An Invitation to Health: Build Your Future

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15TH EDITION
After studying the material in this chapter, you should be able to

- Explain the roles of hormones in sexual development.
- Describe the anatomy and physiology of the male and female reproductive systems.
- Identify women’s and men’s sexual health conditions.
- List life behaviors of sexually healthy and responsible adults.
- Define sexual orientation and give examples of sexual diversity.
- Discuss the range of sexual behaviors practiced by American adults.
- Describe the phases of sexual response.
Charles, several years older than the typical college freshman, usually doesn’t think much about the age difference—until the conversation turns to sex. He understands his younger classmates’ seemingly endless fascination with sex, but his perspective is different. As a teenager, he had plunged recklessly into dangerous territory of every type. Sex—casual and sometimes unprotected—was one of them. “Looking back,” Charles muses, “I feel lucky that I didn’t end up a statistic.” But he still regrets the irresponsible ways he acted.

Personal Sexuality

At 28 Charles is a veteran of military service, a married man, and an expectant father. His enjoyment of sex hasn’t faded—in many ways, it’s deepened and become more gratifying. He now realizes that there is no such thing as casual sex, that sexual choices have consequences and effects on one’s own life and on other people. These are the lessons he hopes someday to pass on to his own children.

As Charles learned with time and experience, you are ultimately responsible for your sexual health and behavior. You make decisions that affect how you express your sexuality, how you respond sexually, and how you give and get sexual pleasure. Yet most sexual activity involves another person. Therefore, your decisions about sex—more so than those you make about nutrition, drugs, or exercise—have important effects on other people. Recognizing this fact is the key to responsible sexuality.

Sexual responsibility means learning about your body, your partner’s body, your sexual development and preferences, and the health risks associated with sexual activity. This chapter is an introduction to your sexual self and an exploration of sexual issues in today’s world. It provides the information and insight you can use in making decisions and choosing behaviors that are responsible for all concerned.

Human Sexuality

Human sexuality—the quality of being sexual—is as rich, varied, and complex as life itself. Along with our sex, or biological maleness or femaleness, it is an integral part of who we are, how we see ourselves, and how we relate to others. Of all of our involvements with others, sexual intimacy, or physical closeness, can
be the most rewarding. But while sexual expression and experience can provide intense joy, they also can involve great emotional turmoil.

Sexuality and the Dimensions of Health

Our sexuality both affects and is affected by the various dimensions of health. Responsible sexuality and high-level sexual health contribute to the fullest possible functioning of body, mind, spirit, and social relationships. In turn, other aspects of health enhance our sexuality. Here are some examples:

- **Physical.** As described in Chapter 11, safer sex practices reduce the risk of sexually transmitted infections that can threaten sexual health, physical health, and even survival. When our bodies are healthy and well, we feel better about how we look and move—which enhances both self-esteem and healthy sexuality.

- **Emotional.** By acknowledging and respecting the intimacy of a sexual relationship, responsible sexuality builds trust and commitment. When our emotional health is high, we can better understand and cope with the complex feelings related to being sexual.

- **Social.** From dating to mating, we express and fulfill our sexual identities in the context of families, friends, and society as a whole. Having strong friendships, intimate relationships, and caring partnerships enables us to explore our sexuality in safe and healthy ways.

- **Intellectual.** Our most fulfilling relationships involve a meeting of minds as well as bodies. High-level intellectual health enables us to acquire and understand sexual information, analyze it critically, and make healthy sexual decisions.

- **Spiritual.** At its deepest, most fulfilling level, sexuality uplifts the soul by allowing us to connect to something greater than ourselves. Individuals who have developed their spirituality bring to their most intimate relationships an awareness and appreciation that lifts them beyond the physical.

- **Environmental.** Responsible sexuality makes people more aware of the impact of their decisions on others. Protecting yourself from sexual threats and creating a supportive environment in which to study and work are crucial to high-level health and to healthy sexuality.

Becoming Male or Female

Physiological maleness or femaleness, or biological sex, is indicated by the sex chromosomes, hormonal balance, and genital anatomy. **Gender** refers to the psychological and sociological, as well as the physical, aspects of being male or female. You are born with a certain sexual identity based on your sexual anatomy and appearance; you, your parents, and society mold your gender identity.

Are You an X or a Y?

Biologically, few absolute differences separate the sexes. Males alone can make sperm and contribute the chromosome that causes embryos to develop as males; females alone are born with sex cells (eggs, or ova), menstruate, give birth, and breast-feed babies. But the process of becoming male or female is a long and complex one.

In the beginning, all human embryos have undifferentiated sex organs. Only after several weeks do the sex organs differentiate, becoming either male or female gonads (testes or ovaries), the structures that produce the future reproductive cells of an individual. This initial differentiation process depends on genetic instructions in the form of the sex chromosomes, referred to as X and Y. If a Y (or male) chromosome is present in the embryo, about seven weeks after conception, it signals the sex organs to develop into testes. If a Y chromosome isn’t present, an embryo begins developing ovaries in the eighth week. From this point on, the sex hormones produced by the gonads, not the chromosomes, play the crucial role in making a male or female.
How Hormones Work

In Greek, hormone means “set into motion”—and that’s exactly what our hormones do. These chemical messengers, produced by various organs in the body, including the sex organs, and carried to target structures by the bloodstream, arouse cells and organs to specific activities and influence the way we look, feel, develop, and behave.

The group of organs that produce hormones is referred to as the endocrine system. Except for the sex organs, males and females have identical endocrine systems. Directing the endocrine system is the hypothalamus, a pea-sized section of the brain. The pituitary gland, directly beneath the hypothalamus, turns the various glands on and off in response to messages from it.

The ovaries produce the sex hormones most crucial to women, estrogen and progesterone. The primary sex hormone in men is testosterone, which is produced by the testes and the adrenal glands. However, both men and women have small amounts of the hormones of the opposite sex. Estrogen, in fact, is crucial to male fertility and gives sperm what researchers describe as their “reproductive punch.”

The sex hormones begin their work early in an embryo’s development. As soon as the testes are formed, they start releasing testosterone, which stimulates the development of other structures, such as the penis. The absence of testosterone in an embryo causes female genitals to form. (If the testes of a genetic male don’t produce testosterone, the fetus will develop female genitals. Similarly, if a genetic female is exposed to excessive testosterone, the fetus will have ovaries but will also develop male genitals.)

As puberty begins, the pituitary gland initiates the changes that transform boys into men and girls into women (Figure 9.1). When a boy is about 14 years old and a girl about 12, their brains stimulate the hypothalamus to secrete a hormone called gonadotropin-releasing hormone (GnRH). This substance causes the pituitary gland to release hormones called gonadotropins. These, in turn, stimulate the gonads to make sex hormones.

The gonadotropins are follicle-stimulating hormone (FSH) and luteinizing hormone (LH). In girls, these hormones travel to the ovary and stimulate the production of estrogen. As estrogen increases, a girl’s secondary sex characteristics develop. Her breasts become fuller, her external genitals grow, her hair becomes coarser, her body shape rounds,

In boys, the gonadotropins stimulate the testes to produce testosterone, which stimulates the growth of secondary sex characteristics. Pubic hair grows, the penis grows, the testes become firm, and the voice deepens.

Prostate, seminal vesicles grow bigger.

The body’s endocrine system produces hormones that trigger body changes, including growth spurts, in boys and girls.

Figure 9.1 Puberty

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enlarge, and fat is deposited on her hips and buttocks. Estrogen keeps her hair thick and skin smooth. She begins menstruating because she has begun ovulating, the process that prepares her body to conceive and carry a baby.

This process seems to be beginning earlier than in the past. “By eight, 15 percent of white girls and 48 percent of African American girls show signs of sexual development,” says Marcia Herman-Giddens, Ph.D., of the University of North Carolina at Chapel Hill, who analyzed 17,077 growth charts from pediatricians around the country. In her study, the mean ages for breast development were 8.87 years for African American girls and 9.96 years for white girls. African American girls reach menarche—the term for first menstruation—at a mean age of 12.16 years; white girls, at 12.88 years. By comparison, a hundred years ago girls didn’t reach menarche until the relatively ripe age of fifteen.

Improved nutrition and good health seem to be the primary factors. Girls today are bigger, taller, better fed, and more sedentary and have a higher percentage of body fat (one of the triggers of sexual maturation). They also grow up amid a host of environmental influences that may further speed development.

Cultural influences affect a girl’s response to menarche. In a cross-cultural study of college students, the most common emotions expressed by American women at menarche were embarrassment, pride, and anxiety. Malaysian women cited fear, embarrassment, and worry. Lithuanian women described themselves as happy or scared, while Sudanese women cited fear, anxiety, embarrassment, and anger. On the positive side, the Lithuanian women reported feeling more valuable and believing they had entered the world of women. American girls worried about whether they could still play sports but felt superior to friends who had not reached menarche and became eager to learn about sex. Malaysians described feeling wise, respected, and mature. In several countries women felt more beautiful because they could now have children.

In boys, the gonadotropins stimulate the testes to produce testosterone, which triggers the development of male secondary sex characteristics. Their voices deepen, hair grows on their faces and bodies, their penises become thicker and longer, and their muscles become stronger.

The sex hormones released during puberty change the growth pattern of childhood, so that a boy or girl may now spurt up four to six inches in a single year. The skeleton matures very rapidly until, at the end of puberty (usually around age 18), the growth centers at the ends of the bones close off. Estrogen causes girls’ bones to stop growing at an earlier age than boys’ bones.

### Sexual and Gender Identity

It’s a boy! It’s a girl! These statements confer an instant identity on a newborn. However, in recent years, researchers have challenged such either/or distinctions as male or female, masculine or feminine, heterosexual or homosexual. Although most people have the biological characteristics of a male or a female, some possess some degree of both male and female reproductive structures. They are referred to as intersexual.

The continuum for gender identity ranges from extreme stereotypical masculine notions to extreme stereotypical feminine behaviors. Different cultures vary in defining what is masculine or feminine. Individuals who consider themselves androgynous choose not to conform to sexual stereotypes. Androgyny includes those who are “positively androgynous,” combining positive attributes linked with both sexes—for example, feminine compassion and masculine independence—and individuals who are “negatively androgynous” and might show less desirable characteristics of each gender, such as feminine dependency and masculine assertiveness. (Transgenderism is discussed on page 293.)

### Women’s Sexual Health

Only recently has medical research devoted major scientific investigations to issues in women’s health. Until about a decade ago, the National Institutes of Health routinely excluded women from experimental studies because of...
Concerns about menstrual cycles and pregnancy. In clinical settings, women are more likely to have their symptoms dismissed as psychological and not to be referred to a specialist than are men with identical complaints. Some physicians are suggesting the creation of a new medical specialty (distinct from obstetrics and gynecology) that would be devoted to women’s health.

Female Sexual Anatomy

As illustrated in Figure 9.2a, the mons pubis is the rounded, fleshy area over the junction of the pubic bones. The folds of skin that form the outer lips of a woman’s genital area are called the labia majora. They cover soft flaps of skin (inner lips) called the labia minora. The inner lips join at the top to form a hood over the clitoris, a small elongated erectile organ, and the most sensitive spot in the entire female genital area. Below the clitoris is the urethral opening, the outer opening of the thin tube that carries urine from the bladder. Below that is a larger opening, the mouth of the vagina, the canal that leads to the primary internal organs of reproduction. The perineum is the area between the vagina and the anus (the opening to the rectum and large intestine).

