, which also has an unclear definition. Due to this confusion, sometimes what is abuse might get minimized by families, social workers or others who see it as natural sibling play (Bertele & Talmon, 2021; McCoy et al., 2021; Tidefors et al., 2010).

SSA may include "intercourse, attempted intercourse, oral–genital contact, fondling of genitals directly or through clothing, exhibitionism, exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography" (Caffaro, 2017, p. 544).

Although it is thought to be the most common type of child sexual abuse, there is much silence around sibling sexual abuse (SSA), even more so than other interfamilial sexual abuse (Caffaro, 2017; Tener et al., 2021; Tidefors et al., 2010; Watts, 2020; Yates, 2020). There is evidence internationally that sibling abuse often goes unrecognized or is minimized by professionals from education, health and social care (Yates, 2020).

Any form of incest violates cultural taboos, and most societies sanction the behavior in differing ways. If the incest is between an adult and a minor, it is always considered child sexual abuse.

Human Trafficking and Forced Prostitution

Figure 10.16.6 - A world map showing countries by prevalence of female trafficking Main articles: Human trafficking and Forced prostitution

Human trafficking refers to the acquisition of persons by improper means, such as force, fraud or deception, with the aim of exploiting them. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children states that:

"Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs".

Because of the illegal nature of trafficking, reliable data on its extent is very limited. The WHO states that: "Current evidence strongly suggests that those who are trafficked into the sex industry and as domestic servants are more likely to be women and children." A 2006 study in Europe on trafficked women found that the women were subjected to serious forms of abuse, such as physical or sexual violence, which affected their physical and mental health.

Forced prostitution is prostitution that takes place as a result of coercion by a third party. In forced prostitution, the party/parties who force the victim to be subjected

to unwanted sexual acts exercise control over the victim (Violence Against Women, 2020).

(The above section on Human Trafficking was shared under a not declared license and was authored, remixed, and/or curated by LibreTexts).

Impact of Sexual Violence and Some Statistics

The impact of SV is not solely left with the survivors, but can be felt in society as a whole (About Sexual Assault, n.d.). Consequences from sexual violence can be felt by survivors themselves to loved ones, communities, and society (About Sexual Assault, n.d.). The section below highlights some additional statistics gathered from RAINN (Rape, Abuse & Incest National Network).

"Number of people victimized per year"

- 80,600 inmates sexually assaulted or raped
- 60,000 children were victims of "substantiated or indicated" sexual abuse
- 433,648 Americans 12 and older were sexually assaulted or raped
- 18,900 military personnel experienced unwanted sexual contact
- Every 68 seconds an American is sexually assaulted
- 1 out of every 6 American women has been the victim of an attempted or completed rape in her lifetime (14.8% completed, 2.8% attempted)
- About 3% of American men (or 1 in 33) have experienced attempted or completed rape in their lifetime
- A majority of child victims are 12-17. Of victims under the age of 18: 34% of victims of sexual assault and rape are under age 12, and 66% of victims of sexual assault and rape are age 12-17

"Locations where sexual assault occurs"

- 55% at or near the victim's home
- 15% in an open public place
- 12% at or near a relative's home
- 10% in an enclosed but public area, such as a parking lot or garage

- 8% on school property

“What was the survivor doing when the crime occurred?”

- 48% were sleeping, or performing another activity at home
- 29% were traveling to and from work or school, or traveling to shop or run errands
- 12% were working
- 7% were attending school
- 5% were doing an unknown or other activity

Reference: *Scope of the problem: Statistics.* RAINN. (n.d.). Retrieved February 26, 2022, from https://www.rainn.org/statistics/scope-problem.

Sexual Violence is a Public Health Crisis

An editorial featured in the *American Journal of Public Health,* written by Randall Waechter, explores sexual violence in the U.S. and prevention efforts. In 1996, the World Health Organization declared violence a public health issue, yet despite this, sexual violence is still seen as a criminal justice problem. Rape is among one of the most costly public health issues in the U.S., estimating $1.03 trillion annually, and when factoring in all other forms of sexual violence, it becomes the most costly public health issue. Waechter provides a contrasting comparison between the swiftness and urges into providing a solution for COVID-19, an expensive public health issue as well but considered a "one-time cost," while sexual violence has maintained prevalence in our society because of slow prevention efforts (Waechter, 2021). Waechter's claim is that funding needs to be reallocated and increased to limit the occurrence of sexual violence, and while there is currently no set methodological pathway, the Centers for Disease Control and Prevention (CDC) offers one.

As a teaching and outreach strategy to prevent sexual violence, the CDC offers a combination strategy/approach method which can be remembered eaily with the acronym: **STOP SV**:

S: Promote **Social Norms** that Protect Against Violence. Approach: Bystander Approaches; Mobilizing men and boys as allies.

T: **Teach** Skills to Prevent Sexual Violence. Approach: Social-emotional learning; Teaching healthy, safe dating and intimate relationship skills to adolescents; Promoting healthy sexuality; Empowerment-based training.

O: Provide **Opportunities** to Empower and Support Girls and Women. Approach: Strengthening economic supports for women and families; Strengthening leadership and opportunities for girls.

P: Creative **Protective** Environments. Approach: Improving safety and monitoring in schools; Establishing and consistently applying workplace policies; Addressing community-level risks through environmental approaches.

SV: **Support Victims** / Survivors to Lessen Harms. Approach: Victim-centered services; Treatment for victims of SV; Treatment for at-risk children and families to prevent problem behavior including sex offending (Prevention Strategies, n.d.).

Many of us are fed up with the shame and secrecy around sexual violence, and we understand that it persists precisely because it is shrouded in a cloak of shame. The #MeToo movement began in the United States as a result of this, and it has now reached global populations. Sexual violence happens worldwide, and the world wishes for a place where sexual violence no longer exists. For this to happen, many changes must occur, both systemically and individually. A good start could involve embracing sexual diversity, teaching children to have autonomy over their own bodies, and creating conditions for consensual sex and relationships.

Conclusion

Sexual violence is both personal and political. So many of us have survived assaults, and maybe we know others who have not been as lucky. Much of what was covered in this chapter is difficult to read and perhaps triggering for some. Being clear about consent is an important part of wanted sexual activity. Rape, sexual assault and domestic violence are all forms of coercive sexual activity that is unwanted and punishable by law. There are a number of resources for survivors of sexual assault, and movements like #MeToo seek to shine a light on sexual violence and survivor stories.

Glossary

1. **Affirmative consent**: A knowing, voluntary, and mutual decision among all participants to engage in sexual activity. Consent can be given by words or actions, as long as those words or actions create clear permission regarding willingness to engage in the sexual activity. Silence or lack of resistance, in and of itself, does not demonstrate consent. The definition of consent does not vary based upon a participant's sex, sexual orientation, gender identity, or gender expression (SUNY, n.d.).
2. **Child molestation**: A crime of any sexual act with a minor.

3. **Human trafficking:** The acquisition of persons by improper means such as force, fraud or deception, with the aim of exploiting them.
4. **Incest**: Sexual relations between people classed as family members or close relatives.
5. **Rape:** A form of sexual assault, that can be defined as, sexual penetration without consent (Sexual Assault, n.d.).
6. **Reproductive coercion:** "Pressuring someone to have sex or messing with their birth control to cause a pregnancy" (What is sexual and reproductive control, n.d.).
7. **Sexual coercion**: "'The act of using pressure, alcohol or drugs, or force to have sexual contact with someone against his or her will" and includes "persistent attempts to have sexual contact with someone who has already refused'" (What is Sexual Coercion, n.d.).
8. **Sexual harassment**: Defined by federal guidelines and legal rulings and statutes, consists of unwelcome sexual advances, requests for sexual favors, or physical conduct of a sexual nature used as a condition of employment or promotion or that interferes with an individual's job performance and creates an intimidating or hostile environment.
9. **Sexual violence (SV):** Any sexual contact or behavior occurring without the explicit consent of the victim (Sexual Assault, n.d.). In other words, any unwanted sexual contact.
10. **Statutory rape:** Any sexual relations with someone under the age of consent.

