INTRODUCTION TO HUMAN SEXUALITY

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Portland Community College

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Introduction to Human Sexuality (Goerling and Wolfe)

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TABLE OF CONTENTS

Licensing

About the Authors

About the Book

1: Part I - Reflections and Explorations in Human Sexuality

- 1.1: Community Agreements and Terminology
- 1.2: Human Sexuality Theories
- 1.3: Sexology through Time and Contemporary Sex Research
- 1.4: Sex Differentiation, Anatomy, and Physiology
- 1.5: Gender
- 1.6: Sexual Orientation
- 1.7: Attraction
- 1.8: Sexual Response and the Biochemistry of Love
- 1.9: Sexual Behaviors (and Safer Sex)
- 1.10: Intimate Relationships

2: Part II - Professional and Clinical Topics in Human Sexuality

- 2.1: Terminology Review and Preview
- 2.2: Sexual Development Through the Lifespan
- 2.3: Contraception
- 2.4: Sexually Transmitted Infections
- 2.5: Conception, Pregnancy, and Birth
- 2.6: Variations in Sexual Behavior
- 2.7: Sexual Dysfunction and Treatment
- 2.8: Sexual Marketplace
- 2.9: Trauma, Therapy, and Trauma Informed Care
- 2.10: Ability, Intersectionality, Body Image, and Reclaiming Our Bodies

Index

Glossary

Detailed Licensing

Detailed Licensing

Licensing LicensingEdit Update titlecancel

*A detailed breakdown of this resource's licensing can be found in **Back Matter/Detailed Licensing**.*

About the Authors About the AuthorsEdit Update titlecancel

1

Ericka Goerling, PhD and Emerson Wolfe, MS

Ericka Goerling, PhD

From an early age, Ericka remembers pondering why people behave the way they do. This expanded and grew to ongoing curiosity of, and respect for, human experiences. A lifelong learner of psychology, she received her BS in psychology from Portland State University in 2000, her MS in counseling psychology from Lewis and Clark College in 2003, and her PhD in psychology from Fielding Graduate University in 2016, with an emphasis in media psychology. Ericka had the incredible fortune of working with crime and trauma survivors for nearly 15 years, before turning to teaching exclusively in 2010. In her instructional capacity at Portland Community College, Ericka teaches Intro to Psych courses, Personality, Social Psychology and Human Sexuality. She enjoys time with her family- both human and fluffy, traveling and exploring, nature, and a decently embarrassing amount of pop-culture.

Emerson Wolfe, MS

As a non-binary transgender person living with a physical disability, Emerson did not always see themself reflected in textbooks and course curriculum. They wanted to create this resource to provide representation in a way that normalizes the vastness of possibilities that exist based on each individual's intersecting identities. Emerson's passion for criticality was sparked during their experience at UC Berkeley where they received their BA in Peace and Conflict Studies with an emphasis in conflict resolution in 2011 followed by obtaining an MS in Counseling Psychology from CSU, Bakersfield in 2015. Emerson worked as a therapist associate primarily with foster care youth and developed community peer support groups for the transgender, non-binary, and gender expansive community in central California. They began teaching psychology classes in 2017 and are now teaching at Portland Community College, Clark College, and Pacific University. They teach Human Sexuality, LGBT Psychotherapy, Personality, Human Development, and Intro to Psych classes. Emerson loves gardening with his partner and watching the hummingbirds. They have 2 cats and 2 dogs who provide endless amounts of joy. Emerson would like to thank those who have come before and shared their wisdom leading to the present and for those who will continue to expand our understanding of human sexuality into the future!

About the Book About the BookEdit Update titlecancel

Welcome to our *Introduction to Human Sexuality* textbook.

Whether you found this resource as a requirement for class or due to your own interest, we hope that you find this reading, engaging, informative, and accessible.

Both Emerson Wolfe and Ericka Goerling teach human sexuality at Portland Community College. Over the course of the last five years, we found that human sexuality textbooks were typically behind in presenting current language, ideas, and contemporary research. Often this wasn't because of author negligence but, rather, the delayed timelines of publication of materials. Additionally, the cost of textbooks, even certain online versions, were just too expensive to be genuinely accessible to many of our students. Finally, many of the resources that were available for teaching human sexuality were still using a very Western, white, hetero-centric lens in presenting information, which we find to be restrictive to the vastness of human experiences with sexuality. This combination of factors led Emerson and Ericka to look for different options for class materials.

Thankfully, the ability for us author, create, and compile a textbook on our own was made available in 2020-21. Indeed, this resource would not be available without the support of Open Oregon Educational Resources. Using the framework of Open Education Resources (OERs), Emerson and Ericka can use existing resources, as well as author our own content, and make this information digitally and freely accessible for a wide variety of students. As a result, this textbook is an organic and dynamic resource, and undergoes regular updating to ensure we're offering current, intersectional, and accessible information. You will find sections that are authored by other OER contributors – sometimes with modifications from us. In other areas, the chapters are entirely designed and written by us and made available to other instructors using OERs. We invite your feedback, Reader, as we view our students as being essential stakeholders and collaborators in this content.

How This Book is Organized

This textbook is divided into two parts because our teaching commitment has course content divided into two, separate 10–12-week terms (Psychology 231 and Psychology 232). You will note that the first section, *Reflections and Explorations in Human Sexuality*, includes ten chapters ranging from *Sexology* to *Gender* to *Sexual Behaviors*. In many ways, Part 1 is a great example of introductory human sexuality and many of the subjects have personal application to one's experiences and learning. Our second section, Part 2, is *Professional and Clinical Topics in Human Sexuality* and covers topics such as *Sexuality Over the Lifespan*, *Sexually Transmitted Infections*, and *Sexual Dysfunctions and Treatment.* While our Part 2 is still considered introductory in nature, it does have a more clinical/professional approach to topics in terms of learning. We feel, strongly, that all these subjects hold value for students' personal and professional development whether they're going into psychology, social work, gender and sexuality studies, nursing, public health, anthropology, or something else entirely.

Final Thoughts

Human sexuality is a richly diverse, engaging, sometimes challenging, and ultimately critical area of psychological inquiry. Emerson and Ericka respectfully strive to introduce this textbook as an inclusive and intersectional resource for learning about human sexuality. With that in mind, we also know that there will be ongoing ways to improve content. As previously stated, we invite feedback from our readers- and seek to make your learning experience relevant, academically sound, and personally/professionally meaningful.

Many thanks for being here and all the best for dynamic learning!

Emerson & Ericka

CHAPTER OVERVIEW

1: Part I - Reflections and Explorations in Human Sexuality

1.1: Community Agreements and Terminology
1.2: Human Sexuality Theories
1.3: Sexology through Time and Contemporary Sex Research
1.4: Sex Differentiation, Anatomy, and Physiology
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1.6: Sexual Orientation
1.7: Attraction
1.8: Sexual Response and the Biochemistry of Love
1.9: Sexual Behaviors (and Safer Sex)
1.10: Intimate Relationships

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1.1: Community Agreements and Terminology 1.1: Community Agreements and TerminologyEdit Update titlecancel

Learning Objectives

- Distinguish between terms related to sex, sexual behavior, gender, sexual orientation and other basic terms for this course
- Understand how the media can shape peoples' perception
- Explore the role of intersecting identities and culture in shaping peoples' perceptions and experiences of the world, including their perspective on sexuality and gender specifically
- Analyze the impacts of microaggressions and discuss ways to combat them

Introduction

Human sexuality is a broad and complex topic that we are still in the early stages of understanding. Language to describe the experiences of people continues to be developed, and the nature of society is to change with time. Sexuality is often not stagnant as well and individuals may experience shifts in identity across their lifespan. Labels can be freeing in some ways yet they can also place barriers around what is believed to be possible. Binary systems and oversimplifying humanity prevent the full story from being told. Gender and sexuality are separate yet interconnected with other identities we hold and are influenced by the concert that exists when all parts of ourselves mix together. The society in which we live, our family backgrounds, the education we have access to, and our own mental processes and behaviors lay the foundation to analyzing sexuality. Allyship and community uplifting occurs as we critically explore sexuality from a biopsychosocial perspective and are humble and curious about what we do not know rather than making assumptions without all the information. Within this chapter, we will go over community agreements and explore some basic terminology that we will continue to expand upon or refer back to throughout this course.

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A Case for Learning About Sexuality

Do you remember how you first learned about sex and/or reproduction? About gender? Perhaps you were one of the many American students who received information about puberty sometime around 5th to 8th grade. Or you may have been a student who attended a school who refused to teach anything health/sexuality related. In many cases, folks have found their education about sex and sexuality to be more experiential versus formal. No matter where you land in terms of education and experience, it can be a useful process to reflect on the ways in which your learning has occurred. In the Unites States, we have a ways to go in terms of pervasive, comprehensive sex education.

In a recent meta-analysis of sexuality education research, Goldfarb and Lieberman (2020) concluded: "Review of the literature of the past three decades provides strong support for comprehensive sex education across a range of topics and grade levels. Results provide evidence for the effectiveness of approaches that address a broad definition of sexual health and take positive, affirming, inclusive approaches to human sexuality. Findings strengthen justification for the widespread adoption of the National Sex Education Standards."

There is much to do when it comes to building a national response for sexuality education. In some ways, you are becoming a default ambassador of the benefits just in taking this class. From this course, you are combining your previous knowledge, skills, and experiences with additional academic information that will build your sexual intelligence in critical ways. Thank you!

An Important Start: Community Agreements

Community Agreements are used in many settings to clarify boundaries and set expectations for communications amongst participants in a group dynamic, whether that be in the classroom, in a therapy group, education committee, etc. This is a living document that can be further developed with specific groups and catered to what will make the participants feel most comfortable. Here are some agreements that past students have found to be most helpful:

1. Confidentiality/Vegas Rule–what happens in this class stays here; we are not to share what other students share outside of this class without their direct prior approval
2. Check your assumptions–everything is actually much more complex than what we may realize at first
3. Utilize curiosity–ask questions of yourself and about the world around you

4. Lean into discomfort–some topics may make you feel uncomfortable and it can be helpful to further analyze this; be open to new perspectives even if they seem different from your own previous understandings
5. Respect personal boundaries–treat others how they'd like to be treated; ask, don't assume!
6. Be open to feedback; check your defensiveness
7. Be open to others' questions and mistakes–we are all coming into this class with different understandings and levels of comfort regarding these topics
8. Approach topics with an open mind
9. Use "I" statements rather than "you" statements–refrain from offering advice and speak from your own perspective instead
10. Respecting disagreement/respectfully disagreeing
11. Be encouraging and offer words of affirmation and validation in your communications (fully online, in-person, or remote) with others
12. No outing of others–people may share their identities in this course but it is inappropriate, and in some cases even dangerous, for us to tell others about their identity; let people share their own stories on their own terms
13. Don't yuck my yum–if I were to say, "I really love chocolate!" and someone responded, "Yuck! Chocolate is gross," I would feel very upset and looked down upon for this. People have a broad range of likes in terms of sexuality and it is not our place to judge others. We will not disparage the likes or perspectives of others.
14. Make space, take space; be mindful to not monopolize and invite in others to share their experiences

Basic Terminology

As we explore these topics, keep these questions in mind:

1. For the purpose of this course, what two ways might the term "sex" be used and how is "sex" (in terms of sexual anatomy) different than "gender"?
2. How might the media influence peoples' views about sexuality?
3. How might someone's particular intersecting identities influence their perspective on gender or sexuality?
4. What are microaggressions, and, in the video by Derald Wing Sue, what are some ways we can combat them?
5. What are some terms within the 2SMLGBTQIA+ umbrella that relate to gender identity and some that relate to sexual orientation?

What Does "Sex" Even Mean?

Sex can mean sexual anatomy and sexual behavior

To further complicate matters: Some people argue that certain sexual behaviors do not count as sex, such as oral sex.

President Clinton: "I did not have sexual relations with that woman."

Sexual Behavior

To avoid this obstacle in terminology, sexual behavior for the sake of this course will be defined as "behavior that produces arousal and increases the chance of orgasm" (Hyde & DeLamater, 2017, p. 3). To be clear- that doesn't mean orgasm needs to happen- the focus is really on behavior that causes sensory arousal.

Gender

Sex and gender are also often used interchangeably; however, they mean very different things.

Sex refers to anatomical and genetic characteristics, such as genitals, sex chromosomes, bodyweight distributions, hormones, etc., and sex is often assigned to individuals by doctors at birth based on the way their genitals look.

Gender is a social construct that includes certain expectations of gender roles and gendered behaviors based on a given society. Each individual person has their own understanding of gender based on other factors as well such as family upbringing, peers, media, religion, personal preferences, etc.

- Gender expression is the way that people dress, walk, talk, alter their natural physical appearance (i.e. shave, wear makeup, etc.), and more to fit in with stereotypical or traditional perspectives on how men or women are meant to present themselves based on a given dominant culture within a society. Individuals may also challenge these dominant cultural norms by aligning more closely with subcultures or marginalized communities who develop alternative norms or flexibility around the way that gender is expressed. In what ways do you perform your gender by the clothing you wear, the way you cut your hair, the mannerisms you use, the way you talk, etc.? People are constantly altering themselves to fit in with these social constructs. Pay

attention to this as we are all playing a part based on the safety we feel in our communities to either conform to tradition or move toward more flexibility.

- Gender perception–how other people perceive our gender regardless of the way we identify. This is often a huge cause of dysphoria, not just for transgender or gender-expansive individuals, making people feel like others are judging or viewing them poorly based on how well they are able to conform to the stereotypes and cultural traditions within a society.
- Gender identity is the way individuals make sense of gender for themselves. This a personal exploration which may fit in with traditional perspectives on maleness/masculinity or femaleness/femininity, combinations of these, something else entirely, additional options outside a gender binary system based on one's culture, none of these, etc. Since gender is a social construct, stereotypes and early learning often influence the way people think about their gender and those of others subconsciously even when they themselves do not fit perfectly into one gender category. People tend to overestimate how much they fit in with a given gender and ignore information that does not align with this internalized narrative.
- Gender binary–the idea that there are only two genders-male and female.
- Gender spectrum–researchers studying human sexuality are moving more toward the belief that gender exists on a continuum with an endless range of personal possibilities.

Throughout previous terms, students have continued to confuse sex and gender, so make sure you understand the difference.

More on this as we go through the term!

Media Influences

In many instances, the media impacts our understanding of sexuality more than scientific research. On the positive side, when information is accurate and up-to-date, this can be a useful mechanism to share information. Unfortunately, widespread consumption of media also means that misinformation can run rampant. In a recent analysis, researchers found that during the COVID-19 pandemic, the disposition to spread false information or rumors is directly linked to the development of anxiety in a variety of of different age populations (Rocha, de Moura, Desidério, *et al.*, 2021*)*.

Cultivation

People begin to think what they see in the media reflects mainstream cultural views on sexuality.

Agenda Setting

News broadcasting companies, such as MSNBC, Fox, etc. choose what news to report on and what to ignore, which shapes what we view as important. Certainly an issue of our time is polarized content and exposure to fake news (and misinformation more broadly). Importantly misinformation is not equally distributed across all users (Pennycook & Rand, 2021).

Social Learning

Behavior is learned through reinforcement, punishment, and imitation. Subconsciously we can start to imitate what we see in the media.

Culture

How would you define culture?

Common Culture Definition

- Where you're from
- A group of people with a standard way of thinking amongst each other
- Ritual or practices you partake in
- Ideas or values passed down from generation to generation
- Religion
- Current times

Dominant Cultures and Co-cultures/Subcultures

- Operate off of power and privilege (dominant cultures) or oppression and marginalization (subcultures or co-cultures) based on the structure of society.

Intersectional View of Culture

Intersecting identities–race, ethnicity, age, health status and/or disability (neurological, mental and/or physical), gender, sexuality, spirituality/religion, body size/body image, education, family wealth/resources, family background, geographical location, immigration status, marital status, parenthood, language, and MORE come together to form our cultural identities. Some of these identities may be privileged within society while others may be oppressed or marginalized. Understanding our totality and the combinations of privilege and marginalization help us to understand the ways these may show up in our interactions with others and create specific power dynamics (Bolding, 2020).

Intersectionality–Term developed by Kimberlé Crenshaw to explain the ways that systems of marginalization interconnect to create particular compounding barriers within society. Originally developed to address the ways that race, gender and class intersect in historical and structural ways to impact the lives of Black cisgender women with less access to financial resources in particular, this term has now been expanded to address many forms of interpersonal and systemic oppressions based on the way that society has marginalized certain identities (Bolding, 2020; CTLT Indigenous Initiatives, 2018).

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Positionality–The way that privileged identities can lead to unintentional (and in some cases intentional) othering of people with marginalized identities. Oftentimes, our oppressed identities are more present in our mind because of the discriminations we face; however, understanding the ways in which we are privileged are necessary to call out our biases and prevent harms from occurring (CTLT Indigenous Initiatives, 2018).

Culture is also constantly changing and evolving, so it is important to remain culturally humble–recognize that it is not possible to know everything about every identity, but we can work to center the experiences of others rather than making assumptions about their experiences from our own outside perspective.

Ethnocentrism–viewing our own cultural backgrounds as superior to others' and from which others should be viewed and judged; an automatic way of thinking in many situations and something to be aware of.

Ethnorelativism–understanding that many perspectives exist and that everything is relative depending on peoples' unique cultural backgrounds; this is thoughtful and reflective which is the better way.

Microaggressions

Microaggressions are subtle insults often done unconsciously that are directed at minorities, such as people of color, women, people who are LGBTQIA+, people who are differently-abled (or disabled), etc.

Watch the following video by Derald Wing Sue who is the leading researcher studying cross-cultural issues in our society and their psychological implications:

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Make sure to reflect on the ways we can combat these microaggressions.

Check out this article by the American Psychological Association (APA) on ways to confront microaggressions: Clay (2017): Did you really just say that? Here's advice on how to confront microaggressions, whether you're a target, bystander or perpetrator.

LGBTQ Umbrella

Many of you have probably heard of LGBT, LGBTQ, or even LGBTQIA+. These are actually a shortened version of a much longer acronym that is constantly expanding as new terms are developed to more accurately represent how people feel about their gender and sexuality. An issue with this acronym is that people often start to confuse gender identity with sexual orientation because terms relating to both are added together here. To help clarify this confusion, an expanded view of this acronym will be explored and the different terms will be sorted based on how they relate to either gender identity or sexual orientation. One term will also relate specifically to biological sex.

Expanded Acronym: 2SMLGGBBTQQIAAPF

While this is an expanded acronym, remember this still does not include all the possible identities.

Terms Relating to Sexual Orientation

LGBQQAPF

- lesbian, gay, bisexual, queer, questioning, asexual, pansexual and fluid

Terms Relating to Gender Identity

2SMGBTQQ2

- two-spirit, māhū, genderqueer, bigender, transgender, queer, and questioning
- transgender is often used as unmbrella term that contains other terms like genderqueer, nonbinary, gendernonconforming, gender expansive, etc. (APA, 2022)

Term Relating to Sex (Anatomy, Chromosomes, Genitals, etc.)

- intersex

Queer and Questioning

Queer and questioning are the only repeat terms for both sexual orientation and gender identity because queer is an umbrella term that can be used for sexuality and/or gender. Also, people can question either their sexuality and gender identity at times.

Why is knowing this important? In order to be inclusive of individuals within human sexuality research, we need to know these terms in order to not accidentally leave people out through the use of non-inclusive language on surveys, forms collecting demographic information, etc. The next section will expand upon terminology further to reflect the most current and respectful terms.

2SMLGBTQIA+

2SMLGBTQIA+ will be used for this text because it centers the experiences of indigenous communities by listing them first–two-spirit (recognized as an umbrella term for those who are members of Alaska Native and Native American communities) and māhū (Native Hawaiian). A common misconception is that gender and sexual fluidity are new when, in reality, this perspective predates binary and rigid views.

Changing Societies, Changing Perspectives

“Homosexual,” “heterosexual,” “transsexual,” and “hermaphrodite” are viewed by some as outdated and especially the last two are viewed as derogatory and offensive by many (APA, 2022). Terms such as “gay”/”lesbian,” “straight,” “transgender”/”gender nonbinary”/”gender expansive,” and “intersex” are viewed now as the more respectful terms (APA, 2022). There may be a generational divide, however, with people who are a part of the older generations still preferring the terms first mentioned (APA, 2022).

Make sure to use the language a person uses to describe themselves or ask what terms they would like you to use to clarify. Some researchers may also use these terms first mentioned in the medical field (i.e. transsexual or hermaphrodite), but the use of such terms may indicate that the study was conducted by people who are not aware of the more respectful language (APA, 2022; Intersex Society of North America, 2008). The most used medical term now to refer to an intersex person’s medical diagnosis is disorder/differences of sex development (DSD) (American Academy of Pediatrics, 2015).

Remember, our language to describe human experience is constantly evolving. An example is how some people within younger generations are reclaiming the word “queer”. Queer means strange, odd, different and was used as an insult toward people in the LGBTQ community from older generations, which may result in them not feeling as comfortable to use this terminology (APA, 2022). Many younger people now use this to identify themselves because they view being different in the eyes of society to be a good thing and are proud of their minoritized identity.

Some people of color may not feel as comfortable using the terms “gay” or “lesbian” because the gay and lesbian liberation movements were often led by white individuals who purposefully excluded people of color. For instance, the early feminists were often white and were specifically fighting for white women’s equality to white men, excluding black women in particular. Thus, QPOC (queer person of color), same gender loving, down low (DL), etc. are some terms that might be used instead (Inman, 2019; Bufanda, n.d.).

Additionally, social movements change our society and lead to progressions over time. For example, the #MeToo Movement is changing how sexual assault and harassment are being discussed compared to the past. This collective discourse around what is considered normative and permissable behavior is shifting from a rape culture more toward a consent culture. The media can be used for good in this way to spread messages and to take a stand against problematic and hurtful behaviors that have long been normalized and accepted.

Consent

Consent will be a central topic of discussion throughout this textbook because we cannot engage in healthy sexual behaviors without consent.

FRIES–freely given, reversible, informed, enthusiastic, specific (Planned Parenthood, 2022)

Planned Parenthood is a helpful resource for more information on consent along with RAINN.

Watch the video provided on the Planned Parenthood website to be able to identify what consent looks like within relationships. If you were presented with different scenarios between people, would you be able to determine if consent is present or not?

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Circles of Sexuality

Sexuality is the total expression of who we are as human beings. It is the most complex human attribute and encompasses our whole psychosocial development—our values, attitudes, physical appearance, beliefs, emotions, attractions, our likes/dislikes, our spiritual selves. This is all influenced by our values, culture, socialization, politics, and laws. One conceptual model of sexuality as developed by Dennis Daily is the “Circles of Sexuality” model.

image

Often represented as the “top circle” is sensuality, which covers the ways our bodies feel pleasure through all of our senses. Sensuality also includes the need we humans have for touch, otherwise referred to as skin hunger. As we age, our desire for sex may diminish, but our need for caring, comforting and intimate touch is as strong as ever. There are incredible emotional and physical health benefits that come from touch, suggesting that touch is truly fundamental to human communication, bonding, and health. Even if you (or your partner) are ill or have physical disabilities, you can engage in touch and/or intimate acts and thereby benefit from closeness with another person. The sensuality circle tends to represent closeness in physiological terms.

Next to sensuality, is the circle of intimacy, which encompasses our emotional behaviors and needs, such as trust, respect, and loving or liking someone. The need for intimacy is ageless. We never outgrow our need for affection, emotional closeness and intimacy though aging does change our perspectives on sex and sexuality. Intimacy tends to represent closeness in emotional and affectionate terms and for seniors can mean companionship, affection and enduring tenderness and concern.

A third circle is titled sexual identity, which contains gender identity, gender roles and sexual orientation. At the very heart of the search for sexual identity is the more general but profound question of, “Who Am I?” Also included in this circle is sexual orientation—who we are attracted to…physically, emotionally, sexually, spiritually.

Then is the sexual health and reproduction circle, which many people think of as “sex”. Indeed it is important to address our sex behaviors and to talk about risk reduction messages such as using condoms, not forgetting the lube, body positioning, playing with sex toys, etc., which are important to STI/HIV prevention.

Finally, there is the circle of sexualization. Sexualization includes things like harassment, rape, misuse of power, and withholding sex. It can include unrealistic portrayals of sexuality in order to sell products, including movies and TV shows.

In summary, the ability to express and enjoy one’s sexuality leads to feelings of pleasure and well being, feelings that are essential at any age if our human needs for intimacy and belonging are to be satisfied, and we are to age successfully (think Maslow and his hierarchy of human needs).

Inviting In

Instead of asking others to “come out” and share parts of themselves when they may not feel comfortable or safe to do so, what can we do to create a more accepting and affirming environment for others to be able to be themselves? The responsibility lies on the shoulders of each one of us to indicate that we are supportive and that we value equity and inclusion. “Invite in” others to be their full selves in the way that you express yourself and create spaces that are safe havens from hatred and shame.

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1.2: Human Sexuality Theories 1.2: Human Sexuality TheoriesEdit Update titlecancel

Learning Objectives

- Explain the differences between bonobos and chimpanzees
- Analyze how social stratification within hunter-gatherer, herding and agricultural societies occurs
- Compare and contrast ancient perspectives regarding gender and sexuality to modern-day perspectives
- Understand the main aspects of various theories that influence the study of human sexuality

Introduction

Societies and individuals across time periods and around the world have long been interested in making sense of human sexuality. From freedom of expression to forced repression, sex and gender continue to be much debated and highly polarizing subjects. To begin to make sense of human sexuality, we will explore our closest primate ancestors regarding their social structure and sexual behaviors, analyze how subsistence strategies may influence social structure, address some ancient perspectives and historical changes influencing social acceptance of sexual behaviors and gender variance, then end by discussing more contemporary psychological theories as we try to understand the evolutionary, historical, political, religious, and other influences that shape our current understanding of gender and sexuality.

Primate Ancestors: Bonobos and Chimpanzees

Bonobos and chimpanzees are both African apes believed to be our closest relatives. To learn about human behavior, researchers often turn to analyzing their social structures and their sexual behaviors to gain insight into those of humans. However, bonobos and chimpanzees differ very much from each other in both of these patterns. One question remains for evolutionary psychologists: How can we be so similar to both bonobos and chimpanzees when they vary so much from each other?

"Bonobos adoring baby" by LaggedOnUser is licensed under CC BY-SA 2.0.

Bonobos

The Hominoid Psychology Research Group at Duke University (2020) explains that bonobos "are female dominant, with females forming tight bonds against males through same-sex socio-sexual contact that is thought to limit aggression" (para. 4). Bonobos also show less sexual dimorphism, meaning that the body sizes, genitals, and overall appearances of female and male bodies are more similar. They tend to band together in larger party sizes than those of chimpanzees. A clear hierarchy amongst the females is not typically present and they work together. A male is never the "alpha" or highest ranking in the group. Bonobos do not engage in lethal aggression and engage in frequent non-reproductive sexual behavior between all partner types and ages. Sexual behaviors are utilized to reduce group tensions and create more secure bonds and are found during greetings as well as times of conflict resolution. Homosexual sexual behaviors are frequent, especially between females.

Chimpanzees

The Hominoid Psychology Research Group at Duke University (2020) then describes how chimpanzees differ from bonobos in that they "are male dominant, with intense aggression between different groups that can be lethal" (para. 5). Chimpanzees show greater sexual dimorphism, meaning that males tend to be larger than females and there are marked differences between the males and females in terms of genital appearance as well as overall body appearance. Male-male bonds are strong while female-female bonds are weak. There is typically an alpha male or a coalition of males leading the group. Chimpanzees are incredibly territorial and

patrol boundaries, resulting in the killing of neighboring chimpanzees. They will also sometimes eat the offspring of neighboring chimpanzee groups during hunting excursions. Chimpanzees do not engage in sexual behaviors outside of mating for reproduction contexts mostly and alpha males will guard females who are ovulating, or during the times they are most fertile, in order to prevent other males from reproducing with them.

So, as asked earlier: How can we be so similar to both bonobos and chimpanzees when they vary so much from each other? What do you think?

Changing Environments, Changing Societies

Anthropologists have spent the better part of the last 100 years studying tribal societies around the world that have remained apart from the technological advances that shape so much of our lives today. What they have found is that there are striking differences between hunter and gatherer societies that tend to be nomadic as they move with changing seasons to find food and hunt wild animals compared to herding and agricultural societies who tend to remain in one general area. What many anthropologists have concluded is that hunter-gatherers tend to be more egalitarian, meaning there are less social divides, especially along gendered lines–the best hunter and the best gatherer would take on these roles regardless. On the other hand, societies that tend to remain in one general location place greater emphasis on property–who do the herds of animals belong to and who will get the land when someone dies? This focus on property is believed to be connected to the greater emphasis on social stratification and divisions of wealth in societies. Rather than being egalitarian, matriarchal and patriarchal societies allowed for property to be passed down based on family connections to the women (matriarchal) or men (patriarchal) in a society. The most common being patriarchal but some examples of matriarchal societies exist currently. Studies based on current tribes and archaeological digs have shown that hunter-gathers and herding/agricultural groups displayed some of these social differences. Archaeological digs uncovering burial sites often provide clues as to what the social structure was like. Questions existed, like were men buried with more objects or were the women buried with more objects? What was the placement of the bodies and what remnants of clothing were found? What kind of art or relics were also found?

A mosaic illustration of hunter gatherers taken from William MacKenzie's National Encyclopaedia (1891) by Free Public Domain Illustrations by rawpixel is licensed under CC BY 2.0.

As with everything in life, we also must be careful in overgeneralizing some of these things, such as "all hunter and gatherer societies are like this" and "all agricultural societies are like this." In more recent studies, the idea of a spectrum of subsistence strategies has emerged in which the two distinct categories of hunters-gatherers and herding/agriculture are being questioned because many societies actually display characteristics of both, complicating this oversimplified model (Arnold et al., 2016). However, what can be seen is that in societies that shared wealth and resources more fluidly, they also tended to be more egalitarian. In others that passed land and belongings down family lines, social stratification and gender roles became more prevalent (Arnold et al., 2016).

Ancient Perspectives

Keep in mind that it is difficult to truly understand the thought processes and perspectives of these ancient civilizations and that archeologists and anthropologists can only make guesses about the materials they have uncovered. Art and writings are the most commonly preserved items that are used to make assumptions about these time periods. A problem that often arises is that we try to use today's perspective regarding gender and sexuality which biases the way we make sense of the past. In reality, unless we develop time travel, we will never know the full realities of what gender and sexuality looked like in antiquity. When we look back across time, the term HIStory is very fitting as well because the public and private lives of men dominate, and the perspectives of women are often not focused upon as much (Carroll, 2017). If men are the main artists and writers in a society, which is often the case and elements of this are still present in our society today, this shapes the narratives being told and passed down. Additionally,

many societies relied on oral traditions that have been lost through the process of colonization because the stories have faded with the erasure of people and their cultures.

The following information is based on Carroll (2017).

Egypt (approx. 1100 B.C.): Erotic images found on carvings and papyrus. Temple prostitutes would have sex with pagan worshippers as sex was seen as a connection to the spiritual. Some depictions of possible gay sexual relationships between men have been found, such as a tomb uncovered featuring two males in close contact similar to how straight relationships were depicted. Early archaeologists and anthropologists said they were probably brothers, but this has been an area recently reviewed and perceived differently.

Greeks (1000-200 B.C.): Pedastery was commonly practiced, which is when an older man would mentor a postpubescent boy in his studies and in his sexual development. This was seen as a rite of passage. Sexual relations between soldiers were also normalized as it was believed that males with close relationships would fight harder for each other in battle. The male body was idolized and Plato is attributed with exploring how nonsexual love between two men was viewed as the ideal love. This is where we get the current day term for “platonic love,” or love without a sexual element. The female Greek poet Sappho, who lived on the Isle of Lesbos, wrote erotic poetry about women. This is where we get the term “lesbian” from.

The Hebrews (1000-200 B.C.): The Hebrew Bible outlines the rules around sexual behavior. Adultery and homosexuality between men (women are not mentioned) were both viewed as being wrong. Some scholars think this was because women were viewed as property, so the idea of a man having sex with another man would reduce one of them to the position of the other’s property. Others, however, believe this is meant to be taken literally and that it should now include lesbianism and other non-heterosexual acts. Marital sexuality was grounded in a focus on procreation rather than pleasure and this stance was adopted by Christianity which would go on to form the groundwork for sexual attitudes in the West, such as the current-day United States.

India (400 B.C.): The Kamasutra is an erotic text that is a detailed manual meticulously containing information about any imaginable sexual position, love, family life, and moral frameworks. Sexuality and spirituality were viewed as connected. While there are stories of powerful women rulers, the society was mostly patriarchal with male lives being valued more than female lives. Female infanticide was not uncommon and killing a woman was not regarded as a serious crime. Hijras, or a third gender in which a person originally designated a male at birth takes on a feminine role in society which often included castration, were also mentioned in the Kamasutra and were given central roles in many religious ceremonies. Marginalization and stigma for these individuals are believed to have become more prevalent through the British colonization of India in the early 1500s.

China (200 B.C.): Balance and harmony between all parts of nature are at the core of Toaist and Confucian thought. Yin (female essence) was viewed as endless whereas yang (male essence contained in semen) needed to be controlled and maintained through prolonged contact with yin. Sex manuals were common teaching men how to experience orgasm without ejaculation to preserve their sperm, while brides were given texts on how to pleasure their husbands. Female orgasm was viewed as important in order to receive the maximum benefit from yin essence. Even though a balance between yin and yang was valued within each individual, yin was viewed as more passive and subservient and, since women were believed to have more of this essence naturally, they were expected to be subservient to the men in their lives–fathers, husbands and sons. Polygamy, a male with multiple wives and concubines, was commonly practiced.

Optional additional resources if you would like to explore these topics further:

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McClure, L. (2002). Sexuality and gender in the classical world : Readings and sources . Oxford, UK ; Malden, MA, USA: Blackwell. eBook permalink

Younger, J. (2005). Sex in the ancient world from A to Z. London; New York: Routledge. eBook permalink

Voss, B., & Casella, E. C. (eds.) (2012). The archaeology of colonialism intimate encounters and sexual effects. Cambridge; New York: Cambridge University Press. eBook permalink

Psychological Theories

As we begin to explore these different perspectives, begin thinking which theories seem to make the most sense to you. Analyze what has occurred in your life to make certain explanations click with you more and why others do not seem quite right. If you were a researcher and theorist, what gaps in these might you try to fill?

Evolutionary Theories

Both sociobiology and evolutionary psychology are based on the initial work of Charles Darwin

Sociobiology–“the application of evolutionary biology to understanding the social behavior of animals, including humans” (Hyde & DeLamater, 2017, p. 23)

Evolutionary Psychology–“the study of psychological mechanisms that have been shaped by natural selection” (Hyde & DeLamater, 2017, p. 25)

Evolution–subtle changes occur over generations that influence how all livings things were in the past, are in the present and will become in the future, as genes are past down from parents to offspring.

Natural selection–evolution occurs through this process; plants and animals that are better suited for their particular environment have the greatest chance of passing on their genes.

Sociobiology and evolutionary psychology assert the following (specific to attraction and sexual behavior):

- We are attracted to what signifies producing healthy offspring
- Parents bond emotionally because, if they stay together, their children have higher rates of survival
- Sexual selection–differences in males and females to increase competition; males will compete with other males and females will provide preferential treatment to whom they deem the most genetically fit to reproduce with

Western Psychological Theories from Freud to Now

Psychoanalytic Theory

Developed by Sigmund Freud

“Sigmund Freud” by Psychology Pictures is licensed under CC BY-NC-ND 2.0.

Libido–“sex energy or sex drive” which Freud believed to be one of the two motivating factors to behavior (the second being death) (Hyde & DeLamater, 2017, p. 26)

The parts of our personality are divided into three parts:

Id–contains libido and operates off of the pleasure principle; if unchecked, would give in to all temptations and desires imaginable

Ego–reality principle; navigates between the id and superego to help us decide our final course of action

Superego–“contains the values and ideals of society that we learn” (Hyde & DeLamater, 2017, p. 26)

Erogenous zones–areas of the body that are a focus for our libidinal energy will cause us to become aroused when they are touched in certain ways

Stages of Psychosexual Development–oral, anal, phallic, latency, and genital (this will be covered in PSY 232 in greater detail as we explore sexual development across the lifespan)

Oedipus and Electra Complexes–we have an innate competition with our same-sex parent and have a sexual attraction to our opposite-sex parent through adolescence

- For boys (Oedipus Complex), castration anxiety, or a fear of having their penis cut off by their father causes them to shift from competing to identifying with their father and taking on his gender role in society.

- For girls (Electra Complex), they experience penis envy in that they wish that they too could have a penis. In this realization that they cannot have a penis, they begin to desire to be impregnated by their father. Since girls have already lost their penis, women will live their lives stunted and less developed than men.

Keep in mind, Freud lived during the Victorian Era, and I encourage you to do a little research on what this time period was like, especially for women. A fun little fact: doctors at this time began helping "hysterical" women achieve orgasm as a cure to this "mental disorder" and this is how the vibrator was invented–the doctors' hands got too tired to keep up with all the demands.

Learning Theory

While evolutionary theories attempt to answer the "nature" behind sexuality, learning theory seeks to answer the "nurture" part of the puzzle.

Classical Conditioning–a neutral stimulus is paired with an unconditioned stimulus in order to produce an unconditioned response. Think of Pavlov's dogs in which the bell (neutral stimulus) is paired with food (an unconditioned stimulus) to produce salivating (unconditioned response). This is done so often that the food (unconditioned stimulus) can now be removed and a once neutral stimulus (the bell) can produce the unconditioned response (salivating) on its own. In terms of sexual behaviors, women's underwear (neutral stimulus) is paired with porn (unconditioned stimulus) producing arousal (unconditioned response) enough times that now the women's underwear produces arousal on its own without porn.

Operant Conditioning–certain behaviors can be "reinforced" to support that they continue or "punished" to try to make them stop

Behavior Modification–utilizing operant conditioning techniques to influence someone's behavior

Social Learning Theory–imitation and identification are the two main processes to this; in other words, we seek to imitate those who we identify with. For instance, if a child sees a character in a movie who they identify with then they will seek to imitate the behaviors of that character. This is particularly helpful in understanding the internalization of gender roles.

Self-Efficacy–a feeling of competence when engaging in a certain behavior; we are more likely to engage in behaviors we have seen others practice and that we have practiced ourselves

We will discuss many parts of Learning Theory in PSY 232 in greater depth as they relate to the development of fetishes and paraphilias.

Social Exchange Theory

This theory believes that people are hedonistic, meaning they are pleasure-seeking. Humans engage in activities that produce rewards and minimize costs.

Relationships are maintained only when the benefits outweigh the costs.

Matching hypothesis (we will discuss this when we explore the theories on love in greater depth in a few weeks).

Cognitive Theory

Our perception becomes our reality–the way we think about sexuality influences the way we behave sexually.

Schema–think of this as a general blueprint, framework or map that you have for some general concept

Sandra Bem, whose notable research was published in the 1980s, would be considered a cognitive theorist. She conducted her research attempting to understand the development of gender roles. She believed that all of us have gender schemas which are "a cognitive structure comprising the set of attributes (behaviors, personality, appearance) that we associate with males and females" (Hyde & DeLamater, 2017, p. 33). These gender schemas are based on stereotypes and influence us to label certain behaviors as "male" or "female." Stereotype-consistent behaviors are accepted while stereotype-inconsistent behaviors are viewed as a fluke or a rare occasion, causing us to believe the stereotypes despite many examples in our lives to disprove the stereotypes. You will take the Bem Sex-Role Inventory during Week 4 developed by Sandra Bem.

The takeaway: Stereotypes are a trap that we often get stuck in because society operates off of them and upholds them. In order to combat this, question everything, especially your own beliefs. Schemas save us time to have everything set aside in our minds in neat little boxes, but life is actually quite messy and disorganized.

Current Critical Theories

Both Feminist Theory and Queer Theory are social constructionist perspectives in which they believe that gender and sexuality are constructed and given meaning by society.

Feminist Theory

- Seeks to call attention and analyze the inequality of power in society regarding gender, especially challenge patriarchical bias.
- Asserts that male control over female sexuality leads to repression and depression amongst people in these types of societies.
- Analyzes the development and continuation of restrictive gender roles
- Intersectionality, as was mentioned during the week 2 reading, has gained particular usage in which gender as it connects with other identities, such as race and ethnicity, is explored and analyzed

Queer Theory

- Challenges binaries, such as in sexuality and gender
- Challenges heteronormativity, which is the belief that being straight (or heterosexual) is what is normative and natural

Sociological Theories

Symbolic interaction theory–"human nature and the social order are the products of communication among people" (Hyde & DeLamater, 2017, p. 35)

- Role taking–viewing ourselves from the perspectives of others in order to predict and meet their needs and achieve our goals
- Sexual scripts–think of this as a script you were asked to perform in a theater play, except this is a script that you believe is how you should behave sexually in your real life based on the messages you have received from the directors of the play (your parents, society, media, peers, teachers, religion, culture, politics, law, medical field, etc.)
- Sexual fields–context is important; invisible social boundaries exist that influence our behavior
- Social institutions–religion, economy, family, medicine (medicalization of sexuality), and law; these institutions then regulate our sexuality in various ways to uphold the norms in a given society

Takeaway: Society and culture shape and control our sexual expression in very profound, yet often unrealized ways.

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1.3: Sexology through Time and Contemporary Sex Research 1.3: Sexology through Time and Contemporary Sex ResearchEdit Update titlecancel

Learning Objectives

- Explore how sexology has developed over time, and analyze the contributions of some notable sex researchers and studies that have been conducted
- Describe and give examples of various research methods employed in conducting sex research, and demonstrate an understanding of the strengths and limitations of each of these methods
- Identify criteria that would be helpful in evaluating various kinds of sex research, and apply this knowledge in evaluating current research published in professional journals as well as the popular press
- Discuss possible biases and ethical concerns with research
- Describe the role of Institutional Review Boards

Sexology

Sexology is the interdisciplinary scientific study of human sexuality, including sexual behaviors, interests and function. A sexologist is a trained professional who specializes in human sexuality.

There are many different ways a sexologist may work, and many different areas they may work in – in clinical settings, in education, and in research. Sexologists are specialists in human sexuality and hold specific knowledge and skills. They study people's sexual behaviors, feelings and interactions, and assist them to reconcile any issues they have about their sexual experiences, with the aim of improving their lives (Tilley, 2015).

Over the discipline's history, there have been many obstacles. Few sciences have a similarly stuttered development as sexology. Thought by some to be purely scientific, others as prurient verging on the putrid, still others as key to the renewal of the nation and the people, sexology has had as varied a history and reception as the activities it has analyzed and recorded.

The History of Scientific Investigations of Sex

An image on an ancient Greek drinking cup of two lovers kissing. ca. 480 BC [Image: Marie-Lan Nguyen, https://goo.gl/uCPpNy, Public Domain]

The history of human sexuality is as long as human history itself—200,000+ years and counting (Antón & Swisher, 2004). For almost as long as we have been having sex, we have been creating art, writing, and talking about it. Some of the earliest recovered artifacts from ancient cultures are thought to be fertility totems. The Hindu Kama Sutra (400 BCE to 200 CE)—an ancient text discussing love, desire, and pleasure—includes a how-to manual for having sexual intercourse. Rules, advice, and stories about sex

are also contained in the Muslim Qur'an, Jewish Torah, and Christian Bible. Books on sexuality and love, such as the Kama Sutra, the Ars Amatoria, and The Perfumed Garden of Sensual Delight, have been around for centuries. But they're not framed within a formal field of scientific or medical research.

People have been scientifically investigating sex for only about 125 years. During the late 1800s – despite the social attitudes of sexual repression in the Victorian era – more liberal attitudes towards sexuality began to be presented in England and Germany. In 1886, for instance, Richard Freiherr von Krafft-Ebing (1840-1902) published Psychopathia Sexualis, which is considered to be the leading work that established sexology as a scientific discipline.

Havelock Ellis challenged the sexual taboos of his era. Stefano Bolognini/Wikimedia Commons

Within a decade or so, English medical doctor and sexologist Havelock Ellis (1859-1939) challenged the sexual taboos of his era, specifically regarding masturbation and homosexuality. His 1897 book Sexual Inversion, described the sexual relations of homosexual males and is considered to be the first objective study of homosexuality. He actually coined this term and, despite the prevailing social attitudes of the time, did not consider homosexuality as a disease, as immoral, or as a crime. From 1897 to 1923, his findings were published in a seven-volume set of books titled Studies in the Psychology of Sex. Among his most noteworthy findings is that transgender people are distinct from homosexual people. Ellis's studies led him to be an advocate of equal rights for women and comprehensive human sexuality education in public schools (Tilley, 2015).

Using case studies, the Austrian neurologist Sigmund Freud (1856-1939) is credited with being the first scientist to link sex to healthy development and to recognize humans as being sexual throughout their lifespans, including childhood (Freud, 1905). Freud (1923) argued that people progress through five stages of psychosexual development: oral, anal, phallic, latent, and genital. According to Freud, each of these stages could be passed through in a healthy or unhealthy manner. In unhealthy manners, people might develop psychological problems, such as frigidity, impotence, or anal-retentiveness.

The American biologist Alfred Kinsey (1894-1956) is commonly referred to as the father of human sexuality research. Kinsey was a world-renowned expert on wasps but later changed his focus to the study of humans. This shift happened because he wanted to teach a course on marriage but found data on human sexual behavior lacking. He believed that sexual knowledge was the product of guesswork and had never really been studied systematically or in an unbiased way. He decided to collect information himself using the survey method, and set a goal of interviewing 100 thousand people about their sexual histories. Although he fell short of his goal, he still managed to collect 18 thousand interviews! Many "behind closed doors" behaviors investigated by contemporary scientists are based on Kinsey's seminal work.

Unlocking the secrets of the chastity belt. Science Museum / Science and Society Picture Library

KINSEY'S RESEARCH

Before the late 1940s, access to reliable, empirically-based information on sex was limited. Physicians were considered authorities on all issues related to sex, despite the fact that they had little to no training in these issues, and it is likely that most of what people knew about sex had been learned either through their own experiences or by talking with their peers. Convinced that people would benefit from a more open dialogue on issues related to human sexuality, Dr. Alfred Kinsey of Indiana University initiated large-scale survey research on the topic. The results of some of these efforts were published in two books—Sexual Behavior in the Human Male and Sexual Behavior in the Human Female—which were published in 1948 and 1953, respectively (Bullough, 1998).

In 1947, Alfred Kinsey established The Kinsey Institute for Research, Sex, Gender and Reproduction at Indiana University, shown here in 2011. The Kinsey Institute has continued as a research site of important psychological studies for decades.

The staff of the Kinsey Institute, 1953 (Alfred Kinsey is center).

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

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

Watch this trailer from the 2004 film Kinsey that depicts Alfred Kinsey's life and research.

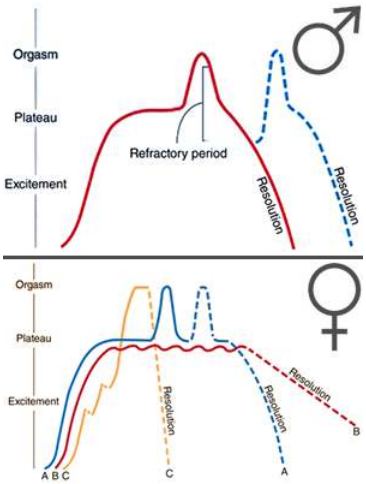
Among the results of Kinsey's research were the findings that women are as interested and experienced in sex as their male counterparts, that both males and females masturbate without adverse health consequences, and that homosexual acts are fairly common (Bancroft, 2004). Kinsey also developed a continuum known as the Kinsey scale that is still commonly used today to categorize an individual's sexual orientation (Jenkins, 2010). Sexual orientation is an individual's emotional and erotic attractions to same-sexed individuals (homosexual), opposite-sexed individuals (heterosexual), or both (bisexual).

MASTERS AND JOHNSON'S RESEARCH

William Masters (1915-2001) and Virginia Johnson (1925-2013) formed a research team in 1957 that expanded studies of sexuality from merely asking people about their sex lives to measuring people's anatomy and physiology while they were actually having sex. Masters was a former Navy lieutenant, married father of two, and trained gynecologist with an interest in studying prostitutes. Johnson was a former country music singer, single mother of two, three-time divorcee, and two-time college dropout with an interest in studying sociology. And yes, if it piques your curiosity, Masters and Johnson were lovers (when Masters was still married); they eventually married each other, but later divorced. Despite their colorful private lives they were dedicated researchers with an interest in understanding sex from a scientific perspective.

In 1966, William Masters and Virginia Johnson published a book detailing the results of their observations of nearly 700 people who agreed to participate in their study of physiological responses during sexual behavior. Unlike Kinsey, who used personal interviews and surveys to collect data, Masters and Johnson observed people having intercourse in a variety of positions, and they observed people masturbating, manually or with the aid of a device. While this was occurring, researchers recorded measurements of physiological variables, such as blood pressure and respiration rate, as well as measurements of sexual arousal, such as vaginal lubrication and penile tumescence (swelling associated with an erection). In total, Masters and Johnson observed nearly 10,000 sexual acts as a part of their research (Hock, 2008).

Based on these observations, Masters and Johnson divided the sexual response cycle into four phases that are fairly similar in men and women: excitement, plateau, orgasm, and resolution.



This graph illustrates the different phases of the sexual response cycle as described by Masters and Johnson.

In addition to the insights that their research provided with regards to the sexual response cycle and the multi-orgasmic potential of women, Masters and Johnson also collected important information about reproductive anatomy. Their research demonstrated the oft-cited statistic of the average size of a flaccid and an erect penis (3 and 6 inches, respectively) as well as dispelling long-held beliefs about relationships between the size of a man's erect penis and his ability to provide sexual pleasure to his female partner. Furthermore, they determined that the vagina is a very elastic structure that can conform to penises of various sizes (Hock, 2008).

Contemporary Sex Research: Methods & Ethics

Now that we have covered a great expanse of time, let us center ourselves in the present moment in which you take on the role of becoming a researcher and theorist yourself. It is your turn to create your own research and theories! Well, before we get too far ahead of ourselves, let's explore current-day human sexuality research methods as well as ways to combat our ever-present biases.

Research Methods: How Should I Conduct My Research?

Psychologists and sexologists test research questions using a variety of methods. Most research relies on either experiments or correlations. In an experiment, researchers manipulate, or cause changes, in the independent variable, and observe or measure any impact of those changes in the dependent variable. The independent variable is the one under the experimenter's control, or the variable that is intentionally altered between groups. The dependent variable is the variable that is not manipulated at all, or the one where the effect happens. One way to help remember this is that the dependent variable "depends" on what happens to the independent variable. The most important thing about experiments is random assignment. Participants don't get to pick which condition they are in (e.g., participants didn't choose whether they were supposed to spend the money on themselves versus others). The experimenter assigns them to a particular condition based on the flip of a coin or the roll of a die or any other random method.

When scientists passively observe and measure phenomena it is called correlational research. Here, we do not intervene and change behavior, as we do in experiments. In correlational research, we identify patterns of relationships, but we usually cannot infer what causes what. Importantly, with correlational research, you can examine only two variables at a time, no more and no less.

Self-Report Measurements

These are the most common of the techniques used by sex researchers because they can be conducted through paper questionnaires, in interviews and online. The researcher will ask questions and record the responses in order to be compiled and compared with all participants in the study to reach conclusions. The questions can be open-ended, yes/no response, or use a Likert Scale. Have you ever completed an end-of-the term review for an instructor while at PCC? If so, these utilize a Likert Scale–a question is asked and you are then meant to choose from a range of options, such as Strongly Disagree, Somewhat Disagree, Neither Disagree Nor Agree, Somewhat Agree, Strongly Agree.

Surveys

A survey is a way of gathering information, using old-fashioned questionnaires or the Internet. Compared to a study conducted in a psychology laboratory, surveys can reach a larger number of participants at a much lower cost. Although surveys are typically used for correlational research, this is not always the case. An experiment can be carried out using surveys as well. Surveys provide researchers with some significant advantages in gathering data. They make it possible to reach large numbers of people while keeping costs to the researchers and the time commitments of participants relatively low.

Important Surveys in Modern Sexology

The National Health and Social Life Survey (NHSLS), conducted in 1991, was the first nationally representative survey of U.S. sexual behavior, providing population estimates of a limited range of sexual behaviors. The NHSLS answered some of these important questions (particularly those related to the prevalence of masturbation, vaginal intercourse, anal intercourse, oral sex, and the appeal of a range of sexual experiences), yet the survey was also limited to younger adults (ages 18–59).

In addition to the NSHLS, there have been several important U.S. national studies that have addressed sexual behavior, though each has focused on a narrow range of ages and/or sexual behaviors. The National Survey of Family Growth (NSFG) and Youth Risk Behavior Survey (YRBS) survey younger age groups and have mostly asked about sexual behaviors related to risk of pregnancy and sexually transmitted infections (STI). The National Social Life, Health, and Aging Project (NSHAP) addresses a limited scope of relational and sexual issues for older Americans.

The National Survey of Sexual Health and Behavior (NSSHB) is the largest nationally representative probability survey focused on understanding sex in the United States. Conducted by researchers at, or affiliated with, the Center for Sexual Health Promotion at the Indiana University School of Public Health, the NSSHB is an ongoing multi-wave study with data collected in 2009, 2012, 2013, 2014, 2015, 2016, and 2018. More than 20,000 people between the ages of 14 and 102 have participated in the NSSHB.

The NSSHB has resulted in dozens of research publications and presentations. Here is a small sampling of some key findings:

- There is enormous variability in the sexual repertoires of U.S. adults, with more than 40 combinations of sexual activity described at adults' most recent sexual event. (2009 NSSHB)
- Many older adults continue to have active pleasurable sex lives, reporting a range of different behaviors and partner types, however adults over the age of 40 have the lowest rates of condom use. Although these individuals may not be as concerned about pregnancy, this suggests the need to enhance education efforts for older individuals regarding STI risks and prevention. (2009 NSSHB)

- Men are more likely to orgasm when sex includes vaginal intercourse; women are more likely to orgasm when they engage in a variety of sex acts and when oral sex or vaginal intercourse is included. (2009 NSSHB)
- Gender plays a critical role in understanding attitudes toward bisexual individuals among heterosexual, gay/lesbian, and other-identified adults. In general, women are more likely to report positive attitudes toward bisexual individuals than men. Additionally, attitudes toward bisexual women are more positive than attitudes toward bisexual men (2015 NSSHB – see Dodge et al.)
- Gay, lesbian and bisexual self-identified participants were less likely to report monogamy and more likely to report both open relationships and non-consensual non-monogamy. (2012 NSSHB – see Levine et al.)

U.S. data on diverse sexual behaviors are needed to improve clinicians', educators', policymakers' and the general public's understanding of human sexual expression. Consequently, human sexual expression can be more richly and accurately described which may also help people to feel "seen" or better represented in terms of their sexualities. In addition to these nation-wide surveys, there are sexual surveys conducted by sex toy manufacturers, colleges and universities, as well as individual sexological researchers.

Behavioral Measurements

- Direct observation–watching an individual or individuals engaged in a particular behavior (are there any ethical considerations on this?).
- Eye-tracking–a device that measures where a participant is looking.

Biological Measurements

The brain and genitals can be measured during sexual activity to understand how the body responds. MRIs can be used to look internally at the size, structure, and shape of the genitals and brain regions while fMRIs actually map the brain activity by measuring the blood flow to certain areas. One particular difficulty with MRIs and fMRIs is that the participant must remain still in order to capture effective images.

Some additional methods:

- Pupil dilation–changes in pupils can indicate arousal, interest or cognitive strain
- Penile plethysmography–placing a band around the penis that can measure blood flow
- Vaginal photoplethysmography–placing a measuring device inside the vagina that uses light to detect changes in blood flow
- Thermology–studying changes to body temperature because arousal creates heat

Do you think any of these techniques might change your sexual responses? How about trying to have an orgasm in an fMRI machine (all for the sake of science)?

Here you can see a brief clip examining EEG responses to orgasm: Inside the Orgasm Lab | Sex.Right.Now.

Media Content Analysis

Researchers develop a system to make inferences about some form of media. Intercoder reliability is very important in that the researcher will train the individuals compiling the data on how to code for the same things accurately. The coders are often given examples of media and they continue to be trained until all of them match each other's responses. Then, they can move on to actually conducting the research.

Qualitative Methods

Just as correlational research allows us to study topics we can't experimentally manipulate (e. g., whether you have a large or small income), there are other types of research designs that allow us to investigate these harder-to-study topics. Qualitative designs, including participant observation, case studies, and narrative analysis are examples of such methodologies. Although something as simple as "observation" may seem like it would be a part of all research methods, participant observation is a distinct methodology that involves the researcher embedding him- or herself into a group in order to study its dynamics.

Meta-Analysis

This involves combining all previous studies on a particular topic to analyze the results altogether. This allows for an enormous sample size and a greater understanding of a particular research question. This also allows the researcher to include results from many different types of research methods that individual studies within the meta-analysis used.

Possible Biases in Research

Did you know that about 90% of all sex research comes from countries in the Global North, such as the United States? This skews data taken from sex research because culture and society influence gender and sexuality in many ways. When most of the research is coming from a small portion of the world, many of the findings will be non-generalizable to individuals outside of that area, and researchers need to be more inclusive of the Global South, which includes Asia, Latin America, Sub-Saharan Africa, and the Middle East (Dworkin et al., 2016). This is the overarching issue with sex research–there is a geographical and cultural bias. Additionally, we will look at some researcher mistakes as well as respondent mistakes that can influence outcomes.

Issues in Research: Researcher

- Too small of a sample size–the fewer number of participants in a study the less generalizable the research can be
- Convenience sample–comprising a sample of participants who are easy to include, such as volunteers at the Queer Resource Center where you work. It may be faster and easier to use this group of individuals, but the results will not reflect the general public within that particular population you are seeking to understand.
- If interviewing someone in person, the researchers' biases about someone based on gender, race, age, etc. may influence the way they ask a question even when sticking to a script. Changes in tone or asking questions in a slightly different way can influence results.
- Direct observations are incredibly beneficial, but lab settings are often not reflective of peoples' natural environments.

Best practices: utilize random or probability sampling so that a greater range of people have the chance of being included in the research and, if conducting an experiment, make it as naturalistic as possible (Hyde & DeLamater, 2017).

Issues in Research: Participants

- Nonresponse to certain parts of a survey or interview making the response rate across the sample inconsistent
- Purposeful distortion–people may exaggerate or minimize the truth related to their sexual thoughts and behaviors
- Volunteer bias–people who are willing to participate in sex research may not share the qualities of the general public
- People are often not good at recalling details or recognizing their own thoughts and physiological responses; self-report is sometimes not reliable
- When being interviewed in person, the participants' biases about the researcher in terms of gender, race, age, etc. can cause them to answer differently. These are considered extraneous factors (Hyde & DeLamater, 2017).

Ways to Reduce Issues

- Test-retest reliability–interview participants twice to see if their responses are the same both times
- Interrater reliability–check for reliability by conducting the interview twice using different interviewers
- Utilize a computer system to read questions to participants and record their responses
- Conduct research using several different methods. For instance, use a self-report survey while participants watch some form of media while also using an eye-tracking device at the same time.

Ethical Concerns with Sex Research

Research involving human subjects must follow certain ethical standards to make sure the subjects are not harmed. Such harm can be quite severe in medical research unless certain precautions are taken. For example, in 1932 the U.S. Public Health Service began studying several hundred poor, illiterate African American men in Tuskegee, Alabama. The men had syphilis, for which no cure then existed, and were studied to determine its effects. After scientists found a decade later that penicillin could cure this disease, the government scientists decided not to give penicillin to the Tuskegee men because doing so would end their research. As a result, several of the men died from their disease, and some of their wives and children came down with it. The study did not end until the early 1970s, when the press finally disclosed the experiment. Several observers likened it to experiments conducted by Nazi scientists. If the subjects had been white and middle class, they said, the government would have ended the study once it learned that penicillin could cure syphilis (Jones, 1981).

In a study that began in 1932 of syphilis among African American men in Tuskegee, Alabama, government physicians decided not to give penicillin to the men after it was found that this drug would cure syphilis. Wikimedia Commons – Public Domain

Fortunately, most sex research does not have this potential for causing death or serious illness, but it still can cause other kinds of harm and thus must follow ethical standards. The federal government has an extensive set of standards for research on human subjects, as do the fields of psychology, sociology and social work.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://openoregon.pressbooks.pub/introtohumansexuality/?p=29#oembed-1

One of the most important ethical guidelines in sexology and other human-subject research concerns privacy and confidentiality. Researchers should protect the privacy and confidentiality of their subjects. When a survey is used, the data must be coded (prepared for computer analysis) anonymously, and in no way should it be possible for any answers to be connected with the respondent who gave them. In field research, anonymity must also be maintained, and aliases (fake names) should normally be used when the researcher reports what she or he has been observing.

In 1970 a sociology student conducted a study, which ultimately led much debate among social science researchers when it came to light. Laud Humphreys studied male homosexual sex that took place in public bathrooms. He did so by acting as the lookout in several encounters where two men had sex; the men did not know Humphreys was a researcher. He also wrote down their license plates and obtained their addresses and a year later disguised himself and interviewed the men at their homes. Many sociologists and other observers later criticized Humphreys for acting so secretly and for violating his subjects' privacy. Humphreys responded that he protected the men's names and that their behavior was not private, as it was conducted in a public setting (Humphreys, 1975).

These and other studies (Reverby, 2009) led to increasing public awareness and concern regarding research on human subjects. In 1974, the US Congress enacted the National Research Act, which created the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research. The commission produced The Belmont Report, a document outlining basic ethical principles for research on human subjects (National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, 1979). The National Research Act (1974) also required that all institutions receiving federal support establish institutional review boards (IRBs) to protect the rights of human research subjects. Since that time, many private research organizations that do not receive federal support have also established their own review boards to evaluate the ethics of the research that they conduct.

Institutional Review Boards (IRBs)

Institutional Review Boards, or IRBs, are tasked with ensuring that the rights and welfare of human research subjects will be protected at all institutions, including universities, hospitals, nonprofit research institutions, and other organizations that receive federal support for research. IRBs typically consist of members from a variety of disciplines, such as sociology, economics, education, social work, and communications. Most IRBs also include representatives from the community in which they reside. For example, representatives from nearby prisons, hospitals, or treatment centers might sit on the IRBs of university campuses near them. The diversity of membership ensures that the complex ethical issues of human subjects research will be considered fully by a knowledgeable, experienced panel.

https://www.youtube.com/watch?v=U8fme1boEbE

Many sexological research projects involve the voluntary participation of all human subjects. In other words, we cannot force anyone to participate in our research without their knowledge and consent. Researchers must therefore design procedures to obtain subjects' informed consent to participate in their research. Informed consent is defined as a subject's voluntary agreement to participate in research based on a full understanding of the research and of the possible risks and benefits involved. Although it sounds simple, ensuring that one has actually obtained informed consent is a much more complex process than you might initially presume.

The informed consent process requires researchers to outline how they will protect the identities of subjects. This aspect of the process, however, is one of the most commonly misunderstood aspects of research. In protecting subjects' identities, researchers typically promise to maintain either the anonymity or confidentiality of their research subjects. Anonymity is the more stringent of the two. When a researcher promises anonymity to participants, not even the researcher is able to link participants' data with their identities. Face-to-face interviewing means that subjects will be visible to researchers and will hold a conversation, making anonymity impossible. In other cases, the researcher may have a signed consent form or obtain personal information on a survey and will therefore know the identities of their research participants. In these cases, a researcher should be able to at least promise confidentiality to participants.

Offering confidentiality means that some of the subjects' identifying information is known and may be kept, but only the researcher can link identity to data with the promise to keep this information private. Confidentiality in research and clinical practice are similar in that you know who your clients are, but others do not, and you promise to keep their information and identity private. This may be difficult if the data collection takes place in public or in the presence of other research participants, like in a focus group study. Researchers also cannot promise confidentiality in cases where research participants pose an imminent danger to themselves or others, or if they disclose abuse of children or other vulnerable populations. These situations fall under a social worker's duty to report, which requires the researcher to prioritize their legal obligations over participant confidentiality.

As you now know, researchers must consider their own ethical principles and follow those of their institution, discipline, and community. We've already considered many of the ways that researchers strive to ensure the ethical practice of research, such as informing and protecting subjects, but the practice of ethical research doesn't end once subjects have been identified and data have been collected. Researchers must also fully disclose their research procedures and findings. This means being honest about subject identification and recruitment, data collection and analyzation, as well as being transparent with the study's ultimate findings.

The Future of Sex Research

Understanding the history of sexology may be helpful in paving the way forward. In particular, note the progress with which cultural shifts curate a much different understanding of sex. For example, Kinsey's finding that masturbation occurs among many people AND that it seems to benefit the experience of an individual's sexual awareness within their future sexual relationships was shocking when it was first presented. Now, it's not just completely acceptable, masturbation as a form of self awareness is

encouraged by psychologists, sexologists, and medical providers. So cultural shifts matter when it comes to what we consider acceptable in terms of research and sexual data.

This, combined with an ongoing conversation around ethics, becomes important when we consider the future of sex/sexuality research. How do we ethically continue and expand the map of neurological responses to pleasure? How do technologies such as augmented reality fit our paradigm? What does it mean to have sex with robots?

https://www.youtube.com/watch?v=dRv70r5F_Ok

For more, check out Sex With Robots – Kate Devlin TEDx Talk

These questions are at the very tip of the iceberg, so to speak. What other considerations might be at play when it comes to research on all things sex?

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Adaptations: Reformatted. Modified content for language, application to subject and cohesion.

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Crash Course. (2018). Henrietta Lacks, the Tuskegee Experiment, and ethical data collection: Crash course statistics #12. https://www.youtube.com/watch?v=CzNANZnoiRs

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1.4: Sex Differentiation, Anatomy, and Physiology 1.4: Sex Differentiation, Anatomy, and PhysiologyEdit Update titlecancel

Learning Objectives

- Distinguish between female, male, and intersex anatomy and recognize the differences and similarities between them
- Identify hormones that influence sex development and sexual behavior
- Explain how bipotential tissues are directed to develop into male or female sex organs
- Name the rudimentary duct systems in the embryo that are precursors to male or female internal sex organs
- Describe the hormonal changes that bring about puberty, and the secondary sex characteristics of men and women
- Analyze the complexity of sex development and gain an understanding of the experiences of intersex and transgender individuals
- Describe the sexual response cycle
- Evaluate theories explaining the sexual arousal and response processes, such as Masters and Johnson, the 4 stages of physiological arousal, etc.
- Distinguish between pleasure and reproduction as motives behind sexuality

Every body is different. But many things about our bodies are the same.

Humans come in a variety of shades, sizes and proportions, yet in total, our bodies are more similar to each other than they are different. In fact the human body shares similarities with bodies across the diversity of life. We share aspects of our reproductive system with all mammals, aspects of our basic physiology with all vertebrates, and aspects of our cell structure, biochemistry and genetics with all living things. In this chapter, we will look at the human body specifically, not because the human body, in terms of reproduction, is very distinct from that of a 3-toed sloth, or because the basic structure is very different from a Galápagos tortoise, or because our cellular biology varies much from that of the fungus that inhabits bleu cheese. Instead, we focus on the human body because the authors and readers of this text presumably each have a human body, and reading about ourselves is interesting.

AUTHOR'S NOTE: Some of the language in this chapter is still held in the binary; that is girl/boy or male/female. This is concurrent with a lot of medical literature. Importantly, however, even biological sex is found on a continuum so there are variations of genital structure and presentation that defies the binary, which is critical to note.

Sex Differentiation

Sex differentiation, also referred to as sexual differentiation, is the process in which genitals and reproductive organs develop within the womb as a result of complex hormonal processes altering neutral tissues to develop along female and male lines and in which varying combinations are possible as well. Secondary sex characteristics begin to develop further as part of the sex differentiation process during puberty. Therefore, prenatal development, as well as changes that further occur during puberty, create a cascade of events that results in physical changes to the body. Chromosomes, genes, gonads, hormones, and hormone receptor sites play key roles within the endocrine system that influence sex development. Sex is both a genetic and environmental experience in which epigenetic factors can alter the way that genes function, resulting in changes to hormone production and hormone receptor sites at different points across the lifespan.

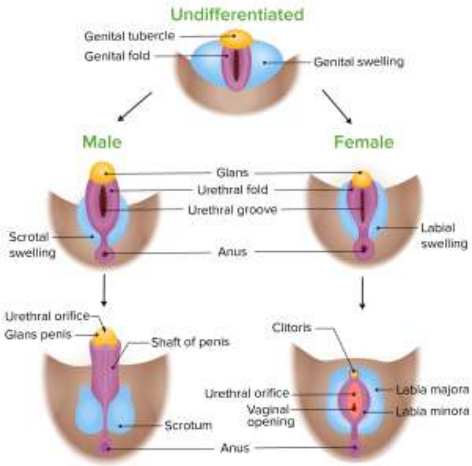
Prenatal

Commonalities between male and female reproductive anatomy

During embryonic development the male and female fetus are indistinguishable before about 10 weeks of pregnancy. Fetal tissues begin in an undifferentiated state, and based on genetic signals and the interuterine environment the reproductive organs usually differentiate into structures typical of males and females. This means that for most of the reproductive parts there is an analogous part in the other sex that arose from the same original tissues. For example, testes and ovaries develop from the same tissue – originally located in the abdomen. In males the testes move down and outside the abdomen as they develop; in female they remain internal. Some structures (such as the oviducts) have a structure that was common in early development, but completely or partially disappears in later development; other structures (such as the uterus) have analogues that are very subtle structures in the male. See the following table for a list of analogous structures in male and female anatomy.

Structure in male	Structure in female
Glans (head) of the penis	Clitoral head
Penis shaft	V-shaped internal structure of clitoris
Foreskin	Clitoral hood
Penis skin	Labia minora
Testicle	Ovary
Scrotum	Labia majora

Some analogous structures in male and female anatomy



Phenotypic differentiation of the external genitalia in male and female embryos
Image by Lecturio. License: CC BY-NC-SA 4.0

Commonalities between male and female reproductive signaling

Much of the reproductive physiology we will address is regulated by hormonal signals that arise in the brain and much of this signaling is shared between males and females.

Within the brain is a region called the hypothalamus (see figure below). This portion of the brain sends signals to the pituitary gland located beneath it. In particular, the hypothalamus sends a hormonal signal called gonadotropin-releasing hormone (GRH) to the pituitary gland. In response to the GRH signal, the pituitary gland releases two hormones that circulate in the blood: luteinizing hormone (LH) and follicle stimulating hormone (FSH). These hormones travel throughout the body, triggering further hormone releases and physiological changes (discussed further below). There are feedback loops that tightly regulate the levels of circulating hormones. In addition to GRH, LH, and FSH, the hormones testosterone, estrogen and progesterone are important in reproductive signaling. While we will focus on the effects of testosterone in males and estrogen and progesterone in females, all of these hormones are present and important in both males and females.

Further Sexual Development Occurs at Puberty

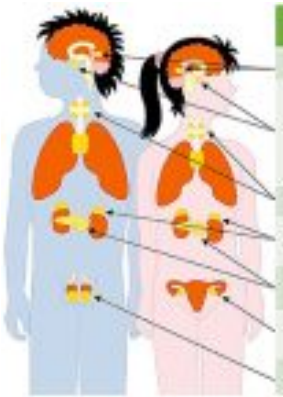
Puberty is the stage of development at which individuals become sexually mature. Though the outcomes of puberty for boys and girls are very different, the hormonal control of the process is very similar. In addition, though the timing of these events varies between individuals, the sequence of changes that occur is predictable for male and female adolescents. As shown in the figure below, a concerted release of hormones from the hypothalamus (GnRH), the anterior pituitary (LH and FSH), and the gonads (either testosterone or estrogen) is responsible for the maturation of the reproductive systems and the development of secondary sex characteristics, which are physical changes that serve auxiliary roles in reproduction.