At the back of the vagina is the cervix, the opening to the womb, or uterus (see Figure 9.2b). The uterine walls are lined by a layer of tissue called the endometrium. The ovaries, about the size and shape of almonds, are located on either side of the uterus and contain egg cells called ova (singular, ovum). Extending outward and back from the upper uterus are the fallopian tubes, the canals that transport ova from the ovaries to the uterus. When an egg is released from an ovary, the fingerlike ends of the adjacent fallopian tube “catch” the egg and direct it into the tube.

Discharge and changes in odor normally occur in a healthy vagina. They typically fluctuate through the menstrual cycle, depending on hormone level. In the past, many women practiced douching, the introduction of a liquid into the vagina, to cleanse the vagina. However, particularly if done frequently, douching may increase the risk of pelvic inflammatory disease (discussed in Chapter 11) and ectopic or out-of-uterus pregnancy. Despite the potential dangers, according to data from a southern university, four in ten female students had douch ed in the past; half currently douche.

African American women were encouraged to douche by their mothers; white women were more influenced by television advertisements. When advised to stop douching by a doctor or nurse, most students do so.

The Menstrual Cycle

Scientists have discovered that the menstrual cycle actually begins in the brain with the production of gonadotropin-releasing hormone (GnRH). Each month a surge of GnRH sets into motion the sequence of steps that lead to ovulation, the potential for conception, and if conception doesn’t occur, menstruation. The hypothalamus monitors hormone levels in the blood and sends messages to the pituitary gland...
to release follicle-stimulating hormone (FSH) and luteinizing hormone (LH).

As shown in Figure 9.3, in the ovaries, these hormones stimulate the growth of a few of the immature eggs, or ova, stored in follicles in every woman's body. Usually, only one ovum matures completely during each monthly cycle. As it does, it increases its production of the female sex hormone estrogen, which in turn triggers the release of a larger surge of LH.

At midcycle, the increased LH hormone levels trigger ovulation, the release of the egg cell, or ovum, from the follicle. Estrogen levels drop, and the remaining cells of the follicle then enlarge, change character, and form the corpus luteum, or yellow body. In the second half of the menstrual cycle, the corpus luteum secretes estrogen and larger amounts of progesterone.

The endometrium (uterine lining) is stimulated by progesterone to thicken and become more engorged with blood in preparation for nourishing an implanted, fertilized ovum. If the ovum is not fertilized, the corpus luteum disintegrates. As the level of progesterone drops, menstruation occurs; the uterine lining is shed during the course of a menstrual period. If the egg is fertilized and pregnancy occurs, the cells that eventually develop into the placenta secrete human chorionic gonadotropin (HCG), a messenger hormone that signals the pituitary not to start a new cycle. The corpus luteum then steps up its production of progesterone.

Many women experience physical or psychological changes, or both, during their monthly cycles. Usually the changes are minor, but more serious problems can occur. One recently recognized culprit is work stress. Women who are overcommitted or in jobs in which they put in a great deal of effort are more likely to report painful periods, possibly because of the effect of stress on the hormones that regulate menstruation.1

**Premenstrual Syndrome** Women with premenstrual syndrome (PMS) experience bodily discomfort and emotional distress for up to two weeks, from ovulation until the onset of menstruation. Up to 75 percent of menstruating women report one or more premenstrual symptoms; 3 to 9 percent experience disabling, incapacitating symptoms.

Once dismissed as a psychological problem, PMS has been recognized as a very real physiological disorder that may be caused by a hormonal deficiency; abnormal levels of thyroid hormone; an imbalance of estrogen and progesterone; or social and environmental factors, particularly stress. Recent studies indicate that PMS may originate in the brain. Changes in brain receptors during the ovarian cycle may be responsible.

Women with a high dietary intake of the B vitamins thiamine and riboflavin have a significantly lower risk of PMS. It is not known if vitamin B supplements also might be effective.2

The most common symptoms of PMS are mood changes, anxiety, irritability, difficulty concentrating, forgetfulness, impaired judgment, tearfulness, digestive symptoms (diarrhea, bloating, constipation), hot flashes, palpitations, dizziness, headache, fatigue, changes in appetite, cravings (usually for sweets or salt), water retention, breast tenderness, and insomnia. For a diagnosis to be made, women—using a self-rating symptom scale or calendar—must report troubling premenstrual symptoms in the period before menstruation in at least two successive menstrual cycles.

**Treatments** Treatments for PMS depend on specific symptoms. Diuretics (drugs that speed up fluid elimination) can relieve water retention and bloating. Relaxation techniques have led to a 60 percent reduction in anxiety symptoms. Sleep deprivation, or the use of bright light to adjust a woman's circadian or daily rhythm, also has proven beneficial. Behavioral approaches, such as exercise or charting cycles, help by letting women know when they're vulnerable.

Low doses of medications known as selective serotonin-reuptake inhibitors (SSRIs) (discussed in Chapter 3), such as fluoxetine (marketed as Prozac and Sarafem and in generic forms) provide relief for symptoms such as tension, depression, irritability, and mood swings, even when taken only during the premenstrual phase rather than daily throughout the month. SSRIs are not effective in all women with PMS, and other factors, including a genetic susceptibility, may play a role. YAZ, a low-dose combination birth control pill made up of the hormones drospirenone and ethinyl estradiol, is the only oral contraceptive

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Figure 9.3  Menstrual Cycle

(a) In response to the hypothalamus, the pituitary gland releases the gonadotropins FSH and LH. Levels of FSH and LH stimulate the cycle (and in turn are affected by production of estrogen and progesterone).

(b) FSH does what its name says—it stimulates follicle development in the ovary. The follicle matures and ruptures, releasing an ovum (egg) into the fallopian tube.

(c) The follicle produces estrogen, and the corpus luteum produces estrogen and progesterone. The high level of estrogen at the middle of the cycle produces a surge of LH, which triggers ovulation.

(d) Estrogen and progesterone stimulate the endometrium, which becomes thicker and prepares to receive an implanted, fertilized egg. If a fertilized egg is deposited in the uterus, pregnancy begins. If the egg is not fertilized, progesterone production decreases, and the endometrium is shed (menstruation). At this point, both estrogen and progesterone levels have dropped, so the pituitary responds by producing FSH, and the cycle begins again.
approved by the FDA to treat emotional and physical premenstrual symptoms. (See Chapter 10 on birth control.)

A diet rich in calcium and vitamin D reduces the risk of PMS; supplements of the two decrease the severity of symptoms. Cognitive-behavioral therapy, described in Chapter 3, may be the most effective psychological approach; simply educating women about PMS has not proven useful. Other treatments with some reported success include exercise; less caffeine, alcohol, salt, and sugar; acupuncture; and stress management techniques such as meditation or relaxation training. Chinese herbal medicine is popular in several nations, but there is insufficient evidence to support its use.

**Premenstrual Dysphoric Disorder**

Premenstrual dysphoric disorder (PMDD), which is not related to PMS, occurs in an estimated 3 to 5 percent of all menstruating women. It is characterized by regular symptoms of depression (depressed mood, anxiety, mood swings, diminished interest or pleasure) during the last week of the menstrual cycle. Women with PMDD cannot function as usual at work, school, or home. They feel better a few days after menstruation begins. Certain birth control pills can help by stopping ovulation and stabilizing hormone fluctuations. SSRIs, which are often used to treat PMS, are also effective in relieving symptoms of PMDD.

**Menstrual Cramps**

Dysmenorrhea is the medical name for the discomforts—abdominal cramps and pain, back and leg pain, diarrhea, tension, water retention, fatigue, and depression—that can occur during menstruation. About half of all menstruating women suffer from dysmenorrhea. The cause seems to be an overproduction of bodily substances called prostaglandins, which typically rise during menstruation. Medications that inhibit prostaglandins can reduce menstrual pain, and exercise can also relieve cramps.

**Amenorrhea**

Women may stop menstruating—a condition called amenorrhea—for a variety of reasons, including a hormonal disorder, drastic weight loss, strenuous exercise, or change in the environment. “Boarding-school amenorrhea” is common among young women who leave home for school. Distance running and strenuous exercise also can lead to amenorrhea. The reason may be a drop in body fat from the normal range of 18 to 22 percent to a range of 9 to 12 percent. To be considered amenorrheic, a woman’s menstrual cycle is typically absent for three or more consecutive months. Prolonged amenorrhea can have serious health consequences, including a loss of bone density that may lead to stress fractures or osteoporosis.

Scientists have developed chemical mimics, or analogues, of GnRH—usually administered by nasal spray—that trigger ovulation in women who don’t ovulate or menstruate normally.

**Toxic Shock Syndrome**

This rare, potentially deadly bacterial infection primarily strikes menstruating women under the age of 30 who use tampons. Both Staphylococcus aureus and group

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**Your Strategies For Prevention**

**How to Reduce Premenstrual Problems**

- **Get plenty of exercise.** Physically fit women usually have fewer problems both before and during their periods.
- **Eat frequently and nutritiously.** In the week before your period, your body doesn’t regulate the levels of sugar (glucose) in your blood as it usually does.
- **Swear off salt.** If you stop using salt at the table and while cooking, you may gain less weight premenstrually, feel less bloated, and suffer less from headaches and irritability.
- **Cut back on caffeine.** Coffee, colas, diet colas, chocolate, and tea can increase breast tenderness and other symptoms.
- **Don’t drink or smoke.** Some women become so sensitive to alcohol’s effects before their periods that a glass of wine hits with the impact of several stiff drinks. Nicotine worsens low blood sugar problems.
- **Watch out for sweets.** Premenstrual cravings for sweets are common, but try to resist. Sugar may pick you up, but later you’ll feel worse than before.
A *Streptococcus pyogenes* can produce **toxic shock syndrome (TSS)**. Symptoms include a high fever; a rash that leads to peeling of the skin on the fingers, toes, palms, and soles; dizziness; dangerously low blood pressure; and abnormalities in several organ systems (the digestive tract and the kidneys) and in the muscles and blood. Treatment usually consists of antibiotics and intense supportive care; intravenous administration of immunoglobulins that attack the toxins produced by these bacteria also may be beneficial.

**Men’s Sexual Health**

Because the male reproductive system is simpler in many ways than the female, it’s often ignored—especially by healthy young men. However, men should make regular self-exams (including checking the penis and testes, as described in Chapter 15) part of their routine.

**Male Sexual Anatomy**

The visible parts of the male sexual anatomy are the **penis** and the **scrotum**, the pouch that contains the **testes** (Figure 9.4). The testes manufacture testosterone, the hormone that stimulates the development of a male’s secondary sex characteristics, and **sperm**, the male reproductive cells. Immature sperm are stored in the **epididymis**, a collection of coiled tubes adjacent to each testis.

The penis contains three hollow cylinders loosely covered with skin. The two major cylinders, the corpora cavernosa, extend side by side through the length of the penis. The third cylinder, the corpus spongiosum, surrounds the urethra, the channel for both seminal fluid and urine; see Figure 9.4.

When hanging down loosely, the average penis is about 3½ inches long. During erection, its internal cylinders fill with so much blood that they become rigid, and the penis stretches to an average length of 6¼ inches. About 90 percent of all men have erect penises measuring between 5 and 7 inches in length. There is no relation, however, between penis size and female sexual satisfaction: A woman’s vagina naturally adjusts during intercourse to the size of her partner’s penis.

Inside the body are several structures involved in the production of seminal fluid, or **semen**, the liquid in which sperm cells are carried out of the body by the **ejaculatory ducts**. The **testes**, **prostate gland**, **seminal vesicles**, and **epididymis** complete the male duct system in which sperm mature.