Discussion Questions

1. How does culture relate to our understanding of sexual norms and violations of the norms?
2. This topic is hard to approach. What do you need to practice self-care after this section of the class?
3. If you are in a situation where you or someone you know experienced a sexual assault, what can you do to get support? Be specific based on what you learned here.

4. Discuss the concept of enthusiastic or affirmative consent. How is this concept being used to prevent unwanted sexual encounters?
5. Do you see a way forward to a society without sexual violence? What types of things would need to change?

Multiple Choice

1. According to the free public resource site, AgeofConsent.net, the legal age of consent in the U.S. varies from _____ years old between states

    a. 16-18 Years old
    b. 18-20 Years old
    c. 18-21 Years old
    d. 10-14 years old

2. _____ is the act of using pressure, alcohol or drugs, or force to have sexual contact with someone against their will

    a. Affirmative consent
    b. Freely Given Consent
    c. Sexual Coercion
    d. Capacity to consent

3. _____ is defined as, any sexual contact or behavior occurring without the explicit consent of the victim (Sexual Assault, n.d.). In other words, any unwanted sexual contact

    a. Domestic Violence
    b. Sexual Violence
    c. Sexual Harassment
    d. All of the Above

4. What percentage of female college students reported being raped or sexually assaulted?

    a. 10%-15%
    b. 15%-30%
    c. 20%-40%
    d. 20%-30%

5. What is considered a date rape drug?

    a. Rohypnol
    b. GHB
    c. Ketamine
    d. All of the above

6. Incest refers to sexual relations between people classed as family members or close relatives

    a. True
    b. False

7. Those who are trafficked into the sex industry and as domestic servants are more likely to be men

    a. True
    b. False

8. Silence or lack of resistance, in and of itself, does not demonstrate consent

    a. True
    b. False

9. Pressuring someone to have sex or messing with their birth control to cause a pregnancy is known as

    a. Mean
    b. Reproductive coercion
    c. Ridiculous
    d. Fertility awareness

10. *Slut walks* are

    a. A way to call out rape culture
    b. Patriarchal
    c. Calls out slut shaming
    d. Both A and C

For Further Exploration

(RAINN) National Sexual Assault Hotline at 800.656.HOPE (4673) or chat online: online.rainn.org

https://www.loveisrespect.org/resources/what-is-sexual-coercion/

Marin County: https://centerfordomesticpeace.org/

YouTube:

https://www.youtube.com/watch?v=Wi41cW6Dol4 Coercion, Consent and Sexual Violence | Dr. Felicia Kimbrough | TEDxSIUC

https://www.youtube.com/watch?v=imr5ZiAY_ao When "Yes" Means "No", the Truth about Consent | Joyce Short | TEDxYouth@UrsulineAcademy

https://www.youtube.com/watch?v=yJiKeWtTWA4 Why we need to change the way young men think about consent | Nathaniel Cole | TEDxLondonWomen

https://www.youtube.com/watch?v=m1ziz2y-2mk&t=27s Short commercial type on sending nudes.

https://www.youtube.com/watch?v=jJ9KRJXERlA The Widespread Effects of Sexual Assault | Tilly Musser | TEDxYouth@AnnArbor

Web:

https://www.sscok.edu/ComSafetyPgs/Consent.html#:~:text=What%20does%20consent%20mean%20in,the%20option%20of%20saying%20no. Good overview of consent

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Photo by Markus Spiske on Unsplash. https://unsplash.com/photos/xWYx7TMvodo

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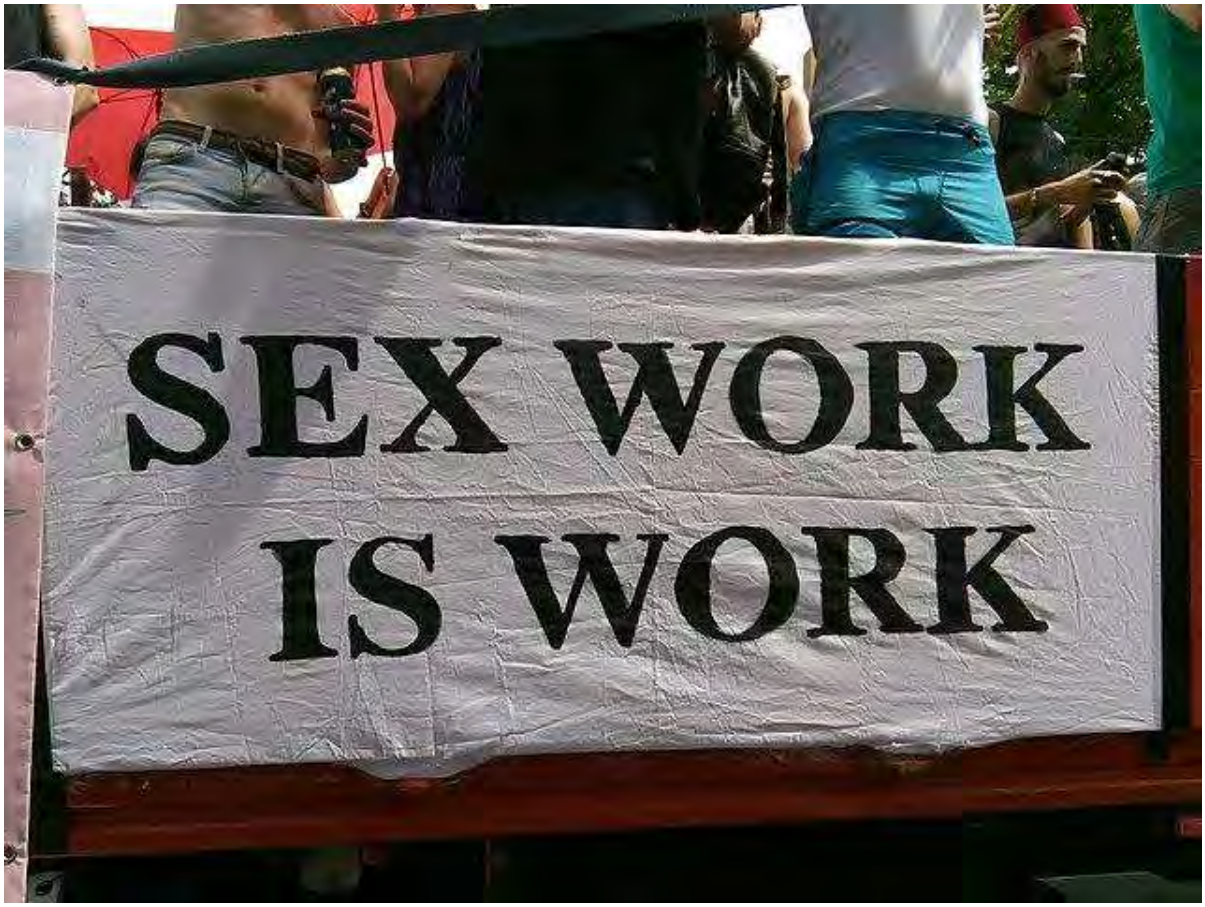
Chapter 15: Sex(uality) Work that Engages with the Body



Learning Objectives

After completing this module, students should have a working knowledge of:

- The varying types of sex(uality) work done
- Stigma around sexually related work that engages with body, intimacy and desire
- Advocacy for sex(uality) workers in the field
- Some examples of what it is like to do sexually related work that engages with body, intimacy and desire

Introduction

You may have heard the term “sex work” before. It is often used as an umbrella term to define work within the sex industry. The sex industry includes both criminalized and decriminalized work selling sexual services. A sex worker is someone working in that industry. Today, we have many categories of sex workers, including escort, sugar baby, stripper, cam girl/boy, porn star, professional dominatrix, etc.

