

~ SEXUALITY ~

LEARNING OBJECTIVES

After reading and studying chapter 4, you should be able to

- 1 Relate the meaning of sex as both a physical and a social phenomenon.
- 2 Describe the impact of sex on intimate relationships.
- 3 Discuss the extent of teenage sex and the consequences of early childbearing.
- 4 Explain the various methods of contraception and the degree to which they are used and by whom.

- 5 Outline the role and the practices of sex in marriage.
- 6 Identify the changing patterns of marital sex.
- 7 Review the functions and consequences of extramarital sex.
- 8 Describe the nature and consequences of the major sexually transmitted diseases.
- 9 Outline the primary types of sexual dysfunction.
- 10 Summarize the important guidelines for engaging in safe sex.

As we look at sexual beliefs and practices throughout the world, we find both similarities with and differences from our own society. Investigate some kinds of sexual beliefs and/or practices in another society that differ from those in your society (e.g., frequency and/or positions of intercourse, the meaning of sex, attitudes about premarital and/or extramarital sex, what techniques and practices are considered erotic). Compare them with your society and with your personal values. How do you feel about the beliefs and/or practices of the other society? Do you think that they are more or less preferable to those of your own? Why?

One way to carry on your investigation is through the library. You can check journals, such as the *Journal of Sex*

Research. Or you can use the *Social Science Index* or *Psychological Abstracts* to locate appropriate articles. Studies by anthropologists are also excellent sources.

Another way to carry on the investigation is to interview someone from another country. If that person is willing to discuss the topic with you, ask him or her to describe sexual attitudes and/or behavior in some area such as premarital sex or sexual techniques.

If the entire class engages in this project, each student could be responsible for a different society. Discuss the findings in terms of the questions given in the first column. ☘

What is the most intense form of human intimacy? Some people would answer “sex.” But sex can be alienating as well as bonding, meaningless as well as exhilarating. Even when it is highly gratifying, sex may not hold a relationship together. Hank got married when he was in his early 30s. When we discussed his impending marriage with him, he told us that he knew it would require a lot of work because he and his future wife had a lot of differences. “What do you have in common?” we asked. The only thing Hank could think of was, “We have great sex together.” Hank’s marriage was built on little else. Within a year of the marriage, Hank and his wife were divorced. “Great sex” didn’t make a lasting marriage.

In this chapter we will look at the meaning of sex and how it affects our relationships. We will examine some of the problems involved with teenage sex, including unwanted pregnancies. We will discuss such issues as contraception, abortion, sexual diseases and dysfunctions, and extramarital sex. And we will see the role of sex in marriage, including long-term marriage.

THE MEANING OF SEX

Like gender roles, sex is social as well as biological. And, as there is in gender roles, there is variation in sexual orientation. We begin with sexual orientation.

Heterosexuality and Homosexuality

Most people are heterosexual, preferring male-female sexual relations only. Others are exclusively homosexual, preferring only those of their own sex. And a small percentage are bisexual, finding gratification with both sexes and having no strong preference for either.

How many people are homosexual? According to a national survey of Americans 18 to 44 years of age, which asked people whether they thought of themselves as heterosexual, homosexual, bisexual, or something else, 2.3 percent of men identified themselves as homosexual and 1.8 percent said they were bisexual (Mosher, Chandra, and Jones 2005). For women, the figures were 1.3 percent homosexual and 2.8 percent bisexual. However, when asked whether they had any same-sex sexual contact in the past 12 months, 2.9 percent of men and 4.4 percent of women said they had. And when asked about their attraction to those of the same sex, 3.2 percent of the men and 3.4 percent of the women said they were attracted mostly or only to those of the same sex or equally to both sexes. Millions of Americans, then, are exclusively homosexual and many more have had some homosexual experience.

Why are some people homosexual? Controversy surrounds the issue, but studies of brain structure and of twins suggest a genetic basis for homosexuality, while findings on peer group relationships and on patterns of sexual behavior over the life span suggest that socio-cultural factors also underlie homosexual behavior (Swaab et al. 2001; Lauer and Lauer 2011). It seems clear that given the strong pressures to be heterosexual and the stigma often attached to being homosexual, the genetic component is strong. That is, some people by virtue of their genetic makeup are only attracted to same-sex relationships.

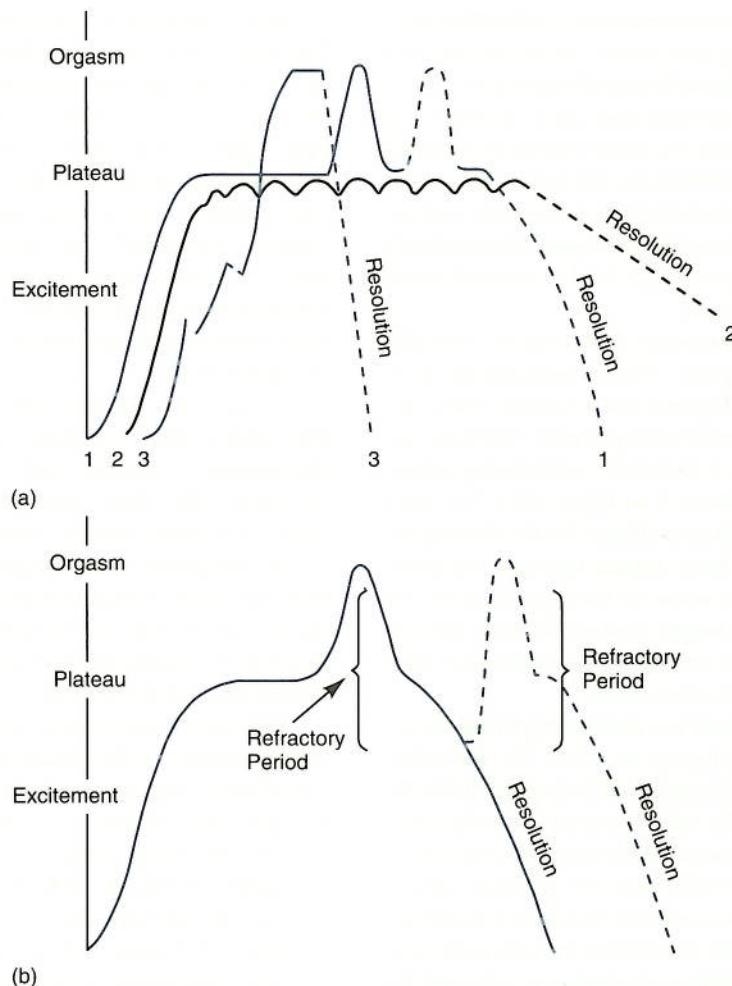
Apart from their differing preferences for relationships, however, heterosexuals and homosexuals share many of the same meanings of sex. They are alike in their physical responses and in a number of social aspects such as motives and variations in activity.

Sex as Physical: The Response Cycle

In the 1960s, William Masters and Virginia Johnson pioneered the investigation of the responses of the body to sex. The researchers identified four stages of human sexual response: excitement, plateau, orgasm, and resolution (Masters, Johnson, and Kolodny 1997). During the response, there are two basic physiological reactions. One involves an increased concentration of blood in bodily tissues in the genitals and the female breasts. The other is increased energy in the nerves and muscles throughout the body.

Excitement, the first stage of arousal, is the result of some kind of physical or psychological stimulation. You can become excited by someone stroking your body, by kissing, by reading erotic literature, by having someone look at you seductively, by remembering a previous sexual experience, by fantasizing about sex, and so on. In the woman, excitement leads to lubrication of the **vagina**, usually within 10 to 30 seconds, along with various other physiological changes. In the man, similar physiological reactions result in erection of the **penis**, usually within three to eight seconds in young males.

The excitement stage may or may not lead to the next phase. Something may interfere with continued response, such as a telephone ringing, something that the partner says or does, or a thought that suddenly comes into your mind. But if the process continues, you move into the second stage, the *plateau*. As figure 4.1 shows, in the plateau stage there is a continuing high level of arousal, preparing the way for orgasm. The actual length of the plateau varies from individual to individual. For men who have trouble controlling **ejaculation**, the plateau may be extremely



- (a) Three types of female response. Pattern 1 is multiple orgasm. Pattern 2 is arousal without orgasm. Pattern 3 involves a number of small declines in excitement and a very rapid resolution.
- (b) The typical male pattern of response. The dotted line indicates the possibility of a second orgasm and ejaculation after the refractory period.

FIGURE 4.1 The Sexual Response Cycle

Source: William H. Masters and Virginia E. Johnson, *Human Sexual Response*, Boston: Little, Brown, 1966, p. 5. Reprinted by permission.

short. For women, a brief plateau sometimes precedes an intense orgasm. Others find a longer plateau to be a kind of sexual high that is very satisfying.

Both men and women continue to experience physiological changes during the plateau. The woman's vagina becomes increasingly moist and the tissues swell with blood. The portion of the vagina nearest the opening becomes so congested that during intercourse the penis tends to be gripped because of the reduced size of the

vaginal opening. The back part of the vagina opens up and out to accommodate the erect penis. In the male, the penis is fully erect, and the **testes** are fluid-swollen, enlarged, and pulled up closer to the body. During the plateau stage, both males and females have increased heart rates, faster breathing, and increased blood pressure.

Orgasm, the third stage, is a discharge of the sexual tension that has been built up and maintained during the plateau. The orgasm takes the least time of any of

the stages. Usually it involves muscular contractions and intense physical feelings that occur in the matter of a few seconds and are followed by rapid relaxation. Again, there are physiological changes that occur in both men and women. In both, there is a good deal of involuntary muscular contraction throughout the body. Sometimes the contractions happen in the facial muscles, making the face appear to be frowning or in pain. But normally such an expression reflects a high level of arousal, rather than any pain or displeasure.