**Personal Sexuality**

The male organ of sex and reproduction is the **penis**. It is a black, tubular, hollow organ that extends beyond the anus to the urinary meatus. The **urinary tract** includes the **urethra**, **bladder**, and **ureters**. The **rectum** is the lower end of the **colon**.

**Scrotum** The external sac or pouch that holds the testes.

**Testes** (singular, testis) The male sex organs that produce sperm and testosterone.

**Sperm** The male gamete produced by the testes and transported outside the body through ejaculation.

**Epididymis** That portion of the male duct system in which sperm mature.

**Semen** The viscous whitish fluid that is the complete male ejaculate; a combination of sperm and secretions from the prostate gland, seminal vesicles, and other glands.
Health in the Headlines

Sexual Health

There are many aspects of sexuality. To investigate the latest news on sexual health, log in to Global Health Watch and enter the phrase "sexual health" in the search box. Scan the search results and find a recent article related to any aspect of sexual health. In your online journal, write a brief summary of the article and use it to start a personal reflection about your sexual health.

Circumcision

In its natural state, the tip of the penis is covered by a fold of skin called the foreskin. About 60 percent of baby boys in the United States undergo circumcision, the surgical removal of the foreskin.

An estimated 1.2 million newborn males are circumcised in the United States annually for reasons that vary from religious traditions to preventive health measures. Circumcision rates are highest in the Midwest and Northeast and lowest in the West. They are significantly higher in states that provide Medicaid coverage for routine circumcision. Until the last half century, scientific evidence to support or repudiate routine circumcision was limited.

According to recent research, circumcision significantly reduces the risk of infection with human immunodeficiency virus (HIV), herpes simplex virus type 2, and human papillomavirus (HPV). Female partners of circumcised men are less likely to develop bacterial vaginosis and Trichomonas vaginalis infection. (Sexually transmitted infections are discussed in Chapter 11.)

Additional health benefits of circumcision include:

- Lower risk of cancer of the penis, a rare type.
- Less risk of urinary tract infections during the first year of life. An uncircumcised baby boy has a 1 in 100 chance of getting a urinary tract infection, compared with a 1 in 1,000 chance for a circumcised baby boy.
- Prevention of foreskin infections and retraction.
- Easier genitil hygiene.

Complications may include bleeding, infection, improper healing, or cutting the foreskin too long or too short. Analgesic creams or anesthetic shots are typically used to minimize discomfort. There is little consensus on what impact the presence or absence of a foreskin has on sexual functioning or satisfaction.

Responsible Sexuality

The World Health Organization defines sexual health as “the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love. . . . Every person has a right to receive sexual information and to consider sexual relationships for pleasure as well as for procreation.”

Sexuality education is a lifelong process. Your own knowledge about sex may not be as extensive as you might assume. Most people grow up with a lot of myths and misconceptions about sex. (See this chapter’s Self Survey: “How Much Do You Know about Sex?”). Rather than relying on what peers say or what you’ve always thought was true, find out the facts. This textbook is a good place to start. The student health center and the library can provide additional materials on sexual identity, orientation, behavior, and health, as well as on options for reducing your risk of acquiring sexually transmitted infections (discussed in Chapter 11) or becoming pregnant.

Creating a Sexually Healthy Relationship

A sexually healthy relationship, as defined by the Sexuality Information and Education Council of the United States (SIECUS), is based on shared values and has five characteristics: It is

- Consensual.
- Nonexploitative.
• Honest.
• Mutually pleasurable.
• Protected against unintended pregnancy and sexually transmitted infections.

All individuals also have sexual rights, which include the right to the information, education, skills, support, and services they need to make responsible decisions about their sexuality consistent with their own values, as well as the right to express their sexual orientation without violence or discrimination.

Communication is vital in a sexually healthy relationship, even though these discussions can be awkward. Yet if you have a need or a problem that relates to your partner, it is your responsibility to bring it up. (See Health on a Budget, p. 288.)

Making Sexual Decisions

Sexual decision making should always take place within the context of an individual’s values and perceptions of right and wrong behavior. Making responsible sexual decisions means considering all the possible consequences—including emotional consequences—of sexual behavior for both yourself and your partner.

Even after they have entered into a relationship, many young people are not clear on whether they will have sex only with one another. According to a recent study of heterosexual married and unmarried couples between ages 18 and 25, in 40 percent of the cases, one partner said the couple had agreed to be monogamous while the other said there was no such understanding. Even among couples who had agreed to have sex exclusively with each other, nearly 30 percent broke this commitment, with at least one partner having sex outside the relationship. Married couples were no more likely than unmarried ones to have an explicit monogamy agreement.8

Prior to any sexual activity that involves a risk of sexually transmitted infection or pregnancy, both partners should talk about their prior sexual histories (including number of partners and exposure to STIs) and other high-risk behavior, such as the use of injection drugs. They should also discuss the issue of birth control and which methods might be best for them to use. If you know someone well enough to consider having sex with that person, you should be able to talk about such sensitive subjects. If a potential partner is unwilling to talk or hedges on crucial questions, you shouldn’t be engaging in sex.

Here are some questions to consider as you think and talk about the significance of becoming sexually intimate with a partner:

• What role do we want relationships and sex to have in our life at this time?

• What are my values and my potential partner’s values as they pertain to sexual relationships? Does each of us believe that intercourse should be reserved for a permanent partnership or committed relationship?

• Will a decision to engage in sex enhance my positive feelings about myself or my partner? Does either of us have questions about sexual orientation or the kinds of people we are attracted to?

• Do I and my partner both want to have sex? Is my partner pressuring me in any way? Am I pressuring my partner? Am

The key to a healthy, happy sexual relationship is open, honest communication—even when you and your partner have different points of view.
Developing Sexual Responsibility
The Sexuality Information and Education Council of the United States (SIECUS) has worked with nongovernmental organizations around the world to develop a consensus about the life behaviors of a sexually healthy and responsible adult. These include:

- Appreciating one's own body.
- Seeking information about reproduction as needed.
- Affirming that sexual development may or may not include reproduction or genital sexual experience.
- Interacting with both genders in respectful and appropriate ways.
- Affirming one's own sexual orientation and respecting the sexual orientation of others.
- Expressing love and intimacy in appropriate ways.
- Developing and maintaining meaningful relationships.
- Avoiding exploitative or manipulative relationships.
- Making informed choices about family options and lifestyles.
- Enjoying and expressing one's sexuality throughout life.
- Expressing one's sexuality in ways congruent with one's values.
- Discriminating between life-enhancing sexual behaviors and those that are harmful to oneself and/or others.

From the preceding list, choose three characteristics that you would like to improve in your intimate relationships. Why did you choose these three? Do they have special significance for you? How will you go about strengthening them? Do you have other goals for responsible sexuality? Record your reflections in your online journal.

I making this decision for myself or for my partner?

- Have my partner and I discussed our sexual histories and risk factors? Have I spoken honestly about any STIs I’ve had in the past? Am I sure that neither my partner nor I have a sexually transmitted infection?
- Have we taken precautions against unwanted pregnancy and STIs?

Saying No to Sex
Whether couples are on a first date or have been married for years, each partner always has the right not to have sex. Unfortunately, “no” sometimes seems to mean different things to men and women.

The following strategies can help you assert yourself when saying no to sex:

- First of all, recognize your own values and feelings. If you believe that sex is something to be shared only by people who’ve already become close in other ways, be true to that belief.
- Be direct. Look the person in the eyes, keep your head up, and speak clearly and firmly.
- Just say no. Make it clear you’re rejecting the offer, not the person. You don’t owe anyone an explanation for what you want, but if you want to expand on your reasons, you might say, “I enjoy your company, and I’d like to do something together, but no,” or “Thank you. I appreciate your interest, but no.”
- If you’re still at a loss for words, try these responses: “I like you a lot, but I’m not ready to have sex.” “You’re a great person, but sex isn’t something I do to prove I like someone.” “I’d like to wait until I’m married to have sex.”
- If you’re feeling pressured, let your date know that you’re uncomfortable. Be simple and direct. Watch out for emotional blackmail. If your date says, “If you really like me, you’d want to make love,” point out that if he or she really likes you, he or she wouldn’t try to force you to do something you don’t want to do.
- If you’re a woman, monitor your sexual signals. Men impute more sexual meaning to gestures (such as casual touching) that women perceive as friendly and innocent.
- Communicate your feelings to your date sooner rather than later. It’s far easier to say, “I don’t want to go to your apartment” than to fight off unwelcome advances once you’re there.
- Remember that if saying no to sex puts an end to a relationship, it wasn’t much of a relationship in the first place.

Sexual Behavior
From birth to death, we are sexual beings. Our sexual identities, needs, likes, and dislikes emerge in adolescence and become clearer as we enter adulthood, but we continue to change and evolve throughout our lives. In men, sexual
interest is most intense at age 18; in women, it reaches a peak in the 30s. Although age brings changes in sexual responsiveness, we never outgrow our sexuality.

**Adolescent Sexuality**

Early in adolescence, sexual curiosity explodes, and sexual exploration—both alone and with a partner—takes on new meaning and intensity. Sexual education programs can make a difference by helping young people become sexually responsible, enabling them to form satisfying relationships, helping them assess their own attitudes toward sex, and giving them information on sexuality. Good programs can clarify values and enhance communication.

It’s not unusual for teenage boys to experience frequent erections during the day and night, including nocturnal emissions, or wet dreams, during which ejaculation occurs. Masturbation (discussed later in this chapter) is the primary form of sexual expression for many teenagers, especially boys. Self-stimulation helps teens learn about their bodies and their sexual potential and serves as an outlet for sexual tension. By the end of adolescence, the majority of teens have masturbated to orgasm.

Other common sexual activities during adolescence include kissing and petting—erotic physical contact that may include holding, touching, manual stimulation of the genitals, and oral sex. As many as 25 percent of teens experience some same-sex attractions. Although many experiment with heterosexual and homosexual sexual experiences, adolescent sexual behavior does not always foretell sexual orientation. Young people, who often feel confused about their sexual identity, may engage in sexual activity with members of the same or the other sex as a way of testing how they really feel.

**Teen Sexual Activity**

More than half of adolescents (58 percent) in the United States have never had sexual intercourse. According to the CDC’s most recent report on teen sexual activity, the percentage of virgins among teens ages 15 to 19 has grown steadily in recent decades.² The reasons teens give for not having sex include the following:

- against religion or morals
- don’t want to get pregnant/get a girl pregnant
- don’t want to get a sexually transmitted infection
- haven’t found the right person yet
- in a relationship but waiting for the right time.³

Among sexually active teens, their most common first partner was someone with whom they were going steady. Boys were more likely than girls to report that their first sexual experience was with someone they had just met. Seven percent of the young women reported that their first sexual experience was not voluntary, particularly when their partner was older.

Teenagers were more likely to become sexually active if their mothers had their first births as teenagers, and if they did not live with both parents at age 14. The younger that teens were at first intercourse, the greater the number of total partners that they reported. Girls who lost

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**nocturnal emissions** Ejaculations while dreaming; wet dreams.

**masturbation** Manual (or nonmanual) self-stimulation of the genitals, often resulting in orgasm.
The Secret to a Good Sexual Relationship

The secret to a healthy, happy sexual relationship isn’t a hot car or sexy outfit. It’s the ability to communicate openly, honestly, and respectfully with your partner. Here are some specific suggestions:

• **Choose an appropriate time and place for an intimate discussion.** In a new relationship, talking in a public place, such as a park bench or a quiet table at a coffee house, can seem safer. If you’re in an established relationship, choose a time when you can give each other complete attention and a setting in which you can both relax.