The purpose of sex work is to provide an opportunity for sexual pleasure and gratification. There are other fields of work that engage directly with the body and sexuality with a therapeutic goal instead. These include sexological bodywork and surrogate partner therapy. This is not to say that sex work can’t be therapeutic, and that therapeutic modalities don’t also have the potential to give pleasure and sexual satisfaction, but the difference lies in the intention of the work.

In this chapter, we will explore some of the ways that sex workers, sexological body workers, and surrogate partners all perform work that engages directly with sexuality. We will also address the movement to decriminalize sex work in the United States, and hear stories from people doing the work.

Whether the goal of the work is to titillate and excite, to give sexual pleasure and release, to help someone learn sexual skills and experience physical and emotional intimacy, or to help someone feel good in their body and embrace their sexuality, sex workers and other sexuality-related practitioners play critical roles in the field of sexuality.

The Dream of the Fisherman's wife, Hokusai, 1814, woodblock print, Japanese shunga. Public Domain

Sidebar 15.1: Some Gentle Erotica

I want

To trace between your shoulder blades

To softly rub the nape of your neck and hairline

To kiss the spot below your ear

To watch you close your eyes in exhale —

I want the hot and heavy

The sweet and tender

Like the taste of sweat and the

Humming while tracing your veins

Slow motion enthusiasm

Medicinal shivers

Part time seduction and full time friend

I want to go to cheap motels with you

And wander around odd shops in small towns

Joy in the mundane, warm comfortable silence

Feverish smiles of unabashed honesty

Shall we pick up a dancing class?

Will you stand there while I take a picture?

I want us to go back home

Where you kneel in front of me

The place Where Shame Dies.

-Anonymous

Sexological Bodywork

"Sexological Bodywork is a body-based educational modality that supports individuals, couples, and groups to learn to direct their erotic development and to deepen their erotic wellbeing and embodiment" (Association of Certified Sexological Bodyworkers, 2022).

Sexological bodywork was developed by Joseph Kramer. Kramer is a gay man who was raised by a strictly Catholic family in the 1950s. It was through his own spiritual journey of discovering the importance of connection to the body and sexuality, that he was inspired to create and provide intimacy workshops for gay men during the AIDS epidemic. He saw how gay men's bodies were being associated with disease and fear, and how a lack of touch and affection was having a negative impact on the community (Dewey, 1992).

According to Kramer "We were in the middle of this AIDS epidemic, I can't tell you how horrible it was, it was really horrible and yet there was this joyous thing we were doing. We were light in the darkness truly and yet the darkness affected all of us. It was a wonderful and a terrible time, the most terrible time of my life" (Rose & Rose, 2019, 47:11)

Joseph Kramer began weaving an international fellowship of gay men. It was through these embodied workshops that he formed the idea that later became the field of sexological bodywork. He partnered with his friend Annie Sprinkle (https://anniesprinkle.org/), in order to learn how to do the work with women's bodies as well (Rose & Rose, 2019, 31:25). Today, sexological bodyworkers work with people of all genders.

Sexological Bodyworkers help clients explore arousal and pleasure using a variety of modalities including erotic massage, breathwork, how to teach and manage consent and boundaries, masturbation coaching and pelvic release bodywork. All touch is one way. This means that the bodyworker is touching the client but the client is not touching the bodyworker. It's an opportunity for the client to focus on the feelings in their own body, without any pressure to please a partner.

There are many reasons why people may seek out sexological bodywork. They may be experiencing physical challenges, such as an inability to orgasm, pelvic pain or premature ejaculation. Maybe they want to improve confidence with their sexuality, or let go of feelings of shame around their body. They may be working on sexual trauma recovery. Perhaps they just want to learn to experience more sexual pleasure.

Practitioners follow a Code of Ethics and maintain professional boundaries with clients (Association of Certified Sexological Bodyworkers, n.d.).

Joseph Kramer, founder of Sexological Bodywork

Surrogate Partner Therapy (SPT)

Surrogate Partner Therapy (SPT) is based on the work of sex researchers Masters and Johnson, and uses their technique of sensate focus (touching for one's own pleasure) as a basis for exploring physical intimacy. SPT is a three-way therapeutic relationship between a licensed therapist, a client, and a surrogate partner. It is designed to help the client become more comfortable with intimacy, sensuality, sex and sexuality, and their body. Masters and Johnson were working with couples in their research lab to help resolve sexual difficulties couples were experiencing. They realized that there were people who didn't have partners who also had challenges, so they enlisted surrogates to work with them (Feder, 2014).

The field of SPT, as it is practiced today, has evolved from that original work. Clients and surrogates don't meet in a research lab, and are not observed by researchers taking notes. They meet privately to work on the client's goals. The surrogate

provides a safe container, in which the client can explore both physical and emotional intimacy, and build skills and self-awareness around their sexuality.

The International Professional Surrogates Association (IPSA) provides training and certification to surrogate partners. According to IPSA, a critical part of SPT is that it also involves a therapist. The client, therapist and surrogate work together as a three-way team to help the client achieve their goals. Each time the client meets with the surrogate, they see the therapist after to process the session. The therapist and surrogate communicate in between sessions, and brainstorm on next steps or address any potential or current issues arising for the client (IPSA, 2020).

“SPT is an interwoven program of psychotherapy, sex education, and experiential learning that aims to understand and resolve clients' difficulties with physical, emotional, and sexual intimacy over the course of weeks, months, and sometimes years,” according to Vena Blanchard, one of the founders and current director of IPSA (V. Blanchard, personal communication, 2022, February 23).

Many people who seek out SPT have never had wanted sexual touch, or have had very little sexual experience. The therapy provides them with a safe space to practice what it’s like to be romantic, sensual and erotic with another person. People of all genders may benefit from SPT, but the majority of clients are heterosexual cisgender men, as these are the people most likely to seek it out.

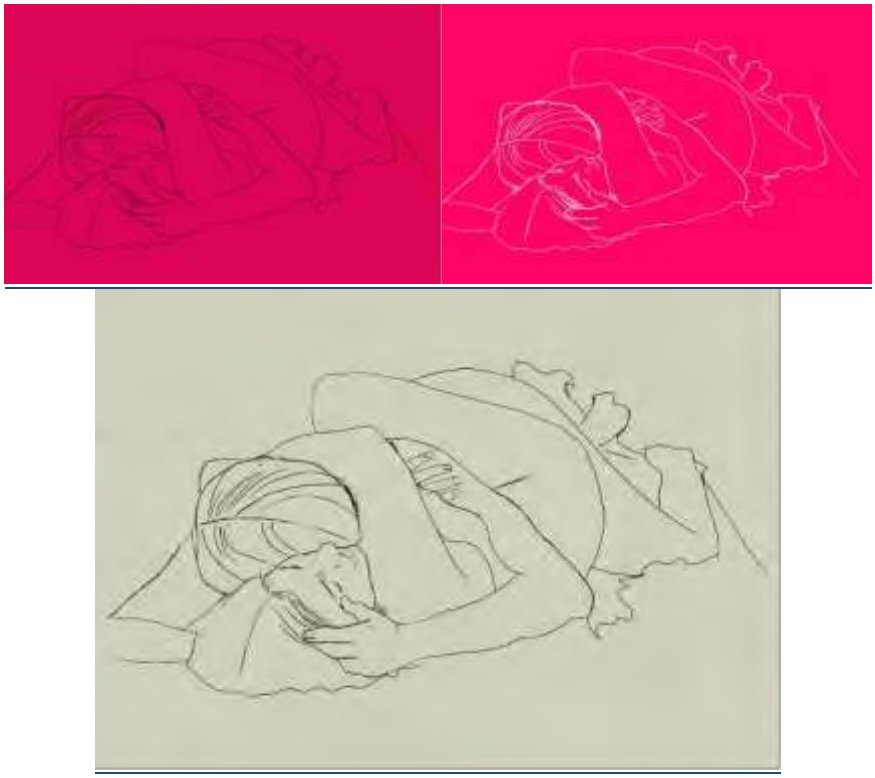
According to one surrogate, “Our job as surrogate partners is to help clients become authentic human beings who accept their birthright to give and receive love, to enjoy affection, to experience sensuality, and to be sexual. I can’t imagine any more meaningful work than this” (Anna, 2016).