Women may have anywhere from 3 to 15 muscular contractions during orgasm. These contractions occur in various muscles throughout their bodies. They also have changes in their brain wave patterns. Women may have multiple orgasms if they have continuing stimulation and interest (pattern 1 in figure 4.1). For men, orgasm occurs in two distinct phases. In the first phase, muscular contractions force **semen** through the penis. The man experiences a sense of having gotten to the point where he can no longer control himself; ejaculation is inevitable. In the second phase, additional muscular contractions lead to ejaculation.

Following orgasm, there is a **refractory period** for the male, a time following orgasm in which the individual needs to recover and is incapable of having an additional orgasm or ejaculation. The refractory period may last anywhere from minutes to hours. As the male ages, the refractory period gets longer. For the male, the refractory period is part of the fourth stage, *resolution*. Resolution is a return to a state of being sexually unaroused. In both males and females, the various physiological changes reverse and the individual becomes like he or she was prior to arousal. If the individual has been highly aroused without orgasm having occurred, the resolution will take longer.

Sex as Social Behavior

Although sex is one of the basic drives in humans, the expression of sex is still a social phenomenon (Waskul and Plante 2010). We must understand the meaning of sex, and that meaning varies not only by individuals but by cultures and differing social settings. For example, an American girl has greater difficulty reconciling with her parents the fact that she is both a daughter and a sexual being than does a Dutch girl (Schalet 2010).

Sex, in short, is not simply a matter of “doing what comes naturally.” There is more learned than unlearned sexual activity. And because culture changes over time, what you learn depends not only on where you live but when you live there. In the United States, for example, the dominant notions about sex from colonial days through the nineteenth to the twentieth centuries changed from “a

decorous enjoyment to a morbid suppression to an uneasy liberation” (Lauer and Lauer 1983:20). Nineteenth-century Americans would be shocked by the views of both their forebears and their progeny. And consider the wife who said, “I get irritable when I don’t have sex. Sex makes me feel good about myself and my marriage.” This frank statement would not have been made openly in earlier generations. Nor would it be made openly in some societies today. Your views about sex and your sexual activity are shaped by your social context. In American society today, most adults find sexual relations to be a significant aspect of a fulfilled life.

Gender and gender roles affect sexual activity. Men tend to have a stronger sex drive than do women (Baumeister, Catanese, and Vohs 2001). Compared to women, they think more often about sex, they have more and more varied sexual fantasies, they desire sexual intercourse more frequently, and they are more likely to initiate sexual activity. Men are also more sexually permissive than are women in terms of such matters as number of partners and having casual sex (Fischtein, Herold, and Desmarais 2007).

Males also tend to begin sexual relations at an earlier age than women do. For those under the age of 13, 8.8 percent of boys compared to 3.7 percent of girls have had sexual intercourse (Eaton et al. 2006). The proportions vary considerably by race/ethnicity: for whites, 5.0 percent of boys and 2.9 percent of girls; for African Americans, 26.8 percent of boys and 7.1 percent of girls; and for Hispanics, 11.1 percent of boys and 3.6 percent of girls.

One other gender difference is that through most of U.S. history, it has been more of a stigma for a woman than for a man to be sexually promiscuous. That may no longer be true. A survey of more than 8,000 people reported disapproval of both men and women who had multiple sexual partners (Marks and Fraley 2005).



Sex is an important part of intimacy.

Finally, a number of different motives enter into sexual behavior (Browning et al. 2000; Meston and Buss 2007). Sexual relations are more than a response to the sexual drive. People also engage in sex because they love each other, they desire the pleasure sex brings, they conform to each other's expectations, and they desire recognition and acceptance.

Thus, a variety of factors affect our sexual behavior. There are variations in behavior both within and among societies. Differences in arousal, techniques, and the experience of unwanted sex further underscore the social nature of our sexual behavior.

Variations in Sexual Activity. There is enormous variation in the extent to which people in differing societies and within a particular society are aroused. Levels of sexual activity among societies vary from the extremely low level of the Grand Valley Dani to the unusually high level of the people of Mangaia (both groups are in the South Pacific; Lauer and Lauer 1983). The Dani do not begin to have sexual relations until about two years after marriage. Weddings are held only about once every four to six years. The frequency of sexual relations is so low that the population is barely maintained. A couple will abstain from sex for four to six years after the birth of a child. Moreover, there is little extramarital sex and no evidence of homosexuality or masturbation. The Dani simply seem to have little interest.

By contrast, sex is a principal interest among the Mangaians. Nearly all, both male and female, have considerable premarital experience with a variety of partners. The Mangaians claim that a typical 18-year-old male will have, on the average, three orgasms per night each night of the week. A 28-year-old male will have about two orgasms per night, five to six times each week. In their late 40s, males have an orgasm two to three times a week.

From a *symbolic interactionist* point of view, there are no sexual techniques that are inherently more appealing than others. What matters is how people define



Symbolic Interactionist Theory Applied

those techniques. Thus, you probably regard mouth-to-mouth kissing as erotic. The Mangaians did not regard it as such until Westerners influenced them. Most Americans regard foreplay as essential to satisfying sex. In other societies, however, foreplay varies from being virtually absent to consuming even more time than it does among Americans (Ford and Beach 1951:41).

The preferred position for intercourse also varies from one society to another. Among the Trobriand Islanders, the man squats and draws the woman toward him until

her legs rest on his hips or his elbows. Islanders maintain that this position gives the man considerable freedom of movement and that it does not inhibit the woman in her movements of response (Malinowski 1932:285).

There are also different preferences within a society. Some people, for example, like or even prefer oral sex, while others do not enjoy or find oral sex satisfying (Brady and Halpern-Feisher 2007). Nationally, among 18- to 26-year-olds, about 80 percent of those in a sexual relationship have had oral sex as well as vaginal intercourse (Kaestle and Halpern 2007). Oral sex was much more likely among those couples who said they had a mutually loving relationship.

A recent form of sexual activity is **sexting**, defined as sending erotic or nude photos or videos of oneself to others via a cell phone or online (Quaid 2009). Although the practice began among young people, older adults have taken it up as well (Leshnoff 2009). The purpose of sexting in most cases is to maintain or enhance sexual desire and/or to culminate in sexual intercourse. Some unexpected consequences have occurred, however. There have been a few cases of young people who were arrested and charged with a felony (engaging in child pornography) when they sent nude pictures of themselves to someone. In one case, a teenage girl committed suicide after she broke up with her boyfriend with whom she had sexted. After the breakup, he sent the girl's nude pictures to other girls in her school, and the subsequent harassment she experienced drove her to take her life. Still, increasing numbers of people, both young and old, are engaging in sexting.

Such diversity underscores the fact that sexual behavior is learned. What is defined as erotic by some people may be defined as disgusting by others. What is defined as good and pleasurable by some will be defined as evil by others. Social factors are powerful, and they may modify, facilitate, or suppress the expression of the sex drive.

Unwanted and Coerced Sex. In an ideal world, there would be reciprocal desire between two people. People in love would desire sexual relations with each other at the same time so that all sexual activity would reflect the desire growing out of mutual love. In the real world, there is a great deal of unwanted and coerced sex, ranging from **sexual harassment** to **rape**. "Unwanted" means that the sexual activity is contrary to the individual's desires. Sexual harassment falls into this category. Another example is the individual who is exhausted and not at all in the mood but who agrees to sex in order to please a partner. "Coerced" means forced sexual activity of some kind, where the coercion can range from the verbal and emotional to the physical (Adams-Curtis and Forbes 2004). Coerced intercourse or attempted



Nearly everyone experiences some unwanted sexual activity.

intercourse is rape. When an individual forcibly touches, fondles, or kisses another, it is not technically rape, but it is both unwanted and coerced sexual behavior.

Sexual harassment occurs in all kinds of settings and among all ages. Among students and workers in every capacity from professionals (e.g., lawyers, professors) to blue-collar workers (e.g., autoworkers), experiences of sexual harassment abound (Swim et al. 2001; Hintz 2004; Buerhaus et al. 2009). Harassment includes such things as unwelcome sexual advances, unwanted touching by someone, requests for sexual favors, or other sexual behavior that creates discomfort or worse in the victim. Unless a dramatic shift occurs, at least half of all women will be harassed at some point during their academic or working lives, and that harassment will be experienced as degrading, frightening, and sometimes violent (Fitzgerald 1993; Wyatt and Riederle 1995).

Coerced sex is also common. Both men and women use a variety of tactics, including manipulation, intoxication, and force, to coerce sex from an unwilling partner (Schatzel-Murphy et al. 2009). These coercive tactics can be experienced at an early age. Forty percent of girls who have sex before the age of 15 say they were forced into it (Mackay 2001). A national survey reported that about 28 percent of young women described their first sexual experience as not wanted (Houts 2005). In another national survey, three researchers found that a fourth of women who had intercourse at age 13 or younger and 20 percent of those between 19 and 24 years of age at first intercourse said they were coerced (Abma, Driscoll, and Moore 1998). Finally, a national survey of young adults found that 7 percent of the men and 8 percent of women had experienced unwanted sex in a dating, cohabiting, or marital relationship (Kaestle 2009). In addition, 12 percent of the women, compared to 3 percent of the

men, had repeatedly engaged in some kind of sexual activity they disliked (mainly fellatio and anal sex).