• **Ask open-ended questions that encourage a dialogue—for instance, “How do you feel about . . .?” or “What are your thoughts about . . .?”**

• **Listen actively rather than passively when your partner speaks.** Show that you’re paying attention by nodding, smiling, and leaning forward. Paraphrase what he or she says to show you understand it fully.

(See “Listen Up” in Labs for IPC.)

• **Use “I” statements, such as “I really enjoy making love, but I’m so tired right now that I won’t be a responsive partner. Why don’t we get the kids to bed early tomorrow so we can enjoy ourselves a little earlier?”**

• **If you would like to try something different, say so.** Practice saying the words first if they embarrass you. If your partner feels uncomfortable, don’t force the issue, but do try talking it through.

• **If you want to request changes or tackle a touchy topic, start with positive statements.** Let your partner know how much you enjoy having sex, and then express your desire to enjoy lovemaking more often or in different ways.

• **Encourage small changes.** If you want your partner to be less inhibited, start slowly, perhaps by suggesting sex in a different room or place.

Sex on Campus

Sexual behavior on campus has changed dramatically in the last 25 years. Surveys conducted in the United States and in Canada since 1980 reveal a steady increase in the number of students who have had intercourse and an increase in safer sex practices among sexually active students.

Today’s undergraduates are more likely to question potential partners about their past, use condoms with a new partner, and maintain fairly long-term monogamous relationships.

College students see sexual activity as normal behavior for their peer group. College students tend to overestimate how much sex their peers are having. According to the American College Health Association National College Health Assessment, about a third of undergraduates reported having no sexual partners within the last 12 months. Among sexually active students, the mean number of partners was two. (See How Do You Compare? The Sex Lives of College Students.)

College students who binge drink or participate in drinking games, which often involve physical skills (such as bouncing a coin into a glass) or word play, increase their odds of sexually risky behavior. Both men and women report being taken advantage of sexually, including someone having sex with them when they were too drunk to give consent, after such games.

Annual spring breaks provide what researchers describe as “ideal conditions for the potentially lethal interaction between alcohol, drugs, and sexual risk-taking.” Students typically engage in binge drinking, illicit drug use, and unsafe sexual practices. The likelihood of casual sex depends on several factors, including peer influences, prior experiences with casual sex, alcohol consumption prior to sex, and impulsivity.

As with other aspects of health, cultural, religious, and personal values affect students’ sexual behaviors.
Researchers raised concern about young Latina women, who have the highest teen birth rate in the United States (twice the national rate) and are at greater risk of sexually transmitted infections. Although Latinas represent about 10 percent of women over age 21, they account for 20 percent of female AIDS cases. Among college students and other populations, Latinas are more likely to engage in unprotected intercourse than women from other ethnic groups.

Acculturation—the process of adaptation that occurs when immigrants enter a new country—also affects sexual behavior. As Latina immigrants become more acculturated in the United States, some aspects of their sexual behavior become more Americanized; for instance, they become more likely to engage in nonmarital sexual activity and to have multiple partners.

In a study of Cuban American college women, older, less religious, and U.S.-born Latinas were more likely to be sexually active and to engage in risky sexual behavior than other Latinas.

The Sex Life of American Adults

The scientific study of Americans’ sexual behavior began in 1938, when Alfred Kinsey, Ph.D.,...
In a loving, committed relationship, every form of physical contact can serve as an intimate form of expressing deep emotion.

a professor of biology at the University of Indiana, and his colleagues asked 5,300 white men and 5,940 white women about their sexual practices. In his landmark studies—Sexual Behavior in the Human Male, published in 1948, and Sexual Behavior in the Human Female, published in 1953—Kinsey reported that 73 percent of men and 20 percent of women had premarital intercourse by age 20, and 37 percent of men and 17 percent of women had some homosexual experience in their lifetime.

The Janus Report on Sexual Behavior, published in 1993, was based on a survey of 2,765 individuals across the United States. A larger survey, conducted by researchers at the University of Chicago, was based on face-to-face interviews with 3,432 Americans, ages 18 to 59. It became the basis for two books published in 1994: Sex in America, aimed at a lay audience, and The Social Organization of Sexuality, a more scholarly work. Since then, the researchers’ General Social Survey (GSS) database on sexual activity has grown to nearly 10,000 respondents.

College students tend to believe that they engage in fewer risky sex behaviors than their peers—yet only about a third report using condoms regularly. Generally they are more likely to do so with a partner they have not known long or well, such as a hookup or one-night stand. Undergraduates who believe they “know” their partners often see safe practices as unnecessary—even though there is no way of “knowing” whether a potential partner has a sexually transmitted infection.11

The average American adult reports having sex about once a week. However, 1 in 5 Americans has been celibate for at least a year, and 1 in 20 engages in sex at least every other day. Men report more sexual frequency than women—not because men are more boastful about their prowess, the researchers contend, but because the sample of women includes many widows and older women without partners. Among married people, the frequency reports of husbands and wives (not in the same couples) are within one episode per year—58.6 for married men and 57.9 for married women. If other differences between men and women are statistically controlled (such as sexual preference, age, and educational attainment), married women actually report a slightly higher frequency than men.

Sexual frequency peaks among those with some college education, then decreases among four-year college graduates, and declines even further among those with professional degrees. Americans who have attended graduate school are the least sexually active educational group in the population. These respondents may be more honest than others in reporting sexual activity, or they may be more precise in their definition of what counts as sex.
Does sex make people happier or healthier? Researchers have concluded that the more sex a person has, the more likely he or she is to report having a happy life and a happy marriage. This connection is stronger among women than among men. A second and more important predictor of sexual frequency is the feeling that one’s life is exciting rather than routine or dull. “Being excited by life is most strongly associated with being happier,” the researchers noted. “It seems that increased sexual activity is one of the many benefits of having a positive attitude.”

**Why People Have Sex**

The reasons people engage in sex long seemed so obvious that scientists didn’t bother to investigate them. They assumed that heterosexuals had sex primarily to reproduce, experience sexual pleasure, and relieve sexual tension.

In the most extensive study of why humans have sex, researchers identified 237 motivations. The study sample included 1,549 undergraduates ranging in age from 16 to 42. The reasons people gave fell into nine categories:

- Pure attraction to the other person in general.
- Experiencing physical pleasure.
- Expressing love.
- Feeling desired by the other.
- Escalating the depth of a relationship.
- Curiosity or seeking new adventures.
- Marking a special occasion for celebration.
- Mere opportunity.
- Sex “just happening” due to seemingly uncontrollable circumstances.

The responses of men and women were generally similar. However, men were significantly more likely to report having sex for reasons of opportunity and experience—for instance, because a person “was available” or wanting “to increase the number of partners I experienced.” Women were more likely to endorse certain emotional motivations, such as, “I wanted to express my love for the person,” or “I realized I was in love.” Men also endorsed more reasons related to pure physical pleasure, such as wanting to have sex because it felt good or because they were “horny.”

**Sexual Diversity**

Human beings are diverse in all ways—including sexual preferences and practices. Physiological, psychological, and social factors determine whether we are attracted to members of the same sex or the other sex. This attraction is our **sexual orientation**. Sigmund Freud argued that we all start off **bisexual**, or attracted to both sexes. But by the time we reach adulthood, most males prefer female sexual partners, and most females prefer male partners. **Heterosexual** is the term used for individuals whose primary orientation is toward members of the other sex. In virtually all cultures, some men and women are **homosexuals**, preferring partners of their own sex.

In our society, we tend to view heterosexuality and homosexuality as very different. In reality, these orientations are opposite ends of a spectrum. Sex researcher Alfred Kinsey devised a seven-point continuum representing sexual orientation in American society. At one end of the continuum are those exclusively attracted to members of the other sex; at the opposite end are people exclusively attracted to members of the same sex. In between are varying degrees of homosexual, bisexual, and heterosexual orientation.

According to Kinsey’s original data, 4 percent of men and 2 percent of women are exclusively homosexual. More recent studies have found lower numbers. For instance, in the University of Chicago’s national survey, 2.8 percent of men and 1.4 percent of women defined themselves as homosexual. However, when asked if they’d had sex with a person of the same gender since age 18, about 5 percent of men and 4 percent of women said yes. When asked if they found members of the same gender sexually attractive, 6 percent of men and 5.5 percent of women said yes.

Most lesbian and bisexual women report that their first sexual experience occurred with a man (at the median age of 18) and that sex with a woman followed a few years later (at median age 21).

**Heterosexuality**

Heterosexuality, the most common sexual orientation, refers to sexual or romantic attraction...
considered part of normal sexual experimentation. Among the Sambia Highlanders in Papua New Guinea, for instance, boys perform oral sex on one another as part of the rites of passage into manhood.

Some people identify themselves as bisexual even if they don’t behave bisexualy. Some are serial bisexuals—that is, they are sexually involved with same-sex partners for a while and then with partners of the other sex, or vice versa. An estimated 7 to 9 million men, about twice the number thought to be exclusively homosexual, could be described as bisexual during some extended period of their lives. The largest group are married, rarely have sexual relations with women other than their wives, and have secret sexual involvements with men.

Fear of HIV infection has sparked great concern about bisexuality, particularly among heterosexual women who worry about becoming involved with a bisexual man. About 20 to 30 percent of women with AIDS were infected by bisexual partners, and health officials fear that bisexual men who hide their homosexual affairs could transmit HIV to many more women.

Homosexuality

Homosexuality—social, emotional, and sexual attraction to members of the same sex—exists in almost all cultures. Men and women homosexuals are commonly referred to as gay; women homosexuals are also called lesbians.

Homosexuality threatens and upsets many people, perhaps because homosexuals are viewed as different, or perhaps because no one understands why some people are heterosexual and others homosexual. Homophobia has led to an increase in gay bashing (attacking homosexuals) in many communities, including college campuses. Some blame the emergence of AIDS as a societal danger. However, researchers have found that fear of AIDS has not created new hostility but has simply given bigots an excuse to act out their hatred.

Different ethnic groups respond to homosexuality in different ways. To a greater extent than white homosexuals, gays and lesbians from ethnic groups tend to stay in the closet longer rather than risk between opposite sexes. The adjective heterosexual describes intimate relationships and/or sexual relations between a man and a woman. The term straight is used predominantly for self-identified heterosexuals of either sex. In his landmark research in the 1940s, Alfred Kinsey reported that while many men and women were exclusively heterosexual, a significant number (37 percent of men and 13 percent of women) had at least one adult sexual experience with a member of the same sex.

Bisexuality

Bisexuality—sexual attraction to both males and females—can develop at any point in one’s life. In some cultures, bisexual activity is
alienation from their families and communities. Often they feel forced to choose between their gay and their ethnic identities.

In general, the African American community has stronger negative views of homosexuals than whites, possibly because of the influence of strong fundamentalist Christian beliefs. Stigma may contribute to a phenomenon called “the Down Low” or DL, which refers to African American men who publicly present themselves as heterosexuals while secretly having sex with other men. This practice, which is neither new nor limited to African American men, can increase the risk of HIV infection in unsuspecting female partners. Hispanic culture, with its emphasis on machismo, also has a very negative view of male homosexuality. Asian cultures, which tend to view an individual as a representative of his or her family, tend to view open declarations of sexual orientation as shaming the family and challenging their reputation and future.