The first changes begin around the age of eight or nine when the production of LH becomes detectable. The release of LH occurs primarily at night during sleep and precedes the physical changes of puberty by several years. In pre-pubertal children, the sensitivity of the negative feedback system in the hypothalamus and pituitary is very high. This means that very low concentrations of androgens or estrogens will negatively feed back onto the hypothalamus and pituitary, keeping the production of GnRH, LH, and FSH low.

As an individual approaches puberty, two changes in sensitivity occur. The first is a decrease of sensitivity in the hypothalamus and pituitary to negative feedback, meaning that it takes increasingly larger concentrations of sex steroid hormones to stop the production of LH and FSH. The second change in sensitivity is an increase in sensitivity of the gonads to the FSH and LH signals, meaning the gonads of adults are more responsive to gonadotropins than are the gonads of children. As a result of these two changes, the levels of LH and

FSH slowly increase and lead to the enlargement and maturation of the gonads, which in turn leads to secretion of higher levels of sex hormones and the initiation of spermatogenesis and folliculogenesis.

In addition to age, multiple factors can affect the age of onset of puberty, including genetics, environment, and psychological stress. One of the more important influences may be nutrition; historical data demonstrate the effect of better and more consistent nutrition on the age of menarche in girls in the United States, which decreased from an average age of approximately 17 years of age in 1860 to the current age of approximately 12.75 years in 1960, as it remains today. Some studies indicate a link between puberty onset and the amount of stored fat in an individual. This effect is more pronounced in girls, but has been documented in boys as well. Body fat, corresponding with secretion of the hormone leptin by adipose cells, appears to have a strong role in determining menarche. This may reflect to some extent the high metabolic costs of gestation and lactation. In girls who are lean and highly active, such as gymnasts, there is often a delay in the onset of puberty.



Gland	Hormone	Target Organ	Function
Pineal gland	Melatonin	Many	Biological clock
Pituitary gland	FSH / LH ADH Growth hormone Oxytocin Prolactin	Ovaries Kidneys Uterus Breast tissue Many others	Menstrual cycle Osmoregulation Growth & division Birth contractions Milk production
Thyroid gland	Thyroxin	Liver	Metabolic rate
Adrenal glands	Adrenaline Cortisol	Many	Fight or flight Anti-stress
Pancreas	Insulin Glucagon	Liver	Blood sugar levels
Ovaries	Estrogen Progesterone	Uterus	Menstrual cycle
Testes	Testosterone	Many	Male characteristics

There are around 50 different kinds of hormones in the human body.
Kabotyanski and Somerville under the terms of the Creative Commons Attribution License (CC BY).

Hormones of Puberty During puberty, the release of LH and FSH from the anterior pituitary stimulates the gonads to produce sex hormones in both male and female adolescents.

Signs of Puberty

Different sex steroid hormone concentrations between the sexes in general and within each individual uniquely also contribute to the development and function of secondary sexual characteristics. Examples of secondary sexual characteristics are listed in Table 1. Each individual's hormone concentrations will depend upon genetics, diet, stress, and more; thus, secondary sex characteristics will progress along a continuum of possibilities based on these nature multiplied by nurture combinations.

Development of the Secondary Sexual Characteristics

Male	Female
Increased larynx size and deepening of the voice	Deposition of fat, predominantly in breasts and hips
Increased muscular development	Breast development
Growth of facial, axillary, and pubic hair, and increased growth of body hair	Broadening of the pelvis and growth of axillary, pubic and body hair

Something to keep in mind as well is that people can experience varying degrees of muscular, breast and hair development depending upon their genetic and environmental makeup. For instance, some boys at the beginning of puberty may see breast tissue growth as well as other body fat increases, and some girls may have facial and body hair growth. One example in this complex process is how unused testosterone is converted to estrogen, for instance, making it not about how much testosterone is present and rather how that testosterone is being used or unused. Also, hormone receptor sites in female cells are often more reactive to lower levels of testosterone. Intersex individuals, females and males all have estrogen and testosterone impacting the changing body during puberty, and it is incorrect to view testosterone as a strictly "male" hormone and estrogen as a strictly "female" hormone. To understand this process, individuals will need to analyze their specific hormone levels, the functionality of genes involved in sex differentiation, and environmental stressors and nutrition that may have epigenetic effects on their genes.

As a girl reaches puberty, typically the first change that is visible is the development of the breast tissue. This is followed by the growth of axillary and pubic hair. A growth spurt normally starts at approximately age 9 to 11, and may last two years or more. During this time, a girl's height can increase 3 inches a year. The next step in puberty is menarche, the start of menstruation.

In boys, the growth of the testes is typically the first physical sign of the beginning of puberty, which is followed by growth and pigmentation of the scrotum and growth of the penis. The next step is the growth of hair, including armpit, pubic, chest, and facial hair. Testosterone stimulates the growth of the larynx and thickening and lengthening of the vocal folds, which causes the voice to drop in pitch. The first fertile ejaculations typically appear at approximately 15 years of age, but this age can vary widely across individual boys. Unlike the early growth spurt observed in females, the male growth spurt occurs toward the end of puberty, at approximately age 11 to 13, and a boy's height can increase as much as 4 inches a year. In some males, pubertal development can continue through the early 20s.

Hormone blockers for transgender individuals are helpful during puberty to prevent the development of inappropriate secondary sex characteristics that may evoke dysphoria. A concern around hormone blockers is that the parent(s) or guardian(s) are consenting to this treatment on their youth's behalf, and some caretakers may not feel comfortable with this process. An ongoing debate exists around whether adolescents are mature and aware enough to advocate for themselves. Pediatricians and advocates who are supportive of prescribing hormone blockers and starting hormone replacement therapy express that transgender identities are often expressed during early childhood and remain consistent across the lifespan, whereas others who are against this process tend to express concern over the weight of this decision due to the epigenetic effects of hormone medications that will permanently alter the body and cannot be undone if an individual were to no longer identify as transgender.

Chromosomes and Hormones, Oh My!

Watch these two videos to gain more insight into the X chromosome and hormones.

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Epigenetics, Surgery, and Medications

Epigenetics

Epigenetics is the way in which environmental factors influence the expression of genes. First, let's look at reptilian and mammalian studies to explore some epigenetic factors that can influence differences between sexes. According to Forger (2016), "In many reptiles and some fish the ambient temperature during incubation determines the sex of the individual. In other words, perfectly good male or female brains and bodies can develop from an identical genome, based on differences in the epigenetic regulation of that genome. Similarly, although there are genetic differences between male and female mammals, many of the sex differences in mammalian brains and behavior are likely epigenetic in origin" (p. 1). In studies conducted on rodents, such as mice, rats, and guinea pigs who share similarities with human males regarding olfactory cues and some sexual behaviors, researchers have found that the development of the brain is influenced by environmental factors at birth that alter cell death in the brain and the way that sex hormones are processed based on activation or inactivation of key genes depending on the presence of certain histones (Forger, 2016).

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Surgeries

The removal of organs, such as gonads, can alter the production of hormones and require an individual to take synthetically produced hormones. Hysterectomy (surgical removal of the uterus), orchiectomy (surgical removal of one or both testes), and other procedures that alter the reproductive organs or other endocrine glands will alter the natural production of hormones and cause changes to the body. Medications can be prescribed to stand in for the lost hormones that can no longer be created, but medications will require adjusting and tweaking over time which may never completely compare to the original levels previously maintained.

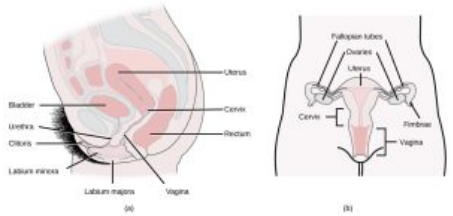
Medications

Many people associate medically prescribed hormones with transgender individuals who are physically transitioning; however, hormone replacement therapy was first developed to help cisgender women with symptoms related to menopause (Cagnacci & Venier, 2019). Additionally, testosterone injections and pills are often advertised to cisgender men under the premise that they will provide them with a confidence boost, higher sex drive, more muscle mass, etc. (Harvard Health Publishing, 2020). Hormones are present in birth control pills, and narcotics and prescribed substances, such as steroids, antihypertensive drugs, chemotherapy and more, can impact the endocrine system in numerous ways which will then impact the way that sex hormones are produced and processed. Thus, these medications beyond hormone replacement therapies can have impacts upon sexual functioning, fat distribution, mood, body hair production and more. Some changes, such as body hair production, may remain even after the medication is stopped.

Female Anatomy

Some of the organs involved in female reproduction are diagrammed in the Figure below.

The reproductive structures of the human female are shown.



Female reproductive anatomy

(credit a: modification of work by Gray's Anatomy; credit b: modification of work by CDC)

Female reproductive anatomy includes external structures (the clitoris and vulva), structures involved in the production of eggs and in fetal development (ovaries corpus luteum, and uterus), and structures involved in the transport of sperm, eggs, and babies (vagina, cervix and oviduct).

For a useful 3-D interactive, check out Pussypedia's 3-D Interactive Pussy.*

Image from Pussypedia.net

> *Pussy**
>
> **We propose a new gender-and-organ-inclusive use of the word. ~Pussypedia*

Egg production and fetal development

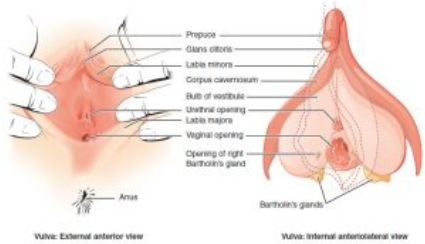
- Ovary: females have two ovaries that are the site of egg production, and, if an egg is fertilized, the site of the corpus luteum. The ovary produces hormones estrogen and progesterone and testosterone.
- Corpus luteum: the site of egg maturation within the ovary. After ovulation (release of the egg) the corpus luteum produces progesterone to maintain a possible pregnancy.
- Uterus: this muscle-lined, triangular organ is where a fertilized egg implants and develops. This organ develops a thick blood lining and sheds this lining on a monthly cycle.

Transport of eggs, sperm, and embryos

- Vagina: a highly expandable pouch structure that serves as the opening of the female reproductive tract to outside the body. The vagina is the point of sperm entry, and the point of exit for unfertilized eggs, menstrual discharge and for babies, if pregnant and having a vaginal delivery.
- Cervix: the opening between the vagina and the uterus. The size of this opening varies from tightly closed – to open for the passage of sperm, to open enough for a baby to pass through.
- Oviducts (sometimes called fallopian tubes): these ducts transport mature eggs from the ovary toward the uterus. If a sperm and egg are in the oviduct at the same time, the egg can be fertilized by a sperm.

Exterior structures

- Vulva: a general term for the exterior parts surrounding the vagina, including the labia majora and labia minora, which are the folds of skin on either side of the clitoris, urethra, and vagina. Often this term is overlooked, with folks referring to the vulva as "vagina," which is the internal structure. It's OK and more accurate to say vulva when referring to the external structure. Importantly, the structure and appearance of the vulva may vary widely. There's no "one size fits all" when it comes to the vulva and diversity in appearance needs to be celebrated.
- Clitoris: the sensitive nerve-rich organ that is analogous to the head of the penis. The part of the clitoris that is visible outside the body is dorsal to (closer to the belly) the urethra and the vagina). The interior part of the clitoris extends internally along either side of the vagina.



Amphis, Public domain, via Wikimedia Commons

Unfortunately, the structure of the clitoris is not well known by many people, including to those folks with a clitoris. Historically (and even in some contemporary settings), this feature of anatomy has been muted or correlated with antiquated notions of female sexuality such as hysteria or neurosis.

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Female reproductive physiology

Female reproductive anatomy and physiology has many similarities to that of the male. As described earlier, females also use LH and FSH secretion from the pituitary triggered by GRH from the hypothalamus to stimulate hormone production by the gonads. There is also negative feedback to regulate hormone production. However, in females, the interplay among the hormonal signals is more complicated than in males. While male hormonal feedbacks and signaling provide a relatively steady level of the sex hormone testosterone, for females there is a monthly cycle over which the circulating hormone levels go up and down at the same time as changes occur in the ovaries and the uterus. This surging of hormones along with the changes in the ovaries and uterus require the more complicated physiological controls described below.

Menstruation

Sometimes a Taboo Topic

The banner in the picture below was carried in a 2014 march in Uganda as part of the celebration of Menstrual Hygiene Day. Menstrual Hygiene Day is an awareness day on May 28 of each year that aims to raise awareness worldwide about menstruation and menstrual hygiene. Maintaining good menstrual hygiene is difficult in developing countries like Uganda because of taboos on discussing menstruation and lack of availability of menstrual hygiene products. Poor menstrual hygiene, in turn, can lead to embarrassment, degradation, and reproductive health problems in females. May 28 was chosen as Menstrual Hygiene Day because of its symbolism. May is the fifth month of the year, and most women average five days of menstrual bleeding each month. The 28th day was chosen because the menstrual cycle averages about 28 days.

CC BY-SA 4.0
World Menstrual Hygiene Day celebration by Satirtha-The Helping Hand a non profit organization.

The monthly female reproductive cycle can be divided into three phases, the follicular phase, ovulation, and the luteal phase. For each of these phases, there are concurrent changes happening in the uterus and in the ovaries. See the figure below for a diagram of the phases of the female reproductive cycle and what is happening in the ovary, the uterus, and circulating hormone levels.

Female hormone cycle.

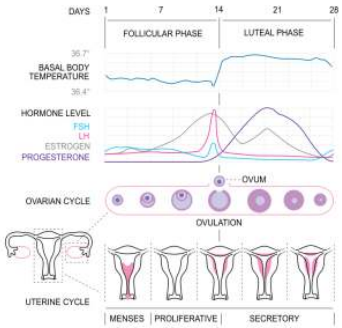

Diagram of the menstrual cycle (based on several different sources)
CC BY-SA 3.0

The Follicular Phase

The name "follicular phase" is in reference to the egg-containing follicle in the ovary that matures during this phase (note the ovarian histology shown in Figure 7). This phase begins on day one of a female's reproductive cycle. Day one is defined as the first day of menstruation (the first day of a period). Menstruation occurs for about the first 5 days of the follicular phase. During these days, if a female is not pregnant, low circulating levels of the hormone progesterone trigger the breakdown of the endometrium (the lining of the uterus). This blood-rich tissue exits the uterus through the cervix and then leaves the body out the vagina. During menstruation, low circulating levels of estrogen and progesterone stimulate GRH production (from the hypothalamus in the brain), which leads to LH and FSH secretion by the pituitary gland. FSH signals the maturation of several follicles within the ovaries. These follicle cells produce a steadily increasing amount of estrogen (note the estradiol (a type of estrogen) increases from day 1-12 in Figure 4.5).

Ovulation

Ovulation refers to the rupture of a mature follicle within the ovary; this ruptured follicle releases an oocyte (an unfertilized egg) into the abdominal space. Because this rupture is an actual breakage, some females will feel a twinge or slight pain during ovulation. Ovulation generally happens around day 14 of the reproductive cycle in one ovary.

Luteal phase

During the luteal phase, the now empty follicle within the ovary collapses. This collapsed mass of cells is called a corpus luteum. The corpus luteum produces progesterone that enters the blood circulation. Progesterone signals the hypothalamus to signal the pituitary to reduce FSH and LH production, which prevents other follicles from maturing. If the oocyte in the oviduct is not fertilized, the corpus luteum degrades, causing a drop in progesterone, which triggers the beginning of menstruation and the return to the follicular phase of the reproductive cycle (back to day 1 after about a 28-day cycle). If the oocyte IS fertilized, then that begins the cellular process of fetal development (pregnancy).

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Menopause

Female fertility (the ability to conceive) peaks when women are in their twenties, and is slowly reduced until a women reaches 35 years of age. After that time, fertility declines more rapidly, until it ends completely at the end of menopause. Menopause is the cessation of the menstrual cycle that occurs as a result of the loss of ovarian follicles and the hormones that they produce. A woman is considered to have completed menopause if she has not menstruated in a full year. After that point, she is considered postmenopausal. The average age for this change is consistent worldwide at between 50 and 52 years of age, but it can normally occur in a woman's forties, or later in her fifties. Poor health, including smoking, can lead to earlier loss of fertility and earlier menopause.

Intersex Anatomy

About 1 in 1,000-1,500 people will be born noticeably intersex, such as having partial elements of both a penis and vulva. However, other intersex conditions may not show up until later, such as during puberty or when trying to conceive children, making this number higher in actuality. Some estimates show that some intersex conditions can be as high as 1 in 66. Taken altogether, some researchers, such as Anne Fausto-Sterling, argue that the number of intersex people is actually closer to about 1 in 100 (Intersex Society of North America, 2008b). Here is a video of 4 individuals sharing some of their experiences:

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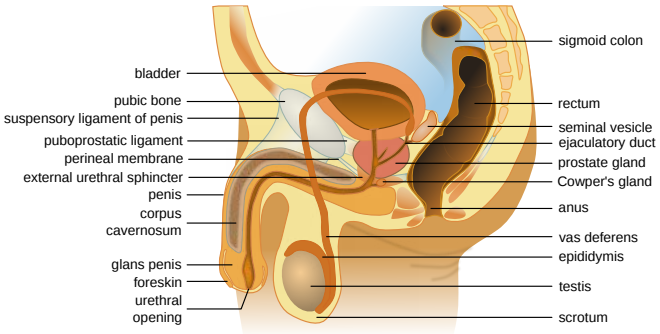
The term intersex is an umbrella term that encompasses many different variations to sex. Some intersex individuals have variations to their sex chromosomes or that the SRY gene on the Y chromosome is not present or was translocated onto an X chromosome. Thus, in some instances, a male can have XX chromosomes and a female can have XY chromosomes. Other variations are possible as well (X0, XXY, XYY, XXX). According to Dr. Charmian Quigley with the Intersex Society of North America (2008a), “The last time I counted, there were at least 30 genes that have been found to have important roles in the development of sex in either humans or mice. Of these 30 or so genes 3 are located on the X chromosome, 1 on the Y chromosome and the rest are on other chromosomes, called autosomes (on chromosomes 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 17, 19). In light of this, sex should be considered not a product of our chromosomes, but rather, a product of our total genetic makeup, and of the functions of these genes during development” (para. 11-12). Therefore, we need to be careful when we oversimplify this process and relate sex to XX or XY chromosomes only.

Male Anatomy

Some of the organs involved with male reproduction are diagrammed below.



Male reproductive anatomy

Male reproductive anatomy involves the organs and glands that produce sperm, create semen to transport sperm, and conduct this liquid semen out of the body. Semen production involves the work of accessory glands, each responsible for the production of one or more key ingredients of semen. Male anatomical structures can be broken down into the following:

Sperm production

- Testis: males typically have two testes (also called testicles), which, in humans, descend from the abdomen during fetal development and are enclosed outside the abdomen in the scrotum. Each testis houses many tube-like structures (the seminiferous tubules) in which sperm are made. Specialized cells (the Leydig cells) in the testes produce testosterone.
- Scrotum: a pouch of skin that holds the testes that contracts or expands to adjust the distance the testes are from the body to regulate their temperature.

External scrotal view:
The central raphe on the far left represents the “seam” where the genital tubercles fused in development. In the central image, note the cremaster and dartos muscles, which are important for temperature regulation. On the right, note a deep layer demonstrating the external testes, epididymis, and neurovasculature.
Image: “The Scrotum and Testes” by Phil Schatz. License: CC BY 4.0

- Seminiferous tubules: these structures within the testes are the actual sites of sperm production (discussed further below)
- Epididymis: this rubbery device sits astride the testis. Sperm mature here and are stored prior to ejaculation (when sperm-bearing semen leaves the body, typically during orgasm)

Semen production

- Seminal vesicles: these two glands produce an alkaline (basic) fluid that can neutralize the acidity of the vagina. This fluid contains fructose and other nutrients to provide energy for the sperm.

image

Diagram of human sperm; LadyofHats, Public domain, via Wikimedia Commons

- Bulbourethral (or Cowper's) glands: these two glands provide a mucus-rich alkaline fluid that lubricates the inside of the urethra to allow for easier passage of sperm and neutralizes the urethra (urine residue is acidic). Some of this fluid exits the penis prior to ejaculation (this pre-ejaculate fluid can also contain sperm). The remainder of the fluid combines with the semen ejaculate.
- Prostate gland: this organ wraps around the urethra and provides muscular contractions that help propel semen during ejaculation and block urine flow from the bladder during ejaculation. It also provides fluid in the ejaculate that contains enzymes and zinc that aid in sperm motility.

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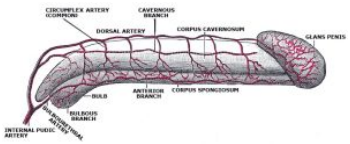
Sperm/semen transport:

- Ductus (or vas) deferens: this pair of muscle-lined tubes carry sperm from the epididymis of each testis into the abdominal cavity where they loop over the bladder and join with the ducts from the seminal vesicles to form the ejaculatory ducts. The muscles that line the ductus deferens contract to propel semen during ejaculation.
- Ejaculatory ducts: these ducts are formed by the joining of the vas deference with the duct from the seminal vesicle. Each ejaculatory duct empties into the urethra.
- Penis: the organ that encircles the urethra as the urethra exits the abdomen. This organ changes from flaccid (soft and limp) to erect (rigid and standing away from the body) during sexual arousal or spontaneously. In uncircumcised men the penis has a fold of skin called a foreskin that during the flaccid state, covers the head of the penis, and during the erect state retracts behind the glans (or head) of the penis.



Arterial circulation of the penis
Image: "Arterial supply of the penis" by Gray's anatomy.
License: Public Domain

- Urethra: the tube that runs from the bladder through the penis through which urine and semen exit the body.

Transgender Anatomy

Further neurobiological research has been conducted to explain why many transgender people experience gender dysphoria, which is an intense feeling that one's sex assigned at birth based on genital presentation does not match the way they feel about themselves. The contrast between the genital-based presentation of sex and the brain's sex can be explained from a neurobiology perspective by taking a closer look at sex differentiation when we are still in the womb. During prenatal development, sex differentiation of the genitals takes place during the first two months of pregnancy while sex differentiation of the brain occurs around 4 months of pregnancy (Swaab & Garcia-Falgueras, 2009). This discrepancy between the development of the genitals and the brain has led biological researchers to believe this may be the reason why some individuals are transgender or experience gender dysphoria. Something to keep in mind: Humans actually show a lot less sex dimorphism than many other species, which means that there are actually a lot of similarities between men and women, making this type of research rather difficult as differences are often very subtle if present at all.

Due to the positive results found with treating some transgender individuals using hormone replacement therapy and hormone blockers in order to bring about desirable changes to the physical body, this adds merit to the perspective that there may be some biological reasons and solutions for people experiencing gender dysphoria from a biopsycho perspective. Transgender men: testosterone therapy will result in enlargement of the clitoris leading to resembling a small penis, facial hair and increased body hair similar to other males in the family, redistribution of body fat and increased muscle mass, deepening of the voice due to testosterone thickening the vocal cords, breast tissue will begin to atrophy, more oily skin, etc. Transgender women: Hormone blockers and estrogen hormone therapy will cause breast tissue growth, redistribution of body fat and reduced muscle mass, body hair will thin and grow less fast, penial tissue (if not having regular sex or masturbating) will begin to atrophy, the skin will become drier, etc. Electrolysis for hair removal may be desired and voice lessons can help train the individual to speak in a more socially expected female register.

Hormone blockers prior to puberty are especially beneficial to prevent these long-lasting impacts and aid the transition process for transgender individuals. Many parents feel conflicted about this, however, and may not consent on their children's behalf to receive these medical services. Surgeries may also be used by some transgender individuals, commonly referred to within these communities as "top surgery" relating to surgery to either remove or enhance breast tissue or "bottom surgery" on the genitals. Creating a vagina can be done by utilizing the existing tissue and has promising results for many individuals allowing them to experience sensation, but this will depend on scar tissue. Creating a penis will require the addition of testicular implants and a penial pump for erection purposes.

Every transgender person will have to decide what steps they want to take to help them feel as comfortable as possible in their bodies. If someone does not use hormones or have surgeries, it does not make them any less transgender than someone who does. Also, keep in mind that access to healthcare is a privilege and not a right in our country, which can be a barrier for many individuals in receiving the care they need. Family, culture, society, etc. also act as barriers in this process. It is never appropriate to question a transgender person about their genitals, surgeries or hormones, and doing so would be examples of microaggressions. This is othering and dehumanizing and reduces transgender individuals to their genitals and body rather than seeing them as a whole person with feelings and the right to privacy. Create a space where someone feels comfortable to share their experiences with you on their own instead rather than questioning them. We will talk more about allyship next week. Until then, here are some resources:

- National Center for Transgender Equity
- Trans Student Educational Research
- Supporting the Transgender People in Your Life: A Guide to Being a Good Ally

Additional resources for your reference: If you or someone you know is interested in learning more about how hormone replacement therapy impacts the body, check out the links provided by the University of California San Francisco Transgender Care. UCSF Transgender Care also has more information on the types of surgeries that are available for transgender individuals.

What about when nonbinary individuals, such as those who identify as agender, bigender, genderqueer, etc., and experience gender dysphoria as well? Or, what about when transgender individuals don't experience gender dysphoria? What might be some biological explanations? We need more research! A question to think about further: If gender is a social construct, then does biology even really matter anyway and are researchers trying too hard to find biological answers? This goes back to the nature/nurture debate once again. We will discuss gender as a social and cultural phenomenon next week to explore this question further from other perspectives.

To hear personal stories and experiences of transgender individuals, watch this video:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://openoregon.pressbooks.pub/introtohumansexuality/?p=42#oembed-8

Bodies are Beautiful and Vary So Much

The authors of this text (Ericka Goerling and Emerson Wolfe) could not find images that represent transgender bodies, apart from images depicting surgeries, in a respectful way. If you know a transgender, non-binary, or gender expansive artist who would like to see their work featuring beautiful bodies added to this resource, please share your instructor's email with them to reach out for more information on this project.

The Medicalization of Gender: The Development of "Sex"

Why do we label different anatomical parts as "female anatomy" and "male anatomy"? Our understanding of the body is usually through the lens of long deceased researchers and doctors who believed in strict gender binary systems with males having "normal" bodies and with women being framed as having less capable bodies. The existence of intersex people indicates that the process of sex differentiation is very complex, yet our understanding today even is misguided by an oversimplification of this process that is shaped by our cultural definition of gender and our gender **schema** (aka a cognitive blueprint based on your experiences). Think to your own upraising and explore how this has shaped your concept of sex and gender even today. We will discuss cross-cultural perspectives on gender and how this impacts our idea of biological sex next week. Until then, explore the following questions: Do you know your hormone levels? Do you know your sex chromosomes? Take this moment to normalize the way your genitals looked at birth and how they look currently and recognize that everyone's bodies are different and beautiful.

Conclusion

As you reach the end of this reading, the hope is that you have more questions than answers about the vast possibilities that contribute to your present bodily form and physiological functioning. Human experiences are genetic and environmental, and sex differentiation further showcases how this process is often oversimplified and discussed from within binary systems of "female" and "male" when the reality lends itself more toward spectrums and continuums from the moment we begin in the womb to how we undergo many changes throughout our life's course. Use this knowledge to understand your body's functioning, and harness this information as you explore

what brings you and others sexual pleasure if this connection is something you seek. Use scientific advancements to be allies to the human experience and also recognize the limitations to scientific study. We do not have all the answers and may never, so continue to ask questions about human sexual development, anatomy, and physiology.

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Betts, J. G., Young, K. A., Wise, J. A., Johnson, E., Poe, B., Kruse, D. H., Korol, O., Johnson, J. E., Womble, M., & DeSaix, P. (2013). Anatomy and physiology. OpenStax. https://openstax.org/books/anatomy-and-physiology/pages/27-3-development-of-the-male-and-female-reproductive-systems#fig-ch28_03_01 (Adapted for the section on Puberty). Licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.

Cotner, S. & Wassenberg, D. (2018). The evolution and biology of sex. PressBooks.https://open.lib.umn.edu/evolutionbiology/ (for sections on Female Anatomy and Male Anatomy). Licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.

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Adaptations: Reformatted. Modified content for language, application to subject and cohesion.

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1.5: Gender 1.5: GenderEdit Update titlecancel

Learning Objectives

- Analyze the impact of colonization upon indigenous traditional practices regarding gender and social structures
- Discuss decolonization and current activism that seek to return to pre-colonial understandings of gender as a basis for intergenerational healing
- Explore gender as a social construct by looking at many perspectives around the world
- Describe gender variations
- Explain how various socialization agents (e.g., parents, peers, schools, textbooks, television and religion) contribute to the formation of gender roles
- Compare psychological theories on gender
- Create a plan to be an ally to others to promote individual and community well-being

Introduction

Sex and gender are often confused for one another and are used interchangeably in many circumstances; however, these are distinct concepts. Sex, like we explored last week, depends on chromosomes, genetics, hormones, hormone receptors, gonads, and epigenetic factors, and secondary sex characteristics continue to unfold during puberty and throughout our lifespans impacting the way that our physical bodies look and feel. Female, intersex, and male bodies exist on a continuum of possibilities. Gender, on the other hand, is a social construct based on gender roles, expectations around behavior, stereotypes concerning vague concepts like femininity and masculinity, and personal internalization of what gender means to each individual person. All of these factors, through socialization, work to influence the way each individual person internalizes concepts around gender.

Some people will conform to what is socially expected of them based on the way others have labeled their gender while others will identify differently and carve out a different path. Additionally, humans do not remain stagnant and gender can also change throughout a person's lifetime depending on life experiences, education, exposure to differing perspectives, religious upbringing, family background, peer interactions, media, and more. Before we can delve into this topic more globally, let's first look at gender in the United States. Then, we will analyze multicultural perspectives to highlight how gender can take on different meanings based on culture and society, we will explore theories around gender, and we will analyze the way in which this culminates in the unique way each person will come to perceive gender and behave based on the internalization of gendered concepts. In order to explore where to go from here, we will discuss ways to be allies to all genders in order to build a healthy and sustainable future.

Gender and the United States

Gender expansive ideas are not new. Many indigenous communities in the United States have long held places of high esteem for those who can move more fluidly between roles. Being able to walk between the worlds of gender also holds spiritual significance and strength. Creating a binary system for gender has always been about power and control, and this is a tool utilized to uphold white supremacy, the patriarchy, and further colonial domination. Religion, namely Christianity and Catholicism, were wielded as swords, not of justice but of genocide and apartheid. In order to understand the ways in which gender is a social construct, let's take a deep dive into US colonization to lead us to this present moment in time. The past is still present in many ways. Decolonizing and indigenizing views on gender can be sources of healing and empowerment.

Indigenous Perspectives

Native Americans and Alaskan Natives

The Secretariat of the United Nations Permanent Forum on Indigenous Issues (UN Forum) (2010) explains that, prior to colonization, indigenous women, men, and intersex individuals held equitable social statuses and were stewards of the land and resources in partnership with each other. The UN Forum (2010) discusses how many indigenous communities thrived off of the concept of generalized reciprocity in which repayment was not expected and rather a sense of generosity and the continual sharing of resources was expected instead. Thus, the concept of property and ownership rights were not present to reinforce gender segregation or differences. Many indigenous communities also relied on symbiotic complementarily which is a means of producing resources in a way that recognizes the need for differentiation in the labor force without one type of role dominating the other or taking on more social importance than another (UN Forum, 2010).

Two-spirit and gender-expansive perspectives have also been documented within many traditional tribal societies. According to Indian Health Service (n.d.), Native American and Alaskan Native tribes, in general, had a more gender-expansive view with many tribes denoting a third or even fourth gender category in which individuals were respected and valued as they took on activities for both women and men and even had specialized roles as spiritual guides, healers, shamans, artists, and more. Some two-spirit individuals would take on a traditional male or female style of dress depending on how they identified while others developed their own ways of self-expression (Indian Health Service, n.d.).

More than 500 indigenous cultures have survived cultural genocide in the United States (Indian Health Service, n.d.) with some preferring the use of specific terms within their language rather than the use of the recently developed term of two-spirit. Two-spirit is a term in English or referred to as a "pan-Indian" word created in the 1990s by an international gathering of indigenous tribes to replace the colonizer word "berdache" which has a harmful connotation and is related to sex acts rather than gender (Matthews-Hartwell, 2014). Many tribes prefer to use the terms in their language rather than using the term two-spirit. Here are some examples of tribal terms (Matthews-Hartwell, 2014):

- Navajo: Nádleehí and Dilbaa'
- Lakota: Winkte
- Zuni: Lhamana
- Osage: Mixu'ga
- Ojibwa: Agokwa and Ogichidaakwe

Native American and Alaskan Native cultures are not monolithic and contain many nuances and differences in practices as well. Thus, it is important to not generalize the concept of two-spirit to all tribal communities by understanding the diverse cultural practices and customs of individual tribes as well as individual people who are tribal members.

Further firsthand accounts by tribal members:

- Native American 'Two-Spirit People' Serve Unique Roles Within Their Communities: One 'Winkte' Talks About Role Of LGBT People In Lakota Culture (Wisconsin Public Radio, 2014)
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    - Not shown in the captioning: Ma-Nee Chacaby mentions identifying as the Anishinaabeg term Niizhojichaagwijig-meaning "ones with two spirits" (Native Justice Coalition, 2020).

Native Hawaiian Perspective

Māhū is a Native Hawaiian third gender that indicates someone who has qualities of both kāne (man) and wahine (woman) (University of Hawai'i, Manoa, 2021). Māhūkāne is another variation of the term māhū which means a wahine who lives his life as a kāne, and māhūwahine which means a kāne who lives her life as a wahine (University of Hawai'i, Manoa, 2021). These terms are not exactly comparable to terms such as transgender or nonbinary because they are specific within Native Hawaiian culture, and individuals with these identities held significant spiritual and cultural importance within pre-colonial life. These identities were nearly erased through colonization and religious demonization but have begun to regain a place of prominence and respect as kānaka maoli (Native Hawaiians) are seeking to reconnect with traditional cultural practices and heal their communities.

The concept of ho'okipa, translated roughly to hospitality, was an important part of traditional Hawaiian culture that was exploited by sailors, missionaries, and businessmen, and continues to be used as justification for overtourism today (Sustainable Tourism Study Native Hawaiian Advisory Group, 2003, p. I-2). "The patriarchal sexualization of islands and their peoples provides justification for continued colonial protection" in the form of economic and governmental control by those who are not kānaka maoli (Na'puti & Rohrer, 2017, p. 543). The Hawaiian islands and people remain exotified today through tourism which reduces women specifically to sexualized, beautiful objects to be consumed by outside visitors (Na'puti & Rohrer, 2017). Over-tourism taxes the people and the land, leading to further marginalization of kānaka maoli (Sustainable Tourism Study Native Hawaiian Advisory Group, 2003, p. I-1).

Videos from the Kumu Hina Project which seek to increase awareness of pre-colonial Native Hawaiian culture and recenter individuals who are māhū as vital to the community:

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Influence of Colonization on Indigenous Peoples

Cultural genocide was inflicted upon Native communities through the death of tribal members as a result of violence and disease (Indian Health Service, n.d.). Native children were placed in boarding schools controlled by white settlers, missionaries, and governmental agencies, which resulted in the loss of Native cultural traditions and perspectives regarding gender (Indian Health Service, n.d.). The UN Forum (2010) explains how colonization imposed gender segregation and unequal power by dictating that men would control resources and thereby reduced the social status of tribal women which worked to deprive them of access to resources and land rights that they previously held equally. This also fractured the stability of communities and worked to erase indigenous traditions to further weaken the interconnectivity of tribal members (UN Forum, 2010). Two-spirit identities were targeted with particular violence and malice, which has resulted in the erasure of many gender-variant traditions that descendants of tribal communities are still trying to uncover, retrace and decolonize today (Indian Health Service, n.d.).

Spillett (2021) explains that the forceful internment of Native peoples by colonizers who imposed a gender binary and heteronormative relationship norms was leveled as a specific means to dislocate people from their tribal lands and take control over tribal resources. Gendered physical and sexual violence is a particular tool repeatedly used during colonization to target indigenous women and individuals with gender-expansive identities to tear apart their social support networks, sense of self, and cultural power in order to gain control (Spillett, 2021). This demoralization process is at the heart of taking over the land (Spillett, 2021). Puritanical or Catholic ideas around what constituted sin, impropriety, impurity, and sickness were used to further glorify and support the subjugation of traditional indigenous cultures and to impose religious perspectives. Manifest Destiny, the idea that it was God's will for man to rule the Earth and dominate nature, connected colonization with furthering the patriarchy and male settler rule over Native communities who they othered and viewed as part of nature (Spillett, 2021).

Foundations of Gendered Violence Lie within White Supremacy

African people engaged in diverse relational and social practices prior to being stolen from their homeland and brought to the Americas (Amadiume, 2001). Some communities held more patriarchal social stratification while a majority were more matriarchal with the women being highly respected and looked to as leaders of their family units and communities (Amadiume, 2001). European analyses of African culture utilized an ethnocentric perspective that prescribed patriarchy as a means of salvation when in reality it sought to destroy the social relations and strength found within family units (Amadiume, 2001). The slavery of African people in the United States furthered the impact of colonization and displaced people from their homelands, families, and cultural traditions. Families were separated and violence was commonplace in order to maintain systems of power that favored white settlers as masters over Black people.

African men were often displaced and separated from their families with mothers and children remaining together until the children reached a certain age to be sold for their labor as well. Women often faced additional sexual violence and their reproductive freedoms were taken away from them as well as their ability to be in romantic relationships without the say of their masters. Castration was a means of punishment for some enslaved men and a preoccupation with Black male masculinity and sexuality was viewed from behind the lens of impurity and criminality (Mack & McCann, 2018). Black women were viewed as overly sexual in order to blame them for the sexual violence that was inflicted upon them (Mack & McCann, 2018).

As slavery was outlawed and slaves were freed, the Ku Klux Klan still terrorized Black people and sought to criminalize male bodies and further disenfranchise Black women and separate family units from one another (Mack & McCann, 2018). Labeling Black men as hypersexual and sexual aggressors allowed white men to justify their violence as a means of protecting white women (Mach & McCann, 2018). Thus, gendered violence and the intersection of race and gender shaped the experiences of Black people and still do to this day as Black men face being labeled criminals and sexual deviants facing harsher prison sentences while Black women are labeled as hypersexual with their sexuality needing to be limited and controlled within the modern-day white supremacist, patriarchal and colonial society (Mack & McCann, 2018). Black transgender women face violence and discrimination at even higher rates than Black cisgender women; thus, intersectionality is key to understanding these interlocking systems impacting the lives of individuals.

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Roles of Systems: Two Examples

Boarding Schools (Education System)

The boarding school system in the United States was first developed to assimilate and endoctriante Native American children into Christian, white supremacist, and patriarchal systems and to rid them of their culture. A binary system of gender was imposed and two-spirit cultural practices and beliefs were attempted to be destroyed. Physical and sexual abuse was rampant; thus, terrorism as a tool of colonization was inflicted upon Indigenous children and families within these schools.

Police Departments and the Origins of "Policing" (Legal System)

Modern police departments in many Southern states started out as "slave patrols." For a more detailed look at the history of policing in the United States, review the information provided by Potter (2013). Race-based violence was sanctioned by the government in Southern states in order to maintain a racial and economic caste system with white people clinging to power through the use of violence and targeted attempts to destroy communities, physically, emotionally, and spiritually.

Anti-masquerading laws, prohibitions and ordinances were passed in the 1800s with some remaining on the books even until recently in some states, such as New York until 2011 (PBS, 2015). In order to attract more middle class white residents to frontier towns, police would use these legal measures to target individuals labeled as cross-dressers (Tagawa, 2015). "In Columbus, Ohio, where one of the earliest ordinances was instituted, an 1848 law forbade a person from appearing in public 'in a dress not belonging to his or her sex.' In the decades that followed, more than 40 U.S. cities created similar laws limiting the clothing people were allowed to wear in public" (PBS, 2015, para. 5). Up until 1974 in San Francisco, the city's anti-masquerading law was used to target men who dressed as women (Tagawa, 2015). The police would also enforce the measures inconsistently, specifically targeting communities deemed more problematic for the city or to use the legal cover to harass specific nonbinary and transgender communities (Tagawa, 2015). In thinking about intersectionality, BIPOC individuals who are also gender nonconforming, transgender and gender expansive receive additional scrunity from police at the intersection of race and gender.

Conformity as a Trauma Response to Systemic Isms

Conformity happens all the time and is used by people subconsciously in order to better fit in with the crowd. When we are cast out, this leads to further marginalization and stigmatization. Humans are social creatures, so we will sometimes sacrifice parts of ourselves in order to more easily fit in with others, especially when the harms to not conform are so great. Terrorism and forced assimilation have long been tactics used by colonizers, and this remains a tool used today by the powerful in various ways. Trauma is tied to nonconformity (religion, race, gender, etc.) within a Christian, white supremacist, patriarchal, and capitalistic society, and people may begin to have prejudices that go against their own cultural and ancestral knowledge in order to conform to these systems. Therefore, these traumatic experiences around identities based on social constructs and caste systems work to speed up assimilation and conformity by fragmenting the spiritual, emotional, and physical parts of a person in order to break them apart from their sense of community and interconnection with others.

Intersectionality and Resiliency

In a white supremacist society, being BIPOC (Black, Biracial, Indigenous, or a Person of Color) alone as an identity causes the individual to face potentially daily microaggressions. In a white supremacist and patriarchal society, being BIPOC and a cisgender female adds another layer to the systemic and social barriers faced. Adding on now again, being BIPOC and a transgender female will lead to even more specfic social struggles that are incurred by not conforming. Therefore, nonconforming should be viewed as a testament to the human spirit and the desire of people to remain whole and not ripped apart from their identities. In the face of trauma and terror, communities continue to rise. Solidarity and being co-conspirators in the liberation of each other leads to community wellbeing and healing.

Decolonization and Intergenerational Healing

Many people of Indigenous and African ancestry are seeking to reconnect and reclaim identities and cultural perspectives that were attempted to be erased through colonization and land displacement. Oral traditions and the sharing of knowledge amongst families and friends passed down for generations have allowed for the current decolonization of gender to take place as a means of healing. Looking at how BIPOC identities intersect with gender specifically allows for an intersectional perspective to reconstruct a new path forward. Additionally, with social movements such as #MeToo, Black Lives Matter, and the Indigenous Peoples Movement to name a few, social discourse is changing around gender and moving more toward women's rights to live without sexual harassment and assault as well as looking at gender as existing within a spectrum of possibilities rather than within binary systems. Social

structures are shifting as activists and scholars are identifying the negative impacts of patriarchal, binary, and heteronormative perspectives.

Indigenous communities starting in Canada and now in the United States are urging both governments to conduct reports and issue formal statements about the abuse in general at the boarding schools and the ways in which this abuse caused the death of Indigenous children and adults. As of May 8th, 2022, the U.S. Department of the Interior released an investigative report and next steps related to the boarding schools. The following is taken directly from the report:

The investigation found that from 1819 to 1969, the federal Indian boarding school system consisted of 408 federal schools across 37 states or then territories, including 21 schools in Alaska and 7 schools in Hawaii. The investigation identified marked or unmarked burial sites at approximately 53 different schools across the school system. As the investigation continues, the Department expects the number of identified burial sites to increase.

"The consequences of federal Indian boarding school policies—including the intergenerational trauma caused by the family separation and cultural eradication inflicted upon generations of children as young as 4 years old—are heartbreaking and undeniable," said Secretary Haaland. "We continue to see the evidence of this attempt to forcibly assimilate Indigenous people in the disparities that communities face. It is my priority to not only give voice to the survivors and descendants of federal Indian boarding school policies, but also to address the lasting legacies of these policies so Indigenous peoples can continue to grow and heal."

Intergenerational Healing: Research Snapshots from Within Communities

Reclaiming Our Voices

In the interviews conducted with two-spirit Native individuals, Frazer and Pruden (2010) found that many expressed the desire for cultural programming that affirmed both their Native and two-spirit identities. Substance use was of great concern regarding engaging in queer nightlife that could affirm their gender expansive identity because many either had personal or familial struggles with addiction while cultural programming and events often excluded two-spirit self-expression–they did not feel like they could be their full selves in either environment. A majority of the participants expressed experiencing bullying and harassment from other tribal members and explained that informing people of pre-colonial practices around gender would be helpful in reducing the stigma and shame (Frazer & Pruden, 2010). Mental health and substance use programs that affirmed both their Native culture and two-spirit identities were identified as lacking and needed.

Emotional Emancipation Circles

Intergenerational trauma, in which harms of the past are passed down from generation to generation in the form of trauma stories, reactivity to environmental stressors, and the compounding impacts of minority stress leading to trauma symptoms in caregivers that is modeled for younger individuals within a family unit, has long been the focus of researchers (Fishbane, 2019). However, recently, a shift toward exploring the healing process has begun in order to center and honor the work that is being done within families and communities to create a new path forward (Fishbane, 2019). The injustices, genocide, and cultural erasure of colonization are called out and addressed while new systems and interconnections are created anew.

Barlow (2018) explores how her use of Emotional Emancipation Circles (EECs) is designed to be a strengths-based and culturally responsive approach to healing. Barlow (2018) explains how she used (EECs) with college students:

"This approach does not represent neoliberal frameworks of a thriving individual. Instead, it harmonizes and coordinates the well-being of people of African descent who are living with the legacy of slavery, Jim Crow, and white supremacy in the US. With learning modules, called keys, dedicated to African culture, history and movements, and imperatives and ethics, this social support group offered my students an opportunity to unpack personal stories and to begin to address the root issues of healing Black communities.

For example, students shared their struggles with colorism, the social rules of dating, navigating social media, thriving in the classroom, and managing challenges at home while in college. (p. 900)

By sharing these stories and supporting each other, they were able to develop social support as a protective factor (Barlow, 2018). Barlow (2018) also discusses how increasing self-care in the form of "meditation, breathing exercises, and physical activity such as walking, dancing, running, and gardening" are beneficial to physical and mental health (p. 901). Engaging in self-care and developing social support systems were encouraged. Barlow (2018) also encouraged her students to share their experiences of intergenerational trauma and healing through social media. By sharing their experiences, further connections were made and students developed skills on how to mobilize their communities and be leaders promoting social change within organizations (Barlow, 2018). Thus, individuals engaging in their own healing are able to model this for others, creating community-based healing that expands onward.

Further Decolonization and Intergenerational Healing Resources

- Celebrating Our Magic: Resources for American Indian/Alaska Native transgender and Two-Spirit youth, their relatives and families, and their healthcare providers
- Trans Care BC: Two-Spirit
  - Lots of resources to both explore one's clinical practice and to learn more about two-spirit and indigenous LGBTQIA+ experiences as well as resources for clients.
  - From Canada but does include United States-based information.
- First Nations Perspective on Health and Wellness
  - This poster can be used to discuss strengths and protective factors with Indigenous gender expansive clients.
- Research Article: Jefferson et al. (2013) found that a strong transgender identity served as a protective factor against depression for transgender women of color.
  - Identity should be explored in a strength-based way with clients. Keep this in mind from an intersectional approach.
- Research Article: Baez, M. S. E., Isaac, P., & Baez, C. A. (2016). H.O.P.E. for Indigenous people battling intergenerational trauma: The Sweetgrass Method. Journal of Indigenous Research, 5(2). Retrieved from https://digitalcommons.usu.edu/cgi/viewcontent.cgi?article=1055&context=kicjir

Multicultural Perspectives on Gender

Make sure to sign out of your PCC email before reviewing this Map of Gender-Diverse Cultures from PBS. Scroll down to where it says, "Explore the Map," to click on the interactive dots across the world map to read about specific places. As you review this map, keep in mind that direct translations are often not possible and the exact meaning may not be as it is loosely written. An ethnorelativistic perspective aids the further understanding of gender.

Role of colonization internationally:

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The Psychology of Gender

Introduction

Though typically considered synonyms by many, sex and gender have distinct meanings that become important when collecting data and engaging in research. First, sex refers to the biological aspects of a person due to their anatomy. This includes the individual's hormones, chromosomes, body parts such as the sexual organs, and how they all interact. When we say sex, we are generally describing whether the person is male or female and this is assigned at birth.

In contrast, gender is socially constructed (presumed after a sex is assigned) and leads to labels such as masculinity or femininity and their related behaviors. People may declare themselves to be a man or woman, as having no gender, or falling on a continuum somewhere between man and woman. How so? According to genderspectrum.org, gender results from the complex interrelationship of three dimensions – body, identity, and social.

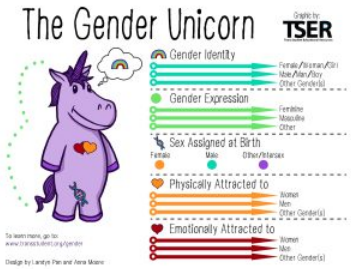
First, body, concerns our physical body, how we experience it, how society genders bodies, and the way in which others interact with us based on our body. The website states, "Bodies themselves are also gendered in the context of cultural expectations. Masculinity and femininity are equated with certain physical attributes, labeling us as more or less a man/woman based on the

degree to which those attributes are present. This gendering of our bodies affects how we feel about ourselves and how others perceive and interact with us."

Next is gender identity or our internal perception and expression of who we are as a person. It includes naming our gender, though this gender category may not match the sex we are assigned at birth. Gender identities can take on several forms from the traditional binary man-woman, to non-binary such as genderqueer or genderfluid, and ungendered or agender (i.e. genderless). Though gaining an understanding of what gender we are occurs by age four, naming it is complex and can evolve over time. As genderspectrum.org says, "Because we are provided with limited language for gender, it may take a person quite some time to discover, or create, the language that best communicates their internal experience. Likewise, as language evolves, a person's name for their gender may also evolve. This does not mean their gender has changed, but rather that the words for it are shifting."

Finally, we have a social gender or the manner in which we present our gender in the world, but also how other people, society, and culture affect our concept of gender. In terms of the former, we communicate our gender through our clothes, hairstyles, and behavior called gender expression. In terms of the latter, children are socialized as to what gender means from the day they are born and through toys, colors, and clothes. Who does this socialization? Anyone outside the child can to include parents, grandparents, siblings, teachers, the media, religious figures, friends, and the community. Generally, the binary male-female view of gender is communicated for which there are specific gender expectations and roles. According to genderspectrum.org, "Kids who don't express themselves along binary gender lines are often rendered invisible or steered into a more binary gender presentation. Pressures to conform at home, mistreatment by peers in school, and condemnation by the broader society are just some of the struggles facing a child whose expression does not fall in line with the binary gender system." The good news is that gender norms do change over time such as our culture's acceptance of men wearing earrings and women getting tattoos.

Here is a resource that is used within counseling and group therapy sessions to help people explore their experiences and identities. People are meant to mark themselves on every single line within each category. The first three categories relate to what we have been discussing so far while the last two relate to sexual orientation which we will discuss next week. Check out the developer's website to see an explanation of relevant terms and how to fill out the Gender Unicorn worksheet.



Gender Unicorn

Gender Congruence

When we feel a sense of harmony in our gender, we are said to have gender congruence. It takes the form of naming our gender such that it matches our internal sense of who we are, expressing ourselves through our clothing and activities, and being seen consistently by other people as we see ourselves. Congruence does not happen overnight but occurs throughout life as we explore, grow, and gain insight into ourselves. It is a simple process for some and complex for others, though all of us have a fundamental need to obtain gender congruence.

When a person moves from the traditional binary view of gender to transgender, agender, or non-binary, they are said to "transition" and find congruence in their gender. Genderspectrum.org adds, "What people see as a "Transition" is actually an alignment in one or more dimensions of the individual's gender as they seek congruence across those dimensions. A transition is taking place, but it is often other people (parents and other family members, support professionals, employers, etc.) who are transitioning in how they see the individual's gender, and not the person themselves. For the person, these changes are often less of a transition and more of an evolution." Harmony is sought in various ways to include:

- Social – Changing one's clothes, hairstyle, and name and/or pronouns
- Hormonal – Using hormone blockers or hormone therapy to bring about physical, mental, and/or emotional alignment
- Surgical – When gender-related physical traits are added, removed, or modified
- Legal – Changing one's birth certificate or driver's license

The website states that the transition experience is often a significant event in the person's life. "A public declaration of some kind where an individual communicates to others that aspects of themselves are different than others have assumed, and that they are now living consistently with who they know themselves to be, can be an empowering and liberating experience (and moving to those who get to share that moment with them)."

Gender and Sexual Orientation

As gender was shown to be different from sex, so too we must distinguish it from sexual orientation which concerns who we are physically, emotionally, and/or romantically attracted to. Hence, sexual orientation is interpersonal while gender is personal. We would be mistaken to state that a boy who plays princess is gay or that a girl who wears boy's clothing and has short hair is necessarily lesbian. The root of such errors comes from our confusing gender and sexual orientation. The way someone dresses or acts concerns gender expression and we cannot know what their sexual orientation is from these behaviors.

The Language of Gender

- Agender – When someone does not identify with a gender
- Cisgender – When a person's gender identity matches their assigned sex at birth
- FtM – When a person is assigned a female sex at birth but whose gender identity is boy/man
- Gender dysphoria – When a person is unhappy or dissatisfied with their gender and can occur in relation to any dimension of gender. The person may experience mild discomfort to unbearable distress. This is classified as a mental health diagnosis and this diagnosis must be given to an individual in most states if they wish to receive hormone and other gender-affirming treatments. Not all transgender or nonbinary people may experience gender dysphoria and some cisgender people may experience this.
- Genderfluid – When a person's gender changes over time; they view gender as dynamic and changing
- Gender role – All the activities, functions, and behaviors that are expected of males and females in a gender binary society
- Genderqueer – Someone who may not identify with conventional gender identities, roles, expectations, or expressions.
- MtF – When a person is assigned a male sex at birth but whose gender identity is girl/woman
- Non–binary – When a gender identity is not exclusively masculine or feminine
- Transgender – An umbrella term that denotes when a person's gender identity differs from their assigned sex

To learn more about gender, we encourage you to explore the https://www.genderspectrum.org/ website.

The World Health Organization also identifies two more key concepts in relation to gender. Gender equality is "the absence of discrimination on the basis of a person's sex in opportunities, the allocation of resources and benefits, or access to services" while gender equity refers to "the fairness and justice in the distribution of benefits and responsibilities between women and men." Keep in mind, this language still caters to the gender binary and leaves out transgender and gender-expansive identities.

Gender Through a Developmental Psychology Lens

Psychoanalytical Theories

We have already previously discussed Freud, so let's continue forward with Karen Horney's Neo-Freudian theory.

Horney developed a Neo-Freudian theory of personality that recognized some points of Freud's theory as acceptable, but also criticized his theory as being overly bias toward the male. There is truth in this if you think about Freud's theory. Ultimately, to really develop fully, one must have a penis – according to Freud's theory. A female can never "fully" resolve penis envy, and thus, she is never fully able to resolve the conflict. As such, according to Freud's theory, if taken literally, a female can never fully resolve the core conflict of the Phallic Stage and will always have some fixation and thus, some maladaptive development. Horney disputed this (Harris, 2016). In fact, she went as far as to counter Freud's penis envy with womb envy (a man envying a woman's ability to have children). She theorized that men looked to compensate for their lack of ability to carry a child by succeeding in other areas of life (Psychodynamic and neo-Freudian theories, n.d.)

The center of Horney's theory is that individuals need a safe and nurturing environment. If they are provided such, they will develop appropriately. However, if they are not, and experience an unsafe environment, or lack of love and caring, they will experience maladaptive development which will result in anxiety (Harris, 2016). An environment that is unsafe and results in abuse, neglect, stressful family dynamics, etc. is termed by Horney as basic evil. As mentioned, these types of experiences (basic evil) lead to maladaptive development which was theorized to occur because the individual began to believe that, if their parent did not love them then no one could love them. The pain that was produced from basic evil then led to basic hostility. Basic hostility

was defined as the individual's anger at their parents while experiencing high frustration that they must still rely on them and were dependent on them (Harris, 2016).

This basic evil and basic hostility ultimately led to anxiety. Anxiety resulted in an individual developing interpersonal strategies of defense (ways a person relates to others). These strategies are considered to fall in three categories (informed by Harris, 2016):

Interpersonal Strategies

Interpersonal Strategy	Key Direction	Actions the Person Takes	How This Presents in Their Personalities
Compliant Solution	Toward	The individual moves toward people. They seek out another person's attention.	This is the people pleaser and dependent person. The person that avoids failure and always takes the "safe" option.
Detachment Solution	Away	These individuals move away from others and attempt to protect themselves by eluding connection and contact with others.	These individuals want independence and struggle with commitment. They often try to hide flaws
Expansive Solution	Against	These individuals move against others. They seek interaction with others, not to connect with them, rather to gain something from them. They seek power and admiration from others, as well as being seen as highly attention-seeking.	This category is further split into three types of individuals: 1. The Narcissist. 2. The Perfectionist. 3. The Arrogant-Vindictive person.

Although Horney disputed much of Freud's male biased theories, she recognized that females are born into a society dominated by males. As such, she recognized that females may be limited due to this, which then leads to developing a masculinity complex. This is the feeling of inferiority due to one's sex. She noted that one's family can strongly influence one's development (or lack thereof) of this complex. She described that if a female was disappointed by males in her family (such as their father or brother, etc.), or if they were overly threatened by females in their family (especially their mothers), they may actually develop contempt for their own gender. She also indicated that if females perceived that they had lost the love of their father to another woman (often to the mother) then the individual may become more insecure. This insecurity then would lead to either (1) withdrawal from competing or (2) becoming more competitive (Harris, 2016). The need for the male attention was referred to as the overvaluation of love (Harris, 2016).

Gender Socialization Theory

It's clear that even very early theories of gender development recognized the importance of environmental or familial influence, at least to some degree. As theories have expanded, it has become clearer that socialization of gender occurs. However, each theory has a slightly different perspective on how that may occur. We will discuss a few of those in brief detail, but will focus more on major concepts and generally accepted processes.

Before we get started, I want you to ask yourself a few questions – When do we begin to recognize and label ourselves as boy or girl, and why? Do you think it happens very young? Is it the same across countries? Let's answer some of those questions.

Theories that suggest that gender identity development is universal across countries and cultures (e.g., Eastern versus Western cultures, etc.) have been scrutinized. Critics suggest that, although biology may play some role in gender identity development, the environmental and social factors are perhaps more powerful in most developmental areas, and gender identity development is no different. It is the same "nature versus nurture" debate that falls on the common response of both nature and nurture playing important roles and to ignore one is a misunderstanding of the developmental process (Magnusson & Marecek, 2012). In this section, we are going to focus on the social, environmental, and cultural aspects of gender identity development

Early Life

Infants do not prefer gendered toys (Bussey, 2014). However, by age 2, they show preferences. (Servin, Bhlin, & Berlin, 1999). Did you know that infants can differentiate between male and female faces and voices in their first year of life (typically between 6-12 months of age; Fagan, 1976; Miller, 1983)? Not only that, they can pair male and female voices with male and female faces (known as intermodal gender knowledge; Poulin-Dubois, Serbin, Kenyon, & Derbyshire, 1994). Think about that for a moment – infants are recognizing and matching gender before they can ever talk! Further, 18-month old babies associated bears, hammers, and trees with males. By age 2, children use words like "boy" and "girl" correctly (Leinbach & Fagot, 1986) and can accurately point to a male or female when hearing a gender label given. It appears that children first learn to label others' gender, then their own. The next step is learning that there are shared qualities and behaviors for each gender (Bussey, 2014).

By a child's second year of life, children begin to display knowledge of gender stereotypes. Research has found this to be true in preverbal children (Fagot, 1974), which is really incredible, if you think about it. After an infant has been shown a gendered item (doll versus a truck) they will then stare at a photograph of the "matching gender" longer. So, if shown a doll, they will then look at a photograph of a girl, rather than a boy, for longer (when shown photographs of both a boy and girl side by side). This is specifically true for girls as young as 18-24 months; however, boys do not show this quite as early (Serbin,Poulin-Dubois, Colburne, Sen, & Eichstedt, 2001). Although interpretations and adherence to gender stereotypes is very rigid, initially, as children get older, they learn more about stereotypes and that gender stereotypes are flexible and varied. We actually notice a curved pattern in how rigid children are to stereotyped gender behaviors and expectations (Bussey, 2014). Initially, children are very rigid in stereotypes and stereotyped play. As they reach middle childhood, they become more flexible. However, in adolescents, they become more rigid again. And, generally, boys are more rigid and girls are more flexible with gender stereotypes, comparatively (Blakemore et al., 2009).

There are many factors that may lead to the patterns we see in gender socialization. Let's look at a few of those factors and influencers.

Parents

Parents begin to socialize children to gender long before they can label their own. Think about the first moment someone says they are pregnant. One of the first questions is "How far along are you?" and then "Are you going to find out the sex of the baby?" We begin to socialize children to gender before they are even born! We pick out boy and girl names, we choose particular colors for nurseries, types of clothing, and decor, all based on a child's gender, often before they are ever born (Bussey, 2014). The infant is born into a gendered world! We don't really give infants a chance to develop their own preferences – parents and the caregivers in their life do that for them, immediately. Parents even respond to a child differently, based on their gender. For example, in a study in which adults observed an infant that was crying, adults described the infant to be scared or afraid when they were told the infant was a girl. However, they described the baby as angry or irritable when told the infant was a boy. Moreover, parents tend to reinforce independence in boys, but dependence in girls. They also overestimate their sons' abilities and underestimate their daughters' abilities. Research has also revealed that prosocial behaviors are encouraged more in girls, than boys (Garcia & Guzman, 2017).

Parents label gender even when not required. When observing a parent reading a book to their child, Gelman, Taylor, & Nguyen (2004) noted that parents used generic expressions that generalized one outcome/trait to all individuals of a gender, during the story. For example, "Most girls don't like trucks." Essentially, parents provided extra commentary in the story, and that commentary tended to include vast generalizations about gender. Initially, mothers engaged in this behavior more than the children did; however, as children aged, children began displaying this behavior more than their mothers did. Essentially, mothers modeled this behavior, and children later began to enact the same behavior. Further, as children got older, mothers then affirmed children's gender generalization statements when made.

Boys are more gender-typed and fathers place more focus on this (Bvunzawabaya, 2017). As children develop, parents tend to also continue gender-norm expectations. For example, boys are encouraged to play outside (cars, sports, balls) and build (Legos, blocks), etc. and girls are encouraged to play in ways that develop housekeeping skills (dolls, kitchen sets; Bussey, 2014). What parents talk to their children about is different based on gender as well. For example, they may talk to daughters more about emotions and have more empathic conversations, whereas they may have more knowledge and science-based conversations with boys (Bussey, 2014).

Parental expectations can have significant impacts on a child's own beliefs and outcomes including psychological adjustment, educational achievement, and financial success (Bvunzawabaya, 2017). When parents approach more gender-equal or neutral

interactions, research shows positive outcomes (Bussey, 2014). For example, girls did better academically if their parents took this approach versus very gender-traditional families.

Peers

Peers are strong influences regarding gender and how children play. As children get older, peers become increasingly influential. In early childhood, peers are pretty direct about guiding gender-typical behaviors. As children get older, their corrective feedback becomes subtler. So how do peers socialize gender? Well, non-conforming gender behavior (e.g., boys playing with dolls, girls playing with trucks) is often ridiculed by peers and children may even be actively excluded. This then influences the child to conform more to gender-traditional expectations (e.g., boy stops playing with a doll and picks up the truck).

We begin to see boys and girls segregate in their play, based on gender, in very early years. Children tend to play in sex-segregated peer groups. We notice that girls prefer to play in pairs while boys prefer larger group play. Boys also tend to use more threats and physical force whereas girls do not prefer this type of play. Thus, there are natural reasons to not intertwine and to instead segregate (Bussey, 2014). The more a child plays with same-gender peers, the more their behavior becomes gender-stereotyped. By age 3, peers will reinforce one another for engaging in what is considered to be gender-typed or gender-expected play. Likewise, they will criticize, and perhaps even reject a peer, when a peer engages in play that is inconsistent with gender expectations. Moreover, boys tend to be very unforgiving and intolerant of nonconforming gender play (Fagot, 1984).

Media and Advertising

Media includes movies, television, cartoons, commercials, and print media (e.g., newspapers, magazines). In general, media tends to portray males as more direct, assertive, muscular, in authority roles, and employed, whereas women tend to be portrayed as dependent, emotional, low in status, in the home rather than employed, and their appearance is often a focus. Even Disney movies tend to portray stereotyped roles for gender, often having a female in distress that needs to be saved by a male hero; although Disney has made some attempts to show women as more independent and assertive in more characters. We have seen a slight shift in this in many media forms, although it is still very prevalent, that began to occur in the mid to late 1980s and 1990s (Stever, 2017; Torino, 2017). This is important, because we know that the more children watch TV, the more gender stereotypical beliefs they have (Durkin & Nugent, 1998; Kimball 1986).

Moreover, when considering print media, we know that there tends to be a focus on appearance, body image, and relationships for teenage girls, whereas print media tends to focus on occupations and hobbies for boys. Even video games have gender stereotyped focuses. Females in video games tend to be sexualized and males are portrayed as aggressive (Stever, 2017; Torino, 2017).

School Influences

Research tends to indicate that teachers place a heavier focus, in general, on males – this means they not only get more praise, they also receive more correction and criticism (Simpson & Erickson, 1983). Teachers also tend to praise boys and girls for different behaviors. For example, boys are praised more for their educational successes (e.g., grades, skill acquisition) whereas girls are acknowledged for more domesticate-related qualities such as having a tidy work area (Eccles, 1987). Overall, teachers place less emphasis on girls' academic accomplishments and focus more on their cooperation, cleanliness, obedience, and quiet/passive play. Boys, however, are encouraged to be more active, and there is certainly more of a focus on academic achievements (Torino, 2017).

The focus teachers and educators have on different qualities may have a lasting impact on children. For example, in adolescence, boys tend to be more career focused whereas girls are focused on relationships (again, this aligns with the emphasis we see placed by educators on children based on their gender). Girls may also be oriented toward relationships and their appearance rather than careers and academic goals, if they are very closely identifying with traditional gender roles. They are more likely to avoid STEM-focused classes, whereas boys seek out STEM classes (more frequently than girls). This may then impact major choices if girls go to college, as they may not have experiences in STEM to foster STEM related majors (Torino, 2017). As such, the focus educators place on children can have lasting impacts. Although we are focusing on the negative, think about what could happen if we saw a shift in that focus!

Okay, so we talked above about how children are socialized to gender – but how? Well there are a few areas we should discuss. We will cover social theories, cognitive theories, social cognitive theories, and biological theories.

Social Theories

Social Learning Theory

Do you remember Albert Bandura from Introduction to Psychology? He's the guy that had children watch others act aggressively toward a doll (the BoBo doll), and then observed children's behaviors with the same doll. Children that watched aggressive acts then engaged in aggression with the doll. Essentially, a behavior was modeled, and then they displayed the behavior. Here is a video with Albert Bandura and footage from his experiment:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://openoregon.pressbooks.pub/introtohumansexuality/?p=58#oembed-6

Let's think about this in a current-life example. You walk into a gym for the first time. It is full of equipment you aren't sure how to use. What do you do if you want to know how to use it (let's assume the nice little instructions with pictures are not posted on the equipment)? The most likely thing, if there is no trainer/employee around to ask, is to watch what someone does on the machine. You watch what how they set it up, what they do, etc. You then go to the equipment and do the same exact thing! This is modeling. You modeled the behavior the person ahead of you did. The same thing can happen with gender – modeling applies to gender socialization.

We receive much of our information about gender from models in our environment (think about all the factors we just learned about – parents, media, school, peers). If a little girl is playing with a truck and looks over and sees three girls playing with dolls, she may put the truck down and play with the dolls. If a boy sees his dad always doing lawn work, he may too try to mimic this, in the immediacy. Here is the interesting part: modeling does just stop after the immediate moment is over. The more we see it, the more it becomes a part of our socialization. We begin to learn rules of how we are to act and what behavior is accepted and desired by others, what is not, etc. Then we engage in those behaviors. We then become models for others as well! Now, some theories question modeling; although, further research has shown that modeling appears to be imperative in development, but the level of specificity or rigidity to gender norms of the behavior being modeled is also important (Perry & Bussey, 1979). Other's incorporate modeling into their theory with some caveats. Kohlberg is one of those theorists, and we will learn about later.

Social Cognitive Theory

Another theory combines the theory of social learning with cognitive theories (we will discuss cognitive theories below). While modeling in social learning explains some things, it does not explain everything. This is because we don't just model behavior, we also monitor how others react to our behaviors. For example, if a little girl is playing with a truck her peers laugh at her, that is feedback that her behavior is not gender-normative and she then may change the behavior she engages in. We also get direct instruction on how to behave as well. Again, girls don't sit with their legs open, boys don't play with dolls, girls don't get muddy and dirty, boys don't cry – you get the point. When peers or adults directly instruct another on what a girl or boy is or is not to do, although not modeling, is a heavily influential socializing factor. To explain this, social cognitive theory posits that one has enactive experiences (this is essentially when a person receives reactions to gendered behavior), direct instruction (this is when someone is taught knowledge of expected gendered behavior), and modeling (this is when others show someone gendered behavior and expectations). This theory posits that these social influences impact children's development of gender understanding and identity (Bussey, 2014). Social cognitive theories of gender development explain and theorize that development is dually influenced by (1) biology and (2) the environment. Moreover, the theory suggests that these things impact and interact with various factors (Bussey & Bandura, 2005). This theory also accounts for the entire lifespan when considering development, which is drastically different than earlier theories, such as psychodynamic theories.

Cognitive Theories

Kohlberg's Cognitive Developmental Theory

Lawrence Kohlberg theorized the first cognitive developmental theory. He theorized that children actively seek out information about their environment. This is important because it places children as an active agent in their socialization. According to cognitive developmental theory, a major component of gender socialization occurs by children recognizing that gender is constant and does not change which is referred to this as "gender constancy". Kohlberg indicated that children choose various behaviors that align with their gender and match cultural stereotypes and expectations. Gender constancy includes multiple parts. One must have an ability to label their own identity which is known as gender identity. Moreover, an individual must recognize that gender remains constant over time which is gender stability and across settings which is gender consistency. Gender identity appears to be established by around age three and gender constancy appears to be established somewhere between the ages of five and seven. Although Kohlberg's theory captures important aspects, it fails to recognize things such as how gender identity regulates gender conduct and how much one adheres to gender roles through their life (Bussey, 2014).

Although Kohlberg indicated that modeling was important and relevant, he posited that it was only relevant once gender constancy is achieved. He theorized that constancy happens first, which then allows for modeling to occur later (although the opposite is considered true in social cognitive theory). The problem with his theory is children begin to recognize gender and model gender behaviors before they have cognitive capacities for gender constancy (remember all that we learned about how infants show gender-based knowledge?!).

Gender Schema Theory

Gender schema theory, although largely a cognitive theory, does incorporate some elements of social learning as well. Schemas are essentially outlines – cognitive templates that we follow, if you will. Thus, a gender schema is an outline about genders – a template to follow regarding gender. The idea is that we use schemas about gender to guide our behaviors and actions. Within this theory, it is assumed that children actively create their schemas about gender by keeping or discarding information obtained through their experiences in their environment (Dinella, 2017).

Interestingly, there are two variations of gender schema theory. Bem created one theory while Martin and Halverson created another. Sandra Bem, whose notable research was published in the 1980s, conducted her research attempting to understand the development of gender roles. She believed that all of us have gender schemas which are "a cognitive structure comprising the set of attributes (behaviors, personality, appearance) that we associate with males and females" (Hyde & DeLamater, 2017, p. 33). These gender schemas are based on stereotypes and influence us to label certain behaviors as "male" or "female." Stereotype-consistent behaviors are accepted while stereotype-inconsistent behaviors are viewed as a fluke or a rare occasion, causing us to believe the stereotypes despite many examples in our lives to disprove the stereotypes.