Coerced sex can have long-term adverse consequences for women. A comparison of adolescents who had experienced early forced intercourse with those who had not found the former to be more depressed and anxious, lower in self-esteem, and more likely to use drugs and engage in delinquent activities (Lanz 1995).

Coerced sex is not merely a problem of women. They are far more likely than men to be coerced, but women also engage in sexual coercion (Russell and Oswald 2001). And sexual coercion is not merely an American problem. A study of Filipino adolescents found that the great majority had been coerced, and 64.6 percent of the victims were females and 42.3 percent were males (Serquina-Ramiro 2005) (see also the Comparison box in this chapter).

Why do people submit to unwanted sex? Why would someone who has no sexual desire agree to kissing, petting, and even intercourse? One factor is the abuse of alcohol and drugs. Under the influence of too much alcohol or the use of various other drugs, people may passively submit to sexual advances that they would otherwise reject (Davis, George, and Norris 2004). Other factors emerged in a study of college women who consent to unwanted sex with a dating partner (Impett and Peplau 2002). As shown in figure 4.2, those factors ranged from the desire or willingness to satisfy a partner's needs to the fear of the relationship breaking up if the individual rejected the advances. Moreover, women who comply with the demand for unwanted sex in order to avoid conflict with a partner report much lower satisfaction with the relationship (Katz and Tirone 2008).

SEX AND INTIMATE RELATIONSHIPS

Human love, according to Erich Fromm (1956), does not reflect a Freudian sexual instinct. Rather, Fromm argued, sexual desire reflects the human need for love and union. In other words, the need for intimacy has primacy over sex. We agree that intimacy is a more fundamental need than the need for sex. The sex drive is strong, and we need to find some outlet for sexual tension. But that tension can be dealt with in ways other than sexual intercourse, if necessary. There are, after all, healthy celibates. You can be celibate and be fulfilled. But you cannot be fulfilled without intimacy.

Sexual relations, then, do bring pleasure and stress relief, but they are also strongly related to emotional and relational well-being, and to the fulfillment of intimacy needs (Metz and McCarthy 2007; Holmberg, Blair, and Phillips 2010). Those who engage in sex may find themselves feeling less stress and more positive in mood the

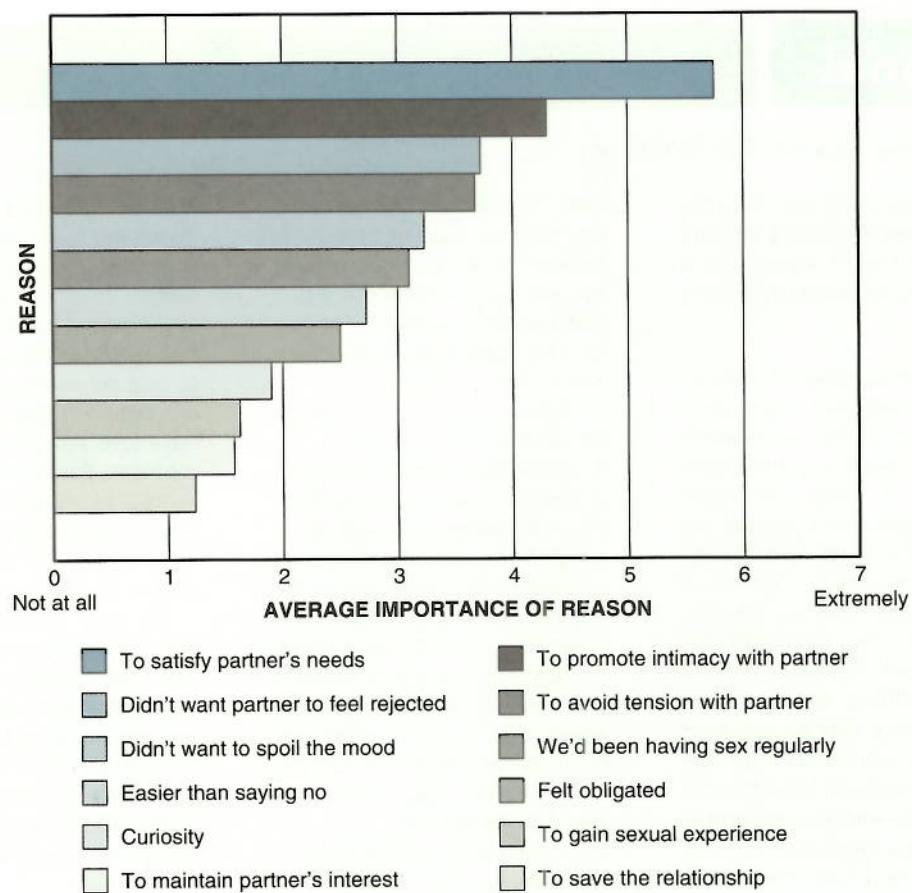


FIGURE 4.2 Reasons for Agreeing to Unwanted Sex

Source: Adapted from Impett and Peplau 2002.

next day (Burleson, Trevathan, and Todd 2007). And this positive mood enhances the quality of the relationship, leading to more physical affection and more sexual activity. It is true, of course, that some people have sex simply for the sake of sex. But a number of experts have argued that sex without intimacy, like the casual sex of the one-night stand, is of little or no value (Fromm 1956). In fact, drug and alcohol use are prominent reasons given by people for casual sex (Harvey and Weber 2002). At best, casual sex fails to fulfill our intimacy needs. At worst, it leaves us feeling more empty and lonely than we were before the experience. Instead of enhancing the quality of our intimate lives, sex without intimacy can become an impediment to the development of relationships that add to our well-being.

Actually, most people seem to sense the fact that sex needs to be an expression of an intimate relationship and that the emotional satisfaction of sex is strongly associated with being in a committed, exclusive relationship

(Waite and Joyner 2001). Most Americans, for example, neither approve of nor engage in **promiscuity**, frequent and indiscriminate sexual relations with many partners. In a national survey of adults 15 to 44 years of age, 62.2 percent said that they had only one opposite-sex sexual partner in the past 12 months, and 0.7 percent said that they had only one same-sex sexual partner (Mosher, Chandra, and Jones 2005). In the 30 to 44 age group, males reported an average of six to eight female sexual partners in their lifetimes; females reported an average of four male partners. It may be that promiscuous sexual behavior diminishes an individual's capacity to eventually form a fully satisfying marital relationship. Garcia and Markey (2007) found that a large discrepancy between a husband and wife in the numbers of sexual partners each had before they met was associated with lower levels of love, satisfaction, and commitment.

Feelings of intimacy often express themselves in sexual activity. In most societies, people continue to have sexual

Personal

Sex and the Search for Intimacy

Charles, a young single man, has tried for years to find a fulfilling intimacy solely through sex. He shares with us the conclusions he has reached in his 28th year:

While I was in college, I lived on campus for two years. I was really promiscuous. I had sex relations with many women. I thoroughly enjoyed it. I thought of myself as a real stud, and I enjoyed the envy of some of my male friends. In time, my sexual experiences had an unexpected and interesting effect on me. I discovered that my so-called manhood, though sexually fulfilled, lacked a quality of intimacy that became more profound as my need for emotional closeness increased. I had thought that what I—and any real man—needed was a lot of good sex. But the more sex I had, the more I

came to realize that something was missing. I would never have believed it a few years earlier, but one day I admitted to myself that sex wasn't enough. I wanted to have something more with a woman than her body.

Unfortunately, I had gotten the label of being a "player." So it became more and more difficult to develop closeness in a relationship. The women I wanted to go out with had the idea that I was a shallow person only looking for a good time. My reputation was established, and it was keeping me from developing the intimacy that I now yearned for. The only women who were interested were the ones just like me. Or just like I used to be. They didn't even appeal to me any more.

I couldn't do anything until I moved away. After graduation, I

went to work in another city. I knew I had to change my lifestyle. I decided to play it cool with women. I was still hot to trot. I really missed having sex. But I finally realized that it wasn't going to help me to keep on the way I had been in college. I wanted to make love and please myself and my lover. But more than that, I wanted to emotionally caress a woman and understand her and relate to her. And I wanted her to do that to me as well.

I'm in a kind of limbo right now. I have dated some women, and I am starting to develop a relationship with one that I think may lead to what I need. In any case, I know that I can't let sex be a deterrent to intimacy anymore. I know what I need. And I know that I can't get it in a one-night stand.

relations throughout life (May and Riley 2002; Nicolosi et al. 2005). Sexual desire and frequency of sexual relations do decline with age, but they do not stop for those with good health and a partner (Lindau and Gavrilova 2010). In a study of older adults (57 to 85 years of age) in the United States, the proportions reporting sexual relations in the past year were 73 percent of those aged 57 to 64, 53 percent of those aged 65 to 74, and 26 percent of those aged 75 to 85 (Lindau et al. 2007). Those with excellent or good health were twice as likely to have sex as those with fair or poor health. Women were less likely than men to be sexually active, but far more of them were widowed. In short, aged people tend to continue sexual intimacy as long as they are healthy and have a partner.

TEENAGE SEX

Pregnancy and sexually transmitted diseases (including AIDS) are serious problems among teenagers, with black girls having high rates of disease and Hispanic girls having the highest rate of births before the age of 20 (Abma et al. 2004; DiClemente et al. 2004). How many teenagers

have sex, and at what age do they start? What are some of the consequences of being sexually active as a teenager?