SPT can also be helpful for people dealing with erection challenges, premature ejaculation, or anorgasmia (inability to orgasm).

"In the 12 years I've been working as a surrogate partner, it's become clear to me how much people are influenced by societal conditioning about sex, gender, and relationships. An important part of Surrogate Partner Therapy is helping clients move from following ‘scripts’ to acting in a way that is authentic for them,” says Andrew Heartman, certified surrogate partner and cofounder of Surrogate Partner Collective (A. Heartman, personal communication, March 3, 2022).

The media often refers to surrogate partners as “sex surrogates.” Many surrogates prefer the term surrogate partner, as it more accurately describes the relationship.

Most of the time spent together is not spent having direct sexual contact, as in many intimate relationships. Tova Feder PhD captures this in the title of her book, *Sex is the Least of It: Surrogate Partners Discuss Love, Life and Intimacy* (2014).



Artwork by Brian Love *Brian Love Art Painting, Illustration & Design*www.bloveart.com

BDSM and Kink: Notes from a Dominatrix

Professional Domination inspires visions of high-powered men being beaten and savagely humiliated by an imposing woman in black tight shiny attire. I am a less-than imposing 5'4," I rarely wear shiny black clothing, I have tons of clients who I have never beaten nor humiliated, yet I've been a successful professional dominatrix for almost 30 years. Rather than a stereotypical cruel Mistress, I provide a safe place for people (men, women, couples, gender nonbinary, etc.) to explore the taboo. Most submissives come to me searching for a feeling: fear, desire, belittlement, and always, acceptance. My biggest asset is my empathy.

Often, people think of kink and BDSM as the activities involved. But those activities can differ greatly depending on the feeling the person is searching for, and in turn,

the intent the dominant invokes. For example, the intent used during a simple spanking can change the whole experience. Is the spanking a punishment, done with a stern tone detailing their misdeed? Or more maternal with words like “it’s for your own good” being whispered in their ear for the duration? Or is it more of a light hearted butt slapping, that includes a lot of giggling, while dressed as a popular 80’s cartoon character?

I find BDSM and kink to be escapist play for adults. We can let go of society’s expectations for our roles in the outside world, and get lost in a private world of taboo activities. We can be slutty and gender bending without fear of real-world repercussions. We can let go of the idea that love needs to be equal, and unabashedly worship another human, without the fear of rejection during a goddess worship session. We can let go of all outside obligations and revel in the intensity of a long spanking. Stop feeling like a weirdo for just a bit, and indulge in kissing and licking feet and heels.

My clients often leave feeling lighter. Feeling seen. Feeling appreciated. It’s hard to hide your non-standard sexual curiosities. Having a kinky secret can feel heavy. You can feel a bit broken. Finding a place to indulge and be accepted exactly as you are can be freeing.

Princessa Natasha Strange

Betterment Through BDSM

www.KittenWithAWhip.com

Proprietrix of Sub Rosa PDX, Portland Oregon's Premiere Kink and BDSM play and education space
@artbymissalicemeow

Camming

Camming is "the internet streaming of adult content" (Dictionary, 2022). This could include nudity and/or masturbation. Often, the person camming is available to chat with online viewers, in exchange for money. Someone may be requested to perform certain activities, often sexual, in front of a webcam for paying clients. People who do camming are referred to as cam girls/boys, or cam or webcam models. There are various online sites that host camming. Most camming is done by women.

According to Dr. Angela Jones, author of *Camming: Money, Power, and Pleasure in the Sex Work Industry*, through camming, people can earn money, feel powerful and experience pleasure, while doing sex work that is safe and legal. She also explores the racism and xenophobia present within the industry. Nonwhite and non-native English speaking cam models have fewer opportunities and make less money than white native English-speaking workers.

During the Covid-19 pandemic, camming became more popular as a way for people to earn income working from home. Some people who had never done sex work entered during the pandemic, frequently through cam work. Others who had been seeing clients in person switched to online as a way to maintain physical and social distancing (Drolet, 2020).

Charles Thomson. Date Unknown. Creative Commons Attribution-Share Alike 3.0

Street-Based Sex Work

Street based sex workers experience some of the highest levels of stigma and violence of all sex work. According to Cimino (2014), in the United States, street-based sex workers are seen as "deviant" and "dangerous" by society, while escorts or so-called "high-class" sex workers are viewed as "seeking economic independence and personal empowerment". Armstrong (2019) documents the connection between stigma and violence, and argues for the decriminalization of sex work, in order to protect sex workers. Street-based sex workers often do not have the option to assess clients for safety before getting in a car or going to a private space with them. They have less control over who their clients are, and they are also at higher risk of harassment and violence by law enforcement. They are subject to loitering laws that criminalize them for being on the street. This allows the police to profile, harass, and arrest them repeatedly (Chabria, 2022).

Reinita Alban Benabides. 2015. Creative Commons Attribution-Share Alike 4.0

McCracken (2013) draws connections between stigma, systemic violence and victim status. She speaks to the danger of attributing a victim status to street-based sex workers. "These individuals have power, expertise and knowledge, and others can learn from them on both individual and systemic levels. Understanding every individual is capable of agentic choice, shifts the kaleidoscope and subsequently changes the view" (McCracken, 2013, p. 239).

Sidebar 15.2: From Behind the Glass

Stripping falls under the umbrella of sexuality work that engages the body. Within stripping, there are various subcategories. The classic **Burlesque** shows (a variety show, typically including striptease), pole dancing, lap dancing and peep-shows are all forms of stripping. Here, "stripping" will be defined as "any act in which money is exchanged for the pleasure of watching another human dance or/and remove items of clothing". This section will include stories from a former sex worker who worked in San Francisco, where various forms of stripping exist as part of the legal sex work trade. Over the years, the number of these establishments have ebbed and flowed, coinciding with various laws and restrictions on sex work in this area of the industry. Support for the workers themselves is as fluid as the laws and attitudes towards sexuality of the culture. As shown throughout this text, the laws about sex work is varied and constructed by norms and values. There are many types of stripping, which can appeal to different people based on their individual preferences. This section will include only strip clubs and venues that housed women strippers and traditionally catered to men, because that is the only sex

work experience the author has had.

Image by The Original Sean

The Cinema on Market Street housed a classic stage, where women would perform dances while removing their clothes. Men in the audience would watch as other women dressed in lingerie would ask to sit on their laps for personal dances. The rules were: no touching below the waist, and a woman would dance on the man's lap for money. Rules were not strictly followed, and in reality, the women would at times rub their thighs/buttocks or use their hands to help the men ejaculate, and in some cases, there was penetration.