Overall, it is widely accepted that there are two types of schemas that are relevant in gender schema theory – superordinate schemas and own-sex schemas. Essentially, superordinate schemas guide information for gender groups whereas own-sex schemas guide information about one's own behaviors as it relates to their own gender group (Dinella, 2017).

So why have schemas? Well, it's a cheat sheet that makes things easier and quicker, essentially. Think about it, if you have an outline for a test that told you that the shortest answer is always the right answer, you wouldn't even have to study. Heck, you don't even have to 'read' the question options. You can simply find the choice that has the least amount of words, pick it, and you'll ace the test (wouldn't that be nice?!). So, gender schemas make it easier to make decisions in the moment, regarding gendered behavior. Here is an example. If a child has created a schema that says boys play with trucks, when the boy is handed a truck, he will quickly choose to play with it. However, if the truck is handed to a girl, she may quickly reject it (Dinella, 2017)

So how do children develop schemas? Well, it likely occurs in three different phases. First, children start recognizing their own gender groups and begin to build schemas. Then, a rigid phase occurs in which things are very black or white, (or, girl or boy, if you will). Things can only be one or the other, and there is very little flexibility in schemas. This occurs somewhere between ages five and seven. Lastly, a phase in which children begin to recognize that schemas are flexible and allow for a bit more of a "gray" area occurs (Dinella, 2017).

Let's think of how schemas are used to begin to interpret one's world. Once a child can label gender of themselves, they begin to apply schemas to themselves. So, if a schema is "Only girls cook", then a boy may apply that to themselves and learn he cannot cook. This then guides his behavior. Martin, Eisenbud, and Rose (1995) conducted a study in which they had groups of boy toys, girl toys, and neutral toys. Children used gender schemas and gravitated to gender-normed toys. For example, boys preferred toys that an adult labeled as boy toys. If a toy was attractive (meaning a highly desired toy) but was label for girls, boys would reject the toy. They also used this reasoning to predict what other children would like. For example, if a girl did not like a block, she would indicate "Only boys like blocks" (Berk, 2004; Liben & Bigler, 2002).

Biological Theories

In regard to biological theories, there tends to be four areas of focus. Before we get into those areas, let's remember that we are talking about gender development. That means we are not focusing on the anatomical/biological sex development of an individual, rather, we are focusing on how biological factors may impact gender development and gendered behavior. So, back to 'there are four main areas of focus.' The four areas of focus include (1) evolutionary theories, (2) genetic theories, (3) epigenetic theories, and (4) learning theories (don't worry, we'll explain how this is biology related, rather than cognitively or socially related).

Evolution Theories

Within evolution-based theories, there are three schools of thought: sex-based explanations, kinship-based explanations, and socio-cognitive explanations. Sex-based explanations explain that gendered behaviors have occurred as a way to adapt and increase the

chances of reproduction. Ultimately, gender roles get divided into females focusing on rearing children and gathering food close to home, whereas males go out and hunt and protect the family. To carry out the required tasks, males needed higher androgens/testosterone to allow for higher muscle capacity as well as aggression. Similarly, females need higher levels of estrogen as well as oxytocin, which encourages socialization and bonding (Bevan, 2017). Although this may seem logical at surface level, it does not account for what we see in more egalitarian homes and cultures.

Then, there is kinship-based explanations that rationalize that very early on, we lived in groups as a means of protection and survival. As such, the groups that formed tended to be kin and shared similar DNA. Essentially, the groups with the strongest DNA that allowed for the best traits for survival, survived. Further, given that this came down to "survival of the fittest" it made sense to divvy up tasks and important behaviors. Interestingly, this was less based on sex and more on qualities of an individual, essentially using people's strengths to the group's advantage. This theory tends to be more supported, than sex-based theories (Bevan, 2017).

Lastly, socio-cognitive explanations explain that we have changed our environment, and that, thus, we have changed in the environment in which natural selection occurs. Essentially, when we use our cognitive abilities to create things, such as tools, we thus change our environment. We are then changing the environment that defined what behaviors/assets were necessary to survive. For example, if we can now use tools to hunt more effectively, the traditional needs of a male (as explained in sex-based theories) may be less critical in this task (Bevan, 2017).

Genetic-based Theories

We can be "genetically predisposed" to many things, mental illness, cancer, heart conditions, etc. It is theorized that we also are predisposed to gendered behavior and identification. This theory is most obvious when individuals are predisposed to a gender that does not align with biological sex, also referred to as transgender. Research has actually revealed that there is some initial evidence that gender involves somewhat of a genetic predisposition. Specifically, twin studies have shown that nonconforming gender traits, or transgender, is linked to genetic gender predispositions. More specifically, when one twin is transgender, it is more likely that the other twin is transgender as well. This phenomenon is not evidenced in fraternal twins or non-twin siblings to the same degree (Bevan, 2017).

Genetic gender predisposition theorists further reference case studies in which males with damaged genitalia undergo plastic surgery as infants to modify their genitalia to be more female aligned. These infants are then raised as girls, but often seek out transitioning back to being boys or become gender nonconforming. David Reimer is an example of one of these cases (Bevan, 2017). To learn more about this case, you can read his book, *As Nature Made Him*. He is given the name Joan/John in many research studies and was surgically altered by doctors to present as a female after an accident during circumcision that resulted in his castration.

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John Money, a psychologist and sexologist, was the one who encouraged David's family to surgically alter David's body and continued to conduct studies on the child. You can read an account of the unethical and sexual abuse that David explained he faced while participating in Money's research. David committed suicide in 2004 after facing lifelong depression as a result of the trauma he endured.

AUTHOR'S NOTE: If you or someone you know is struggling with suicidal ideation/thoughts, there is free, confidential and 24/7 accessible assistance via 988 Suicide & Crisis Lifeline. You can dial 988 or access information at https://988lifeline.org/. You are not alone.

Epigenetics

This area of focus does not look at DNA, but rather things that may impact DNA mutations or the expression of DNA. Really, this area falls into two subcategories: prenatal hormonal exposure and prenatal toxin exposure.

Let's quickly recap basic biology. It is thought that gender, from a biological theory stance, begins in the fetal stage. This occurs due to varying levels of exposure to testosterone. Shortly after birth, boys experience an increase in testosterone, whereas girls experience an increase in estrogen. This difference has actually been linked to variations in social, language, and visual development between sexes. Testosterone levels have been linked to sex-typed toy play and activity levels in young children. Moreover, when females are exposed to higher levels of testosterone, they are noted to engage in more male-typical play (e.g., preference for trucks over dolls, active play over quiet), rather than female-typical play compared to their counterparts (Hines et al., 2002; Klubeck, Fuentes, Kim-Prieto, 2017; Pasterski et al., 2005). Although this has been found to be true predominantly utilizing

only animal research, it is a rather simplified theory. What we have learned is that, truthfully, things are pretty complicated and other hormones and chemicals are at play (Bevan, 2017).

Prenatal toxin exposure appears to be relevant when examining diethylstilbestrol (DES), specifically. DES was prescribed to pregnant women in late 1940's through the early 1970's. DES was designed to mimic estrogen, and it does; however, it has many negative side effects that estrogen does not. One of the negative side-effects is that it mutates DNA and alters its expression. The reason it was finally taken off the market was because females were showing higher rates of cancer. In fact, they found that this drug had cancer-related impacts out to three generations! While there was significant research done on females, less research was done on males. However, recent studies suggest that 10% of registrants (in a national study) that were exposed to DES reported identifying as transgender or transsexual. For comparison, only 1% of the general population identifies as transgender or transsexual. Thus, it is theorized that gender development in those exposed to DES, particularly biological males, were impacted (Bevan, 2017).

Conclusion and Tips for Allyship

In reading through the ways in which gender is a social construct and varies between and within cultures, we explored BIPOC perspectives and the role of colonization in the United States from an intersectional perspective. We questioned the foundation of gender itself from an ethnorelativistic lens by looking at varying social and cultural labelings of gender around the world. While exploring psychological theories, the hope is that you have gained a better understanding of yourself and others. Gender socialization and the ways we have internalized aspects of gender shape our behavior and the way we engage with others. We may take on certain gender roles while rejecting others. Gender stereotypes and biases are present and we must analyze them to promote individual and community healing. Gender is as vast and deep as the ocean with many parts still unknown. The self is unfolding over time and it is okay to not have all the answers regarding what gender means. Moving forward, review the references and documentary below to develop skills on how to be an ally to others in order to support them along their own gender journey.

Allyship Resources

- Making Sure Your Writing is Free of Bias Related to Gender (APA, 2019)
- APA Psychological Practice with Transgender and Gender Nonconforming People
- APA Psychological Practice with Girls and Women
- APA Psychological Practice with Boys and Men
- Transgender Allyship
- Women of Color Allyship
- Men as Allies to Women
- Supporting Men: Documentary The Mask You Live In
    - Disclaimer: This video addresses many aspects of toxic masculinity and shows violent imagery, discusses sexual assault and explores violence against women in particular.

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Brown, C. S., Jewell, J. A., & Tam, M. J. (2020). Gender. In R. Biswas-Diener & E. Diener (Eds), Noba textbook series: Psychology. Champaign, IL: DEF publishers. Retrieved from https://nobaproject.com/modules/gender. Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License

Washington State University. (n.d.). The psychology of gender. Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License. https://opentext.wsu.edu/psychology-of-gender/chapter/chapter-1/

Adaptations: Reformatted. Modified content for language, application to subject and cohesion.

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BBC World Service. (2020). Gender identity: 'How colonialism killed my culture's gender fluidity.' https://www.youtube.com/watch?v=AqEgsHGiK-s

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1.6: Sexual Orientation 1.6: Sexual OrientationEdit Update titlecancel

Learning Objectives

- Define sexual orientation, heterosexuality, homosexuality, asexuality, bisexuality, and pansexuality
- Explain what scientists mean when they say “sexual orientation is not binary”
- Defend, using examples, the statement: “homosexuality is widespread in nature”
- Cite evidence for a genetic basis of homosexuality, as well as evidence that homosexuality is environmentally influenced
- Understand that homosexuality is widespread in nature—in human and non-human animals
- Appreciate that our understanding of same-sex sexual preferences is part of an emerging field of study, thus, many of the scientific studies we’ll mention are relatively recent and, like all science, subject to revision
- Consider homophobia, the challenges of hate crimes and the importance of being an ally.

Introduction

Which one of these penguins is male?

“Day 119, April 28th: Penguin love” by katybird is licensed under CC BY-NC-SA 2.0.

There are known to be gay penguins couples all over the world.

Both of the penguins are male. In fact, they are a relatively famous couple of zoo penguins; in their desire to become fathers, they actually have attempted to steal eggs from other penguin couples, apparently going so far as to attempt deceit by leaving rocks in the place of the stolen eggs.

A related story involves the internationally renowned penguin dads, Jumbs and Kermit. If you’re not familiar with their story, check out: http://www.bbc.com/news/uk-england-kent-27405652

Similarly, a same-sex penguin couple at the Central Park Zoo raised the now-famous Tango, star of the children’s book, And Tango Makes Three.

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Clearly, there is something compelling about same-sex penguin couples. Our attraction (or aversion) to these stories is itself interesting, and leads to a lot of biologically relevant questions about sexual attraction.

What do we mean by “Sexual Orientation?”

Sexual Orientation is an umbrella term that is used to refer to patterns of attraction—sexual, romantic, or both. Under this umbrella, individuals may assort themselves into categories such as homosexual, heterosexual, bisexual, pansexual, and asexual.

“Queer,” “Bisexual,” “Pansexual,” “Polyamorous,” “Asexual,”

Queer as an identity term refers to a non-categorical sexual identity; it is also used as a catch-all term for all LGBTQ (lesbian, gay, bisexual, transgender, queer) individuals. The term was historically used in a derogatory way, but was reclaimed as a self-referential term in the 1990s United States. Although many individuals identify as queer today, some still feel personally insulted by it and disapprove of its use.

Bisexual is typically defined as a sexual orientation marked by attraction to either men or women. This has been problematized as a binary approach to sexuality, which excludes individuals who do not identify as men or women. Pansexual is a sexual identity marked by sexual attraction to people of any gender or sexuality.

Polyamorous (poly, for short) or non-monogamous relationships are open or non-exclusive; individuals may have multiple consensual and individually-negotiated sexual and/or romantic relationships at once (Klesse 2006).

Asexual is an identity marked by a lack of or rare sexual attraction, or low or absent interest in sexual activity, abbreviated to “ace” (Decker 2014). Asexuals distinguish between sexual and romantic attraction, delineating various sub-identities included under an ace umbrella. https://core.ac.uk/download/pdf/268096211.pdf

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Read More

You’ll find an excellent overview of terms at: https://www.plannedparenthood.org/learn/sexual-orientation-gender/sexual-orientation

You’ll note from the definitions the use of qualifiers such as “may,” and “often.” This pattern should serve as a clue that sexual orientation is COMPLICATED, and our understanding of the diversity of presentations is quickly changing.

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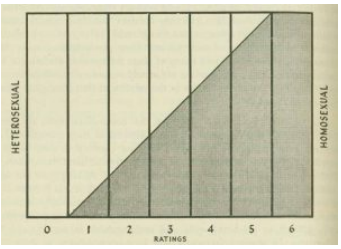
You can also check out this helpful Ally’s Guide to Terminology here.

Sexual preference is not binary

You may have heard things like “most people are bisexual,” and “sexual preferences exist on a continuum,” but are such claims scientific? That is, do we have evidence to justify such statements?

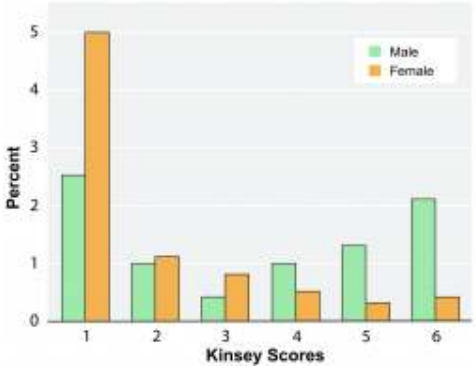
The Kinsey Scale



Some key work on sexuality was conducted in the 1940’s and 1950’s by the biologist Alfred Kinsey. Alfred Kinsey pioneered research in human sexuality through thousands of interviews and the development of “The Kinsey Scale” of human sexual preferences. The Kinsey Scale is a 7-point metric that categorizes individuals from 0 (exclusively heterosexual) to 6 (exclusively homosexual), and includes the midpoint 3 (equally homosexual and heterosexual).

Alfred Kinsey in TIME, 1953 by BORIS ARTZYBASHEFF, Public domain, via Wikimedia Commons

Kinsey’s main contributions were to (1) reveal that many people have preferences that aren’t “0” or “6”—in other words, sexual preferences do exist on a continuum; and (2) revolutionize how we view female sexuality—that is, women are not just recipients of sex, women have sexual desires, and women cheat, fantasize, and masturbate. For many people, these ideas may be obvious, but at the time they were shocking and revolutionary.



Based off of research from Bailey & Martin, 2000.

Above: distribution of Kinsey scores for 147 men and 238 women (who were not exclusively heterosexual) in an Australian sample from 2000.

More recent work has investigated the "continuum" concept of sexuality, with a focus on the prevalence of bisexuality. For example, an analysis of several reports revealed the presence of bisexuality in from ~2% to ~6% of individuals who identified as heterosexual, and from ~18% to ~88% in self-identified homosexuals. In the latter example, far more women, on average, expressed bisexual tendencies than did male homosexuals. In sum, bisexuality is fairly common, and sexual preference is not binary.

Social Constructionism

Social constructionism is a theory of knowledge that holds that characteristics typically thought to be immutable and solely biological—such as gender, race, class, ability, and sexuality—are products of human definition and interpretation shaped by cultural and historical contexts (Subramaniam 2010).

The Social Construction of Heterosexuality

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

Looking at this historical example makes visible the process of the social construction of heterosexuality. First of all, the example shows how social construction occurs within institutions—in this case, a medical doctor created a new category to describe a particular type of sexuality, based on existing medical knowledge at the time. "Hetero-sexuality" was initially a medical term that defined a deviant type of sexuality. Second, by seeing how Kiernan—and middle class culture, more broadly—defined "hetero-sexuality" in the 19th century, it is possible to see how drastically the meanings of the concept have changed over time. Typically, in the United States in contemporary usage, "heterosexuality" is thought to mean "normal" or "good"—it is usually the invisible term defined by what is thought to be its opposite, homosexuality. However, in its initial usage, "hetero-sexuality" was thought to counter the norm of reproductive sexuality and be, therefore, deviant. This gets to the third aspect of social constructionism. That is, cultural and historical contexts shape our definition and understanding of concepts. In this case, the norm of reproductive sexuality—having sex not for pleasure, but to have children—defines what types of sexuality are regarded as "normal" or "deviant." Fourth, this case illustrates how categorization shapes human experience, behavior, and interpretation of reality. To be a "heterosexual" in middle class culture in the US in the early 1900s was not something desirable to be—it was not an identity that most people would have wanted to inhabit. The very definition of "heterosexual" as deviant, because it violated reproductive sexuality, defined "proper" sexual behavior as that which was reproductive and not pleasure-centered.

Social constructionist approaches to understanding the world challenge the essentialist or biological determinist understandings that typically underpin the "common sense" ways in which we think about race, gender, and sexuality. Essentialism is the idea that the characteristics of persons or groups are significantly influenced by biological factors, and are therefore largely similar in all human cultures and historical periods.

Essentialism typically relies on a biological determinist theory of identity. Biological determinism can be defined as a general theory, which holds that a group's biological or genetic makeup shapes its social, political, and economic destiny (Subramaniam 2014). For example, "sex" is typically thought to be a biological "fact," where bodies are classified into two categories, male and female. Bodies in these categories are assumed to have "sex"-distinct chromosomes, reproductive systems, hormones, and sex characteristics. However, "sex" has been defined in

many different ways, depending on the context within which it is defined. For example, feminist law professor Julie Greenberg (2002) writes that in the late 19th century and early 20th century, "when reproductive function was considered one of a woman's essential characteristics, the medical community decided that the presence or absence of ovaries was the ultimate criterion of sex" (Greenberg 2002: 113). Thus, sexual difference was produced through the heteronormative assumption that women are defined by their ability to have children. Instead of assigning sex based on the presence or absence of ovaries, medical practitioners in the contemporary US typically assign sex based on the appearance of genitalia.

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Differential definitions of sex point to two other primary aspects of the social construction of reality. First, it makes apparent how even the things commonly thought to be "natural" or "essential" in the world are socially constructed. Understandings of "nature" change through history and across place according to systems of human knowledge. Second, the social construction of difference occurs within relations of power and privilege. Social constructionist analyses seek to better understand the processes through which racialized, gendered, or sexualized differentiations occur, in order to untangle the power relations within them.

Exploring heteronormativity, you may want to look at this Straight Questionaire, which flips the script on the questions commonly asked of sexual minorities. If you think it's uncomfortable for a straight person to get asked these questions, then you will understand how problematic it is to ask LGB+ individuals these questions. Think back to when we explored microaggressions during the second week of class. Any questions on this list asked of a person who is perceived to be a sexual minority would be considered a microaggression. Be aware of this for yourself and educate others who may ask similar questions of others.

This takes us to our next section, which- given the lens of social constructionism, can be a bit challenging. Researchers have been inquiring about the origins of sexual orientation for quite some time and it's still a point of examination. But challenges emerge in these areas. How does one investigate this area of sexuality without endorsing heteronormative structures?

Is sexual orientation genetic?

Asking this question is a bit like asking, "Are we born gay? Or straight?" This question can be problematic for some, because the motivation for asking the question may not be scientific. For example, individuals who have a social problem with homosexuality may be motivated to see sexual orientation as a choice, making homosexuality a characteristic one could choose not to exhibit. And in recent history, eugenicists (individuals who promote selective reproduction among "favored" types of humans) used a presumed genetic basis for homosexuality as an argument in favor of sterilizing gay people. The question can also be problematic because the stated or implied focus is typically on the cause of homosexuality, rather than heterosexuality. (We'll say more about that in a bit.)

But, for now, let's focus on the biology of homosexuality's origins. While no serious scientist is claiming that same-sex mating preferences arise in a simple Mendelian fashion, or that there is a single "gay gene," many have found evidence of a possible genetic basis. Some intriguing data are from the literature on twins. For example, researchers discovered that identical twins (who arise from the same sperm and egg, and have nearly 100% identical genetics) are more alike with respect to sexual orientation than are non-identical twins (who arise from different eggs and sperm). However, identical twins don't overlap completely in sexual preferences, a finding that suggests other factors—besides genetics—may be at work.

Is sexual orientation influenced by the environment?

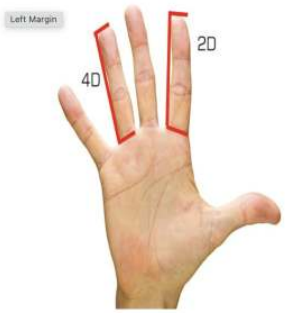
Several studies have found correlations between same-sex sexual preferences and environmental conditions. In this case the "environment" can be the uterine environment, and refer to conditions during fetal development, or the environment can refer to conditions after birth.

The literature on post-birth experiences, and their impacts on sexual orientation, is challenging for many reasons, but largely because it is so difficult to disentangle the impact of a tolerant environment on someone's inclination to express their homosexuality. For example, there has been work suggesting that children of gay parents are more likely to grow up expressing same-sex sexual preferences. Is this because growing up in a gay family actually influences an individual's sexuality, or because a family that is accepting of homosexuality creates a safe space for a gay or bisexual individual to express their sexuality?

Similarly, work in Denmark has shown that growing up in an urban environment is associated with the choice to marry a person of the same sex later in life. Diverse metropolitan areas are typically associated with greater tolerance towards gays and lesbians, so is it simply that this tolerance supports the expression of an existing characteristic, or is there something else about cities that promotes homosexuality? A summary from the Danish study includes the following statements: "For men, homosexual marriage was associated with having older mothers, divorced parents, absent fathers, and being the youngest child. For women, maternal death during adolescence and being the only or youngest child or the only girl in the family increased the likelihood of homosexual marriage."

Somewhat more compelling is the work on the prenatal environment and homosexuality. According to many of these studies, differential exposure to prenatal hormones, specifically testosterone, influences sexuality later in life.

Several studies have found evidence, through the development of certain body parts (e.g., fingers, ears) that lesbians were exposed to more testosterone in utero than were straight women. Finger (or "digit") lengths, especially the ratio between the second (2D) and fourth (4D) fingers, seems to vary as a function of exposure to testosterone in the womb. In one study of identical twins, researchers found that, on average, the 2D:4D ratio is larger in lesbian women than men (Watts, Holmes, Raines, *et al*, 2018). It's important to note that these differences are rarely noticeable without doing precise measurements of an individual's finger lengths. It's also critical to mention that a subsequent, more recent study (Holmes, Watts-Overall, Slettevold, *et al*, 2022) found no evidence that increased prenatal androgen exposure influenced masculinity in homosexual women. Critically, while there is some evidence correlating androgen exposure with sexual orientation, there is no *causal* explanation.



Visual representation of 2D and 4D

Fraternal birth order and the uterine environment

What is the fraternal birth order effect?

In males, it appears to be that number of older brothers alters the likelihood of same-sex preferences later in life. Specifically, more older brothers (not sisters) is associated with homosexuality in men (not women). This is called the fraternal birth-order (FBO) effect in the scientific literature, and the evidence for the FBO effect is compelling. Simply, homosexual men, on average, have more older brothers than do heterosexual men, a difference that is not seen in homosexual versus heterosexual women.

A logical response to this finding would be to wonder whether growing up with older brothers somehow led more men to develop with same-sex sexual preferences, or if there was something about the uterine environment that favored homosexuality in successive male offspring.

Anthony Bogaert was interested in the FBO effect and whether it was due to exposures in the uterus during fetal development, or somehow due to the impact of growing up with older brothers. He tested this by analyzing data on sexual preferences in several groups of men, including one sample of men raised in step- or adoptive families. That is, he was able to compare homosexuality in men raised with their older brothers, and those raised apart from their older, biological brothers. He found that only biological older brothers were associated with male homosexuality, regardless of the amount of time spent with those older brothers. Bogaert used these data to suggest that it is uterine conditions, not how a person is raised, that is associated with same-sex sexual preferences in men.

For an accessible summary of the FBO effect, read: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1502267/pdf/zpq10531.pdf

Caution: These differences in uterine influences on male and female homosexuality also illustrate a key point: male homosexuality and female homosexuality appear to have different causes, thus we should be careful not to transfer the findings of research on men to the reality of sexuality in women. Further, male and female homosexuality are likely influenced by multiple factors.

Evolutionary Approach

Some biologists have referred to the evolutionary problem with homosexuality, because same-sex sexual behavior is non-reproductive, yet homosexuality occurs in relatively high numbers—enough to support an adaptive function for homosexuality. So the big question is: how can natural selection work on a trait that seems unable to increase an individual's fitness?

The literature on the evolution and occurrence of homosexuality has focused on several hypotheses, including some that are adaptive (fitness-enhancing) explanations and several that are non-adaptive explanations.

Suggested adaptive explanations include (but are not limited to),

1. Social glue: according to the social glue hypothesis, same-sex sexual interactions help to form bonds, reduce tension, repair relationships after conflict, and prevent future conflicts from occurring
2. Kin selection: this hypothesis centers on the idea that individuals can increase their fitness either by direct mechanisms (having their own offspring) or by indirect mechanisms (investing in, or somehow providing a benefit to, the offspring of their relatives. A homosexual individual might forego having his or her own direct offspring, but could benefit the family (and help get their own genes into the next generation) by investing in siblings, nieces, nephews, etc.

3. Alliance formation: similar to social glue, the alliance formation hypothesis posits that bonds forged during sex lead individuals to greater acts of bravery or sacrifice, to benefit those with whom they've been intimate. If same-sex sexual relationships lead to stronger alliances, and these alliances make better warriors or soldiers who are more likely to survive conflicts, that would lend support for the alliance formation.
4. Practice: according to the practice hypothesis, same-sex activities during immature stages make an individual more adept at courtship and copulation, with opposite-sex partners, as an adult.
5. Enhanced family fertility: according to the enhanced fertility hypothesis, some of the genetic components that can lead to homosexuality are also associated with enhanced fertility or success in getting mates. From this hypothesis we would predict that individuals who share genetic information with homosexual individuals would have greater reproductive success than those who do not.

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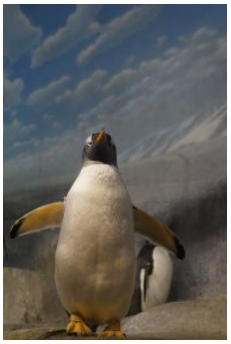
You can probably imagine ways to test all of the above explanations, as well as potential problems associated with each suggestion.

There's Just No ONE Factor (aka- Reasons We Love Psychology)

Remember "And Tango Makes Three", the children's book about two male penguins, Roy and Silo, who adopted an egg? That book became notorious, making the American Library Associations top-ten list of "most challenged [or banned] books" during the most recent decade: http://www.ala.org/bbooks/top-100-bannedchallenged-books-2000-2009

Soon after the book's publication, and after a six-year partnership, Silo left Roy for a female penguin named Scrappy. Reactions to the split were mixed but, as Roberta Sklar, a spokeswoman for the National Gay and Lesbian Task Force, said: "There's almost an obsession with questions such as, 'Is sexual orientation a birthright or a choice?' And looking at the behavior of two penguins in captivity is not a way to answer that question." She continued by noting that the public outcry (over the book, the penguin pair, and then their split) "is a little ridiculous. Or maybe a lot ridiculous."



"Penguin" by C Simmons is licensed under CC BY-NC 2.0.

As we've discussed, the 'why' of sexual orientation is complicated, non-binary, and often fluid. In humans and in penguins. http://www.nytimes.com/2005/09/24/nyregion/new-love-breaks-up-a-6year-relationship-at-the-zoo.html?_r=0

LGBTQ Brief U.S. Historical Sketch

As discussed in the section on social construction, heterosexuality is no more and no less natural than gay sexuality or bisexuality, for instance. As was shown, people—particularly sexologists and medical doctors—defined heterosexuality and its boundaries. This definition of the parameters of heterosexuality is an expression of power that constructs what types of sexuality are considered "normal" and which types of sexuality are considered "deviant."

LGBTQ history has developed through four stages Gerda Lerner first identified for women's history: compensation, contributions, revision, and social construction (Lerner, 1975). LGBTQ historians first compensated for heterosexism and cissexism by finding LGBTQ people to reinsert into historical narratives, then determined how LGBTQ people contributed to history. As they analyzed primary sources, they slowly revised historical narratives through testing generalizations and periodization against evidence by and about LGBTQ people. Finally, the field understood that sexual orientation and gender themselves are social constructions.

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Political organizing by oppressed Americans in the 1970s helped create U.S. lesbian, gay, bi/pansexual, trans, and queer history as a field. Why would people's struggles for rights and freedom include wanting to be represented in historical accounts? Inclusive histories reflect the diversity of people in the U.S., expose institutional discrimination against minoritized people, trace how minorities have contributed, and outline their work toward the American democratic experiment.

Stonewall Riots

In 1969, the Stonewall Inn riot broke out due to a New York City police raid. This Mafia-run dive bar blackmailed gay Wall Street patrons and used those funds to pay off police. In return, police gave the Stonewall advanced warning of raids. Raids targeted those in full drag and trans sex workers like Sylvia Rivera. But raids could also ruin lives of white, Black, and Latino gay and lesbian customers; newspaper exposure led to being fired or evicted. On June 28, 1969 there was no tip off. Trans and lesbian patrons resisted—refusing to produce identification or to follow a female officer to the bathroom to verify their sex for arrest. They also objected to officers groping them (Carter, 2004, pp. 68, 80, 96-103, 124-5, 141, 156; Duberman, 1993, pp. 181-193). A growing crowd outside spontaneously responded to police violence by hurling coins and cans at officers who retreated into the bar. Rioting resumed a second and third night. Gay poet Allen Ginsberg heard slogans and crowed, "Gay power! Isn't that great! We're one of the largest minorities in the country – 10 percent, you know. It's about time we did something to assert ourselves" (Truscott, 1969, p. 18).

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The Stonewall Riot also did not stop police raids, but mainstream and gay coverage and leafleting spurred the creation of new, more militant gay organizing than previous homophile groups. The Gay Liberation Front (GLF) sought to combine freedom from homophobia with a broader political platform that denounced racism and opposed capitalism. The Gay Activists Alliance rose from the GLF with confrontational "zaps" where they surprised politicians in public to force them to acknowledge gay and lesbian rights (Carter, 2004, pp. 245-246). Gay liberationists like Carl Wittman drew on past New Left anti-war student activism and the Women's Liberation Movement. Wittman's "Refugees from Amerika: A Gay Manifesto" (1970) rails against homophobia, imploring gays to free themselves by coming out while also acknowledging that will be too dangerous for some yet. Gay men must discard male chauvinism as antigay. Rather than "mimic" "straight society," gay liberation should reject gender roles and marriage and embrace queens as having gutsily stood out. Wittman was attuned to the rise of lesbian feminism, which tied sexism together with homophobia. Lesbian feminists emphasized their focus on women's autonomy and well-being rather than identification as mothers, wives, and daughters who indirectly gained from what benefitted men (Jay and Young, 1992; Pomerleau, 2010).

Gay liberationists demonstrated against the American Psychiatric Association (APA) to remove homosexuality from its list of mental disorders. Activists and gay counselors knew they were not sick. They marshaled psychological research homophile ally, Dr. Evelyn Hooker, created from 1957 on, that demonstrated gay men were equally stable as heterosexual men based on personality tests and sometimes showed more resilience (Minton, 2002, pp. 219-236). In 1973 the APA voted unanimously to define homosexuality in their diagnostic manual as "one form of sexual behavior, like other forms of sexual behavior which are not by themselves psychiatric disorders" (Eaklor, 2008, pp. 150-151). This was a major win on the long road to discrediting conversion therapies. Simultaneously, though, the APA's third manual introduced "gender identity disorder of childhood" and "transsexualism" in 1980, preserving a concern about variety in gendered behavior and sustaining forced conversion programs for children and adolescents without increasing access to medical services some trans adults wanted. Despite the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM) removal of the term "transexualism" in 1994, issues like conversion therapy on children still exist.

The AIDS Epidemic

In 1981 the New York Times stated that a rare, aggressive skin cancer had struck forty-one recently healthy homosexuals (Andriote, 1999, p. 49; Shilts, 1987, pp. 37, 54-66). By late 1982 related immunosuppression cases existed among infants, women, heterosexual men, intravenous drug users and hemophiliacs. The mortality rate of the original patients was 100%. Panic spread. Media, many government officials, and the gay community asked what linked the affected gay men. Connecting deadly disease to gay male sexuality provided a new rationale for discriminatory laws and harassment as the political power of the Christian Right continued to ascend (Bronski, 2011, p. 225; Eaklor, 2008, p. 176; Stein, 2012, pp. 143-144).

In response to AIDS, LGBTQ Americans organized new institutions and created new methods to get needed resources, which furthered lively debates over tactics. A major contributor to the AIDS epidemic was willful neglect from the federal government. For the first five years of the epidemic, President Reagan remained silent about it. In 1986 he and governors from both parties proposed cutting government spending on AIDS. That year the Supreme Court ruled in Bowers v. Hardwick that gay adults did not have constitutional privacy rights that would protect them from prosecution for private, consensual sex. The Justice Department announced that federal law allowed employment discrimination based on HIV/AIDS.

This spurred high-impact radical organizing. Larry Kramer and cofounders formed AIDS Coalition to Unleash Power or ACT UP in 1987. It further publicized the NYC slogan "Silence = Death" in demonstrations. ACT UP dramatically disrupted Wall Street, the Food and Drug Administration, the Center for Disease Control, and St. Patrick's Cathedral to protest the high cost of AZT (the first drug treatment).

In tandem with responses to AIDS, often overlooked portions of LGBT Americans organized. Bisexuals started forming social groups and then National Bisexual Liberation Group in 1972 based on N.Y., S.F.'s Bisexual Center in 1976, and the national BiPOL in San Francisco in 1983. Although the 1987 March on Washington organizers would not include bi or trans in the march title of demands, both constituents argued "gay and lesbian" was not inclusive (Garber, 1991; Garber, 1995; Queen, 1995; Queen, 1997; Queen and Schimel, 1997).

Over the 1990s and 2000s, new drug therapies prolonged the lives of people living with AIDS. Although radical, multi-community AIDS activism continued, work for mainstream legal protections and rights dominated activism. LGBT Americans and supporters sought inclusion in the military, antidiscrimination law, and marriage equality.

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State legislatures and popular ballots featured both anti-discrimination and antigay measures, creating grassroots organizing for and against protecting LGBT Americans from being rejected from jobs, fired or excluded from housing and public accommodations. Cultural conservatives lamented gradually increasing acceptance of LGBT people as celebrity musicians and television stars slowly started to come out and weathered backlash to continue their careers. Meanwhile, the Hawai'i state supreme court win, Baehr v. Miike, temporarily legalized same-sex marriage there in 1996. National LGBT organizations pushed to extend marriage equality nationwide. Over the next decade states split on whether to ban or legalize marriage equality. Popular support steadily grew over the 2000s, reaching sixty percent in 2015 when the Supreme Court ruled in Obergefell v. Hodges that the fourteenth Amendment guarantees same-sex couples the right to marry.

As sexologists categorized sexuality into normal or pathological identities, heteronormativity developed that added psychology and medical science to the church and state as anti-LGBT institutions. Communities of gay and bi men, lesbian and bi women, and trans people multiplied in the 1950s despite heightened repression, and a portion of these minorities organized for equal rights. Even an epidemic blamed on and falsely identified with gays could not stop LGBT organizing. Activists further developed radical tactics from the 1970s to call for liberation from heteronormativity. Arduous legal gains have been easier than rooting out the foundational power imbalances by race, class, gender, ability, and citizenship, but both legal and cultural changes continue to transform society.

Anti LGBTQ Hate Crimes in the United States

On June 12, 2016, 49 people were killed and 53 wounded in the Pulse nightclub shooting in Orlando, Florida. It was the deadliest single person mass shooting and the largest documented anti-LGBTQ attack in United States history. The attack on a gay nightclub on Latin night resulted in over ninety percent of the victims being Latinx and the majority being LGBTQIA-identified. This act focused on an iconic public space that provided LGBTQIA adults an opportunity to explore and claim their sexual and gender identities. The violence at Pulse echoed the 1973 UpStairs Lounge fire attack in New Orleans that killed thirty two people. These mass killings are part of a broader picture of violence that LGBTQIA people experience, from the disproportionate killings of transgender women of color to domestic violence and bullying within schools. There are different perspectives within the LGBTQIA community about responses to hate-motivated violence. These debates concern whether the use of punitive measures through the criminal legal system supports or harms the LGBTQIA community, and whether there is a need for more radical approaches to address the root causes of anti-LGBTQIA violence. This research profile explores hate crimes as both a legal category and broader social phenomenon.

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What are Hate Crimes?

Anti-LGBTQ hate crimes have had a simultaneously spectacular and invisible role in U.S. society. Today, hate crimes are defined as criminal acts motivated by bias towards victims' real or perceived identity groups (Blazak 2011, 245). Hate crimes are informal social control mechanisms utilized in stratified societies as they are part of what Barbara Perry calls a "contemporary arsenal of oppression" used to police identity boundaries (Perry 2009, 56). Hate crimes occur within social dynamics of oppression, where othered groups are vulnerable to systemic violence, pushing marginalized groups further into the political and social edges of society. It is theorized that hate crimes are driven by conflicts over cultural, political and economic resources, bias and hostility towards relatively powerless groups, and the failure of authorities address hate in society (Turpin-Petrosino 2009, 34).

The 1998 beating and torture death of college student Matthew Shepard in Laramie, Wyoming became a rallying point to address hate crimes more fully in the late 1990s. His murder received substantial media coverage and inspired artistic works as well as political action. As an affluent, white gay young man, Shepard became a symbol of anti-gay violence. His attackers were accused of attacking him because of anti-gay bias, but were not charged with committing a hate crime as Wyoming had no laws that covered anti-LGBT crimes.

While federal laws address constitutional rights violations, each state has or does not have its own specific hate crime laws (Levin and McDevitt 2002). Today, there are a wide range of laws regarding hate crime protections across states, and they vary in regards to protected groups, criminal and/or civil approaches, crimes covered, complete or limited data collection, and law enforcement training (Shively 2005, ii). As of 2019, 19 states did not have any LGBT hate crime laws, and 12 states had laws that covered sexual orientation but did not address gender identity and expression (Movement Advancement Project 2009). Twenty states included both sexual orientation and gender identity in their hate crimes laws (Movement Advancement Project 2009). The majority of these laws were created in the early 2000s, with the inclusion of gender identity and expression following in recent decades.

Hate crime laws require law enforcement agencies to investigate and prosecute crimes committed with bias against LGBTQ people. Some state laws also require collection of data on anti-LGBTQ hate crimes.

The federal Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act allows the federal government to prosecute hate crimes, including those based on sexual orientation and gender identity. State laws may also allow for state or local prosecution of certain hate crimes, depending on what, if any, protections the state law offers. Read the State-by-State Statutes.

Hate Crime Laws

Movement Advancement Project. "Equality Maps: Hate Crime Laws." https://www.lgbtmap.org/equality-maps/hate_crime_laws.

The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act is a federal law that amended federal hate crime law to include gender, sexual orientation, gender identity, and disability. Several states have hate crime laws that require data collection for sexual orientation or gender identity and expression, but do not impose additional penalties: Indiana (sexual orientation), Michigan (sexual orientation) and Rhode Island (gender identity or expression). For additional information, check out the Human Rights Campaign, the National Gay & Lesbian Task Force, the National Center for Transgender Equality, or the Equality Federation.

Hate crime laws are intended to deter bias-motivated crimes, but there is no consensus around the efficacy of these laws in preventing hate crimes against LGBTQ people. Additionally, some advocates argue that hate crime laws may be counterproductive to that goal. Research further suggests that the enforcement of hate crime laws disproportionately impacts marginalized communities, particularly communities of color. Read more about how criminalization impacts people of color here.

Contemporarily, there is no universal consensus about the role of hate crime laws in furthering the acceptance and inclusion of LGBTQ people in American society. For many people such laws carry with them an emphasis on the value of their lives and help to further their sense of belonging. Others, particularly LGBTQ activists engaged in broader social justice struggles, argue that such laws shore up a broken criminal justice system that is predicated on a violent logic that cannot truly benefit the LGBTQ community.

Coming Out

The gay liberation movement of the 1970s advocated for "coming out" as an LGBTQ person as an important strategy of political change and personal fulfilment. This concept is illustrated in this now famous quote by the late San Francisco Supervisor, and hero of the LGBTQ rights movement, Harvey Milk:

Every gay person must come out. As difficult as it is, you must tell your immediate family. You must tell your relatives. You must tell your friends if indeed they are your friends. You must tell the people you work with. You must tell the people in the stores you shop in. Once they realize that we are indeed their children, that we are indeed everywhere, every myth, every lie, every innuendo will be destroyed once and all. And once you do, you will feel so much better."

The benefit and buffering effects of coming out have been well established in the literature (Stirratt, Meyer, Ouellette, Gara, 2007; Cass, 1984; Troiden, 1989). Meyer's LGBTQ Minority Stress model (see Frost, click here for more) connects minority identification with positive outcomes in terms of coping and social support resources necessary to address minority stress, but it also highlights how minority identification is related to minority stressors within the individual such as expectations of rejection, concealment, and internalized homophobia. In addition, identification and community connectedness can increase visibility, which may increase vulnerability to things like employment discrimination, harassment, and violence (Meyer, 2003).

Review this resource on the coming out process by the University of Washington.

Realize that it may not always be safe to come out to others due to concerns around physical or emotional safety, loss of housing, unsafe living situations, etc. Every individual must weigh the pros and cons of coming out because the people around us may not always react in supportive ways.

Also, keep in mind the role of an ally is to not out someone to others. It is up to the individual to tell others about their identity, and we could even cause them physical or emotional harm if we out them to others. Do not do this without the person's express and direct permission beforehand.

Inviting In

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Historians and other social scientists have also suggested that the increased visibility of LGBTQ people was a critical element in the formation of LGBTQ communities and the progress of the LGBTQ rights movements (D'Emilio, 1983; Chauncey, 1995). Herek's and Allport's contact hypothesis (Herek & Capitanio, 1996; Allport, 1956), Harvey Milk's rallying cry of "Come on out!" (Shiltz, 1982), and research that highlights the importance of role models and positive representatives in various forms of media (GLAAD, 2016; Craig, McInroy, McCready, Alaggia, 2015; Forenza, 2017), all suggest that coming out, and increasing the visibility of LGBTQ people, is an important and often positive strategy for improving social attitudes (Levina, Waldo, Fitzgerald, 2000). As stated earlier, increased visibility does come with risks. However, positive contact between heterosexuals and LGBTQ people has been found to result not only in positive attitude change, but also in the possibility of increasing the dominant group's identification with the marginalized, creating the possibility of allyship—the mobilization of heterosexuals to work toward change benefiting the LGBTQ community (Reimer et al., 2017).

Review these tips from the University of Southern California on how to be an ally to someone who is coming out and check out the video below:

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APA Guidelines for Writing about Sexual Orientation without Bias

- Review this resource in order to be up-to-date on current requirements for writing about sexual orientation in psychological research

American Psychological Association. (2020). APA style: Sexual orientation. Retrieved from https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/sexual-orientation.

Conclusion

This section provided an introduction to sexual orientation, defining several key terms and providing a brief overview of LQBTQ+ history in the United States. Additionally, we explored social constructionism and the challenges of research related to sexual orientation. Finally – we discussed some of the ongoing challenges to the safety and well-being for sexual minority folks, coming out processes and ways to be allies.

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Harvey Milk. Provided by: Wikimedia Commons. Located at: https://commons.wikimedia.org/wiki/File:Harvey_Milk_at_Gay_Pride_San_Jose,_June_1978_(cropped).jpg. License: CC BY-SA: Attribution-ShareAlike

Introduction to Women, Gender, Sexuality Studies by Miliann Kang, Donovan Lessard, Laura Heston, Sonny Nordmarken is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

Massey, S. G., Young, S. R. & Merriwether, A. (2020). The Benefits and Risks of Coming Out. License: CC BY: Attribution

U.S. LGBTQ History. Authored by: Clark A. Pomerleau. Provided by: University of North Texas. Project: LGBTQ Studies. License: CC BY-NC-SA: Attribution-NonCommercial-ShareAlike

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Additional References

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J.M. (2009). And Tango Makes Three. https://www.youtube.com/watch?v=WyPjUa908hM

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NBC New York. (2019). Pride 2019: Did the AIDS crisis accelerate LGBTQ rights in America? | NBC New York. https://www.youtube.com/watch?v=HcqVXSL15X4

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The Root. (2020). Why some Black LGBTQIA+ folks are done 'coming out.' https://www.youtube.com/watch?v=jdCKe0QBuwQ

chescaleigh. (2014). 5 tips for being an ally. https://www.youtube.com/watch?v=_dg86g-QlM0

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TEDx Talks. (2016). Homosexuality: It's about survival – not sex | James O'Keefe | TEDxTallaght. https://www.youtube.com/watch?v=4Khn_z9FPmU

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1.7: Attraction 1.7: AttractionEdit Update titlecancel

Learning Objectives

- Summarize the variables that lead to initial attraction between people.
- Outline the variables that lead us to perceive someone as physically attractive, and explain why physical attractiveness is so important in liking.
- Describe the ways that similarity and complementarity influence our liking for others.
- Define the concept of mere exposure, and explain how proximity influences liking.
- Provide a very brief overview of evolutionary research into attraction.

Introduction

As we've discussed in class, and in our overview of sexology, studying attraction can be challenging. Attraction between two (or more) people can be difficult to predict, determine, or cause. Can you imagine compelling yourself or others to be attracted to someone? It's typically not an experience that someone can force. So what are elements that optimize attraction? What are the variables present when attraction does occur? Where does the attraction come from? Is it biological or learned? The study of attraction covers a huge range of topics. It can begin with first impressions, then extend to courtship and commitment. It involves the concepts of beauty, sex, and evolution. Attraction researchers might study stalking behavior. They might research divorce or remarriage. They might study changing standards of beauty across decades.

When we say that we like or love someone, we are experiencing interpersonal attraction—the strength of our liking or loving for another person. Although interpersonal attraction occurs between friends, family members, and other people in general, and although our analysis can apply to these relationships as well, our primary focus in this section will be on romantic attraction. There is a large literature on the variables that lead us to like others in our initial interactions with them, and we'll review the most important findings here (Sprecher, Wenzel, & Harvey, 2008).

Physical Attractiveness

Although it may seem inappropriate or shallow to admit it, and although it is certainly not the only determinant of liking, people are strongly influenced, at least in initial encounters, by the physical attractiveness of their partners (Swami & Furnham, 2008). Elaine Walster and her colleagues (Walster, Aronson, Abrahams, & Rottman, 1966) arranged a field study in which college boys and girls were randomly paired with one another at a "computer dance." After the partners had danced and talked for a couple of hours, they were interviewed separately about their own preferences and characteristics as well as about their perceptions of their date. Walster and her colleagues found that the only important determinant of participants' liking for their date was his or her physical attractiveness. None of the other characteristics—even the perceived intelligence of the partner—mattered.

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Perhaps this finding doesn't surprise you too much, given the importance of physical attractiveness in our culture. Movies and TV shows feature attractive people, TV ads use attractive people to promote their products, and we spend millions of dollars each year to make ourselves look more attractive. Even infants who are only a year old prefer to look at faces that adults consider attractive rather than at unattractive faces (Langlois, Ritter, Roggman, & Vaughn 1991).

People who are attractive are also seen as having a variety of positive characteristics, and these traits are activated quickly and spontaneously when we see their faces (Olson & Marshuetz, 2005; van Leeuwen & Macrae, 2004). Attractive people are seen as more sociable, altruistic, and intelligent than their unattractive counterparts (Griffin & Langlois, 2006). Attractive people also have more choices of sex partners (Epstein, Klinkenberg, Scandell, Faulkner, & Claus, 2007), are more likely to be offered jobs (Dubois & Pansu, 2004), and may even live longer (Henderson & Anglin, 2003).

Although it is sometimes said that "beauty is in the eyes of the beholder" (i.e., that each person has his or her own idea about what is beautiful), this is not completely true. There is good agreement among people, including children, and within and across cultures, about which people are most physically attractive (Berry, 2000; Ramsey, Langlois, Hoss, Rubenstein, & Griffin, 2004). If your instructor asked the students in your class to rate each other on their attractiveness, there would be general agreement among them on which students are most and least attractive. This agreement is in part due to shared norms within cultures about what is attractive, but it is also due to evolutionary predispositions to attend to and be influenced by specific characteristics of others.

Leslie Zebrowitz and her colleagues have extensively studied the tendency for both men and women to prefer facial features that have youthful characteristics (Zebrowitz, 1996). These features include large, round, and widely spaced eyes, a small nose and chin, prominent cheekbones, and a large forehead. Zebrowitz has found that individuals who have youthful-looking faces are more liked, are judged as warmer and more honest, and also receive other positive outcomes. Parents give baby-faced children fewer chores and punishments, and people with young-looking faces are also required to pay lower monetary awards in courtroom trials (Zebrowitz & McDonald, 1991). On the other hand, baby-faced individuals are also seen as less competent than their more mature-looking counterparts (Zebrowitz & Montpare, 2005).

The preference for youth is found in our perceptions of both men and women but is somewhat stronger for our perceptions of women (Wade, 2000). This is because for men, although we do prefer youthful faces, we also prefer masculine faces—those with low, broad jaws and with pronounced bone ridges and cheekbones—and these men tend to look somewhat older (Rhodes, 2006). We may like baby-faced people because they remind us of babies, or perhaps because we respond to baby-faced people positively, they may act more positively to us.

Some faces are more symmetrical than others. People are more attracted to faces that are more symmetrical in comparison with those that are less symmetrical. This may be in part because of the perception that people with symmetrical faces are more healthy and thus make better reproductive mates (Rhodes, 2006; Rhodes et al., 2001) and in part because symmetrical faces seem more familiar and thus less threatening to us (Winkielman & Cacioppo, 2001). The attraction to symmetry is not limited to face perception. Body symmetry is also a likely indicator of good genes, and women favor more symmetrical men as sexual partners (Gangestad & Thornhill, 1997).

Although you might think that we would prefer faces that are unusual or unique, in fact the opposite is true (Langlois, Roggman, & Musselman, 1994). Langlois and Rodman (1990) showed college students the faces of men and women. The faces were composites made up of the average of 2, 4, 8, 16, or 32 faces. The researchers found that the more faces that were averaged into the stimulus, the more attractive it was judged (see Figure 7.1 “Facial Averageness”). As with the findings for facial symmetry, one possible explanation for our liking of average faces is that because they are more similar to the ones that we have frequently seen, they are thus more familiar to us (Grammer, Fink, Juette, Ronzal, & Thornhill, 2002).

Other determinants of perceived attractiveness are healthy skin, good teeth, a smiling expression, and good grooming (Jones et al., 2004; Rhodes, 2006; Willis, Esqueda, & Schacht, 2008). These features may also have evolutionary significance—people with these characteristics probably appear to be healthy.

Although the preferences for youth, symmetry, and averageness appear to be universal, at least some differences in perceived attractiveness are due to social factors. What is seen as attractive in one culture may not be seen as attractive in another, and what is attractive in a culture at one time may not be attractive at another time. To consider one example, in modern Western cultures, “thin is in,” and people prefer those who have little excess fat and who look physically fit (Crandall, Merman, & Hebl, 2009; Hönekopp, Rudolph, Beier, Liebert, & Müller, 2007; Weeden & Sabini, 2005).

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However, the norm of thinness has not always been in place. The preference for women with slender, masculine, and athletic looks has become stronger over the past 50 years in Western cultures, and this can be seen by comparing the figures of female movie stars from the 1940s and 1950s with those of today. In contrast to the relatively universal preferences for youth, symmetry, and averageness, other cultures do not show such a strong propensity for thinness (Anderson, Crawford, Nadeau, & Lindberg, 1992).

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Gender Differences in Perceived Attractiveness

You might wonder whether men and women find different mates attractive. The answer is yes, although as in most cases with research on binary gender differences, the differences are outweighed by overall similarities. Overall, both men and women value physical attractiveness, as well as certain personality characteristics, such as kindness, humor, dependability, intelligence, and sociability; this is true across many different cultures (Berry, 2000; Li, Bailey, Kenrick, & Linsenmeier, 2002). For men, however, the physical attractiveness of women is most important; women, although also interested in the attractiveness of men, are relatively

more interested in the social status of a potential partner. When they are forced to choose one or the other, women from many different cultures have been found to prioritize a man's status over his physical attractiveness, whereas men prioritize a woman's attractiveness over her status (Li, Bailey, Kenrick, & Linsenmeier, 2002).

Age also matters, such that the preference for youthful partners is more important for men than for women. Women have been found to be more likely to respond to personal ads placed by relatively older men, whereas men tend to respond to ads placed by younger women—men of all ages (even teenagers) are most attracted to women who are in their 20s. Younger people (and particularly younger women) are more fertile than older people, and research suggests that men may be evolutionarily predisposed to like them for this reason (Buunk, Dijstra, Kenrick, & Warntjes, 2001; Dunn, Brinton, & Clark, 2010; Kenrick & Li, 2000).

Another research finding consistent with the idea that men are looking for cues to fertility in their partners is that across many cultures, men have a preference for women with a low waist-to-hip ratio (i.e., large hips and a small waist), a shape that is likely to indicate fertility. On the other hand, women prefer men with a more masculine-appearing waist to hip ratio (similar waist and hip size; Singh, 1995; Swami, 2006). Recent research, however, has suggested that these preferences, too, may be in part due to a preference for averageness, rather than to a specific preference for a particular waist-to-hip ratio (Donohoe, von Hippel, & Brooks, 2009).

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But gender differences in mate preferences may also be accounted for in terms of social norms and expectations. Overall, women have lower status than men, and as a result, they may find it important to attempt to raise their status by marrying men who have more of it. Men who, on average, already have higher status may be less concerned in this regard, allowing them to focus relatively more on physical attractiveness. Some studies show that women's preference for men of high status, rather than for physically attractive men, is greatest in cultures in which women are less well educated, poorer, and have less control over conception and family size (Petersen & Hyde, 2010).

Why Is Physical Attractiveness So Important?

You might find yourself wondering why people find physical attractiveness so important when it seems to say so little about what the person is really like as a person. If beauty is really only "skin deep," as the proverb goes, why are we so concerned with it?

One reason that we like attractive people is because they are rewarding. We like being around attractive people because they are enjoyable to look at and because being with them makes us feel good about ourselves. Attractiveness implies high status, and we naturally like being around people who have it. Furthermore, the positive features of attractive people tend to "rub off" on those around them as a result of associational learning (Sigall & Landy, 1973).

We may also like attractive people because they are seen as, and in fact may actually be, better friends and partners. The physical attractiveness stereotype (or attractiveness halo effect) refers to the tendency to perceive attractive people as having positive characteristics, such as sociability and competence, and meta-analyses have found substantial support for it (Dion, Berscheid, & Walster, 1972). Physically attractive people are seen as more dominant, sexually warm, mentally healthy, intelligent, and socially skilled than are physically unattractive people (Eagly, Ashmore, Makhijani, & Longo, 1991). One outcome of the physical attractiveness stereotype is that attractive people receive many social benefits from others. Attractive people are given better grades on essay exams, are more successful on job interviews, and receive lighter sentences in court judgments in comparison with their less attractive counterparts (Hosoda, Stone-Romero, & Coats, 2003). We are all of course aware of the physical attractiveness stereotype and make use of it when we can. We try to look our best on dates, at job interviews, and (not necessary, we hope!) for court appearances.

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Research has found at least some evidence for the idea that attractive people are actually more sociable, more popular, and less lonely in comparison with less attractive individuals (Diener, Wolsic, & Fujita, 1995; Langlois et al., 2000). These results are probably the result of self-fulfilling prophecies. Because people expect attractive others to be friendly and warm, and because they want to be around them, they treat attractive people more positively than they do unattractive people. In the end, this may lead attractive people to develop these positive characteristics (Zebrowitz, Andreoletti, Collins, Lee, & Blumenthal, 1998). However, as with most stereotypes, our expectations about the different characteristics of attractive and unattractive individuals are much stronger than the real differences between them.

Similarity: We Like Those Who Are Like Us

Although it is a very important variable, finding someone physically attractive is of course only the first stage in developing a close relationship with another person. If we find someone attractive, we may want to pursue the relationship. And if we are lucky, that person will also find us attractive and be interested in the possibility of developing a closer relationship. At this point, we will begin to communicate, sharing our values, beliefs, and interests, and begin to determine whether we are compatible in a way that leads to increased liking. Couples, whether same-sex or heterosexual, tend to fall within similar ranges of size, education, religious beliefs, values, and socioeconomic status.

Relationships are more likely to develop and be maintained to the extent that the partners share values and beliefs. Research has found that people tend to like and associate with others who share their age, education, race, religion, level of intelligence, and socioeconomic status. It has even been found that taller people tend to like other tall people, that happy people tend to like other happy people, and that people particularly enjoy others who have the same birthday and a similar sense of humor (Jones, Pelham, Carvallo, & Mirenberg, 2004; Pinel, Long, Landau, Alexander, & Pyszczynski, 2006). One classic study (Newcomb, 1961) arranged for male undergraduates, all strangers, to live together in a house while they were going to school. The men whose attitudes were similar during the first week ended up being friends, whereas those who did not initially share attitudes were significantly less likely to become friends.

Why Does Similarity Matter?

Similarity leads to attraction for a variety of reasons. For one, similarity makes things easier. You can imagine that if you only liked to go to action movies but your girlfriend or boyfriend only liked to go to foreign films, this would create difficulties in choosing an evening activity. Things would be even more problematic if the dissimilarity involved something even more important, such as your attitudes toward the relationship itself. Perhaps you want to have sex but your partner doesn't, or perhaps your partner wants to get married but you don't. These dissimilarities may go on to create real problems. Romantic relationships in which the partners hold different religious and political orientations or different attitudes toward important issues such as premarital sex, marriage, and child rearing are of course not impossible—but they are more complicated and take more effort to maintain.

In addition to being easier, relationships with those who are similar to us are also reinforcing. Imagine you are going to a movie with your very best friend. The movie begins, and you realize that you are starting to like it a lot. At this point, you might look over at your friend and wonder how they are reacting to it. One of the great benefits of sharing beliefs and values with others is that those others tend to react the same way to events as you do. Wouldn't it be painful if every time you liked a movie, your best friend hated it, and every time they liked it, you hated it? But you probably don't need to worry too much about this, because your friend is probably your friend in good part because they likes the same things you like. Sharing our values with others and having others share their values with us help us validate the worthiness of our self-concepts. Finding similarities with another makes us feel good and makes us feel that the other person will reciprocate our liking for them (Singh, Yeo, Lin, & Tan, 2007).

Status Similarity

We all naturally want to have friends and form relationships with people who have high status. We prefer to be with people who are healthy, attractive, wealthy, fun, and friendly. But our ability to attract such high-status partners is limited by the principles of social exchange. It is no accident that attractive people are more able to get dates with other attractive people, or that men with more money can attract more attractive women. The basic principles of social exchange and equity dictate that there will be general similarity in status among people in close relationships because attractiveness is a resource that allows people to attract other people with resources (Kalick & Hamilton, 1986; Lee, Loewenstein, Ariely, Hong, & Young, 2008). You can do the test for yourself. Go to a movie or a concert, and watch the couples who are together. You'll find that the attractive people are together, as are the less attractive ones. It seems surprising to us when one partner appears much more attractive than the other, and we may well assume that the less attractive partner is offering some type of (perhaps less visible) social status in return (this appears to be true no matter what sexual orientation folks adhere to).

There is still one other type of similarity that is important in determining whether a relationship will grow and continue, and it is also based on the principles of social exchange and equity. The finding is rather simple—we tend to prefer people who seem to like us about as much as we like them. Imagine, for instance, that you have met someone and you are hoping to pursue a relationship with them. You begin to give yourself to the relationship by opening up to the other person, telling them about yourself and making it clear that you would like to pursue a closer relationship. You make yourself available to spend time with the person and contact them regularly. You naturally expect the same type of behaviors in return, and if the partner does not return the openness and giving, the relationship is not going to go very far.

There is a clear moral to the importance of liking similarity, and it pays to remember it in everyday life. If we act toward others in a positive way, this expresses liking and respect for them, and the others will likely return the compliment. Being liked, praised, and even flattered by others is rewarding, and (unless it is too blatant and thus ingratiating) we can expect that others will enjoy it.

In sum, similarity is probably the most important single determinant of liking. Although we may sometimes prefer people who have different interests and skills from ours (Beach, Whitaker, Jones, & Tesser, 2001; Tiedens & Jimenez, 2003), when it comes to personality traits, it is similarity that matters—complementarity (being different from the other) just does not have much influence on liking.

Proximity

If I were to ask you who you might end up in a long-term relationship with (assuming you are not with someones already), I would guess that you'd respond with a list of the preferred personality traits or an image of your desired mate. You'd probably say something about being attractive, rich, creative, fun, caring, and so forth. And there is no question that such individual characteristics matter. But social psychologists realize that there are other aspects that are perhaps even more important. Consider this: You'll never be with someone that you never meet!

Although that seems obvious, it's also really important. There are about 7 billion people in the world, and you are only going to have the opportunity to meet a tiny fraction of those people before you choose a partner. This also means that you are likely to date someone who's pretty similar to you because, unless you travel widely, most of the people you meet are going to share your cultural background and therefore have some of the values that you hold. In fact, the person you partner with probably will live in the same city as you, attend the same college, take similar classes, and be pretty similar to you in most respects (Kubitschek & Hallinan, 1998).

Although meeting someone is an essential first step, simply being around another person also increases liking. People tend to become better acquainted with, and more fond of, each other when the social situation brings them into repeated contact. This is the basic principle of proximity liking. For instance, research has found that students who sit next to each other in class are more likely to become friends, and this is true even when the seating is assigned by the instructor (Back, Schmukle, & Egloff, 2008). Festinger, Schachter, and Back (1950) studied friendship formation in people who had recently moved into a large housing complex. They found not only that people became friends with those who lived near them but that people who lived nearer the mailboxes and at the foot of the stairway in the building (where they were more likely to come into contact with others) were able to make more friends than those who lived at the ends of the corridors in the building and thus had fewer social encounters with others.

Mere exposure refers to the tendency to prefer stimuli (including, but not limited to, people) that we have seen frequently. Consider the research findings presented in Figure 7.2 "Mere Exposure in the Classroom". In this study, Moreland and Beach (1992) had female confederates attend a large lecture class of over 100 students 5, 10, or 15 times or not at all during a semester. At the end of the term, the students were shown pictures of the confederates and asked to indicate if they recognized them and also how much they liked them. The number of times the confederates had attended class didn't influence the other students' recognition of them, but it did influence their liking for them. As predicted by the mere-exposure hypothesis, students who had attended more often were liked more.

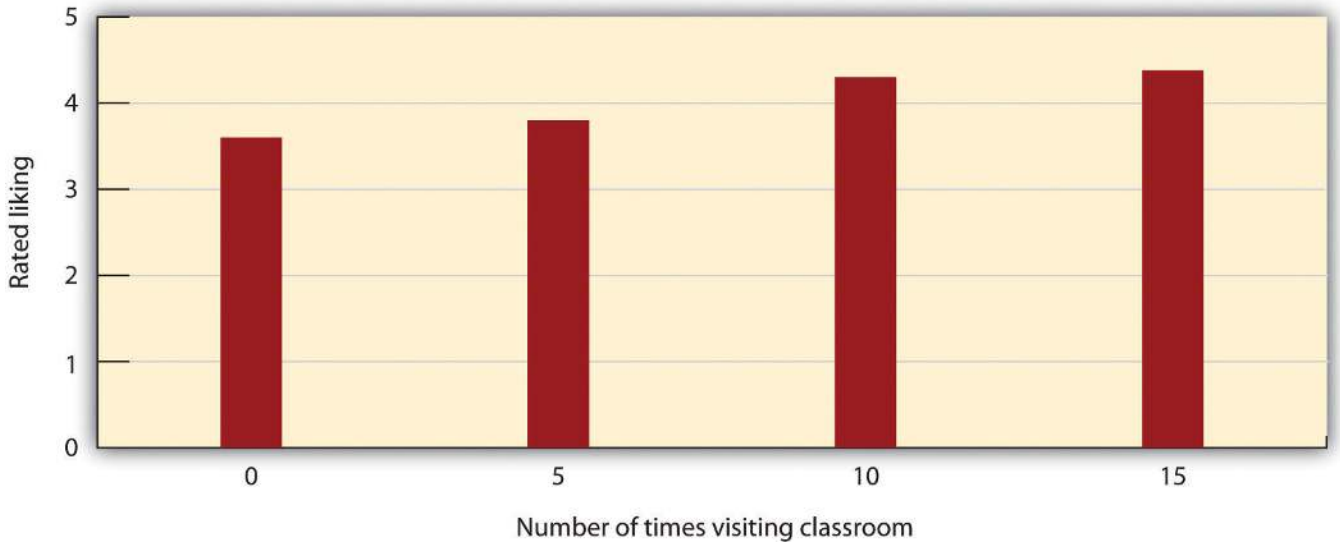

Figure 7.2 "Mere Exposure in the Classroom": Richard Moreland and Scott Beach had female confederates visit a class 5, 10, or 15 times or not at all over the course of a semester. Then the students rated their liking of the confederates. The mere-exposure effect is clear. Data are from Moreland and Beach (1992).

The effect of mere exposure is powerful and occurs in a wide variety of situations (Bornstein, 1989). Infants tend to smile at a photograph of someone they have seen before more than they smile at someone they are seeing for the first time (Brooks-Gunn & Lewis, 1981). And people have been found to prefer left-to-right reversed images of their own faces over their normal (nonreversed) face, whereas their friends prefer their regular face over the reversed one (Mita, Dermer, & Knight, 1977). This also is expected on the basis of mere exposure, since people see their own faces primarily in mirrors and thus are exposed to the reversed face more often.

Mere exposure may well have an evolutionary basis. Many people have an initial and potentially protective fear of the unknown, but as things become more familiar, they produce more positive feelings and seem safer (Freitas, Azizian, Travers, & Berry, 2005; Harmon-Jones & Allen, 2001). When the stimuli are people, there may well be an added effect—familiar people are more likely to be seen as part of the ingroup rather than the outgroup, and this may lead us to like them even more. Leslie Zebrowitz and her colleagues showed that we like people of our own race in part because they are perceived as familiar to us (Zebrowitz, Bronstad, & Lee, 2007).

It should be kept in mind that mere exposure only applies to the change that occurs when one is completely unfamiliar with another person (or object) and subsequently becomes more familiar with them. Thus mere exposure applies only in the early stages of attraction. Later, when we are more familiar with someone, that person may become too familiar and thus boring (some are experiencing this through the pandemic if they're with their partner 24/7!). You may have experienced this effect when you first bought some new songs and began to listen to them. Perhaps you didn't really like all the songs at first, but you found yourself liking them more and more as you played them more often. If this has happened to you, you have experienced mere exposure. But perhaps one day you discovered that you were really tired of the songs—they had become too familiar. You put the songs away for a while, only bringing them out later, when you found that liked them more again (they were now less familiar). People prefer things that have an optimal level of familiarity—neither too strange nor too well-known (Bornstein, 1989).

Affect and Attraction

Because our relationships with others are based in large part on emotional responses, it will come as no surprise to you to hear that affect is particularly important in interpersonal relationships. The relationship between mood and liking is pretty straightforward. We tend to like people more when we are in good moods and to like them less when we are in bad moods. This prediction follows directly from the expectation that affective states provide us with information about the social context—in this case, the people around us. Positive affect signals that it is safe and desirable to approach the other person, whereas negative affect is more likely to indicate danger and to suggest avoidance.

Moods are particularly important and informative when they are created by the person we are interacting with. When we find someone attractive, for instance, we experience positive affect, and we end up liking the person even more. However, mood that is

created by causes other than the other person can also influence liking. Alice Isen and her colleagues (Isen & Levin, 1972) created a variety of situations designed to put people in good moods. They had participants unexpectedly find a coin in a phone booth, played them some soothing music, or provided them a snack of milk and cookies at an experimental session. In each of these cases, the participants who had been provided with the pleasant experience indicated more positive mood in comparison with other participants who had not received the positive experience—and they also expressed more liking for other things and other people. The moral of the story is clear—if you want to get someone to like you, put them in a good mood. Furthermore, it is pretty easy to do so—simply bringing flowers, looking your best, or telling a funny joke might well be enough to be effective.

Arousal and Attraction

Although the relationship between mood and liking is very simple, the relationship between our current state of physiological arousal and liking is more complex. Consider an experiment by Gregory White and his colleagues (White, Fishbein, & Rutsein, 1981) in which the participants, male college students, were asked to complete a number of different tasks in a laboratory setting. In one part of the study, the men were asked to run in place for either a short time (15 seconds) or a longer time (120 seconds). Then the men viewed a videotape of either an attractive or an unattractive woman who was supposedly a sophomore at the college. In the video, she talked about her hobbies and career interests and indicated that she was interested in meeting people and did not have a boyfriend. The men, who thought that they would soon be meeting the woman, rated how romantically attracted they were to her.

Confirming that the experimental manipulation had created high and low levels of arousal, White and his colleagues found that the heart rate and other signs of physiological arousal were higher for the participants who had exercised longer. They did not find that the arousal created by running in place for 2 minutes increased or decreased liking directly, but they did find an interaction between arousal level and the attractiveness of the woman being judged. As you can see in the following figure, the men who had been aroused by running in place liked the attractive woman more and the unattractive woman less than the men who were less aroused.

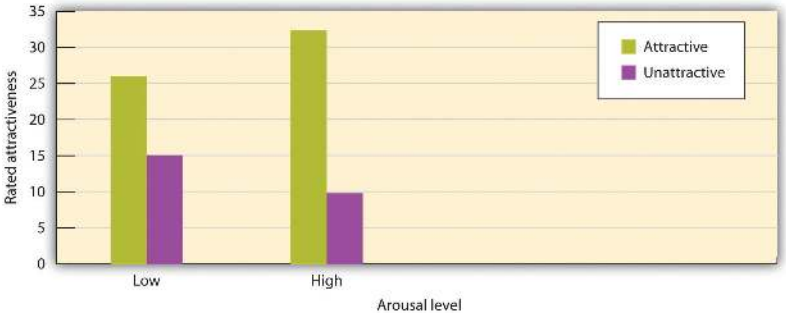

Figure 8.4: Arousal polarizes judgments. In this experiment, male college students rated an attractive or an unattractive woman after they had run in place for 15 seconds (low arousal) or for 120 seconds (high arousal). The judgments under arousal are polarized. Data are from White, Fishbein, and Rutstein (1981).

In another interesting field study, Dutton and Aron (1974) had an attractive young woman approach individual young men as they crossed a long, wobbly suspension bridge hanging over 200 feet above the Capilano River in British Columbia. The woman asked each man to help her fill out a questionnaire for a class project. When he had finished, she wrote her name and phone number on a piece of paper and invited him to call if he wanted to hear more about the project. Over half of the men who had been interviewed on the bridge later called her. In contrast, men who were approached on a low solid bridge by the same experimenter or who were interviewed on the suspension bridge by men called the woman significantly less frequently. One interpretation of this finding is that the men who were interviewed on the bridge were experiencing arousal as a result of being on the bridge but that they misattributed their arousal as liking the interviewer.

What these studies and many others like them demonstrate is that arousal polarizes liking (Foster, Witcher, Campbell, & Green, 1998). When we are aroused, everything seems more extreme. This effect is not unexpected because the function of arousal in emotion is to increase the strength of an emotional response. Love that is accompanied by arousal (sexual or otherwise) is stronger love than love that has a lower level of arousal. And our feelings of anger, dislike, or disgust are also stronger when they are accompanied by high arousal.