**Roots of Homosexuality** Most mental health experts agree that nobody knows what causes a person’s sexual orientation. Research has discredited theories tracing homosexuality to troubled childhoods or abnormal psychological development. Sexual orientation probably emerges from a complex interaction that includes biological and environmental factors.

**Homosexuality on Campus** In a study of almost 700 heterosexual students at six small liberal arts colleges, attitudes toward homosexuals and homosexuality varied, depending on students’ membership in fraternities or sororities, sex-role attitudes, religion and religiosity, and contact with and knowledge of gays, lesbians, and bisexuals. The students most likely to be accepting were those who were women, had less traditional sex-role attitudes, were less religious, attended colleges that did not have Greek social clubs, and had gay, lesbian, and/or bisexual friends.

In a study of heterosexual African American college students, women expressed positive attitudes toward homosexuality, whereas men’s attitudes were slightly negative. A survey of colleges and universities found great variation in the resources available to gay, lesbian, and bisexual students. Most have a student organization; about a third provide a paid staff member to deal with the students’ needs and issues, provide a support identification program, or offer at least one course on gay, lesbian, and bisexual issues.

**Transgenderism and Transsexuality** The term transgender is used as an umbrella term to describe people who have gender identities, expressions, or behaviors not traditionally associated with their birth sex. Male-to-female transgenders have been assigned a male gender at birth, but identify their gender as female. Female-to-male people were assigned a female gender at birth, but identify their gender as male.

Transgender individuals may be happy with the biological sex in which they are born but enjoy dressing up and behaving like the other sex. Most do so for psychological and social pleasure rather than sexual gratification.

Transsexuals feel trapped in the body of the wrong gender—a condition called gender dysphoria. In general, more men than women have this experience. Transsexualism is now viewed as a disorder that can be treated with sexual reassignment surgery. However, this intervention, which requires long psychological counseling, hormonal treatments, and complicated operations, remains controversial. Some studies report healthy postoperative functioning, while others note that many male and female transsexuals do not escape their psychological misery.

Transgender individuals face varied health risks, including unprotected sex, sexually transmitted diseases, and HIV infection. Violence, including rape, sexual abuse, physical abuse, and suicide, is a major public health issue.

**Sexual Activity** Part of learning about your own sexuality is having a clear understanding of human sexual behaviors. Understanding frees us from fear and anxiety so that we can accept ourselves and others as the natural sexual beings we all are.
Celibacy

A celibate person does not engage in sexual activity. Complete celibacy means that the person doesn’t masturbate (stimulate himself or herself sexually) or engage in sexual activity with a partner. In partial celibacy, the person masturbates but doesn’t have sexual contact with others. Many people decide to be celibate at certain times of their lives. Some don’t have sex because of concerns about pregnancy or STIs; others haven’t found a partner for a permanent, monogamous relationship. Many simply have other priorities, such as finishing school or starting a career, and realize that sex outside of a committed relationship is a threat to their physical and psychological well-being.

Abstinence

The CDC defines abstinence as “refraining from sexual activities which involve vaginal, anal, and oral intercourse.” The definition of abstinence remains a subject of debate and controversy, with some emphasizing positive choices and others avoidance of specific behaviors. In reality, abstinence means different things to different people, cultures, and religious groups.

Increasing numbers of adolescents and young adults are choosing to remain virgins and abstain from sexual intercourse until they enter a permanent, committed, monogamous relationship. About 2.5 million teens have taken pledges to abstain from sex.

Many people who were sexually active in the past also are choosing abstinence because the risk of medical complications associated with STIs increases with the number of sexual partners a person has. Practicing abstinence is the safest, healthiest option for many. However, there is confusion about what it means to abstain, and individuals who think they are abstaining may still be engaging in behaviors that put them at risk for HIV and STIs. (See Chapter 10 for more on abstinence as a form of birth control.)

Why abstain? Among the reasons students give are:

- Remaining a virgin until you meet someone you love and see as a life partner.
- Being true to your religious and moral values.
- Getting to know a partner better.
- If you’re heterosexual, to avoid pregnancy.
- To be sure you’re safe from sexually transmitted infections.

Abstinence education programs, which received federal support and became widespread in American schools, have had little, if any, impact on teen sexual behavior.

Fantasy

The mind is the most powerful sex organ in the body, and erotic mental images can be sexually stimulating. Sexual fantasies can accompany sexual activity or be pleasurable in themselves.

Fantasies generally enhance sexual arousal, reduce anxiety, and boost sexual desire. They’re also a way to anticipate and rehearse new sexual experiences, as well as to bolster a person’s self-image and feelings of desirability. Part of what makes fantasies exciting is that they provide an opportunity for expressing forbidden desires, such as sex with a different partner or with a past lover.

Men and women have different types ofsexy thoughts, with man’s fantasies containing more explicit genital images and culminating in sexual acts more quickly than women’s. In women’s fantasies, emotional feelings play a greater role, and there is more kissing and caressing rather than genital contact. For many women, fantasy helps in reaching orgasm during intercourse; a loss of fantasy often is a sign of low sexual desire.

Fantasies lived out via the Internet are becoming more common but may also be harmful to psychological health. (See Consumer Alert.)

Masturbation

Not everybody masturbates, but most people do. Kinsey estimated that 7 out of 10 women and 19 out of 20 men masturbate (and admit they do). Their reason is simple: It feels good. Masturbation produces the same physical responses as sexual activity with a partner and can be an enjoyable form of sexual release.

Masturbation has been described as immature; unsocial; tiring; frustrating; and a cause of hairy


CONSUMER ALERT

Sex in Cyberspace

Sex is the number one word searched for online. About 15 percent of Americans logging onto the Internet visit sexually oriented sites. Most people who check out sex sites on the Internet do not suffer any negative impact, but be aware of some potential risks.

Facts to Know

- Men are the largest consumers of sexually explicit material and outnumber women by a ratio of six to one. However, while men look for visual erotica, women are more likely to visit chat rooms, which offer more interactions.
- While most individuals use their home computers when surfing the Internet for sex-related sites, one in ten has used a school computer. Some universities have strict policies barring such practices and may take punitive actions against students or employees who violate the rules.

Steps to Take

- Limit time online. Individuals who spend 11 hours or more a week online in sexual pursuits show signs of psychological distress and admit that their behavior interferes with some areas of their lives.
- Be skeptical. Most Internet surfers admit that they occasionally “pretend” about their age on the Internet. Most keep secret how much time they spend on sexual pursuits in cyberspace.
- Monitor yourself for signs of compulsivity. A small but significant number of users are at risk of a serious problem as a result of their heavy Internet use.
- Don’t do anything “virtually” that you wouldn’t do in real life. For instance, “sexting” a photo of yourself nude or partially nude to your boyfriend or girlfriend might seem funny and flirty at the time. But would you flash your body on the quad or at a mall? Remember that nothing remains totally private once it makes its way into cyberspace.

Nonpenetrative Sexual Activity (Outercourse)

Various pleasurable behaviors can lead to orgasm with little risk of pregnancy or sexually transmitted infection. The options for “outercourse” include kissing, hugging, and touching but do not involve genital-to-genital, mouth-to-genital, or insertive anal sexual contact.

A kiss is a universal sign of affection. A kiss can be just a kiss—a quick press of the lips—or it can lead to much more. Usually kissing is the first sexual activity that couples engage in, and even after years of sexual experimentation and sharing, it remains an enduring pleasure for partners.

Touching is a silent form of communication between friends and lovers. Although a touch

palms, warts, blemishes, and blindness. None of these myths is true. Sex educators recommend masturbation to adolescents as a means of releasing tension and becoming familiar with their sexual organs.

In a recent survey of college students, nearly all learned about masturbation through the media or from peers, rather than from parents or teachers. Most of the women reported struggling with feelings of stigma and taboo and enjoying this pleasurable act. Most of the men saw masturbation as part of healthy sexual development.

Throughout adulthood, masturbation often is the primary sexual activity of individuals not involved in a sexual relationship and can be particularly useful when illness, absence, divorce, or death deprives a person of a partner. In the University of Chicago survey, about 25 percent of men and 9 percent of women said they masturbate at least once a week.

White men and women have a higher incidence of masturbation than African American men and women. Latina women have the lowest rate of masturbation, compared with Latino men, white men and women, and African American men and women. Individuals with a higher level of education are more likely to masturbate than those with less schooling, and people living with sexual partners masturbate more than those who live alone.
to any part of the body can be thrilling, some areas, such as the breasts and genitals, are especially sensitive. Stimulating these **erogenous** regions can lead to orgasm in both men and women. Though such forms of stimulation often accompany intercourse, more couples are gaining an appreciation of these activities as primary sources of sexual fulfillment—and as safer alternatives to intercourse.

**Intercourse**

Vaginal **intercourse**, or coitus, refers to the penetration of the vagina by the penis (Figure 9.5). This is the preferred form of sexual intimacy for most heterosexual couples, who may use a wide variety of positions. The most familiar position for intercourse in our society is the so-called missionary position, with the man on top, facing the woman. An alternative is the woman on top, either lying down or sitting upright. Other positions include lying side by side (either face-to-face or with the man behind the woman, his penis entering her vagina from the rear); lying with the man on top of the woman in a rear-entry position; and kneeling or standing (again, in either a face-to-face or rear-entry position). Many couples move into several different positions for intercourse during a single episode of lovemaking; others may have a personal favorite or may choose different positions at different times.

Sexual activity, including intercourse, is possible throughout a woman’s menstrual cycle. However, some women prefer to avoid sex while menstruating because of uncomfortable physical symptoms, such as cramps, or concern about bleeding or messiness. Others use a diaphragm or cervical cap (see Chapter 10) to hold back menstrual flow. Since different cultures have different views on intercourse during a woman’s period, partners should discuss their own feelings and try to respect each other’s views. If they choose not to have intercourse, there are other gratifying forms of sexual activity.

Vaginal intercourse, like other forms of sexual activity involving an exchange of body fluids, carries a risk of sexually transmitted infections, including HIV infection. In many other parts of the world, in fact, heterosexual intercourse is the most common means of HIV transmission (see Chapter 11).

**Oral Sex**

The formal terms for oral sex are **cunnilingus**, which refers to oral stimulation of the woman’s genitals, and **fellatio**, oral stimulation of the man’s genitals. For many couples, oral sex is a regular part of their lovemaking. For others, it’s an occasional experiment. Oral sex with a partner carrying a sexually transmitted infection, such as herpes or HIV infection, can lead to infection, so a condom should be used (with cunnilingus, a condom cut in half to lay flat can be used). According to the CDC, 90 percent of men and 88 percent of women ages 25 to 44 report having had oral sex with a partner of the opposite sex.

**Anal Stimulation and Intercourse**

Because the anus has many nerve endings, it can produce intense erotic responses. Stimulation of
the anus by the fingers or mouth can be a source of sexual arousal; anal intercourse involves penile penetration of the anus. An estimated 25 percent of adults have experienced anal intercourse at least once. However, anal sex involves important health risks, such as damage to sensitive rectal tissues and the transmission of various intestinal infections, hepatitis, and STIs, including HIV.

Cultural Variations

While the biological mechanisms underlying human sexual arousal and response are essentially universal, the particular sexual stimuli or behaviors that people find arousing are greatly influenced by cultural conditioning. For example, in Western societies, where the emphasis during sexual activity tends to be heavily weighted toward achieving orgasm, genitally focused activities are frequently defined as optimally arousing. In contrast, devotees to Eastern Tantric traditions (where spirituality is interwoven with sexuality) often achieve optimal pleasure by emphasizing the sensual and spiritual aspects of shared intimacy rather than orgasmic release.