Across the street was the Regal Show World, which housed pornography booths where customers could drop quarters into a slot to watch pornographic movies. There were also rentals of movies and booths for longer viewings of the movies. These booths included a bench for sitting, tissue for cleaning up and a locked door. The Show World also had booths with live girls that worked behind glass. As you walked into the Regal Show World, it was like walking into a large movie theater with a sloped ramp leading you down to the action. On the right hand side, there was a desk where typically two men worked, mostly making change, renting and selling movies and "cashing out" the workers. On the wall next to the counter was a window to a hallway, where women would check in and out of work. As customers walked past the counter, there were booths of women on one side and movies on the other, and at the end of the hall was a dome for pole dancing. The dome was closed with small booths with signal doors around the stage for viewing. Customers could talk to the women that were in the booths preceding the "dome" and

negotiate what might happen if they were to enter a signal booth, or they could duck right in. The women would close the booth door where they were sitting and wait for the customer behind the glass to insert at least $5 to clear the glass window. The worker was sitting on a very small "bed" and had a phone, with which they could communicate with the customer. These conversations would range from complex fantasy work and role playing of sexual intercourse, to simply watching the women take off their clothes. The women generally started in a bra and panties, so the layers of clothes needed to be removed was minimal. Since the glass only stayed clear as long as money was being pumped in through an electronic slot, the worker's skill was to continue to prolong a session so that the customer would "feed the meter." The women that worked there would informally discuss the pay scale in the upstairs dressing room prior to our shifts. There was an understanding that for $5 (of which the worker got half), the viewer would get the bra off, and $10 would call for the removal of the panties. This of course was part of the game. The skill involved trying to get the customer to pick up the phone and ask, "what do you like?" While slowly negotiating this, we would remove our bra so that just as it came off the glass would fade. At this point in the transaction the customer would either leave or insert another $5, or a larger tender depending on the situation. Upstairs in the dressing room, the conversations about money, shows and what the women would or would not do continued. For example, "Betsey would masturbate with a coke bottle for $5" and, "Maria, she always got guys in her booth for $20 off the bat." Thinking back on these situations, the conversations and interactions in the dressing room were rich and complex. The women were diverse in age, race and life choices.

Workers were paid half of all the money they got in their booth during their 4 hour shift, but it was set up so that the worker actually was paying a fee to the theater to rent the booth. This fee was 50% of the money made during the rental time. In most of the stripping world, both women and men were paid as independent contractors. There was no guarantee of work or healthcare, which led to a unionization movement in San Francisco during the late 1990's. Unlike prostitution, this field of sex work is legal, and therefore, workers could mobilize. In a similar way to prostitution, the world of strippers provided a needed service for people that desired human touch or fantasy. In many cases, stripping did border towards

prostitution, with lines blurred, or in many cases, even crossed. For example, in the lap dancing world of a dark theater, sometimes penetration took place.

The author for this section worked in both peep-shows and lap dance theaters, but found greater comfort in the peepshow area. The glass provided a safety net, the phone and the "booths" provided an intimate environment to exchange nudity, sexual interactions and fantasies. In the era this took place, the workers were all women, and the majority of the customers were men. The story below describes a real experience the author had with a client who was seeking an outlet for their sexual needs.

The Cum Eater

At the Regal Show World, there was a man who regularly visited the girls that worked there. He was a tall, older, and professional man that worked in the financial district in San Francisco. After you had been working consistently for a number of months, he might pop into your booth. The first time, he would slip in a $20, which was always delightful for any of the women working. Once the window was clear, he introduced himself and asked a few introductory type questions. This was always welcomed in this workplace, since each $5 put about 2 minutes on the clock, and so burning time was essential. Keeping the customer talking about what they "liked" was a necessary skill and could take a good 3-5 minutes. This man liked to "eat" the cum of other men, and specifically, off the window. His request was, "please get one of the men to cum on the window" (easy!), but to convince him not to clean up after themselves. This was always tricky since most of the men would automatically wipe their bodily fluids off the glass. Once the request was explained, the man would leave the booth and linger outside of the booth area and wait for the signal. If you were lucky, the cum eater would come in a second time and drop another $20. Interestingly, he wanted you to watch him lick the cum off the window, which he would do in a way that suggested he was eating the most delicious delicacy. He would scoop it off with his fingers and play with it around his face. He would stick out his tongue and let the cum wrap around his lips and tongue. This would go on until the time ran out on the $20. I always wondered if his fantasy was to gross out the worker that watched. At some point, this man asked me to come to his house and do a private show. This was a common request, and

the terms of this show were usually negotiated in the booth. Interestingly, I had never stripped for this particular customer.

The cum eater and I discussed the terms and agreed that I would go to his home, strip and masturbate there for him. There would be no touching and the price was $100 in cash. He lived close to Dolores Park in SF. I rang the bell and he answered dressed much more casually than I was used to seeing him at the Regal. I distinctly remember that the front door was a glass pane with a deadbolt, because after letting me in, he deadbolted the door with a key on the inside and took the key out of the lock and placed it into his pocket. This really freaked me out, but I continued up the stairs into this flat. It was nice, and he showed me around and played tapes of his wife having sex with other men. After about 15-20 minutes of this, I stripped for him while he sat in his living room on this couch. After I was nude I sat next to him so he could watch me masturbate. I distinctly remember him touching my leg and feet with his feet which was technically breaking the agreed upon "rules" but I let him. After a while he came, gave me my money and I was on my way.

I experienced a world of diversity in terms of the sexual needs of clients during my time in the field of sexuality work that engages with the body. I have no regrets working in this industry; I found it both humane and lucrative. Stripping is a good paying job that allows for a flexible schedule. This was important for me as a college student at the time, and was a great way to pay off debt.

Pornography

A terracotta plaque depicting a man and a woman having sexual intercourse. From Mesopotamia, early 2nd millennium BCE. Creative Commons Attribution-Share Alike 4.0

Pornography is the 'portrayal of sexual subject matter for the purpose of arousal." Pornography has been around for as long as human beings have been creating art. Before the internet, film, photography, and the printing press, there were people creating sexual imagery for the purpose of arousal, as depicted by ancient drawing, painting and sculpture.

The professional porn industry is often referred to as the "adult industry." Child pornography, or any sexual imagery depicting people under the age of 18, is illegal in the United States. We also see a lot of what is known as "amateur porn" on the Internet today. This refers to pornography that someone is creating on their own, not as a job, but often for their own enjoyment, and for others to enjoy as well. There are big differences between professional porn created by the adult industry and amateur pornography.

Professional porn does not represent reality, nor is it meant to. It is a fantasy. Just as in other professional films, many techniques are used to create that fantasy. Lighting, makeup, camera angles, photoshopping are all used to create visual imagery and to enhance how people look. As far as obtaining and maintaining erections, there are fluffers off camera (people to help with erections). The use of pills such as Viagra, penis pumps and penile injections are all also commonly used for this purpose. Keeping this in mind, it is best not to compare oneself or one's sex life with pornography (LAD Bible, 2022).

For many young people today, pornography is being used as an unofficial sex education. Due to a lack of comprehensive sex education and porn literacy in the United States, it is easy to see why some young people may believe that real sex should look like sex in pornography. This creates a false sense of what real sex is like (LAD Bible, 2022).

Many sex educators believe it is important youth receive education about pornography, but not be shamed for being curious about it, or for receiving pleasure from it. Education should include teaching that it is illegal to consume pornography if you're under the age of 18, that although the naked human body is not shameful, they should not take or share naked pictures of themselves or others, or pictures or videos that are sexual in nature. This could be considered child pornography, and there could be serious legal and social consequences for this.

The largest online adult content sites average about 3 trillion monthly visitors. This is more than popular sites such as Amazon, Netflix and Reddit. The annual revenue from pornography is anywhere from $6-$15 billion in the United States (Grant, 2020). Clearly, there is a high demand for pornography, and the industry is not going anywhere. However, it is going through changes. Due to the Covid-19 pandemic, when everything shut down at first, many porn actors began working from home, offering their own content online. Some predict that this trend will continue to have an effect on the adult industry, as more people opt to work for themselves (Grant, 2020).

Sidebar 15.3: Adult Pornography Industry: The Industry Response to an HIV Outbreak in 2013

By Sam Zia, LMFT

In the Summer of 2013, the adult film industry was in flux. The industry was transitioning from the distribution of traditional, physical forms of media, such as DVD and VHS, to online streaming services. Los Angeles had just passed Measure B (requiring condoms to be used on porn sets) the previous year, a decision that was in the process of being appealed. The argument from the adult film industry, in defense of not needing condoms in porn, was based around the idea that with mandated, frequent testing of performers (every two weeks, at most 4 weeks), they could "police themselves," and prevent major outbreaks of STIs.