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As with mood states, arousal may sometimes come directly from the partner. Both very attractive and very unattractive people are likely to be more arousing than are people who are more average in attractiveness, and this arousal may create strong feelings of like or dislike. In other cases, the arousal may come from another source, such as from exercising, walking across a high bridge, or a roller-coaster ride.

The strong feelings that we experience toward another person that are accompanied by increases in arousal and sexual attraction are called passion, and the emotionally intense love that is based on passion is known as passionate love—the kind of love that we experience when we are first getting to know a romantic partner. Again, there is a clear take-home for you: If you like a person and think that the person likes you in return, and if you want to get that person to like you more, then it will be helpful to create some extra arousal in that person, perhaps by going to a scary movie, doing in-line skating, or even meeting for a workout at the gym. On the other hand, you need to be sure that the other person is initially positively inclined toward you. If not, arousing experiences could make matters even worse.

The Science of Attraction

Evidence for human mating preferences is, by its very nature, complicated. Who we choose for mates is affected by factors such as appearance, grooming, education, class, dancing ability and preferred sports team. However there is evidence that human mate choice might be linked to MHC genes. A number of experiments have suggested that human females prefer the scent of males who are dissimilar to them in MHC (Box 4). Moreover, women rank a man's scent as the most important factor (more important than sight, sound and feel) in mate choice. In a fascinating twist, one study has shown that people who share MHC genotypes choose similar perfumes, suggesting that perfume preferences might serve to amplify your MHC display.

The Stinky T-shirt Experiments

Human mate choices are complicated! Recent work has attempted to isolate females' preferences for male scents. In a typical experiment, men are asked to refrain, from smoking, sex, spicy foods, and from using any scented products during the study period. In addition, the men are asked to sleep in the same t-shirt for two or three days. Female participants then smell the t-shirts that have been stored in sealed plastic bags and rate the attractiveness of the smell.

On average, women rate the smell of the t-shirts of men whose MHC genotype was distinct from their own as significantly more pleasant than those with a similar MHC genotype. Interestingly, this trend only held up for women not taking oral contraceptives. A recent phenomenon is the interest in scent parties, in which people can rate the attractiveness of each other's t-shirts and then meet the person whose scent is interesting to them.

Hormones and Attraction

Because liking and loving are so central to human experience, they are determined in large part by fundamental human biological mechanisms. And one important determinant of our responses to others is the release of hormones. The one that is most directly involved in interpersonal attraction is oxytocin, a hormone that is important in female reproduction and that also influences social behaviors, including the development of long-term romantic attachments. Levels of oxytocin increase when mothers nurse their infants, and its presence helps mothers and infants bond (Feldman, Weller, Zagoory-Sharon, & Levine, 2007; Penton-Voak et al., 2003; Pedersen, 2006). But oxytocin also binds us to others in adult close relationships (Floyd, 2006). Oxytocin leads us to trust and cooperate with others (Kirsch et al., 2005; Kosfeld, Heinriches, Zak, Fischbacker, & Fehr, 2005) and, particularly, to respond positively to others who are members of our ingroups. The experience of romantic love is also associated with the release of oxytocin (Gonzaga, Turner, Keltner, Campos, & Altemus, 2006).

The hormones that are released during the female menstrual cycle influence women's attraction to men. Women become more attracted to men, especially to those with symmetrical and particularly masculine characteristics, during the times in their menstrual cycles when they are most likely to become pregnant (Gangestad, Thornhill, & Garver-Apgar, 2005; Pillsworth & Haselton, 2006). It is likely that these preferences were selected evolutionarily because the men who have these characteristics are also more genetically fit (Johnston, Hagel, Franklin, Fink, & Grammer, 2001; Pawlowski & Jasienska, 2005).

The male sex hormone testosterone also relates to liking, but particularly for passionate love. Testosterone is related to an increased sex drive in both men and women. However, over the long term, testosterone does not help people stay together. In comparison with men who are in short-term sexual relationships, those in long-term relationships have relatively lower levels of testosterone, and people who are married have lower levels of testosterone in comparison with people who are single (Dabbs & Dabbs, 2000; Gray et al., 2004).

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Key Takeaways

- Particularly in initial encounters, people are strongly influenced by the physical attractiveness of the other person.
- We prefer people who are young, who have symmetrical facial features and bodies, and who appear average. These preferences may be because these features suggest to us that the person is healthy.
- Although men and women agree on many aspects of what they find attractive, women are relatively more focused on the social status of their romantic partners, whereas men are more focused on the youth and attractiveness of their partners.
- We tend to like people who share our values and beliefs, both because similarity makes things easier and because similarity reinforces our own values and beliefs.
- Proximity and the principle of mere exposure are two important determinants of interpersonal attraction.
- We tend to like people more when we are in good moods.
- Our current state of physiological arousal tends to polarize our liking.
- Science sheds some insights into attraction, but there's still a lot more to learn.

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HeroicImaginationTV. (2011). The Halo Effect. https://www.youtube.com/watch?v=UEho_4ejkNw

SciShow Psych. (2017). Misattribution: How we mistake fear for love. https://www.youtube.com/watch?v=EqhXH2TsN9U

TED-Ed. (2014).The science of attraction – Dawn Maslar. https://www.youtube.com/watch?v=169N81xAffQ

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1.8: Sexual Response and the Biochemistry of Love 1.8: Sexual Response and the Biochemistry of LoveEdit Update titlecancel

Learning Objectives

- Consider intersectionality as it applies to individual's sexual responses
- Explore the role of brain and hormonal mechanisms in sexual response, as well as sensation & perception
- Distinguish between hormones and pheromones
- Describe the seminal work of Master's & Johnson's EPOR model of sexual response
- Compare other theories of sexual response, including Kaplan, Basson & the Dual Control approach
- Analyze the concept of love with emerging research on evolution & physiology
- Explore the importance of oxytocin in social interactions

Introduction

If you remember (or go back and revisit) the "Circles of Sexuality" model from Chapter 1, you will see that sensuality plays a key role in our sexuality. Sensuality is also interconnected with intimacy, sexual identity, sexual health and reproduction, and sexualization. Let's take a closer look at the sensual aspect of sexuality by analyzing physiological responses while also seeing the whole picture in which many interlocking parts are influencing the way individuals make meaning out of their physical, bodily experiences. The changes to brain chemistry, the hormones that rush through the bloodstream, the sensory neurons behind that electric and tingling feeling of intimate touch, the role of erogenous zones in enhancing pleasure, and the pheromones that we put off that are picked up without conscious awareness by others will be explored. The psychological interpretation of the physical changes that are happening during arousal and orgasm are also influenced by society, culture, and personal perspective that can alter the way that meaning is made out of these experiences. The biochemistry of love will be discussed in which heartbreak and the epigenetic and healing effects of oxytocin will be explored.

Sexual Response

Sexual response is both biological and based on socialization factors. Each individual person has a natural degree to which they become aroused in response to sexual stimuli similar to how some people react more intensely to loud sounds or have a low to high pain tolerance. Life experiences across the lifespan continue to influence and change these as well. Individual differences in how sexual stimuli are experienced will influence the degree of desire to engage in certain sexual behaviors. Social factors, such as shame and stigma around certain sexual behaviors, can also influence this process by reworking the way that touch and sexual contact are perceived. In this section, we will look at different aspects of the nervous system that are implicated in this process, explore the groundbreaking Masters and Johnson research on the sexual response cycle, and discuss additional theories that have been developed over time that explore the ways the social environment interacts with sensory experiences.

Sex on the Brain

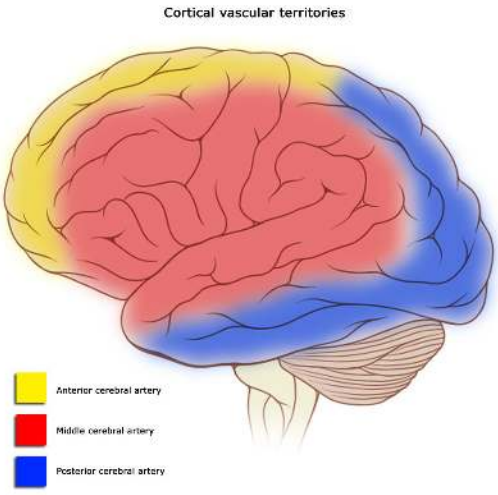

Figure 3: Some of the many regions of the brain and brainstem activated during pleasure experiences. [Image: Frank Gaillard, https://goo.gl/yCKuQ2, CC-BY-SA 3.0. Identifying marks added]

At first glance—or touch for that matter—the clitoris and penis are the parts of our anatomies that seem to bring the most pleasure. However, these two organs pale in comparison to our central nervous system's capacity for pleasure. Extensive regions of the brain and brainstem are activated when a person experiences pleasure, including: the insula, temporal cortex, limbic system, nucleus accumbens, basal ganglia, superior parietal cortex, dorsolateral prefrontal cortex, and cerebellum (see Figure 3, Ortigue et al., 2007). Neuroimaging techniques show that these regions of the brain are active when patients have spontaneous orgasms involving no direct stimulation of the skin (e.g., Fadul et al., 2005) and when experimental participants self-stimulate erogenous zones (e.g., Komisaruk et al., 2011). Erogenous zones are sensitive areas of skin that are connected, via the nervous system, to the somatosensory cortex in the brain.

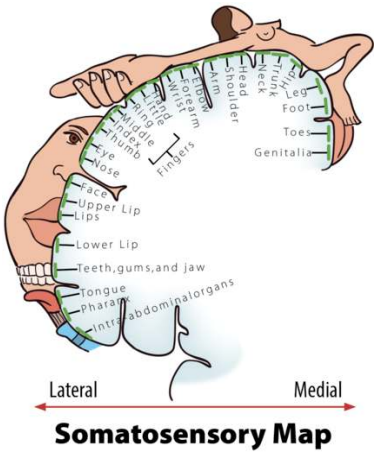

Figure 4: Erogenous Zones Mapped on the Somatosensory Cortex.

The somatosensory cortex (SC) is the part of the brain primarily responsible for processing sensory information from the skin. The more sensitive an area of your skin is (e.g., your lips), the larger the corresponding area of the SC will be; the less sensitive an area of your skin is (e.g., your trunk), the smaller the corresponding area of the SC will be (see Figure 4, Penfield & Boldrey, 1937). When a sensitive area of a person's body is touched, it is typically interpreted by the brain in one of three ways: "That tickles!" "That hurts!" or, "That…you need to do again!" Thus, the more sensitive areas of our bodies have greater potential to evoke pleasure. A study by Nummenmaa and his colleagues (2016) used a unique method to test this hypothesis. The Nummenmaa research team showed experimental participants images of same- and opposite-sex bodies. They then asked the participants to color the regions of the body that, when touched, they or members of the opposite sex would experience as sexually arousing while masturbating or having sex with a partner. Nummenmaa found the expected "hotspot" erogenous zones around the external sex organs, breasts, and anus, but also reported areas of the skin beyond these hotspots: "[T]actile stimulation of practically all bodily regions trigger sexual arousal…." Moreover, he concluded, "[H]aving sex with a partner…"—beyond the hotspots—"…reflects the role of touching in the maintenance of…pair bonds."

Sensation and Perception

Sensation is the way the nervous system, such as different areas of the brain, processes sensory information from the environment, such as light, sound, smell, and touch/pain. Let's take a look at touch in the context of sensual contact by explaining the process of transduction–receptors in the skin relay the message of being touched to transmitters in the spinal cord that converts this to neural signals interpreted by the brain which then allows effectors, neurons within muscles, to signal a response to the stimuli, such as by jerking away the hand when something is hot. Perception is how an individual associates meaning with what they are sensing. For instance, masturbation will cause the genital's skin receptor sites and nervous system to respond to this sensation producing arousal; however, the self-talk regarding the morality of masturbation will impact the way the person perceives the arousal. Pay attention to the way that stigma and shame around pleasure and sensuality have influenced the way you attach meaning to your physiological experiences.

Exploring your erogenous zones: What areas of your body feel particularly pleasurable to the touch? Some common areas, apart from the genitals, are the lower back, inner thighs, lips, nipples, feet, hands, and more! Each individual will have specific areas so explore this question with your sexual partners as well.

Sensate focus is sometimes utilized within sex therapy to increase control over physiological responses and to provide insight into sexual partners' pleasure points in addition to one's own without touching or stimulating the genitals. Anxiety is experienced by many individuals as being sensual can feel very vulnerable and scary. Sensate focus uses aspects of cognitive-behavioral therapy and behavioral modification to focus on the senses and alter the meaning that has been associated with sexual interactions. Check out this article on sensate focus techniques from Cornell University (2019). These techniques can be utilized by anyone who is interested and can enhance sexual pleasure through increasing self-awareness and communication focused on pleasure with partners.

Hormones and Pheromones

Androgens, estrogen, and progestin bind to hormone receptor sites that allow the synthesis of neurochemicals (Hyde & DeLamater, 2017). During excitement and arousal, dopamine, oxytocin, and norepinephrine are released into the bloodstream, and during orgasm, opioids and endocannabinoids are released (Hyde & DeLamater, 2017). Hormones have activating effects in which they can activate and deactivate sexual arousal. Testosterone is particularly implicated in increasing desire for sex. Too high or too low of testosterone reduces desire. Intense emotions increase sexual arousal such as happiness, anger, anxiety, sadness, etc. because of their physiological impacts on our endocrine and nervous systems. For instance, sex and aggression both involve the hormones epinephrine and norepinephrine (which are also neurotransmitters) as they invoke a sense of excitement then resolution. This connection between emotions and our physiological reactions is a growing focus within research (Hyde & DeLamater, 2017).

While hormones are typically released within the bloodstream and influence sexual arousal, pheromones are biochemicals secreted outside the body that communicate to others on a chemical level about hormonal levels and ovulation which subconsciously attracts us to them based on our own body's chemistry (Hyde & DeLamater, 2017). Researchers are still trying to understand the role of pheromones in sexual responses, but what is known is that when people are presented with the scent of others they are typically more attracted to the smell of someone in a way that matches with their sexual orientation even without any other information provided (Savic, 2014). Additionally, the scent of people who are biologically related is rated as less attractive and possibly connects to evolution protecting against unintentional incest (Savic, 2014). Animal studies on male monkeys indicate that they experience increases in testosterone when exposed to an ovulating female's urine (Hyde & DeLamater, 2017). Pheromones are believed to influence the hormones in others and this can be seen by women's menstrual cycles syncing up when they spend a lot of time with each other as well. This further showcases how interconnected humans are with one another biologically in addition to socially.

Theories and Models Regarding Sexual Response

Masters and Johnson

Although people have always had sex, the scientific study of it has remained taboo until relatively recently. In fact, the study of sexual anatomy, physiology, and behavior wasn't formally undertaken until the late 19th century, and only began to be taken seriously as recently as the 1950's. Notably, William Masters (1915-2001) and Virginia Johnson (1925-2013) formed a research team in 1957 that expanded studies of sexuality from merely asking people about their sex lives to measuring people's anatomy and physiology while they were actually having sex. Masters was a former Navy lieutenant, married father of two, and trained gynecologist with an interest in studying prostitutes. Johnson was a former country music singer, single mother of two, three-time divorcee, and two-time college dropout with an interest in studying sociology. And yes, if it piques your curiosity, Masters and Johnson were lovers (when Masters was still married); they eventually married each other, but later divorced. Despite their colorful private lives they were dedicated researchers with an interest in understanding sex from a scientific perspective.

Masters and Johnson used primarily plethysmography (the measuring of changes in blood- or airflow to organs) to determine sexual responses in a wide range of body parts—breasts, skin, various muscle structures, bladder, rectum, external sex organs, and lungs—as well as measurements of people's pulse and blood pressure. They measured more than 10,000 orgasms in 700 individuals (18 to 89 years of age), during sex with partners or alone. Masters and Johnson's findings were initially published in two best-selling books: Human Sexual Response, 1966, and Human Sexual Inadequacy, 1970. Their initial experimental techniques and data form the bases of our contemporary understanding of sexual anatomy and physiology.

Physiology and the Sexual Response Cycle

The brain and other sex organs respond to sexual stimuli in a universal fashion known as the sexual response cycle (SRC; Masters & Johnson, 1966). The SRC is composed of four phases:

1. Excitement: Activation of the sympathetic branch of the autonomic nervous system defines the excitement phase; heart rate and breathing accelerates, along with increased blood flow to the penis, vaginal walls, clitoris, and nipples (vasocongestion). Involuntary muscular movements (myotonia), such as facial grimaces, also occur during this phase.
2. Plateau: Blood flow, heart rate, and breathing intensify during the plateau phase. During this phase, often referred to as "foreplay," females experience an orgasmic platform—the outer third of the vaginal walls tightening—and males experience a release of pre-seminal fluid containing healthy sperm cells (Killick et al., 2011). This early release of fluid makes penile withdrawal a relatively ineffective form of birth control (Aisch & Marsh, 2014). (Question: What do you call a couple who use the withdrawal method of birth control? Answer: Parents.)
3. Orgasm: The shortest but most pleasurable phase is the orgasm phase. After reaching its climax, neuromuscular tension is released and the hormone oxytocin floods the bloodstream—facilitating emotional bonding. Although the rhythmic muscular contractions of an orgasm are temporally associated with ejaculation, this association is not necessary because orgasm and ejaculation are two separate physiological processes.
4. Resolution: The body returns to a pre-aroused state in the resolution phase. Most males enter a refractory period of being unresponsive to sexual stimuli. The length of this period depends on age, frequency of recent sexual relations, level of intimacy with a partner, and novelty. Because most females do not have a refractory period, they have a greater potential—physiologically—of having multiple orgasms.

Of interest to note, the SRC occurs regardless of the type of sexual behavior—whether the behavior is masturbation; romantic kissing; or oral, vaginal, or anal sex (Masters & Johnson, 1966). Further, a partner or environmental object is sufficient, but not necessary, for the SRC to occur.

Kaplan's Triphasic Model

Helen Singer Kaplan was a sex therapist seeking a model that would aid her in explaining the sexual response cycle to her clients. Kaplan adjusted Masters and Johnsons' model by adding the desire phase and reduced excitement and plateau to just the excitement phase in which she focused on vasocongestion occurring. By focusing on the psychological and physiological processes more than trying to separate these experiences, her model became:

1. Desire: Desire activates excitement and excitement can cause desire, motivating a person toward sexual activity. This phase is psychological while the next two are physiological.
2. Arousal: Vasocongestion causes blood to flow to the genitals and increase in blood pressure and is controlled by the parasympathetic division of the autonomic nervous system (Hyde & DeLamater, 2017, p. 191)
3. Orgasm: Reflex muscular contractions also involve anatomical structures and are connected to the nervous system. The ejaculation reflex can be controlled whereas the erection reflex typically cannot. Ejaculation and orgasm are controlled by the sympathetic division of the autonomic nervous system in order to return the body to homeostasis.

Unfortunately, Kaplan's model did not seem to reflect women's experience (Lieblum, 2000). Many women never experience spontaneous desire and for those who do, it does not always lead to sexual engagement or arousal. Furthermore, for many people, arousal occurs before desire. Finally, Kaplan's model didn't address sexual satisfaction (though her clinical work was built on that).

Basson's Nonlinear Approach to Sexual Response

In response to to Masters & Johnson, linear model (where there is a start, a middle, and a finish line) and Kaplan's incomplete model, Rosemary Basson articulated a more complex, circular model of sexual response. Basson's circular diagram shows how sex is cyclical: desire often comes in response to something else, like a touch or an erotic conversation. If the sex is hot, even the fading memory of it could become motivation for more sex/arousal later on. Finally, sexual encounters don't have to end with a mutual orgasm. They end with satisfaction, however a couple defines that, whether that's five orgasms or none.

While this model was first conceptualized with female sexuality in mind, it's applicable to all.

The Dual Control Model

This model was developed by former Kinsey Institute director Dr. John Bancroft and Dr. Erick Janssen in the late 1990s. It "proposes that two basic processes underlie human sexual response: excitation (responding with arousal to sexual stimuli) and inhibition (inhibiting sexual arousal)" (Hyde & DeLamater, 2017, p. 191). We have evolutionarily developed an inhibition aspect to the sexual response process to protect us from dying. Imagine you are in the middle of having sex and a dinosaur begins to run at you. Survival requires the ability to inhibit sexual arousal to focus on getting away to safety. Or, perhaps a more realistic example

could be masturbating in the privacy of a bedroom when there is a sudden knock on the door and mom saying she is coming in. Mom is not a dinosaur but she is going to have that same inhibiting impact.

This perspective also explores the reason why some people may be more easily aroused by sexual stimuli while others may be less impacted. Every person has their own degree of excitation and inhibition similar to how each person has different tolerances for loud sounds or pain. If a person has high excitation and low inhibition, it may be easier for them to become aroused and take more time to return to homeostasis. Touch and sensations may be heightened and they may require less stimulation to reach orgasm. On the other hand, if someone has low excitation and high inhibition, sexual stimuli may be less arousing and they may require a broader range of sensual stimulation to achieve orgasm. Excitation and inhibition are negatively correlated with one another because as one increases the other decreases.

We are genetically predisposed to having a certain combination of sexual excitation and inhibition. However, the dual control model also recognizes that there are cognitive factors shaping this process. Our experiences impact the interpretation of the senses and can cause heightened distress or increased tolerance. Early learning and culture can then drastically shape someone's excitation and inhibition combination. Many researchers liken it to having both a gas pedal (excitation or SES) and a brake pedal (inhibition or SIS) in a car – people will often engage one or both pedals to a differing degree in any particular sexual situation, depending on their unique sexual physiology, history, and personality.

In thinking about intersecting identities, how could generation, physical health, mental health, religion, education, family background, financial resources, body image, and more influence excitation and inhibition? What messages about various sexual behaviors have you internalized, and how might this influence your neurological sexual response? Having a conversation with your partners about their degree of excitation and inhibition can be helpful to know in relation to your own as well.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://openoregon.pressbooks.pub/introtohumansexuality/?p=78#oembed-1

The Biochemistry of Love

Love is deeply biological. It pervades every aspect of our lives and has inspired countless works of art. Love also has a profound effect on our mental and physical state. A "broken heart" or a failed relationship can have disastrous effects; bereavement disrupts human physiology and may even precipitate death. Without loving relationships, humans fail to flourish, even if all of their other basic needs are met. As such, love is clearly not "just" an emotion; it is a biological process that is both dynamic and bidirectional in several dimensions. Social interactions between individuals, for example, trigger cognitive and physiological processes that influence emotional and mental states. In turn, these changes influence future social interactions. Similarly, the maintenance of loving relationships requires constant feedback through sensory and cognitive systems; the body seeks love and responds constantly to interactions with loved ones or to the absence of such interactions. The evolutionary principles and ancient hormonal and neural systems that support the beneficial and healing effects of loving relationships are described here.

Introduction to the Study of Love

Although evidence exists for the healing power of love, only recently has science turned its attention to providing a physiological explanation for love. The study of love in this context offers insight into many important topics, including the biological basis of interpersonal relationships and why and how disruptions in social bonds have such pervasive consequences for behavior and physiology. Some of the answers will be found in our growing knowledge of the neurobiological and endocrinological mechanisms of social behavior and interpersonal engagement.

The evolution of social behavior

Nothing in biology makes sense except in the light of evolution. Life on earth is fundamentally social: The ability to dynamically interact with other living organisms to support mutual homeostasis, growth, and reproduction evolved very early. Social interactions are present in primitive invertebrates and even among prokaryotes: Bacteria recognize and approach members of their own species. Bacteria also reproduce more successfully in the presence of their own kind and are able to form communities with physical and chemical characteristics that go far beyond the capabilities of the individual cell (Ingham & Ben-Jacob, 2008).

The evolutionary pathways that led from reptiles to mammals allowed the emergence of the unique anatomical systems and biochemical mechanisms that enable social engagement and selectively reciprocal sociality. Reptiles show minimal parental investment in offspring and form nonselective relationships between individuals. Pet owners may become emotionally attached to their turtle or snake, but this relationship is not reciprocal. In contrast, most mammals show intense parental investment in offspring and form lasting bonds with their children. Many mammalian species—including humans, wolves, and prairie voles—also develop

long-lasting, reciprocal, and selective relationships between adults, with several features of what humans experience as "love." In turn, these reciprocal interactions trigger dynamic feedback mechanisms that foster growth and health.

What is love? An evolutionary and physiological perspective

Human love is more complex than simple feedback mechanisms. Love may create its own reality. The biology of love originates in the primitive parts of the brain—the emotional core of the human nervous system—which evolved long before the cerebral cortex. The brain "in love" is flooded with vague sensations, often transmitted by the vagus nerve, and creating much of what we experience as emotion. The modern cortex struggles to interpret love's messages, and weaves a narrative around incoming visceral experiences, potentially reacting to that narrative rather than to reality. It also is helpful to realize that mammalian social behavior is supported by biological components that were repurposed or co-opted over the course of mammalian evolution, eventually permitting lasting relationships between adults.

Stress and love

Emotional bonds can form during periods of extreme duress, especially when the survival of one individual depends on the presence and support of another. There also is evidence that oxytocin is released in response to acutely stressful experiences, perhaps serving as hormonal "insurance" against overwhelming stress. Oxytocin may help to ensure that parents and others will engage with and care for infants; develop stable, loving relationships; and seek out and receive support from others in times of need.

The absence of love in early life can be detrimental to mental and physical health

During early life in particular, trauma or neglect may produce behaviors and emotional states in humans that are socially pathological. Because the processes involved in creating social behaviors and social emotions are delicately balanced, these be may be triggered in inappropriate contexts, leading to aggression toward friends or family. Alternatively, bonds may be formed with prospective partners who fail to provide social support or protection.

Loving relationships in early life can have epigenetic consequences

Love is "epigenetic." That is, positive experiences in early life can act upon and alter the expression of specific genes. These changes in gene expression may have behavioral consequences through simple biochemical changes, such as adding a methyl group to a particular site within the genome (Zhang & Meaney, 2010). It is possible that these changes in the genome may even be passed to the next generation.

Although we are all born with a finite set of genes, experiences in childhood will cause some genes to express themselves (e.g., encourage certain personality traits), while other genes will remain dormant.

Social behaviors, emotional attachment to others, and long-lasting reciprocal relationships also are both plastic and adaptive, and so is the biology upon which they are based. For example, infants of traumatized or highly stressed parents might be chronically exposed to vasopressin, either through their own increased production of the peptide, or through higher levels of vasopressin in maternal milk. Such increased exposure could sensitize the infant to defensive behaviors or create a lifelong tendency to overreact to threat. Based on research in rats, it seems that in response to adverse early experiences of chronic isolation, the genes for vasopressin receptors can become upregulated (Zhang et al., 2012), leading to an increased sensitivity to acute stressors or anxiety that may persist throughout life.

Epigenetic programming triggered by early life experiences is adaptive in allowing neuroendocrine systems to project and plan for future behavioral demands. But epigenetic changes that are long-lasting also can create atypical social or emotional behaviors (Zhang & Meaney, 2010) that may be especially likely to surface in later life, and in the face of social or emotional challenges.

Exposure to exogenous hormones in early life also may be epigenetic. For example, prairie voles treated postnatally with vasopressin (especially males) were later more aggressive, whereas those exposed to a vasopressin antagonist showed less aggression in adulthood. Conversely, in voles the exposure of infants to slightly increased levels of oxytocin during development increased the tendency to show a pair bond. However, these studies also showed that a single exposure to a higher level of oxytocin in early life could disrupt the later capacity to pair bond (Carter et al., 2009).

There is little doubt that either early social experiences or the effects of developmental exposure to these neuropeptides holds the potential to have long-lasting effects on behavior. Both parental care and exposure to oxytocin in early life can permanently modify hormonal systems, altering the capacity to form relationships and influence the expression of love across the life span. Our

preliminary findings in voles further suggest that early life experiences affect the methylation of the oxytocin receptor gene and its expression (Connelly, Kenkel, Erickson, & Carter, 2011). Thus, we can plausibly argue that love is epigenetic.

The absence of social behavior or isolation also has consequences for the oxytocin system

Given the power of positive social experiences, it is not surprising that a lack of social relationships also may lead to alterations in behavior as well as changes in oxytocin and vasopressin pathways. We have found that social isolation reduced the expression of the gene for the oxytocin receptor, and at the same time increased the expression of genes for the vasopressin peptide. In female prairie voles, isolation also was accompanied by an increase in blood levels of oxytocin, possibly as a coping mechanism. However, over time, isolated prairie voles of both sexes showed increases in measures of depression, anxiety, and physiological arousal, and these changes were observed even when endogenous oxytocin was elevated. Thus, even the hormonal insurance provided by endogenous oxytocin in face of the chronic stress of isolation was not sufficient to dampen the consequences of living alone. Predictably, when isolated voles were given additional exogenous oxytocin, this treatment did restore many of these functions to normal (Grippo, Trahanas, Zimmerman, Porges, & Carter, 2009).

In modern societies, humans can survive, at least after childhood, with little or no human contact. Communication technology, social media, electronic parenting, and many other recent technological advances may reduce social behaviors, placing both children and adults at risk for social isolation and disorders of the autonomic nervous system, including deficits in their capacity for social engagement and love (Porges, 2011).

Social engagement actually helps us to cope with stress. The same hormones and areas of the brain that increase the capacity of the body to survive stress also enable us to better adapt to an ever-changing social and physical environment. Individuals with strong emotional support and relationships are more resilient in the face of stressors than those who feel isolated or lonely. Lesions in various bodily tissues, including the brain, heal more quickly in animals that are living socially versus in isolation (Karelina & DeVries, 2011). The protective effects of positive sociality seem to rely on the same cocktail of hormones that carries a biological message of “love” throughout the body.

Can love—or perhaps oxytocin—be a medicine?

Although research has only begun to examine the physiological effects of these peptides beyond social behavior, there is a wealth of new evidence showing that oxytocin can influence physiological responses to stress and injury. As only one example, the molecules associated with love have restorative properties, including the ability to literally heal a “broken heart.” Oxytocin receptors are expressed in the heart, and precursors for oxytocin appear to be critical for the development of the fetal heart (Danalache, Gutkowska, Slusarz, Berezowska, & Jankowski, 2010). Oxytocin exerts protective and restorative effects in part through its capacity to convert undifferentiated stem cells into cardiomyocytes. Oxytocin can facilitate adult neurogenesis and tissue repair, especially after a stressful experience. We now know that oxytocin has direct anti-inflammatory and antioxidant properties in in vitro models of atherosclerosis (Szeto et al., 2008). The heart seems to rely on oxytocin as part of a normal process of protection and self-healing. Researchers are interested in the medical/therapeutic potential of oxytocin.

Thus, oxytocin exposure early in life not only regulates our ability to love and form social bonds, it also affects our health and well-being. Oxytocin modulates the hypothalamic–pituitary adrenal (HPA) axis, especially in response to disruptions in homeostasis (Carter, 1998), and coordinates demands on the immune system and energy balance. Long-term, secure relationships provide emotional support and down-regulate reactivity of the HPA axis, whereas intense stressors, including birth, trigger activation of the HPA axis and sympathetic nervous system. The ability of oxytocin to regulate these systems probably explains the exceptional capacity of most women to cope with the challenges of childbirth and childrearing.

Dozens of ongoing clinical trials are currently attempting to examine the therapeutic potential of oxytocin in disorders ranging from autism to heart disease. Of course, as in hormonal studies in voles, the effects are likely to depend on the history of the individual and the context, and to be dose-dependent. As this research is emerging, a variety of individual differences and apparent discrepancies in the effects of exogenous oxytocin are being reported. Most of these studies do not include any information on the endogenous hormones, or on the oxytocin or vasopressin receptors, which are likely to affect the outcome of such treatments.

Research in this field is new and there is much left to understand. However, it is already clear that both love and oxytocin are powerful. Of course, with power comes responsibility. Although research into mechanisms through which love—or hormones such as oxytocin—may protect us against stress and disease is in its infancy, this knowledge will ultimately increase our understanding of the way that our emotions impact upon health and disease. The same molecules that allow us to give and receive love also link our need for others with health and well-being.

Conclusion

In this section, we've discussed historical and emerging approaches to sexual response. An important take-away to this section is that sexual responsiveness isn't simply physiological: Psychological factors are also present. At the same time, biology matters and consideration for hormonal and neurological information can be important in our sexual experiences. Keeping an intersectional lens can be a helpful way of learning, evaluating and growing in your own sexual responses.

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1.9: Sexual Behaviors (and Safer Sex) 1.9: Sexual Behaviors (and Safer Sex)Edit Update titlecancel

Learning Objectives

- Demonstrate an understanding of the range of options for sexual expression
- Analyze relationship boundaries in order to express wants, desires, limits, and consent
- Summarize how people might appraise (make sense of) sexual behaviors differently (i.e. some may perceive negative associations whereas others may experience positive associations)
- Explore the benefits of sexual behaviors physically, emotionally and socially as well as understand how sexual behavior influences identity development

Introduction to Sexual Behavior

When we first discussed research and human sexuality, you may remember reading about the National Survey of Sexual Health and Behavior (NSSHB), which is the largest nationally representative survey focused on understanding sex in the United States. With more than 20,000 respondents, ranging in age from 14 to 102, the NSSHB yields incredible data regarding American sexual behaviors. In one of the initial data collections (data has been collected in 2009, 2012, 2013, 2014, 2015, 2016, and 2018), Americans reported 41 different combinations of sex acts during their most recent sexual encounter (Herbernick, et al., 2010). That's a fair amount of sexual behavior happening!

While we have a lot of unique types of sexual behavior happening, actually defining sex is a bit daunting. When researchers asked college students what constituted as sex, their replies were varied (Lehmiller, 2016).

https://www.sexandpsychology.com/blog/2016/1/10/infographic-how-do-college-students-define-sex/

A subsequent follow-up study asked medical students what constituted sex and the findings were similar (though, thankfully, both penile-vagina penetration AND anal sex were considered sex; Talley, Cho, Strassberg, & Rullo, 2016, as cited in Lehmiller, 2021). Perhaps the biggest take-away from both of these studies is that definitions of what is sex vary. Additionally, sexual variation is very much a part of the human, sexual experience.

Just as we may wonder what characterizes particular gender or sexual orientations as "normal," we might have similar questions about sexual behaviors. What is considered sexually "normal" likely depends on culture. Some cultures are sexually-restrictive—such as one extreme example off the coast of Ireland, studied in the mid-20th century, known as the island of Inis Beag. The inhabitants of Inis Beag detested nudity and viewed sex as a necessary evil for the sole purpose of reproduction. They wore clothes when they bathed and even while having sex. Further, sex education was nonexistent, as was breast feeding (Messenger, 1989). By contrast, Mangaians, of the South Pacific island of A'ua'u, are an example of a highly sexually-permissive culture. Young Mangaian boys are encouraged to masturbate. By age 13, they're instructed by older males on how to sexually perform and maximize orgasms for themselves and their partners. When the boys are a bit older, this formal instruction is replaced with hands-on coaching by older females. Young girls are also expected to explore their sexuality and develop a breadth of sexual knowledge before marriage (Marshall & Suggs, 1971). These cultures make clear that what are considered sexually normal behaviors depends on time and place.

With cultural context in mind, how do you think American culture impacts your own definition of sexual behavior?

Sexual Scripts

A script is what actors read or study and what guides their behavior in a certain role. A script is a blueprint for what we "should do" in our roles. Sexual scripts are blueprints and guidelines for what we define as our role in sexual expression, sexual orientation, sexual behaviors, sexual desires, and the sexual component of our self-definition. All of us are sexual beings, yet none of us is exactly identical to another in our sexual definitions and script expectations. Having said that, keep in mind that we are not just born with sexual scripts in place; they are learned. Sexual socialization is the process by which we learn how, when, where, with whom, why, and with which motivations we are sexual beings.

We are all born with drives, which are biological needs that demand our attention and behavioral responses to them. The most powerful drives are circulation, breathing, voiding our urine and other waste, eating, drinking, sleeping, and sexual involvement. Sexual drives are biological urges to participate in sexual activity and in certain sexual roles. Sexual scripts, once learned, will

shape how that drive is answered. Sexuality is learned via culture and socialization. There are as many unique sexual scripts as there are people, yet some of these scripts have common themes and can be viewed as a collective pattern or trend in the larger social level.

Many of us learn our sexual scripts in a passive way. In other words, we don't learn from experience, but from a synthesis of concepts, images, ideals, and sometimes misconceptions. For example, the commonly held belief that men and women are two different creatures, perhaps even from different planets, was a very successful fad in recent years that led an entire generation to believe that men might be from "Mars" while women might be from "Venus."

Today more and more people living in the U.S. have less religious values and more diverse experiences with sexuality. Further, much of the younger generations' focus on sex is on the orgasm. An orgasm is the sexual climax that accompanies sexual intercourse and includes muscle tightening in the genital area, electrical sensations radiating from the genitals, and a surge of a variety of pleasure-producing hormones throughout the body. Many cultures have records of sexual expression and some even have records of sexual pleasure maximization.

Some traditional sexual scripts that have been studied include a number of problematic assumptions. Some of these assumptions include but are not limited to: the man must be in charge, the woman must not enjoy (or let on that she enjoys) the sexual experience, the man is a performer whose skills are proven effective upon arrival of his partner's orgasm, men are sexual while women are not, women can't talk about it and turn to men for sexual interests and direction, and finally sex always leads to a female orgasm (her orgasm being proof of his sexual capacity). Numerous studies have shown that most of these traditional scripts are not realistic, healthy, conducive to open communication, nor negotiation of sexual needs and desires for couples. In sum, rather, these traditional notions can be an undermining influence in a couple's intimacy. Scripts that are more contemporary include these simple ideas:

1. Both partners need to learn to take ownership of the couple's sexual experiences.
2. Both partners need to learn to communicate openly and honestly about their feelings.
3. Both partners need to learn to meet one another's desires, needs, and wishes while making sure that their own needs are being met.

Solitary Activities

Fantasies

Sexual behaviors are linked to, but distinct from, fantasies. And, while this category is classified as a "solitary" activity (something you may do or use alone), it's also typical for people's fantasies to join them when they're engaged with partnered sexual contact. Still, ultimately, you are the arbiter of your sexual fantasies and get to choose to keep them private or share them.

Leitenberg and Henning (1995) define sexual fantasies as "any mental imagery that is sexually arousing." One of the more common fantasies is the replacement fantasy—fantasizing about someone other than one's current partner (Hicks & Leitenberg, 2001). In addition, more than 50% of people have forced-sex fantasies (Critelli & Bivona, 2008). However, this does not mean most of us want to be cheating on our partners or be involved in sexual assault. Sexual fantasies are not equal to sexual behaviors.

It's important to note that sexual fantasies can also be different from sexual desire. Sex researcher Justin Lehmiller surveyed over 4,000 Americans about their sex fantasies and collected detailed information on their personalities, sexual histories, and demographics for his book, *Tell Me What You Want* (2018). Lehmiller describes sexual fantasy as a sexually arousing thought or mental picture that we have while awake (i.e., it's not a dream). Fantasies can be spontaneous, or you can deliberately call a fantasy to mind for various purposes, such as becoming or staying aroused, dealing with boredom, or relaxing. On the other hand, sexual desire is something that you actually want to do. It's a future plan or goal for your sex life—something that you'd like to try at some point.

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The distinction between sexual fantasy and sexual desire is important. Let's consider a top sexual fantasy for many people- the idea of group sex or, more distinctively, gangbangs. While someone may have a fantasy about engaging in group sex (with desire and intent to match), their fantasy about being in a gangbang may remain simply that: a fantasy. While it may be exciting to consider, the actual act could, in fact, be deeply disturbing and not something someone wants to try. Indeed, there's many types of sexual fantasies that remain distinctively in that category.

Sometimes our sexual fantasies are therapeutic. They don't just help us to experience sexual pleasure, but also to cope with the psychological needs that we have at a given moment. And because our psychological needs change over the course of our lives, our fantasies, it seems, often adjust to correspond with those needs—and that may help to explain why the things that turn you on now may be very different from the things that turned you on in the past (Lehmiller, 2018).

Lehmiller (2021) writes that in some cases, fantasy and desire can prompt sexual behavior—some people make the decision to act things out. He discovered that about 1 in 5 people have acted on their favorite fantasy before. Note that this means that most people tend to have unrealized fantasies and desires. In some cases, sexual behavior can can occur and you didn't even know it was something you liked or desired. For instance, your partner may suggest trying something completely new that you agree to, despite the fact that you've never thought about it or wanted to try it before. And, if you enjoyed engaging in that behavior, it could potentially become a future fantasy and/or desire (Lehmiller, 2021).

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It's helpful to understand that fantasy, desire, and behavior are all separate, but overlapping concepts. This is especially useful when talking about fantasies with your partner(s). Importantly, when sharing fantasies, it's usually a good idea to clarify whether these are fantasies that you have vs. desires that you'd like to try. If people automatically assume that all fantasies their partner shares are things they actually want to try, this can cause confusion or lead to avoidable conflict. So when sharing fantasies, it's worth getting on the same page about what this is and isn't. Are you sharing fantasies to enhance intimacy, learn about each other, and/or turn each other on? Or are you sharing ideas for things you want to try together (Lehmiller, 2021)? For a useful tool that may help sharing preferences of sexual activities with a partner(s), check out this guide from HERE or Sexapalooza

Masturbation

Sexual fantasies are often a context for the sexual behavior of masturbation—tactile (physical) stimulation of the body for sexual pleasure. Historically, masturbation has earned a bad reputation; it's been described as "self-abuse," and falsely associated with causing adverse side effects, such as hairy palms, acne, blindness, insanity, and even death (Kellogg, 1888). Cultural values may still influence the way that masturbation is perceived. For instance, can you think of any common sayings you have heard shaming masturbation? One phrase might be: "You'll grow hair on your palms" indicating that others will know you have masturbated and it will be viewed as shameful by others. It is important to reflect on your own perspective on this topic.

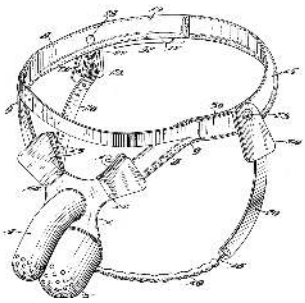

Figure: A United States patent drawing of an early 20th century anti-masturbation chastity belt. [Image: unknown, https://goo.gl/D15Lnw, Public Domain]

Sex research pioneer, Alfred Kinsey (1894-1956), was among the first to ask questions about Americans' sexual behavior, including masturbation. In sum, Kinsey surveyed approximately 18,000 participants. Among the results of Kinsey's research were the findings that women are as interested and experienced in sex as their male counterparts, and that both males and females masturbate without adverse health consequences (Bancroft, 2004). These findings were not well-received but certainly launched further inquiry into the advantages of masturbatory behaviors.

Some people view masturbation as beneficial, and it is linked with lower stress levels, reduced risky sexual behaviors, and greater levels of knowledge about one's own body functioning, which some view as empowering and reclaiming their sexuality. It's not uncommon for clinical providers to recommend masturbation as a tool in physical and sensual exploration, as well as challenges with sexual functioning (Coleman, 2003). Indeed, empirical evidence links masturbation to increased levels of sexual and marital satisfaction, and physical and psychological health (Hurlburt & Whitaker, 1991; Levin, 2007). There is even evidence that masturbation significantly decreases the risk of developing prostate cancer among males over the age of 50 (Dimitropoulou et al., 2009).

Masturbation is common among males and females in the United States. Robbins et al. (2011) found that 74% of males and 48% of females reported masturbating. However, frequency of masturbation is affected by culture. An Australian study found that only 65% of males and 35% of females reported masturbating. And in the UK, 86%of men and 57% of women ages 16–44 reported masturbating within the past year (Regenerus, Price, & Gordon, 2017). Further, rates of reported masturbation by males and females in India are even lower, at 46% and 13%, respectively (Ramadugu et al., 2011). For many people masturbation is shrouded with shame and guilt. Again, characteristics of culture, family upbringing, and faith can factor into one's experience of solitary sexual behavior. Importantly, however, Kinsey was onto something – there are little to no adverse consequences for masturbating (except in cases where one feels guilt and shame).

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For helpful information, check out local feminist and queer friendly resource, SheBop's Blog Entry, How to Become Comfortable With Masturbation.

Solitary & Partnered Considerations

Erogenous Zones

People often think of sexual behaviors as the act of sex itself usually focusing on what is happening with the genitals; however, the whole body can be implicated in the process of being sexual. Some common erogenous zones are the neck, inner thighs, lower back, and lips. Each person is different and additional areas on the body may also be utilized to enhance sexual arousal and pleasure. Exploring areas of your body that seem to have enhanced sensitivity in a pleasurable way and exploring these areas with partners can be beneficial. Also, asking partners about the areas of their body that they like touched can be beneficial to their sexual experience as well.

Sex Toys

Sex toys are material objects selected, created, and used to generate or enhance sexual arousal and pleasure in both individual and partnered sex acts (Döring, 2021). When it comes to the history of sex toys, archaeological have found phallus-shaped artifacts seemingly used for sexual stimulation that date back 30,000 years. Prehistoric dildo-shaped objects made of jade, stone, copper, leather, or bones are now exhibited in museums all over the world. Drawings, paintings, and novels from early recorded times, the Middle Ages to the modern era document the existence and use of sexual aids in many different cultures (Döring, 2021).

Credit: Wellcome Library, London. Wellcome Images images@wellcome.ac.uk http://wellcomeimages.org Various sex aids, including dildos, artificial vulva, penis supports etc. Colour woodcut, ca. 1830. Published: [ca. 1830]

Toys can be used to enhance sexual experiences. Some examples are:

- Strap-ons–special underwear or straps designed to hold a dildo in place for penetrative sex.
- Dildos–mimic the shape of a penis but range in terms of realism; some are flesh-colored and look like an actual penis whereas some are bright pink, rainbow, etc.

- vibrators–these toys vibrate and are used because the human hand can only do so much before getting tired and some people benefit from direct, consistent stimulation. For a lovely history of the vibrator, check out Jen Bell's Brief History of the Vibrator.
- Anal play items–anal beads, butt plugs, anal stimulators similar to a vibrator and small dildo combined, or dildos can also be used (please remember that the rectum can act like a vacuum and suck objects inside so be sure to use something with a flared bottom, pull cord or ring to prevent anal toys from getting lost inside you).
- Penis extenders–fit over a penis; looks like a dildo with a hole inside the base.
- Penis sleeve or "fleshlight"–mimics penetrative sex and is used during masturbation.
- and so many more!
- Important considerations…
  - Safe sex using all these items involves thoroughly cleaning them with hot water or soap after and before using and between use on another person.
  - Some dildos can be boiled in hot water or placed on the top rack of the dishwasher, but read the cleaning instructions upon purchase to avoid melting them.
  - Also, some lubricants (commonly referred to as lube) are oil-based which are not compatible with toys made from silicone; water-based lubes are better for most toys to prevent them from becoming sticky overtime.
  - SheBop in Portland has sex-positive experts as staff, so they can provide assistance for any of your questions
- Sex dolls, which can be defined as material representations of the human body for sexual use have been used by approximately 2% of women and 9% of men (Döring & Pöschl, 2018).
- Sex robots coming soon–Sex robots can be defined as humanoid robots that are designed for sexual use (Levy, 2007; as cited in Döring & Pöschl, 2018). They look like sex dolls but are equipped with artificial intelligence (AI).

Viceland's Slutever: Meet Harmony the Sex Robot:

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Technology affords some exciting opportunities in terms of sexual expression. However, with all innovation there are some complex considerations to be made. Of import- how does technology enhance someone's sexual experiences? Does technology like sex robots have the potential to enhance or subdue human connection? There are no clear answers to these questions but the emergence of these technologies do require further conversations regarding these issues.

Partnered Activities

Coital sex is the term for vaginal-penile intercourse, which occurs for about 3 to 13 minutes on average—though its duration and frequency decrease with age (Corty & Guardiani, 2008; Smith et al., 2012). Traditionally, people are known as "virgins" before they engage in coital sex, and have "lost" their virginity afterwards. Durex (2005) found the average age of first coital experiences across 41 different countries to be 17 years, with a low of 16 (Iceland), and a high of 20 (India). There is tremendous variation regarding frequency of coital sex. For example, the average number of times per year a person in Greece (138) or France (120) engages in coital sex is between 1.6 and 3 times greater than in India (75) or Japan (45; Durex, 2005).

Oral sex includes cunnilingus—oral stimulation of the female's external sex organs, and fellatio—oral stimulation of the male's external sex organs. Sixty-nining – mutual oral sex at the same time. The prevalence of oral sex widely differs between cultures—with Western cultures, such as the U.S., Canada, and Austria, reporting higher rates (greater than 75%); and Eastern and African cultures, such as Japan and Nigeria, reporting lower rates (less than 10%; Copen, Chandra, & Febo-Vazquez, 2016; Malacad & Hess, 2010; Wylie, 2009).

Not only are there differences between cultures regarding how many people engage in oral sex, there are differences in its very definition. For example, most college students in the U.S. do not believe cunnilingus or fellatio are sexual behaviors—and more than a third of college students believe oral sex is a form of abstinence (Barnett et al., 2017; Horan, Phillips, & Hagan, 1998; Sanders & Reinisch, 1999).

Anal sex refers to penetration of the anus by an object. Anal sex is not exclusively a "homosexual behavior." The anus has extensive sensory-nerve innervation and is often experienced as an erogenous zone, no matter where a person is on the Heterosexual-Homosexual Rating Scale (Cordeau et al., 2014). When heterosexual people are asked about their sexual behaviors, more than a third (about 40%) of both males and females report having had anal sex at some time during their life (Chandra,

Mosher, & Copen, 2011; Copen, Chandra, & Febo-Vazquez, 2016). Comparatively, when homosexual men are asked about their most recent sexual behaviors, more than a third (37%) report having had anal sex (Rosenberger et al., 2011).

Like straight-identifying people, gay-identifying people engage in a variety of sexual behaviors, the most frequent being masturbation, romantic kissing, and oral sex (Rosenberger et al., 2011). The prevalence of anal sex widely differs between cultures. For example, people in Greece and Italy report high rates of anal sex (greater than 50%), whereas people in China and India report low rates of anal sex (less than 15%; Durex, 2005).

In contrast to "more common" sexual behaviors, there is a vast array of alternative sexual behaviors. Some of these behaviors, such as voyeurism, exhibitionism, and pedophilia are classified in the DSM as paraphilic disorders—behaviors that victimize and cause harm to others or one's self (American Psychiatric Association, 2013). Sadism—inflicting pain upon another person to experience pleasure for one's self—and masochism—receiving pain from another person to experience pleasure for one's self—are also classified in the DSM as paraphilic disorders. However, if an individual consensually engages in these behaviors, the term "disorder" is replaced with the term "interest." Janus and Janus (1993) found that 14% of males and 11% of females have engaged in some form of sadism and/or masochism.

Kink is defined by clinicians Yates and Neuer-Colburn (2019) as "a culture or lifestyle outside of the social norm centered around consensual non-egalitarian relationship practices, concepts of monogamy, sexual interactions, sexual activities and/or fantasies as a means for heightened intimacy between partners" (p. 15). They go on to define BDSM as "the overlapping acronym for bondage and discipline (BD – the use of physical or psychological restraints), dominance and submission (DS or D/s – active participation in the consensual and negotiated exchange or handing over of power or authority to another), sadism and masochism or sadomasochism (SM or S&M – engaging in activities that involve intense or strong sensation and/or stimuli"; Yates & Neuer-Colburn, 2019, p. 15). Members of the Kink community engage in a variety of behaviors. In some cases, there's an understanding that BDSM is a large part of identifying as Kink for the majority of members, and so the terms Kink and BDSM can be interchangeable as well as exclusive terms in community terminology.

https://www.sexandpsychology.com/blog/2017/8/16/how-many-americans-have-had-a-bdsm-experience-infographic/

Sexual Behavior, Consent, & Safer Sex Practices

Clearly, people engage in a multitude of behaviors whose variety is limited only by our own imaginations. Further, our standards for what's normal differs substantially from culture to culture. However, there is one aspect of sexual behavior that is universally acceptable—indeed, fundamental and necessary. At the heart of what qualifies as sexually "normal" is the concept of consent. Sexual consent refers to the voluntary, conscious, and empathic participation in a sexual act, which can be withdrawn at any time (Jozkowski & Peterson, 2013). Sexual consent is the baseline for what are considered normal—acceptable and healthy—behaviors; whereas, nonconsensual sex—i.e., forced, pressured or unconscious participation—is unacceptable and unhealthy. When engaging in sexual behaviors with a partner, a clear and explicit understanding of your boundaries, as well as your partner's boundaries, is essential. We recommend safer-sex practices, such as condoms, honesty, and communication, whenever you engage in a sexual act. Discussing likes, dislikes, and limits prior to sexual exploration reduces the likelihood of miscommunication and misjudging nonverbal cues. In the heat of the moment, things are not always what they seem. For example, Kristen Jozkowski and her colleagues (2014) found that females tend to use verbal strategies of consent, whereas males tend to rely on nonverbal indications of consent. Awareness of this basic mismatch between heterosexual couples' exchanges of consent may proactively reduce miscommunication and unwanted sexual advances.

The universal principles of pleasure, sexual behaviors, and consent are intertwined. Consent is the foundation on which sexual activity needs to be built. Understanding and practicing empathic consent requires sexual literacy and an ability to effectively communicate desires and limits, as well as to respect others' parameters.

Sexual Positions and Safer Sex Recommendations

Coitus

Penis-in-vagina; can be: face-to-face, from behind, man on top, woman on top, side-to-side; condom used for safer sex

Cunnilingus

Oral sex to stimulate the vulva, especially the clitoris; dental dam for safer sex or a condom cut with clean scissors to act as a dental dam

Fellatio

Oral sex to stimulate the penis; condom for safer sex

Sixty-nining

Mutual oral sex at the same time; condom/dental dam for safer sex

Anal intercourse

Penis-to-anus; condom for safer sex

Anilingus

Oral stimulation of the anus; dental dam for safer sex

Hand stimulation

Mutual (at the same time) or turn-taking (one partner is touched first then the other is touched next)

Mutual masturbation

Partners pleasuring themselves in front of each other at the same time

Interfemoral intercourse

Thrusting of the penis between the thighs of a partner

Tribadism

Lesbian sex in which one partner humps the other causing stimulation in both partners

Concerns with These Terms

- Please note how some of these terms leave out language to be more inclusive of transgender and intersex bodies and are heteronormative
- The word "tribadism" has origins from a Greek word that implies a woman is trying to behave like a male in a lesbian dynamic; this is problematic because this sex is between two women and not one who is trying to be a man
- What about other practices that people commonly engage in that aren't on this list?

One Last Note on Safer Sex

Having sex with people who can ejaculate directly into the body of another person is the riskiest of sex practices because viruses and bacteria have a greater chance of surviving. As they come into contact with air, they cannot survive. Precum (small amounts of ejaculate that comes out throughout the process of being aroused) is also a factor to consider in safer sex. This is the reason the "pull-out method" is ineffective for preventing pregnancy and the spread of illnesses.

Additional Readings:

- Read the following sections on Birth Control, STIs and Safe Sex
- For more information on safer sex practices, check out 16 Safer Sex Practices from Concordia University.

Diversify Your Sex Practices

If you are feeling unsatisfied with the sex you are having, say something and explore your desires to see what feels good. Explore your body and that of others in a safe place to try new positions and toys and remember you can revoke consent at any time if it turns out you or your partners don't like something. Check egos throughout as well because adding toys does not mean you are lacking and aren't good at sex. Sex toys have been around for a long time (archaeological digs of ancient societies can attest to this) and serve the purpose of increasing pleasure for many individuals. For some, adding sex toys has been a game-changer in the quality of sex they experience.

Conclusion

There are many variations in human sexual behavior. Many of the solitary sexual behaviors people have are linked to enhanced pleasure, greater personal awareness, and increased sexual functioning. In terms of partnered sexual behavior, consent is key. Experiences matter, personality, age, and other elements. Finally, culture and socialization are important factors when considering norms and attitudes about diverse sexual activities.

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An example of how social/cultural paradigms, such as a pandemic, can shift sexual behaviors.

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Adaptations: Reformatted. Modified content for language, application to subject and cohesion.

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Justin Lehmiller. (2018). The 7 most common sexual fantasies – From Tell Me What You Want by Dr. Justin Lehmiller. https://www.youtube.com/watch?v=MZ64JYmCpkQ

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1.10: Intimate Relationships 1.10: Intimate RelationshipsEdit Update titlecancel

Learning Objectives

- Summarize and analyze evolutionary, biological, social, and psychological perspectives on love and the development of long-term intimate relationships
- Demonstrate an understanding of how various writers and researchers have attempted to define, describe and measure love
- Explore the benefits and challenges of consensual non-monogamous relationships
- Discuss ways to be an ally within romantic relationships and analyze the ways that intersecting identities of partners can be acknowledged in order to address and prevent harm related to imbalances of social power

Introduction

As we discussed previously, humans are the descendants of a common relatives shared by both chimpanzees and bonobos and, while these two apes differ significantly from one another, humans share many relational and sexual behaviors common in both apes (Prüfer et al., 2012). In terms of mating and relational behaviors, some human males are more protective and aggressive of perceived sexual conquests while others are not and respect the strong women in their lives. Some human societies are more rigid regarding sexuality and believe engaging in sexual behaviors should only be allowed for procreation purposes only while others are accepting and acknowledging of sexual fluidity for pleasure, connection and community. Thus, humans exhibit characteristics of both chimpanzees and bonobos based on evolution, the structure of the given society, and social norms present that shape the development of relationships. As we explore the driving factors that cause humans to seek out long-term intimate relationships with others, evolutionary psychology, social psychology, current evidence-based research on healthy relationships, and the critical theories with a focus on intersectionality will be utilized to help us understand the many perspectives regarding this topic.

Evolutionary Theories

The passing of genes to the next generation and having children might be a factor in what drives certain people to enter into intimate relationships. In a heterosexual/straight dynamic between cisgender individuals, certain behaviors have been developed over time and through behavioral evolution to increase the chances of producing healthy offspring. One critique is that this theoretical perspective can often leave out sexual minorities and gender-diverse perspectives. As you read the following on sexual selection theory and sexual strategies theory, you will see the term “sex” rather than “gender.” Keep in mind that the evolutionary theories are focusing on the binary differences in anatomy and functionality as this relates to sexual behavior.

Sexual Selection Theory

Darwin noticed that there were many traits and behaviors of organisms that could not be explained by “survival selection.” For example, the brilliant plumage of peacocks should actually lower their rates of survival. That is, the peacocks’ feathers act like a neon sign to predators, advertising “Easy, delicious dinner here!” But if these bright feathers only lower peacocks’ chances at survival, why do they have them? The same can be asked of similar characteristics of other animals, such as the large antlers of male stags or the wattles of roosters, which also seem to be unfavorable to survival. Again, if these traits only make the animals less likely to survive, why did they develop in the first place? And how have these animals continued to survive with these traits over thousands and thousands of years? Darwin’s answer to this conundrum was the theory of sexual selection: the evolution of characteristics, not because of survival advantage, but because of mating advantage.

Modern sports like boxing can be seen as modified/stylized versions of the evolutionary behavior of intrasexual competition. [Image: Dave Hogg, https://goo.gl/fL5U2Z, CC BY 2.0, https://goo.gl/9uSnqN]

Sexual selection occurs through two processes. The first, intrasexual competition, occurs when members of one sex compete against each other, and the winner gets to mate with a member of the opposite sex. Male stags, for example, battle with their antlers, and the winner (often the stronger one with larger antlers) gains mating access to the female. That is, even though large antlers make it harder for the stags to run through the forest and evade predators (which lowers their survival success), they provide the stags with a better chance of attracting a mate (which increases their reproductive success). Similarly, human males sometimes also compete against each other in physical contests: boxing, wrestling, karate, or group-on-group sports, such as football. Even though engaging in these activities poses a "threat" to their survival success, as with the stag, the victors are often more attractive to potential mates, increasing their reproductive success. Thus, whatever qualities lead to success in intrasexual competition are then passed on with greater frequency due to their association with greater mating success.

The second process of sexual selection is preferential mate choice, also called intersexual competition. In this process, if members of one sex are attracted to certain qualities in mates—such as brilliant plumage, signs of good health, or even intelligence—those desired qualities get passed on in greater numbers, simply because their possessors mate more often. For example, the colorful plumage of peacocks exists due to a long evolutionary history of peahens' (the term for female peacocks) attraction to males with brilliantly colored feathers.

In all sexually-reproducing species, adaptations in males and females exist due to survival selection and sexual selection. However, unlike other animals where one sex has dominant control over mate choice, humans have "mutual mate choice." That is, all partners typically have a say in choosing their mates. And mates value qualities such as kindness, intelligence, and dependability that are beneficial to long-term relationships—qualities that make good partners and good parents.

Sexual Strategies Theory

Sexual strategies theory is based on sexual selection theory. It proposes that humans have evolved a list of different mating strategies, both short-term and long-term, that vary depending on culture, social context, parental influence, and personal mate value (desirability in the "mating market").

In its initial formulation, sexual strategies theory focused on the differences between men and women in mating preferences and strategies (Buss & Schmitt, 1993). It started by looking at the minimum parental investment needed to produce a child. For women, even the minimum investment is significant: after becoming pregnant, they have to carry that child for nine months inside of them. For men, on the other hand, the minimum investment to produce the same child is considerably smaller—simply the act of sex.

These differences in parental investment have an enormous impact on sexual strategies. For a woman, the risks associated with making a poor mating choice are high. She might get pregnant by a man who will not help to support her and her children, or who might have poor-quality genes. And because the stakes are higher for a woman, wise mating decisions for her are much more

valuable. For men, on the other hand, the need to focus on making wise mating decisions isn't as important. That is, unlike women, men 1) don't biologically have the child growing inside of them for nine months, and 2) do not have as high a cultural expectation to raise the child. This logic leads to a powerful set of predictions: In short-term mating, women will likely be choosier than men (because the costs of getting pregnant are so high), while men, on average, will likely engage in more casual sexual activities (because this cost is greatly lessened). Due to this, men will sometimes deceive women about their long-term intentions for the benefit of short-term sex, and men are more likely than women to lower their mating standards for short-term mating situations.

An extensive body of empirical evidence supports these and related predictions (Buss & Schmitt, 2011). Men express a desire for a larger number of sex partners than women do. They let less time elapse before seeking sex. They are more willing to consent to sex with strangers and are less likely to require emotional involvement with their sex partners. They have more frequent sexual fantasies and fantasize about a larger variety of sex partners. They are more likely to regret missed sexual opportunities. And they lower their standards in short-term mating, showing a willingness to mate with a larger variety of women as long as the costs and risks are low.

However, in situations where both the man and woman are interested in long-term mating, both sexes tend to invest substantially in the relationship and in their children. In these cases, the theory predicts that both sexes will be extremely choosy when pursuing a long-term mating strategy. Much empirical research supports this prediction, as well. In fact, the qualities women and men generally look for when choosing long-term mates are very similar: both want mates who are intelligent, kind, understanding, healthy, dependable, honest, loyal, loving, and adaptable.

Nonetheless, women and men do differ in their preferences for a few key qualities in long-term mating, because of somewhat distinct adaptive problems. Modern women have inherited the evolutionary trait to desire mates who possess resources, have qualities linked with acquiring resources (e.g., ambition, wealth, industriousness), and are willing to share those resources with them. On the other hand, men more strongly desire youth and health in women, as both are cues to fertility. These male and female differences initially appeared to be universal in humans. They were first documented in 37 different cultures, from Australia to Zambia (Buss, 1989), and have been replicated by dozens of researchers in dozens of additional cultures (for summaries, see (Perilloux, Easton, & Buss, 2012). Still- there is evidence emerging that these trends are shifting, especially in industrialized western cultures.

As we know, though, just because we have these mating preferences (e.g., men with resources; fertile women), people don't always get what they want. There are countless other factors which influence who people ultimately select as their mate. For example, the sex ratio (the percentage of men to women in the mating pool), cultural practices (such as arranged marriages, which inhibit individuals' freedom to act on their preferred mating strategies), the strategies of others (e.g., if everyone else is pursuing short-term sex, it's more difficult to pursue a long-term mating strategy), and many others all influence who we select as our mates.

Sexual strategies theory—anchored in sexual selection theory— predicts specific similarities and differences in men's and women's mating preferences and strategies. Whether we seek short-term or long-term relationships, many personality, social, cultural, and ecological factors will all influence who our partners will be.

Social Psychology: Liking and Loving Over the Long-Term

Previously, we have focused upon the attraction that occurs between people who are initially getting to know one another. But the basic principles of social psychology can also be applied to help us understand relationships that last longer. When good friendships develop, when people get married and plan to spend the rest of their lives together, and when families grow closer over time, the relationships take on new dimensions and must be understood in somewhat different ways. Yet the principles of social psychology can still be applied to help us understand what makes these relationships last.

The factors that keep people liking and loving each other in long-term relationships are at least in part the same as the factors that lead to initial attraction. For instance, regardless of how long they have been together, people remain interested in the physical attractiveness of their partners, although it is relatively less important than for initial encounters. And similarity remains essential. Relationships are also more satisfactory and more likely to continue when the individuals develop and maintain similar interests and continue to share their important values and beliefs over time (Davis & Rusbult, 2001). Both actual and assumed similarity between partners tend to grow in long-term relationships and are related to satisfaction in opposite-sex marriages (Schul & Vinokur, 2000). Some aspects of similarity, including that in terms of positive and negative affectivity, have also been linked to relationship satisfaction in same-sex marriages (Todosijevic, Rothblum, & Solomon, 2005). However, some demographic factors like education and income similarity seem to relate less to satisfaction in same-sex partnerships than they do in opposite sex ones (Todosijevic, Rothblum, & Solomon, 2005).

Proximity also remains important—relationships that undergo the strain of the partners being apart from each other for very long are more at risk for breakup.

But what about passion? Does it still matter over time? Yes and no. People in long-term relationships who are most satisfied with their partners report that they still feel passion for their partners—they still want to be around them as much as possible, and they enjoy making love with them (Simpson, 1987; Sprecher, 2006). And they report that the more they love their partners, the more attractive they find them (Simpson, Gangestad, & Lerma, 1990). On the other hand, the high levels of passionate love that are experienced in initial encounters are not likely to be maintained throughout the course of a long-term relationship (Acker & Davis, 1992). Recall, though, that physical intimacy continues to be important.

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Over time, cognition becomes relatively more important than emotion, and close relationships are more likely to be based on companionate love, defined as love that is based on friendship, mutual attraction, common interests, mutual respect, and concern for each other's welfare. This does not mean that enduring love is less strong—rather, it may sometimes have a different underlying structure than initial love based more on passion.

Closeness and Intimacy

Although it is safe to say that many of the variables that influence initial attraction remain important in longer-term relationships, other variables also come into play over time. One important change is that as a relationship progresses, the partners come to know each other more fully and care about each other to a greater degree. In successful relationships, the partners feel increasingly close to each other over time, whereas in unsuccessful relationships, closeness does not increase and may even decrease. The closeness experienced in these relationships is marked in part by reciprocal self-disclosure—the tendency to communicate frequently, without fear of reprisal, and in an accepting and empathetic manner.

When the partners in a relationship feel that they are close, and when they indicate that the relationship is based on caring, warmth, acceptance, and social support, we can say that the relationship is intimate (Sternberg, 1986). Partners in intimate relationships are likely to think of the couple as "we" rather than as two separate individuals. People who have a sense of closeness with their partner are better able to maintain positive feelings about the relationship while at the same time are able to express negative feelings and to have accurate (although sometimes less than positive) judgments of the other (Neff & Karney, 2002). People may also use their close partner's positive characteristics to feel better about themselves (Lockwood, Dolderman, Sadler, & Gerchak, 2004).

Arthur Aron and his colleagues (Aron, Aron, & Smollan, 1992) have assessed the role of closeness in relationships directly, using the simple measure shown in Figure 10.1, "Measuring Relationship Closeness." You might try completing the measure yourself for some different people that you know—for instance, your family members, your friends, your spouse, or your girlfriend or boyfriend. The measure is simple to use and to interpret. If a person chooses a circle that represents the self and the other as more overlapping, this means that the relationship is close. But if they choose a circle that is less overlapping, then the relationship is less so.

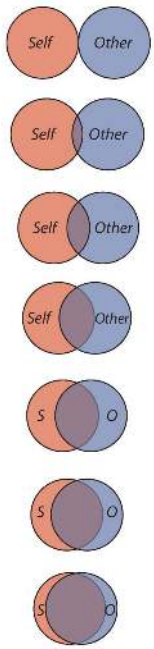

Figure 10.1 Measuring Relationship Closeness

This measure is used to determine how close two partners feel to each other. The respondent simply circles which of the figures he or she feels characterizes the relationship. From Aron, Aron, and Smollan (1992).

Although the closeness measure is simple, it has been found to be highly predictive of people's satisfaction with their close relationships and of the tendency for couples to stay together. In fact, the perceived closeness between romantic partners can be a better predictor of how long a relationship will last than is the number of positive feelings that the partners indicate having for each other. In successful close relationships, cognitive representations of the self and the other tend to merge together into one, and it is this tie—based on acceptance, caring, and social support—that is so important (Aron, Aron, Tudor, & Nelson, 1991).

Aron and his colleagues (Aron, Melinat, Aron, & Vallone, 1997) used an experimental design to test whether self-disclosure of intimate thoughts to others would increase closeness. In a laboratory, they paired college students with another student, one whom they did not know. Some of the students were asked to share some intimate thoughts with each other by asking and answering questions such as "When did you last cry in front of another person?" In comparison with control participants who only engaged in small talk with their partners (answering questions such as "What is your favorite holiday?"), the students who disclosed more intimate experiences reported feeling significantly closer to each other at the end of the conversation.

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Aron pioneered the 36-question intimacy builder (seen above). For more information on the questions, check out Arthur Aron's 36 questions.

Communal and Exchange Relationships

In intimate close relationships, the partners can become highly attuned to each other's needs, such that the desires and goals of the other become as important as, or more important than, one's own needs. When people are attentive to the needs of others—for instance, parents' attentiveness to the needs of their children or the attentiveness of partners in a romantic relationship—and when they help the other person meet his or her needs without explicitly keeping track of what they are giving or expecting to get in return, we say that the partners have a communal relationship. Communal relationships are close relationships in which partners suspend their need for equity and exchange, giving support to the partner in order to meet his or her needs, and without consideration of the costs to themselves. Communal relationships are contrasted with exchange relationships, relationships in which each of the partners keeps track of his or her contributions to the partnership.

Research suggests that communal relationships can be beneficial, with findings showing that happier couples are less likely to "keep score" of their respective contributions (Buunk, Van Yperen, Taylor, & Collins, 1991). And when people are reminded of the

external benefits that their partners provide them, they may experience decreased feelings of love for them (Seligman, Fazio, & Zanna, 1980).

Although partners in long-term relationships are frequently willing and ready to help each other meet their needs, and although they will in some cases forgo the need for exchange and reciprocity, this does not mean that they always or continually give to the relationship without expecting anything in return. Partners often do keep track of their contributions and received benefits. If one or both of the partners feel that they are unfairly contributing more than their fair share, and if this inequity continues over a period of time, the relationship will suffer. Partners who feel that they are contributing more will naturally become upset because they will feel that they are being taken advantage of. But the partners who feel that they are receiving more than they deserve might feel guilty about their lack of contribution to the partnership.

Members of long-term relationships focus to a large extent on maintaining equity, and marriages are happiest when both members perceive that they contribute relatively equally (Van Yperen & Buunk, 1990). Interestingly, it is not just our perception of the equity of the ratio of rewards and costs we have in our relationships that is important. It also matters how we see this ratio in comparison to those that we perceive people of the same sex as us receiving in the relationships around us. Buunk and Van Yperen (1991), for example, found that people who saw themselves as getting a better deal than those around them were particularly satisfied with their relationships. From the perspective of social comparison theory, which we discussed in chapter 3 in relation to the self, this makes perfect sense. When we contrast our own situation with that of similar others and we perceive ourselves as better off, then this means we are making a downward social comparison, which will tend to make us feel better about ourselves and our lot in life. There are also some individual differences in the extent to which perceptions of equity are important. Buunk and Van Yperen, for example, found that the relationship between perceptions of equity and relationship satisfaction only held for people who were high in exchange orientation. In contrast, those low in exchange orientation did not show an association between equity and satisfaction, and, perhaps even more tellingly, were more satisfied with their relationships than those high in exchange orientation.