Kissing on the mouth, a universal source of sexual arousal in Western society, may be rare or absent in many other parts of the world. Certain North American Eskimo people and inhabitants of the Trobriand Islands would rather rub noses than lips, and among the Thonga of South Africa, kissing is viewed as odious behavior. The Hindu people of India are also disinclined to kiss because they believe such contact symbolically contaminates the act of sexual intercourse. One survey of 190 societies found that mouth kissing was acknowledged in only 21 societies and practiced as a prelude or accompaniment to coitus in only 13.

Oral sex (both cunnilingus and fellatio) is a common source of sexual arousal among island societies of the South Pacific, in industrialized nations of Asia, and in much of the Western world. In contrast, in Africa (with the exception of northern regions), such practices are likely to be viewed as unnatural or disgusting behavior.

Foreplay in general, whether it be oral sex, sensual touching, or passionate kissing, is subject to wide cultural variation. In some societies, most notably those with Eastern traditions, couples may strive to prolong intense states of sexual arousal for several hours. While varied patterns of foreplay are common in Western cultures, these activities often are of short duration as lovers move rapidly toward the “main event” of coitus. In still other societies, foreplay is either sharply curtailed or absent altogether. For example, the Lepcha farmers of the southeastern Himalayas limit foreplay to men briefly caressing their partners’ breasts, and among the Irish inhabitants of Inis Beag, precoital sexual activity is reported to be limited to mouth kissing and rough fondling of the woman’s lower body by her partner.

Sexual Response

Sexuality involves every part of you: mind and body, muscles and skin, glands and genitals. The pioneers in finding out exactly how human beings respond to sex were William Masters and Virginia Johnson, who first studied more than 800 individuals in their laboratory in the 1950s. They discovered that sexual response is a well-ordered sequence of events, so predictable it could be divided into four phases: excitement, plateau, orgasm, and resolution (Figure 9.6). In real life, individuals don’t necessarily follow this well-ordered pattern. But the responses for
both sexes are remarkably similar. And sexual response always follows the same sequence, whatever the means of stimulation.

**Excitement**

Stimulation is the first step: a touch, a look, a fantasy. In men, sexual stimuli set off a rush of blood to the genitals, filling the blood vessels in the penis. Because these vessels are wrapped in a thick sheath of tissue, the penis becomes erect. The testes lift.

Women respond to stimulation with vaginal lubrication within 10 to 20 seconds of exposure to sexual stimuli. The clitoris becomes larger, as do the vaginal lips (the labia), the nipples, and later the breasts. The vagina lengthens, and its inner two-thirds increase in size. The uterus lifts, further increasing the free space in the vagina.

**Plateau**

During this stage, the changes begun in the excitement stage continue and intensify. The penis further increases in both length and diameter. The outer one-third of the vagina swells. During intercourse, the vaginal muscles grasp the penis to increase stimulation for both partners. The upper two-thirds of the vagina become wider as the uterus moves up; eventually its diameter is $2\frac{1}{2}$ to 3 inches.
Orgasm

Men and women have remarkably similar orgasm experiences. Both men and women typically have 3 to 12 pelvic muscle contractions approximately four-fifths of a second apart and lasting up to 60 seconds. Both undergo contractions and spasms of other muscles, as well as increases in breathing and pulse rates, and blood pressure. Both can sometimes have orgasms simply from kisses, stimulation of the breasts or other parts of the body, or fantasy alone.

The process of ejaculation (the discharge of semen by a male) requires two separate events. First, the vas deferens, the seminal vesicles, the prostate, and the upper portion of the urethra contract. The man perceives these subtle contractions deep in his pelvis just before the point of no return—which therapists refer to as the point of “ejaculatory inevitability.” Then, seconds later, muscle contractions force semen out of the penis via the urethra.

Female orgasms follow several patterns. Some women experience a series of mini-orgasms—a response sometimes described as “skimming.” Another pattern consists of rapid excitement and plateau stages, followed by a prolonged orgasm. This is the most frequent response to stimulation by a vibrator.

Female orgasms are primarily triggered by stimulating the clitoris. When stimulation reaches an adequate level, the vagina responds by contracting. Although it sometimes seems that vaginal stimulation alone can set off an orgasm, the clitoris is usually involved—at least indirectly during full penile penetration.

Some researchers have identified what they call the Grafenberg (or G) spot (or area) just behind the front wall of the vagina, between the cervix and the back of the pubic bone (see Figure 9.5). When this region is stimulated, women report various sensations, including slight discomfort, a brief feeling that they need to urinate, and increasing pleasure. Continued stimulation may result in an orgasm of great intensity, accompanied by ejaculation of fluid from the urethra. However, other researchers have failed to confirm the existence and importance of the G spot, and sex therapists disagree about its significance for a woman’s sexual satisfaction.

Is sexual satisfaction different for lesbians and heterosexual women? Not according to a recent study of married heterosexual women and lesbian/bisexual women in committed same-sex relationships. The same factors—the quality of the relationship, sexual functioning, social support, symptoms of depression—affect all the women’s sexual satisfaction more than a partner’s gender.17

Resolution

The sexual organs of men and women return to their normal, nonexcited state during this final phase of sexual response. Heightened skin color quickly fades after orgasm, and the heart rate, blood pressure, and breathing rate soon return to normal. The clitoris also resumes its normal position and appearance very shortly thereafter, whereas the penis may remain somewhat erect for up to 30 minutes.

After orgasm, men typically enter a refractory period, during which they are incapable of another orgasm. The duration of this period varies from minutes to days, depending on age and the frequency of previous sexual activity. If either partner doesn’t have an orgasm after becoming highly aroused, resolution may be much slower and may be accompanied by a sense of discomfort.

Other Models of Sexual Response

Since Masters and Johnson’s pioneering work, other researchers have challenged and expanded their theories. Some argue that their model neglects the importance of desire in sexual response and that the plateau stage is virtually indistinguishable from excitement. Others note that arousal may come before desire, particularly for women who may not have spontaneous feelings of sexual desire.

As many experts have concluded, physiology alone can never explain the complexity of human sexual response. Desire, arousal, pleasure, and satisfaction are highly subjective. Positive feelings like trust and happiness enhance them. Negative emotions like anger and anxiety can undermine them. For women, sexual satisfaction cannot be defined, as it typically is for men, by whether or not they achieved orgasm.
Sexual Concerns

Many sexual concerns stem from myths and misinformation. There is no truth, for instance, behind these misconceptions: men are always capable of erection, sex always involves intercourse, partners should experience simultaneous orgasms, or people who truly love each other always have satisfying sex lives.

Cultural and childhood influences can affect our attitudes toward sex. Even though America’s traditionally puritanical values have eased, our society continues to convey mixed messages about sex. Some children, repeatedly warned of the evils of sex, never accept the sexual dimensions of their identity. Others—especially young boys—may be exposed to macho attitudes toward sex and feel a need to prove their virility. Young girls may feel confused by media messages that encourage them to look and act provocatively and a double standard that blames them for leading boys on. In addition, virtually everyone has individual worries. A woman may feel self-conscious about the shape of her breasts; a man may worry about the size of his penis; both partners may fear not pleasing the other.

The concept of sexual normalcy differs greatly in different times, cultures, or racial and ethnic groups. In certain times and places, only sex between a husband and wife has been deemed normal. In other circumstances, “normal” has been applied to any sexual behavior—alone or with others—that does not harm others or produce great anxiety and guilt. The following are some of the most common contemporary sexual concerns.

Safer Sex

Having sex is never completely safe; the only 100 percent risk-free sexual choice is abstinence. By choosing not to be sexually active with a partner, you can safeguard your physical health, your fertility, and your future.

For men and women who are sexually active, a mutually faithful sexual relationship with just one healthy partner is the safest option. For those not in such relationships, safer-sex practices are essential for reducing risks. See Chapter 11 and “The Seduction of Safer Sex” in Labs for IPC for a complete discussion of safer sex.

Difficulties and Sexual Dysfunctions

SIECUS defines sexual dysfunction as the inability to react emotionally and/or physically to sexual stimulation in a way expected of the average healthy person or according to one’s own standards. Sexual dysfunctions, which have a wide range of psychological and physiological origins, can affect different stages in the sexual response cycle. They are not all-or-nothing problems but vary considerably in how severe they are and how frequently they occur. In as many as one-third of people with sexual problems, the partner also has a sexual dysfunction.

Most men and women at one time or another experience some sort of sexual difficulty, but they tend to develop different types. The most common male sexual problems are early ejaculation, reported by 26 percent of men in a recent survey; erectile difficulties, reported by 23 percent; and lack of sexual interest, reported by 18 percent. The most common female problems are lack of sexual interest (reported by 33 percent), lubrication difficulties (reported by 22 percent), inability to reach orgasm (21 percent), and lack of sexual pleasure (20 percent).

Although sexual problems are common, fewer than 25 percent of men and women sought help from a health professional.18 Why don’t more people seek help? Many are hesitant about bringing up the subject. Others are not informed about available treatments. Some are fatalistic and feel that nothing can help.19 Men are more likely to seek and receive treatment for sexual problems. Nevertheless, they find them very difficult to talk about and may delay or avoid seeking help.

Erectile Dysfunction (ED) An NIH consensus conference has defined erectile dysfunction (ED), also referred to as impotence, as the consistent inability to maintain a penile erection sufficient for adequate sexual relations. Virtually all men are occasionally unable to achieve or maintain an erection because of fatigue, stress, alcohol, or drug use, but the incidence
of erectile disorders increases with age. Recent research has overturned many common misconceptions about ED. Rather than a chronic condition that worsens with age, ED can be a temporary symptom that improves on its own much more commonly than was thought.20

Erectile dysfunction affects an estimated 18 million men—about 18 percent of those over age 20—in the United States. Only 5 percent of men between ages 20 and 40 report ED, which becomes more prevalent with age and illness. Almost 90 percent of men with ED have at least one risk factor for cardiovascular disease, including hypertension or diabetes.

Psychological factors, such as anxiety about performance, may cause erectile dysfunction. But in as many as 80 percent of cases, the problem has physical origins. Diabetes and reactions to drugs—including an estimated 200 prescription medications—are the most frequent organic causes. Even cigarettes can create erection problems for men sensitive to nicotine.

**Preventing Erectile Dysfunction** “The way a man lives can affect the way he loves.” This was the conclusion of the Harvard’s Health Professionals Follow-up Study, which found that healthy habits directly affect a man’s risk of ED. Here are their key findings:

- **Smoking.** Men who smoke are twice as likely to develop ED than nonsmokers.
- **Exercise.** Men who exercise for 30 minutes a day are less likely to develop erectile dysfunction than sedentary men.
- **Obesity.** Overweight men are more likely to have ED, even after age, diabetes, exercise, and other risk factors are taken into account. For example, a man with a 42-inch waist is 50 percent more likely to be impotent than a man with a 32-inch waist.
- **Alcohol.** The effects of alcohol are complex: A man who averages one to two drinks a day is less likely to have erectile dysfunction than a nondrinker, but a man who drinks more will increase his risk of sexual dysfunction.
- **Cycling.** Sitting on a bicycle for a long time puts pressure on the perineum, the area between the genitals and anus. This pressure can harm nerves and temporarily block blood flow, causing tingling or numbness in the penis and eventually leading to ED. To prevent this problem:
  - Wear well-padded or gel-filled seat rather than a narrow one. Position the seat so you don’t have to extend your legs fully.
at the bottom of your pedal stroke. Don’t tilt the seat upward.