This idea was put to the test that August, when an adult film star tested positive for HIV. The ripple effect was immediate. The industry called for a moratorium on all shooting, allowing for any performers testing positive to be removed from the talent pool before resuming production/filming. Over a period of a month, four performers were found to have contracted HIV. It was determined that none of the cases of transmission occurred on-set (the last known case of on-set HIV transmission occurred in 2004). This incident, however, highlighted a glaring problem within the Adult Film industry. Although testing is mandated by production companies on shoots featuring a man and women, or two women, some companies that shoot scenes involving two men do not require STD/STI testing. Despite this, the only times the industry had to shut down filming since 2013, was in 2017, when three performers tested positive for HIV, and in 2020, with the Covid-19 pandemic.

Since the 2013 HIV outbreak, the industry has continued to evolve. Many production companies left Los Angeles County, settling in surrounding counties, or Las Vegas. With the Covid-19 pandemic, shooting shut down temporarily, with many adult film stars creating their own websites and webcamming pages to continue to make money. However, since the industry has had experience with transmissible illnesses, it was not long before production companies adapted to the need for more stringent testing, and filming resumed.

Sidebar 15.4: Men in Sex Work: A Personal Story

My name is Lance and I began doing sex work when I was 29, and it has been my career for the last 12 years. During the 2008 recession, I was laid off from my retail management job, so I decided to explore my passion for massage therapy, and went to school to learn more technique. I was quite comfortable with my body and a very sexual person, and had previously attended a few all-male massage workshops that were rooted in The Body Electric School, which seeks to connect the erotic and the sacred.

Doing erotic work felt like a very natural extension to my massage work, though there was certainly a learning and growth curve.

One of the questions I often get from others is how do I have sex with someone that I'm not attracted to, and in all honesty, it took some effort in the beginning. I've observed that most people tend to look at themselves and rather than focus on all that is beautiful and blessed we focus on what is "imperfect" and we tend to place that judgment on other people as well. As I grew to love myself more, I began to see others differently. While in the beginning, focusing on what was attractive about a client was something I had to make a conscious effort to do, it soon became natural. I soon began to realize that the vulnerability and trust they showed me was not only beautiful but was also sacred and spiritual.

As a white, cisgender male at 6'3" I do recognize my privilege in this industry. I don't have to be nearly as cautious or do as much screening of my clients as cis & trans women, and I'm rarely the focus of legal persecution, which unfairly equates sex work with human trafficking, as some feel that through their pious efforts, they need to "save" people from their work.

I absolutely love my work and even though making money is a motivator (just like any job) there really is nothing else I would rather be doing. I have had the honor to share erotic energy with a man in his 70's, who was recently widowed and had never been with a man, though had been longing for it for 50+ years. I've laid in a hospice bed and held a man dying of brain cancer, because his best friend wanted him to experience one last time naked with a man (I'm crying while I type this).

Though everyone's experience and motivation in this industry is different, for me, bringing deep intimacy in every session is my hope and intention. One can have

sex and an erotic experience without much intimacy, but it's intimacy that really gets to the heart and soul and, that's where I hope to reside with my clients, even if it's just for an hour or so. As I like to say Sex Work is Soul Work.

Picture of Lance given to author for use

Sidebar 15.5: What are FOSTA, the Fight Online Sex Trafficking Act, and SESTA, the Stop Enabling Sex Traffickers Act?

Because many types of sexuality work that engages with the body are currently illegal in most of the United States, workers face additional risk of legal prosecution for doing their job. While the issue remains complicated, this new pair of laws, FOSTA, the Fight Online Sex Trafficking Act, and SESTA, the Stop Enabling Sex Traffickers Act essentially pose greater risk to sex workers who rely on the internet to make a living.

Watch the following for more information, and also read FOSTA-SESTA, a law intended to curb sex trafficking, threatens the internet's future - Vox

Sex Worker Rights and Activism: The Decriminalization Movement

In order to understand the sex worker right's movement, it is important to understand the differences between decriminalization, legalization, and what is referred to as the Nordic model, of sex work. With decriminalization, it would no longer be a crime to trade sex for money or other goods. No aspect of the transaction would be criminalized. Legalization, which is what we have in the United States in a few areas of Nevada, makes it legal to trade sex for money, but only under strict policies, and this excludes most people and keeps law enforcement in control. In fact, Nevada has the highest arrest rate for prostitution in the U.S. Finally, the Nordic model makes it a crime for the person purchasing the sex, but not for the person selling it. This model also does not protect sex workers, as people purchasing services are scared of arrest, and therefore, it pushes sex work into more desolate areas, leaving sex workers more vulnerable to violence and abuse (Decriminalize Sex Work, 2022). Most sex workers advocate for decriminalization over the other options.

Msmornington. 2011. Creative Commons Attribution 2.0

Two new United States laws passed in 2018 known as the SESTA (Stop Enabling Sex Traffickers (SESTA) and Fight Online Sex Trafficking (FOSTA) Acts, have had a negative impact on the safety of sex workers in the U.S. The law shut down websites that sex workers used to advertise and find clients. The purpose of the law, as it is written, is to fight human trafficking. Human trafficking is when coercion or force is used to make someone engage in sex acts. This is not the same as consensual adult sex work (Decriminalize Sex Work, 2022). Unfortunately, the law

has not been successful in fighting trafficking, and actually, agencies that work to fight trafficking say that it has made it more difficult to find human traffickers, since the websites were shut down due to the law (Schmidt & Lang, 2019). These websites allowed sex workers to advertise safely, find and screen clients before meeting them, and have more ownership over their work (Transgender Law Center, 2022). It also allowed for sex workers to exchange information with one another, in order to keep each other safe. Due to the loss of these websites, sex work was once again pushed into the underground market, and many sex workers returned to the streets to work, where they are at higher risk for violence from law enforcement and predators who pose as clients.

Transgender women of color are far more likely to be targeted by law enforcement for sex work, resulting in higher rates of harassment, assault, rape and arrest by law enforcement officers. Transgender women of color who engage in sex work are also more often victims of murder (Transgender Law Center, 2022).

As Black and brown transgender sex workers, we demand the full decriminalization of sex work and the end to the stigma, violence, and policing that plagues our communities. It is impossible to be genuinely committed to ending violence against trans communities, particularly trans women of color, without a commitment to decriminalizing sex work. (Transgender Law Center, 2022)

Decriminalizing sex work decreases rates of human trafficking, and increases the safety and well-being of sex workers (Decriminalize Sex Work, 2022). Some states are realizing the disproportionate effect that these laws have on populations already at risk of harm, specifically, Black, Brown and Trans sex workers. In July of 2022, CA Governor Gavin Newsom signed CA senate bill 357 into law, which repeals a law regarding loitering for the intent to sell sex. A few other cities, including Seattle, WA, have already done so, along with the State of New York. While seen as controversial by some, repealing the loitering law adds a protective layer for sex workers who work at the margins and are often forced into dangerous meeting spaces in order to make a living. In a July 2022 interview by LA Times Reporter Hannah Wiley, Ayako Miyashita-Ochoa, co-director of the Southern California HIV/AIDS Policy Research Center and adjunct professor at the UCLA Lushkin School of Public Affairs says criminalization “pushes sex workers into isolated and unsafe spaces with scant evidence of any positive health outcomes (Wiley, 2022).

Sidebar 15.6: Social Media and Sexuality Based Work that Engages with the Body

Social media has played a major role in shaping the way people perceive sexuality based work that engages with the body. While stigma surrounding this work persist, platforms like OnlyFans have helped legitimize sexuality based work that engages with the body, and has given people opportunities to generate more income as a result.