People generally stay in relationships longer when they feel that they are being rewarded by them (Margolin & Wampold, 1981). In short, in relationships that last, the partners are aware of the needs of the other person and attempt to meet them equitably. But partners in the best relationships are also able to look beyond the rewards themselves and to think of the relationship in a communal way.

Interdependence and Commitment

Another factor that makes long-term relationships different from short-term ones is that they are more complex. When a couple begins to take care of a household together, has children, and perhaps has to care for elderly parents, the requirements of the relationship become correspondingly bigger. As a result of this complexity, the partners in close relationships increasingly turn to each other not only for social support but also for help in coordinating activities, remembering dates and appointments, and accomplishing tasks (Wegner, Erber, & Raymond, 1991). The members of a close relationship are highly interdependent, relying to a great degree on each other to meet their goals.

It takes a long time for partners in a relationship to develop the ability to understand the other person's needs and to form positive patterns of interdependence in which each person's needs are adequately met. The social representation of a significant other is a rich, complex, and detailed one because we know and care so much about him or her and because we have spent so much time in his or her company (Andersen & Cole, 1990). Because a lot of energy has been invested in creating the relationship, particularly when the relationship includes children, breaking off the partnership becomes more and more costly with time. After spending a long time with one person, it may also become more and more difficult to imagine ourselves with anyone else.

In relationships in which a positive rapport between the partners is developed and maintained over a period of time, the partners are naturally happy with the relationship and they become committed to it. Commitment refers to the feelings and actions that keep partners working together to maintain the relationship. In comparison with those who are less committed, partners who are more committed to the relationship see their mates as more attractive than others, are less able to imagine themselves with another partner, express less interest in other potential mates, are less aggressive toward each other, and are less likely to break up (Simpson, 1987; Slotter et al., 2011).

Commitment may in some cases lead individuals to stay in relationships that they could leave, even though the costs of remaining in the relationship are very high. On the surface, this seems puzzling because people are expected to attempt to maximize their rewards in relationships and would be expected to leave them if they are not rewarding. But in addition to evaluating the outcomes that one gains from a given relationship, the individual also evaluates the potential costs of moving to another relationship or not having any relationship at all. We might stay in a romantic relationship, even if the benefits of that relationship are not high,

because the costs of being in no relationship at all are perceived as even higher. We may also remain in relationships that have become dysfunctional in part because we recognize just how much time and effort we have invested in them over the years. When we choose to stay in situations largely because we feel we have put too much effort in to be able to leave them behind, this is known as the sunk costs bias (Eisenberg, Harvey, Moore, Gazelle, & Pandharipande, 2012). In short, when considering whether to stay or leave, we must consider both the costs and benefits of the current relationship and the costs and benefits of the alternatives to it (Rusbult, Olsen, Davis, & Hannon, 2001).

Although the good news about interdependence and commitment is clear—they help relationships last longer—they also have a potential downside. Breaking up, should it happen, is more difficult in relationships that are interdependent and committed. The closer and more committed a relationship has been, the more devastating a breakup will be.

What Is Love?

Although we have talked about it indirectly, we have not yet tried to define love itself—and yet it is obviously the case that love is an important part of many close relationships. Social psychologists have studied the function and characteristics of romantic love, finding that it has cognitive, affective, and behavioral components and that it occurs cross-culturally, although how it is experienced may vary.

Robert Sternberg and others (Arriaga & Agnew, 2001; Sternberg, 1986) have proposed a triangular model of love, an approach that suggests that there are different types of love and that each is made up of different combinations of cognitive and affective variables, specified in terms of passion, intimacy, and commitment. The model, suggests that only consummate love has all three of the components (and is probably experienced only in the very best romantic relationships), whereas the other types of love are made up of only one or two of the three components. For instance, people who are good friends may have liking (intimacy) only or may have known each other so long that they also share commitment to each other (companionate love). Similarly, partners who are initially dating might simply be infatuated with each other (passion only) or may be experiencing romantic love (both passion and liking but not commitment).

The triangular model of love, proposed by Robert Sternberg (1986). Note that there are seven types of love, which are defined by the combinations of the underlying factors of intimacy, passion, and commitment.

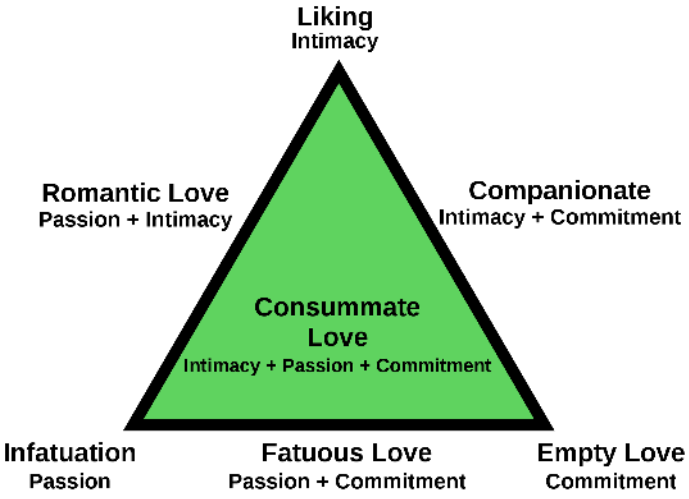

Image credit: Lnesa (2006)

Research into Sternberg's theory has revealed that the relative strength of the different components of love does tend to shift over time. Lemieux and Hale (2002) gathered data on the three components of the theory from couples who were either casually dating, engaged, or married. They found that while passion and intimacy were negatively related to relationship length, that commitment was positively correlated with duration. Reported intimacy and passion scores were highest for the engaged couples.

As well as these differences in what love tends to look like in close relationships over time, there are some interesting gender and cultural differences here. Contrary to some stereotypes, men, on average, tend to endorse beliefs indicating that true love lasts forever, and to report falling in love more quickly than women (Sprecher & Metts, 1989). In regards to cultural differences, on average, people from collectivistic backgrounds tend to put less emphasis on romantic love than people from more individualistic

countries. Consequently, they may place more emphasis on the companionate aspects of love, and relatively less on those based on passion (Dion & Dion, 1993).

Individual Differences in Loving: Attachment Styles

One of the important determinants of the quality of close relationships is the way that the partners relate to each other. These approaches can be described in terms of attachment style—individual differences in how people relate to others in close relationships. We display our attachment styles when we interact with our parents, our friends, and our romantic partners (Eastwick & Finkel, 2008).

Attachment styles are learned in childhood, as children develop either a healthy or an unhealthy attachment style with their parents (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Shaver, 1999). Most children develop a healthy or secure attachment style, where they perceive their parents as safe, available, and responsive caregivers and are able to relate easily to them. For these children, the parents successfully create appropriate feelings of affiliation and provide a secure base from which the child feels free to explore and then to return to. However, for children with unhealthy attachment styles, the family does not provide these needs. Some children develop an insecure attachment pattern known as the anxious/ambivalent attachment style, where they become overly dependent on the parents and continually seek more affection from them than they can give. These children are anxious about whether the parents will reciprocate closeness. Still other children become unable to relate to the parents at all, becoming distant, fearful, and cold (the avoidant attachment style).

These three attachment styles that we develop in childhood remain to a large extent stable into adulthood (Caspi, 2000; Collins, Cooper, Albino, & Allard, 2002; Rholes, Simpson, Tran, Martin, & Friedman, 2007). Fraley (2002) conducted a meta-analysis of 27 studies that had looked at the relationship between attachment behavior in infants and in adults over 17 years of age and found a significant correlation between the two measures. A fourth infant attachment style has been identified more recently, the disorganized attachment style, which is a blend of the other two insecure styles. This style also shows some links to adulthood patterns, in this case an avoidant-fearful attachment style.

The consistency of attachment styles over the life span means that children who develop secure attachments with their parents as infants are better able to create stable, healthy interpersonal relationships with other individuals, including romantic partners, as adults (Hazan & Diamond, 2000). They stay in relationships longer and are less likely to feel jealousy about their partners. But the relationships of anxious and avoidant partners can be more problematic. Insecurely attached men and women tend to be less warm with their partners, are more likely to get angry at them, and have more difficulty expressing their feelings (Collins & Feeney, 2000). They also tend to worry about their partner's love and commitment for them, and they interpret their partner's behaviors more negatively (Collins & Feeney, 2004; Pierce & Lydon, 2001). Anxious partners also see more conflict in their relationships and experience the conflicts more negatively (Campbell, Simpson, Boldry, & Kashy, 2005).

In addition, people with avoidant and fearful attachment styles can often have trouble even creating close relationships in the first place (Gabriel, Carvallo, Dean, Tippin, & Renaud, 2005). They have difficulty expressing emotions, and experience more negative affect in their interactions (Tidwell, Reis, & Shaver, 1996). They also have trouble understanding the emotions of others (Fraley, Garner, & Shaver, 2000) and show a relative lack of interest in learning about their romantic partner's thoughts and feelings (Rholes, Simpson, Tran, Martin, & Friedman, 2007).

One way to think about attachment styles, shown in Table 10.1, "Attachment as Self-Concern and Other-Concern," is in terms of the extent to which the individual is able to successfully meet the important goals of self-concern and other-concern in his or her close relationships. People with a secure attachment style have positive feelings about themselves and also about others. People with avoidant attachment styles feel good about themselves (the goal of self-concern is being met), but they do not have particularly good relations with others. People with anxious/ambivalent attachment styles are primarily other-concerned. They want to be liked, but they do not have a very positive opinion of themselves; this lack of self-esteem hurts their ability to form good relationships. The fourth cell in the table, lower right, represents the avoidant-fearful style, which describes people who are not meeting goals of either self-concern or other-concern.

This way of thinking about attachment shows, again, the importance of both self-concern and other-concern in successful social interaction. People who cannot connect have difficulties being effective partners. But people who do not feel good about themselves also have challenges in relationships—self-concern goals must be met before we can successfully meet the goals of other-concern.

Because attachment styles have such an important influence on relationships, you should think carefully about your potential partner's interactions with the other people in his or her life. The quality of the relationships that people have with their parents and

close friends will predict the quality of their romantic relationships. But although they are very important, attachment styles do not predict everything. People have many experiences as adults, and these interactions can influence, both positively and negatively, their ability to develop close relationships (Baldwin & Fehr, 1995; Scharfe & Bartholomew, 1994). There is also some diversity in the distribution of attachment styles across different groups. For example, in a multicultural sample including people from over 50 different countries of origin, Agishtein and Brumbaugh (2013) found that attachment style varied as a function of ethnicity, religion, individualism-collectivism, and acculturation. For instance, anxious attachment was found to be significantly higher in those whose countries of origin were in East Asia, the Middle East, and Eastern Europe, compared with those from nations in South America, the Caribbean, North America, Western Europe, and South Asia. These types of findings clearly remind us of the need to consider cultural diversity when we are reviewing the research on attachment. They also raise the interesting possibility that some types of attachment may be more normative and adaptive in some cultures than others.

As well as showing some cross-cultural diversity, attachment styles within individuals may be more diverse over time and across situations than previously thought. Some evidence suggests that overall attachment style in adults may not always predict their attachment style in specific relationships. For instance, people's attachment styles in particular relationships, for example those with their mothers, brothers, and partners, although often correlated, can also be somewhat distinct (Pierce & Lydon, 2001; Ross & Spinner, 2001). As well as showing this variability across relationships, attachment styles can also shift over time and with changing relationship experiences. For example, there are some age-related trends in attachment, with younger adults higher in anxious attachment than middle-aged and older adults, and middle-aged adults higher in avoidant attachment than the other two groups (Chopik, Edelstein, & Fralay, 2013). In regards to changing experiences, people with an anxious style who find a very trusting and nurturing romantic relationship may, over time, come to feel better about themselves and their own needs, and shift toward a more secure style (Davila & Cobb, 2003). These findings have many potential psychotherapeutic settings. For example, couples who are attending therapy to address relationship issues can benefit from this process in part by developing more secure attachments to each other (Solomon, 2009). Therapists can also try to help their clients to develop a more secure attachment style, by creating a trusting and supportive relationship with them (Obegi, 2008).

Social Psychology in the Public Interest

Internet Relationships

As we saw in the chapter on Self, many of us are spending more time than ever connecting with others electronically. Online close relationships are also becoming more popular. But you might wonder whether meeting and interacting with others online can create the same sense of closeness and caring that we experience through face-to-face encounters. And you might wonder whether people who spend more time on Facebook, Twitter, and the Internet might end up finding less time to engage in activities with the friends and loved ones who are physically close by (Kraut et al., 1998).

Despite these potential concerns, research shows that using the Internet can relate to positive outcomes in our close relationships (Bargh, 2002; Bargh & McKenna, 2004). In one study, Kraut et al. (2002) found that people who reported using the Internet more frequently also reported spending more time with their family and friends and indicated having better psychological health.

The Internet also seems to be useful for helping people develop new relationships, and the quality of those relationships can be as good as or better than those formed face-to-face (Parks & Floyd, 1996). McKenna, Green, and Gleason (2002) found that many people who participated in news and user groups online reported having formed a close relationship with someone they had originally met on the Internet. Over half of the participants said that they had developed a real-life relationship with people they had first met online, and almost a quarter reported that they had married, had become engaged to, or were living with someone they initially met on the Internet.

McKenna, Green, and Gleason (2002) studied how relationships developed online using laboratory studies. In their research, a previously unacquainted male and female college student met each other for the first time either in what they thought was an Internet chat room or face-to-face. Those who met first on the Internet reported liking each other more than those who met first face-to-face—even when it was the same partner that they had met both times. People also report being better able to express their own emotions and experiences to their partners online than in face-to-face meetings (Bargh, McKenna, & Fitzsimons, 2002).

There are probably a number of reasons why Internet relationships can be so successful. For one, relationships grow to the extent that the partners self-disclose by sharing personal information with each other, and the relative anonymity of Internet interactions may allow people to self-disclose more readily. Another characteristic of Internet relationships is the relative lack of physical cues to a person's attractiveness. When physical attractiveness is taken out of the picture, people may be more likely to form relationships on the basis of other more important characteristics, such as similarity in values and beliefs. Another advantage of the

Internet is that it allows people to stay in touch with friends and family who are not nearby and to maintain better long-distance relationships (Wellman, Quan Haase, Witte, & Hampton, 2001). The Internet also may be helpful in finding others with shared interests and values. Finally, the major purpose of many Internet activities is to make new friends. In contrast, most face-to-face interactions are less conducive to starting new conversations and friendships.

Online interactions can also help to strengthen offline relationships. A recent study by Fox, Warber, & Makstaller (2013) explored the effects of publically posting one's relationship status to Facebook, or going "Facebook official" (FBO) on romantic relationships between college students. They found that offline discussions between partners often preceded going FBO, and, that once couples had gone FBO, they reported more perceived relationship commitment and stability.

Overall, then, the evidence suggests that rather than being an isolating activity, interacting with others over the Internet helps us maintain close ties with our family and friends and in many cases helps us form intimate and rewarding relationships.

Making Relationships Last

Now that you have a better idea of the variables that lead to interpersonal attraction and that are important in close relationships, you should be getting a pretty good idea of the things that partners need to do to help them stay together. It is true that many marriages end in divorce, and this number is higher in individualistic cultures, where the focus is on the individual, than it is in collectivistic cultures, where the focus is on maintaining group togetherness. But even in many Western countries, for instance, the United States, the number of divorces is falling, at least for the most educated segments of society (Kreider & Fields, 2001). Successful relationships take work, but the work is worth it. People who are happily married are also happier overall and have better psychological and physical health. And at least for men, marriage leads to a longer life (Kiecolt-Glaser & Newton, 2001).

Let's look at some of the things that enduring couples seem to have done and compare them with what we might expect on the basis of social psychological research.

- Be prepared for squabbles. Every relationship has conflict. This is not unexpected or always bad. Working through minor conflicts can help you and your partner improve your social skills and make the relationship stronger (Pickett & Gardner, 2005).
- Don't be negative. Negative cognitions and emotions have an extremely harmful influence on relationships (Gottman, 1994). Don't let a spiral of negative thinking and negative behaviors get started. Do whatever you can to think positively.
- Be fair in how you evaluate behaviors. Many people in close relationships, as do most people in their everyday lives, tend to inflate their own self-worth. They rate their own positive behaviors as better than their partner's, and rate their partner's negative behaviors as worse than their own. Try to give your partner the benefit of the doubt—remember that you are not perfect either.
- Do things that please your partner. The principles of social exchange make it clear that being nice to others leads them to be nice in return.
- Have fun. Relationships in which the partners have positive moods and in which the partners are not bored tend to last longer (Tsapelas, Aron, & Orbuch, 2009).

Partners who are able to remain similar in their values and other beliefs are going to be more successful. Partners must also display positive affect toward each other. Happy couples are in positive moods when they are around each other—they laugh together, and they express approval rather than criticism of each other's behaviors. Partners are happier when they view the other person in a positive or even "idealized" sense rather than in a more realistic and perhaps more negative one (Murray, Holmes, & Griffin, 1996).

Next, the partners must share, in the sense that they are willing to express their thoughts about each other. Successful relationships involve individuals self-disclosing their own needs and desires, which allows their partners to become aware of their needs and attempt to meet them if possible. If the partners are not able to express their concerns, then the relationship cannot become more intimate. Successful relationships have successful communication patterns.

Finally, but not least important, are sexual behaviors. Compatibility of sexual preferences and attitudes are an important predictor of relationship success. For instance, it is very important that partners are on the same page about how they feel about pursuing sex outside of the relationship, as infidelity in relationships is linked to increased risk of divorce (Wiederman, 1997).

Even if a partner does not actually have sex with someone else, his or her partner may still be jealous, and jealously can harm relationships. Jealousy is a powerful emotion that has been evolutionarily selected to help maintain close relationships. Both men and women experience jealousy, although they experience it to different extents and in different ways. Men are more jealous than women overall. And men are more concerned than women about sexual infidelities of their partners, whereas women are relatively more concerned about emotional infidelities of their partners (Buss, Larsen, Westen, & Semmelroth, 1992). Men's concern with

sexual cheating is probably due in part to evolutionary factors related to kin selection: men need to be particularly sure that their partners are sexually faithful to them to ensure that the time they spend raising children is spent on raising their own children, not those of others. And women's concern with emotional fidelity fits with a focus on maintaining the relationship intact. Flirting suggests that the man is not really committed to the relationship and may leave it.

Resources

Healthy Communication and Conflict Resolution:

- Fair Fighting Rules (Therapist Aid, 2020)–having rules for how disagreements will be discussed can help to make sure healthy communication techniques are being utilized
- "I" Statements (Therapist Aid, 2017)
- Active Listening: Communication Skill (Therapist Aid, 2020)
- Assertive Communication (Therapist Aid, 2017)
- Relationship Conflict Resolution (Therapist Aid, 2013)
- How to Apologize (Therapist Aid, 2021)

Relationship Growth:

- Relationship Gratitude Tips (Therapist Aid, 2017)
- Relationship Growth Activity: Discovery Questions (Therapist Aid, 2015)
- The Four Horsemen and Their Antidotes (Therapist Aid, 2021)

Abuse

Abuse can occur in multiple forms and across all family relationships. Breiding, Basile, Smith, Black, & Mahendra (2015) define the forms of abuse as:

- Physical abuse, the use of intentional physical force to cause harm. Scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, and hitting are common forms of physical abuse;
- Sexual abuse, the act of forcing someone to participate in a sex act against his or her will. Such abuse is often referred to as sexual assault or rape. A marital relationship does not grant anyone the right to demand sex or sexual activity from anyone, even a spouse;
- Psychological abuse or aggression is the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally and/or to exert control over another person.
- Stalking is a pattern of repeated, unwanted attention and contact by a partner that causes fear or concern for one's own safety or the safety of someone close to the victim.

Abuse between partners is referred to as intimate partner violence (IPV); however, such abuse can also occur between a parent and child (child abuse), adult children and their aging parents (elder abuse), and even between siblings (family violence).

IPV is common. It affects millions of people in the United States each year. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate:

- About 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.
- Over 43 million women and 38 million men have experienced psychological aggression by an intimate partner in their lifetime.

IPV starts early and continues throughout the lifespan. When IPV occurs in adolescence, it is called teen dating violence (TDV). TDV affects millions of U.S. teens each year. About 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before the age of 18.

Image credit: CDC (2021)

What are the consequences?

IPV is a significant public health issue that has many individual and societal costs. About 35% of female IPV survivors and more than 11% of male IPV survivors experience some form of physical injury related to IPV. IPV can also result in death. Data from U.S. crime reports suggest that about 1 in 5 homicide victims are killed by an intimate partner. The reports also found that over half of female homicide victims in the U.S. are killed by a current or former male intimate partner.

There are also many other negative health outcomes associated with IPV. These include a range of conditions affecting the heart, digestive, reproduction, muscle and bones, and nervous systems, many of which are chronic. Survivors can experience mental health problems such as depression and posttraumatic stress disorder (PTSD) symptoms. They are at higher risk for engaging in behaviors such as smoking, binge drinking, and sexual risk behaviors.

Although the personal consequences of IPV are devastating, there are also many costs to society. The lifetime economic cost associated with medical services for IPV-related injuries, lost productivity from paid work, criminal justice and other costs, was $3.6 trillion. The cost of IPV over a victim's lifetime was $103,767 for women and $23,414 for men.

How can we stop it before it starts?

Promoting healthy, respectful, and nonviolent relationships and communities can help reduce the occurrence of IPV. It also can prevent the harmful and long-lasting effects of IPV on individuals, families, and communities. CDC developed a technical package, Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices, that includes multiple strategies and approaches to prevent IPV. It also includes approaches that provide support to survivors and lessen harms. The strategies and approaches are meant to be used in combination with each other at many levels of society to prevent IPV.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://openoregon.pressbooks.pub/introtohumansexuality/?p=96#oembed-3

When Relationships End

Inevitably, some relationships do break up, and these separations may cause substantial pain. When the partners have been together for a long time, particularly in a relationship characterized by interdependence and commitment, the pain is even greater (Simpson, 1987). The pain of a breakup is in part due to the loneliness that results from it. People who lose someone they care about also lose a substantial amount of social support, and it takes time to recover and develop new social connections. Lonely people sleep more poorly, take longer to recover from stress, and show poorer health overall (Cacioppo et al., 2002).

The pain of a loss may be magnified when people feel that they have been rejected by the other. The experience of rejection makes people sad, angry, more likely to break social norms, and more focused on self-concern. The ability to effectively self-regulate is lowered, and people are more likely to act on their impulses (Baumeister, DeWall, Ciarocco, & Twenge, 2005). But people who have been rejected are also more motivated by other-concern; they are particularly likely to try to make new friends to help make up for the rejection (Gardner, Pickett, & Brewer, 2000). Although people who have been rejected are particularly hurt, people who have rejected others may feel guilty about it.

Breaking up is painful, but people do recover from it, and they usually move on to find new relationships. Margaret Stroebe and her colleagues (Stroebe, Hansson, Schut, & Stroebe, 2008) found that people adjusted to the loss of a partner, even one with whom they had been with for a long time, although many did have increased psychological difficulties, at least in the short term.

Monogamy Alternatives

While 90% of people in Western cultures will marry by age 50, the divorce rate in the United States ranges between 40% and 50% of all first marriages (APA, 2021). Serial monogamy, engaging in a series of monogamous sexual relationships, is often very common. Cheating, also known as non-consensual non-monogamy, is when someone within an agreed-upon closed sexual and romantic relationship engages in sexual and romantic behavior with a person outside the relationship without the permission of the partner. Kruger et al. (2013) discuss how certain behaviors are viewed as more clearly cheating, such as engaging in sexual intercourse, whereas romantic and emotional connections were rated as more ambiguous and unclear by most participants. Women, on average, rated infidelity on the basis of dating and spending time with another while keeping secrets about it while men, overall, gauged that it was infidelity based on if the partner was engaging in sexual behaviors with someone else (Kruger et al., 2013). Mark et al. (2011) found that almost 25% of men and 20% of women had perceived their own behaviors as cheating within their current heterosexual/straight relationship.

The idea of "true love" or finding our "soul mate" places a lot of pressure on one person to meet all of our needs emotionally, sexually, romantically, spiritually, intellectually, etc. With friends, we can recognize that we go to certain people when we want to have deep intellectual conversations and someone else perhaps when we want to get advice or support when we are upset. Consensual non-monogamy (CNM) is an umbrella term that encompasses relational flexibility in which sexual and romantic behaviors involving others are permitted and agreed upon by people within primary relationships. Boundaries are established and each relationship will have particular rules around what is permitted and what is not permitted. If behaviors break what is agreed-upon, then this would be considered non-consensual. Thus, effective and healthy communication around boundaries, needs, wants, and limits are of the greatest importance. As with any relationship, feelings of jealousy and self-esteem can evoke strong emotions, but navigating this space with compassion and openness allows for resolution and transformation. As with monogamy, open relationships require work and dedication to maintaining the relationships. If you are considering being in a CNM relationship, review Is Consensual Non-Monogamy for You? by the American Counseling Association (2019). Consensual non-monogamy is becoming more accepted within American culture, but stigma and shame can still lead to minority stress and stigma (Schechinger, 2017). 20% of Americans surveyed indicated that have participated in CNM relationships at some time in their life while 5% indicated they are currently in CNM relationships. A growing body of research is also exploring how animals and humans are more non-monogamous by nature and are seeing evolutionary benefits to increased relational and mating opportunities (Orion, 2018).

Intersecting Identities and Power Dynamics

"I am not racist because I am married to a Black man." This quote reflects the view that merely being in a relationship with someone means that love can transgress all socialization, internalization of stereotypes, and power inequalities within a society. The reality is that loving someone with differing intersecting identities involves intentionality and mindfulness around hierarchies of power that exist within the greater society and how that can influence power dynamics within relationships. Some examples of dominant identities would be white, male, cisgender, straight, Christian, etc. "Systemically non-dominant refers to membership outside of the dominant group within systems of oppression. Systems of oppression are created to provide benefits and assets for members of specific groups. The recipient groups are referred to as dominant groups because such advantages grant impacting levels of power, privilege, and status within social, economic, and political infrastructures of a society" (Jenkins, 2015). When a romantic partner, or even a friend, is of the dominant group in terms of one identity and the other partner or friend is of a systemically non-dominant group, then microaggressions can intentionally or unintentionally be inflicted upon the person from the non-dominant group. Thus, the greatest amount of work must be done by the person of the dominant group to not inflict harm upon the other.

Gender, race, and class are just a few identities that intersect to create power imbalances within relationships (Viveros Vigoya, 2015). Through colonization in many parts of the world, modernity has been associated with whiteness and patriarchy which invades relationships by privileging the voices of the members of families and the community that more closely resemble whiteness and maleness (Viveros Vigoya, 2015). This is then internalized and comes out within interpersonal dynamics between romantic partners. The biggest amount of strain is then inflicted upon sexual minorities, gender non-conforming people and cisgender women, especially when they are BIPOC and have access to fewer available financial resources because of additional social constructs acting as barriers (Viveros Vigoya, 2015).

Relationships as a Protective Factor

Relationships can shield partners from the destructiveness of marginalization through social support and countering the dominant narrative. Intersecting identities exist in a way in which one partner may have a privileged and dominant identity in one context but a different marginalized and oppressed identity in another context or partners may both have marginalized identities but in different ways. If a partner, who is a member of the dominant culture, uses this power differential against a partner with a marginalized culture, then the relationship will not serve as a protective factor against the harms incurred by the larger society.

Queering Straight Relationships

Ober (2020) argues that all relationships can benefit from utilizing the tools found within queer (LGB+) relationships from a queer critical theory lens. For instance, within many queer relationships, gender roles are questioned and more egalitarian practices between partners are utilized, leading to healthier relationships (Ober, 2020). Within heterosexual/straight dynamics, some men can value their status and seek sexual conquests because of the way other males will perceive them, which devalues the pleasure of women and relegates them to objects (Ober, 2020). This causes women within these straight relationships to be unhappy and unsatisfied, which is normalized within a patriarchal and heteronormative society (Ober, 2020). Thus, straight people, especially straight men, can learn a lot from queer relationships from this perspective. “This does not necessarily mean embracing common queer practices such as nonmonogamy, kink, or chosen families. It means straight people can learn to desire, objectify, satisfy, and respect their partners all at the same time, as well as have hot sex and equitable relationships in the way that most queer couples strive to do” (Ober, 2020).

Being an Ally within Romantic Relationships

While intersecting identities are incredibly complex and cause shifting power dynamics within relationships, returning once again to the concept of allyship can help to alleviate the minority stress and strain experienced by partners. By practicing allyship in general and within relationships, community change and developing dynamics that are protective rather than harmful are possible. Here are some tips on ways to be an ally and think about how you can incorporate these techniques within intimate, romantic relationships as well as with friends and acquaintances:

- Be An Ally (Cornell University, 2021)
- Becoming an Ally (University of Nevada Las Vegas, 2021)
- 8 Ways To Be a (Better) Ally (Syracuse University, 2020)

Final Remarks: Out of Complexity Comes Simplicity

As Part 1 of the textbook comes to an end, we want to highlight once again that human sexuality is incredibly complex and each person has a unique perspective based on the way their multiple identities come together and shape their development. Human experience exists on continuums of possibilities and even labels can mean different things to different people. However, out of all this complexity comes simplicity–humanity is about connection.

If you are ever stuck in understanding something, simply ask questions and explore with curiosity and humility. We do not know all of the answers, and that is okay and beautiful. By educating ourselves and constantly researching the world around us while also creating space for people to share their perspectives and identities, we let the complexity of human experience unfold without putting pressure on ourselves to find predetermined labels or operate off of our assumptions. At the end of the day, creating safe environments through our actions and statements, listening to and honoring the experiences of others, and sharing our life’s stories with others are all that matters.

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Adaptations: Reformatted. Added learning objectives. Modified content for language, application to subject and cohesion. Updated sources. Added links to resources for further enagement.

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CHAPTER OVERVIEW

2: Part II - Professional and Clinical Topics in Human Sexuality

Part 2 of this human sexuality textbook contains 10 chapters oriented toward professional and clinical topics within human sexuality.

2.1: Terminology Review and Preview
2.2: Sexual Development Through the Lifespan
2.3: Contraception
2.4: Sexually Transmitted Infections
2.5: Conception, Pregnancy, and Birth
2.6: Variations in Sexual Behavior
2.7: Sexual Dysfunction and Treatment
2.8: Sexual Marketplace
2.9: Trauma, Therapy, and Trauma Informed Care
2.10: Ability, Intersectionality, Body Image, and Reclaiming Our Bodies

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2.1: Terminology Review and Preview 2.1: Terminology Review and PreviewEdit Update titlecancel

The following reading is to introduce you to some basic concepts we will be covering in greater depth throughout the quarter. Some terminology overlaps and will be a review for those who took PSY 231, but overall much of this information will be new. Re-read Chapter 1 if you would like a refresher on the terminology and safe space rules from 231 that will be utilized for this course as well. The rest of the definitions and topics covered below will be specific to this course as it is more clinical in perspective with many overlaps to health psychology, nursing, medicine, public health, community health, and more.

Health Psychology and Human Sexuality

Health psychology is a subfield that seeks to understand the health-seeking and risk-taking behaviors of people. Self-efficacy, feeling competent to engage in certain behaviors, plays a central role in determining the actions people will take based on a number of social, interpersonal, personal, and structural factors. Health psychology explores ways that public health workers and medical providers can communicate effectively to not reproduce social stigma and shame and ways that educational materials can be developed utilizing health communication techniques to make them more relevant and representative of the target audience. Take for instance the Covid-19 pandemic, to outreach to community members, public health departments needed to make sure testing and vaccination information was available in the languages spoken by the populations who needed the information and that the testing and vaccination sites had staff who were able to communicate with the public effectively. In many cases, partnering with local agencies, such as local chapters of the NAACP (National Association for the Advancement of Colored People) or LULAC (the League of United Latin American Citizens), was vital to the success of the public outreach campaign. The intersecting identities of the target audiences of health information need to be represented in the outreach materials, and centering the voices of those who identify as members of the target audience is a priority.

Relating this to human sexuality, health psychology is utilized to attempt to predict risky sexual behaviors and develop interventions to alter behaviors toward being safer. Sex education in high school as well as public service announcements are ways to educate the public. More specific campaigns can be utilized when there is an outbreak of certain STIs within communities or when therapists are creating brochures for their offices to normalize sexual dysfunctions and inform the public about possible treatments. This course will be focused on developing community-based educational tools for specific populations with intersecting identities in mind to make the messages more relevant and representative in order to address gaps in human sexuality outreach.

Differently-Abled/Disabled

While definitions were previously provided in Chapter 1 related to gender, LGBTQIA+ identities, and intersecting identities as a whole, differently-abled/disabled were not previously defined. This course will pay special attention to the way that being differently-abled or disabled may impact sexual functioning and relationships and are defined in the following ways:

- Differently-abled is an umbrella term that many individuals now prefer
- Some individuals still prefer the term disabled
- Can be visible or invisible
- Could be constant or flare up at different times
- May be mental (intellectual, cognitive, information processing, mental health, etc.) or physical
- Have genetic or environmental causes
- Chronic pain may be a factor

Most people will become differently-abled at some point in their life; some permanently, some only for a period of time.

Disorder versus Atypical

Sexual disorders, dysfunctions, paraphilias, and fetishes will be explored from a mental health and psychopharmacological clinical perspective. We will also explore atypical sexual behaviors that others often label using similar terms to clinical diagnoses but are not related to mental health concerns. Keep this in mind:

- Atypical means less common; this is not a mental health diagnosis
- Disorder means that it causes an individual distress, impairment in daily functioning, relationships, work, or schooling, or causes the self or others (including animals) harm; a mental health practitioner can provide a diagnosis

Did you know that homosexuality used to be classified as a disorder by the American Psychological Association until 1973 (Drescher, 2015)? Conversion Therapy is still practiced in many states even today. 20 states, Puerto Rico, and Washington, D.C. have banned the practice with Virginia becoming the most recent state to ban this practice as of March 2nd, 2020 (Weir, 2020).

Two highly debated disorders remain: transvestic fetishism and gender dysphoria.

Interesting Statistics

LGB people make up about 3.5% (The Williams Institute, 2011)-4.5% (Newport, 2018) of the general population; highest amongst younger generations–Millennials come in at 8.2% (Newport, 2018).

BDSM or kink–How many people are into it? Check out this interesting read from Magliano (2015).

Sexual Disorders

Divided into two categories (Comer, 2016):

1. Sexual dysfunctions–problems with sexual responses
2. Paraphilias–repeated and intense sexual urges and fantasies in response to socially inappropriate objects or situations

*Again, must meet the threshold for distress, impairment or harm to be diagnosed

Sex Work

Sex work is an umbrella term that encompasses many roles within the sex industry in which an individual receives compensation for their role. Sex work includes:

- Those who provide direct sexual services, even through the phone or online
- Staff members at all levels within the sex industry
- Talent managers

In ideal situations, sex workers are freely consenting at all times, but, due to the underground and unregulated nature of much of the sex industry, exploitation and harm are still possible.

The World Health Organization (2021) states that decriminalizing sex work will benefit health outcomes.

Sex Trafficking

- Sex traffickers target vulnerable populations, particularly foster care youth, sexual minorities, transgender women, racial minorities, and undocumented immigrants–if any of these identities intersect, then the person becomes even more vulnerable to exploitation due to social, structural and systemic barriers.
- Psychological and physical abuse are used as tools by sex traffickers.
- Sometimes the individuals being trafficked can begin to believe their captors and even help them in recruiting others.
- The individuals being trafficked are always victims and consent is not possible due to many factors.

Trauma-Informed Care

Trauma-informed care means interacting with others in a safe and sensitive way that prevents retraumatization and promotes the development of healthy coping skills. Many individuals will experience trauma, specifically a trauma of sexual nature, so it is important to develop skills to promote healing. Important competencies:

- Recognize trauma symptoms and address behaviors rather than further blame the individual (re-victimizing)
- Develop interpersonal, community-based, and institutional levels of intervention and support

Resources:

Overview of trauma and what being trauma-informed looks like with the mental health field (SAMHSA, 2014) and the medical field (Tello, 2018)

Questions and Empowerment

Questions: Society

1. What is the role of shame and stigma in influencing sexuality? How can we work to promote consent, healthy communication, and community-based change?
2. What are some ways that society might influence people in developing harmful sexual behaviors?

3. What is the role of isms (sexism, racism, ableism, classism, etc.) in promoting sexual violence?
4. How has colonialism contributed to the shaming and spread of disinformation regarding sexuality?
5. What changes need to be made in order to make our society better?

Questions: Allyship

1. What can we do in our interactions with others to be supportive rather than further add to the shame and stigma people may feel?
2. What can we actively do to counter isms both intrapersonally (within ourselves in the form of bias, stereotyping, cognitive schemas, etc.) and interpersonally (in our communication and interactions with other people)?
3. What can we do to support victims of sexual violence?
4. How can we support people who are at risk of harming others, and how can we support perpetrators of sexual violence in their change process?

Empowerment

This will be a recurring theme throughout this course in order to:

1. Analyze and heal from society-based harms related to sexuality
2. Understand our rights and the resources available
3. Advocate for ourselves and others
4. Maintain a sex-positive and consent-based perspective and be able to recognize when our own or others' behaviors are harmful
5. Develop a sense of community and support
6. Utilize skills to be a changemaker in our relationships, workplace, community, and society

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2.2: Sexual Development Through the Lifespan 2.2: Sexual Development Through the LifespanEdit Update titlecancel

Learning Objectives

- Acquire knowledge about the biological, psychological and cultural milestones in human sexual development.
- Critically differentiate between theoretical perspectives of childhood sexual development.
- Demonstrate an understanding of childhood and adolescent sexual growth and development from biological, psychological, social and cultural perspectives, and reflect on this process from a personal perspective.
- Explain how sexual values, attitudes and behavior may be expressed during the adult years within different contexts including: single living, cohabitation, marriage, consensual and non-consensual extramarital relationships, divorce, aging, widowhood.

Introduction

While sex and sexuality are often linked to late adolescence/early adulthood, this week's topic explores sexuality throughout the entire lifespan. From neonatal observations to the experience of octogenarians, elements of sexuality are present throughout most of life. Although the context is surely different based on age and experience, there are still considerable domains to explore in terms of sensate experiences, genital awareness, maturation and individual and/or partnered sexual interactions. Using a biopsychosocial approach, including aspects of psychodynamic theory, we will explore elements of sex and sexuality that may occur throughout one's lifetime. Sexual education is often taught in middle school or high school, unless an abstinence-only program is in place, but could there be benefits to openly talking about sex and being a lifelong learner when it comes to relationships and sexual satisfaction?

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Theoretical Approaches

Using both a historical lens, as well as a more contemporary approach we want to first examine influential theories applied to sexuality through the lifespan. If you've taken any other psychology courses, you may find the following section a bit of a review since we are going to primarily discuss and apply Freud's psychosexual stages of development as well as Erik Erikson's psychosocial stages of development. As you read, consider- how do their ideas still show up in modern understanding of sexual development, including language, cultural norms, and/or values? Can you see any aspects of these theories as applied to your own experiences?

Freud's Psychosexual Stages of Development

Freud believed that personality develops during early childhood: Childhood experiences shape our personalities as well as our behavior as adults. He asserted that we develop via a series of stages during childhood. Each of us must pass through these childhood stages, and if we do not have the proper nurturing and parenting during a stage, we will be stuck, or fixated, in that stage, even as adults.

In each psychosexual stage of development, the child's pleasure-seeking urges, coming from the id, are focused on a different area of the body, called an erogenous zone. The stages are oral, anal, phallic, latency, and genital.

Freud's psychosexual development theory is quite controversial. To understand the origins of the theory, it is helpful to be familiar with the political, social, and cultural influences of Freud's day in Vienna at the turn of the 20th century. During this era, a climate of sexual repression, combined with limited understanding and education surrounding human sexuality, heavily influenced Freud's perspective. Given that sex was a taboo topic, Freud assumed that negative emotional states (neuroses) stemmed from suppression of unconscious sexual and aggressive urges. For Freud, his own recollections and interpretations of patients' experiences and dreams were sufficient proof that psychosexual stages were universal events in early childhood.

Stage	Age (years)	Erogenous Zone	Major Conflict	Adult Fixation Example
Oral	0–1	Mouth	Weaning off breast or bottle	Smoking, overeating

Stage	Age (years)	Erogenous Zone	Major Conflict	Adult Fixation Example
Anal	1–3	Anus	Toilet training	Neatness, messiness
Phallic	3–6	Genitals	Oedipus/Electra complex	Vanity, overambition
Latency	6–12	None	None	None
Genital	12+	Genitals	None	None

Oral Stage

In the oral stage (birth to 1 year), pleasure is focused on the mouth. Eating and the pleasure derived from sucking (nipples, pacifiers, and thumbs) play a large part in a baby's first year of life. At around 1 year of age, babies are weaned from the bottle or breast, and this process can create conflict if not handled properly by caregivers. According to Freud, an adult who smokes, drinks, overeats, or bites her nails is fixated in the oral stage of her psychosexual development; she may have been weaned too early or too late, resulting in these fixation tendencies, all of which seek to ease anxiety.

Anal Stage

After passing through the oral stage, children enter what Freud termed the anal stage (1–3 years). In this stage, children experience pleasure in their bowel and bladder movements, so it makes sense that the conflict in this stage is over toilet training. Freud suggested that success at the anal stage depended on how parents handled toilet training. Parents who offer praise and rewards encourage positive results and can help children feel competent. Parents who are harsh in toilet training can cause a child to become fixated at the anal stage, leading to the development of an anal-retentive personality. The anal-retentive personality is stingy and stubborn, has a compulsive need for order and neatness, and might be considered a perfectionist. If parents are too lenient in toilet training, the child might also become fixated and display an anal-expulsive personality. The anal-expulsive personality is messy, careless, disorganized, and prone to emotional outbursts.

Phallic Stage

Freud's third stage of psychosexual development is the phallic stage (3–6 years), corresponding to the age when children become aware of their bodies and recognize the differences between boys and girls. The erogenous zone in this stage is the genitals. Conflict arises when the child feels a desire for the opposite-sex parent, and jealousy and hatred toward the same-sex parent. For boys, this is called the Oedipus complex, involving a boy's desire for his mother and his urge to replace his father who is seen as a rival for the mother's attention. At the same time, the boy is afraid his father will punish him for his feelings, so he experiences castration anxiety. The Oedipus complex is successfully resolved when the boy begins to identify with his father as an indirect way to have the mother. Failure to resolve the Oedipus complex may result in fixation and development of a personality that might be described as vain and overly ambitious.

Girls experience a comparable conflict in the phallic stage—the Electra complex. The Electra complex, while often attributed to Freud, was actually proposed by Freud's protégé, Carl Jung (Jung & Kerenyi, 1963). A girl desires the attention of her father and wishes to take her mother's place. Jung also said that girls are angry with the mother for not providing them with a penis—hence the term penis envy. While Freud initially embraced the Electra complex as a parallel to the Oedipus complex, he later rejected it, yet it remains as a cornerstone of Freudian theory, thanks in part to academics in the field (Freud, 1931/1968; Scott, 2005).

Perhaps one of the most important take-aways from this aspect of Freud's theory, is the unfortunate application of sexualizing children's genital curiosity and sensate process. Children are inherently curious about their bodies at this stage of development, which is something that Freud observed. However, it's critical to note that curiosity and even some aspects of individual or social physical exploration isn't inherently sexual like what mature folks experience. Part of the reason this is still covered in human sexuality is to address the cultural legacy of aspects of over-sexualizing children, as well as victim-blaming (creating culpability for sexual offenses where none exists).

Latency Period

Following the phallic stage of psychosexual development is a period known as the latency period (6 years to puberty). This period is not considered a stage, because sexual feelings are dormant as children focus on other pursuits, such as school, friendships, hobbies, and sports. Children generally engage in activities with peers of the same sex, which serves to consolidate a child's gender-role identity.

Genital Stage

The final stage is the genital stage (from puberty on). In this stage, there is a sexual reawakening as the incestuous urges resurface. The young person redirects these urges to other, more socially acceptable partners (who often resemble the other-sex parent). People in this stage have mature sexual interests, which for Freud meant a strong desire for the opposite sex. Individuals who successfully completed the previous stages, reaching the genital stage with no fixations, are said to be well-balanced, healthy adults.

While most of Freud's ideas have not found support in modern research, we cannot discount the contributions that Freud has made to the field of psychology. It was Freud who pointed out that a large part of our mental life is influenced by the experiences of early childhood and takes place outside of our conscious awareness; his theories paved the way for others. Most importantly, the notion that early attachment matters in terms of our future personal relationships (including romantic and sexual) are domains of important modern research and application.

Erik Erikson's Psychosocial Theory of Development

Erik Erikson (1902–1994), another stage theorist, took Freud's theory and modified it as psychosocial theory. Erikson's psychosocial development theory emphasizes the social nature of our development rather than its sexual nature. While Freud believed that personality is shaped only in childhood, Erikson proposed that personality development takes place all through the lifespan. Erikson suggested that how we interact with others is what affects our sense of self, or what he called the ego identity.

In each stage of Erikson's theory, there is a psychosocial task that we must master in order to feel a sense of competence.

Erikson proposed that we are motivated by a need to achieve competence in certain areas of our lives. According to psychosocial theory, we experience eight stages of development over our lifespan, from infancy through late adulthood. At each stage there is a conflict, or task, that we need to resolve. Successful completion of each developmental task results in a sense of competence and a healthy personality. Failure to master these tasks leads to feelings of inadequacy.

Although Erikson's theory is still subject to controversies, it does have modern application to lifespan development, especially when one considers that, unlike Freud, Erikson sought to describe the entirety of a person's life. Each of his psychosocial stages will be applied as we discuss each phase of development below. The chart below highlights Erikson's original ideas around age and timing of developmental tasks. With advances in our understanding of brain maturation, as well as our increased lifespan, these ages may be adjusted in our discussion.

Stage	Age (years)	Developmental Task	Description
1	0–1	Trust vs. mistrust	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
2	1–3	Autonomy vs. shame/doubt	Develop a sense of independence in many tasks
3	3–6	Initiative vs. guilt	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
4	7–11	Industry vs. inferiority	Develop self-confidence in abilities when competent or sense of inferiority when not
5	12–18	Identity vs. confusion	Experiment with and develop identity and roles
6	19–29	Intimacy vs. isolation	Establish intimacy and relationships with others
7	30–64	Generativity vs. stagnation	Contribute to society and be part of a family

Stage	Age (years)	Developmental Task	Description
8	65–	Integrity vs. despair	Assess and make sense of life and meaning of contributions

Erikson's Psychosocial Stages of Development

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Sexual Development in Early Childhood

Historically, children have been thought of as innocent or incapable of sexual arousal (Aries, 1962). Yet, the physical dimension of sexual arousal is present from birth. However, to associate the elements of seduction, power, love, or lust that are part of the adult meanings of sexuality would be inappropriate. Sexuality begins in childhood as a response to physical states and sensation and cannot be interpreted as similar to that of adults in any way (Carroll, 2007).

Infancy

Boys and girls are capable of erections and vaginal lubrication even before birth (Martinson, 1981). Arousal can signal overall physical contentment and stimulation that accompanies feeding or warmth. Infants begin to explore their bodies and touch their genitals as soon as they have the sufficient motor skills. This stimulation is for comfort or to relieve tension rather than to reach orgasm (Carroll, 2007).

According to Erikson (1963), trust is the basis of our development during infancy (birth to 12 months). Therefore, the primary task of this stage is trust versus mistrust. Infants are dependent upon their caregivers, so caregivers who are responsive and sensitive to their infant's needs help their baby to develop a sense of trust; their baby will see the world as a safe, predictable place. Unresponsive caregivers who do not meet their baby's needs can engender feelings of anxiety, fear, and mistrust; their baby may see the world as unpredictable.

Early Childhood

Self-stimulation is common in early childhood for both boys and girls. Curiosity about the body and about others' bodies is a natural part of early childhood. As children grow, they are more likely to show their genitals to siblings or peers, and to take off their clothes and touch each other (Okami, Olmstead, & Abramson, 1997). As toddlers (ages 1–3 years) begin to explore their world, they learn that they can control their actions and act on the environment to get results. They begin to show clear preferences for certain elements of the environment, such as food, toys, and clothing. A toddler's main task is to resolve the issue of autonomy versus shame and doubt, by working to establish independence. This is the "me do it" stage. For example, we might observe a budding sense of autonomy in a 2-year-old child who wants to choose her clothes and dress herself. Although her outfits might not be appropriate for the situation, her input in such basic decisions has an effect on her sense of independence. If denied the opportunity to act on her environment, she may begin to doubt her abilities, which could lead to low self-esteem and feelings of shame.

Once children reach the preschool stage (ages 3–6 years), they are capable of initiating activities and asserting control over their world through social interactions and play. According to Erikson, preschool children must resolve the task of initiative versus guilt. By learning to plan and achieve goals while interacting with others, preschool children can master this task. Those who do will develop self-confidence and feel a sense of purpose. Those who are unsuccessful at this stage—with their initiative misfiring or stifled—may develop feelings of guilt.

During the preschool years, children may become increasingly aware of their bodies, which can lead to individual and peer-to-peer sexual play. Indeed physical exploration games are very common between young children, with 50 to 85 percent of kids engaging in some sort of game play that involves fantasy sexual play, exposure or stimulation of genitals (O'Donovan, 2010). How adult caregivers respond to this play can be critically important to later, mature sexual experiences.

Middle Childhood Sexual Development

Although Freud determined that middle childhood was simply a time of latency, that it's a time when children's sexual interests are dormant, modern understanding of sexuality tells a different story. Even Erikson noted that this stage of development is significant and that the objective is to move through industry vs. inferiority. In other words, kids are intent on gaining a sense of self and

ability, of competency in their tasks and relationships. If not, Erikson argued that they may experience inferiority. With regard to sexual development, children this age may not experience the wide-eyed curiosity of their earlier years, but they also may not have entered puberty yet. Interestingly, in one survey men and women, regardless of sexual orientation, reported that the average age of their first sexual attraction was around 10 years old (Lehmiller, 2018), which reflects that there are more factors impacting school-aged children than early theory suggests.

In many western societies, school-aged children are often given their first set of educational information about their upcoming changing bodies, puberty and reproduction. For trans youth, this time can be challenging based on concerns around physical changes at the onset of puberty. Early messages about bodies, sex and sexuality can have important effects on later attitudes and behavior. There is ongoing evidence that comprehensive sex education before young people become sexually active results in a delay in the onset of sexual activity AND an increase in sexual well being (O'Donovan, 2010). Additionally, support for trans youth in terms of available health options is imperative for their ongoing physical and mental health outcomes (Turban, King, Carswell, & Keuroghlian, 2020).

Sexual Development in Adolescence

Adolescent Sexual Development

Typically, the growth spurt is followed by the development of sexual maturity. Sexual changes are divided into two categories: Primary sexual characteristics and secondary sexual characteristics. Primary sexual characteristics are changes in the reproductive organs. For males, this includes growth of the testes, penis, scrotum, and spermarche or first ejaculation of semen. This occurs around 9-14 years old (Breehl & Caban, 2020). For females, primary characteristics include growth of the uterus and menarche or the first menstrual period. The female gametes, which are stored in the ovaries, are present at birth, but are immature. Each ovary contains about 400,000 gametes, but only 500 will become mature eggs (Crooks & Baur, 2007). Beginning at puberty, one ovum ripens and is released about every 28 days during the menstrual cycle. Stress and a higher percentage of body fat can bring menstruation at younger ages. According to Breehl & Caban (2020), puberty begins on average for girls around 8-13 years old with African American girls starting puberty earlier at around 6 years old.

Stress and elevated levels of cortisol are associated with earlier puberty, especially in girls (Belsky et al., 2015). Racial microaggressions and minority stress take a toll on the body and influence mental and physical health at the intersection of race and gender (Lewis et al., 2017). In addition to most research being conducted on White girls and when they reach puberty, other health outcomes that disproportionately impact Black girls have not been researched enough (Salsbury et al., 2009). While puberty for girls of all races and ethnicities has been decreasing over the past several years, Black girls "have the lowest median age of menarche and the highest rate of childhood obesity" (Salsbury et al., 2009, p. 2). Latina youth also start puberty earlier due to similar impacts of stress and higher body mass indexes (BMIs) at a younger age (Jean et al., 2009). Something to keep in mind, research based on race and ethnic differences in pubertal timing are still very limited and it is important to question the notion of what constitutes normative BMI, especially when studies are conducted on mostly White populations. Additionally, while the timing of puberty has significant social implications which then impacts self-esteem, this interaction is also context-dependent and based on many intersecting and complex factors. Every single person may have a different experience related to puberty due to the way peers treat them and the messages they receive from the media, teachers, family, religious institutions, and more about this process.

Precocious and Delayed Puberty

If a girl begins puberty before age 8 and boys before age 9, then they would be considered to have precocious (or early) puberty (National Institute of Child Health and Human Development [NICHD], 2016). Some children may experience psychological and social problems related to feeling different than their peers (NICHD, 2016). Boys are less likely to experience negative consequences, such as bullying, if they develop earlier. Individuals who develop earlier may be perceived by others as more mature and older than they are developmentally. Thus, girls may face greater levels of sexualization earlier and boys may experience reduced levels of bullying due to their size and increased body mass.

Delayed puberty is when a girl experiences a lack of breast growth by age 13 or the lack of a period (menarche) by age 16 (Tang et al., 2020). For boys, this is when testicular enlargement has not occurred by age 14 (Tang et al., 2020). Girls and boys may experience bullying from peers due to their smaller and more child-like appearance. Boys in particular may face heightened levels of bullying and negative self-esteem consequences.

Context is Important

According to the literature review conducted by Seaton & Carter (2018), "Given ethnic/racial variations in standards of physical attractiveness, being a member of a racial group can influence body image norms. African American girls tend to describe their beauty ideals in terms of personality characteristics such as style, attitude, pride, and confidence; whereas White girls tend to describe their beauty ideals in terms of fixed physical attributes such as tall, thin, and high cheekbones… Researchers have speculated that adolescent girls who adopt body ideals in terms of personality characteristics are less vulnerable to the distress generated by puberty" (p. 42). Seaton & Carter (2018) found in their research that Black girls who view their racial identity as more central to their sense of self will experience more distress if they enter puberty later, especially if they attend a school that is predominately White. Late developing Black girls also may be further bullied by peers, so earlier puberty could act as a protection against racialized microaggressions since early maturing girls are perceived as more mature and advanced by peers within the school context (Seaton & Carter, 2018).

Jean et al. (2009) explored family dynamics and differences in acculturation between younger and older generations of Mexican Americans. The researchers found that mothers who immigrated to the United States in adulthood viewed their body size more favorably compared to their daughters who grew up attending school in the United States. Fathers were also generally very supportive of their daughters' weight and size. Based on interviews with the girls compared to their parents, acculturation caused internalized beauty ideals that favored thinness and height more than that of their mothers and fathers. The length of time in the United States was associated with peer influence shaping standards of beauty more than family. Therefore, generational differences and acculturation can also influence body image and self-esteem. The girls who resisted acculturation actually showed more body satisfaction as their bodies began to change due to puberty when compared to the girls who internalized more American beauty standards (Jean et al., 2009).

Hormone Blockers for Transgender Individuals

An area of debate is whether transgender youth should be able to take hormone blockers prior to and during puberty in conjunction with hormone therapy in order to prevent unwanted changes during puberty and to bring about a puberty that more closely matches that of their gender identity because our society heavily correlates physical features with gender. For example, testosterone acts on the vocal cords to deepen the voice and body mass begins to redistribute which can be distressing to some transgender girls. Hormone blockers would prevent this process from occurring. However, some people argue that children cannot make such serious decisions for themselves and legally parents or guardians are the ones who consent to medical care on their youths' behalf. This commonly results in a person needing to wait until they can consent to medical care for themselves before they can receive hormone therapy. At this point, puberty has already made lasting changes to the body that will take greater levels of medical intervention to alter.

Turban et al. (2020) and Achille et al. (2020) found that transgender youth who wanted and were provided with pubertal suppression hormones experienced a significant decrease in suicidal ideation, depression, and anxiety and reported improved overall mental health. According to Turban et al. (2020), the Endocrine Society guidelines and the World Professional Association for Transgender Health (WPATH) Standards of Care both recommend that transgender adolescents be offered puberty blockers, which are formally called gonadotropin-releasing hormone analogues (GnRHas).

People who are Intersex and Puberty

- Read "What Happens During Puberty If I'm Intersex" by Planned Parenthood (2021)

How to Support Youth Going through Puberty and Early Adolescence

- "Staying Connected: A Guide for Parents on Raising an Adolescent Daughter"- a brochure by the American Psychological Association (2001)
- "Helping Your Child through Early Adolescence" – a booklet by the US Department of Education (2005)

Adolescent Sexual Activity

By about age ten or eleven, most children experience increased sexual attraction to others that affects social life, both in school and out (McClintock & Herdt, 1996). By the end of high school, more than half of boys and girls report having experienced sexual intercourse at least once, though it is hard to be certain of the proportion because of the sensitivity and privacy of the information. (Center for Disease Control, 2004; Rosenbaum, 2006). The birth rate for teenagers has declined by 58% since 2007 and 72% since 1991, the most recent peak (Hamilton, Joyce, Martin, & Osterman, 2019). It appears that adolescents seem to be less sexually active than in previous years, and those who are sexually active seem to be using birth control (CDC, 2016).

Romantic Relationships

Adolescence is the developmental period during which romantic relationships typically first emerge. By the end of adolescence, most American teens have had at least one romantic relationship (Dolgin, 2011). However, culture does play a role as Asian Americans and Latinas are less likely to date than other ethnic groups (Connolly, Craig, Goldberg, & Pepler, 2004). Dating serves many purposes for teens, including having fun, companionship, status, socialization, sexual experimentation, intimacy, and partner selection for those in late adolescence (Dolgin, 2011). There are several stages in the dating process beginning with engaging in mixed-sex group activities in early adolescence (Dolgin, 2011). The same-sex peer groups that were common during childhood expand into mixed-sex peer groups that are more characteristic of adolescence. Straight romantic relationships often form in the context of these mixed-sex peer groups (Connolly, Furman, & Konarski, 2000). Interacting in mixed-sex groups is easier for teens as they are among a supportive group of friends, can observe others interacting, and are kept safe from a too early intimate relationship.

By middle adolescence, teens are engaging in brief, casual dating or in group dating with established couples (Dolgin, 2011). Then, in late adolescence, dating involves exclusive, intense relationships. These relationships tend to be long-lasting and continue for a year or longer, however, they may also interfere with friendships.

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Although romantic relationships during adolescence are often short-lived rather than long-term committed partnerships, their importance should not be minimized. Adolescents spend a great deal of time focused on romantic relationships, and their positive and negative emotions are more tied to romantic relationships, or lack thereof, than to friendships, family relationships, or school (Furman & Shaffer, 2003).

According to the Pew Research Center (2013), individuals who identify as gay, lesbian and bisexual first realized they may not be straight around age 12, knew for sure they weren’t straight by about 17, and first told someone at about age 20. LGB+ individuals may face discrimination and bullying if they date openly depending on the specific culture and acceptance found at their school site. The prevalence of Gay-Straight Alliances and other types of supportive clubs at school sites mixed with administration and teacher support can serve as protective forces. Younger generations are also coming out much sooner compared to older generations due to society becoming more accepting overall.

Romantic relationships contribute to adolescents’ identity formation, changes in family and peer relationships, and emotional and behavioral adjustment. Furthermore, romantic relationships are centrally connected to adolescents’ emerging sexuality. Parents, policymakers, and researchers have devoted a great deal of attention to adolescents’ sexuality, in large part because of concerns related to sexual intercourse, contraception, and preventing teen pregnancies. However, sexuality involves more than this narrow focus. For example, adolescence is often when individuals who are lesbian, gay, bisexual, or transgender come to perceive themselves as such (Russell, Clarke, & Clary, 2009).

Thus, romantic relationships are a domain in which adolescents’ experiment with new behaviors and identities. However, a negative dating relationship can adversely affect an adolescent’s development. Soller (2014) explored the link between relationship inauthenticity and mental health. Relationship inauthenticity refers to an incongruence between thoughts/feelings and actions within a relationship. Desires to gain partner approval and demands in the relationship may negatively affect an adolescent’s sense of authenticity. Soller found that relationship inauthenticity was positively correlated with poor mental health, including depression, suicidal ideation and suicide attempts, especially for females.

Sexual Attraction and Sexual Identity Development

In Erikson’s terms, the time during adolescence is marked by the formation of identity versus role confusion. According to Carroll (2016), by age 14 most adolescents become interested in intimate relationships, and they may begin sexual experimentation. Many adolescents feel pressure to express interest in opposite-sex relationships, even if they are not ready to do so. This pressure can be

especially stressful for those adolescents who are gay, lesbian, bisexual or questioning their sexual identity. Many adolescents who are LGB+ struggle with negative peer and family reactions during their exploration. A lack of parental acceptance especially can adversely affect the gay, lesbian or bisexual adolescent's emerging sexual identity and can result in feelings of depression. In contrast, adolescents whose families support their sexual identity have better health outcomes.

In terms of sexual exploration with their peers, there is a fairly typical progression of behavior patterns that exists. Among Americans, the average of kissing is between 12-14, heavy petting and genital fondling occurs between 15 and 16 and average of first intercourse typically occurring between ages 16 and 18 (Lehmiller, 2018). Of course, there are numerous factors that may vary these averages (biopsychosocial factors, such as onset of puberty, physical abilities, sense of identity and/or acceptance of sexual engagement, social standing, safety, etc). Research demonstrates that the earlier teens engage in penile-vagina sex, the less likely they are to use contraception, more likely to contract a sexually transmitted infection (STI) or experience unplanned, teen pregnancy (Lehmiller, 2018). Two important notes here: First, early sexual debut doesn't always result in negative health consequences (especially when comprehensive sex education is available). And, secondly, one of the challenges of translating sexual behaviors among all teens is that research has often limited its' scope of inquiry to penile-vagina intercourse. Certainly, this information is relevant, yet more research into LGB+ sexual behavior, as well as cultural and societal influences in teen attitudes, are important considerations.

Sexual Development During Emerging and Early Adulthood

Emerging adulthood is the period between the late teens and early twenties; ages 18-25, although some researchers have included up to age 29 in the definition (Society for the Study of Emerging Adulthood, 2016). Jeffrey Arnett (2000) argues that emerging adulthood is neither adolescence nor is it young adulthood. Individuals in this age period have left behind the relative dependency of childhood and adolescence but have not yet taken on the responsibilities of adulthood. "Emerging adulthood is a time of life when many different directions remain possible, when little about the future is decided for certain, when the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course" (Arnett, 2000, p. 469).

Erikson's (1950, 1968) sixth stage, intimacy versus isolation, focuses on establishing intimate relationships or risking social isolation. Intimate relationships are more difficult if one is still struggling with identity. Achieving a sense of identity is a life-long process, as there are periods of identity crisis and stability. However, once identity is established intimate relationships can be pursued. These intimate relationships include acquaintanceships and friendships, but also the more important close relationships, which are the long-term romantic relationships that we develop with another person, for instance, in a marriage (Hendrick & Hendrick, 2000).

Hooking Up

United States demographic changes have significantly affected the romantic relationships among emerging and early adults. As previously described, the age for puberty has declined, while the times for one's first marriage and first child have been pushed to older ages. This results in a "historically unprecedented time gap where young adults are physiologically able to reproduce, but not psychologically or socially ready to settle down and begin a family and child rearing," (Garcia, Reiber, Massey, & Merriwether, 2012, p. 172). Consequently, according to Bogle (2007, 2008) traditional forms of dating have shifted to more casual hookups that involve uncommitted sexual encounters. Table 7.6 Reasons for Staying Single Have not met the right person 30% Do not have financial stability 27% Not ready to settle down 22% Too young to marry 22% Based on Data from Wang & Parker (2014) Pew Research Center Figure 7.26 Source 284 Even though most research on hooking up involves college students, 70% of sexually active 12- 21 year olds reported having had uncommitted sex during the past year (Grello, Welsh, Harper, & Dickson, 2003). Additionally, Manning, Giordano and Longmore (2006) found that 61% of sexually active seventh, ninth, and eleventh graders reported being involved in a sexual encounter outside of a dating relationship.

Hooking up Gender Differences

When asked about their motivation for hooking up, both males and females indicated physical gratification, emotional gratification, and a desire to initiate a romantic relationship as reasons (Garcia & Reiber, 2008). Although males and females are more similar than different in their sexual behaviors, a consistent finding among the research is that males demonstrate a greater permissiveness to casual sex (Oliver & Hyde, 1993). In another study involving 16,288 individuals across 52 nations, males reported a greater desire of sexual partner variety than females, regardless of relationship status or sexual orientation (Schmitt et al., 2003). This difference can be attributed to gender role expectations for both males and females regarding sexual promiscuity. Additionally, the risks of sexual behavior are higher for females and include unplanned pregnancy, increased sexually transmitted diseases, and

susceptibility to sexual violence (Garcia et al., 2012). Although hooking up relationships have become normalized for emerging adults, some research indicates that the majority of both sexes would prefer a more traditional romantic relationship (Garcia et al., 2012). Additionally, Owen and Fincham (2011) surveyed 500 college students with experience with hookups, and 65% of women and 45% of men reported that they hoped their hookup encounter would turn into a committed relationship. Further, 51% of women and 42% of men reported that they tried to discuss the possibility of starting a relationship with their hookup partner. Casual sex has also been reported to be the norm among gay men, but they too indicate a desire for romantic and companionate relationships (Clarke & Nichols, 1972).

The Physiological Peak – Early Adulthood

People in their mid-twenties to mid-forties are considered to be in early adulthood. By the time we reach early adulthood, our physical maturation is complete, although our height and weight may increase slightly. Those in their early twenties are probably at the peak of their physiological development, including muscle strength, reaction time, sensory abilities, and cardiac functioning. The reproductive system, motor skills, strength, and lung capacity are all operating at their best. Most professional athletes are at the top of their game during this stage, and many women have children in the early-adulthood years (Boundless, 2016).

The aging process actually begins during early adulthood. Around the age of 30, many changes begin to occur in different parts of the body. For example, the lens of the eye starts to stiffen and thicken, resulting in changes in vision (usually affecting the ability to focus on close objects). Sensitivity to sound decreases; this happens twice as quickly for men as for women. Hair can start to thin and become gray around the age of 35, although this may happen earlier for some individuals and later for others. The skin becomes drier and wrinkles start to appear by the end of early adulthood. This includes a decline in response time and the ability to recover quickly from physical exertion. The immune system also becomes less adept at fighting off illness, and reproductive capacity starts to decline (Boundless, 2016).

Sexual Development in Middle Adulthood

Erikson's notion of middle adulthood placed this age range between 30 and 65, though many argue that that middle aged impacts people aged 45 to 69. The psychosocial conflict, per Erikson, is generativity versus stagnation. In other words, are people experiencing a sense of continued growth and contribution or are they resigned to their lives as-is?

"Middle Aged Couple, Morbi India" by AdamCohn is licensed under CC BY-NC-ND 2.0.

Sexuality is an important part of people's lives at any age, and many middle aged and older adults are very interested in staying sexually active (Dimah & Dimah, 2004). According to the National Survey of Sexual Health and Behavior (NSSHB) (Center for Sexual Health Promotion, 2010), 74% of males and 70% of females aged 40-49 engaged in vaginal intercourse during the previous year, while 58% of males and 51% of females aged 50-59 did so.

Despite these percentages indicating that middle adults are sexually active, age-related physical changes can affect sexual functioning. For women, decreased sexual desire and pain during vaginal intercourse because of menopausal changes have been identified (Schick et al., 2010). A woman may also notice less vaginal lubrication during arousal which can affect overall pleasure (Carroll, 2016). Men may require more direct stimulation for an erection and the erection may be delayed or less firm (Carroll, 2016). Men may experience erectile dysfunction or experience a medical conditions (such as diabetes or heart disease) that impact sexual functioning.

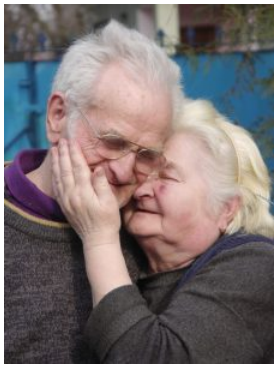
Couples can continue to enjoy physical intimacy and may engage in more foreplay, oral sex, and other forms of sexual expression rather than focusing as much on sexual intercourse. Risk of pregnancy continues until a woman has been without menstruation for at least 12 months, however, and couples should continue to use contraception. People continue to be at risk of contracting sexually transmitted infections, such as genital herpes, chlamydia, and genital warts. In 2014, 16.7% of the country's new HIV diagnoses (7,391 of 44,071) were among people 50 and older, according to the Centers for Disease Control and Prevention (2014e). This was an increase from 15.4% in 2005. Practicing safe sex is important at any age, but unfortunately adults over the age of 40 have the

lowest rates of condom use (Center for Sexual Health Promotion, 2010). This low rate of condom use suggests the need to enhance education efforts for older individuals regarding STI risks and prevention. Hopefully, when partners understand how aging affects sexual expression, they will be less likely to misinterpret these changes as a lack of sexual interest or displeasure in the partner and more able to continue to have satisfying and safe sexual relationships.

Sexuality in the Elderly

In Erikson's final psychosocial stage for people 70 and over, the major conflict exists with integrity versus despair. Through living life, are elderly adults able to reflect on their lives with a sense of meaning or do they feel that their regrets in life cancel out its' importance. Indeed- this is also a time in which, based one's physical health and well-being, where a person may still feel a genuine sense of engagement and purpose in their activities (integrity).

According to Kane (2008), older men and women are often viewed as genderless and asexual. There is a stereotype that elderly individuals no longer engage in sexual activity and when they do, they are perceived to have committed some kind of offense. These ageist myths can become internalized, and older people have a more difficult time accepting their sexuality (Gosney, 2011). Physicians rarely inquire after elderly patients' sexual health, lending to further challenges of sexual functioning conversations and/or STI prevention (Lehmiller, 2018).



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In reality, many older couples find greater satisfaction in their sex life than they did when they were younger. They have fewer distractions, more time and privacy, no worries about getting pregnant, and greater intimacy with a lifelong partner (NIA, 2013). Results from the National Social Life Health, and Aging Project indicated that 72% of men and 45.5% of women aged 52 to 72 reported being sexually active (Karraker, DeLamater, & Schwarz, 2011). Additionally, the National Survey of Sexual Health data indicated that 20%-30% of individuals remain sexually active well into their 80s (Schick et al., 2010). Indeed, no matter what a person's sexual orientation, the single biggest factor on whether someone maintains a healthy sex life in their senior years is their – and/or their partner's – health and well-being (Lehmiller, 2018). Finally, some studies indicate that sexual satisfaction declines with age. Interestingly, what seems to be the more consistent attribute to sexuality in later life, is that how sexual satisfaction gets defined shifts. Where early adults might find that frequency matters in terms of sexual activity, older adults determine that the quality of engagement is what matters (in other words, quality not quantity is most important).

Conclusion

Sexuality influences all of us. Throughout our lifetime, the relationship with ourselves and others may shift, sexually speaking, making the understanding of development all the more important. In this section, we've discussed sensate experiences from in-utero development to elderly experiences with sexuality in a way that barely covers the tip of the iceberg. Indeed – much more can be written to include the importance of social shifts in conversations around sexuality here in the US, moving from non-heteronormative research modalities (a slow work-in-progress), and how culture, race, gender and other identifications matter in our developmental processes and sexuality. Whether it's the influence of media and technology on our sex lives or how to manage the sexual experiences of dementia patients in appropriate ways, we are still unraveling vital areas of sexual functioning. To do this adequately, we need to consistently apply biopsychosocial approaches, as well as stay curious about the many domains of sexual development.