Extent of Sex among Teenagers

A substantial proportion of people become sexually active in the teen years. Nationally, 6.2 percent of U.S. youth have sexual intercourse before the age of 13 (Eaton et al. 2006). By the time they are in the 15- to 17-year age group, 27.7 percent of females and 28.8 percent of males have had sexual intercourse (Abma, Martinez, and Copen 2010). And the proportions go up to 59.7 percent of females and 65.2 percent of males in the 18 to 19 age group. These figures represent a dramatic decline from past decades. In 1988, for example, the proportions for 15- to 17-year-olds were 37.2 percent of females and 50 percent of males, and the proportions for 18- to 19-year-olds were 72.6 percent of females and 77.3 percent of males.

The age at which sex begins varies among the racial/ethnic groups. African Americans tend to begin earlier than others, followed by whites, Hispanics, and Asian Americans (Regan et al. 2004).



Sexually active teenagers face the prospect of an unwanted pregnancy.

Among all racial/ethnic groups, adolescents who are sexually active are more likely than those who are not to differ in a number of ways. Specifically, those who are sexually active are more likely to rarely attend church, live with only one parent, have a troubled relationship with parents or lack close relationships with parents, use drugs (including tobacco and alcohol), have close friends who are sexually active, and be in the lower social classes (Meier 2003; Fingerson 2005; Regnerus and Luchies 2006; Sieving et al. 2006; Manlove et al. 2008; Longmore et al. 2009). There are also some long-term negative consequences of early sexual activity, including a higher probability of risky sexual behavior and a lower likelihood of educational achievement (Steward, Farkas, and Bingenheimer 2009).

Unwanted Pregnancy and Early Childbearing

One consequence of teenage sex is a high rate of unwanted pregnancies and giving birth at an early age. Eighty-eight percent of births to teens, age 17 or younger,

were unwanted or mistimed. Birth rates among teenagers have fluctuated over time, reaching a peak in the early 1990s then declining until they increased again in 2006 (Forum on Child and Family Statistics 2009). The rates vary considerably among racial/ethnic groups. For 15- to 17-year-old adolescents in 2007, the rates per 1,000 were 8.4 for Asians or Pacific Islanders; 11.8 for white, non-Hispanics; 31.7 for American Indians or Alaskan Natives; 35.8 for black, non-Hispanics; and 47.8 for Hispanics (Forum on Child and Family Statistics 2009).

Many teenagers give birth to children who are unwanted at the time of conception, in part because of the mother being unmarried. But married people also bear children who are unwanted at the time of conception. The fact that a child is not wanted at the time of conception does not mean that the child is still unwanted at birth, of course. But we can justly wonder about the well-being of the children who remain unwanted at birth.

Why Pregnancy? Birth control measures are readily available in most communities. In fact, the decline in teenage pregnancy is attributed to an improved use of contraceptives (Santelli et al. 2006). Why, then, do so many teenagers continue to get pregnant?

First, no contraceptive is foolproof. Failure rates during the first year of use vary from a low of 8 percent for users of the pill to 15 percent for condom users and 25 percent for users of spermicides (Jones and Forrest 1992).

Second, although the use of contraceptives at the time of first and times of subsequent intercourse has increased, the failure to use any method of birth control is still a significant factor in teenage pregnancies (Abma et al. 2004; Lance 2004). Birth control measures are readily available, but the sex may be an unplanned response to the strong drive of teenagers. Or the teenagers may be too embarrassed or too poor to purchase birth control measures. Or they may believe that using such things as condoms reduces pleasure (Parsons et al. 2000).

Third, not all teenagers find the prospect of pregnancy to be unsettling (Unger, Molina, and Teran 2000). While the majority of teenage women who become mothers say they did not intend it, about 7.5 percent of the female adolescents in a national survey indicated that they *expected* to bear a child in adolescence out of wedlock (Trent and Crowder 1997). Those more likely to have such an expectation came from families that were black or Hispanic rather than non-Hispanic white, in the lower social classes, and single-parent rather than two-parent (Blake and Bentov 2001). Why would they want to get pregnant out of wedlock? Many of such teenagers had troubled childhoods. In a small sample of whites

and Mexican Americans, half had lost a parent during their childhood years (de Anda, Becerra, and Fielder 1990). A study of 535 young women reported that two-thirds of those who became pregnant had been sexually abused (Boyer and Fine 1992). With such experiences, teenagers may feel isolated and alone and that a baby is the one way to find someone to love. Others may use pregnancy to get attention, to assert their independence from their parents, or, particularly for those in the lower social classes, to do something creative in a world of very limited opportunities. Perhaps that is why there is more tolerance for unmarried parenthood in economically distressed communities (South and Baumer 2000).

Fourth, certain parental attitudes and behaviors can significantly reduce the likelihood of out-of-wedlock pregnancy (Fingerson 2005; Regnerus and Luchies 2006; Wildeman and Percheski 2009). Teenage girls who grow up with their two biological parents, who attend church regularly as children, who are close to their parents, whose parents can talk with them about sexual matters, and whose parents teach them to be responsible are less likely to get pregnant.

Finally, among both whites and African Americans, the chances of pregnancy are much higher if a girl is going steady and if she has had discipline problems in school. In essence, then, girls who feel good about themselves, have high expectations and aspirations for their lives, and have good relationships with concerned parents are much less likely to get pregnant than others. This is only partly due to a lower amount of sexual activity. It is also due to a greater probability of using birth control.

Some Consequences of Teenage Births. Whether wanted or not, the children of teenagers differ in important ways from other children. And the parents of those children differ from parents who wait at least until their 20s to have children.

Teenagers who father or give birth to children are more likely than those who become parents at later ages to experience a variety of negative consequences (Hanna 2001; Mirowsky 2005; Henretta 2007; Mollborn 2007). If they are in high school, they are less likely to complete their education, due largely to a lack of such resources as housing, child care, and financial support. They are more likely to be and remain poor; to suffer from chronic unemployment; and, when they do find work, to get low-paying jobs. They have higher levels of health problems (including heart disease, lung disease, and cancer) and a higher risk of dying early.

Detrimental consequences affect not just the teenage parents but their children as well (Jaffee et al. 2000; Gueorguieva et al. 2001; Levine, Pollack, and Comfort 2001; Abel, Kruger, and Burd 2002; Pogarsky, Thornberry, and Lizotte 2006). The children are more likely to be preterm and low weight, which are factors in infant mortality. They are more likely to exhibit learning disabilities when they begin school. During their school years, they are more likely to be involved in truancy, fighting, early sexual activity, and other kinds of problem behavior. And when the children grow up, they are more likely than others to repeat the same kind of pattern—leave school early, be unemployed, and become parents in their teens.

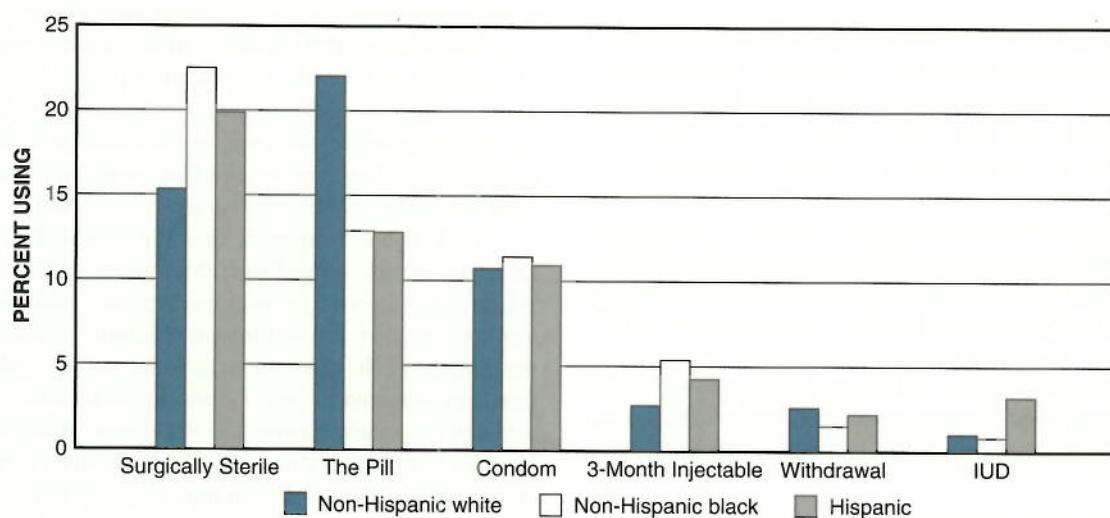


FIGURE 4.3 Percentage Distribution of Women 15–44 Years of Age Using Contraceptive Methods

Source: U.S. Census Bureau 2010b.

Clearly, little positive can be said for teenage pregnancy and childbearing. Both parents and children are likely to suffer a wide variety of negative consequences. Your chances for maximizing your well-being and the quality of your intimate relationships are much less if you bear children in your teens.

CONTRACEPTION

Contraception, a method of birth control, is the use of devices or techniques to prevent fertilization. When a couple wants to avoid pregnancy, knowledge and use of effective contraception can enhance sexual pleasure and intensify sexual intimacy by removing the fear of conception.

Amount and Kinds of Contraceptive Use

Although few women desire to get pregnant when they first become sexually active, about 16 percent use no contraceptive method (Mosher and Jones 2010). This represents a dramatic decrease since the early 1980s, when 45 percent used no method. As sexual activity continues, contraceptive use is even more likely. The most commonly used method is the oral contraceptive pill, followed by **sterilization** (figure 4.3). Table 4.1 shows the more common methods, how they work, and some of their benefits and limitations.