Due to the expansion of social media, virtually anybody can participate in sexuality based work that engages with the body through the gig economy, where there are less 'middle-men' involved in the process. Many people who participate in sexuality based work that engages with the body in the twenty-first century are able to build sustainable businesses from their work, allowing them to enter the world of entrepreneurship. Digital technology is extremely helpful in the new age of sexuality based work that engages with the body because it provides safer opportunities for people to participate in this type of work.

Thoughts on Sexual Wellness as Related to Sex(uality) Work that Engages with the Body

Our sexuality is a part of our overall wellness. As we've discussed in other chapters of this book, the World Health Organization (WHO) and other health related organizations see sexual health as a necessary part of our well-being. Work in this field, whether currently legal or not, is a therapeutic intervention for some. To revisit, the WHO asserts:

> Sexual health is fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries.
>
> Sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
>
> The ability of men and women to achieve sexual health and well-being depends on their:
>
> - access to comprehensive, good-quality information about sex and sexuality
> - knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity
> - ability to access sexual health care
> - living in an environment that affirms and promotes sexual health (World Health Organization, 2022).

If our sexual health is suffering for whatever reason and we wish to intervene, many of the professions discussed in this chapter could potentially serve as a remedy. Western culture, particularly in the United States, has stigmatized sex and sexuality to a point where we are all a bit conflicted when it comes to sexual expression and freedom. In particular, we have a history that presupposes that sex is just for procreation, or that only cisgender, straight, white, male people are supposed to enjoy sex. When sexual relationships happen between gendered male and gendered female people, there is often a disconnect because of these cultural

messages. When we force people into gendered boxes that come accompanied with prescribed behaviors around sexuality, we come together and are not sure how everything works with our partners, because we've been taught entirely different sexual scripts. Sex education often does not teach students about pleasure and the parts of the body that are designed for sexual enjoyment. I've looked long and hard, and have not heard of a high school class that teaches their students the beauty of erectile tissue. Imagine how empowering that knowledge could potentially be. In a society that touts freedom as one of their main cultural values, this is ironic.

Because many of us were forced to unlearn some of those messages and reclaim our sexuality, sex(uality) work that engages with the body can be a useful tool. Whether it be gendered messages around our sexuality, past traumas, or lack of knowledge about our bodies and what they are capable of, sometimes finding support in this realm is a great option. I encourage everyone to watch GOOD LUCK TO YOU, LEO GRANDE | Official Trailer | Searchlight Pictures. It is a beautiful, awkward, and messy story about a woman finding her pleasure through the help of a kind and compassionate sex worker. As pointed out in this chapter, this type of work can offer someone lifesaving wellness.

Decriminalizing sex(uality) work that engages with the body could potentially be a step in the direction of removal of stigma. The result of cultural messages that conflate sexuality with sin is that people don't talk openly about sex. What if we were to celebrate sexuality and teach students from a young age that our sexuality is part of our overall physical health? I think the world would be a better place. I know that's a large assertion, but take a moment and think about how your life would be if you had no sexual or body hang-ups. Hypothetically, remove those barriers from your life, and imagine what would be different for you.

As we mentioned earlier in the chapter, decriminalizing sex(uality) work that engages with the body would also help protect sex workers. We see what happens to sex workers as restrictions against their work increases, forcing them deeper into secretive websites that put them at great danger. If, as is the case with new SESTA/FOSTA internet guidelines, people are forced to arrange appointments and services in only the darkest corners of the internet, workers have little to no protection from client harm. Those who provide legal health services of any kind, including legal sex work, have the option to call law enforcement to intervene if they feel in danger, and may be protected by various workplace measures. Those

working illegally cannot. Sex(uality) work that engages with the body is part of societies worldwide. How each nation decides to institutionalize it varies, and these decisions have consequences. It would be a large but doable leap to shift how we view sexuality. Other models exist, and nations like Norway and Sweden who have adopted more inclusive and accepting policies and attitudes toward sexuality have not fallen into moral decay. In fact, their overall quality of life is far better than those in the United States based on multiple measures (Eglitis, n.d.).

On Stigma

The ways in which sexuality is policed, stigmatized and separated from our overall wellness in the U.S. creates a specific backdrop to learn about our sexuality. There is nothing natural about the way in which children learn about sex; we have demonstrated in this text that the sex education children receive growing up varies drastically from nation to nation. It is steeped in culture and disseminated to us based on social norms. Because of the frame in which sexuality appears in U.S. culture, it may even be strange for you to read a book discussing the idea that all consensual sex work should be legal.

There is a vast array of sexuality-related workers who engage with the body that fulfill needs for intimacy and sexual desire. The work provides much needed sexual health care to many people and yet, it remains highly stigmatized, pathologized and criminalized. This type of prejudice goes unchallenged, whereas others would be called out. Sexuality workers are often seen as morally suspect, and much of public discourse denies them any agency over their profession. Media representations of sexuality-related workers who engage with the body, intimacy and sexual desire are often laden in stereotypes and tropes that are insulting and inaccurate. Because the cultural narrative around sexuality is still framed in the white, cis, heteronormative, monogamous, penis in vagina (PIV) sex, anyone who engages in sex for reasons other than love and intimacy with one committed partner challenge the sexual scripts we've learned to follow.

Conclusion

The field of sex(uality) work that engages with the body is diverse and serves many purposes. Some services are legal in the U.S., and others are illegal. Sexological

Bodywork, Surrogate Partner Therapy, and working with a trained BDSM bodyworker can help individuals or partners explore arousal and pleasure using a variety of modalities including erotic massage, breathwork, and how to teach and manage consent and boundaries. Camming, Porn, Street Based Sex Work, and Stripping all provide outlets of sexual desire and gratification. Depending on the nation where this work is being done, it is either legally sanctioned and protected, or it is not, and workers put themselves at considerable risk. Sex(uality) work that engages with the body is not illegal in every nation. Decriminalizing the types of consensual sex(uality) work that engages with the body that are now illegal in the United States would allow for added protection of the workers.

Glossary

1. **Burlesque:** a variety show, typically including striptease.
2. **Camming**: the internet streaming of adult content" (Dictionary, 2022)
3. **Fight Online Sex Trafficking Act (FOSTA)**: adds penalties for hosting illegal sex work-related content
4. **Kink**: consensual, non-traditional sexual, sensual, and intimate behaviors such as sadomasochism, domination and submission, erotic roleplaying, fetishism, and erotic forms of discipline
5. **Pornography**: the portrayal of sexual subject matter for the purpose of arousal
6. **Professional Dominatrix**: paid professional who takes the dominant role in BDSM/kink activities, sometimes referred to as a pro-domme.
7. **Sexological Bodywork**: body-based educational modality that supports individuals, couples, and groups to learn to direct their erotic development and to deepen their erotic wellbeing and embodiment" (Association of Certified Sexological Bodyworkers, 2022)
8. **Street-based sex-work**: a form of sex work in which a sex worker solicits customers from a public place, most commonly a street, while waiting at street corners or walking alongside a street, but also other public places such as parks, benches, etc.
9. **Stop Enabling Sex Traffickers Act (SESTA)**: The Stop Enabling Sex Traffickers Act and Allow States and Victims to Fight Online Sex Trafficking Act are the U.S. Senate and House bills that as the FOSTA-SESTA package became law on April 11, 2018

10. **Surrogate Partner Therapy (SPT)**: is based on the work of sex researchers Masters and Johnson and uses their technique of sensate focus (touching for one's own pleasure) as a basis for exploring physical intimacy

Discussion Questions

1. Thinking of the various types of sex(uality) work that engages with the body, can you identify any common themes throughout in terms of the intended outcome that go beyond sexual gratification? Explain.
2. What are some of the issues that people seek support with when they enlist the services of sex(uality) workers who engage with the body?
3. If the U.S. had quality sex education throughout a student's life what would be different in society? (very broad, I know, so think big)
4. What if all sex work was legal? Debate this idea.
5. Do we "*live in an environment that affirms and promotes sexual health" (World Health Organization, 2022)?* There may be ways that we do and we do not, you get to assess this. Provide examples for your answer.