- Shift position and take regular breaks during long rides.
- If you feel tingling or numbness in the penis, stop riding for a week or two.

Lifestyle therapy has promise for erectile dysfunction, but men have to make changes early enough to prevent irreversible changes in the arteries and nerves required for normal sexual function.

**Treating Erectile Dysfunction**  Men with erectile dysfunction can get help. If medication for a chronic medical problem is the culprit, a change in treatment may work. Treating underlying diseases, such as diabetes, may also help restore erectile function.

Millions of men, including about 1 percent of male undergraduates, have used the “erection pills”: Viagra, Levitra, and Cialis. The three ED medications have similar success rates. In all, about 70 percent of men respond to the drugs but the rates vary according to what is responsible for ED. About half of men with diabetes respond well, while 90 percent of those without an underlying disease benefit.

Because of their effects on the arteries, men with cardiovascular disease should try ED pills only with their doctors’ supervision, and some cannot use them under any circumstances. Recent research has shown that erectile dysfunction drugs do not cause vision loss or abnormalities as once was thought. Some side effects include headache, facial flushing, nasal congestion, indigestion, and diarrhea.

Men can purchase ED drugs on the Internet, but they are taking a risk in using them without a legitimate medical evaluation. Other men turn to herbal remedies. The FDA warns that “all-natural” supplements may actually contain prescription-strength levels of Viagra that could be life-threatening for men with heart disease.

Erection drugs are not aphrodisiacs, but they can improve the erectile response to erotic stimulation. They correct impotence but do not enhance sexual performance. However, successful treatment correlates with greater emotional well-being. Wives of men treated for ED also report high levels of satisfaction with their sexual lives.

**Orgasm Problems in Men**  About 20 percent of men complain of premature ejaculation, which is defined as ejaculating within 30 to 90 seconds of inserting the penis into the vagina, or after 10 to 15 thrusts. Another definition is that a premature ejaculator cannot control or delay his ejaculation long enough to satisfy a responsive partner at least half the time. By this definition, a man may be premature with some women but not with others.

To delay orgasm, men may try to think of baseball or other sports, but this just makes sex boring. Others may masturbate before intercourse, hoping to take advantage of the refractory period, during which they cannot ejaculate again. Others may bite their lips or dig their nails into their palms—although usually this just results in premature ejaculators with bloody lips and scarred palms. Topical anesthetics used to prevent climax dull pleasurable sensations for the woman as well as for the man.

Researchers are studying several medications, including clomipramine, SSRIIs, and Viagra, in the treatment of premature ejaculation. The combination of medication and psychological and behavioral counseling seems most effective.

Men can learn to control their ejaculation by concentrating on their sexual responses, rather than by trying to distract themselves or ignore their reactions. Some men find that they have greater control by lying on their backs with their partner on top, by relaxing during intercourse, and by communicating with their partner about when to stop or slow down movements.

Other techniques for delaying ejaculation include stop-start, in which a man learns to sense the feelings that precede ejaculation and stop his movements before the point of ejaculatory inevitability, allowing his arousal to subside slightly before restarting sexual activity. In the squeeze technique, a man’s partner applies strong pressure with the thumb on the frenum (the thin strip of skin that connects the glans to the shaft on the underside of the penis) and the second and third fingers on the top side of the penis, one above and one below the corona (rim of penile glans), until the man loses the urge to ejaculate.
Female Sexual Dysfunction  The American Foundation for Urological Disease classifies female sexual dysfunction into four categories: sexual desire disorders, arousal disorders, orgasmic disorders, and sexual pain disorders. How common are these problems? That’s hard to estimate. Some sex therapists have speculated that as many as 43 percent of American women may have some form of sexual dysfunction.

Many health professionals remain dubious about the “medicalization” of various patterns of female sexual response. Scientists at the Kinsey Institute for Research in Sex, Gender, and Reproduction, for instance, caution that a pill, whatever its nature, may not be the solution to many women’s sexual concerns. Among the medications that have been tried for female sexual dysfunction are tibolone, a steroid used to treat osteoporosis in Europe that has been linked to improved sexual functioning in postmenopausal women, and phosphodiesterase inhibitors, which help erectile dysfunction in men but have been less effective in women. In women, psychology often is as important as or even more important than physiology, and effective therapy must address psychological problems in a sexual relationship as well as social constraints and inhibitions.

Some forms of female sexual dysfunction do respond to various therapies. These include dyspareunia, or pain during intercourse, and vaginismus, an extreme form of painful intercourse in which involuntary contractions of the muscles of the outer third of the vagina are so intense that they totally or partially close the vaginal opening. This problem often derives from a fear of being penetrated. Relaxation techniques, such as Kegel exercises (alternately tightening and relaxing the muscles of the pelvic floor), or the use of fingers or dilators to gradually open the vagina, can make penetration easier.

The female orgasm has long been a controversial sexual topic. According to recent estimates, about 90 percent of sexually active women have experienced orgasm, but only a much smaller percentage achieve orgasm through intercourse alone. Even fewer reach orgasm if intercourse isn’t accompanied by direct stimulation of the clitoris. Is intercourse without orgasm a sexual problem? The best answer is that it is a problem if a woman wants to experience orgasm during intercourse but doesn’t.

Many counseling programs urge women who have never had orgasms to masturbate. They are then encouraged to share with their partners what they’ve learned, communicating with words or gestures what is most pleasing to them. Some women want more than a single orgasm during intercourse. Partners can help by varying positions and experimenting with sexual techniques. However, in sexual response, more is not necessarily better, and the couple should keep in mind that no one else is counting.

Sex Therapy

Modern sex therapy, pioneered by Masters and Johnson in the 1960s, views sex as a natural, healthy behavior that enhances a couple’s relationship. Their approach emphasizes education, communication, reduction of performance anxiety, and sexual exercises that enhance sexual intimacy.

Today most sex therapists, working either alone or with a partner, have modified Masters and Johnson’s approach. Most see couples once a week for eight to ten weeks; the focus of therapy is on correcting dysfunctional behavior, not exploring underlying psychodynamics.

Contrary to common misconceptions, sex therapy does not involve conducting sexual activity in front of therapists. The therapist may review psychological and physiological aspects of sexual functioning and evaluate the couple’s sexual attitudes and ability to communicate. The core of the program is the couple’s “homework”—a series of exercises, carried out in private, that enhances their sensory awareness and improves nonverbal communication. These techniques have proved effective for couples regardless of their age or general health.

You and your partner should consider consulting a sex therapist if any of the following is true for you:

- Sex is painful or physically uncomfortable.
- You’re having sex less and less frequently.
- You have a general fear of, or revulsion toward, sex.

dyspareunia A sexual difficulty in which a woman experiences pain during sexual intercourse.
vaginismus A sexual difficulty in which a woman experiences painful spasms of the vagina during sexual intercourse.
• Your sexual pleasure is declining.
• Your sexual desire is diminishing.
• Your sexual problems are increasing in frequency or persisting for longer periods.

Drugs and Sex

Many recreational drugs, such as alcohol and marijuana, are believed to enhance sexual performance. However, none of the popular drugs touted as aphrodisiacs—including amphetamines, barbiturates, cantharides (“Spanish fly”), cocaine, LSD and other psychedelics, marijuana, amyl nitrite (“poppers”), and L-dopa (a medication used to treat Parkinson’s disease)—is truly a sexual stimulant. In fact, these drugs often interfere with normal sexual response. Researchers are studying one drug that may truly enhance sexual performance: yohimbine hydrochloride, which is derived from the sap of the tropical yohimbe tree that grows in West Africa.

Because many psychiatric problems can lower sexual desire and affect sexual functioning, medications appropriate to the specific disorders can help. In addition, psychiatric drugs may be used as part of therapy. Drugs such as certain antidepressants may be used to prolong sexual response in conditions such as premature ejaculation.

Medications can also cause sexual difficulty. In men, drugs that are used to treat high blood pressure, anxiety, allergies, depression, muscle spasms, obesity, ulcers, irritable colon, and prostate cancer can cause impotence, breast enlargement, testicular swelling, priapism (persistent erection), loss of sexual desire, inability to ejaculate, and reduced sperm count. In women, they can diminish sexual desire, inhibit or delay orgasm, and cause breast swelling or secretions.

Sexual Addiction

Some men and women can get relief from their feelings of restlessness and worthlessness only through sex (either masturbation or with a partner). Once the sexual high ends, however, they’re overwhelmed by the same negative feelings and driven, once more, to have sex.

Some therapists describe this problem as sexual addiction; others, as sexual compulsion. Professionals continue to debate exactly what this controversial condition is, how to diagnose it, and how to overcome it. However, most agree that for some people, sex is more than a normal pleasure: It is an overwhelming need that must be met, even at the cost of their careers and marriages.

Sex addicts can be heterosexual or homosexual, male or female. Their behaviors include masturbation, phone sex, reading or viewing pornography, attending strip shows, having affairs, engaging in anonymous sex with strangers or prostitutes, exhibitionism, voyeurism, child molestation, incest, and rape. Many were physically and emotionally abused as children or have family members who abuse drugs or alcohol. They typically feel a loss of control and a compulsion for sexual activity, and they continue their unhealthy (and sometimes illegal) sexual behavior despite the dangers, including the risk of contracting STIs.

With help, sex addicts can deal with the shame that both triggers and follows sexual activity. Professional therapy may begin with a month of complete sexual abstinence, to break the cycle of compulsive sexual behavior. Several organizations, such as Sexaholics Anonymous and Sexual Addicts Anonymous, offer support from people who share the same problem.

Sexual Deviations

Sexual deviations listed by the American Psychiatric Association include the following:

• Fetishism. Obtaining sexual pleasure from an inanimate object or an asexual part of the body, such as the foot.
• Transvestitism. Becoming sexually aroused by wearing the clothing of the opposite sex.
• Exhibitionism. Exposing one’s genitals to an unwilling observer.
• **Voyeurism.** Obtaining sexual gratification by observing people undressing or involved in sexual activity.

• **Sadism.** Becoming sexually aroused by inflicting physical or psychological pain.

• **Masochism.** Obtaining sexual gratification by suffering physical or psychological pain.

Another, increasingly common sexual variation, hypoxophilia, involves attempts to enhance the pleasure of orgasm by reducing oxygen intake. Individuals who do so by tying a noose around the neck have accidentally killed themselves.

Psychiatrists distinguish between passive sexual deviancy, which doesn’t involve actual contact with another, and aggressive deviancy. Most voyeurs and obscene phone callers don’t seek physical contact with the objects of their sexual desire. These behaviors are performed predominantly, but not exclusively, by males.

### The Business of Sex

Sex, without affection and individuality, becomes a product to be packaged, marketed, traded, bought, and sold. Two of the billion-dollar industries that treat sex as a commodity are prostitution and pornography.

Prostitution, described as the world’s oldest profession, is a nationwide industry grossing more than $1 billion annually. In every state except Nevada (and in all but a few counties there), prostitution is illegal. Besides the threat of jail and fines, prostitutes and their clients face another danger: sexually transmitted infections, including HIV infection and hepatitis B.

Pornography is a multimedia industry—books, magazines, movies, the Internet, phone lines, and computer games are available to those who find sexually explicit material entertaining or exciting. Most laws against pornography are based on the assumption that such materials can set off uncontrollable, dangerous sexual urges, ranging from promiscuity to sexual violence. Research indicates that exposure to scenes of rape or other forms of sexual violence against women, or to scenes of degradation of women, does lead to tolerance of these hostile and brutal acts.
We remain sexual beings throughout life. At different ages and stages, sexuality can take on different meanings. As you forge relationships and explore your sexuality, you may encounter difficult situations and unfamiliar feelings. But sex is never just about hormones and body parts. People describe the brain as the sexiest of our organs. Using your brain to make responsible sexual decisions leads to both a smarter and a more fulfilling sex life.