There are a number of other methods that are newer and less commonly used (Neergaard 2000; Schwetz 2002; Clark 2005). Injections of the drug Depo-Provera

TABLE 4.1 Methods of Birth Control

Popular Name	Description	Effectiveness (pregnancies per 100 women using method for 1 year)	Advantages	Disadvantages
The pill (oral contraceptive; consultation with physician required)	Contains synthetic hormones (estrogens and progestin) to inhibit ovulation. The body reacts as if pregnancy has occurred and so does not release an egg. No egg—no conception. The pills are usually taken for 20 or 21 consecutive days; menstruation begins shortly thereafter.	2* (for combination pills)	Simple to take, removed from sexual act, highly reliable, reversible. Useful side effects: relief of premenstrual tension, reduction in menstrual flow, regularization of menstruation, relief of acne.	Weight gain (5–50 percent of users), breast enlargement and sensitivity; some users have increased headaches, nausea, and spotting. Increased possibility of vein thrombosis (blood clotting) and slight increase in blood pressure. Must be taken regularly. A causal relationship to cancer can neither be established nor refuted.
IUD (intrauterine device; consultation with physician required)	Metal or plastic object that comes in various shapes and is placed within the uterus and left there. Exactly how it works is not known. Hypotheses are that endocrine changes occur, that the fertilized egg cannot implant in the uterine wall because of irritation, and that spontaneous abortion is caused.	3–6	Once inserted, user need do nothing more about birth control. High reliability, reversible, relatively inexpensive. Must be checked periodically to see if still in place.	Insertion procedure requires specialist and may be uncomfortable and painful. Uterine cramping, increased menstrual bleeding. Between 4 and 30 percent are expelled in first year after insertion. Occasional perforation of the uterine wall. Occasional pregnancy that is complicated by the presence of the IUD. Associated with pelvic inflammatory disease.
Diaphragm and jelly (consultation with physician required)	Flexible hemispherical rubber dome inserted into the vagina to block entrance to the cervix, thus providing a barrier to sperm. Usually used with spermicidal cream or jelly.	10–16	Can be left in place up to 24 hours. Reliable, harmless, reversible. Can be inserted up to 2 hours before intercourse.	Disliked by many women because it requires self-manipulation of genitals to insert and is messy because of cream. If improperly fitted, it will fail. Must be refitted periodically, especially after pregnancy. Psychological aversion may make its use inconsistent.

(continued)

TABLE 4.1 (continued)

Popular Name	Description	Effectiveness (pregnancies per 100 women using method for 1 year)	Advantages	Disadvantages
Condom	Thin, strong sheath or cover, usually of latex, worn over the penis to prevent sperm from entering the vagina.	7-14	Simple to obtain and use; free of objectionable side effects. Quality control has improved with government regulation. Protection against various sexually transmitted diseases.	Must be applied just before intercourse. Can slip off, especially after ejaculation when penis returns to flaccid state. Occasional rupture. Interferes with sensation and spontaneity.
Chemical methods	Numerous products to be inserted into the vagina to block sperm from the uterus and/or to act as a spermicide. Vaginal foams are creams packed under pressure (like foam shaving cream) and inserted with an applicator. Vaginal suppositories are small cone-shaped objects that melt in the vagina; vaginal tablets also melt in the vagina.	13-17 (more effective when used in conjunction with an other method, such as the diaphragm)	Foams appear to be most effective, followed by creams, jellies, suppositories, tablets. Harmless, simple, reversible, easily available.	Minor irritations and temporary burning sensations. Messy. Must be used just before intercourse and reapplied for each act of intercourse.
Sponge	Small sponge that fits over the cervix, blocking and killing sperm.	9-11	Simple to purchase and use. Can be inserted hours before intercourse and left in place up to 24 hours.	Possible health problems, including toxic shock syndrome and vaginitis. Difficult to remove. May make intercourse dry.
Sterilization	Surgical procedure to make an individual sterile.	Less than 1	Safest method. Does not affect sexual drive. No planning or additional steps before intercourse necessary.	May be irreversible. Possibility of postoperative infections for women.
Natural family planning (rhythm method)	Abstinence from intercourse during fertile period each month	10-29	Approved by the Roman Catholic church. Costless, requires no other devices.	Woman's menstrual period must be regular. Demands accurate date keeping and strong self-control. Difficult to determine fertile period exactly.

Note: Individuals vary in their reaction to contraceptive devices. Advantages and disadvantages listed are general ones.

*If taken regularly pregnancy will not occur. If one or more pills are missed, there is a chance of pregnancy. Combination pills contain both estrogen and progesterone.

Sources: U.S. Department of Health and Human Services, *Contraceptive Efficacy among Married Women Aged 15-44 Years*. Publication no. (PHS) 80-1981 (Hyattsville, MD: U.S. National Center for Health Statistics, 1980). Pamphlets published by Planned Parenthood Federation.

provide 99 percent protection for three months. Norplant (capsules implanted under the skin of a woman's upper arm) protects for about five years. A female condom is available, though it does not seem to be as effective as the male condom. In 2000, the Food and Drug Administration approved use in this country of the abortion pill RU-486, which is taken under a physician's supervision. In 2004, however, the Food and Drug Administration said the warning label should be strengthened because a number of women died after taking the pills (Harrison 2004). There is also a

contraceptive patch that releases hormone compounds that prevent ovulation (Clark 2005). As with all of the above methods, the patch carries the risk of serious side effects, including an elevated risk of blood clots, and its long-term effects are unknown. Finally, there is Plan B, the "morning after" pill, which may prevent pregnancy after another contraceptive has failed or a woman has had unprotected sex (Payne 2007). The pill is to be taken within 72 hours after sex. It can prevent the release of an egg from the ovary, or the union of sperm and egg, or a fertilized egg attaching itself to the womb. It will

not work if a fertilized egg is already attached. As of this writing, there are no known serious side effects, but the user may experience some mild effects such as nausea, headache, and stomach pain.

People also try a number of other techniques that have little or no use. For example, some people believe that a woman cannot get pregnant the first time she has intercourse and, therefore, no device need be used. That belief has resulted in many pregnancies. Still others try withdrawal (removing the penis from the vagina before ejaculation) or a vaginal douche immediately after intercourse. These were the two most popular methods in the nineteenth century. Neither is reliable. Even if withdrawal occurs before ejaculation, many men have a leakage of seminal fluid prior to ejaculation that can result in pregnancy. And the vaginal douche, ironically, may actually facilitate pregnancy. Rather than flushing out, the douche may force sperm up into the cervix. Moreover, some of the sperm may have already traveled into the cervix, making the douche useless.

Thus, there are both effective and ineffective methods of contraception. Some of the modern methods may not be quite as ineffective or hazardous as the ancient Egyptian mixture that contained crocodile dung, but people continue to use methods that are not effective. In part, this is due to a lack of education. A substantial proportion of adolescents get no formal sexual education in the years when most are becoming sexually active. Of course, not all who receive the information make use of it. An unwanted pregnancy is a painful experience. Today, there is ample information available; no one need get pregnant out of ignorance.

Who Uses Contraceptives?

We can distinguish the groups most likely to use some form of contraception on the basis of demographics and other characteristics.

Demographic Differences. As the discussion so far indicates, contraceptive use is less likely among younger people who are sexually active. A national survey found that the proportion of women using some contraceptive method ranged from 28.2 percent of those aged 15 to 19, to 54.7 percent of those aged 20 to 24, to 64.2 percent of those aged 25 to 29, to 70.3 percent of those aged 30 to 34, to more than 75 percent of those aged 35 to 44 years (Mosher and Jones 2010).

The survey showed that the proportions also vary slightly by racial/ethnic background. The proportion of women aged 15 to 44 years who used any method of

contraception was 99.7 percent of whites, 99.0 percent of African Americans, 98.6 percent of Asian Americans, and 97.2 percent of Hispanics.

One reason for the lower rate of contraceptive use by the young may be what someone has called the “illusion of unique invulnerability.” The illusion means that a young woman thinks of herself as, for some reason, less likely than others to get pregnant. This sense of invulnerability is the same thing that leads people into various kinds of self-destructive behavior. For example, many people who smoke or have an unhealthy diet feel that they will escape the negative consequences of their behavior even though others do not.

Similarly, the young woman who adopts the stance of “I just don’t think that I will get pregnant” is less likely to use birth control methods . . . and quite likely to get pregnant.

Some younger people, of course, do use contraceptives, and the proportion is increasing. Younger people more likely to use contraceptives are those who have good communication with their parents about sexual matters generally and contraceptives in particular (Wilson et al. 1994; Miller 2002). Peer influence is also important. Those who perceive their peers as using contraceptives are more likely to use them for themselves.

One other important related factor is the age at which the individual first has sexual intercourse. Those who have intercourse early (age 16 or younger) are less likely than those who begin sexual relations later to know about and use effective methods of contraception. The early experimenters are also less likely to use effective contraception at the time of first intercourse (Abma and Sonenstein 2001). Ironically, they may not use contraceptives out of fear that their parents will discover them and know that they are sexually active (Juliano, Speizer, Santelli, and Kendall 2006).

Other Factors. The proportion of religious women who practice birth control is about the same as for the nonreligious (Goldscheider and Mosher 1991). And the proportion is about the same for Protestants, Catholics, and Jews. However, there are differences in the preferred method; the most frequently used methods are sterilization for Protestants, the pill for Catholics, and diaphragms for Jews.

Religion has another interesting effect. Some religions hold that contraception is wrong. Married people in those religions may refrain from using contraceptives (although many do use them), with resulting large families. Some of the younger, unmarried people, however, may refrain from contraception but not from sexual

relations (Zaleski and Schiaffino 2000). It is as though they are willing to violate one but not two of their religions' precepts.