Multiple Choice

1. Sexological bodywork was developed by _____ who was raised by a strictly catholic family in the 1950s.

    a. Joseph Kramer
    b. Margaret Sanger
    c. Sigmund Freud
    d. Master Johnson

2. Surrogate Partner Therapy (SPT) is based on the work of sex researchers Masters and Johnson and uses their technique of sensate focus (touching for one's own pleasure) as a basis for exploring physical intimacy.

    a. True
    b. False

3. Camming can include the following:
    a. Masturbation
    b. Nudity
    c. Both A and B

4. Street based sex work is legal in the U.S.
    a. True
    b. False

5. It is illegal to view pornography if you are under the age of 18 years.
    a. True
    b. False

6. What is Burlesque?
    a. a variety show, typically including striptease
    b. A strong person who chops wood
    c. A type of olive tree
    d. An old fashioned game show

7. What is Kink?
    a. consensual, non-traditional sexual, sensual, and intimate behaviors
    b. sadomasochism, domination and submission,
    c. erotic roleplaying, fetishism, and erotic forms of discipline
    d. All of the above

8. Why can street based sex work be dangerous for the sex worker?

a. Street-based sex workers often do not have the option to assess clients for safety before getting in a car with them or going to a private space with them.
b. They have less control over who their clients are and they are also at higher risk of harassment and violence by law enforcement.
c. They are subject to loitering laws that criminalize them for just being on the street. This allows for police to harass and arrest them repeatedly
d. All of the above

9. What does SESTA stand for?

a. Stop Eating Sugar Today All
b. Stop Enabling Sex Traffickers
c. Someone Everyone Sees Together Always
d. Sex Early Sounds Terrific Anyday

10. What does FOSTA stand for?

a. Fight Online Sex Trafficking
b. For Once Susan Answers
c. Fight Opera Singing Artists
d. Friendly Owls Stand Together Always

For Further Exploration

Association of Certified Sexological Bodyworkers -
https://sexologicalbodyworkers.org/

Podcasts - On the Whorizon and Peepshow

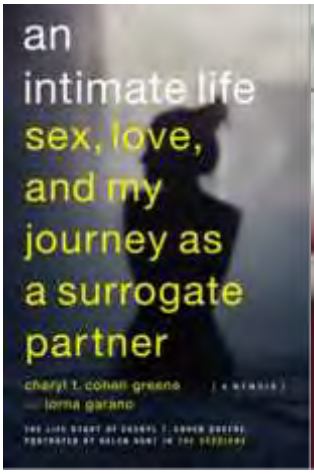
https://podcasts.apple.com/us/podcast/on-the-whorizon/id1588429195

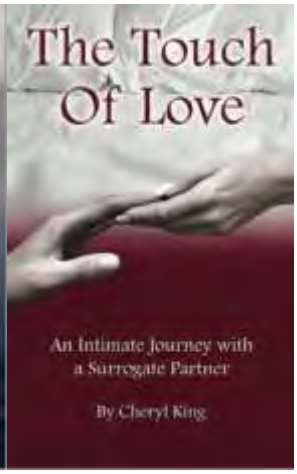
https://podcasts.apple.com/us/podcast/peepshow-podcast/id1291753966

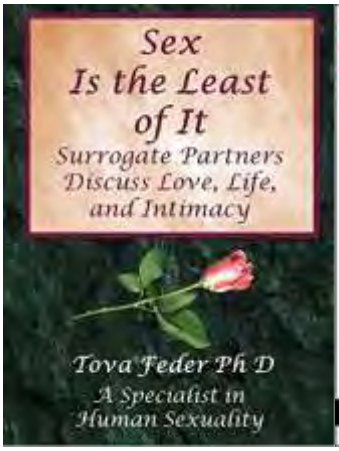
International Professional Surrogates Association -
https://www.surrogatetherapy.org/

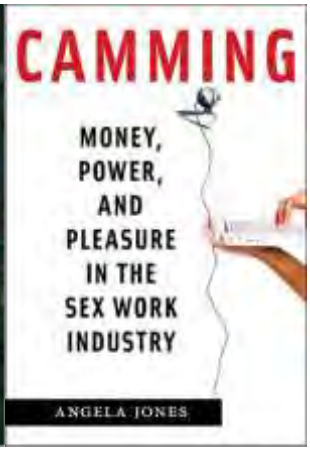
Certified Surrogate Partner - www.surrogatepartner.us

Surrogate Partner Collective - www.surrogatepartnercollective.org









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Sexuality, The Self, and Society Conclusion

As the final touches get put on this book and I sit down to write a concluding section, I must reflect on culture and society. We do not exist in a vacuum, but rather live in relation to the rules, norms and values put forth by the culture. We become human through interactions with others and all we do and learn seeps into our lives and how we live them. Throughout this textbook, I have invited you to make this content personal. Learning about our sexuality while academic in theory directly applies to our quality of life. I hope you have found this content empowering, validating and useful for your daily endeavors.

As they say in some circles, the personal is political. This concluding piece is being written the day after a major constitutional precedent was overturned. Roe v. Wade, discussed throughout this text which ensured federal protection for abortion rights has been struck down by the U.S. Supreme Court. Many people have taken to the streets to protest this while some are celebrating. As I try to wrap my head around a nation without that right, I feel fearful and deeply saddened. From a personal standpoint, I have been able to access free, legal, and safe abortion and most likely would not be in the position I am in were I not able to access this right. As a mother I grieve for the next generation of women who will not have that right

guaranteed. Autonomy over one's body is something we have discussed in this textbook, the right to make choices about our reproductive rights, when to have sexual contact with others, and how to ask for what we want; all are part of sexual literacy and overall wellness. Not to sound cliché or fall into a binary trap but if it were men who could be impregnated, I do not think we would be having this discussion. Abortion would be free, safe, and legal nationally.

Throughout this book you have had an opportunity to look at sexuality from a variety of angles with a focus on social justice throughout. The development of the field and the various directions it has gone means that the study of our sexuality is multifaceted. Having the opportunity to look at our sexuality through an interdisciplinary lens allows us the opportunity to have a more complete picture. This book touched different ways of understanding human sexuality. I hope this is just the beginning for you as a learner in understanding the realm of human sexuality, yourself, and how you make your way in the world.

I sincerely hope you took the tasks of embracing yourself, learning to ask for what you want, and opening your mind to new ideas to heart. Now that you have made your way through this book, can you practice radical self-love? Whatever that looks and feels like for you, please always know that this gift you can give yourself reaches far beyond your sexuality. Self-empowerment is motivating, exciting, and we all deserve to feel it. Thank you for coming along with me on this ride.

Susan Rahman, PhD.

June 25, 2022

Final Assignment:

Before we end the course, there is one small assignment I need all of you to undertake one more time. This time it might feel different. Ready to revisit your sexual literacy? Before we end the course, there is one small assignment I need all of you to undertake one more time. Please get yourself a small mirror and a quiet private place. You have one of three options to choose from.

Option 1: Please use the mirror to inspect your sex organs-however you define them. This may feel strange at first, as we do not spend a great deal of time looking at those parts of our bodies. Do not rush, take some time to look at the structure. Do you know what all the parts are? Pay attention to how this process feels to you.

Option 2: Using your largest sex organ, your brain (yes it is!), think about what you love about yourself. Look in the mirror and tell yourself what it is. Could be one thing directly related to your sexuality, could be a long list and maybe some of the things have to do with sexuality maybe they don't.

Option 3: Do both of these :)

Write 2-3 sentences about how it was doing this. You will not be turning this in. It is for you and only you to share with as you wish.

Thank you again for taking this journey,
Susan

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