Which of the following characterize your behavior or the way you would want to behave in an intimate relationship?

___ Communicate openly. If you or your partner cannot talk openly and honestly about your sexual histories and contraception, you should avoid having sex. For the sake of protecting your sexual health, you have to be willing to ask—and answer—questions that may seem embarrassing.

___ Share responsibility in a sexual relationship. Both partners should be involved in protecting themselves and each other from STIs and, if heterosexual, unwanted pregnancy.

___ Respect sexual privacy. Revealing sexual activities violates the trust between two partners. Bragging about a sexual conquest demeans everyone involved.

___ Never sexually harass others. Pinches, pats, sexual comments or jokes, and suggestive gestures are offensive and disrespectful.

___ Be considerate. A public display of sexual affection can be extremely embarrassing to others. Roommates, in particular, should be sensitive and discreet in their sexual behavior.

___ Be prepared. If there’s any possibility that you may be engaging in sex, be sure you have the means to protect yourself against unwanted pregnancy and sexually transmitted infections.

___ In sexual situations, always think ahead. For the sake of safety, think about potential dangers—parking in an isolated area, going into a bedroom with someone you hardly know, and the like—and options to protect yourself.

___ Be aware of your own and your partner’s alcohol and drug intake. The use of such substances impairs judgment and reduces the ability to say no. While under their influence, you may engage in sexual behavior you’ll later regret.

___ Be sure sexual activity is consensual. Coercion can take many forms: physical, emotional, and verbal. All cause psychological damage and undermine trust and respect. At any point in a relationship, whether the couple is dating or married, either individual has the right to say no.

Source: Adapted from Robert Hatcher, et al., Sexual Etiquette 101 and More (Atlanta, GA: Emory University School of Medicine, 2002).

How Much Do You Know about Sex?

Mark each of the following statements True or False:

1. Men and women have completely different sex hormones.
2. Premenstrual syndrome (PMS) is primarily a psychological problem.
3. Circumcision diminishes a man’s sexual pleasure.
4. Sexual orientation may have a biological basis.
5. Masturbation is a sign of emotional immaturity.
6. Only homosexual men engage in anal intercourse.
7. Despite their awareness of AIDS, many college students do not practice safe sex.
8. After age 60, lovemaking is mainly a fond memory, not a regular pleasure of daily living.
9. Doctors advise against having intercourse during a woman’s menstrual period.
10. Only men ejaculate.
11. It is possible to be infected with HIV during a single sexual encounter.
12. Impotence is always a sign of emotional or sexual problems in a relationship.
Answers:

1. False. Men and women have the same hormones, but in different amounts.
2. False. PMS has been recognized as a physiological disorder that may be caused by a hormonal deficiency, abnormal levels of thyroid hormone, or social and environmental factors, such as stress.
3. False. Sex therapists have not been able to document differences in sensitivity to stimulation between circumcised and uncircumcised men.
5. False. Throughout a person’s life, masturbation can be a form of sexual release and pleasure.
6. False. As many as one in every four married couples under age 35 have reported that they occasionally engage in anal intercourse.
7. True. In one recent study, more than a third of college students had engaged in vaginal or anal intercourse at least once in the previous year without using effective protection from conception or sexually transmitted infections (STIs).
8. False. More than a third of American married men and women older than 60 make love at least once a week, as do 10 percent of those older than 70.
9. False. There’s no medical reason to avoid intercourse during a woman’s menstrual period.
10. False. Some researchers say that stimulation of the Grafenberg spot in a woman’s vagina may lead to a release of fluid from her urethra during orgasm.
11. True. Although the risk increases with repeated sexual contact with an infected partner, an individual can contract HIV during a single sexual encounter.
12. False. Many erection difficulties have physical causes.
Creating True Intimacy

Intimacy doesn’t happen at first sight—or in a day or a week or a string of weeks. Intimacy needs time and nurturing. It is a process of self-revelation, of exposing rather than hiding, or expressing rather than suppressing, or wanting someone to know us as fully as possible, and of wanting to know that someone as fully as possible. Although intimacy isn’t the same as sex, it often includes a sexual relationship.

Like every other worthwhile endeavor in life, quality relationships require attention and effort—but of the most delightful and rewarding type. “What’s Your Intimacy Quotient?” in Labs for IPC assesses and strengthens the skills you need to enrich your life with warm, close, supportive intimate relationships. Here’s a preview.

Get Real
To create and maintain intimate relationships, you need to assess nine essential skills, including the following three:

• **Receptivity.** If you are text-messaging or checking e-mail while talking to your partner, friend, or child, the message you're sending them is, “Don’t bother me. I’ve got something better to do” . . .

Do you spend some time every day simply sitting and reconnecting with your partner? Do you spend some time every day simply sitting and reconnecting with you?

• **Expressing yourself.** Don’t expect your partner to read your mind. Avoid the “If-you-loved-me-you’d-know” trap. Avoid fuzzy expressions like “sort of” and “kind of maybe.”

Do you spend time every day communicating your thoughts, needs, and wishes to yourself and your partner?

• **Trust.** In an intimate relationship, trust creates a safe harbor where you can be who you are without being attacked, rejected, or abandoned—and without attacking, rejecting, or abandoning.

Do you honor the trust between you every day by following a basic rule: no secrets, no lies, no deceptions, no excuses, no illusions?

On a scale of 0 (clueless) to 10 (masterful), how did you rate yourself?

Get Ready
For the sake of your future, you and your partner need to coordinate your schedules and, if necessary, make appointments for quality time together. You also have to ask whether you spend more time on intimacy substitutes like blogging, gaming, gambling, shopping, or working out than you do enjoying your relationship.

Get Going
This section consists of seven exercises, each with daily, weekly, and monthly components and designed to create more intimacy in your most personal relationship. Here are three examples:

• **Receptivity.**

  Every day: Clear the decks for some real one-on-one time. But beware . . .

  Every week: Make a date to go out for a meal, walk together, or curl up on the couch and just talk . . .

• **Expressing yourself.**

  Every day: Let your partner in on things you know would be of interest . . .

  Every week: Share your perspective on the issues that came up during your week . . .

  Every month: If you journal, review the themes that have been on your mind. Are you rethinking your major? Concerned about expenses?

• **Trust.**

  Every day: Honor your partner’s trust by not discussing private matters with friends.

  Every week or so: Confide in your partner to demonstrate your trust.

  Every month or so: Let your partner know how much you value the trust you have in each other. Be consistently trustworthy.

Lock It In
In this stage you set a goal for which intimacy skills to focus on in the coming week. Continue working to deepen and enrich your relationships throughout your life.
Chapter 9  Personal Sexuality

Review Questions

1. Which of the following behaviors is most likely to be a characteristic of sexually healthy and responsible adults?
   a. engages in frequent sexual encounters with many partners
   b. avoids the use of condoms in order to heighten sexual enjoyment for both partners
   c. uses alcohol sparingly and only to help loosen the inhibitions of a resistant partner
   d. engages in sex that is unquestionably consensual

2. Which statement about sexual activity is not true?
   a. College students consider sexual activity normal for their peer group.
   b. The frequency of sexual activity is highest among those with some college education.
   c. Men and women have sex for generally similar reasons.
   d. Masters and Johnson discovered five stages in human sexual response.

3. Which of the following statements about erectile dysfunction (ED) is false?
   a. ED is usually caused by physical factors.
   b. A popular treatment for ED is Viagra.
   c. ED is usually caused by psychological factors.
   d. Men who are heavy smokers are at risk for developing ED.

4. The hormones that influence the early development of sexual organs
   a. are released by the ovaries in the female and the testes in the male.
   b. begin to work soon after conception during the embryo’s development.
   c. begin to work during puberty, when they stimulate the development of secondary male and female sex characteristics.
   d. determine one’s biological sex.

5. Women may experience which of the following problems during intercourse?
   a. vaginismus
   b. excitement
   c. vaginal expansion
   d. amenorrhea

6. Which of the following statements is true about sexual orientation?
   a. Most individuals who identify themselves as bisexual are really homosexual.
   b. Homosexuality is caused by a poor family environment.
   c. Homosexual behavior is found only in affluent and well-educated cultures.
   d. The African American, Hispanic, and Asian cultures tend to be less accepting of homosexuality than the white community.

7. Which of the following statements about the menstrual cycle is true?
   a. The pituitary gland releases estrogen and progesterone.
   b. Ovulation occurs at the end of the menstrual cycle.
   c. Premenstrual syndrome is a physiological disorder that usually results in amenorrhea.
   d. The endometrium becomes thicker during the cycle and is shed during menstruation.

8. According to the Centers for Disease Control, abstinence is defined as
   a. refraining from all sexual behaviors that result in arousal.
   b. refraining from all sexual activities that involve vaginal, anal, and oral intercourse.
   c. having sexual intercourse with only one partner exclusively.
   d. refraining from drinking alcohol before sexual activity.

9. Atypical sexual behaviors include which of the following?
   a. masochism
   b. sexual desire
   c. masturbation
   d. celibacy

10. Which statement about male anatomy is incorrect?
    a. The testes manufacture testosterone and sperm.
    b. Sperm cells are carried in the liquid semen.
    c. Cowper’s glands secrete semen.
    d. Circumcision is the surgical removal of the foreskin of the penis.

Answers to these questions can be found on page 672.
Critical Thinking
1. Amara signed an abstinence pledge through her church group before leaving for college. She feels strongly that sex should be saved for marriage. Early in her sophomore year, Amara fell deeply in love with Raul, and she now wonders if she will be able to maintain her commitment to abstinence. Raul respects her choice, but expresses frustration that they can’t fully express their feelings. What would you advise Amara to do? What would you say to Raul?

2. Sex education is always a controversial topic. In SIECUS national surveys, nine in ten parents believe it is important to have sex education as part of the curriculum. Other parents feel that boys and girls should learn about sex and sexual values in the home. Did you have “sex ed” in junior high or high school? What do you think about such classes—and why?

3. Do you think it is okay to read or look at pornographic books, magazines, websites, and videos? Why or why not?

Media Menu
Visit www.cengagebrain.com to access course materials and companion resources for this text that will:
• Help you evaluate your knowledge of the material.
• Allow you to prepare for exams with interactive quizzing.
• Use the CengageNOW product to develop a Personalized Learning Plan targeting resources that address areas you should study.

Internet Connections
www.siecus.org
This website is sponsored by SIECUS, a national nonprofit organization that promotes comprehensive education about sexuality and advocates the right of all individuals of all sexual orientations to make responsible sexual choices. The site features a library of fact sheets and articles on a variety of sexuality topics and STIs designed for educators, adults, teens, parents, media, international audiences, and religious organizations.

www.hrc.org
The Human Rights Campaign is America’s largest gay, lesbian, bisexual, and transgender civil rights organization. Its website features up-to-date information on issues related to gay rights and suggests courses of action to change government policies.

www.goaskalice.columbia.edu/
Sponsored by the health education and wellness program of the Columbia University Health Service, this site features educators’ answers to questions on a wide variety of topics of concern to young people, including those related to sexual orientation and healthy sexuality.
Key Terms
The terms listed are used on the page indicated. Definitions of the terms are in the Glossary at the end of the book.

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Making This Chapter Work for You

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