A number of other factors also affect people's likelihood of using contraceptives (Whitley 1990; Luster and Small 1994; Langer, Warheit, and McDonald 2001; Frisco 2005; Shafii, Stovel, and Holmes 2007). In particular, usage is more likely among those who

- used a contraceptive at the time of their first sexual experience.
- have a partner who supports the use.
- hold positive attitudes about contraception.
- have high self-esteem.
- do well in school.
- have parents who monitor and support them.
- come from two-parent families.
- use alcohol, if at all, only in moderation.

ABORTION

Abortion, the expulsion of the fetus from the uterus, is a highly controversial subject. Abortion may be either spontaneous (so-called *natural abortion* or *miscarriage*) or induced by some medical or surgical procedure. We include the topic here because induced abortion is used as a method of birth control. That is, women have abortions for the same kinds of reasons that they use birth control (Finer et al. 2005). They claim that a child would interfere with their education or work or other responsibilities, or that they can't afford a baby, or that they are single and do not want to be a single parent, or that they already have as many children as they want.

Abortion has been used throughout history to deal with unwanted pregnancies. In the United States, abortion was illegal in most states until the Supreme Court's famous 1973 decision in the *Roe v. Wade* case. That case allowed abortion on demand in the first trimester of a pregnancy. The case was the result of increasing pressures from various groups to give legitimacy to the procedure and protect women from the pain and risks of back-alley abortions. Some women died and many others nearly died from illegal abortions, which could be performed by people who ranged from midwives to bookies.

How many pregnancies end in abortion? The numbers and rates have been declining. In 1990, there were 1.6 million abortions (27.4 per 1,000 women), compared to the 1.2 million (19.4 per 1,000 women) in 2005 (table 4.2).

TABLE 4.2 Legal Abortions, by Selected Characteristics

Characteristic	Number (1,000)	Percent Distribution
Total legal abortions	1,206	100
Age of woman:		
Less than 15 years	7	0.6
15–19 years old	196	16.2
20–24 years old	396	32.8
25–29 years old	287	23.7
30–34 years old	179	14.8
35–39 years old	104	8.7
40 years old and over	38	3.2
Race and ethnicity of woman:		
White	662	54.9
Black	452	37.5
Other	92	7.6
Hispanic	263	21.8
Marital status of woman:		
Married	208	17.2
Unmarried	999	82.8

Source: U.S. Census Bureau 2010b.

The decline is probably due to such things as the aging of the population (younger women are most likely to have abortions), fewer abortion services (a result of violence and harassment by pro-life activists), and perhaps some change in attitudes.

Abortion will probably continue to divide the nation into *conflicting camps* for some time. A *New York Times* poll found that 36 percent agree that abortion should

 **Conflict Theory Applied**
be generally available to those who want it, 38 percent agree that it should be available but would impose stricter limits than now exist, and 23 percent said it should not be permitted (3 percent weren't sure of their position) (The Polling Report 2010).

Abortion poses psychological risks for some women. At the least, there is likely to be a short-term grief response, a sense of loss and anxiety about death (Williams 2001). There is also the possibility of the "postabortion syndrome," which includes four components: (1) perceiving the abortion as a painful, intentional destruction of one's unborn child; (2) negative reexperiencing of the abortion; (3) failure to avoid or deny traumatic recollections of the abortion; and (4) varying negative emotions such as guilt (Speckhard and Rue 1992). Many clinics have both pre- and

postprocedure counseling in order to help with such problems. One young woman who had two abortions told us that she is now ready to bear a child: "But I'm having trouble getting pregnant. I'm beginning to feel like I had my children and they died." She was clearly grieving over losses that had occurred some years earlier. Only in a few cases, however, are the problems severe enough to warrant psychiatric care.

PREMARITAL SEX

Most religious traditions link sex with marriage. But premarital sex occurs in all societies. How much occurs in the United States, and how do Americans feel about it?

The Double Standard

As *conflict theory* suggests, men and women have differing interests, and their interaction often takes the form of a power struggle. One outcome of the struggle is the



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Applied**

double standard, a long-standing fixture of U.S. society that favors male interests. Thus, in terms of premarital sex, this

means that boys traditionally were expected to have some experience, while girls were expected to remain virgins until marriage. In his classic study of a small

Missouri town, James West (1945:194) captured the essence of the double standard:

It is expected . . . that most boys will acquire a limited amount of sexual experience before marriage, as they are expected to experiment with drinking and "running around." All these "outlaw traits" are associated with a young man's "sowing his wild oats." It is better if he sows his wild oats outside the community, if possible . . . A girl who sows any wild oats, at home or abroad, is disgraced, and her parents are disgraced.

Has the double standard changed? To some extent it has. Premarital sexual activity is nearly as acceptable for females as for males. Nevertheless, experimental studies continue to show that the standard still exists for many people, so that men are rewarded and women are stigmatized to some extent for premarital sexual activity (Marks and Fraley 2006; Kreager and Staff 2009).

Changing Attitudes

Although the double standard accepted the fact that most boys would have premarital sexual experience, it did not mean that such behavior was considered ideal. Surveys from the first half or so of the twentieth century found that less than a third of Americans agreed that premarital sex was all right (Hyde and DeLamater 2007). And fewer agreed that it was all right for a woman than those who agreed it was all right for a man. Such

What Do You Think?

There is disagreement about whether abortion should be legal and readily available. What follows are pro and con arguments. What do you think?

Pro

- Abortion should be legal and readily available because
 - women should have control over their own bodies.
 - no one should be forced to accept a child conceived through rape.
 - abortion is a better alternative than an unwanted child.
 - no one should bring a child into the world who cannot afford to meet that child's needs for food, clothing, etc.
 - "back-alley" abortions would otherwise replace legal abortions and some women will die from the procedure.

Con

- Abortion should be neither legal nor available because
 - it violates the rights of the unborn child.
 - it contradicts moral and religious beliefs that prohibit killing.
 - when mothers kill their own children, the entire society degenerates morally.
 - women who abort suffer emotional and physical distress.
 - the child who is unwanted can be adopted by people who are desperate to have their own family.

attitudes have changed rapidly in the last few decades, however (Harding and Jencks 2003). A 2007 Gallup poll reported that 59 percent of the respondents viewed premarital sex as morally acceptable, while 38 percent said it is morally wrong.

Whether people believe that premarital sex is wrong depends on a number of factors, including age, education, race, and religion. In the Gallup poll, young adults (35 years or younger) were much more accepting of premarital sex than were older adults. A survey of college students found that Asian students were more conservative in their sexual views than were white or Hispanic students (Ahrold and Meston 2010). And conservative Christians are much less likely to approve of premarital sex than are moderate or liberal Christians (McConkey 2001; Ahrold and Meston 2010).

It is interesting that a majority of Catholics agree that premarital sex is “not wrong.” Officially, the Catholic church continues to teach that premarital relationships are a sin. A 1976 declaration from the Congregation for the Doctrine of the Faith noted that many people justify premarital sex in cases in which people intend to marry and in which they have an affection for each other that is like that in the marital state. But even in those cases, the declaration pointed out, the belief was contrary to Catholic doctrine, which continued to affirm that all sexual intercourse must take place in the context of marriage (Hyde and DeLamater 2007).

Traditionally, all Christian groups have taught that premarital sex is morally wrong. Whatever the official teachings, however, belief in the immorality of premarital sex has declined among members of all groups except conservative Protestants who attend church often (Petersen and Donnenwerth 1997). Mainline Protestants, Catholics, and conservative Protestants who attend church infrequently have all followed the national trend of increasing acceptance of premarital sex.

Some male-female differences in attitudes exist. Males are more permissive than females, particularly about the use of pornography and engaging in casual sex (Cohen and Shotland 1996; Petersen and Hyde 2010). Males and females tend to be similar in their attitudes about sex, however, when the couple is in love or engaged. Both tend to approve of sexual relations under such circumstances.

Changing Behavior

Attitudes do not necessarily reflect behavior. That is, because people approve of premarital sex does not mean that they are actually engaging in it. How much

premarital sexual behavior actually occurs, and how does the amount now compare with the past?

Extent of Premarital Sex. We pointed out in chapter 1 that the amount of premarital sex has increased considerably in recent decades. In the famous Kinsey studies of the 1940s, the data showed that about a third of all females and 71 percent of all males had premarital sexual relations by the age of 25 (Hyde and DeLamater 2007). After the 1960s, the proportions rose dramatically. By the first decade of the present century, a survey reported that 95 percent of Americans who were 44 years of age (94 percent of women and 96 percent of men) had had premarital sex (Finer 2007). That is, they were still unmarried but had had sex, or they reported having had sex before they were married at some point earlier in their lives. Figure 4.4 breaks this research down by various age cohorts and at which age they first had sex. Note that the probability of having premarital sex—at any age—tends to increase with each succeeding generation. Also note that the proportions of those having premarital sex increases in each cohort as the people age.

Of course, some people remain celibate for many years before engaging in sexual relationships. Women who refuse to have premarital sex do so for a variety of reasons and handle the pressure in various ways. For instance, a student who had decided to wait for sex until marriage told us,

I'm up front with the guys I date. I tell them that I don't have hangups. I really look forward to sex. But I just believe that it should wait until marriage. That turns some guys off. At first, I was troubled by some guys that I liked who didn't want to date me any more because of my attitude. But I decided that if a guy didn't respect me for my stand on sex, we probably shouldn't be together anyway.

Premarital Sex and Social Background. As in the case of dating patterns, premarital sexual patterns vary depending on background factors. *Religion* is one such factor. In general, the more religious the individual (in terms of such things as regular attendance at church, praying, etc.), the less likely is that individual to have premarital sex (Rostosky et al. 2004). Some churches have programs that encourage young people to make a pledge of abstinence until marriage. While substantial numbers of those who make the pledge eventually do have premarital sex, they are much more likely than nonpledgers to abstain until marriage (Uecker 2008). And when they do have premarital sex, they are likely to have it only with their future spouse.