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2.3: Contraception 2.3: ContraceptionEdit Update titlecancel

Learning Objectives

- Analyze psychosocial and cultural factors impacting contraception use.
- Discuss best practices to promote equity within healthcare systems and regarding access to resources.
- Be able to demonstrate the following in regard to contraception:
  - ways in which sexual participants or partners can share responsibility for it;
  - how various methods work as well as the advantages and disadvantages of each method;
  - and finally, the effectiveness of various hormone-based contraceptives, barrier methods, intrauterine devices, emergency contraception, methods based on the menstrual cycle, and sterilization.

Introduction

One could argue that as long as humankind has had an awareness of how conception occurs, there have been steps taken to thwart that process. The history of contraception (the deliberate use of techniques to prevent pregnancy or sexually transmitted infections) is long and varied. In the United States, contraception is fraught with complexities. On one hand, there have been remarkable innovations, but on the other hand, there's a sordid history of the mistreatment and forced sterilization of marginalized folks. This week's reading attempts to highlight historical features of contraception, describe different types of contraception and how they work, and illuminate intersectional imbalances in access and delivery of contraceptive services.

Early History of Contraception – An Overview

As the old adage goes, "Necessity is the mother of invention" and, indeed, contraception is no exception to this rule. The first known record of contraception dates back to 3000 BCE and was the brainchild of Pasiphae, the wife of King Minos of Crete. Fearing that his semen had "serpents and scorpions" in it, she inserted a goat bladder into her vagina before having sex with her husband (Khan, Mukhtar, Dickinson, & Sriprasad, 2013). There's also evidence in support of Ancient Greeks and Egyptians using a diaphragm made out of crocodile dung, honey, and sodium carbonate (Lehmiller, 2019; Tye, 2020) to prevent pregnancy. The Ancient Egyptians were one of the first civilizations to use barrier methods in the form of sheaths, often made out of linen while Chinese civilizations utilized silk paper applied with oil. Early Japanese civilization used a shell to cover the glans of the penis and the Djukas tribe of New Guinea are on record for using an internal condom made out of a specific plant, which prevented conception (Khan, et al, 2013; Lehmiller, 2019).

By the Renaissance, contraception was regarded as being both a safeguard from disease, as well as unintended pregnancy with condoms emerging with greater use (most were made from linen or animal intestines or bladders of goats, sheep, cattle, or fish). From Ancient cultures to the Renaissance and forward, the wisdom of herbs, teas and tinctures were also passed down from woman to woman. The popular ballad, "Scarborough Fair" was thought to hold the secret to avoiding pregnancy through the use of parsley, sage, rosemary and thyme and pennyroyal tea was commonly used as an abortifacient (Bilger, 1998). By the middle to late 19th century condoms and investigations to hormonal contraceptives were underway, paving the way for 20th and 21st century innovation and use.

Types of Contraceptives

Behavioral Methods

In early lore, behavioral techniques to prevent pregnancy were often based on superstition or storytelling. For example, women were often instructed to jump up and down to get rid of the semen in their vagina or to sneeze or cough heartily (Lehmiller, 2019). Unsurprisingly, these methods weren't very effective. Perhaps the most successful form of contraception is abstinence and, indeed, its virtue has been touted for generations. Although, theoretically, abstinence emerges as the most cost effective and reliable form of contraception, it's not always the most attainable or realistic. In cases where sexual intercourse is likely to occur but where accessibility to contraception is limited or religiosity forbids certain forms of protection, behavioral methods are often employed. These methods are typically designed to reduce the chance of conception versus STI prevention.

In the United States, there are over 61 million women who fall within reproductive age (15-44) and about 70% of them are at risk for unintended pregnancy (Guttmacher Institute, 2020). Importantly, 99% of women within this age group disclosed using at least one contraceptive method with over 10% using a behavioral method (Guttmacher Institute, 2020). One of the most commonly

known behavioral methods of contraception is the withdrawal method in which the penis is withdrawn from the vagina before ejaculating. Unfortunately, this method is the least effective form of birth control since sperm may be released in pre-ejaculate, it can enter via contact with labia or clitoris, and/or because timing of the withdrawal isn't done before ejaculation. Indeed, research notes that over a quarter of women (27%) using this method will become pregnant within a year (Tye, 2020).

Timed abstinence, or the rhythm method, is another common behavioral strategy. This approach utilizes reliance of menstrual cycle tracking with avoidance of sex during ovulation. Again, its efficacy is compromised when there are variation of implementation. Additionally, even with more technological advances in tracking menstrual cycles (period apps, ease of temperature recording, etc), physiological variations (like irregular periods) can reduce this method's efficacy.

Finally, another behavioral contraceptive method that is very specific to certain situations involves breastfeeding. Indeed, intensive breast-feeding (6-8 times per day) can aid in suppressing ovulation. This results in a physiologically based contraception, with only 2% of women becoming pregnant within the year. There are contrary data regarding how long this method is effective with some research supporting six months while other supports nine months postpartum (Tye, 2020).

One behavioral method that isn't often discussed, in part because of continued taboos about the behavior, is sex during menstruation. It's actually more common than one may realize (some like the additional lubrication and/or the spike in arousal), while others may be averse to the idea. To be clear, sex during menstruation is completely safe (do watch for STI prevention, however). Importantly, sex on your period in NOT a contraceptive strategy. Indeed, because some sperm can live up to a week and because some menstrual cycles are irregular, pregnancy can still occur so additional contraception may be needed (Tye, 2020).

Barrier Methods

Earlier we discussed how evidence of barrier methods, be it a condom or a diaphragm, appeared in ancient civilizations. By the time we reach mid-late 19th century, significant advances were made, and in 1860, condoms were produced on a large scale. In part, this was because the vulcanized rubber introduced by Charles Goodyear (yep- the tire guy) changed the ability to mass produce condoms (versus relying on animal products). Originally, rubber condoms were made to scale and were reusable (Khan, et al, 2013). Unfortunately, U.S. Postal Inspector and secretary of the New York Society for the Suppression of Vice, Anthony Comstock, lobbied for the prohibition of any type of advertising or print materials involving contraception. In 1873, the Comstock Act was passed, making it a federal offense to disseminate contraceptive information and, ultimately, a series of "Comstock Laws" were implemented nationwide, resulting in the criminalization of contraceptive use (Bailey, 2010).

In 1920, the invention of latex reshaped condom production. During World Wars I and II, rates of STIs among American soldiers skyrocketed and distribution of condoms finally appeared on scene during WW II. Post-war attitudes toward contraception started to shift in the late 1940s (Khan, et al, 2013). Still, it wasn't until 1965, in the Supreme Court decision on Griswold vs. Connecticut that attitudes and accessibility of contraception takes a dramatic shift toward legality and acceptance (Bailey, 2010).

The most commonly used barrier method in the United States is the male condom (Copen, 2017; Daniels & Abma, 2018). According to the Guttmacher Institute (2020), 5.5 million women rely on male condoms for their contraception needs, making it the most common among 15 to 19 year olds, those born outside of the U.S. and uninsured college graduates (and a few others). While condom use is the most efficacious in the prevention of STIs, its use in pregnancy prevention yields more variable results.

With perfect use, condoms have a 98% efficacy rate in preventing pregnancy. However, that number declines to 82% when human error is factored in (Lehmiller, 2019). The most common mistakes with condom use is not using them correctly, not using them each time intercourse occurs, and breakage (Tye, 2020). Other issues include failing to withdraw promptly after ejaculation, using latex-incompatible lubricant (remember not to mix oil-based lube with latex), and reusing condoms (Lehmiller, 2019).

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Other barrier methods include the internal condom (sometimes called the female condom) and cervical barriers, such as the diaphragm and cervical cap. The internal condom is typically made out of polyurethane (versus latex) and is a hollow closed cylinder with an outer and an inner ring. The inner ring fits close to the cervix, while the out ring remains outside the labia (some report enjoying the extra clitoral stimulation). If the inner ring is removed, it can also be used for anal sex. Available widely throughout Europe, the internal condom can be obtained in the US by prescription, online, or through some reproductive health clinics (Lehmiller, 2019; Tye, 2020). When it's used as a female condom and barring any errors, the internal condom is believed to be as effective as the male condom in preventing pregnancy and STIs. Unfortunately, the internal condom is a bit more complicated, resulting in less efficacy (Tye, 2020).

The diaphragm and cervical cap are both designed to be inserted into the vagina before sexual intercourse (and typically with the addition of spermicide). Once quite popular in the United States, this is one of the least common forms of contraception today. Still, it is cost-effective (a diaphragm or cervical cap can last up to a year) but it does require fitting it to your particular cervix and a comfort in insertion before sex. Additionally, they need to be left in the body six hours post intercourse to ensure protection. When used without error, the effectiveness of preventing pregnancy is up to 96%, though 88% effective with typical use (Lehmiller, 2019). For more information comparing and contrasting barrier methods of contraception, check out the Center for Disease Control or Planned Parenthood website.

Hormonal Contraception

Historical Notes

Similar to barrier methods, the history of hormonal contraception has a complex and varied background. As previously discussed, there was a range of contraceptive practices used by people for hundreds of years. Despite some informational and technological advances, the Comstock Act of 1873 reduced access and knowledge regarding contraception throughout the United States. One of the most critical opponents of Comstock laws was Margaret H. Sanger (1879 – 1966). A suffragette and advocate for social reform, Sanger argued that a woman's right to control her body was a fundamental human right and that every person should be able to decide when and whether they should have a child. As a nurse she began speaking and writing about women's reproductive health, ultimately being held in contempt for violating the Comstock Act in 1912.

In attending poverty-stricken patients from the Lower East Side of New York, she was overwhelmed with the lack of options for women desperate to limit their pregnancies. Following the tragic loss of one mother who died from a self-induced abortion, Sanger left nursing to advocate for women's birth control later that year. A constant target of law enforcement officials keen on prosecuting Sanger for her work, she consistently moved forward with advocacy and education, ultimately creating the American Birth Control League in 1921 (which later became the Planned Parenthood Federation of America). Ultimately, Sanger's work helped bring about the reversal of federal and state 'Comstock laws' and pioneered the medical efforts of the birth control pill (Nunez-Eddy & Malladi, 2016; 2018; Planned Parenthood, 2016; Tye, 2020).

As pioneering and innovative as Margaret Sanger was, there were also racist and ableist attitudes of the time that impacted her advocacy. A number of sources have noted her alignment with eugenicist thinking (the notion of selective 'breeding' to reinforce more favorable traits). Indeed, the birth control pill was created in response to difficulties with family planning and population control. After the Great Depression, when poverty was a serious problem throughout the nation, smaller families were seen as an affordable way to tackle poverty.

Since eugenics promoted the reproduction of only the healthiest (and let's face it… the whitest) offspring, the implications of prejudice are abhorrent. Unfortunately, during the time the eugenics movement was popularized, it influenced Sanger and the ideas of birth control (Buttar & Seward, 2009; 2018). To her credit, she never reinforced the notion of sterilization, as did other eugenicists (Nunez-Eddy & Malladi, 2016), but it's critical to evaluate all aspects of this notable figure versus glamorizing or ignoring elements of her advocacy that may have been problematic. Because, there is no question that aspects of ableism and racism are to be repudiated. For a more thorough response to criticism of Sanger's perspective, please read Planned Parenthood's statement on this.

Image from Liberty Magazine, circa 1939

Because of Sanger's advocacy and the efforts of many other individuals, groups, and corporations, the first commercial birth control pill, Enovid, was introduced, publicly, in 1960 (Bailey, 2010; Buttar & Seward, 2009; 2018). Marketed specifically for married couples, some states still banned the sale of contraception due to the last hold of Comstock provisions throughout the country. In 1965, the Supreme Court ruled in Griswold vs. Connecticut that married couples had the right to privacy in terms of

contraception (opening up the sale and distribution of contraceptive items, including the pill; Bailey, 2010; Tye, 2020). In 1972, a second Supreme Court case, Eisenstadt vs. Baird extended contraceptive protections to unmarried women (Tye, 2020). The accessibility of birth control, combined with various cultural shifts, were instrumental in moving women's rights forward in remarkable ways (Bailey, 2010; Tye, 2020).

Oral Contraceptives

There are several forms of hormonal contraception to discuss. Importantly, these interventions are primarily used for menstrual cycle care and/or to prevent unintended pregnancies (defined as mistimed and/or unwanted pregnancies; Jackson, Wang, & Morse, 2017). The birth control pill (also known as oral contraceptives) is the second most common form of contraception globally (Guttmacher Institute, 2020) and the most commonly prescribed contraceptive in the United States (Cooper & Mahdy, 2020). Approximately four out of five sexually active women have used the pill (though numbers are shifting based on availability of other hormonal options; Guttmacher Institute, 2020).

There are three different oral contraceptive options; combined estrogen-progesterone (most commonly prescribed), progesterone only and the continuous or extended use pill (Cooper & Mahdy, 2020; Lehmiller, 2019; Tye, 2020). When used perfectly, that is taken at the same time, everyday, with no deviation, the efficacy of the pill is 98-99%. However, typical use, which accounts for human error, failure rate for oral contraception is 9% (Cooper & Mahdy, 2020). For more on the types of oral contraceptive options, please check out the CDC and Planned Parenthood.

As revolutionary as the birth control pill has been, it is not without its challenges, as many users can attest to. There are wide-range of side-effects of taking oral contraceptives that have been reported in the 60+ years of its existence. In addition to changes in menstrual cycle, potential for spotting between periods, cramping, nausea, vomiting, weight loss, weight gain, sleep change and shifts in bone density, evidence also supports changes in mood, changes in sexual attraction and libido, increase in anxiety symptoms, shifts in emotion regulation and detection, stress response changes, and mixed data about both increased and decreased levels of cognitive functioning Cooper & Mahdy, 2020; de Wit, Booij, Giltay, Joffe, Schoevers, & Oldehinkel, 2020; Hill, 2020; Lehmiller, 2019; Lewis, Kimmig, Zsido, Jank, Derntl, & Sacher, 2019; Pahnke, Mau-Moeller, Junge, Wendt, Weymar, Hamm, & Lischke, 2019). These are all areas for continued exploration, elaboration, and intervention, especially as symptoms may affect marginalized communities differently and deleteriously.

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Other Hormonal Contraceptive Options

There are two other types of hormonal contraceptives to be aware of. First, there are hormonal interventions that have various compositions similar to the variety of oral contraceptives. The primary difference is the form of modality since these hormonal contraceptives are delivered through injection (e.g. Depo-Provera, administered once every three months), transdermal patches (e.g. Ortho Evra, administered once a month) or a vaginal ring (e.g. NuvaRing, placed vaginally once a month; Lehmiller, 2019; Planned Parenthood, 2020, Tye, 2020).

The other hormonal contraceptive category is long-acting reversible contraceptives (LARC). One of these options is administered through an implant (administered under the skin of the upper arm), lasts for five years and has an efficacy rate of 99%. There's also the placement of an intrauterine device (IUD), which once placed can last for 3 to 12 years, making it one of the most convenient options for long-term pregnancy prevention.

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Perhaps the biggest change in the use of hormonal contraceptives is the increase in the use of LARCs. The new options available to women has seen widespread adoption among all ages and races. LARC use was highest among women aged 25-34 (as compared to other age ranges from 15 to 49; Daniels & Abma, 2018; Guttmacher Institute, 2020). The proportion of women who have used the injectable method increased from 5% in 1995 to 23% in 2006–2010 (Guttmacher Institute, 2020). Approximately 9% of Latina women are using LARC methods as compared to 7% of white and 5% of black users (Jackson, Wang, & Morse, 2017).

Important Considerations

Gaining access to hormonal contraception remains a significant issue, negatively impacting marginalized communities (minorities, economically disadvantaged, immigrants, disabled, etc). Indeed, the majority of oral contraceptive users are white, young,

childless, and college educated (Guttmacher Institute, 2020). White women use the pill more often (19%) compared to Latina and black women (11% and 10% respectively). Although there has been a decline of unintended pregnancies across all racial groups, 45% in 2011 compared to 51% in 2008, the racial differences have remained fixed with blacks and Latinas experiencing higher rates than white women (even when stratified by income; Jackson, Wang, & Morse, 2017; Rocca & Harper, 2012; Wright, 2020).

Many of the disparities rooted in structural racism, which impacts minority women also impact women with disabilities. Among American women who fall within the reproductive age range, 12 to 18 percent have a disability related to mobility, vision, hearing, cognitive functioning and/or independent living. Unfortunately, women with disabilities are often subjected to healthcare bias and deemed asexual, which is not rooted in the experience of many these women. Multiple studies have shown that disabled women are less likely to receive gynecological exams and/or contraceptive counseling (Horner-Johnson, Akobirshoev, Amutah-Onukagha, Slaughter-Acey, & Mitra, 2021).

An additional area of consideration for contraceptive counseling, access, and patient-centered care is in the responsiveness to transgender and gender-diverse people. With approximately one in 200 adults identifying as transgender, this domain of care is essential to update. In one study of 26 transgender men, half were at risk for unintended pregnancy (Cipres, Seidman, Cloniger, Nova, O'Shea, & Obedin-Maliver, 2017). Importantly, evidenced-based care, which includes a patient-centered approach, is of paramount importance since each transmasculine or gender diverse patient has their own unique set of goals and concerns in terms of their reproductive health (Bonnington, Dianat, Kerns, Hastings, Hawkins, De Haan, & Obedin-Maliver, 2020).

In the examination of intersectional identities and contraceptive use, a few important findings come to light. First – there is consistent evidence that Black, Latina, Native American, Pan-Asian, disabled, gender diverse and poor women experience barriers to contraceptive access, have higher rates of contraceptive failure, and increased risks of adverse outcomes (Horner-Johnson, et al, 2021; Jackson, Wang, & Morse, 2017; Wright, 2020).

Secondly, practitioners of all types should acknowledge the history of inequity and structural racism, generally and as it pertains to contraceptive access since it still has a residual impact on women to this day.

Finally, there is an increased need to address women's intersectional identities in response to their contraceptive needs, taking into account historical injustices and current, systemic inequities. As Kelsey Wright contends in her paper refuting the idea that contraception is a panacea for poverty reduction, "…contraceptive services should be offered to women in ways that ensure access to reproductive justice without obscuring the need for social changes in the institutions that create disadvantages and shape contraceptive use itself" (Wright, 2020, p. 1).

Sterilization

The final form of contraception to discuss is sterilization, an irreversible form of birth control that is the most commonly used in the United States and globally (Daniels & Abma, 2018; Guttmacher Institute, 2020). Typically applied to folks on the older end of the reproductive spectrum (ages 35-44) who have already had children, there are two kinds of sterilization to know. Female sterilization, or tubal ligation (tubectomy), is the process of clamping or severing the fallopian tubes so that any eggs released cannot meet sperm for fertilization. Male sterilization occurs in the form of a vasectomy, which involves the sealing or severing of the vas deferens so that sperm can no longer be in the ejaculate. Note that sperm is only a tiny fraction of seminal fluid so the difference in ejaculate is typically undetectable. Both of these procedures are considered low risk, 99% effective and cause no impairment in sexual functioning (Lehmiller, 2019; Tye, 2020).

Forced Sterilization as a Form of Racism

Although sterilization is a sound and viable option for many people in terms of contraception, there are some inequities in terms of who receives sterilization, which is born from a sordid history of coerced and forced sterilization. Summarized in Guttmacher Institute (2020) report, sterilization "is most common among blacks and Hispanics, women aged 35 or older, ever-married women, women with two or more children, women living below 150% of the federal poverty level, women with less than a college education, women living outside of a metropolitan area, and those with public or no health insurance" (p. 2). When considering issues of contraceptive decision making with minority and underrepresented women, listening and understanding their potential distrust in medical systems is essential (Horner-Johnson, et al, 2021; Jackson, Wang, & Morse, 2017; Wright, 2020).

In the mid-19th century, the eugenics movement, spearheaded by Sir Francis Galton, advocated for the advancement of promising heritability. By the late 1800s this campaign endorsed the elimination of hereditary "blights" such as non-whiteness, 'feeble-mindedness,' physical impairments or criminality. The United States was the first nation to enact laws of forced sterilization and in 1907, the state of Indiana allowed and/or required the sterilization of criminals, the intellectually disabled (ID) and institutionalized

people with other mental and physical impairments. Other states soon followed and in 1927, the case Buck vs. Bell was struck down by the US Supreme Court (SCOTUS), ensuring the constitutionality of forced sterilization. The lawsuit had been filed by Virginia woman, Carrie Buck, who was forcibly sterilized and deemed unfit due to her 'feeble-mindedness.' The SCOTUS ruling all but ensured the continuation of negative eugenics throughout the country for decades to come (Amy & Rowlands, 2018; Asbury, 2015; Stern, 2005).

Films on Demand Video Clip: 'Ann Cooper Hewitt' – From Title:The Eugenics Crusade

When World War II came to an end, there was a collective, global outrage at the atrocities committed by the Nazis (who were well-documented to have learned a great deal from American eugenics). The presence of eugenics in the United States was no longer as heartily supported. Unfortunately, there was little to no change in the legality and practice of eugenics; simply a shift in the framing of the practice. Indeed, by the mid-20th century, tens of thousands of forced sterilizations had occurred in at least 32 states (with a third of those coming from California, alone; predominantly on poor black and Latina women; Stern, 2005). The states of Virginia and North Carolina had alarmingly high rates, dramatically impacting poor, black women (Amy & Rowlands, 2018; Asbury, 2015).

By the 1960s, forced sterilization started to take a different shape, shifting from the public health concerns of heritability issues to a form of public welfare. With the rise of contraceptive availability, sterilizations were seemingly 'voluntary,' however, frequently women did not have all of the information, were required to agree to sterilization in order to receive federal benefits, were coerced or simply lied to about the nature of the procedure. A devastating example of this emerged in the late 60s when it was publicized that 35% of all Puerto Rican women (ages 20-49) were sterilized (Krase, 2014).

In 1973, the Relf sisters gained notoriety among activists because at the ages of 12 and 14 they were forcibly sterilized in the state of Alabama. Their mother thought she was consenting to a reversible procedure and was threatened with the loss of her public benefits if she did not sign. In the federal lawsuit, the judge ruled in their favor, noting that "an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that variously supported welfare benefits would be withdrawn unless they submitted" (as cited in Stern, 2015, p. 7).

Similar experiences for other minority groups were going on throughout the country. During the 60s and 70s, Native American women were especially at risk. About 40% (60,000–70,000) of all Native American women alive at that time, and 10% of Native American men underwent sterilization during the 1970s (Amy & Rowlands, 2018, p. 126; Blakemore, 2016). In 1979, Mexican American women in California filed a federal lawsuit, Madrigal v Quilligan, due to the forcible, coercive "consent" to sterilization. Almost all of the victims were in the midst of a painful, complex birthing process and were only given medication if they consented to the sterilization procedure. Unfortunately, they did not win their case, as the federal judge ruled in favor of the attending physicians (since they meant no harm). Still – the case garnered attention and effected changes in the formulation of sterilization stipulations (e.g. need to provide bilingual consent forms; Stern, 2015).

Under the guise of family planning, coercive sterilization was still an issue in the late 20th century, still predominantly affecting minority women. By 1983, forty-three percent of women sterilized in federally funded family planning programs were black (when blacks only made up 12% of the general population; Asbury, 2015). In the 90s, linking more experimental contraceptive options, like Norplant, were also connected to benefits for disadvantaged women. As Asbury (2015) wrote, "What is here worth noting is that the targeting of coercive contraception to poor, black women is antithetical to promoting their reproductive freedom and should be understood as a modern manifestation of historical eugenic efforts seeking to discourage reproduction by marginalized populations" (p. 13).

Current Issues

Unfortunately, coercive and forced sterilization in the United States is still happening. In September 2020 (just a few months ago), whistleblower and nurse Dawn Wooten, who worked at the Irwin County Detention Center (ICDC) in Georgia, shared that ICE detained women were being transferred to a physician who sterilized them without proper informed consent. In her complaint, Wooten also described multiple forms of medical abuse, from failures to protect patients against COVID-19, to forced hysterectomies (Manian, 2020).

Is it any wonder that, based on rampant, systemic injustice against many marginalized bodies that underrepresented folks are still cautious about contraceptive counseling? Indeed, there's so much to rectify in terms of reproductive healthcare. Recognizing and reconciling the United States' abhorrent practices is part of the process. Providing restitution and remedy for those deeply impacted, presently and historically, can certainly serve as another part of the solution. Finally, enacting, implementing, and enforcing reproductive rights policy that protects our most vulnerable citizens is certainly an essential feature, as well.

Conclusion

The innovation and use of contraceptive devices have a long, complex history. On one hand, our creative ingenuity can empower options to care for reproductive processes in really responsive ways. On the other hand, certain contraceptive practices are marred with abuse and exploitation, which has continued implications in reproductive justice. Thankfully, modern processes can afford us continued opportunities to correct past mistakes, ensure present accessibility and accountability, and innovate for diverse, responsive future options.

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2.4: Sexually Transmitted Infections 2.4: Sexually Transmitted InfectionsEdit Update titlecancel

Learning Objectives

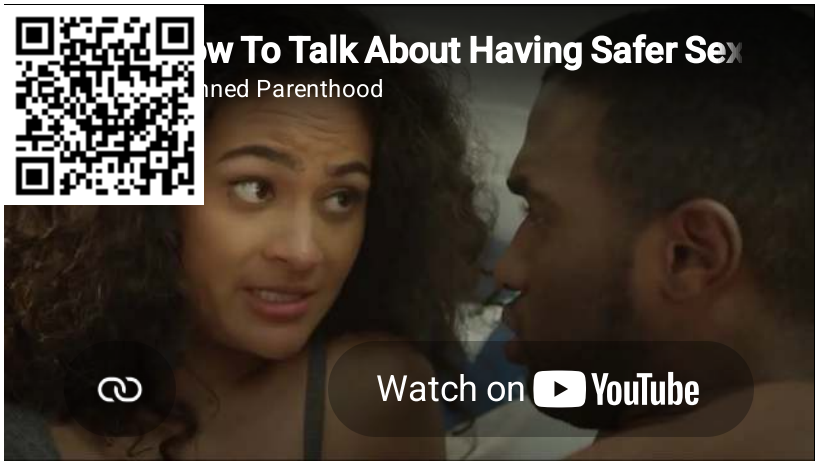
- Develop a plan to implement safer sex practices with partners and ways to discuss sexual health with healthcare providers.
- Compare and contrast treatment options for sexually transmitted infections and ways to outreach to diverse community members about STI prevention and intervention utilizing health psychology and community-based educational techniques.
- Analyze and address the unethical and inhumane research regarding STIs paid for by the United States government.

Introduction

Topics addressed this week will include safer sex practices, history of sexually transmitted infections (STIs a.k.a. sexually transmitted diseases or STDs), symptoms, treatments, and statistics. Tips on how to talk with healthcare providers and partners about STIs will be provided. The harmful past (and still ongoing) wrongs committed by researchers will be analyzed and called out as they intersect with race, poverty, nationality, and gender. Distrust of medical research and regarding the development of treatment options remains among many minority groups due to the unethical research that was done. In moving forward, what are the best ways to outreach to reluctant participants who have reason to question motives based on these historical experiences?

Talking with Partners about Safer Sex Practices

Preventing STIs starts with developing skills to talk with partners about safer sex practices. Here is a video from Planned Parenthood (2017) on how to talk with partners about “Safer Sex”:



How to Prevent Sexually Transmitted Infections: Safer Sex Techniques

Abstaining from sexual behaviors, such as anal, vaginal, or oral sex in which you physically come into direct contact with another person’s bodily fluids and skin, is the only way to prevent the transmission of an STI (Centers for Disease Control and Prevention [CDC], 2020). Some sexual behaviors in which you are not directly in contact with others’ bodily fluids or skin, such as masturbating in front of each other, touching body parts through clothing, and more, can be done safely as well. Keep in mind, STIs are transmitted through contact with skin anywhere on the body that might have an active viral load and others are spread through the exchange of bodily fluids. As direct, naked, and penetrative contact increases, so do the risks of STI transmission.

Vaccination against certain viral STIs, such as hepatitis A and B and human papillomavirus (HPV), are important prevention measures (CDC, 2020). Vaccinations for HPV are recommended beginning as early as age 9 through age 26, and individuals 27 and older have less benefit from a vaccine due to likely already being exposed (CDC, 2020). Ask your healthcare provider about being vaccinated for HPV if you are 27 years and older as it is possible to have not been exposed prior depending on previous sexual activity history. Hepatitis vaccines are recommended at any age if not previously inoculated. Most children in the United States receive hepatitis B vaccinations as requirements to attend public school with very limited mandates regarding HPV vaccination throughout the United States (North & Niccolai, 2016). As of 2014, HPV vaccination rates were at about 60% for girls and about 42% for boys in the United States (North & Niccolai, 2016).

Condoms should be used every time when engaging in penetrative sexual behavior with a new partner in which a penis is entering a vagina, anus, or mouth. Often referred to as a "male" condom, "external" condom, or just "condom," this type is meant to be rolled down over the penis (CDC, 2016b). Check out these infographics provided by the CDC on "The Right Way to Use a Male Condom." Commonly referred to as a "female" condom or "internal" condom, this type of condom is placed within the vagina until it rests against the cervix with the outer ring remaining outside the body. They can also be used anally by using the fingers to place the internal condom. It is especially important that the outer ring remains outside the body in order to not get lodged internally. Check out another infographic from the CDC on "The Right Way to Use a Female Condom." Next time you are at the store, try to find and compare different types of condoms. According to Planned Parenthood (2021a), internal condoms are harder to find and may require a prescription to purchase at some drug stores.

Dental dams can be used during oral sex (using the mouth to pleasure the penis or vulva) or anilingus (more commonly known as "rimming" or providing pleasure to the anus with the mouth) as a protective barrier. Check out the CDC infographic on "How To Use A Dental Dam As A Barrier For Oral Sex," which also provides guidance on how to create a dental dam out of a condom.

Safe sex with sex toys is important to reduce the likelihood of spreading STIs by using mild soap and water in between uses and before sharing the toy with a partner (Planned Parenthood, 2021b). Condoms can also be used on some types of toys, such as dildos, as long as the condom is changed to a clean one in between uses as well (Planned Parenthood, 2021b).

Mutual monogamy is when two people within a relationship agree to be exclusive or only sexually active with one another (CDC, 2020). After being tested for STIs, engaging in sexual behaviors is safe as long as no new partners are engaged with sexually. A common issue with this is that an individual within an agreed-upon monogamous relationship may cheat and expose the partner to STIs since using safe sex practices may alert the partner that something has changed requiring protection (Lehmiller, 2015). Safer sex in consensually non-monogamous relationships, such as using condoms with primary and additional partners and getting tested more frequently for STIs, was practiced more frequently than in monogamous relationships (Lehmiller, 2015). In the study by Lehmiller (2015), about 25% of the monogamous participants reported having sex outside their primary relationship with a majority of these individuals stating their primary partners did not know about this.

Getting tested and knowing your STI status is vital to preventing the spread of STIs. Individuals who are engaging in unprotected sexual behaviors with new partners or have partners who are engaging in sexual behaviors with other people should be tested at least once a year (CDC, 2014). Pregnant individuals should be tested early in pregnancy and testing should be repeated if necessary depending on sexual behavior and risks (CDC, 2014).

Check out "Your Safer Sex Toolkit" by the American Sexual Health Association that includes questions for you to decide your own "safer sex boundaries" based on what is most important to you as well as additional information on safer sex techniques.

This "LGBTQIA Safer Sex Guide" by Healthline (2020) is another helpful resource, which also includes information regarding ways to be safer while engaging in "outercourse," "hand sex," and more.

For ways to better outreach to men who are African American, straight, and 18-30 years old about safer sex practices, the American Sexual Health Association (2015) developed the "Health is Power" Toolkit to be used by their partner agencies. This toolkit provides guidance to sexual health organizations on ways to better outreach to and educate community members with these particular intersecting identities.

History of the Most Common STIs

The following timelines will provide background concerning how the understanding of STIs has changed over time. The information summarized in this section is taken from Britannica (2020).

Gonorrhea and Syphilis

- Gonorrhea named by an ancient Greek physician, Galen
- Gonorrhea was present in ancient Egypt and China as well
- An epidemic of Syphilis was reported in Europe in the 1490s
- In the 1930s, effective medications (sulfa drugs and penicillin) were used to treat both syphilis and gonorrhea
- Eradication was expected but the lack of people using safer sex practices and the development of antibiotic-resistant strains caused infections to rise by the 1950s
- Gonorrhea and syphilis were thought to be the same until the early 20th century
- Gonorrhea and syphilis remain global health concerns today

Herpes

- Herpes became prevalent in the 60s and 70s
- No cure but symptoms can be reduced (remission) through the development of antiviral medications

HIV/AIDS

- HIV clearly identified in 1981 and AIDS, which develops from untreated HIV
  - Gay men in the US and western Europe and straight individuals in tropical Africa were at the greatest risk of infection due to lack of access to education and resources regarding safer sex practices
  - Communities were devastated as many people died

STIs: Symptoms, Classifications, and Treatments

General symptoms will be addressed and STIs will be broken down by whether they are caused by a bacteria, virus, etc. because treatments may be similar for many of the STIs that fall under each of these categories.

General Symptoms to Look Out For

According to the National Institutes of Health (NIH, 2017b), some people may have an STI and experience no symptoms which is why getting tested is best. Others may experience an immune response in which they feel ill. Common symptoms of STIs include (NIH, 2017b):

- Unusual discharge from the penis or vagina; this can sometimes be discolored as well (yellowish, greenish, etc.)
- Blisters, sores, or warts on the genital area
- Painful or frequent urination
- Itching and redness on or around the genitals
- Blisters or sores in or around the mouth
- Abnormal vaginal odor
- Anal itching, soreness, or bleeding
- Abdominal pain
- Fever or chills

Check out this factsheet from the CDC (2011) on "10 Ways STDs Impact Women Differently from Men."

Bacteria

Types of bacterial infections:

• Chlamydia
• Gonorrhea
• Syphilis
• Trichomoniasis
  ○ This is technically caused by a parasite but is treated as a bacterial infection
• Bacterial vaginosis
• Mycoplasma genitalium (MGen) (American Sexual Health Association, 2021)
	• Urinary tract infections
	  ○ Caused by bacteria entering the urethra specifically
	Pelvic Inflammatory Disease is a possible complication if any bacterial infection goes untreated, which may impact future fertility in women specifically. Check out the Pelvic Inflammatory Disease (PID) – CDC Fact Sheet for more information.

Treatment

- Antibiotics (NIH, 2017a)

Viral Infections

Types of viral infections:

- Human Papillomavirus (HPV)
  - Genital warts and some types of cancers (i.e. cervical) are side effects
  - Vaccines have been developed
- Herpes

  - Cause sores on parts of the body; can still be contagious without a sore present if the viral load is high enough
  - No cure, but outbreaks can be reduced or prevented with antiviral medications
- Human Immunodeficiency Virus (HIV)
  - Acquired Immune Deficiency Syndrome (AIDS) develops from untreated HIV
  - The virus interferes with the functioning of the immune system and weakens the body's ability to fight off diseases and infections
- Hepatitis B (HBV)
  - Infects the liver and can lead to chronic liver disease if untreated
  - Vaccines have been developed
- Hepatitis A (HAV) and Hepatitis C (HCV)
  - Infects the liver, causing damage
  - Less common than HBV

Treatments

- Antiviral medications
- Vaccines that increase the immune system's ability to fight off the virus and prevent the illness
- Drugs that prevent transmission that are taken by an individual before they are potentially exposed to a virus by an infected person (i.e. PrEP for HIV)
- Antiretroviral medications, such as for HIV, work by preventing the life cycle of the virus from continuing to the next stage (NIH, 2017a)

Here is another resource from the CDC regarding "HIV Treatment."

Parasites

Types of infections due to parasites:

- Trichomoniasis
  - Parasite in ejaculate/vaginal fluids
  - Treated with an antibacterial medication
- Pubic lice
  - Commonly known as "crabs"
- Scabies

Treatments

- Insecticide cream
- Insecticide oral medication

Fungus

- Candidiasis (yeast infections)

Treatment

- Antifungal medicine

Statistics and Education versus Stigma and Shame

Due to the way that our society discusses STIs, they are often associated with words like "dirty." This leads to discomfort or worry when discussing them with healthcare providers and partners. Let's take a look at the statistics in order to educate about the prevalence and risks of contracting various STIs. Various organizations are also actively trying to undo the stigma and shame by creating community education campaigns around ways to talk with healthcare providers and partners about STIs.

Statistics

The following statistics are from the American Sexual Health Association (ASHA, 2020).

1 in 2 people who are engaging in sexual behaviors will get an STI by the age of 25

Human Papillomavirus (HPV)

- 80% of sexually active people have HPV
  - HPV vaccine has been very helpful (64% reduction in younger individuals)

Herpes

- 1 in 2 people have oral herpes
- 1 in 8 have genital herpes
- 90% don't know they have either type

Chlamydia, Gonorrhea, and Syphilis

- Most commonly reported
- Young people most at risk
- Annual screening recommended but rarely followed
- 2013-2016 diagnosis for all 3 on the rise
- PID results when untreated from gonorrhea and chlamydia leading to infertility in 1 in 8 women

Hepatitis

- Hepatitis B drastically decreased by 82% since 1991 due to routine vaccination of children
- Hepatitis C most common among baby boomers (born 1945-1965); they are 5 times more likely to have this

HIV

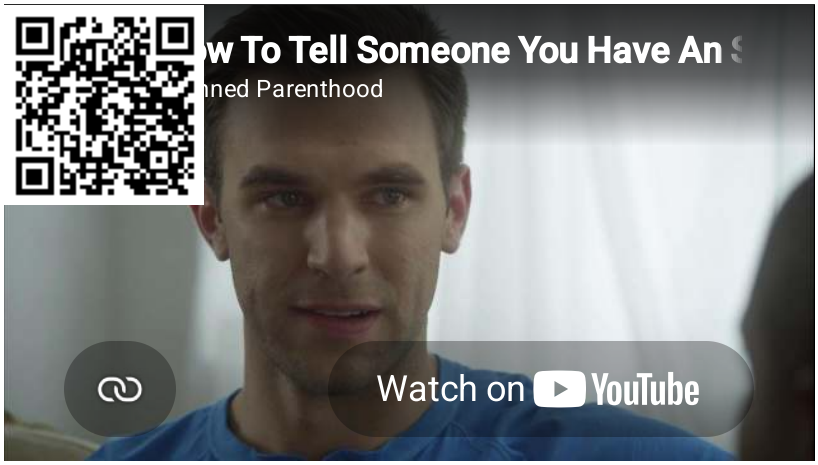
- In the US, 1.1 million people are living with HIV; 1 in 7 don't know
- PrEP reduces HIV infection risk up to 92%

Undoing Stigma and Shame: Moving Forward

Check out this campaign by ASHA that is seeking to reduce stigma around STIs in order to encourage people to get tested called, "Yes Means Test."

How to Talk with Healthcare Providers and Partners about Getting Tested

How to Talk about Having an STI with Partners



The Tuskegee Timeline

This following content is currently under review by CDC to ensure the content is accurate and verifiable.

The Study Begins

In 1932, the Public Health Service, working with the Tuskegee Institute, began a study to record the natural history of syphilis in hopes of justifying treatment programs for blacks. It was called the “Tuskegee Study of Untreated Syphilis in the Negro Male.”

The study initially involved 600 black men – 399 with syphilis, 201 who did not have the disease. The study was conducted without the benefit of patients’ informed consent. Researchers told the men they were being treated for “bad blood,” a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years.

What Went Wrong?

In July 1972, an Associated Press story about the Tuskegee Study caused a public outcry that led the Assistant Secretary for Health and Scientific Affairs to appoint an Ad Hoc Advisory Panel to review the study. The panel had nine members from the fields of medicine, law, religion, labor, education, health administration, and public affairs.

The panel found that the men had agreed freely to be examined and treated. However, there was no evidence that researchers had informed them of the study or its real purpose. In fact, the men had been misled and had not been given all the facts required to provide informed consent.

The men were never given adequate treatment for their disease. Even when penicillin became the drug of choice for syphilis in 1947, researchers did not offer it to the subjects. The advisory panel found nothing to show that subjects were ever given the choice of quitting the study, even when this new, highly effective treatment became widely used.

The Study Ends and Reparation Begins

The advisory panel concluded that the Tuskegee Study was “ethically unjustified”–the knowledge gained was sparse when compared with the risks the study posed for its subjects. In October 1972, the panel advised stopping the study at once. A month later, the Assistant Secretary for Health and Scientific Affairs announced the end of the Tuskegee Study.

In the summer of 1973, a class-action lawsuit was filed on behalf of the study participants and their families. In 1974, a $10 million out-of-court settlement was reached. As part of the settlement, the U.S. government promised to give lifetime medical benefits and burial services to all living participants. The Tuskegee Health Benefit Program (THBP) was established to provide these services. In 1975, wives, widows and offspring were added to the program. In 1995, the program was expanded to include health as well as medical benefits. The Centers for Disease Control and Prevention was given responsibility for the program, where it remains today in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The last study participant died in January 2004. The last widow receiving THBP benefits died in January 2009. There are 11 offspring currently receiving medical and health benefits.

Important Timeline

1895 – Booker T. Washington at the Atlanta Cotton Exposition, outlines his dream for black economic development and gains support of northern philanthropists, including Julius Rosenwald (President of Sears, Roebuck and Company).

1900 – Tuskegee educational experiment gains widespread support. Rosenwald Fund provides monies to develop schools, factories, businesses, and agriculture.

1915 – Booker T. Washington dies; Robert Moton continues work.

1926 – Health is seen as inhibiting development and a major health initiative is started. Syphilis is seen as a major health problem. Prevalence of 35 percent observed in the reproductive age population.

1929 – Aggressive treatment approach initiated with mercury and bismuth. Cure rate is less than 30 percent; treatment requires months and side effects are toxic, sometimes fatal.

"Wall Street Crash"–economic depression begins.

1931 – Rosenwald Fund cuts support to development projects. Clark and Vondelehr decide to follow men left untreated due to lack of funds in order to show the need for treatment programs.

1932 – Follow-up effort organized into study of 399 men with syphilis and 201 without. The men would be given periodic physical assessments and told they were being treated. Moton agrees to support study if "Tuskegee Institute gets its full share of the credit" and black professionals are involved (Dr. Dibble and Nurse Rivers are assigned to study).

1934 – First papers suggest health effects of untreated syphilis.

1936 – Major paper published. Study criticized because it is not known if men are being treated. Local physicians asked to assist with study and not to treat men. Decision was made to follow the men until death.

1940 – Efforts made to hinder men from getting treatment ordered under the military draft effort.

1945 – Penicillin becomes accepted as treatment of choice for syphilis.

1947 – USPHS establishes "Rapid Treatment Centers" to treat syphilis; men in study are not treated, but syphilis declines.

1962 – Beginning in 1947, 127 black medical students are rotated through units doing the study.

1968 – Concern raised about ethics of study by Peter Buxtun and others.

1969 – CDC reaffirms need for study and gains local medical societies' support (AMA and NMA chapters officially support continuation of study).

1972- First news articles condemn studies.

Study ends.

1973 – Congress holds hearings and a class-action lawsuit is filed on behalf of the study participants.

1974 – A $10 million out-of-court settlement is reached.

The U.S. government also promised to give lifetime medical benefits and burial services to all living participants; the Tuskegee Health Benefit Program (THBP) was established to provide these services.

1975 – Wives, widows and offspring were added to the program.

1995 – The program was expanded to include health as well as medical benefits.

1997 – On May 16th President Clinton apologizes on behalf of the United States.

1999 – Tuskegee University National Center for Bioethics in Research and Health Care hosts 1st Annual Commemoration of the Presidential Apology.

2001 – President's Council on Bioethicsexternal icon was established.

2004 – CDC funds 10 million dollar cooperative agreement to continue work at Tuskegee University National Center for Bioethics in Research and Health Care.

2004 – The last U.S. Public Health Service Syphilis Study at Tuskegee participant dies on January 16.

2006 – Tuskegee University holds formal opening of Bioethics Center.

2007 – CDC hosts Commemorating and Transforming the Legacy of the United States Public Health Service (USPHS) Syphilis Study at Tuskegee.

2009 – The last widow receiving THBP benefits dies on January 27.

The content here can be syndicated (added to your web site).

Watch this interview with the reporter, Jean Heller, who served as a whistleblower alerting the public about what was going on:

The United States' Experiments in Guatemala

Beginning in 1946, the National Institutes of Health, which is part of the United States government, funded research in Guatemala in which "5128 vulnerable people, including children, orphans, child and adult prostitutes, Guatemalan Indians, leprosy patients, mental patients, prisoners, and soldiers" were used for inhumane medical experimentation without their informed consent (Rodriguez & García, 2013, p. 2122). By 1948, over 1300 individuals were purposefully infected with syphilis, gonorrhea, and chancroid while others were subjected to diagnostic tests on their blood serum (Rodriguez & García, 2013). Additionally, the experiments conducted were not done in sterile environments causing additional infections, individuals were injected and re-injected with multiple types of STIs, and were withheld treatment (Rodriguez & García, 2013). John C. Cutler, the main researcher, and his colleagues purposefully withheld information from the public and did not publish anything about the experiments they were conducting because they knew many would find it unethical (Spector-Bagdady & Lombard, 2019). Cutler donated his records to the University of Pittsburgh School of Public Health, and it wasn't until 2003 that the historian, Susan Reverby, discovered the documents (Spector-Bagdady & Lombard, 2019). After 7 years of trying to uncover the truth of what happened, Reverby presented her findings and alerted the CDC, and President Obama instructed the U.S. Presidential Commission for the Study of Bioethical Issues (PCSBI) to conduct a thorough review of what had occurred (Spector-Bagdady & Lombard, 2019). "As of February 2019—despite repeated calls for compensation—no governmental, organizational, or institutional responses have focused on identifying or making reparations to still-living subjects of the Guatemala experiments or their relatives. The only direct advocacy on behalf of the subjects came from the private lawsuits that, nine years after public revelation and sixty years after the studies occurred, have yet to provide a remedy to the subjects or their families" (Spector-Bagdady & Lombard, 2019, p. 33).

Disclaimer: This video is not required to view due to the upsetting nature of the content.

Research and Community Outreach Moving Forward

Instead of ignoring the painful history of STI research, healing is not possible without first addressing the harms done by researchers. Fear and distrust remain among communities that have been abused and disenfranchised, and the United States government holds the blame in many cases along with individuals who knowingly supported these inhumane projects. At the same time, allyship and advocacy have also been documented as Jean Heller, the researcher breaking the news to the public about what was happening in Tuskegee, and Susan Reverby, the historian who uncovered the truth about the experiments being conducted in Guatemala, worked to bring the truth to the public's attention.

In moving forward, how can we make sure that communities who are most vulnerable are represented and supported by treatment and educational outreach programs? What are the specific needs and concerns for those who are BIPOC, LGBTQIA+, neuroatypical, differently-abled/disabled, adolescents, young adults, and older? How can we make sure people with these various intersecting identities can receive the best preventative education, care, and treatment possible?

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2.5: Conception, Pregnancy, and Birth 2.5: Conception, Pregnancy, and BirthEdit Update titlecancel

Learning Objectives

- Analyze psychosocial and cultural factors impacting abortion, pregnancy and the birthing process and discuss best practices to promote equity within healthcare systems.
- Demonstrate an understanding of the process of conception including:
  - how to enhance the possibility of conception
  - infertility problems and how they might be dealt with
  - spontaneous and elective abortion
  - aspects of a healthy pregnancy
  - sexual interaction during pregnancy
  - stages of childbirth
  - psychological and sexual adjustments postpartum

Introduction

This week's reading is all about conception, pregnancy and birth. Much of the content we'll be covering will be physiological, in nature. However, as you go through the material, please keep your intersectional lens on. For example, when we're discussing the biology of fertilization, how might environmental conditions influence the process (conception through intercourse versus IVF). Or perhaps when we consider pregnancy, how might socio-economic status and/or race impact folks' access to prenatal care? And when we address issues of birth, note the disparity in how everything from pain care to maternal and infant mortality impact BIPOC. As with many of these topics in human sexuality, we can marvel at the complexities and wonder of our bodies and their many responses. At the same time, we can challenge the areas in which culture, race, poverty, ethnicity, abilities, and marginalization can impede some people's opportunities.

One more note

This chapter is very much a work-in-progress. One of the challenges we've had authoring this chapter is finding the balance of maintaining the respectful and safe space that pregnancy and birthing has afforded generations of women. This is especially true for BIPOC communities that push back against dominant, white, medical establishments. At the same time, we seek to broaden the language, awareness, and understanding of pregnancy and birth, since so much of the traditional, western approaches have excluded gender-diverse people and families. In that vein, we are embracing the ***and;*** that is- we're striving to consistently honor our foremothers and visionaries of birth who've held safe space for women, as well as respectfully embrace our non-binary, trans, and gender-diverse families in the amazing process of pregnancy and birth.

Conception

Fertilization occurs when a sperm and an oocyte (egg) combine and their nuclei fuse. Because each of these reproductive cells is a haploid cell containing half of the genetic material needed to form a human being, their combination forms a diploid cell. This new single cell, called a zygote, contains all of the genetic material needed to form a human—half from the egg and half from the sperm.

Transit of Sperm

Fertilization is a numbers game. During ejaculation, hundreds of millions of sperm (spermatozoa) are released into the vagina. Almost immediately, millions of these sperm are overcome by the acidity of the vagina, and millions more may be blocked from entering the uterus by thick cervical mucus. Of those that do enter, thousands are destroyed by phagocytic uterine leukocytes. Thus, the race into the uterine tubes, which is the most typical site for sperm to encounter the oocyte, is reduced to a few thousand contenders. Their journey—thought to be facilitated by uterine contractions—usually takes from 30 minutes to 2 hours. If the sperm do not encounter an oocyte immediately, they can survive in the uterine tubes for another 3–5 days. Thus, fertilization can still occur if intercourse takes place a few days before ovulation. In comparison, an oocyte can survive independently for only approximately 24 hours following ovulation. Intercourse more than a day after ovulation will therefore usually not result in fertilization.

During the journey, fluids in the female reproductive tract prepare the sperm for fertilization through a process called capacitation, or priming. The fluids improve the motility of the spermatozoa. They also deplete cholesterol molecules embedded in the membrane of the head of the sperm, thinning the membrane in such a way that will help facilitate the release of the lysosomal (digestive) enzymes needed for the sperm to penetrate the oocyte's exterior once contact is made. Sperm must undergo the process of capacitation in order to have the "capacity" to fertilize an oocyte. If they reach the oocyte before capacitation is complete, they will be unable to penetrate the oocyte's thick outer layer of cells.

Contact Between Sperm and Oocyte

Upon ovulation, the oocyte released by the ovary is swept into—and along—the uterine tube. Fertilization must occur in the distal uterine tube because an unfertilized oocyte cannot survive the 72-hour journey to the uterus.

As it is swept along the distal uterine tube, the oocyte encounters the surviving capacitated sperm, which stream toward it in response to chemical attractants released by the cells of the corona radiata. To reach the oocyte itself, the sperm must penetrate the two protective layers. Eventually, a single sperm makes contact with sperm-binding receptors on the oocyte's plasma membrane. The plasma membrane of that sperm then fuses with the oocyte's plasma membrane, and the head and mid-piece of the "winning" sperm enter the oocyte interior.

How do sperm penetrate the corona radiata? As you can see, the first sperm to reach the oocyte is never the one to fertilize it. Rather, hundreds of sperm cells must undergo the acrosomal reaction, each helping to degrade the corona radiata and zona pellucida until a path is created to allow one sperm to contact and fuse with the plasma membrane of the oocyte. If you consider the loss of millions of sperm between entry into the vagina and degradation of the zona pellucida, you can understand why a low sperm count can cause infertility.

The Zygote

Most of the time, a single egg is released during an ovulation cycle. However, in approximately 1 percent of ovulation cycles, two eggs are released and both are fertilized. Two zygotes form, implant, and develop, resulting in the birth of dizygotic (or fraternal) twins. Because dizygotic twins develop from two eggs fertilized by two sperm, they are no more identical than siblings born at different times.

Much less commonly, a zygote can divide into two separate offspring during early development. This results in the birth of monozygotic (or identical) twins. Although the zygote can split as early as the two-cell stage, splitting occurs most commonly during the early blastocyst stage, with roughly 70–100 cells present. These two scenarios are distinct from each other, in that the twin embryos that separated at the two-cell stage will have individual placentas, whereas twin embryos that form from separation at the blastocyst stage will share a placenta and a chorionic cavity.

In Vitro Fertilization

IVF, which stands for in vitro fertilization, is an assisted reproductive technology. In vitro, which in Latin translates to “in glass,” refers to a procedure that takes place outside of the body. There are many different indications for IVF. For example, someone may produce normal eggs, but the eggs cannot reach the uterus because the uterine tubes are blocked or otherwise compromised. There are also challenges with low sperm count, low sperm motility, sperm with an unusually high percentage of morphological abnormalities, or sperm that are incapable of penetrating the zona pellucida of an egg.

A typical IVF procedure begins with egg collection. A normal ovulation cycle produces only one oocyte, but the number can be boosted significantly (to 10–20 oocytes) by administering a short course of gonadotropins. The course begins with follicle-stimulating hormone (FSH) analogs, which support the development of multiple follicles, and ends with a luteinizing hormone (LH) analog that triggers ovulation. Right before the ova would be released from the ovary, they are harvested using ultrasound-guided oocyte retrieval. In this procedure, ultrasound allows a physician to visualize mature follicles. The ova are aspirated (sucked out) using a syringe.

In parallel, sperm are obtained from a partner or from a donor/sperm bank. The sperm are prepared by washing to remove seminal fluid because seminal fluid contains a peptide, FPP (or, fertilization promoting peptide), that—in high concentrations—prevents capacitation of the sperm. The sperm sample is also concentrated, to increase the sperm count per milliliter.

Next, the eggs and sperm are mixed in a petri dish. The ideal ratio is 75,000 sperm to one egg. If there are severe problems with the sperm—for example, the count is exceedingly low, or the sperm are completely nonmotile, or incapable of binding to or penetrating the zona pellucida—a sperm can be injected into an egg. This is called intracytoplasmic sperm injection (ICSI).

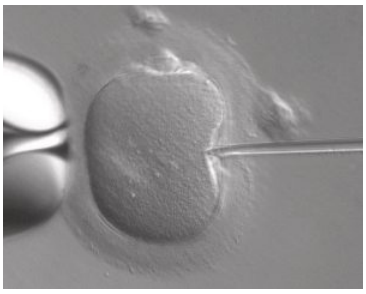

Figure 2.5.1: “IVF Capillary Tube Insertion” by ZEISS Microscopy is licensed under CC BY-NC-ND 2.0.

The embryos are then incubated until they either reach the eight-cell stage or the blastocyst stage. In the United States, fertilized eggs are typically cultured to the blastocyst stage because this results in a higher pregnancy rate. Finally, the embryos are transferred to the uterus using a plastic catheter (tube).

IVF is a relatively new and still evolving technology, and until recently it was necessary to transfer multiple embryos to achieve a good chance of a pregnancy. Today, however, transferred embryos are much more likely to implant successfully, so countries that regulate the IVF industry cap the number of embryos that can be transferred per cycle at two. This reduces the risk of multiple-birth pregnancies.

Pregnancy

Pregnancy begins with the fertilization of an egg and continues through to the birth of the individual. The length of time of gestation varies among animals, but is very similar among the great apes: human gestation is 266 days, while chimpanzee gestation is 237 days, a gorilla’s is 257 days, and orangutan gestation is 260 days long. The fox has a 57-day gestation. Dogs and cats have similar gestations averaging 60 days. The longest gestation for a land mammal is an African elephant at 640 days. The longest gestations among marine mammals are the beluga and sperm whales at 460 days.

Twenty-four hours before fertilization, the egg has finished meiosis and becomes a mature oocyte. When fertilized (at conception) the egg becomes known as a zygote. The zygote travels through the oviduct to the uterus. The developing embryo must implant into the wall of the uterus within seven days, or it will deteriorate and die. The outer layers of the zygote (blastocyst) grow into the endometrium by digesting the endometrial cells, and wound healing of the endometrium closes up the blastocyst into the tissue. Another layer of the blastocyst, the chorion, begins releasing a hormone called human beta chorionic gonadotropin (β-HCG) which makes its way to the corpus luteum and keeps that structure active. This ensures adequate levels of progesterone that will maintain the endometrium of the uterus for the support of the developing embryo. Pregnancy tests determine the level of β-HCG in urine or serum. If the hormone is present, the test is positive.

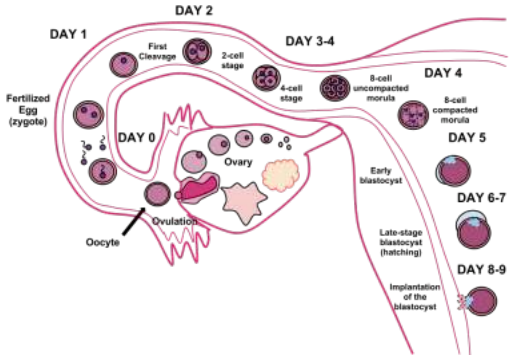

Figure 2.5.2: By Ttrue12 – Own work, CC BY-SA 3.0, https://commons.wikimedia.org/w/inde...curid=19679961

The gestation period is divided into three equal periods or trimesters. During the first two to four weeks of the first trimester, nutrition and waste are handled by the endometrial lining through diffusion. As the trimester progresses, the outer layer of the embryo begins to merge with the endometrium, and the placenta forms. This organ takes over the nutrient and waste requirements of the embryo and fetus, with the parent's blood passing nutrients to the placenta and removing waste from it.

First Trimester

Internal organs and body structures begin to develop during the first trimester. By five weeks, limb buds, eyes, the heart, and liver have been basically formed. By eight weeks, the term fetus applies, and the body is essentially formed, as shown in Figure 15.4. The individual is about five centimeters (two inches) in length and many of the organs, such as the lungs and liver, are not yet functioning. Exposure to any toxins is especially dangerous during the first trimester, as all of the body's organs and structures are going through initial development. Anything that affects that development can have a severe effect on the fetus' survival.

Figure 2.5.3: Fetal development is shown at nine weeks gestation. (Credit: Ed Uthman)

Second Trimester

During the second trimester, the fetus grows to about 30 cm (12 inches), as shown in Figure 2.5.4. It becomes active and the mother usually feels the first movements. All organs and structures continue to develop. The placenta has taken over the functions of nutrition and waste and the production of estrogen and progesterone from the corpus luteum, which has degenerated. The placenta will continue functioning up through the delivery of the baby.

Third Trimester

During the third trimester, the fetus grows to 3 to 4 kg (6 ½ -8 ½ lbs.) and about 50 cm (19-20 inches) long. This is the period of the most rapid growth during the pregnancy. Organ development continues to birth (and some systems, such as the nervous system and liver, continue to develop after birth).

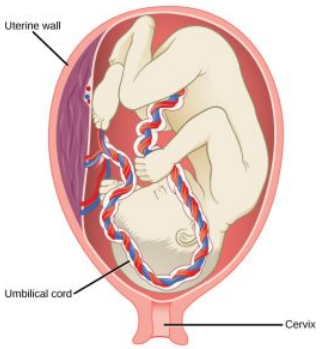

Figure 2.5.4: There is rapid fetal growth during the third trimester. (credit: modification of work by Gray's Anatomy)

Changes During Pregnancy

A full-term pregnancy lasts approximately 270 days (approximately 38.5 weeks) from conception to birth. Because it is easier to remember the first day of the last menstrual period (LMP) than to estimate the date of conception, obstetricians set the due date as 284 days (approximately 40.5 weeks) from the LMP. This assumes that conception occurred on day 14 of the woman's cycle, which is usually a good approximation. The 40 weeks of an average pregnancy are usually discussed in terms of three trimesters, each approximately 13 weeks. During the second and third trimesters, the pre-pregnancy uterus—about the size of a fist—grows dramatically to contain the fetus, causing a number of anatomical changes in the pregnant person.

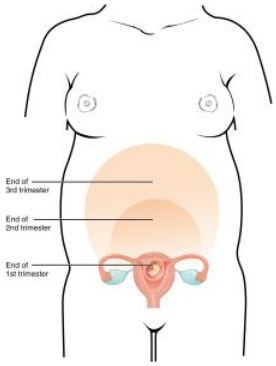

Figure 2.5.5: Anatomy & Physiology, Connexions Web site. http://cnx.org/content/col11496/1.6

Weight Gain

The second and third trimesters of pregnancy are associated with dramatic changes in anatomy and physiology. The most obvious anatomical sign of pregnancy is the dramatic enlargement of the abdominal region, coupled with weight gain. This weight results from the growing fetus as well as the enlarged uterus, amniotic fluid, and placenta. Additional breast tissue and dramatically increased blood volume also contribute to weight gain (Table 15.1). Surprisingly, fat storage accounts for only approximately 2.3 kg (5 lbs) in a normal pregnancy and serves as a reserve for the increased metabolic demand of breastfeeding.

During the first trimester, the parent does not need to consume additional calories to maintain a healthy pregnancy. However, a weight gain of approximately 0.45 kg (1 lb) per month is common. During the second and third trimesters, the pregnant person's appetite increases, but it is only necessary for them to consume an additional 300 calories per day to support the growing fetus. Contributors to Weight Gain During Pregnancy

Component	Weight (kg)	Weight (lb)
Fetus	3.2–3.6	7–8
Placenta and fetal membranes	0.9–1.8	2–4
Amniotic fluid	0.9–1.4	2–3
Breast tissue	0.9–1.4	2–3
Blood	1.4	4

Component	Weight (kg)	Weight (lb)
Fat	0.9–4.1	3–9
Uterus	0.9–2.3	2–5
Total	10–16.3	22–36

Table 2.5.1

Changes in Organ Systems During Pregnancy

As the body adapts to pregnancy, characteristic physiologic changes occur. These changes can sometimes prompt symptoms often referred to collectively as the common discomforts of pregnancy.

Digestive and Urinary System Changes

Nausea and vomiting, sometimes triggered by an increased sensitivity to odors, are common during the first few weeks to months of pregnancy. This phenomenon is often referred to as “morning sickness,” although the nausea may persist all day. The source of pregnancy nausea is thought to be the increased circulation of pregnancy-related hormones, specifically circulating estrogen, progesterone, and hCG. Decreased intestinal peristalsis may also contribute to nausea. By about week 12 of pregnancy, nausea typically subsides.

A common gastrointestinal complaint during the later stages of pregnancy is gastric reflux, or heartburn, which results from the upward, constrictive pressure of the growing uterus on the stomach. The same decreased peristalsis that may contribute to nausea in early pregnancy is also thought to be responsible for pregnancy-related constipation as pregnancy progresses.

The downward pressure of the uterus also compresses the urinary bladder, leading to frequent urination. The problem is exacerbated by increased urine production. In addition, the maternal urinary system processes both maternal and fetal wastes, further increasing the total volume of urine.

Integumentary System Changes

The dermis (skin) stretches extensively to accommodate the growing uterus, breast tissue, and fat deposits on the thighs and hips. Torn connective tissue beneath the dermis can cause striae (stretch marks) on the abdomen, which appear as red or purple marks during pregnancy that fade to a silvery white color in the months after childbirth.

An increase in melanocyte-stimulating hormone, in conjunction with estrogens, darkens the areolae and creates a line of pigment from the umbilicus to the pubis called the linea nigra (Figure 15.8). Melanin production during pregnancy may also darken or discolor skin on the face to create a chloasma, or “mask of pregnancy.”

Figure Runaway argument for \eatSpaces?: Linea Nigra The linea nigra, a dark medial line running from the umbilicus to the pubis, forms during pregnancy and persists for a few weeks following childbirth.

Birth

Labor is the physical efforts of expulsion of the fetus and the placenta from the uterus during birth (parturition). Toward the end of the third trimester, estrogen causes receptors on the uterine wall to develop and bind the hormone oxytocin. At this time, the baby reorients, facing forward and down with the back or crown of the head engaging the cervix (uterine opening). This causes the cervix to stretch and nerve impulses are sent to the hypothalamus, which signals for the release of oxytocin from the posterior pituitary. The oxytocin causes the smooth muscle in the uterine wall to contract. At the same time, the placenta releases prostaglandins into the uterus, increasing the contractions. A positive feedback relay occurs between the uterus, hypothalamus, and the posterior pituitary to assure an adequate supply of oxytocin. As more smooth muscle cells are recruited, the contractions increase in intensity and force.

Stages of Childbirth

The process of childbirth can be divided into three stages: cervical dilation, expulsion of the newborn, and afterbirth (Figure 15.9).

Cervical Dilation

For vaginal birth to occur, the cervix must dilate fully to 10 cm in diameter—wide enough to deliver the newborn’s head. The dilation stage is the longest stage of labor and typically takes 6–12 hours. However, it varies widely and may take minutes, hours, or days, depending in part on whether the mother has given birth before; in each subsequent labor, this stage tends to be shorter.

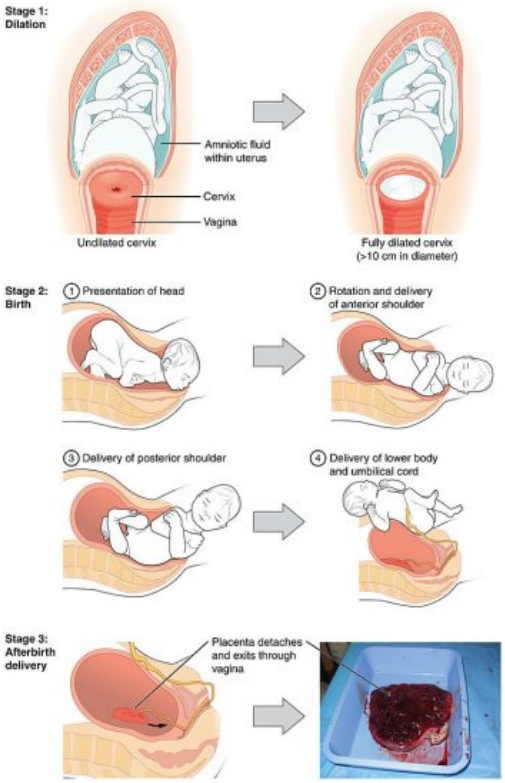

Figure 2.5.7: Stages of Childbirth The stages of childbirth include Stage 1, early cervical dilation; Stage 2, full dilation and expulsion of the newborn; and Stage 3, delivery of the placenta and associated fetal membranes. (The position of the newborn's shoulder is described relative to the mother.)

True labor progresses in a positive feedback loop in which uterine contractions stretch the cervix, causing it to dilate and efface, or become thinner. Cervical stretching induces reflexive uterine contractions that dilate and efface the cervix further. In addition, cervical dilation boosts oxytocin secretion from the pituitary, which in turn triggers more powerful uterine contractions. When labor begins, uterine contractions may occur only every 3–30 minutes and last only 20–40 seconds; however, by the end of this stage, contractions may occur as frequently as every 1.5–2 minutes and last for a full minute.

Each contraction sharply reduces oxygenated blood flow to the fetus. For this reason, it is critical that a period of relaxation occur after each contraction. Fetal distress, measured as a sustained decrease or increase in the fetal heart rate, can result from severe contractions that are too powerful or lengthy for oxygenated blood to be restored to the fetus. Such a situation can be cause for an emergency birth with vacuum, forceps, or surgically by Caesarian section.

The amniotic membranes rupture before the onset of labor in about 12 percent of women; they typically rupture at the end of the dilation stage in response to excessive pressure from the fetal head entering the birth canal.

Expulsion Stage

The expulsion stage begins when the fetal head enters the birth canal and ends with birth of the newborn. It typically takes up to 2 hours, but it can last longer or be completed in minutes, depending in part on the orientation of the fetus. The vertex presentation known as the occiput anterior vertex is the most common presentation and is associated with the greatest ease of vaginal birth. The fetus faces the maternal spinal cord and the smallest part of the head (the posterior aspect called the occiput) exits the birth canal first.

In fewer than 5 percent of births, the infant is oriented in the breech presentation, or buttocks down. In a complete breech, both legs are crossed and oriented downward. In a frank breech presentation, the legs are oriented upward. Before the 1960s, it was common for breech presentations to be delivered vaginally. Today, most breech births are accomplished by Caesarian section.

Vaginal birth is associated with significant stretching of the vaginal canal, the cervix, and the perineum. Until recent decades, it was routine procedure for an obstetrician to numb the perineum and perform an episiotomy, an incision in the posterior vaginal wall and perineum. The perineum is now more commonly allowed to tear on its own during birth. Both an episiotomy and a perineal tear need to be sutured shortly after birth to ensure optimal healing. Although suturing the jagged edges of a perineal tear may be more

difficult than suturing an episiotomy, tears heal more quickly, are less painful, and are associated with less damage to the muscles around the vagina and rectum.

Upon birth of the newborn's head, an obstetrician will aspirate mucus from the mouth and nose before the newborn's first breath. Once the head is birthed, the rest of the body usually follows quickly. The umbilical cord is then double-clamped, and a cut is made between the clamps. This completes the second stage of childbirth.

Afterbirth

The delivery of the placenta and associated membranes, commonly referred to as the afterbirth, marks the final stage of childbirth (Figure 15.10). After expulsion of the newborn, the myometrium continues to contract. This movement shears the placenta from the back of the uterine wall. It is then easily delivered through the vagina. Continued uterine contractions then reduce blood loss from the site of the placenta. Delivery of the placenta marks the beginning of the postpartum period—the period of approximately 6 weeks immediately following childbirth during which the pregnant person's body gradually returns to a non-pregnant state. If the placenta does not birth spontaneously within approximately 30 minutes, it is considered retained, and the obstetrician may attempt manual removal. If this is not successful, surgery may be required.

It is important that the obstetrician examines the expelled placenta and fetal membranes to ensure that they are intact. If fragments of the placenta remain in the uterus, they can cause postpartum hemorrhage. Uterine contractions continue for several hours after birth to return the uterus to its pre-pregnancy size in a process called involution, which also allows the abdominal organs to return to their pre-pregnancy locations. Breastfeeding facilitates this process.

Miscarriages

Unfortunately, some instances of pregnancy do not end in a healthy birth. Miscarriage, or spontaneous pregnancy loss before 28 weeks of gestation, occurs in up to 20-25 percent of pregnancies (Sohr-Preston, Morain, Chapman, Pardue, & Ford, 2018; Bellhouse, Temple-Smith, & Bilardi, 2018). The majority of these miscarriages tend to occur before 12 weeks of gestation (often before women realize they're pregnant). Nearly half of all miscarriages have no known cause, leading to widespread misperceptions about frequency. In cases where there is a known cause, half are attributed to chromosomal abnormalities. Consequently, most miscarriages are largely out of the control of the expectant parent. Additionally, most miscarriages do not inform the parent's past or future success in bringing a baby to full-term (Sohr-Preston, et al, 2018).

In addition to some confusion regarding prevalence and frequency of miscarriage rates, there are often mixed responses to families impacted by miscarriage from the medical community, the general public, family members and friends. In so many ways, pregnancy loss is a time when many people need emotional support from those around them. There are a number of grass-roots agencies and hospital facilitated programs now in place to support families who've experienced loss. Partners are often a huge source of support, but research also identifies the need for more public discourse and education around pregnancy loss generally, which boosts well-being for all members of the families involved (Bellhouse, Temple-Smith, & Bilardi, 2018).

Abortion

The issues surrounding abortion, the deliberate termination of a pregnancy, remain highly charged throughout the United States and around the globe. In the US, there were over 600,000 abortions in 2018 reported to the Centers for Disease Control (CDC); a rate of 11.3 abortions per 1,000 women aged 15-44 years (Kortsmit, Jatlaoui, Mandel, Reeves, Oduyebo, Petersen, & Whiteman, 2020). Over half of the abortions (57.7%) in 2018 occurred among women in their 20s. Interestingly, 2018 was the first year in almost a decade where there was a slight increase in the rate of abortions (1-2% across measure). Overall, the total number of reported abortions, abortion rate, and abortion ratio decreased 22% from 2009-2018 (Kortsmit, et al, 2020). For more details on the CDC data, which outlines age of parent, gestational periods, race/ethnicity, and more can be found here and below.

On June 24, 2022, the US Supreme Court overturned Roe v. Wade, the 1973 Supreme Court decision protecting a pregnant person's liberty to choose to have an abortion without government prohibition. Over decades, research has demonstrated that abortion bans most severely impact people in marginalized groups who already struggle to access health care, including abortion.

Figure 2.5.8: https://www.guttmacher.org/2023/01/s...-do-so-roundup

Interestingly, states with the most limitations in access to abortion care also tend to have the most conservative (or absence) of sex education, the highest rates of unintended pregnancies and the lowest indicators of infant/child well-being (Dreweke, 2016; Medoff, 2018).

Caesarean Section

Cesarean section (c-sections), the surgical operation to remove an infant out of their pregnant parent's body, has been part of human culture since ancient times (Sewel, 1998). Since 1996, c-sections have been on an almost steady rise in the United States. In 2018, approximately one-third (31.9%) of all births occurred through cesarean delivery (Martin, Hamilton, Osterman, & Driscoll, 2019). There is no question that c-sections can save lives; both of parents and children. However, there is a rising concern that many of these procedures are unnecessary, causing needless risk of complications to both mother and baby, as well as potential long-term implications (e.g. following the first c-section, there is a low probability, 10%, of later vaginal delivery; Osterman & Martin, 2014).

One of the ongoing criticisms about the high rate of c-sections is that it is primarily financially driven in terms of payout to physicians/hospitals, rather than due to patient care. Considering that a c-section costs twice as much as a vaginal delivery, the economic boon for attending medical staff/facilities can be high. On the public side of things, almost half of US births are compensated through Medicaid (with double the payout for c-sections; Kozhimannil, Graves, Ecklund, Shah, Aggarwal, & Snowden, 2018). Added to that, one meta-analysis found that c-sections are more likely to be performed on privately insured women as compared with women using public health insurance coverage (Hoxha, Syrogiannouli, Braha, Goodman, da Costa, & Jüni, 2017). Thankfully, more efforts are being examined and implemented to reduce unnecessary births via cesarean section (Kozhimannil, et al, 2018).

Disparities in Prenatal and Perinatal Care

Racial and ethnic disparities in maternal care have been an issue in the United States for generations. Just as we discussed in last week's reading, abuse against black and brown bodies has been excessive and consequential. In terms of prenatal and perinatal care, there have been ongoing discrepancies in care, resulting in inexcusable outcomes. Nearly a quarter of black women experience delays in their prenatal healthcare and they are almost twice as likely to experience pregnancy complications (Slaughter-Acey, Sneed, Parker, Keith, Lee, & Misra, 2019).

Among industrialized nations, the US has the highest level of maternal deaths (Declercq & Zephyrin, 2020). Wang and her colleagues (2021) reported that black women are three to four times more likely to die of pregnancy-related causes compared to non-Hispanic White women. A black or indigenous person is up to 5 times more likely to die in pregnancy or up to a year after pregnancy than their white peer (Maykin & Tsai, 2020). This disparity is akin to what we saw in the 1940s (Declercq & Zephyrin, 2020).

Importantly, when controlling for other variables, such as education, socio-economic status, accessibility, findings consistently suggest that lived experiences, in the form of racial microaggressions, influence Black women's use of health care, particularly perinatal services (Slaughter-Acey, et al, 2019). Despite advances in healthcare, antibiotics, surgical processes, and accessibility, the data provides a stark reality of rampant, systemic inequity. As Declercq and Zephyrin (2020) note, "The US has to intentionally focus on disparities between Black and white women, in particular by naming and seeking to reduce the impacts of structural racism" (p. 12). Please see the Commonwealth Fund's recent briefing here.

There is a great deal of work to do to rectify the massive inequities facing this country. There are a variety of initiatives at both state-wide and the national level to address the disparities in perinatal care. To see a state by state comparison, go here. The Centers for Disease Control also has launched the "Hear Her Campaign."

To be clear, the disparities in maternal health are not the result of any one, single factor. It's at the intersection of sexism and racism, that many women of color are not being heard or seen. The initiatives noted above are a very small part in rectifying this. Continued efforts to name and eliminate structural racism, as well as provide comprehensive health care for pregnant bodies, are essential.

Conclusion

This week's reading covers a wide range of concepts related to conception, pregnancy, and birth. Additionally, we highlighted some of the major disparities of perinatal care for BIPOC. There are other marginalized populations that need further examination; individuals with disabilities and gender nonconforming folks. There are also other stakeholders that were omitted from this section; partners, surrogates, midwives, and doulas. Finally, some considerations about lactation and postpartum adjustments can be explored further. Still, hopefully you got a solid introduction into the brilliance of conception, the marvel of pregnancy and birth, as well as the pressing issue of our time; building equity into the wrap-around healthcare of all people.

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2.6: Variations in Sexual Behavior 2.6: Variations in Sexual BehaviorEdit Update titlecancel

Learning Objectives

- Distinguish between sexual disorders in the DSM-V (coercive, paraphilic) and functional sexual behaviors (consensual, less common).
- Give examples of atypical sexual behavior, including noncoercive paraphilias (e.g., fetishism, transvestism, sexual sadism and sexual masochism, etc.) and coercive paraphilias (e.g., exhibitionism, obscene phone calls, voyeurism, frotteurism, etc.).
- Describe some of the dynamics involved in these behaviors as well as treatment strategies for coercive paraphilias.

Introduction

This week's reading is both fascinating and, potentially, triggering. We are covering variations in sexual behaviors, which includes everything from consensual activities, such as agreed upon sex play involving bondage (blindfolding, binding, tying up a partner, etc) to nonconsensual sexual activities, such as exhibitionism (exposing your genitals to someone without their consent). Inevitably, we must take cultural norms and shifts into account as we examine how the field (and society) responds and treats folks engaged in paraphilic behavior. With that in mind, issues of consent, levels of distress, and legal matters are all factors to consider. Additionally, we are tasked with being curious in our academic thinking around sexual norms, taboos, and behaviors in order to best navigate psychological positions/interventions of disordered vs. typical sexual behaviors.

Paraphilic Disorders of the DSM-5

Paraphilias are persistent and recurrent sexual interests, urges, fantasies, or behaviors of marked intensity involving objects, activities, or even situations that are atypical in nature (Fisher & Marwaha, 2020). Although paraphilias are not innately pathological, a paraphilic disorder can evolve if paraphilia invokes harm, distress, or functional impairment on the lives of the affected individual or others. A total of eight paraphilias are listed in the DSM-V (American Psychiatric Association [APA], 2013) and include pedophilia, exhibitionism, voyeurism, sexual sadism, sexual masochism, frotteurism, fetishism, and transvestic fetishism. Indeed, if these interests cause a "clinically significant" level of distress or dysfunction for the person or if they were conducted with/against a non-consenting other (child, adult, animal, or corpse) then they become a paraphilic disorder (Joyal, 2018).

Paraphilia	Behavior in which an individual has recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving (1) nonhuman objects, (2) children or other non-consenting persons, or (3) the suffering or humiliation of self or partner
Exhibitionistic disorder	Derive pleasure from exposing genitals to an unsuspecting person
Transvestic disorder	Engages in cross-dressing associated with intense distress or impairment
Fetishistic disorder and partialism	Fetishism is sexual arousal from an object Partialism is sexual arousal from a part of the body
Frotteuristic disorder	Sexual urges and sexually arousing fantasies of rubbing up against or fondling unsuspecting persons
Sexual masochism	Masochism is being aroused by being made to suffer (beaten, humiliated, bound)
Pedophilic disorder	Sexual arousal for children or adolescents
Sexual sadism	Sadism is being aroused by inflicting suffering on another person
Voyeuristic disorder	Derive sexual pleasure from observing an unsuspecting person who is naked, disrobing, or engaged in intimate behavior

People with paraphilias have historically been rejected by society. In some cases, such as voyeurism and pedophilia, the behavior is unacceptable (and illegal) because it involves a lack of consent on the part of the recipient of the sexual advance. But other paraphilias are rejected simply because they are unusual, even though they are consensual and do not cause distress or dysfunction to the partners. Sexual sadism and sexual masochism, for instance, are usually practiced consensually, and thus may not be harmful to the partners or to society.

When considering the evolution of acceptance of sexual behaviors in different cultures, we can actively see shifts in attitudes about acceptability (e.g. sex for pleasure, masturbation, etc). Current research in areas of sexual behavior once thought to be entirely deviant (e.g. BDSM), find that practitioners who aren't experiencing levels of shame or distress have high levels of psychological well-being (Joyal, 2018; Labrecque, Potz, Larouche & Joyal, 2020). Again, as sociocultural norms about the appropriateness of behaviors change, the revision of the DSM (APA, 2013), changed its classification system of these behaviors. Similarly, the World Health Organization's International Classification of Disease (ICD) has also shifted many of their definitions and eliminated three paraphilias from their diagnostic list (Krueger, Reed, First, Marais, Kismodi & Briken, 2017; Moser & Kleinplatz, 2020).

As Jusin Lehmiller summarized (2019), "We can think of a paraphilia as simply representing an unusual sexual interest that does not require any type of treatment. In contrast, a paraphilic disorder represents an unusual sexual interest that is personally distressing to the individual and/or involves victimization of others (p. 365).

Types of Paraphilia – Nonconsensual Pedophilic disorder

1 in 5 girls and 1 in 20 boys is a victim of child sexual abuse, making pedophilia a common paraphilia (Watford, 2020) . Offenders are usually family friends or relatives. Types of activities vary and may include just looking at a child or undressing and touching a child. However, acts often involve oral sex or touching of genitals of the child or the offender. Studies suggest that children who feel uncared for or lonely may be at higher risk for sexual abuse.

Associated features

The key feature of this disorder is that the individual experiences sexual arousal when with children that may be equal to, if not greater than, that which they experience with individuals who are physically mature.

This may also include recurring sexual dreams, behaviors, or urges concerning children that are 13 years old or younger. Some pedophiles are attracted to both boys and girls. Some are attracted to only children, while others are attracted to children as well as adults. These issues must be persistent for at least 6 months and must cause impairment to everyday functioning to be considered symptoms. If an individual is 16 years old and exhibits these behaviors with someone that is at least 5 years younger, he would be considered for this disorder.

To be diagnosed as having pedophilia, the individual must be at least 16 years of age. The disorder typically begins in adolescence, although some individuals with Pedophilia report that they did not become sexually aroused by children until middle adulthood.

Pedophiles may limit their activity to exposing themselves to the child (sometimes known as flashing), touching and fondling the child gently, undressing the child and looking at him or her, or masturbating in front of the child.

Gender and cultural differences in presentation

The word “Pedophilia” is derived from the Greek words “paidos” (child) and “philia” (love). Awareness of Pedophilia has been raised in the past two decades, and it has become more difficult for these individuals to find children with whom to act out their fantasies. In response to the scarcity of vulnerable children, many pedophiles have turned to chatrooms and child pornography.

Males are more often diagnosed with this disorder than women. Pedophilia is more prevalent among Caucasians than among other ethnicities. It is also known that if a male prefers males, it is more likely that he will repeat his pedophilic actions. This has led certain religious or otherwise radical activists to suggest that pedophilia and homosexuality are “one and the same,” resulting in further media attention to an already well-covered topic.

One of the biggest issues in assessing behavior as pedophilic or normal is the criteria for pedophilia by Western standards. Some cultures allow “child weddings,” or unions between mature males and prepubescent females. In some tribal societies across the globe, pedophilic behavior is considered perfectly normal; men often take “boy-wives” in addition to wives. The men engage in sexual activity with these boy-wives until it is deemed time for the young boy to choose a wife of his own. At this point, the boy’s “husband” will then aid him in choosing a wife, and the boy will be allowed to leave to start a family of his own. Clearly, it is important to note any religious or cultural backgrounds in individuals being examined as having pedophilia. This is a very difficult situation, as some groups have voiced the concern that any pedophile can simply convert to a belief system that accommodates and excuses their behaviors.

Epidemiology

There is very little known about the prevalence of pedophilia at this time because, due to the severely negative stigma associated with having pedophilia, many people with pedophilia rarely seek help from a mental health professional. The ratio of sex offenders against female children and sex offenders against male children is about 2:1. It’s important to consider that not all sex offenders who victimize children are pedophiles; only about 40 percent of convicted sex offenders meet the diagnostic criteria for the disorder. Note: The large commercial market in pedophiliac pornography suggests a much higher prevalence than the limited medical data indicates.

Exhibitionist Disorder

The term exhibitionist was first used in 1877 by French physician and psychiatrist Charles Lasègue. Various earlier medical-forensic texts discuss genital self-exhibition, however. Exhibitionism is the act of exposing in a public or semi-public context those parts of one’s body that are not normally exposed – for example, the breasts, genitals or buttocks. The practice may arise from a desire or compulsion to expose themselves in such a manner to groups of friends or acquaintances, or to strangers for their amusement or sexual satisfaction or to shock the bystander. Exposing oneself only to an intimate partner is normally not regarded as exhibitionism. In law, the act of exhibitionism may be called indecent exposure, “exposing one’s person”, or other expressions.

When exhibitionistic sexual interest is acted on with a non-consenting person or interferes with a person’s quality of life or normal functioning, it can be diagnosed as exhibitionist disorder in the DSM-5. The DSM states that the highest possible prevalence for exhibitionistic disorder in men is 2% to 4%. It is thought to be much less common in women. In one survey, men were twice as likely as women to have exposed their genitals to a stranger (Lehmiller, 2019).

DSM-V DIAGNOSTIC CRITERIA FOR EXHIBITIONISTIC DISORDER

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.

AND

- B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether:

Sexually aroused by exposing genitals to prepubertal children.

Sexually aroused by exposing genitals to physically mature individuals Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals.

Specify if;

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted.

In full remission: The individual has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Associated features

In some cases exhibitionists masturbate while exposing themselves (or while fantasizing that he/she is exposing himself/herself) to another person. There is a pattern in which males exhibit themselves and there are three characteristic features of the exhibition: 1) It is performed for unknown women. 2) It takes place where sexual intercourse is impossible (e.g. a crowded shopping center). 3) It seems designed to surprise and shock the woman. The male exhibitionist usually exposes his erect penis, but it is not necessarily essential for the activity. Ejaculation may occur at the moment of exposure or develop later with masturbatory stimulation. Some exhibitionists are aware of a conscious desire to shock or upset their target; while others fantasize that the target will become sexually aroused by their display.

Child vs. adult presentation

Generally, society accepts exhibitionism in children as a natural curiosity, not a disorder, however if the behaviors continue a paraphilia is probable. Disorder appears to develop before the age of 18, and rarely is found in people over the age of 50.

Gender and cultural differences in presentation

Most reported cases of exhibitionism involve males. Some scientists argue that women who undress in front of windows (as to invite a person to watch), or who wear low cut gowns are exhibitionists in a sense. Exhibitionism generally appears in Western society and is believed to be almost absent in such countries as Japan, Burma, and India. Additionally, in American society it can be a crime when committed by a male, particularly when there is an erection present.

Epidemiology

Prevalence and incidence are not easily defined because people with this disorder usually do not seek treatment voluntarily. Exhibitionism is one of the three most common sexual offenses, the other two being voyeurism and pedophilia. It is rarely diagnosed in general mental health clinics, but most professionals believe that it is probably under diagnosed and under-reported.

Risk Factors appear to be Antisocial history, Antisocial personality disorder, Alcohol misuse and Pedophilic sexual preference.

Voyeuristic Disorder

Voyeurism is the sexual interest in or practice of spying on people engaged in intimate behaviors, such as undressing, sexual activity, or other actions usually considered to be of a private nature. The term comes from the French voir which means "to see". A male voyeur is commonly labelled as "Peeping Tom" or a "Jags", a term which originates from the Lady Godiva legend. However, that term is usually applied to a male who observes somebody secretly and, generally, not in a public space.

DSM-V DIAGNOSTIC CRITERIA FOR VOYEURISTIC DISORDER

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors.

AND

- B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

AND

- C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

Specify if:

- In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in voyeuristic behavior are restricted.

OR

- In full remission: The individual has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Associated features

Voyeurism, a form of paraphilia, refers to the achievement of sexual gratification by observing or spying on unsuspecting people, especially while they dress, undress, or engage in sexual activity. The observers, often known as “Peeping Tom’s”, may not feel guilt or remorse when intruding upon other individuals’ privacy. Voyeuristic individuals may rationalize their behavior, claiming “no harm, no foul.” Voyeurism is considered a crime in several states, but the definition of voyeurism varies from state to state.

The voyeur may wait outside their victims window and masturbate to the subject undressing, taking a shower, or even a couple having sex. They also may wait until afterwards to masturbate while replaying the incident in their mind. The voyeur may risk injury by assuming precarious positions to catch a preferred view of their target.

Child vs. adult presentation

Lack of maturity and understanding prevents children from being diagnosed with voyeurism.

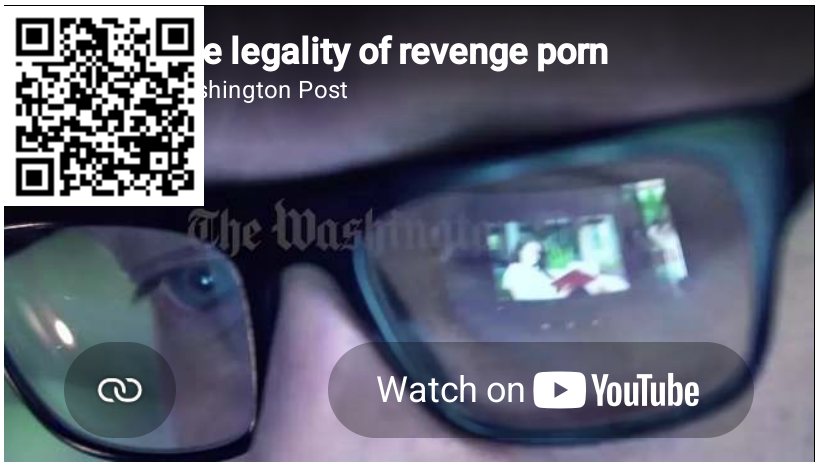
Gender and cultural differences in presentation

Men are much more likely to be diagnosed with voyeurism than women. There does not seem to be any differences with the cultural presentation of voyeurism. However, with the social nature of the prohibited activity it appears to be an important factor in the sexual arousal pertaining to voyeurism. Some suggest that voyeurs tend to harbor feelings of inadequacy and to lack social and sexual skills (APA, 2013).

Epidemiology

The onset for the disorder is normally before the age of 15 years. Some studies have shown that men express voyeuristic tendencies more often than women, but the disorder is not unique to males (American Psychiatric Association, 2013). The prevalence of voyeuristic disorder is 12,000 per 100,000 (12%) among the male population and 4,000 per 100,000 (4%) among the female population. The prevalence rate of this abnormality is not known. Some research suggests that people in the U.S. are showing more voyeuristic characteristics due to the increase in reality television shows being aired. Risk factors appear to be Childhood sexual abuse, Substance misuse, Sexual preoccupation and Hypersexuality.

Revenge Porn



Frotteuristic Disorder

Frotteurism is a paraphilic interest in rubbing, usually one's pelvic area or erect penis, against a non-consenting person for sexual pleasure. It may involve touching any part of the body, including the genital area. A person who practices frotteuristic acts is known as a frotteur. "Frottage" derives from the French verb frotter, meaning "to rub". The term frotteur, originally meaning "floor polisher", entered police jargon around 1882. Frotteuristic acts were interpreted as signs of a psychological disorder in 1887 and in ensuing work by French psychiatrist Valentin Magnan, who described three acts of "frottage" in an 1890 study. It was popularized by German sexologist Richard von Krafft-Ebing in his book Psychopathia Sexualis, borrowing from Magnan's French terminology.

Frotteuristic disorder is a sexual dysfunction disorder characterized by sexual arousal from rubbing against or touching a non-consenting person.

DSM-V DIAGNOSTIC CRITERIA FOR FROTTEURISTIC DISORDER

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from touching or rubbing against a non consenting person, as manifested by fantasies, urges, or behaviors.

AND

- B. The individual has acted on these sexual urges with a non consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to touch or rub against a non consenting person are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Associated features

A person who is suffering from frotteurism usually experiences symptoms such as intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person for over a period of at least six months. These fantasies, urges, and behaviors can cause distress and problems associated with work, social atmospheres, and other important daily activities.

Toucherism is sexual arousal based on grabbing or rubbing one's hands against an unexpecting (and non-consenting) person. It usually involves touching breasts, buttocks or genital areas, often while quickly walking across the victim's path. Some psychologists consider toucherism a manifestation of frotteurism, while others distinguish the two.

Frotteurism is also known as "mashing". Mashing has been reported exclusively among males (DSM, 2000). Mashing usually takes place in crowded places, such as buses, elevators, or subway cars. The man usually incorporates images of his mashing within his masturbation fantasies. Mashing is related to "toucherism", which is the fondling of non-consenting strangers. Mashing can be so furtive and fleeting that the victim may not realize what has happened.

Child vs. adult presentation

Typically, children under the age of 12 do not have Frotteurism due to lack of understanding and maturity. Most individuals who participate in frotteurism are between the ages of 15 and 25.Tendencies typically increase the age of 15 and decrease after the age of 25.

Epidemiology

Frotteurism is associated with paraphilic fantasies, but it occurs most commonly in adolescents. This disorder is not associated with traumatic experiences in either adolescent or adult life. Risk Factors appear to be Nonsexual antisocial behavior and Sexual preoccupation/hypersexuality. The DSM estimates that 10%–14% of men seen in clinical settings for paraphilias or hypersexuality have frotteuristic disorder, indicating that the population prevalence is lower. However, frotteuristic acts, as opposed to frotteuristic disorder, may occur in up to 30% of men in the general population. The majority of frotteurs are male and the majority of victims are female, although female on male, female on female, and male on male frotteurs exist. This activity is often done in circumstances where the victim cannot easily respond, in a public place such as a crowded train or concert. Usually, such nonconsensual sexual contact is viewed as a criminal offense: a form of sexual assault albeit often classified as a misdemeanor with minor legal penalties. Conviction may result in a sentence or psychiatric treatment.

Paraphilias – Mixed Fetishistic Disorder

A fetish (from French fétiche; from Portuguese feitiço; from Latin facticius, "artificial" and facere, "to make") is an object believed to have supernatural powers, or in particular a man-made object that has power over others. Later Sigmund Freud appropriated the concept to describe a form of paraphilia where the object of affection is an inanimate object or a specific part of a person.

Sexual fetishism or erotic fetishism is a sexual fixation on a nonliving object or nongenital body part. The object of interest is called the fetish; the person who has a fetish for that object is a fetishist. A sexual fetish may be regarded as a non-pathological aid to sexual excitement, or as a Fetishistic disorder if it causes significant psychosocial distress for the person or has detrimental effects on important areas of their life. Sexual arousal from a particular body part can be further classified as partialism. Partialism is sexual interest with an exclusive focus on a specific part of the body other than the genitals. Partialism is categorized as a fetishistic disorder in the DSM-5 only if it causes significant psychosocial distress for the person or has detrimental effects on important areas of their life.

Individuals who exhibit partialism sometimes describe the anatomy of interest to them as having equal or greater erotic attraction for them as do the genitals. Partialism occurs in heterosexual, bisexual, and homosexual individuals. The foot is considered one of the most common partialisms.

The following are some of the partialisms commonly found among people:

Formal name	Common name	Source of arousal
Podophilia	Foot fetish	Foot

Formal name	Common name	Source of arousal
Oculophilia	Eye fetish	Eye
Maschalagnia	Armpit fetish	Armpits
Mazophilia	Breast fetish	Breasts
Pygophilia	Buttocks fetish	Buttocks
Nasophilia	Nose fetish	Nose
Trichophilia	Hair fetish	Hair
Alvinophilia	Navel/Belly button fetish	Navel
Alvinolagnia	Belly/Stomach fetish	Belly
Cheirophilia	Hand fetish	Hands
Crurophilia	Leg fetish	Legs

In a review of 48 cases of clinical fetishism in 1983, fetishes included clothing (58.3%), rubber and rubber items (22.9%), footwear (14.6%), body parts (14.6%), leather (10.4%), and soft materials or fabrics (6.3%). A 2007 study counted members of Internet discussion groups with the word fetish in their name.

Of the groups about body parts or features, 47% belonged to groups about feet (podophilia), 9% about body fluids (including urophilia, scatophilia, lactaphilia, menophilia, mucophilia), 9% about body size, 7% about hair (hair fetish), and 5% about muscles (muscle worship). Less popular groups focused on navels (navel fetishism), legs, body hair, mouth, and nails, among other things. Of the groups about clothing, 33% belonged to groups about clothes worn on the legs or buttocks (such as stockings or skirts), 32% about footwear (shoe fetishism), 12% about underwear (underwear fetishism), and 9% about whole-body wear such as jackets. Less popular object groups focused on headwear, stethoscopes, wrist wear, pacifiers, and diapers (diaper fetishism).

While medical definitions restrict the term sexual fetishism to objects or body parts, fetish can, in common discourse, also refer to sexual interest in specific activities. This broader usage of fetish covers parts or features of the body (including obesity and body modifications), objects, situations and activities (such as BDSM – a variety of often erotic practices or roleplaying involving bondage, discipline, dominance and submission, sadomasochism, and other related interpersonal dynamics). Paraphilias such as urophilia (urination) and coprophilia (poop) have been described as fetishes. Many people who reveal that they have fetishes don't experience any significant distress or dysfunction from their behavior, hence they do not meet the criteria for fetishistic disorder (Lehmiller, 2019). In some instances, such as in cases of necrophilia (corpses) or zoophilia (animals), consent is an issue thereby rendering a more likely determination of fetishistic disorder.

Devotism involves being attracted to body modifications on another person that are the result of amputation. Devotism is only a sexual fetish when the person who has the fetish considers the amputated body part on another person the object of sexual interest.

Under the DSM-5, fetishism is sexual arousal from nonliving objects or specific nongenital body parts, excluding clothes used for cross-dressing (as that falls under transvestic disorder). Fetishism usually becomes evident during puberty, and may develop prior to that. No single cause for fetishism has been conclusively established, though issues of classical and operant conditioning have been studied.

DSM-V DIAGNOSTIC CRITERIA FOR FETISHISTIC DISORDER

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non genital body part(s), as manifested by fantasies, urges, or behaviors.

AND

- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

AND

- C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

AND

Specify:

- Body part(s)
- Nonliving object(s)
- Other

Specify if:

- In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in fetishistic behaviors are restricted.
- In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Sexual Masochism And Sexual Sadism Disorders

Figure 2.6.1: "The Entryway" by mrbill is licensed under CC BY 2.0

Sexual masochism disorder (SMD) is the condition of experiencing recurring and intense sexual arousal in response to enduring moderate or extreme pain, suffering, or humiliation. Conversely, Sexual sadism disorder is the condition of experiencing sexual arousal in response to the extreme pain, suffering or humiliation of others. The words sadism and sadist are derived from Marquis de Sade. Many of Marquis de Sade's books, including Justine (1791), Juliette (1797) and The 120 Days of Sodom (published posthumously in 1905), are written from a cruelly sadistic viewpoint.

BDSM (bondage, domination, sadomasochism) is a colloquial term relating to individuals who willingly engage in consenting forms of pain or humiliation, typically for sexual purposes. The term BDSM describes the activities between consenting partners that contain sadistic and masochistic elements. Many behaviors such as erotic spanking, tickling and love-bites that many people think of only as "rough" sex also contain elements of sadomasochism. It is not currently a diagnosable condition in either the DSM or ICD system.

There are a lot of misnomers about BDSM practitioners (those that engage in BDSM behaviors). Importantly, BDSM practices are relatively common, with some surveys indicating that 14% of men and 11% of women have had at least one experience with sadomasochistic experiences (Lehmiller, 2019). For many people, BDSM behaviors are not pathological, in fact, people who practice BDSM are no more psychologically disturbed than anyone else and there's no correlation to having been a victim of childhood sexual assault (Lehmiller, 2019). Additionally, the personality of BDSM practitioners indicate they experience less neuroticism, more extraversion, more openness to new experiences, more conscientiousness (safe, sane and consenting), have less fear of rejection, and higher subjective well-being than average (Joyal, 2018). Similar to issues in fetishism, one must look at high levels of distress/dysfunction and/or nonconsensual behaviors in order for a diagnosis to occur.

DSM-V DIAGNOSTIC CRITERIA FOR SEXUAL SADISM DISORDER

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.

AND

- B. The individual has acted on these sexual urges with a non consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behaviors are restricted.
- In full remission: The individual has not acted on the urges with a non consenting person,and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

DSM-V DIAGNOSTIC CRITERIA FOR SEXUAL MASOCHISM DISORDER

• A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. AND • B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: • With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing. Specify if: • In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in masochistic sexual behaviors are restricted. • In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at last 5 years while in an uncontrolled environment.	”

The prevalence of sexual masochism disorder in the population is unknown, but the DSM-5 suggests that 2.2% of males and 1.3% of females may be involved in BDSM, whether they have sexual masochism disorder or not. Extensive use of pornography depicting humiliation is sometimes associated with sexual masochism disorder.

Behaviors associated with sexual masochism disorder can be acted out alone (e.g., binding, self-sticking pins, self-administration of electric shock, or self-mutilation) or with a partner (e.g., physical restraint, blindfolding, paddling, spanking, whipping, beating, electric shock, cutting, pinning and piercing, and humiliation such as by being urinated or defecated upon, being forced to crawl and bark like a dog, or being subjected to verbal abuse). Behaviors sometimes include being forced to cross-dress or being treated like an infant.

Erotic asphyxiation is the use of choking to increase the pleasure in sex. The fetish also includes an individualized part that involves choking oneself during the act of masturbation, which is known as auto-erotic asphyxiation. This usually involves a person being connected and strangled by a homemade device that is tight enough to give them pleasure but not tight enough to suffocate them to death. This is dangerous due to the issue of hyperactive pleasure seeking which can result in strangulation when there is no one to help if the device gets too tight and strangles the user.

Paraphilic coercive disorder refers to the preference for non-consenting over consenting sexual partners. It differs from sexual sadism disorder in that although the individual with this disorder may inflict pain or threats of pain in order to gain the compliance of the victim, the infliction of pain is not the actual goal of the individual. The condition is typically described as a paraphilia and

continues to undergo research, but does not appear in the current DSM or ICD. Alternate terms for the condition have included Biastophilia, Coercive Paraphilic Disorder, and Preferential Rape.

With paraphilic coercive disorder, the individual employs enough force to subdue a victim, but with sexual sadism disorder, the individual often continues to inflict harm regardless of the compliance of the victim, which sometimes escalates not only to the death of the victim, but also to the mutilation of the body. What is experienced by the sadist as sexual does not always appear obviously sexual to non-sadists: Sadistic rapes do not necessarily include penile penetration of the victim. In a survey of offenses, 77% of cases included sexual bondage, 73% included anal rape, 60% included blunt force trauma, 57% included vaginal rape, and 40% included penetration of the victim by a foreign object. In 40% of cases, the offender kept a personal item of the victim as a souvenir.

On personality testing, sadistic rapists apprehended by law enforcement have shown elevated traits of impulsivity, hypersexuality, callousness, and psychopathy. Although there appears to be a continuum of severity from mild (hyperdominance or BDSM) to moderate (paraphilic coercive disorder) to severe (sexual sadism disorder), it is not clear if they are genuinely related or only appear related superficially.

Very little is known about how sexual sadism disorder develops. Most of the people diagnosed with sexual sadism disorder come to the attention of authorities by committing sexually motivated crimes. Surveys have also been conducted to include people who are interested in only mild and consensual forms of sexual pain/humiliation (BDSM).

Most of the people with full-blown sexual sadism disorder are male, whereas the sex ratio of people interested in BDSM is closer to 2:1 male-to-female. People with sexual sadism disorder are at an elevated likelihood of having other paraphilic sexual interests.

Paraphilia Disorders – Consensual

Transvestic Disorder

Figure 2.6.2: Large group of cross-dressing party-goers" by simpleinsomnia is licensed under CC BY 2.0

Transvestism is the practice of cross-dressing, which is the act of wearing items of clothing and other accoutrements commonly associated with the opposite sex within a particular society. The term cross-dressing refers to an action or a behavior, without attributing or implying any specific causes or motives for that behavior. Cross-dressing is not synonymous with being transgender. A transvestic fetishist is a person who cross-dresses as part of a sexual fetish (though cross-dressing, alone, doesn't equal disordered behavior, Lehmiller, 2019). According to the fourth edition of Diagnostic and Statistical Manual of Mental Disorders, this fetishism was limited to heterosexual men; however, DSM-5 does not have this restriction, and opens it to women and men, regardless of their sexual orientation.

There are two key criteria before a psychiatric diagnosis of transvestic disorder is made:

1. Recurrent, intense sexually arousing fantasies, urges, or behavior, involving cross-dressing.
2. This causes clinically significant distress or impairment, whether socially, at work, or elsewhere.

Thus, transvestism is not considered a mental illness unless it causes significant problems for the person concerned. Transvestic disorder, transvestic fetishism and sometimes transvestism are also often used to describe any sexual behavior or arousal that is in any way triggered by the clothes of the other gender. Especially the latter is problematic, because transvestism and cross-dressing are neither a sexual fetish, nor do they necessarily have anything to do with sexual behavior or arousal.

Also, not every sexual behavior where clothes of the opposite gender are involved is transvestic disorder, they are also often used in sexual role play without being a fetish. Also, many transgendered people cross-dress before coming out in sexual or social contexts. This behavior is likewise not considered transvestic disorder, as it is not cross-dressing for sexual pleasure, rather it is simply their gender expression.

There is a popular stereotype that most transvestites are gay men, however that's not the case; 87% identified as straight and 83% are currently married (or married before; Lehmiller, 2019). Most transvestic fetishists are said to be heterosexual men, although

there are no studies that accurately represent either their sexual orientation or gender, and most information on this is based on anecdotal evidence or informal surveys.

Some male transvestic disordered people collect women's clothing, e.g. nightgowns, baby dolls, slips, and other types of nightwear, lingerie stockings and pantyhose, items of a distinct feminine look and feel. They may dress in these feminine garments and take photographs of themselves while living out their secret fantasies. Many men love the feeling of wearing silk or nylon and adore the silky fabric of women's nightwear, lingerie and nylons. This is where the issue of culture and gender, combined with disordered vs. normative behavior becomes all the more pressing to consider. Why is it culturally acceptable for female identifying folks to wear men's clothing but not vice-versa (and indeed…if there's any form of arousal then it's considered disordered?). Perhaps the even the issue of distress should be evaluated in terms of actual distress due to the behavior or distress due to cultural norms/ideas about gendered clothing.

DSM-V DIAGNOSTIC CRITERIA FOR TRANSVESTIC DISORDER

"	• A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross dressing, as manifested by fantasies, urges, or behaviors. AND • B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: • With fetishism: If sexually aroused by fabrics, materials, or garments. • With autogynephiiia: If sexually aroused by thoughts or images of self as female. Specify if: • In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to cross-dress are restricted. • In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.	"

Future Considerations/Conclusion

As indicated earlier, cultural and social norms are consistently shifting, which can impact society's acceptance of a wide-range of sexual behaviors. Currently, the DSM-V (APA, 2013) identifies eight (8) types of paraphilic diagnoses. Interestingly, the International Classification of Disease recommendations in the definition of paraphilias has opted to remove fetishism, masochism, sadism (not to be confused with coercive sexual sadism), and transvestism since these behaviors are not inherently harmful (Joyal, 2018). Instead, paraphilias in the ICD-11 are focused on non-consent and criminogenic behaviors. This has been applauded as a step in the right direction in terms of reducing stigma of normative, albeit occasionally atypical, sexual activities. Still- the ICD-11 refers to the international version via the World Health Organization (the IDC-10 is still synced with the U.S. DSM-V).

Paraphilic interests have been increasingly important to study as the growth of the internet is allowing individuals access to communities made up of others with atypical interests. Potter (2013) suggested that such communities may allow people to experiment with atypical behavior in a safe manner, rather than acting upon such interests. However, the question remains whether

individuals can entertain atypical sexual fantasies (e.g., rape fantasies or sexual interest in children) and not be moved to act on them (Potter, 2013; as cited in Mundy & Cioe, 2019, pp. 304-5). Indeed, more research is required in these domains.

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Learning Objectives

- Apply the biopsychosocial approach in analyzing sexual dysfunctions.
- Distinguish various sexual dysfunctions under the umbrella of the DSM-V.
- Compare and contrast treatment options for sexual dysfunctions and ways to outreach to diverse community members.

Introduction

Movies and music videos often depict characters engaging in romantic, passionate sexual activity without challenges or inhibitions. Reality is often very different and conversations around sexual difficulties are sometimes met with shame, reducing their frequency and silencing individuals. However, sexual dysfunctions impact the lives of about 1 in 3 Americans (Fawcett & Crane, 2013). Instead of a one-size-fits-all model of sexual excitation and inhibition, further research has indicated that sexual arousal to internal (thoughts, fantasies, etc.) and external stimuli (images, touch, etc.) are based on individual traits, with some people being highly excitable while others experience reduced reactions (Rodriguez-Nieto et al., 2019). Arguably, sexual arousal operates similarly to other emotions in which a thought or experience produces arousal. Some individuals are more quick-tempered while others are more methodical and calm in their reactions. Biological, social, and psychological processes intersect to produce individuals' responses, and a similar process can be seen in terms of sexual responsiveness. Additionally, for some people experiencing sexual dysfunctions, other underlying causes may be factors as well, such as anxiety, sexual trauma, depression, etc.

Terms have been developed, such as asexual, demisexual, sapiosexual, and more to explain how sexual attraction and sexual desire are complex processes. As with all human traits, sexual responsiveness exists on a continuum of possibilities rather than within a binary system in which sexual functioning equates health and a lack of sexual responsiveness equates disorder. At the same time, some people may want to be sexual and are distressed or experience relational difficulties when they face challenges. This unit will explore: the role of distress and impairment as a requirement for diagnosis, co-diagnosis and the importance of understanding underlying causes, the specific classifications of sexual dysfunctions (also known as disorders of sexual function) based on when they occur according to the sexual response cycle, the particular factors influencing sexual wellbeing for gender diverse individuals and sexual minorities, and sexual dysfunction treatments.

Distress and Impairment as a Diagnosis Requirement

In the DSM-5, sexual dysfunctions are defined as "a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure" (American Psychiatric Association, 2013, p. 423). For some, sexual dysfunction has always been present whereas for others difficulties may develop later on in life. Additionally, individual differences may occur in which specific contexts cause dysfunction to arise or dysfunction can be present in all sexual situations for some people as well. More on this will be covered shortly. However, if significant distress is not present, then this is not considered a diagnosis. This is important because no one should be forced into being sexual if they do not want to be and sexual activity may be more distressing than not engaging in the behavior in some instances. Some people may have low sexual arousal or desire and are completely okay with this. Each person gets to decide their own unique sexual boundaries. If they do want to engage in sexual behavior but experience challenges, then this is when therapy can be useful. In the case of diagnosis, symptoms will need to be present for a minimum of six months, be present in 75% or more sexual situations in a persistent or recurrent fashion, and have caused the individual clinically significant distress (Mitchell et al., 2016).

Co-Diagnoses and Underlying Causes

Conducting a biopsychosocial assessment in which relationship factors, personal, cultural and religious beliefs, body image, underlying health concerns, mental health co-diagnoses, life stressors, and more can be explored to develop a comprehensive analysis of the many moving parts that may influence sexual wellbeing. For instance, conservative and stigmatized views regarding sexual behavior are associated with the development of sexual dysfunctions for individuals regardless of sexual orientation (Peixoto & Nobre, 2014). Mental health concerns, such as depression, anxiety, trauma, and more, can lead to the development of sexual difficulties (Basson & Gilks, 2018). Mitchell et al. (2016) found that individuals with one sexual dysfunction diagnosis, especially if experiencing a lack of interest or arousal disorder specifically, often met the criteria for additional sexual dysfunction diagnoses. Health concerns, such as high blood pressure, cancer, heart disease, etc., may also have the side effect of impacting

sexual responsiveness, interest, and maintaining arousal. Medications for physical health as well as mental health concerns can have side effects that cause changes to sexual functioning, leading to the development of sexual dysfunctions. Exploring these underlying causes can aid the client and therapist (and medical doctor) in understanding the best treatment plan moving forward.

Disorders of Sexual Function

Sexual dysfunction is difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm. According to the DSM-5, sexual dysfunction requires a person to feel extreme distress and interpersonal strain for a minimum of six months (excluding substance or medication-induced sexual dysfunction). Sexual dysfunctions can have a profound impact on an individual's perceived quality of sexual life. The term sexual disorder may not only refer to physical sexual dysfunction, but to paraphilias as well; this is sometimes termed disorder of sexual preference.

A thorough sexual history and assessment of general health and other sexual problems (if any) are very important. Assessing performance anxiety, guilt, stress and worry are integral to the optimal management of sexual dysfunction. Many of the sexual dysfunctions that are defined are based on the human sexual response cycle, proposed by William H. Masters and Virginia E. Johnson, and then modified by Helen Singer Kaplan, a psychologist and psychiatrist by training, who viewed human sexual response as a triphasic phenomenon, consisting of separate—but interlocking—phases: desire, arousal, and orgasm.

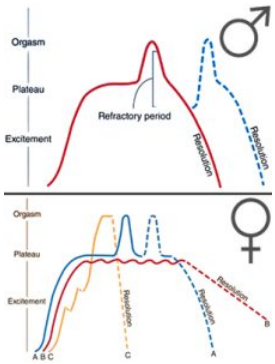

Figure 2.7.1: Sexual Response Cycle, Avril1975, Public domain, via Wikimedia Commons

The Masters and Johnson research team pioneered research into the nature of human sexual response and the diagnosis and treatment of sexual disorders and dysfunctions from 1957 until the 1990s. One of the most enduring and important aspects of their work has been the four stage model of sexual response, which they described as the human sexual response cycle and defined as:

- Excitement phase (initial arousal)
- Plateau phase (at full arousal, but not yet at orgasm)
- Orgasm
- Resolution phase (after orgasm)

Their model shows no difference between Sigmund Freud's purported categories of "vaginal orgasm" and "clitoral orgasm": the physiological response was identical, even if the stimulation was in a different place.

Masters and Johnson's findings also revealed that men undergo a refractory period following orgasm during which they are not able to ejaculate again, whereas there is no refractory period in women: this makes women capable of multiple orgasm. They also were the first to describe the phenomenon of the rhythmic contractions of orgasm in both sexes occurring initially in 0.8 second intervals and then gradually slowing in both speed and intensity.

The work of Masters and Johnson began in the Department of Obstetrics and Gynecology at Washington University in St. Louis and was continued at the independent not-for-profit research institution they founded in St. Louis in 1964, originally called the Reproductive Biology Research Foundation and renamed the Masters and Johnson Institute in 1978.

In the initial phase of Masters and Johnson's studies, from 1957 until 1965, they recorded some of the first laboratory data on the anatomy and physiology of human sexual response based on direct observation of 382 women and 312 men in what they conservatively estimated to be "10,000 complete cycles of sexual response". Their findings, particularly on the nature of female sexual arousal (for example, describing the mechanisms of vaginal lubrication and debunking the earlier widely held notion that vaginal lubrication originated from the cervix) and orgasm (showing that the physiology of orgasmic response was identical

whether stimulation was clitoral or vaginal, and, separately, proving that some women were capable of being multiorgasmic), dispelled many long-standing misconceptions.

They jointly wrote two classic texts in the field, Human Sexual Response and Human Sexual Inadequacy, published in 1966 and 1970, respectively. Both of these books were best-sellers and were translated into more than thirty languages. The team has been inducted into the St. Louis Walk of Fame. Additionally, they are the focus of a television series called Masters of Sex for Showtime based on the 2009 biography by author Thomas Maier.

Their research into the anatomy and physiology of sexual response was a springboard to developing a clinical approach to the treatment of sexual problems in a revolutionary manner. Prior to 1970, when they described their treatment program to the world for the first time, sexual dysfunctions such as premature ejaculation, impotence, vaginismus, and female frigidity had been generally treated by long-term (multi-year) psychotherapy or psychoanalysis with very low rates of success. Masters and Johnson revolutionized things by devising a form of rapid treatment (2 week) psychotherapy always involving a couple, rather than just an individual, working with a male-female therapist team that resulted in a success rate of more than 80%. This was strictly a talking therapy – couples in their sex therapy program were never observed in sexual activity.

A more modern day approach to sexual response is the Dual Control Model of arousal, which is described by Emily Nagoski below:

Sexual disorders affect up to 43% of women and 31% of men (Laumann, Paik, & Rosen, 1999). Sexual disorders are often difficult to diagnose because in many cases the dysfunction occurs at the partner level (one or both of the partners are disappointed with the sexual experience) rather than at the individual level.

The sexual dysfunctions described in the DSM- 5 include delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction. See descriptions below.

Disorder	Description
Male hypoactive sexual desire disorder(MHSDD)	Persistent or recurrently deficient sexual or erotic thoughts, fantasies, and desire for sexual activity.
Female sexual interest/arousal disorder	A complete lack of or significant reduction in sexual interest or sexual arousal. It is diagnosed with three or more of the following symptoms are manifested. These include the absence of an interest in sexual activity; or a decided reduction of such; and an absence of fantasizing or even thinking sexual or erotic thoughts.
Erectile disorder	Recurrent inability to achieve or maintain an adequate erection during partnered sexual activities.
Female orgasmic disorder	A significant change in orgasm such as delay, reduction of intensity or cessation.

Delayed ejaculation (DE)	Persistent difficulty or inability to achieve orgasm despite the presence of adequate desire, arousal, and stimulation.
Premature (early) ejaculation	Persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within about one minute following vaginal penetration and before the individual wishes it.
Genito-pelvic pain/penetration disorder	Difficulty having intercourse and feeling significant pain upon penetration.
Substance/medication-induced sexual dysfunction	A condition in both men and women in which patients have difficulties with sexual desire, arousal, and/or orgasm due to a side effect of certain medications (legal or illicit).
Other specified sexual dysfunction, and unspecified sexual dysfunction	Used when symptoms of a sexual dysfunction are present and cause significant distress or impairment, but do not meet full criteria for any of the other disorders.

Prevalence of Sexual Dysfunction in Men and Women. This chart shows the percentage of respondents who reported each type of sexual difficulty over the previous 12 months.

Sexual arousal disorders

Sexual arousal disorders were previously known as frigidity in women and impotence in men, though these have now been replaced with less judgmental terms. Impotence is now known as erectile dysfunction, and frigidity has been replaced with a number of terms describing specific problems that can be broken down into four categories as described by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: lack of desire, lack of arousal, pain during intercourse, and lack of orgasm.

For both men and women, these conditions can manifest themselves as an aversion to, and avoidance of, sexual contact with a partner. In men, there may be partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity.

Hypoactive sexual desire disorder (HSDD) is considered a sexual dysfunction and is characterized as a lack or absence of sexual fantasies and desire for sexual activity, as judged by a clinician. For this to be regarded as a disorder, it must cause marked distress or interpersonal difficulties and not be better accounted for by another mental disorder, a drug (legal or illegal), or some other medical condition. A person with ISD will not start, or respond to their partner's desire for, sexual activity. HSDD affects approximately 10% of all pre-menopausal women in the United States, or about 6 million women.

There are various subtypes. HSDD can be general (general lack of sexual desire) or situational (still has sexual desire, but lacks sexual desire for current partner), and it can be acquired (HSDD started after a period of normal sexual functioning) or lifelong (the person has always had no/low sexual desire.)

In the DSM-5, HSDD was split into male hypoactive sexual desire disorder (MHSDD) and female sexual interest/arousal disorder (FSIAD).

The DSM 5 has characterised the diagnostic features of male hypoactive sexual desire disorder (MHSDD) as males experiencing deficient or no erotic fantasies and desire for sexual activity for a period of at least 6 months. The level of deficiency in patients is determined by clinicians who take factors such as age and socio-cultural environment of the individual into account which may affect the individual's sexual functioning. The manifestation of personal distress due to the disorder in the absence of non-sexual disorders, significant relationship stress, other forms of stress and other medical conditions distinguishes MHSDD. As with FSIAD, it can also be subdivided into the subtypes: lifelong, acquired, generalised, situational and distress severity can be classified as either: mild, moderate or severe.

Female sexual interest/arousal disorder is defined as the lack of or significantly reduced sexual interest/arousal with at least three of the following: absent/reduced interest in sexual activity; absent/reduced sexual/erotic thoughts or fantasies; no/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate; absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (75 – 100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts); absent/reduced sexual interest/arousal in response to any internal or external sexual/ erotic cues (e.g. written, verbal,

visual); absent/reduced genital or non-genital sensations during sexual activity in almost all or all (75 – 100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).

Masters and Johnson were the first to conduct research on the sexual responsiveness of older adults, finding that given a state of reasonably good health and the availability of an interested and interesting partner, there was no absolute age at which sexual abilities disappeared. While they noted that there were specific changes to the patterns of male and female sexual responses with aging – for example, it takes older men longer to become aroused and they typically require more direct genital stimulation, and the speed and amount of vaginal lubrication tends to diminish with age as well – they noted that many older men and women are perfectly capable of excitement and orgasm well into their seventies and beyond, a finding that has been confirmed in population-based epidemiological research on sexual function in the elderly.

Men with erectile disorder cannot attain or maintain an erection during sexual activity that is sufficient to allow them to initiate or maintain sexual activity. The erectile dysfunction or impotence is a sexual dysfunction characterized by the inability to develop or maintain an erection of the penis. There are various underlying causes, such as damage to the nervi erigentes which prevents or delays erection, or diabetes as well as cardiovascular disease, which simply decreases blood flow to the tissue in the penis, many of which are medically reversible.

The causes of erectile dysfunction may be psychological or physical. Psychological erectile dysfunction can often be helped by almost anything that the patient believes in; there is a very strong placebo effect. Physical damage is much more severe. One leading physical cause of ED is continual or severe damage taken to the nervi erigentes. These nerves course beside the prostate arising from the sacral plexus and can be damaged in prostatic and colorectal surgeries.

Diseases are also common causes of erectile dysfunction; especially in men. Diseases such as cardiovascular disease, multiple sclerosis, kidney failure, vascular disease and spinal cord injury are the source of erectile dysfunction.

Due to its embarrassing nature and the shame felt by sufferers, the subject was taboo for a long time, and is the subject of many urban legends. Folk remedies have long been advocated, with some being advertised widely since the 1930s. The introduction of perhaps the first pharmacologically effective remedy for impotence, sildenafil (trade name Viagra), in the 1990s caused a wave of public attention, propelled in part by the news-worthiness of stories about it and heavy advertising.

It is estimated that around 30 million men in the United States and 152 million men worldwide suffer from erectile dysfunction. However, social stigma, low health literacy and social taboos lead to under reporting which makes an accurate prevalence rate hard to determine.

Orgasm disorders

Female orgasmic disorder refers to the inability to obtain orgasm in women. The woman enjoys sex and foreplay and shows normal signs of sexual arousal but cannot reach the peak experience of orgasm. Male orgasmic disorder refers to a delay in or absence of orgasm following a normal phase of excitement and an adequate degree of stimulation. Male orgasmic disorder is most often situational. The male may have an issue reaching orgasm with a certain partner, but not through masturbation. Male orgasmic disorder includes a delayed ejaculation (very rare) or (more commonly) premature ejaculation.

One of the most common sexual dysfunctions in men is premature ejaculation. It is not possible to exactly specify what defines premature, but if the man ejaculates before or immediately upon insertion of the penis into the vagina, most clinicians will identify the response as premature. Most men diagnosed with premature ejaculation ejaculate within one minute after insertion (Waldinger, 2003). Premature ejaculation is one of the most prevalent sexual disorders and causes much anxiety in many men.

Orgasm disorders, specifically anorgasmia, present as persistent delays or absence of orgasm following a normal sexual excitement phase in at least 75% of sexual encounters. The disorder can have physical, psychological, or pharmacological origins. SSRI antidepressants are a common pharmaceutical culprit, as they can delay orgasm or eliminate it entirely. A common physiological culprit of anorgasmia is menopause, where one in three women report problems obtaining an orgasm during sexual stimulation following menopause.

Sexual pain disorders

Genito-pelvic pain/penetration disorder (GPPPD) is a new diagnosis included in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which merged the revised definitions of both female sexual dysfunctions dyspareunia (painful sex) and vaginismus (involuntary vaginal muscle spasms). At least one of the following persistent or recurrent criteria characterizes GPPPD: (1) difficulties with vaginal penetration during intercourse, (2) genito-pelvic pain during vaginal intercourse or penetration attempts, (3) fear or anxiety associated with genito-pelvic pain or vaginal penetration, or (4) tightness of the pelvic

floor muscles during attempted vaginal penetration. One or more of these symptoms have to be present for at least 6 months and must cause clinically significant distress. GPPPD can be classified as either lifelong or acquired and, depending on the level of distress as mild, moderate or severe. The fusion of vaginismus and dyspareunia under a new classification and set of criteria was due to the significant overlap in clinical presentation, and exceeding difficulties to distinguish between the two reliably.

The prevalence of GPPPD has not been ascertained due to the novel criteria set. Reported prevalence rates in the general population vary between 3 and 25% for dyspareunia and 0.4 and 6.6% for vaginismus. Prevalence estimates are heterogeneous due to, e.g., varying diagnostic criteria, assessment methods, study design, and sample characteristics.

The burden of suffering associated with GPPPD and linked conditions such as vulvodynia and provoked vestibulodynia is high as symptoms have a detrimental impact on physiological and psychological health, and relational well-being. Vulvodynia is chronic pain in the vulva, the area on the outside of a woman's genitals. It is usually described as a sensation of burning, stinging, itching or rawness. Vestibulodynia is chronic pain and discomfort that occurs in the area around the opening of the vagina, inside the inner lips of the vulva. This area is known as the vestibule.

GPPPD has been shown to have a negative effect on the women's overall quality of life, with 60% of women reporting that the disorder compromised their ability to enjoy life. Moreover, it has been linked to depression and anxiety disorder. GPPPD symptoms are often comorbid with a wide range of other sexual dysfunctions and reduced sexual behavior. Many women with GPPPD also experience problems when using tampons or during gynecological examinations. GPPPD has been shown to contribute to declines in self-esteem and feelings of femininity and is associated with a negative body and genital self-image. It can pose a considerable burden on a couples' relationship, especially if they would like to have children.

Sexual Dysfunctions and the LGBTQIA+ Community

As you can see from the previous section of the reading going over the classifications of the sexual dysfunctions, much of the research and language centers the experiences of cisgender and straight individuals. The particular contextual factors that influence the sexual functioning of gender diverse individuals and sexual minorities deserve specific attention.

Sexual Functioning and Gender Diversity

Nikkelen and Kreukels (2018) found that transgender individuals who desired gender-confirming care, such as hormones and/or surgery, and received these services experienced increases in sexual satisfaction and sexual wellbeing. Individuals who desired services but were unable to receive them reported less body satisfaction and less sexual satisfaction. People who did not desire transition services were the most satisfied with their bodies and with their sexual behaviors. Thus, the role of body satisfaction can be seen as having an impact on sexual functioning and satisfaction. Body satisfaction was somewhat more important to the transgender women participants in relation to their sexual wellbeing than the transgender men participants as a whole. This research is important to understand that some transgender individuals may desire hormones and/or surgeries more than others and that body satisfaction plays an important role in sexual functioning (Nikkelen & Kreukels, 2018). Unfortunately, research is lacking regarding the experiences of gender-expansive, gender non-conforming, and gender non-binary individuals.

Sexual Functioning and Sexual Minorities

Li et al. (2019) found that internalized stigma and shame related to sexual orientation was associated with less sexual satisfaction in the study of participants who identified as men who have sex with men (both gay and bisexual men were included together). If the

participants perceived the neighborhood in which they lived to be accepting of their sexual orientation, then this was correlated with higher levels of sexual satisfaction as well. This indicates that internalized and social stigma may have an impact on some individuals' sexual wellbeing. Shindel et al. (2012) found no significant statistical difference between the incidence of sexual dysfunctions between men who have sex with men and straight men. The same factors that increased the chance of sexual dysfunctions in straight men, such as increasing age, underlying health concerns, urinary tract issues and lack of a consistent, stable romantic relationship, impacted men who have sex with men as well (Shindel et al., 2012).

Stereotypes exist regarding lesbian sexual behaviors and desire in which the term "lesbian bed death" derives, meaning that after a few years of being in a relationship, lesbians will no longer engage in sexual behaviors with each other (Peixoto & Nobre, 2014, p. 2691). However, the reality lies in how women are socialized to be more passive regarding sex causing them to initiate less frequently. Understanding the influence of gender socialization and sexual scripts in the lives of lesbian women can be helpful instead. For instance, Peixoto and Nobre (2014) found that the biggest factor in influencing the development of sexual dysfunctions in both straight and lesbian women was internalizing the belief that sexual desire and pleasure are sins.

Theories and Treatment of Sexual Dysfunctions

Sexual dysfunctions have a variety of causes. In some cases the primary problem is biological, and the disorder may be treated with medication. Other causes include a repressive upbringing in which the parents have taught the person that sex is dirty or sinful, or the experience of sexual abuse (Beitchman, Zucker, Hood, & DaCosta, 1992). In some cases the sex problem may be due to the fact that the person has a different sexual orientation than he or she is engaging in. Other problems include poor communication between the partners, a lack of sexual skills, and (particularly for men) performance anxiety.

It is important to remember that most sexual disorders are temporary — they are experienced for a period of time, in certain situations or with certain partners, and then (without, or if necessary with, the help of therapy) go away. It is also important to remember that there are a wide variety of sex acts that are enjoyable. Couples with happy sex lives work together to find ways that work best for their own styles. Sexual problems often develop when the partners do not communicate well with each other, and are reduced when they do.

Sexual arousal disorders

Figure 2.7.2 *https://commons.wikimedia.org/wiki/F...ra_in_Pack.jpg*

Contrary to popular belief, sexual arousal disorder is not always caused from a lack of sexual arousal. Possible causes of the disorder include psychological and emotional factors, such as depression, anger, and stress; relationship factors, such as conflict or lack of trust; medical factors, such as depleted hormones, reduced regional blood flow, and nerve damage; and drug use. The lack of sexual arousal may be due to a general lack of sexual desire or due to a lack of sexual desire for the current partner (i.e., situational). A person may always have had no or low sexual desire or the lack of desire may have been acquired during the person's life. Certain medications like SSRIs may be a contributing factor.

Treatment depends on the cause of the disorder. Hormone therapy or a blood-flow enhancing medication, like Viagra, may be appropriate. Bremelanotide (formerly PT-141) is being studied in clinical tests to increase sexual desire in women. In 2014, Palatin, the company developing the drug, announced the beginning of a Phase 3 clinical trial to determine its effectiveness. Flibanserin, sold under the trade name Addyi, is a medication approved for the treatment of pre-menopausal women with hypoactive sexual desire disorder (HSDD).

Disorders Involving Orgasm

The condition is sometimes classified as a psychiatric disorder. However, it can also be caused by medical problems such as diabetic neuropathy, multiple sclerosis, genital mutilation on either gender, complications from genital surgery, pelvic trauma (such as from a straddle injury caused by falling on the bars of a climbing frame, bicycle or gymnastics beam), hormonal imbalances, total hysterectomy, spinal cord injury, cauda equina syndrome, uterine embolisation, childbirth trauma (vaginal tearing through the use of forceps or suction or a large or unclosed episiotomy), vulvodynia and cardiovascular disease.

Primary anorgasmia is a condition where one has never experienced an orgasm. This is significantly more common in women, although it can occur in men who lack the gladipudendal (bulbocavernosus) reflex. Women with this condition can sometimes achieve a relatively low level of sexual excitement. Frustration, restlessness, and pelvic pain or a heavy pelvic sensation may occur because of vascular engorgement. On occasion, there may be no obvious reason why orgasm is unobtainable. In such cases, women report that they are unable to orgasm even if they have a caring, skilled partner, adequate time and privacy, and an absence of medical issues which would affect sexual satisfaction.

About 15% of women report difficulties with orgasm, and as many as 10% of women in the United States have never climaxed. Only 29% of women always have orgasms with their partner.

Secondary anorgasmia is the loss of the ability to have orgasms (as opposed to primary anorgasmia which indicates a person who has never had an orgasm). Or loss of the ability to reach orgasm of past intensity. The cause may be alcoholism, depression, grief, pelvic surgery (such as total hysterectomy) or injuries, certain medications, death-grip, illness, estrogen deprivation associated with menopause, or rape.

Orgasmic dysfunction is more prevalent in younger and less sexually experienced women. Primary (life-long) anorgasmia is found in about 5-10% of women and is less common than secondary (acquired) anorgasmia.

Research has shown that almost two-thirds of women have concerns about their sexual relationships. In a study in America 43% of the 1749 women interviewed reported experiencing in the past year events such as a lack of interest in sex, inability to achieve orgasm and trouble lubricating compared with 31% of men.

Many factors affect orgasmic function, e.g. age, education, job, folklore (taboos), religious beliefs, drugs, psychological disorders and gynecological surgery.

Sexual dysfunction causes many problems for couples; some researchers found that up to 67% of divorces are related to sexual disorders. It seems that counseling and education in sexual behavior is the most effective treatment for sexual dysfunction.

Genito-Pelvic Pain/Penetration Disorder

Regarding the broad symptom profile of GPPPD, its etiology and maintenance can be best explained by a biopsychosocial framework considering a wide range of interdependent pathophysiological, psychological, social, cultural, and relational factors as well as critical life events. According to the fear-avoidance model, maladaptive cognitions including worrying about losing control of one's body, genital incompatibility, and pain catastrophizing are crucial in maintaining and reinforcing genito-pelvic pain and associated GPPPD symptoms, by leading to fear and hypervigilance in sexual situations, or complete avoidance of sexual intimacy. Beyond individual aspects, relationship dynamics such as dyadic communication and stress coping, as well as partners' responses have been shown to have profound influence on GPPPD symptoms. To an appreciable extent, GPPPD has also been found to concur with male partners' sexual dysfunctions.

Due to the biopsychosocial nature of GPPPD, a multidimensional integrative treatment approach is needed that targets not only difficulties with vaginal penetration, pain, anxiety, and muscle tightness associated with sexual intercourse but also sexual satisfaction and couple dynamics. Psychological interventions for vaginismus and dyspareunia include strategies such as pain management, systematic desensitization, cognitive restructuring, pelvic-floor exercises, sensate focus, and mindfulness. Only few interventions, however, have been empirically tested so far. Of these trials, only few studies have applied randomized controlled trial (RCT) design, most of them with only small sample sizes. Findings of these RCTs indicate that psychological treatments can result in significant improvement of intercourse penetration ability, decrease in pain during intercourse, and higher levels of sexual functioning. However, none of these studies targeted all symptoms of GPPPD.

Sex Therapy

Sex therapy is a strategy for the improvement of sexual function and treatment of sexual dysfunction. This includes sexual dysfunctions such as premature ejaculation or delayed ejaculation, erectile dysfunction, lack of sexual interest or arousal, and painful sex. It includes dealing with problems imposed by atypical sexual interests (paraphilias), gender dysphoria and being transgender; highly overactive libido or hypersexuality, a lack of sexual confidence, recovering from sexual abuse, such as rape, sexual assault, and sexual issues related to aging, illness, or disability.

It can include sensate focus, communication, and fantasy exercises as well as psychodynamic therapy. Sensate focus is a sex therapy technique introduced by the Masters and Johnson team. It works by refocusing the participants on their own sensory perceptions and sensuality, instead of goal-oriented behavior focused on the genitals and penetrative sex. Sensate focus has been used to treat problems with body image, erectile dysfunction, orgasm disorders, and lack of sexual arousal.

The exercises are conducted by the couple at home, between therapy sessions. Although the couple are nude and touching each other during the exercises, they are instructed to abstain from sexual intercourse during or close to the sessions. Both participants are instructed instead to focus on their own varied sense experience, instead of focusing on performance or orgasm. Initially, the emphasis is on touching in a mindful way for oneself without regard for sexual response or pleasure for oneself or one's partner.

The second stage increases the touch options to include breasts. Sensation and gathering information about the partner's body is still encouraged and intercourse and touching of the genitals is still forbidden. The participants then use a technique of placing their hand over their partner's hand in order to show what they find pleasurable in terms of pace and pressure. Learning about the partner's body is still the goal rather than pleasure. Further stages gradually re-introduce touching of breasts and genitals, then intercourse. Orgasm is never the focus.

Cognitive Sexual Therapy

Cognitive-behavioral therapy is recognized by its efforts in developing and providing evidence-based psychotherapeutic interventions to various kinds of psychological and interpersonal problems, being this ideological standpoint a trigger to continuous actualization of its theory and practice. Cognitive sexual therapy (CST) is a cognitive-behavioral integrative psychotherapy aimed specifically to address and treat SDs, articulating evidence-based clinical interventions to scientific understandings of human sexuality. In a CST perspective, distorted sexual cognitions, allied to individuals´ misinterpretations of sexual demands, directly affect emotional, physiological and behavioral regulation in sexual situations. In this sense, restructuring central and intermediate cognitive processes is essential to foster the acquisition of sexual skills and to promote the development of a more adapted sexual

repertoire. Thus, cognitions are understood as mediating factors to be modified, aiming sexual skills implementation and emotional regulation during sexual encounters.

Sexual Scripts are ideas of how males and females are supposed to interact with each other, including how each gender should behave in sexual or romantic situations. Being able to flexibilize sexual scripts and behaviors leads to better adaptation to physiological, environmental and relational changes that negatively impact sexuality over the life cycle, contributing to booster sexual satisfaction even in the presence of sexual function disturbances. The focus of CST interventions is to aid patients and partners towards the development of more flexible and adaptable sexual cognitions and behavioral patterns. CST could permit a regain in sexual function and satisfaction during and after treatment with psychotropic medication, lessen the negative impact of sexual adverse effects in quality of life and therefore, increase adherence and therapeutic effects of pharmacotherapy. Although the theoretical rationale supporting this proposal is evidence-based, feasibility, efficacy, treatment modalities and procedural aspects of the intervention remain to be empirically tested.

Additional Resources

- From OHSU: "Sexual Medicine 101/201: Treating Low Libido in Women" (Adams, 2019)
- From Standford Medicine: "Disaggregating gender from sex in sexual dysfunction epidemiology." (Obedin-Maliver, 2020)

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Adaptations: Reformatted. Added learning objectives. Modified content for language, application to subject and cohesion. Updated sources.

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2.8: Sexual Marketplace 2.8: Sexual MarketplaceEdit Update titlecancel

Learning Objectives

- Demonstrate an understanding of the commercialization of sex as it relates to prostitution, pornography, and adult entertainment.
- Analyze the impact of erotic media on sexual knowledge and behavior.
- Distinguish between porn consumption and moral distress as it relates to problematic porn use.
- Examine the historical considerations of sex work, as well as current sex work practices in the United States.
- Discuss the impact of stigma in the lives of sex workers and explore stigma-resistant strategies.

Introduction

As a bridge between the last section on sexual disorders and treatment, we begin to make our way to the topic of the sexual marketplace and sex work by first examining the complexities of pornography. In the United States, pornography is both reviled by many (evoking legislation to shut down content) and yet is consumed with the highest frequency of anywhere throughout the world. This section seeks to provide the most recent research in terms of creation, consumption, benefits, challenges, and the impact of pornography.

Pornography History

Some may argue that for as long as people have been having sex, folks have also sought out ways to portray sex. Originally defined as art or literature that depicted the life of prostitutes, the word pornography comes from the Greek term porni ('prostitute') and graphein ('to write'; Jenkins, 2020). With time, the term pornography has evolved to generally mean content (in imagery, language, sound) that is generated with the intent to elicit sexual arousal or excitement. Whereas erotica tends to be generally acceptable artistic content, pornography encompasses illicit and condemned materials (Jenkins, 2020; Lehmiller, 2018). The challenge with these differences, of course, is the subjectivity of definitions. Indeed, even cultural and religious artifacts completely acceptable by one culture, may be viewed as completely offensive by another (Jenkins, 2020). Consequently, the history of pornography can be challenging to synthesize.

In addition to ancient cave drawings of naked people, one of the most archaic artifacts ever discovered is the Venus of Willendorf, a 30,000 year old rock carving of a naked, voluptuous figure. Ancient Greeks and Romans shared literature and art portraying all sorts of heterosexual and homosexual sex, as well as orgies. Across the globe, the Moche of Peru depicted sex acts on their pottery and throughout India, images of the Kama Sutra were present (Lenz, 2020). For centuries, many cultures developed content combining art and sex. From illustrated sex manuals during the Renaissance (I Modi) to woodblock renderings of erotica in Japan, explicit content could be found throughout the world (Jenkins, 2020; Lenz, 2020).

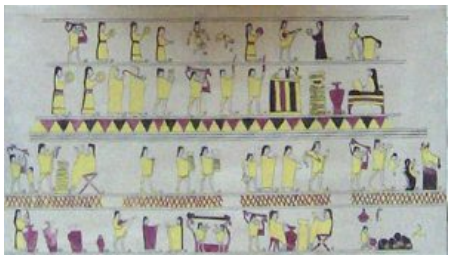


Figure 2.8.1: *Museum of Anatolian Civilization (c. 1600BC)*
Georges Jansoone (JoJan), CC BY-SA 3.0 <http://creativecommons.org/licenses/by-sa/3.0/>, via Wikimedia Commons

With the advent of the printing press, written and visual materials became more available to the masses. Incorporating romance, humor, and/or political and religious critiques, pornographic materials became a popular medium worldwide. By the Victorian era, Britain and the United States enacted laws prohibiting the creation, publication and/or distribution of 'obscene' materials (remember that Comstock Act?). Interestingly, some scholars argue that these restrictions only heightened the taboo nature of sexual depictions, heralding in many 'underground' means in the creation and dissemination of pornographic content (Jenkins, 2020; Lenz, 2020).

With the advent of photography and moving pictures, pornography took on additional features. In 1896, French directors Eugène Pirou and Albert Kirchner, produced Le coucher de la mariée which featured a newlywed slowly undressing in front of her husband

(down to her bloomers!). Although tame by today's standards, this tittilating film popularized more projects in France and throughout the United States, heralding a vast underground marketplace for pornographic material. In 1969, Denmark was the first country to decriminalize pornographic films by removing censorship laws (Lenz, 2020). With the intersecting "Free Love" movement hitting the United States, pornographic films started to become more commonplace, including being profiled in major motion picture arts (e.g. Blue Movie, The Last Tango in Paris, Deep Throat). In 1973, the U.S. Supreme Court reduced its' standards of obscenity (Miller v. California), although the remaining criteria were left fairly subjective, ultimately allowing community standards to influence the legality of produced material (hence the difference between what is acceptable in rural Bible belt areas versus the Vegas Strip or brothels in Nevada; Lehmiller, 2018). With the advent of VHS tapes in the 1980s and DVDs in the mid-90s, video pornography became more available.

Of course- perhaps the most profound shift in the accessibility of pornographic material arrived with the invention and ultimate ubiquity of the INTERNET. By the late 1990s, pornographic content on the internet became one of the most profitable industries (Jenkins, 2020). The private, affordable (often free), and diverse material available online has been an absolute game changer in terms of sheer consumption. By 2003 there were 1.3 million sites and 260 million pages of pornography. In 2019, the most popular mainstream pornography website, PornHub, received 42 billion visits, which means there was an average of 115 million visits per day Pornhub Insights, 2019). To be clear, that's just one site; some scholars maintain that 10 to 20 percent of all internet activity is related to pornography (Lenz, 2020; Lehmiller, 2018).