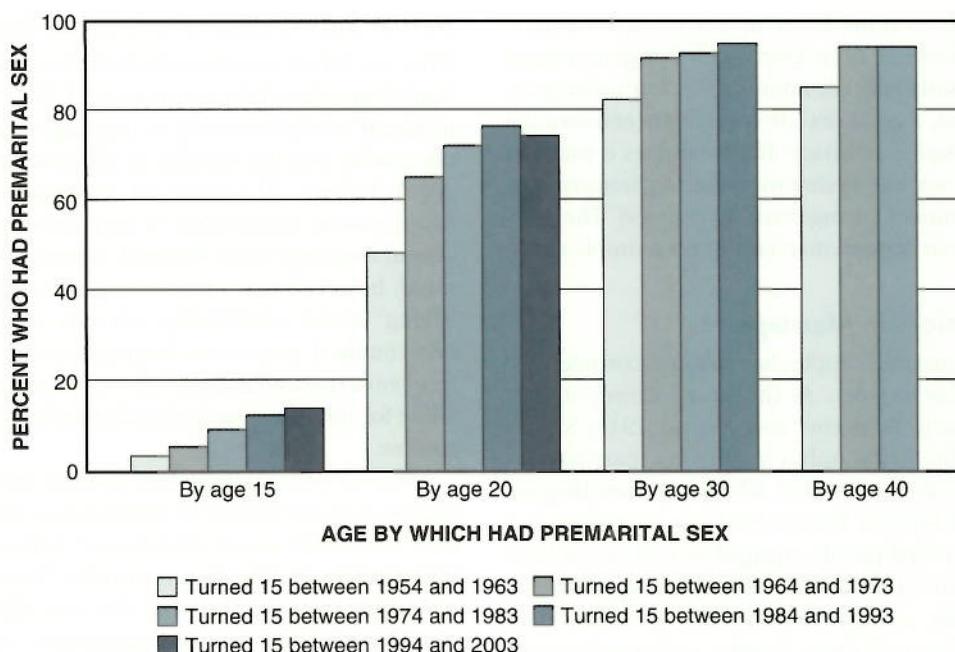


FIGURE 4.4 Proportion Having Premarital Sex

Source: Adapted from Finer 2007.

A second factor is the source of sexual information. Parents tend to give more restrictive sex messages to their daughters than to their sons (Morgan, Thorne, and Zurbriggen 2010). But young people who say that they learned about sex from their parents or grandparents or religious leaders are more likely to delay sex, while those who learn about sex from friends or the media have an increased likelihood of having sexual intercourse (Bleakley et al. 2009).

A third factor in premarital sexual activity is *family background*, including the family atmosphere, parenting styles, and the marital status of the parents. With regard to atmosphere, the more conflict in the home, the more a young person is likely to have early sexual experience (McBride, Paikoff, and Holmbeck 2003). With regard to parenting styles, when parents are more heavily involved in their children's lives, the children are less likely to have early sexual experience (Roche et al. 2005). Parental attitudes are also important. Although young people have more permissive sexual attitudes and behavioral patterns than their parents, children tend to reflect the attitudes of their parents. Thus, mothers with more permissive attitudes are likely to have children who have permissive attitudes and who therefore are more sexually active (Small and Luster 1994; Hovell et al. 1994; Whitbeck et al. 1999).

Also important is the extent to which parents monitor the child's behavior (Longmore, Manning, and Giordano 2001). Sexual activity is less likely when the child is not allowed to be home alone, when the child is required to let parents know where he or she is when not at home, and when some restrictions are placed on the amount and kind of television the child can watch. Parents need to monitor the child's peer relationships as well. Children whose involvement with friends leads to delinquent behavior and alcohol consumption are more likely to be sexually active (Whitbeck et al. 1999; Woodward, Fergusson, and Horwood 2001).

Such close monitoring becomes more difficult in a single-parent home. So it is not surprising that a higher rate of sexual activity and premarital pregnancy occurs among children who live with one parent (Upchurch et al. 1999; Moore and Chase-Lansdale 2001).

SEX IN MARRIAGE

Among the things necessary for a successful marriage, how would you rate a good sex life? Most Americans would say it is very important. As we noted in chapter 1, however, sex is not among the top 10 reasons people give for a satisfying, long-term marriage. The point is, sex

itself is unlikely to either break up a marriage or keep it together. At the same time, given such things as a sense of friendship, satisfying communication, mutual respect, and admiration, a good sex life can greatly enhance the quality of a couple's intimacy. But what does it mean to have a "good" sex life? Is that measured by frequency of sex? By the number of orgasms? By variety? The relationship between sex and marriage is not a simple one.

Sexual Practices in Marriage

The sex life of married couples has changed considerably over the last few decades. As the famed Kinsey studies reported (Kinsey, Pomeroy, and Martin 1948; Kinsey et al. 1953) in the 1940s, only a minority of married people engaged in oral sex, either **fellatio** or **cunnilingus**. By the time of Morton Hunt's 1974 survey, however, a majority of married people engaged in oral sex at least some of the time (Hunt 1974). Hunt also reported that married couples, compared with those in earlier decades, engaged in much more foreplay and experimented with a greater number of positions in intercourse. These changes may reflect an increased concern with the woman's enjoyment and orgasm, both of which tend to be enhanced if more time is given to sexual activity.

On the average, Americans have sexual relations from two to four times a month (Blanchflower and Oswald 2004). And although comics have talked about marriage as the end of romance and sex, and a popular image of the single person includes frequent sex with many different partners, married people have more and better sex than do singles. And this is true not only in the United States but in scores of other nations that have been studied (Wellings et al. 2006). The frequency varies by such things as age and work (Robinson and Godbey 1998). In general, reported sexual activity is higher among the younger than the older, among those who work 40 hours or more a week than those who work fewer hours, and among those identifying themselves as liberals than those identifying themselves as conservatives.

While many people are interested (perhaps for comparison purposes—how well am I doing compared to others?) in the average number of times Americans have sex, the average is misleading, because the range of activity is considerable. Some couples never have sex relations while others may have them every day or a number of times each day. It is also important to realize that *average* does not mean *normal*. People sometimes read such statistics and believe that something is wrong with them if they do not follow the average practice. But sexual needs and desires vary widely. There is no "normal" frequency.

Sexual Satisfaction and Marital Satisfaction

How important is sexual satisfaction to marital satisfaction? A number of things can be said. First, a high degree of sexual satisfaction early in marriage tends to increase the quality and the stability of the marriage (Yeh et al. 2006). Indeed, 70 percent of Americans agree that a happy sexual relationship is very important for a successful marriage (Pew Research Center 2007a). Keep in mind, however, that the meaning of a "happy" or "satisfying" sexual relationship can vary considerably. For one couple it may mean frequent sexual relations and frequent experimentation with varied sexual techniques, while for another couple the sex may be occasional and routine.

Second, sexual satisfaction involves more than intercourse. A man married 25 years told us that he "remembers little about sexual intercourse" in the early years of his marriage. But he does remember "laying at night in my wife's arms. In that way, she was telling me that I was all right. That was very important." Sex, he noted, was not as important as caring and affection. In fact, it is precisely such caring and affection that enables couples to have a satisfying sex life. Once again, we can have intimacy without sex, but we cannot have satisfying sex without intimacy. In other words, sexual satisfaction is likely to be the result of, rather than the cause of, marital satisfaction (Henderson-King and Veroff 1994).

Third, although sexual satisfaction is important, it is less important than other things in the quality of an intimate relationship. More important than sex in intimacy are such things as the ease with which differences are handled, the extent to which the partners express affection, the degree of commitment to the marriage, and the amount of self-disclosure.

Fourth, the relationship between sexual satisfaction and marital satisfaction is one of mutual influence. That is, marital satisfaction affects sexual satisfaction and vice versa (Young 2000). In other words, it is true both that sexual dissatisfaction can detract from marital intimacy and that a troubled marriage can detract from sexual satisfaction.

Finally, in our study of long-term married couples, we came to three conclusions about the role of sex that are in accord with the findings of other researchers (Lauer and Lauer 1986:73; Mackey and O'Brien 1995; Alford-Cooper 1998; Hinckliff and Gott 2004):

1. A couple can have a meaningful sexual relationship for the duration of their marriage; neither age nor amount of years together necessarily diminishes the quality of sex.

2. Some couples have long-term, satisfying marriages even though one or both have a less-than-ideal sex life.
3. The most important thing in a couple's sexual relationship is agreement about the arrangement.

The last point stresses something we mentioned earlier—there is no such thing as a normal or ideal sex life for all couples. It isn't the kind or frequency of sexual activities that is most important but the extent to which the couple agrees on whatever arrangement they make.

Changes in Marital Sex over the Life Span

Perhaps the most obvious change in sexual activity over the course of a marriage is the decline in frequency. That decline is a function of a number of factors. First, as people age, their sexual needs and desires change (Birnbaum, Cohen, and Wertheimer 2007). For most, sex becomes somewhat less urgent. In addition, people come to recognize that other things are as important or more important in their relationships.

Still, sexual activity remains strong and important to many people as they age. And its importance is not merely for physical release. As an 84-year-old woman said, "Sex means more to me than just physical satisfaction. I need to have my husband near to me. I need to hold him and have him hold and hug me."