[redacted]

As a consequence of the massive proliferation of pornographic material, research in the area is starting to increase. In 2014, the first international peer-reviewed scholarly journal, Porn Studies, was launched. This is certainly understandable since the potential saturation of explicit sexual content is new and distinctive to this era of humankind. Indeed, many questions and considerations abound and, as history has certainly illuminated before, the issues are not as black and white as one might initially predict.

What are the impacts of porn? (Or…everything you wanted to know about pornography but were afraid to ask.)

Pornography is one of those topics that have catalyzed public, political, faith-based, legal, and personal interest. On the one hand, the growing engagement in topics around porn use can be instructive and helpful. On the other hand, assumptions about porn use and/or ongoing misinformation can be reductionistic and harmful. Unfortunately, this section isn't exhaustive on all the issues, however our intent is to balance the emerging data with folks' unique experiences in ways that will be educational and empowering, especially in terms of one's own decision making.

(Spoiler: For almost all of these questions, the answer typically involves the concept of… it depends.)

Is pornography a public health concern?

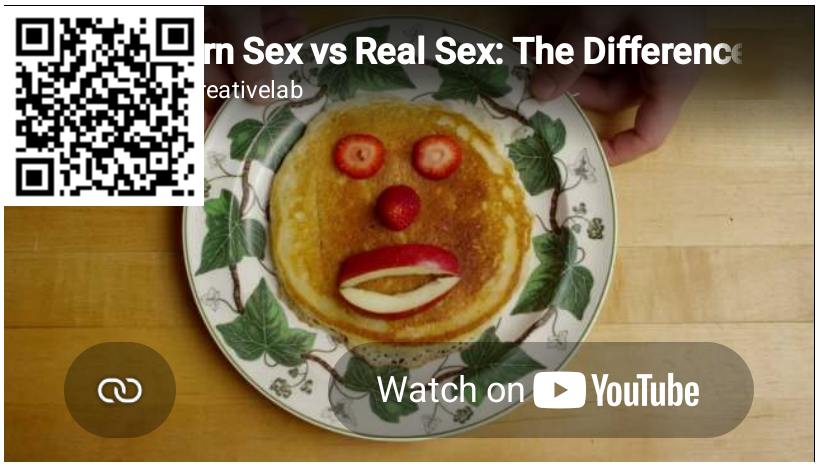
In 2016, pornography became a campaign issue among Republicans and the state of Utah officially declared pornography a "public health crisis" (Lehmiller, 2018). In the next three years, 16 more U.S. states introduced resolutions stating that pornography is deemed a crisis of public health (Nelson & Rothman, 2020). So…is it? Well- it depends on how you define a public health crisis. If one defines a public health crisis as something in which there is an acute event needing immediate response, direct or imminent contagion leading to death (e.g. Covid), an event with property destruction, population displacement, and/or an event that overwhelms local response to community health, then pornography consumption likely does not meet that criteria (Nelson &

Rothman, 2020). Importantly, that doesn't preclude engagement from public health processes, especially in terms of education, awareness, and harm reduction.

In the U.S. an estimated 36-75% of men and 16-41% of women report pornography usage (Berger, Kehoe, Doan, Crain, Klam, Marshall, & Christman, 2019). Between twenty to thirty percent of kids between 10-12 years old have reported some exposure to pornographic in the United States (Efrati, 2019). With exposure to pornography occurring in early adolescence, concerns have risen regarding kids' and teens' developmental impact of viewing such explicit materials. Interestingly, the evidence that porn exposure (particularly intentional, repeated engagement) has entirely negative consequences isn't corroborated. In Peter and Valkenburg's (2016) review of 20 years of research on adolescents and pornography, only a few, consistent findings emerged. Pornography use was associated with more permissive sexual attitudes (e.g. acceptance of casual sex, early sexual activity, which was stronger for girls), as well as linked with stronger gender-stereotypical sexual attitudes. They also noted a higher likelihood to engage in sexual aggression (male) as well as to experience it (female). Finally, there were mixed data regarding pornography consumption and the use of condoms. Importantly, this massive review covered studies from all over the world with multiple perspectives, laws and norms informing their respective outcomes. Still- there's some critical information yielded, which may certainly have public health and education implications. Ultimately- this leads to another question:

Is pornography a sex educator?

In a review of qualitative studies, some consistencies emerged regarding an association between exposure to porn and acquisition of sexual education (both positive and negative; Peter & Valkenburg, 2016). There were some initial indicators that showed some adolescents learn sexual scripts from pornography, with some teens imitating what they see. On average, adolescents reported pornographic scripts as "unrealistic," however with frequent consumption, that perception shifted, as did more permissive sexual attitudes. Ultimately, more research will want to examine the role of pornography as a sex educator (especially in areas where comprehensive sexuality education is not occurring).



Although the evidence regarding the impact of pornography on adolescents is mixed, public health officials argue that media literacy skills help adolescents think critically about sexualized and non-sexualized media to which they are exposed (Rothman, Daley, & Alder, 2020). Consequently, a rising number of porn literacy programs are emerging as an adjunct to CSE or as stand-alone training. Certainly expanding notions of healthy sexuality, consent, and media engagement may be quite essential in equipping teens with more information (initial results of program efficacy are promising; Rothman, Daley, & Alder, 2020).

One area for consideration, of course, is when pornography consumption becomes compulsive in nature. Indeed, in one study, 10-18% of adolescent porn users met the criteria for compulsive sexual behavior disorder (Efrait, 2019). This leads to our next question:

Is pornography addictive?

Perhaps one of the most recurrent questions in terms of porn consumption is "Can watching porn become addictive?" This question often stems from fear; fear of out-of-control behavior, fear that one's partner will only want to watch porn versus engage in physical intimacy with them, and/or fear of moral/religious recriminations. Indeed, there's been little public discourse about what it means to engage with porn, nor any widespread porn literacy available yet to emerging adolescents and young adults. Just like the other questions, our answer: It depends. Let's break it down.

There are two major domains that need to be considered. The first is how we define addiction, along with the social/moral standards of the acceptance of porn use, including relationships with frequency of porn use. What the literature consistently shows is that perceptions of morality impact distress, which lends to self-identified problematic pornography use. The second area we will examine is the recent inclusion of Compulsive Sexual Behavior Disorder (CSBD) in the International Classification of Disease and both practical and neurological underpinnings of the CSBD.

Frequency of Porn Usage and Moral Incongruity as Factors of Distress

Pornography use is controversial, despite its' perceived ubiquitous nature (one 2016 study found 70% of men and 40% women reported consuming porn in the previous year; Grubbs, Kraus, & Perry, 2019). There are many notable and public cases of porn use being depicted as an indicator of sexual deviancy, moral failing, a relationship killer, a 'new drug' and much more. While there has been a massive amount of public sentiment about pornography, empirical evidence about porn use has emerged with more clarity in the past decade. One of the most important and consistent findings is that distress linked to porn use is certainly real; in one national sample over 10% of men and 7% of women perceived themselves as having difficulty controlling their sexual feelings, urges, and behaviors in a way that causes them distress (Dickenson, Gleason, Coleman, Minder, 2018).

The challenge of determining if this distress is clinically significant has also been explored. How does one know if their porn usage is too much? In some instances, just viewing an image or watching a video once is deemed as something immoral and problematic. In other cases, daily intake of pornography may seem completely normative and non-problematic. In other words- frequency of usage is quite subjective and, taken alone, not a useful indicator of problematic porn use. Indeed, frequency of pornography use is not considered to be a reliable indicator of problematic pornography use. Research finds that the number of people with high frequency of porn use with no reported problems were 3 to 6 times higher than those with problematic high rates of porn use (Bőthe, Tóth-Király, Potenza, Orosz, & Demetrovics, 2020). In other words, how often someone consumes pornography is not, by itself, a clinical indicator of problematic use.

Research has generated a considerable amount of evidence finding that many people have strong moral, often religiously based, restrictions on the use of pornography and/or masturbation (Grubbs, Kraus, & Perry, 2019; Grubbs, Perry, Wilt, & Reid, 2018; Grubbs, Kraus, Perry, Lewczuk, & Gola, 2020). Although a belief system may exist that condemns pornography usage, people might still engage in porn consumption. Scholars have termed this experience moral incongruence, feelings or thoughts related to a behavior (using pornography) that are in opposition to one's core values or beliefs (Brand, Blycker, & Potenza, 2019; Grubbs, et al 2020). This moral incongruence is a distinctive consideration when considering problematic porn usage and, accompanying that, religiousness emerges as a frequent correlate in people's perception of problematic use (Grubbs, et al, 2018). As Grubbs and his team write (2020),

> *"People may report feeling addicted to pornography or sexual behavior for various reasons, but morality and moral distress seem to be key parts of why individuals might they they are addicted to pornography or sexual behavior" (italics mine; 2020, p. 266).*

Even in a cursory review of religion and pornography on YouTube, there were dozens upon dozens of videos condemning porn use from a variety of faiths (Christianity, Latter Day Saints, Catholicism, Judaism, Islam, even a Yogic admonishment). In sum, if one is aligned with faith practices that condemn pornography, but they're still consuming porn – they are more likely to experience moral incongruence and, consequently, are more likely to self-diagnose that their behavior is problematic.

Importantly, whether someone is actually experiencing problematic, excessive pornography use or if they are distinctively undergoing distress because of any/all use are important factors in clinical response. Certainly, if someone is experiencing emotional pain, psychological consequences, and/or significant interpersonal consequences, intervention may be critical (Grubbs, et al, 2018). With that in mind, more guidance has recently emerged for diagnostic purposes.

Compulsive Sexual Behavior Disorder (CSBD)

In 2020, the World Health Organization's International Classification of Disease (ICD-11) adopted a new disorder (categorized under Impulse Control Disorders), known as Compulsive Sexual Behavior Disorder. It's important to note that this is different than the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-V; 2013), which currently does not have a correlating disorder (although hypersexual disorder was considered it was, ultimately, not included in the DSM-V). The criteria are below:

CSBD Defined	Symptoms Include	Duration/Intensity	Considerations

CSBD Defined	Symptoms Include	Duration/Intensity	Considerations
Compulsive sexual behavior disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behavior.	Repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities Numerous unsuccessful efforts to significantly reduce repetitive sexual behavior; Continued repetitive sexual behavior despite adverse consequences or deriving little or no satisfaction from it.	The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behavior is manifested over an extended period of time (e.g., 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.	Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviors is not sufficient to meet this requirement.

(WHO, 2020)

Please note that this definition/diagnosis isn't exclusively about excessive or problematic pornography use. However, in the field trials for this disorder, the most common application (81% of the cases) was for compulsive porn use (Grubbs, et al, 2020) and some researchers advocate for problematic pornography usage to emerge as a subtype of CSBD (Gola, et al, 2020). Also note that there is a rule-out in terms of moral incongruence. That is- just because someone's cultural/religious underpinnings disapprove of their sexual engagement does not, inherently, make their behavior diagnosable.

With the advent of CSBD, additional research continues to emerge. Neurological imaging notes brain activity among those diagnosed with CSBD as being similar to other impulse control disorders, including Obsessive-Compulsive Disorder and other addictions (Draps, et al, 2020; Gola, et al, 2017). Ultimately, these findings inform efficacious practices for clinical interventions for folks with this diagnosis.

Modernized Sex Work

In addition to cultural and religious norms often denouncing consumption of pornography, the creation of pornography can be reviled. Consequently, a full understanding of the psychological make-up of those who create and act in pornography is only recently coming to light. Despite assumptions that porn stars are flawed in some way, numerous psychological studies find evidence to the contrary. The characteristics of people acting in pornography show them to be just as psychologically healthy as anyone else in most regards and, overall, they tend to have a very positive self-image (Lehmiller, 2018).

Some scholars argue that shifts in the well-being of actors in pornography has been, in part, based on the high levels of commercial consumption of pornographic materials. Certainly, there is a long legacy of very little rights and protections (to include stories of rampant abuse and coercion) among porn actors. This is, fortunately, shifting (albeit slowly). California leads the way in policy making (it's also the world capital of porn production). Porn workers looking to unionize are incredibly active. In 2012 California passed a provision requiring that all pornography actors are over the age of 18. This is currently being revisited to increase that age to 21. There is also more pressure for the industry to employ the display of condom use in pornography. This has been hotly contested by the industry, who alleges that it will reduce profitability, even though second highest porn producer, Brazil, sees no reduction in consumption or profitability with that policy in place (Mellish, 2018).

Other advancements in the field include the proliferation of numerous platforms that allow people to create and generate content in distinctive ways. On one hand, this flexibility has empowered many folks to enter the field of pornography/sex work in independent, manageable, and entrepreneurial ways. On the other hand, because of the lack of public policy, employment laws, as well as public support, there still remains a tenuousness in job security. To be sure, however, the Internet has shifted the ways in which sex work gets performed; webcam performers, amateur porn production, escort and companion services with no Johns, have all seen a significant uptick in activity, with no indication of ebbing anytime soon.

There are, of course, challenges that technology brings to the world of pornography, as well as to folks' personal safety. Child pornography, which is unlawful and unacceptable in most cultures throughout the globe, still occurs at alarming rates. Additionally, issues of revenge porn, or nonconsensual pornography (NCP), which is defined as the distribution of sexually graphic images of individuals without their consent have become increasingly problematic (Cyber Civil Rights Initiative, 2021). Currently, 46 states,

the District of Columbia and Guam all have revenge porn statutes in place (CCRI, 2021). There's also the challenge of technology and the ease of creating Deep Fakes, AI generated fake videos. According to Guardian writer, Ian Sample (2020), "The AI firm Deeptrace found 15,000 deepfake videos online in September 2019, a near doubling over nine months. A staggering 96% were pornographic and 99% of those mapped faces from female celebrities on to porn stars." We are definitely on the cusp of emerging technologies that can be both exploratory and exciting, but which also compel aspects of oversight that are essential for safety and well-being for all.

Sex Work

Individuals may engage in sex work for a variety of complex reasons. Some may enjoy performing for others, having sex, or being sexual alone for others to watch. Others may see sex work as providing them with access to resources for themselves or their families and feel like this is their only or best option due to being disenfranchised by society. Some may be coerced or forced into sex work against their will. Any combinations of these reasons and more may exist, creating unique experiences in the lives of sex workers. "The term 'sex work' is an umbrella term for the provision of sexual services or performances by one person for which a second person, the client or customer, provides money or other markers of economic value (i.e., goods, services). Sex work refers to prostitutes, escorts, strippers, porn actors, sex phone operators, or dominatrixes" (Sawicki et al., 2019, p. 355). Anyone working within the industry, managers, camera operators, video editors, marketing agents, etc. are also part of the sex industry and can exert varying degrees of power and influence over the individuals providing direct sexual services (Overs, 2002). Sex workers are defined as adults who receive money, housing, food, etc. as compensation for sexual acts (Overs, 2002). Taking a look at sex work in the past can provide us with insights into the present. While a majority of sex workers are cisgender women, transgender individuals, cisgender men, and intersex individuals can also be sex workers as well. The health and safety concerns will be different based on the types of sexual services being offered, access to health and mental healthcare, the stigma in the community, and the intersecting identities of the sex workers.

From Pompeii to Western Expansion

While examples of sex work can be found from around the world, time periods, and contain specifics related to the social fabric of the community in which it took place, two examples from different times and geographic locations will be explored to analyze the way that resources, social power, and the commercialization of sex connect to influence the lives of sex workers.

Sexual Art and Graffiti of Pompeii

The complexities of sex work cannot be stressed enough, and sexual services as part of slavery and victimization as well as leverage to gain access to resources and social status are not dichotomous and may share many overlapping features. For instance, in Pompeii, archaeologists have long been studying the ancient Roman community buried in ash from an explosion at Mount Vesuvius in current-day Italy. While most people have seen images of the inhabitants of Pompeii who tried to shelter and cover themselves, what is less known is the extensive erotic graffiti and art that has been uncovered and preserved. Slavery was commonly practiced within the society and this included sexual slavery (Baird, 2015; Levin-Richardson, 2011; Severy-Hoven, 2013). Female, male and intersex bodies are present in sexual imagery within homes in varying degrees of what appears to be consensual to sadistic and violent (Severy-Hoven, 2013).

Figure 2.8.2: "Pompeii, Brothel,menu 1" by michael clarke stuff is licensed under CC BY-SA 2.0

Themes of power, femininity, and masculinity can only be analyzed with the biases present from the gaze of today which make it difficult to know the full extent of what was truly happening in the society at the time (Severy-Hoven, 2013). Material remnants in addition to the graffiti and art have been uncovered, such as a gold bracelet with the translated words of 'The master to his very own slave-girl' inscribed on the inside (Baird, 2015, p. 164). While most of the images show women's bodies at the whim of the males (Levin-Richardson, 2011; Severy-Hoven, 2013), images of men having sex with men were also depicted within the prominent brothel known as the Lupanare (Levin-Richardson, 2011). While many wealthy free individuals could afford to have their own slaves at home, others who were soldiers, slaves themselves, free but poor, etc. would go to the brothel to seek sexual services as noted by the professions and names inscribed on the walls of the brothel which represented the names of clients as well as the prostitutes (Levin-Richardson, 2011).

While scholars can only try to piece together the material and artistic remains of the past, themes of slavery, sexual service as normative, and power dynamics between wealthy, free men and others in the society remain consistent, recurring themes to explore and analyze (Baird, 2015; Levin-Richardson, 2011; Severy-Hoven, 2013). In the context of slavery, consent is questioned (Baird, 2015). Arguably, the experiences of sex workers in Pompeii were likely varied with some effectively navigating how to gain social and economic status through the use of their sexual desirability whereas others were more victimized and abused by those in power (Baird, 2015). Since we will never know the full details or complexities of this society, perhaps the greatest lesson comes from our own perceptions of the graffiti and artwork and the way that we use our current-day experiences to analyze the past.

Brothels as Foundations to America's Western Cities

Western expansion of the United States in the 19th century provided numerous labor opportunities (mining, timber, construction, cattle, and freight) for men based on the way that labor and gender were viewed in the early colonies (Marek, 2018). Women's work, such as being maids, teachers, waitresses, and seamstresses, were low status and poorly paid opportunities (Marek, 2018). With the desire for better economic situations and adventure, many women began migrating out West and some found prostitution to be their sole or supplemental source of income (Marek, 2018). Many of the women engaged in this work would refer to it as 'sporting' (Marek, 2018, p. 3). Prostitutes ranged in ages from early teens to older adulthood and races and ethnicities based on the impact of colonization, slavery and immigration patterns (Marek, 2018). Race was a large factor in how successful a prostitute was with Native American and red-headed women's services costing more due to being labeled as "exotic" (Marek, 2018, p. 3).

Men outnumbered women 1 to 9 in California by the mid-1800s, and some women became madams in which they opened their own brothels and inns whereas the sex workers gained differences in status based on the services they provided with direct sexual services being seen as lower status and those who were dancers, brought men drinks in saloons, and provided entertainment for male customers as having higher status (Marek, 2018). The urban areas became to be known as 'red light districts' because of the relaxation and entertainment they offered to those passing through and specifically because of the brothels (Marek, 2018, p. 4). Small mining towns often developed into large urban cities following the presence of brothels which provided a huge economic source for the developing region (Marek, 2018).

The women who worked and lived in more wealthy areas had access to increases in amenities provided to them by the madams they worked for, but this came in the exchange of following the directives of the madam which may have included dictations on how to dress and requirements to walk at local parks to attract the gaze, and possible services, of onlookers (Marek, 2018). Dancers and prostitutes received lavish and expensive gifts from returning clients, their mistreatment was viewed negatively by the society at the time with repercussions at the very least of the perpetrator being outcast from the community, and it was socially acceptable and commonplace that wealthy men would sometimes marry dancers or prostitutes (Marek, 2018). Violence, abuse, and murder did occur, however, sometimes at the hands of ex-clients, madams, other sex workers seeking to reduce competition, and by suicide or

drug overdose (Marek, 2018). Additionally, sexually transmitted infections began to rise, resulting in serious illness and death, and dangerous attempts at abortions caused many women to die (Marek, 2018).

By the end of the 1800s, seeing the brothels as a taxable income for cities, city councils began to pass lays criminalizing prostitution as a means of imposing fines, which resulted in madams being arrested at frequent intervals and fined for the number of women working for them (Marek, 2018). Indecent exposure laws and further ordinances began to allow police to arrest and impose fines on more and more activities related to sex work, and sex workers were thereby relegated to an inferior social status with their incomes taken away by the legal system in order for that legal system to inflate itself through often corrupt means (Marek, 2018).

As Western expansion began to continue in the late 1800s and military personnel increased in numbers at the urban centers, they engaged in gambling, drinking, and hiring prostitutes at incredibly high rates so much so that the military began to employ many women in various positions with the expectation that they would also provide sexual services to the military personnel to keep them from leaving the bases despite having their own rules on the books denouncing prostitution and sex workers (Marek, 2018). The stigmatization, shaming, policing, and criminalization began while the greater society (often even the same politicians passing laws and ordinances against the practice) continued to pay for services in a more and more underground and hidden fashion, and, at the same time, some wealthy madams who owned many properties and invested in the stock market gave back to their communities by funding a public school system in Seattle and a hospital in Omaha (Marek, 2018). Thus, urban development owes itself to the sex workers who are credited with building the wealth of communities, and the morality and illegality placed upon such actions could be viewed as economic business opportunity on the part of local city councils and the larger government as a whole moving forward.

Intersectional Feminist and Queer Perspectives

While today in the United States prostitution is illegal in all states except for Nevada, feminist and queer theory seek to question the status quo and analyze the impacts of socially constructed aspects related to women's sexuality and the commodification of sex. In 2008, Natalie Dylan decided to auction off her virginity through a legal Nevada brothel, Moonlite Bunny Ranch, in which she received over 10,000 bids with the highest amounting to 3.8 million dollars (Dunn & Vik, 2014). When asked why she was auctioning off her virginity, Dylan "claimed a third wave feminist perspective that emphasized her right to choose what to do with her own body as well as a right to profit from it" (Dunn & Vik, 2018, p. 1432). "Dylan's statements draw from cultural norms regarding women's agency and virginity, both challenging them and allowing them to materialize as a site for interrogation via her actions, while simultaneously extending discourse about those actions" (Dunn & Vik, 2014, p. 489).

Within the heterosexual economy of a patriarchal society, a woman's virginity is tied to the validity of a man's children being his own to ensure he is not financially responsible for the children of another man (Dunn & Vik, 2014). This Victorian ideal that the purity of women is tied to the value of the state through women being the property of their husbands lies within the discourse around virginity and women's sexual freedoms today (Dunn & Vik, 2014). Purity laws in the Bible pay special attention to women's virginity and divide men and women from one in another in a way that imposes more regulations upon women's sexuality than that of men's, especially around the ideas of chastity and saving one's self for marriage and procreation purposes (Dunn & Vik, 2014).

Some feminists argue that sex workers do not sell their bodies any more than any other worker does under a capitalistic system in which corporations use and abuse those with less access to resources (Dunn & Vik, 2014). Yet, bodies and sexualities become socially constructed and altered within capitalistic and hierarchical power structures and within the backdrop of traditional religious beliefs. While Dylan did not go on to sell her virginity in the auction, she did make at least $125,000 from a deposit paid by an Australian businessman who won but whose wife would not let him participate (Dunn & Vik, 2018). Katherine Stone in 2015 decided to participate in 'America's Next Top Bunny Ranch Virgin' auction (Dunn & Vik, 2018, p. 1432). Unlike with Dylan, Stone was labeled by the original Moonlite Bunny Ranch announcement as a 'bi-lingual Latina (born in Chile)' (as cited in Dunn & Vik, 2018, p. 1434). From an intersectional feminist approach, discourses around her virginity and actions to auction it off occurred at the intersection of gender and ethnicity (Dunn & Vik, 2018). Spanish colonization of Latin America and the influence of the Catholic Church thereby impose specific constructions that influenced Stone's experiences as compared to those of Dylan (Dunn & Vik, 2018). "Latina women are held to higher standards than their white peers particularly in respect to relationships between self and family and child and family" (Dunn & Vik, 2018, p. 1437).

Feminist and queer theory call out and name these factors that are present in a heterosexual and patriarchal dynamic and the intersectional perspective draws attention to the way that a multitude of power dynamics related to marginalized and privileged

social identities influence social discourse regarding women and their bodies and sexuality. The experiences of Dylan and Stone exemplify the complicated nature of agency in which they both were actively participating in the auction while also at the whim of third parties (the brothel owner, the individuals making auction bids, and the media) (Dunn & Vik, 2018). Thus, the discourse present in the online conversations around Dylan's and Stone's experiences in auctioning off their virginities speaks volumes about the way that religion, gender, sexuality, class, and ethnicity intersect in American society (Dunn & Vik, 2018).

Stigma and the Social Determinants of Health

In recent years, social determinants of health have gained greater attention in relation to public health, physical and mental healthcare, and education in order to provide better access to services and resources. According to the Centers for Disease Control and Prevention (2021), social determinants of health are defined as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."

Stigma is defined as "socially constructed, context-specific experience of Othering that devalues one's identity, social contributions and potentiality in ways that limit how one can interact within one's world of socio-structural relationships" (Bowen & Bungay, p. 187). Stigma then acts as a harmful social determinant of health. While sex workers engage in various types of labor, such as stripping, pole dancing, having sex with clients, dominating, engaging in sexually explicit phone calls, acting in pornography, and more, certain forms of sex work will come with greater levels of risk to safety. The type of sex work that will pose the greatest risk depends on many external factors and the role and influence of third parties (such as clients or consumers, pimps or managers, and police and judges). Online sex work in which an individual can post a video of themselves masturbating without consumers being able to find out where they live is on the low end of the risk spectrum with street walking and engaging in sexual behaviors with clients existing on the more risky end due to possible contact with STIs, potential for abuse, and the fact that prostitution (unless being sexually trafficked) is a crime.

Manifestations of Stigma

"Symbolic stigma," in particular, impacts the lives of sex workers by placing them at greater risk for mental and physical health concerns because of the way that society associates their existence with crime, disease, and immorality (Bowen & Bungay, 2016, p. 186). The stigma leaves them disenfranchised as they live and work within systems that seek to penalize them for their means of income, which is also reinforced by discrimination when they seek education opportunities, medical and mental health services, and forms of public assistance. "Whore stigma" is a particular threat to women's lives as sex workers because society seeks to devalue their humanity based on the concept that they are less honorable or pure (Bowen & Bungay, 2016, p. 186). Bowen and Bungay (2016) discuss that sex workers often have higher health literacy than the general population but are still stereotyped and thought of as "careless" (p. 187).

Stigma has the impact of causing people to hide their experiences as sex workers and distance themselves from people and systems that they perceive to be discriminatory or judgmental of them, which at times serves as a protective factor and at other times may prevent them from attaining needed help (Bowen & Bungay, 2016; Grittner & Walsh, 2020). Being talked down to and treated as if they cannot make decisions for themselves was a common experience reported because the assumption by members of out-groups is that they must lack personal agency to engage in sex work (Bowen & Bungay, 2016; Grittner & Walsh, 2020). Stigma can also work within the sex worker industry by shaming certain professions more than others, with streetwalking prostitutes viewed with the most stigma (Bowen & Bungay, 2016). "Systems of power, such as race, socioeconomic status, and the local sex work status hierarchy, influence" the way sex workers are perceived (Vaughn, 2019, p. 826). Due to the social structures and hierarchies of power present within society, sex workers with a greater number of marginalized intersecting identities will be further stigmatized, silenced, and criminalized. Isolation is the manifestation of stigma that is the most detrimental to physical and mental health by maintaining unsafe work environments (Bowen & Bungay, 2016; Grittner & Walsh, 2020). The social system that sex workers live, work, etc. within is what removes their agency and not the sex work itself.

Stigma-Resistant Strategies

Creating stigma-resistant strategies to improve the lives of sex workers exist at the individual level to heal from internalized discrimination and shame, community level to provide consciousness-raising education, peer support, and non-judgmental social and legal services, and institutional level to foster safe working environments.

Individual Level

Sex workers can work to dismantle internalized stigma and shame by creating boundaries around their work and personal lives, developing a support network and disclosing information about their job to mental and physical healthcare providers who are

trusted, reframing sex work by highlighting the positives and rejecting generalized stigma around sexuality, resisting dominant discourses of power by reclaiming their agency and personal power, and challenging social values and beliefs (Grittner & Walsh, 2020).

Community Level

Community education that frames sex work as legitimate forms of labor through the use of consciousness-raising media campaigns can be utilized (Grittner & Walsh, 2020). Peer support groups where sex workers can support each other and provide resources, social service agencies providing non-judgmental services, and legal free of charge and financial services actively dismantle stigma across multiple fronts within communities (Grittner & Walsh, 2020).

Local activists in places around the country are working to promote community health by reducing stigma and providing education and resources. One such activist is Ashunte Coleman, a black transgender woman and former sex worker, who is working to provide support to other transgender women who are sex workers in the Tampa Bay, Florida area and started the organization Ladies Intervention Project For Success (LIPS). Check out this interview and information about Coleman's organization from WSUF Public Radio (2021): 'Consider Me An Essential Worker.' How One Woman Supports Black Trans Sex Workers In The Tampa Bay Area.

Institutional Level

Here is the current law related to prostitution in Oregon (Legislative Counsel Committee, 2019):

1. A person commits the crime of prostitution if the person engages in, or offers or agrees to engage in, sexual conduct or sexual contact in return for a fee.
2. Prostitution is a Class A misdemeanor.
3. It is an affirmative defense to prosecution under this section that the defendant, at the time of the alleged offense, was a victim of the crime of trafficking in persons as described in ORS 163.266 (Trafficking in persons) (1)(b) or (c). [1971 c.743 §250; 1973 c.52 §1; 1973 c.699 §6; 2011 c.151 §1; 2017 c.246 §1]

Multnomah County, the county in which Portland, OR is located, has been working since 2009 to focus police resources on preventing human sex trafficking rather than criminalizing prostitutes and has created the Multnomah County Sex Trafficking Collaborative.

Sex workers and their allies create stigma-resistant strategies that seek avenues to decriminalize sex work and to label violence against sex workers as hate crimes (Grittner & Walsh, 2020).

Conclusion

Like so many things that are discussed in this class, we are only touching the surface of the complexities of issues around pornography and sex work. And- like so many of our topics, what has been illuminated shows both the normative aspects of human sexuality, as well as the challenges of complex responses to sexual stimuli. Certainly we are compelled to effortfully consider culture, norms and attitudes, physiology, technology and our own personal preferences as we navigate through the emerging issues of pornography and sex work.

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Learning Objectives

- Demonstrate an understanding of the issues involved in sexual violence (rape, child sexual abuse, and sexual harassment) including factors that may contribute to these types of violence; characteristics of offenders, treatment resources and prevention strategies.
- Differentiate between human trafficking and sex work.
- Examine the impact of sexual trauma on individuals and discuss trauma-informed clinical practices.

Introduction

At the outset of this particular section, we want to apply a CONTENT TRIGGER WARNING since we are discussing issues associated with sexual violence. It will be especially important, if you are a survivor of assault yourself, if you love a survivor, or if you deeply feel the inherent injustices of gendered and/or sexual violence, that you take good care of yourself during this section's reading and discussions (take lots of breaks, remember to prioritize hydration, good food, and sleep, talk to a friend/loved one if you need to, exercise, random dance parties, or gentle care of your body are all useful).

This section will identify, though an historical lens, the development of rape culture. We seek to define and give rates of various forms of sexual violence, as well as offer important, emerging practices of response to survivors. As always, we view the complex issues of sexual trauma through an intersectional lens.

Definitions: Rape Culture and Types of Sexual Violence

Rape Culture

In a society ruled by rape culture, women and gender minorities are told to protect themselves from the wrath of cisgender men because they cannot control themselves in regards to their sexual gratification needs and their unrelenting anger. Violence in this system is normalized and justified with those harmed being blamed for not taking enough precautions to prevent the attack from occurring. Not only is this harmful to women and other gender minorities, but men are also harmed when they are perceived as too feminine or gay. Only the most masculine, absent of empathy, prevail in this broken culture.

The criminal justice system is devoid of true justice when recourse is provided to a select few who jump through the endless emotional and retraumatizing hoops to finally have their voices heard and validated in court. Systems work to protect perpetrators, whether that be through the backlog of untested rape kits in storage at police departments to the people around those in power who support or do nothing to stop sexual harassment and abuse from occurring (the Catholic Church, the Boy Scouts of America, Harvey Weinstein and Hollywood, and so many more). "A rape culture is one that tolerates and even glorifies male sexual aggression against women" including these additional elements: "rape myth acceptance (Lee, Kim, & Lim, 2010; Suarez & Gadalla, 2010), ambivalent sexism (Chapleau, Oswald, & Russell, 2007; Masser, Lee, & McKimmie, 2010), victim blaming (Abrams, Viki, Masser, & Bohner, 2003; Sleath & Bull, 2012), and normalization of sexual violence (i.e., a sense that sexual violence and assault is inevitable and ubiquitous; Hlavka, 2014)" (as cited in Klement et al., 2017, p. 131).

Sexual Violence: Definition, Tactics, and the Law

Sexual violence is when a sexual act is carried out or attempted against someone who does not freely consent, cannot consent or cannot refuse; may also involve coercing the victim to engage in sexual acts with other people, animals or objects (Basile et al., 2014).

Basile et al. (2014) elaborates further on the terms related to consent or lack of consent and their exact definitions are provided:

- Consent
  Words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.
- Inability to Consent
  A freely given agreement to have sexual intercourse or sexual contact could not occur because of the victim's age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated

(e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
- Inability to Refuse
  Disagreement to engage in a sexual act was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority. (p. 11)

Sexual harassment, sexual assault, sexual abuse, rape, incest, child sexual abuse, and sex trafficking are all forms of sexual violence.

How do we define sexual harassment? The difficulty here is that it is often based on individual perceptions of comments which can be difficult to prove without witnesses or others who have experienced similar experiences of sexual harassment. The term "social-sexual behavior" has been developed "in order to include behaviors that potentially could be perceived as sexual harassment and that contains sexual elements such as impersonal, derogatory jokes, unwanted dating requests, or physical contact" (Kessler et al., 2019, p. 1272). Perception of these social-sexual behaviors is dependent upon individual factors (experiences, values, attitudes, etc.) and contextual factors (relationship type and situation) (Kessler et al., 2019).

Tactics

Perpetrators of sexual violence and human sex trafficking may use the following tactics against those in which they seek to sexually harm:

- use or threat of physical harm
- providing alcohol or substances to gain compliance
- taking advantage of someone who voluntarily became intoxicated and cannot consent
- exploitation of vulnerabilities (exploiting someone based on their intersecting marginalized identities, such as an undocumented immigration status, threats of outing someone for their undisclosed sexual orientation or gender identity, disability, age, etc.)
- intimidation
- misuse of authority
- economic coercion (promise of money, housing and other resources)
- degradation through increasingly demeaning comments and treatment
- fraud (pretending to be someone they are not)
- continued verbal pressure
- false promises by the perpetrator (promising resources they don't actually have, promise of marriage or a relationship, etc.)
- emotionally manipulative threats (i.e. threat to spread rumors)
- grooming to gain trust
- threats to control someone's sexual behavior (pregnancy, STIs, etc.) (Basile et al., 2014)

Profile of Someone Who Harms Others

This information was taken from the Center for Disease Control and Prevention (CDC) (2020)

- We all have the capacity to hurt others or be hurt by someone else
- All gender identities, sexual orientations, ages, etc.
- The perpetrator is usually someone known to the victim
- Most commonly a cisgender, straight male

Click on this resource for more information on the CDC's Violence Prevention programs.

Legal Definitions

According to the United States Department of Justice (2020), "the term 'sexual assault' means any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent."

Sexual harassment in the workplace is divided under US law into two categories (Kessler et al., 2019):

1. quid pro quo harassment (employment advancements contingent upon sexual conduct)
2. hostile work environment type harassment (such as sexism or homonegativity)

Check out PCC's information on Sexual Harassment and Misconduct which includes definitions for sexual harassment and misconduct as well as information on your rights, how to seek help, and how to file a report.

Historical Origins and Current Times

Ancient Beginnings: Colonialism, War, and Sexual Violence

Rape culture connects with colonialism through warfare and sexual violence toward communities who are caught along the warpath. Writings, images, and art depicting sexual violence during war by Israelites, Greeks and Romans have been uncovered by archaeologists and historians (Vikman, 2005).

Israelites: Rape and sexual violence are condoned during wartime in the Old Testament (Deuteronomy, Numbers, and more).

Greeks: Homer's the Iliad has many rape scenarios and normalizes this as part of the chaos and plundering of war. Homer begins to explore sexual violence from the lens of disgust and morality while at the same time women are described as lesser than men and making men seem more feminine is meant to insult masculinity.

Romans: Boys and men were also depicted as being sexually violated by out-of-control soldiers unable to be controlled by their commanders–kill first then plunder the city and rape the people. The Romans were particularly brutal in how they sexually terrorized the communities they attacked.

Common themes: revenge, anger, power, subjugation, sexual gratification, making enemies more pure by passing on their line through them impregnating the women, breakdown of social order, and chaos (Vikman, 2005).

Thinking about the way that colonization, cultural genocide, and slavery impacted Native Americans and African peoples in the United States, how might rape culture be a part of American history that has shaped our present realities? In what ways does rape culture connect with sexism as well as racism, queer discrimination, classism, and more?

#MeToo Movement and Changing Norms

As the harms of rape culture are being discussed more openly through the #MeToo movement and social outcry is increasing against those who are accused of sexual misconduct and sexual violence, a culture of consent is gaining traction and support (Kessler et al., 2019).

Check out this article from Klement et al. (2017) titled, "Participating in a Culture of Consent May Be Associated With Lower Rape-Supportive Beliefs" for more information on research being conducted on this concept.

The Oregon Department of Education has created these lesson plans to teach consent to students in elementary school in an age and developmentally appropriate way:

- K-2 My Space, Your Space Lesson (Online/Offline Adaptation)
- K-2 Seeking Help Lesson (Online/Offline Adaptation)
- K-2 Understanding Our Bodies: The Basics Lesson (Online/Offline Adaptation)
- 3-5 Your Body, Your Rights Lesson (Online/Offline Adaptation)
- Grade 5 Sexual and Reproductive Anatomy Lesson (Online/Offline Adaptation)

Risk and Protective Factors

The following information in this section is taken directly from the CDC (2020) in regards to risk and protective factors for sexual violence.

Risk Factors for Perpetration

Individual Risk Factors

- Alcohol and drug use
- Delinquency
- Lack of concern for others
- Aggressive behaviors and acceptance of violent behaviors
- Early sexual initiation
- Coercive sexual fantasies
- Preference for impersonal sex and sexual-risk taking
- Exposure to sexually explicit media
- Hostility towards women
- Adherence to traditional gender role norms

- Hyper-masculinity
- Suicidal behavior
- Prior sexual victimization or perpetration

Relationship Factors

- Family history of conflict and violence
- Childhood history of physical, sexual, or emotional abuse
- Emotionally unsupportive family environment
- Poor parent-child relationships, particularly with fathers
- Association with sexually aggressive, hypermasculine, and delinquent peers
- Involvement in a violent or abusive intimate relationship

Community Factors

- Poverty
- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- General tolerance of sexual violence within the community
- Weak community sanctions against sexual violence perpetrators

Societal Factors

- Societal norms that support sexual violence
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness
- Weak laws and policies related to sexual violence and gender equity
- High levels of crime and other forms of violence

Protective Factors for Perpetration

Protective factors may lessen the likelihood of sexual violence victimization or perpetration. These factors can exist at individual, relational, community, and societal levels.

- Families where caregivers work through conflicts peacefully
- Emotional health and connectedness
- Academic achievement
- Empathy and concern for how one's actions affect others

Rates and Statistics

According to the CDC's (2021) information on Preventing Sexual Violence:

- 1 in 3 women and 1 in 4 men experienced sexual violence involving physical contact during their lifetimes. Nearly 1 in 5 women and 1 in 38 men have experienced completed or attempted rape and 1 in 14 men was made to penetrate someone (completed or attempted) during his lifetime.
- 1 in 3 female rape victims experienced it for the first time between 11-17 years old and 1 in 8 reported that it occurred before age 10. Nearly 1 in 4 male rape victims experienced it for the first time between 11-17 years old and about 1 in 4 reported that it occurred before age 10.
- Sexual violence is costly. Recent estimates put the cost of rape at $122,461 per victim, including medical costs, lost productivity, criminal justice activities, and other costs.

Here are some more statistics from RAINN (2020) titled, "Victims of Sexual Violence: Statistics."

Since many statistics leave out transgender individuals, here is a resource that specifically focuses on the impact of sexual assault on transgender individuals from the Office for Victims of Crime.

Human Sex Trafficking

Sex work is consensual whereas prostitution and engaging in sexual acts as a result of being human trafficked is not at all consensual no matter the degree to which the individual is bought into this way of life. Immense psychological suffering and psychological manipulation tactics are used by perpetrators to lock in people in a way that makes them feel or believe that engaging

in prostitution or other sex acts is the only way to survive. Perpetrators seek out people who have marginalized intersecting identities and use their power to control and coerce them.

Sexual trafficking is legally defined by Basile et al. (2014) as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. In order for a situation to be considered trafficking, it must have at least one of the elements within each of the three criteria of process, means, and goal. If one condition from each criterion is met, the result is trafficking. For adults, victim consent is irrelevant if one of the means is employed. For children, consent is irrelevant with or without the means category.

- Process: Recruitment, transportation, transferring, harboring, or receiving.
- Means: Threat, coercion, abduction, fraud, deceit, deception, or abuse of power.
- Goal: Prostitution, pornography, violence/sexual exploitation, or involuntary sexual servitude" (p. 16).

Read this dissertation titled, "From the Voices of Domestic Sex Trafficking Survivors: Experiences of Complex Trauma & Posttraumatic Growth," by Evans (2019).

Trauma Responses and Impacts: PTSD Explained

Trauma: In this text, the term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing" (SAMHSA, 2012, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. It generally overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze" reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness.

It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual's immediate response and longterm reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude.

For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect his or her life in significant ways. For the full diagnostic criteria of posttraumatic stress disorder, click HERE.

Distinctive Characteristics for Sexual Assault Survivors

It's important to consider that the experience and aftermath of a traumatic event are influenced by social identity factors such as age, race, class, sexual orientation, disability, and gender (Richmond, Geiger, & Reed, 2013). Particularly in cases of sexual assault, practitioners must confront the pervasive societal messages that unnecessarily blame victims and minimize the experience of rape/incest (Ryan, 2011; as cited in Richmond, Geiger, & Reed, 2013). These messages can become internalized, resulting in self-defeating thoughts and powerful emotions, such as shame and guilt. Unfortunately, it's not uncommon for survivors of sexual trauma to describe themselves in terms of self-loathing and intense vulnerability, which can undermine resiliency and growth (Lewis, Robillard, Billings, & White, 2019). For this reason, most trauma therapies recognize that attention to a survivor's identity, as well as social constructs as critical to the healing process (Richmond, Geiger, & Reed, 2013).

Often, shame distorts sexual assault survivor's perception of responsibility for the trauma. Some survivors, especially those who have kept the trauma secret, may not receive needed comfort and acceptance from others; they are also are more likely to struggle with issues of causation (e.g., feeling responsible for the sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized (Center for Substance Abuse Treatment, 2014). In cases in which the survivor knows their

assailant, issues of victim-blaming may be more pronounced. Yet, several studies have demonstrated that survivors of known offenders are as likely to develop symptoms of trauma as victims of stranger sexual assault (Lewis, et al., 2019).

Sexual violence is often traumatic, and experiencing it can affect how the brain and body work together. During any traumatic event, the body goes into crisis mode and processes memories and reactions very differently. The brain releases chemicals that control how a person will react to the event and alter how a survivor experiences and/or remembers the violence that happened. How a person reacts is not a conscious choice, survivors can experience automatic reflexes that make them immobile and unable to fight or flee (Wilson, Lonsway, Archambault, & Hopper, 2016; as cited in Benner, 2018, p. 32). When a danger or threat is detected, different defense states emerge including hypervigilance (freeze-alert), fight or flight, tonic immobility (freeze-fright), and collapse (for more on the specifics to these mechanism, see Cuevas, et al., 2018)

For one of the best narrations on the topic of trauma's impact on the body, check out the On Being interview between psychiatrist Bessel van der Kolk and Krista Tippett (not required but a useful resource).

Trauma Recovery (Trauma Informed Care & Evidenced Based Interventions)

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. In May 2012, SAMHSA convened a group of national experts who identified three key elements of a trauma-informed approach: "(1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2012, p 4).

Psychological First Aid

Building on the work of Everly (Everly & Lating, 2012), a group of practitioners and researchers formalized a protocol called Psychological First Aid (Brymer, et al., 2006, 2012). This program incorporated a growing consensus regarding the nature of resilience, the neurological impact of stress and trauma, and factors that maximize post-traumatic growth. It was designed for first responders, regardless of their role as medical, mental health, or citizen volunteers, as all persons serving the needs of survivors are providing a type of first aid necessary for long-term recovery.

The protocol consists of eight identified need themes of survivors, entitled Core Actions. Each of the Core Actions is accompanied by a description of the knowledge, skills, and dispositions required to enact it. The sponsors of the protocol, the National Child Traumatic Stress Network and the National Center for Post-Traumatic Stress Disorder, offer a guided tutorial in Psychological First Aid, and recommend that professional as well as citizen responders receive training in the protocol from an experienced trauma-informed trainer. See Figure 5.1 for a summary of the Core Actions, along with a link to access the online tutorial. This protocol is now the gold standard guiding all first responders, including educators responding to school-based traumatic events.

Psychological First Aid: Eight Core Actions

1. Contact and Engagement: To [connect with survivors as] initiated by survivors, or to initiate [contact] in a non-intrusive, compassionate, and helpful manner.
2. Safety and Comfort: To enhance immediate and ongoing safety, and provide physical and emotional comfort.
3. Stabilization (if needed): To calm and orient emotionally overwhelmed or disoriented survivors [as appropriate for role and training].
4. Information Gathering on Current Needs and Concerns: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.
5. Practical Assistance: To offer practical help to survivors in addressing immediate needs and concerns.
6. Connection with Social Supports: To help establish brief or ongoing [contact] with primary support persons and other sources of support, including family members, friends, and community helping resources.
7. Information on Coping: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning [as designed by trauma-informed sources].
8. Linkage with Collaborative Services: To link survivors with available services needed at the time or in the future.

At the core of Psychological First Aid is the provision of safety—making sure a survivor knows they are physically safe, their needs and distress are seen, and help is available to them, leading to a sense of emotional safety as precursor to beginning the work of recovery.

Psychological First Aid recognizes the benefits of connecting survivors with their community. As you dig deeper into the Core Actions, a responder is advised to recognize that they can serve the survivor best by connecting them with known, trusted others, such as the survivor's immediate family and friends, as their relational community—their attachment base—has the greatest potential for activating their coping skills.

The Psychological First Aid protocol was created in response to the vast array of trauma responders who were misapplying good strategies or employing strategies that were doing more harm than good. We see this tendency continuing today, as many settings attempt to be trauma-informed without a grounding in the knowledge, skills, and dispositions prerequisite to exercising the perceptual, conceptual, and executive skills key to safe and effective implementation.

Trauma Informed Care

Trauma-informed care (TIC): TIC is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.

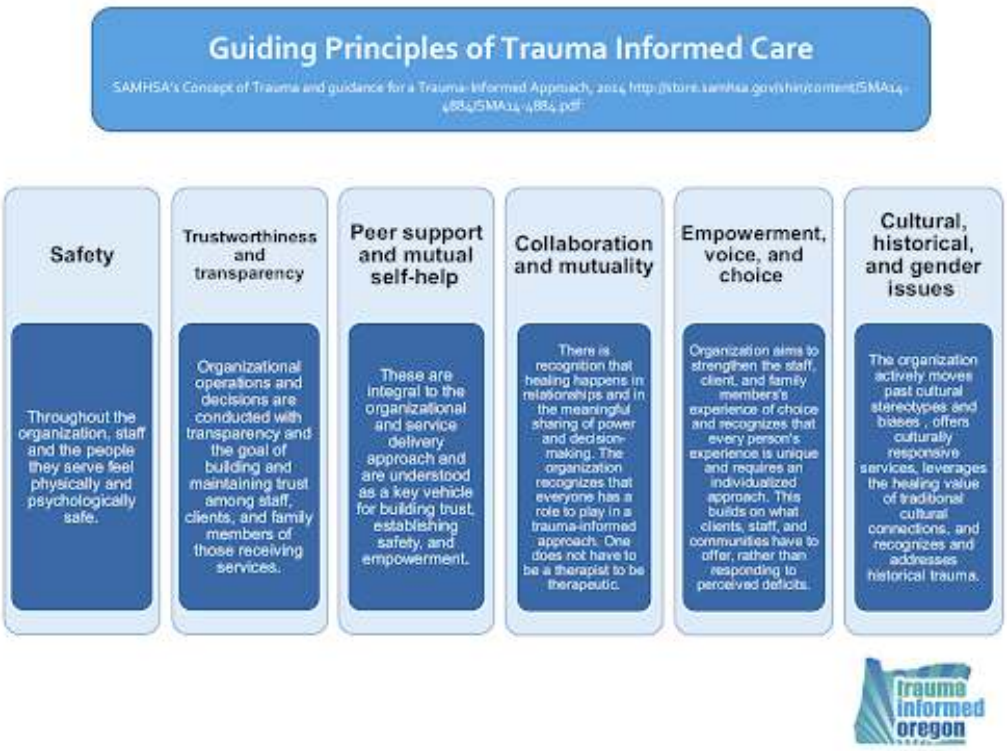


Figure 2.9.1: SAMHSA's Concept of Trauma and guidance for a Trauma-Informed Approach, 2014 http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

The Tri-Phasic Model of Recovery

As early as 1886, Pierre Janet (Van Der Hart, Brown, & van der Kolk, 1989) identified that persons in a state of distress required professionals to envision a three-phase treatment process:

- First, help a distressed person establish an inner sense of safety and stabilization, given that the nature of their past or some current stressor is causing social, cognitive, and/or emotional dysregulation. This safety and stabilization phase requires professionals to recognize that the person seeking services needs to trust the provider and trust that they are not in immediate danger before they can dedicate energy to strengthening external and internal resources needed to increase their window of tolerance for distressing thoughts, feelings, and physical sensations.

- Once the person can self-stabilize, thereby increasing their capacity to tolerate and self-regulate when encountering distressing thoughts, feelings, and sensations, the person is then ready to engage in the emotionally stressful work of articulating the traumatic events causing the distress, and work through the meaning and impact of those events. The heart of this phase is what we now describe as memory integration work, in which we encounter and rework inner positive and negative neural networks. It is the working-through process that is the heart of therapy or recovery.
- Once the person is able to remember and mourn, hence integrate, these realities in a more conscious (aware) way, they can envision how they might want to let their history inform rather than stop their life. Moving forward with a renewed sense of purpose and meaning is now more possible.

This tri-phasic model comprised of (a) safety and stabilization, (b) remembrance and mourning, and (c) reintegration or re-engagement is a foundational concept guiding trauma recovery, whether working with children or adults, and regardless of treatment model (Baranowsky, Gentry, & Schultz, 2005; Herman, 1992; Shapiro, 2018).

Once again we see best practices supporting a universal principle that when we feel seen and valued, our anxiety circuits calm down, and we are more able to learn coping skills needed to tolerate anxiety and stress. And once we have gained mastery over our internal responses to current or past traumatizing events, we are in a place to learn new ways of thinking and responding to those realities.

Interventions Beyond the Initial Response to Trauma

A majority of this section is pulled from https://www.ncbi.nlm.nih.gov/books/NBK207184/. Please see this site for additional treatment strategies.

In the interest of increasing your overall familiarity with relevant approaches, the following sections review several traumatic stress treatment approaches that counselors will most likely encounter when collaborating with clinicians or agencies that specialize in trauma-specific services and treating traumatic stress.

Cognitive–behavioral therapies

Most PTSD models involve cognitive–behavioral therapy (CBT) that integrates cognitive and behavioral theories by incorporating two ideas: first, that cognitions (or thoughts) mediate between situational demands and one's attempts to respond to them effectively, and second, that behavioral change influences acceptance of altered cognitions about oneself or a situation and establishment of newly learned cognitive–behavioral interaction patterns. In practice, CBT uses a wide range of coping strategies.

There are many different varieties of CBT. CBT originated in the 1970s (Beck, Rush, Shaw & Emery, 1979; Ellis & Harper, 1975) and has expanded since then to address various populations, including people who use substances, people who experience anxiety, people with PTSD or personality disorders, children and adolescents, individuals involved in the criminal justice system, and many others. CBT has also been expanded to include various techniques, coping skills, and approaches, such as dialectical behavior therapy (DBT; Linehan, 1993), Seeking Safety (Najavits, 2002a), and mindfulness (Segal, Williams, & Teasdale, 2002). Traditional CBT emphasizes symptom reduction or resolution, but recent CBT approaches have also emphasized the therapeutic relationship, a particularly important dynamic in trauma treatment (Jackson, Nissenson, & Cloitre, 2009).

CBT has been applied to the treatment of trauma and has also been widely and effectively used in the treatment of substance use. A review of efficacy research on CBT for PTSD is provided by Rothbaum, Meadows, Resick, and Foy (2000). Najavits and colleagues (2009) and O'Donnell and Cook (2006) offer an overview of CBT therapies for treating PTSD and substance abuse. In addition, a free online training resource incorporating CBT for traumatized children within the community, Trauma-Focused CBT, is available from the Medical University of South Carolina (http://tfcbt.musc.edu/).

Cognitive processing therapy

Cognitive processing therapy (CPT) is a manualized 12-session treatment approach that can be administered in a group or individual setting (Resick & Schnicke, 1992, 1993). CPT was developed for rape survivors and combines elements of existing treatments for PTSD, specifically exposure therapy (see the "Exposure Therapy" section later in this chapter) and cognitive therapy. The exposure therapy component of treatment consists of clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes identified by McCann and Pearlman (1990): safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs.

Results from randomized, placebo-controlled trials for the treatment of PTSD related to interpersonal violence (Resick, 2001; Resick, Nishith, Weaver, Astin, & Feuer, 2002) support the use of CPT. CPT and prolonged exposure therapy models are equally and highly positive in treating PTSD and depression in rape survivors; CPT is superior in reducing guilt (Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Nishith, & Griffin, 2003). CPT has shown positive outcomes with refugees when administered in the refugees' native language (Schulz, Marovic-Johnson, & Huber, 2006) and with veterans (Monson et al., 2006). However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. CPT requires a 3-day training plus consultation (Karlin et al., 2010). Resick and Schicke (1996) published a CPT treatment manual, Cognitive Processing Therapy for Rape Victims: A Treatment Manual.

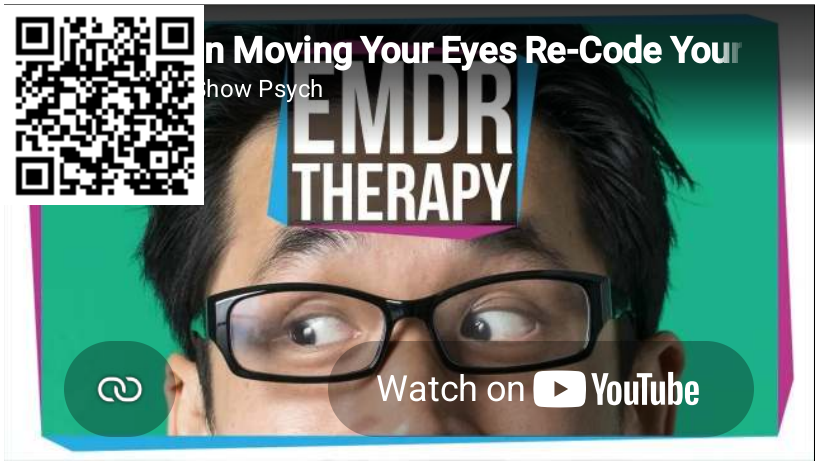
[redacted]

Exposure therapy

Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent retraumatization (clients can become conditioned to fear the trauma-related material even more). Clients must have ample time to process their memories and integrate cognition and affect, so some sessions can last for 1.5 hours or more. For simple cases, exposure can work in as few as 9 sessions; more complex cases may require 20 or more sessions (Foa, Hembree, & Rothbaum, 2007). Various techniques can expose the client to traumatic material. Two of the more common methods are exposure through imagery and in vivo ("real life") exposure.

The effectiveness of exposure therapy has been firmly established (Rothbaum et al., 2000); however, adverse reactions to exposure therapy have also been noted. Some individuals who have experienced trauma exhibit an exacerbation of symptoms during or following exposure treatments. Even so, the exacerbation may depend on counselor variables during administration. Practitioners of exposure therapy need comprehensive training to master its techniques (Karlin et al., 2010); a counselor unskilled in the methods of this treatment model can not only fail to help his or her clients, but also cause symptoms to worsen.

Exposure therapy is recommended as a first-line treatment option when the prominent trauma symptoms are intrusive thoughts, flashbacks, or trauma-related fears, panic, and avoidance. However, counselors should exercise caution when using exposure with clients who have not maintained stability in managing mental illness symptoms or abstinence from substance use disorders. Studies and routine use of exposure have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality. The only trial of exposure therapy with a substance dependence sample found that it did not outperform standard substance abuse treatment on most variables (Mills et al., 2012).



Eye movement desensitization and reprocessing

EMDR (Shapiro, 2001) is one of the most widely used therapies for trauma and PTSD. The treatment protocols of EMDR have evolved into sophisticated paradigms requiring training and, preferably, clinical supervision. EMDR draws on a variety of theoretical frameworks, including psychoneurology, CBT, information processing, and nonverbal representation of traumatic memories. The goal of this therapy is to process the experiences that are causing problems and distress. It is an effective treatment for PTSD (Seidler & Wagner, 2006) and is accepted as an evidence-based practice by the U.S. Department of Veterans Affairs (VA), the Royal College of Psychiatrists, and the International Society for Traumatic Stress Studies (Najavits, 2007a); numerous reviews support its effectiveness (e.g., Mills et al., 2012). EMDR values the development of "resource installation" (calming procedures) and engages in exposure work to desensitize clients to traumatic material, using external tracking techniques across the visual field to assist in processing distressing material. Training in EMDR, available through the EMDR Institute, is required before counselors use this treatment. It is listed in SAMHSA's NREPP (EMDR Network, 2012). Thus far, there is no study examining the use of EMDR with clients in substance abuse treatment. See Part 3 of this TIP, available online, to review empirical work on EMDR.

A Brief Description of EMDR Therapy

Treatment involves three main concentrations (past memories, present disturbances, future actions) and eight phases. Counselors may work with several phases in one session. Each phase is meant to be revisited either in every session or when appropriate (e.g., the closure process is meant to be conducted at the end of every session, in preparation for the next).

- Phase 1: History and Treatment Planning (1–2 sessions)
- Phase 2: Preparation
- Phase 3: Assessment and Reprocessing
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body Scan
- Phase 7: Closure
- Phase 8: Reevaluation

Source: EMDR Network, 2012.

EMPOWER Model

In 2013, the Engage, Motivate, Protect, Organize, self- Worth, Educate, Respect (EMPOWER) Clinic for Survivors of Sex Trafficking and Sexual Violence was created to offer trauma- informed, long-term gynecologic and psychiatric care to survivors of sexual and gender-based violence in the New York City area. The EMPOWER Clinic recognizes that sexual and gender-based violence encompasses a wide range of acts, including rape and sexual assault, sex trafficking, child sexual abuse, intimate partner violence, and female genital cutting and responds inclusively to all survivors. There are numerous clinics throughout the U.S. that provide immediate physical care to survivors of sexual assault, just as there are practitioners who provide emotional support. However the EMPOWER Clinic is dedicated to both long-term medical and psychological care for survivors of sexual trauma, employing an evidenced-based, trauma informed approach (Ades, et al, 2019). With highly conscientious practices in response to

the range of trauma response from sexual assault survivors, the EMPOWER Model provides a useful example for many other practitioner/clinic responses.

An example of reference points for health care providers within the EMPOWER Model.

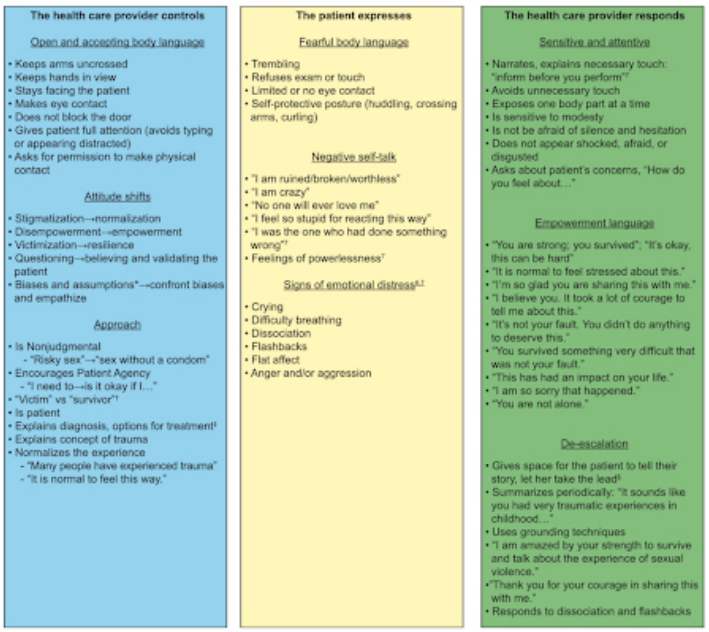


Fig. 1. Summary of considerations for physicians when interacting with survivors based on experiences with patients at the EMPOWER Clinic. *The patient may have been treated badly in the past in health care settings and may be defensive for that reason. †"Victim" can be used in the context of someone who has not yet escaped a traumatic situation and can also be valuable in emphasizing that a trauma was perpetrated by someone else and was not the fault of the person themselves; however, it can be disempowering, and "survivor" may be more appropriate. ‡Explaining the diagnosis, options for treatment, and associated reasons help the patient feel in control.[9] The health care provider may need to explain these options and rationales repeatedly. §Let the patient take the lead but avoid allowing the patient to tell a long narrative owing to the risk of retraumatizing.

Ades. The EMPOWER Clinic. Obstet Gynecol 2019.

Figure 2.9.2: EMPOWER Model
https://openoregon.pressbooks.pub/ap...OWER-Model.jpg

Conclusion

Issues of sexual assault are complex, varied and deeply impactful both personally and societally. This section sought to identify rates of sexual assault, intersectional challenges for survivors, as well as response and treatment modalities.

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Adaptations: Reformatted. Added learning objectives. Modified content for language, application to subject and cohesion. Updated sources. All Rights Reserved

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2.10: Ability, Intersectionality, Body Image, and Reclaiming Our Bodies 2.10: Ability, Intersectionality, Body Image, and Reclaiming Our BodiesEdit Update titlecancel

Learning Objectives

- Discuss the way that acute and chronic illnesses and disabilities may interact with sexuality and analyze the ways sexuality may be impacted by other identities as well from an intersectional perspective.
- Identify various types of chronic illness (multiple sclerosis, diabetes, heart disease, cancer, arthritis, stroke) and disability (spinal cord injury, cerebral palsy, blindness and deafness, mental disabilities) on sexual desire and expression.
- Explain how additional marginalized identities may further impact body image for those living in the United States and identify techniques to develop a positive counter narrative and healthy self-esteem.

Introduction

While this may be the end of our journey together, each of us is just beginning our exploration into human sexuality and the complexities of human existence. The topics in this course are jumping-off points for further inquiry. We will undergo changes across our lifespans and the people around us will experience shifts as well. From a systems perspective, a change in us creates movement in the lives of others and vice versa. We are unique individuals yet we are also interconnected with each other and our surroundings. Throughout the term, we have taken a clinical approach in which we seek ways to educate and uplift our communities, and it is fitting to end now on ourselves. We cannot help and support others if we are exhausted and emotionally taxed. By focusing on our own sexual wellbeing and reclaiming our bodies, we can best be there for others.

Ability

Ability is not something we either have or don't have. This is a concept that lies in perception and is constantly in flux as we cope with pain, emotional distress, sickness, and accidents. We could also be born with neurodivergent or physical differences that give us insight into the way society is often created without flexibility in mind as we develop techniques to navigate and live our lives to the fullest. Being differently-abled or disabled exist on visible to invisible continuums and are experienced in ways that are psychological and physical.

Sexuality connects with ability in profound ways that can be beneficial to explore. While people who are differently-abled or disabled are clumped together under these umbrella terms, the reality of peoples' experiences is vast and multidimensional. What is known is that mainstream media effectively erases the experiences of individuals who are differently-abled or disabled and reduces representation for individuals to see people like themselves engaged in relationships and exploring their sexuality.

Psychological Health

Looking at sexuality as it connects with mental health is vitally important because people who are coping with anxiety, depression, bipolar disorder, ADHD, trauma, schizophrenia, substance dependence, etc. may experience changes in their self-perception related to the status or severity of current flare-ups of their symptomatology. Sexual risk-taking behavior, relationship distress, taking medication (prescribed or self-medicating), and body image are interwoven with mental health status and sexual functioning. Some symptoms can either increase (i.e. manic episode) or decrease (i.e. depressive episode) sexual desire or responsiveness, or increase risk-taking behaviors. Medications often have sexual side-effects that can be addressed by changing medications (by discussing this with a psychiatrist) or seeking substance use treatment. People who are neurodivergent or experience cognitive impairments are sometimes desexualized by caregivers, teachers, and healthcare workers which opens them up to engaging in risky behaviors because they do not have access to much-needed information regarding their bodies, boundaries, and consent (Manoj & Suja, 2018; Grove et al., 2018). Thus, education, resources, and support tailored to each individuals' experiences related to their psychological abilities are necessary.

Providing individuals with the tools to understand their mental health diagnoses and how this connects with their sexuality can be empowering. Mental health symptoms can also make people feel uncomfortable and uneasy within their minds and bodies (dysphoria). For instance, normalizing and validating the way that hypervigilance and trauma reminders can interfere with relationship intimacy and sexual engagement and developing methods to cope with the underlying trauma will benefit sexual functioning. Treating people holistically and recognizing that sexual difficulties are often a surface-level symptom for other interconnected struggles are important.

Physical Health and Pain

Being differently-abled or disabled physically can be something people experience across their lifespan or this can be developed at some point in time. People may also be able to fully heal or some may have residual symptoms. Illnesses can be acute (sudden) or chronic (over a long period). These experiences may be visible (wheelchair, cane, hearing aid, hair loss, etc.) while others may be invisible (pain levels, fatigue, etc.). Some examples of physical health concerns are cardiovascular diseases, cancer, autoimmune diseases, diabetes, multiple sclerosis, cerebral palsy, experiencing visual or auditory differences, spinal cord injuries (paraplegia and quadriplegia), etc. All of these can impact desire and cause sexual difficulties. The relationship with one's own body and self-perception shift throughout different stages of illness, pain, frustration, and acceptance. Relationships with others change as lovers may also become caregivers and feelings of weakness or relying on others can cause strains in this dynamic. Reframing roles and letting go of labels allows for greater possibilities. Loss of a body part due to a surgery or injury can cause specific self-image alterations, challenge feelings of attractiveness and self-worth, and cause people to question aspects of their femininity and/or masculinity.

Grief and Self-Acceptance

When grief is discussed, it is usually in the context of a loved one or pet dying. However, any loss can cause a grieving process and mental health and physical health concerns can sometimes be accompanied by grief as one adjusts to a new normal or as they make sense of their diagnosis. Here are some educational resources on this process and ways to cope.

- Finding Acceptance: Psychological Stages of Chronic Illness
- APA (2013): Coping with a Diagnosis of Chronic Illness
- Stages of Grief

Intersectionality

This has been a recurring theme throughout this course because our lived experiences are based on the ways our multiple identities come together and our wellbeing is heavily influenced by the way in which these identities are marginalized or privileged by society. These identities are social constructs and are not based in reality yet power structures and social hierarchies cause them to manifest and influence our lives in very real ways. Race, ethnicity, financial resources (class), education, religion, spirituality, age, gender, immigration status, language, acculturation, etc. are interwoven with our body image and sexuality based on the society we are living in. The impact of colonization and the meaning and value placed on these social constructs by society are then internalized or rejected. Borders and nations are not real to birds and butterflies yet they dictate our movement and way of being in this world. How can we work to develop positive perspectives around our identities while also recognizing and not minimizing or ignoring the flaws in society? What does it mean to decolonize our body image?

Resources to Call Out and Combat Patriarchy, Colonization, and Self-Doubt

- An Introduction to Feminism and Cross-Cultural Body Image in the United States (Darnell, 2018)
- Body Image Experiences Among Asian American Women: A Qualitative Intersectionality Framework (Brady, 2016)
- Opara, I., & Santos, N. (2019). A conceptual framework exploring social media, eating disorders, and body dissatisfaction among latina adolescents. Hispanic Journal of Behavioral Sciences, 41(3), 363–377.
- Colonizing Black Female Bodies Within Patriarchal Capitalism: Feminist and Human Rights Perspectives (Benard, 2016)
- Tabaac, A., Perrin, P. B., & Benotsch, E. G. (2018). Discrimination, mental health, and body image among transgender and gender-non-binary individuals: Constructing a multiple mediational path model. Journal of gay & lesbian social services, 30(1), 1–16.
- Is Beauty in the Eyes of the Colonizer? (NPR Code Switch, 2019)

Body Image

Our bodies are just vessels that carry us through this life, yet society places labels upon our flesh that politicize, marginalize, and dehumanize us. The stretch marks, scars, cellulite, acne, muscles, fat, curves, and birthmarks are devoid of meaning except the meaning we ascribe to them. Fitness magazines, airbrushed images of celebrities, CGI movies, and music videos are sold to us as reality which causes a warped perception about what actual human bodies look like naked and clothed. If beauty is in the eye of the beholder, how can we hold ourselves more closely with compassion and look upon ourselves with a fresh perspective that is cleansed of falsehoods? Moving forward, how can intersecting identities be used as sources of sexual strength that collide to undo stigma and shame?

Techniques

"Beauty ideal internalization" and the frequency of social comparisons are correlated with body image (Alleva et al., 2015, p. 11). Cognitive Behavioral Therapy techniques have shown promise to improve body image by recognizing and challenging cognitive distortion and by implementing perception checking and reality testing methods (Alleva et al., 2015). Restructuring of thoughts, changing the language used to describe the body from judgmental to neutral phrases, revisiting times of feeling self-conscious or uncomfortable and creating a new narrative, and improving media literacy and media resistance strategies were some of the techniques that Alleva et al. (2015) found to be effective in their meta-analysis of previous research studies conducted.

Implementation

Utilizing this knowledge, try out some of these methods and make notes about how you feel about yourself throughout the process.

- Take a look at your social media accounts (TikTok, Instagram, YouTube, Twitter, Facebook, etc.) and unfollow people or products that make you feel bad about your body. Increase your media literacy by reminding yourself that what is shown is not reality. Be more selective about what you watch and expose yourself to, and pay attention to the way the media impacts your thoughts, feelings, and behaviors. Choose media that uplifts and supports you. Resist media that is judgmental and negative.
- When you see images of people who have attributes you desire or see something that makes you feel self-conscious about the way you look, reality check your experiences by asking yourself Socratic Questions.
- Recognize common thinking errors related to our body image.
- Reality check and restructure our cognitions by putting thoughts on trial and challenging negative thoughts.

Reclaiming Our Bodies

Resources

- The Body is Not an Apology: Radical Self-Love for Everybody and Every Body
- Seaman (2018): A Guide to Reclaiming Sexual Health
- Dissertation by Espinoza (2013): The Erotic Intelligence of Plants: A Heuristic Inquiry of Women's Sexual/Spiritual Experiences with Sacred Amazonian Plant Teachers
- Savage, L. E. (2014). Reclaiming women's sexuality: The intersection of Shamanic practices and sex therapy. Sexual & Relationship Therapy, 29(1), 121–131. https://doi-org.libproxy.pcc.edu/10.1080/14681994.2013.861061

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