Health is the second factor that can alter a couple's sexual pattern. People who must take painkilling drugs or medication for high blood pressure may find their sexual functioning impaired. Chronic health problems, such as arthritis and diabetes, can diminish sexual desire and activity. A hysterectomy may make intercourse more painful for a woman.

A third factor, the arrival of children, can drastically alter a couple's sex life. Typically, there is a decline in sexual relations after couples become parents (Ahlborg, Persson, and Hallberg 2005). New parents may experience a decline in sexual desire because the demands of parenthood leave them feeling exhausted at day's end. The decline in frequency of sexual relations, incidentally, may be frustrating to one or both partners, but it does not necessarily mean a decline in commitment or affection. In fact, new parents may assert that their love for each other is stronger than ever even though the frequency of their sexual relations has declined.

Finally, our study of long-term marrieds identified three patterns in sexual functioning (Lauer and Lauer 1986). In one pattern, the level and satisfaction with the couple's sex life remained fairly stable over time. A second pattern involved a decline in sexual frequency.



Sexual activity tends to remain important to people as they age.

Sometimes that was associated with less sexual satisfaction, but in other cases it was not. Third, the sex life of some couples improved over time. In some cases, even the frequency increased. Independently of frequency, however, some couples perceived the quality of their sex life as improving over time. As a woman married 40 years told us, "It's better than ever."

EXTRAMARITAL SEX

What do you think about someone who is married having sex with a partner other than his or her spouse? How does that affect marital intimacy? Polls over the past decade consistently show that more than 90 percent of Americans believe that extramarital sex is morally wrong (Polling Report 2010). And only a third of Americans say they would forgive a spouse who had an affair. Most people, then, agree that extramarital sex damages the marital relationship. In fact, infidelity is the most commonly reported reason for divorce (Amato and Previti 2003). Nevertheless, a substantial number of people have extramarital sex. A large-scale, national study of married individuals reported a rate of infidelity of 2.3 percent in any one year (Whisman, Gordon, and Chatav 2007). That does not tell us the proportion who will have extramarital sex over a lifetime, but it's probable that at least 10 percent of all married people will be unfaithful one or more times. This proportion is comparable to that found for contemporary China, where it is estimated that 15 percent of married men and 5 percent of married women have had extramarital sex (Zhang 2010).

Clearly, most Americans practice fidelity. Just as clearly, many people engage in extramarital sex who say they do not approve of it. And because only one of the partners in some marriages has the extramarital relationship, a great many couples are affected. Tens of millions of Americans face the problem of a spouse who has been unfaithful. The extent of the unfaithfulness varies, of course. Extramarital sex may involve either an affair or a one-night stand. Affairs may continue for weeks or even years, with regular or periodic sexual relations. The one-night stand involves a single encounter. Clearly, an affair is much more difficult to maintain than the single encounter.

Why Extramarital Sex?

Many married people fantasize about what it would be like to have sex with someone other than their spouse. But fantasies are not usually enough to motivate someone to have extramarital sex. Most Americans express disapproval of extramarital sex. The disapproval is often rooted in religious beliefs, and, in fact, those who are very religious are less likely than others to have extramarital sex (Burdette, Ellison, Sherkat, and Gore 2007). The rationale for an affair differs by gender. Women tend to justify their infidelity on the basis of emotional need. Men tend to assert a need for more variety and more frequency of sex (which helps explain the fact that pregnancy raises the risk of infidelity).

People give other reasons. They may be sexually frustrated (a substantial proportion of women indicate sexual dissatisfaction with their husbands). They may believe that they were seduced. They may use an affair or one-night stand to get revenge against a mate who has cheated or who has angered them. In general, the lower an individual evaluates his or her marriage and the quality of his or her sex life, the more likely that individual is to have extramarital activity (Wiederman and Allgeier 1996; Treas and Giesen 2000; Previti and Amato 2004). In other words, the rate of extramarital sex in the nation is an indicator of marital problems. Extramarital sex causes problems, but it also reflects a troubled relationship.

Some Consequences of Extramarital Sex

On the positive side, some people report that the extramarital experience provided them with a brief but meaningful thrill. But for the most part, extramarital sex doesn't solve people's problems; it only intensifies them (Previti and Amato 2004).

As a therapist who has dealt with many cases of infidelity notes, most affairs involve "a little bad sex and hours on the telephone" (Pittman 1993:36). The thrill of engaging in the forbidden turns out to be disappointing.

Those who get involved in extramarital sex because they have "fallen in love" are also likely to be disappointed. "Romantic affairs lead to a great many divorces, suicides, homicides, heart attacks, and strokes, but not to very many successful remarriages" (Pittman 1993:35).

In addition, there is the crisis in the marriage if the extramarital activity is discovered. The betrayed spouse is likely to undergo a time of great trauma. He or she may have trouble concentrating, sleeping, and eating. There may be a preoccupation with the betrayal and an agonizing effort to try to understand it. There may be a feeling of having been victimized to the extent that marital trust is no longer possible. A wife who discovered her husband's extramarital activity told an interviewer that, in the week following her discovery, she found herself standing in a department store with no idea why she had come there. She said that she felt "as if the very floor I stood on were moving, waving and buckling underneath me. It was as if I myself, and the world around me, were completely unreal" (Scarf 1987:138).

Various outcomes of infidelity are possible (Charny and Parnass 1995). The harm may be irreparable; the couple may divorce. The marriage may survive but provide a low level of satisfaction and little or no intimacy. And in a few cases, the marriage may survive and improve. If the latter is to occur, the main problems that the couple must work through are the factors in their relationship that might have contributed to the infidelity and the problem of a spouse who was emotionally involved with someone else (having your spouse emotionally involved seems harder to cope with than the purely sexual involvement).

At times, both spouses may be having extramarital activity, sometimes with both knowing this and sometimes not. Even in those cases, the marriage might survive. A professional woman shared the following account with us:

We have a two-career marriage. We seemed to have less and less time for each other. I got involved in an affair with a man at work. Then one day I discovered that my husband was also having an affair. That made me furious! Suddenly we had to confront the fact that our marriage was on the rocks. We both agreed that we didn't want it to end. We were both hurt, but we got counseling and worked through the pain. That was three years ago. So far, it's working well. And I intend for that to continue.

SEXUAL DISEASES AND DYSFUNCTIONS

Our examination of sexual diseases and dysfunctions is necessarily brief. But it is important that you at least be familiar with them. Getting, or the fear of getting, a disease can lower or even eliminate the intimacy of sexual relations. You also should be aware of some of the rules of safe sex, our final topic in this chapter.

Sexual Diseases

Sexually transmitted diseases (a term now preferred to *venereal diseases*) have plagued humankind throughout history. Some believe that with the advent of AIDS, the risk is greater than ever, but many people died of sexual diseases before the advent of modern medicines that can cure or control most of those diseases.

Major Types of Sexually Transmitted Diseases. AIDS, or acquired immunodeficiency syndrome, is caused by a virus that attacks certain white blood cells, eventually causing an individual's immune system to stop functioning. The individual then falls prey to one infection after another. Even normally mild diseases can prove fatal. Many AIDS patients develop rare cancers or suffer serious brain damage. HIV, the virus that causes AIDS, spreads in a number of ways, including through anal or vaginal intercourse with an infected person, blood transfusions, accidental exchange of blood from a contaminated hypodermic needle, and contact of infected mothers with their infants before or during birth. Initially, those most likely to get infected with HIV and develop AIDS were homosexual and bisexual men and intravenous drug users. Increasingly, however, HIV is being passed on through heterosexual contacts and women and children comprise a growing number of the victims (Hosain and Chatterjee 2005; Merchant and Lala 2005). Between 1997 and 2006, the annual rate of diagnosed AIDS cases among 15- to 19-year-old males nearly doubled (Gavin et al. 2009). In terms of racial/ethnic differences, a disproportionate number of Hispanics and black women are HIV-infected (Essien et al. 2005; Peragallo et al. 2005).

No cure exists for AIDS, but certain preventive measures can enable people to avoid HIV infection and those who are infected can take measures to delay and perhaps stop the virus from developing into AIDS. Safe sexual practices and the use of clean needles for injections are important preventive measures. For those infected, a variety of drugs and a healthy lifestyle (including diet and exercise) are effective in slowing the disease for at

least some people. Efforts are also under way to develop an AIDS vaccine, though no one knows when or if such a vaccine might be available.

Gonorrhea is one of the oldest forms of sexual disease. It can be transmitted by any kind of sexual contact, including kissing. In men, gonorrhea causes a thick discharge from the penis and burning while urinating. In women, it has no visible symptoms, but it can damage their fallopian tubes—causing them to become infertile—and also cause lower abdominal pain, nausea, and pain during intercourse. Gonorrhea is treated with penicillin.

Syphilis appeared in Europe in the fifteenth century (Masters, Johnson, and Kolodny 1997), killing hundreds of thousands of people. It is transmitted by sexual contact but also can be transmitted in a blood transfusion or, if a pregnant woman acquires it, to the fetus. The first symptom of syphilis is a sore on some part of the body. The sore usually heals and goes away, but untreated syphilis will go into a second stage involving rash, fever, and pains. If still untreated, it can result in brain damage, heart problems, and ultimately death. Pregnant women with untreated syphilis may experience stillbirth or neonatal death or give birth to babies that are deaf or have neurologic or bone disorders (Centers for Disease Control 2001). Syphilis also is treated with penicillin.

Genital herpes is caused by a virus. It is transmitted by sexual intercourse and shows up in the form of painful blisters on or in the area of the genitals. The blisters eventually disappear, but they may reappear periodically because the virus continues to live in the human body. Some people suffer repeated 7- to 14-day periods of the sores. At the present, there is no cure for genital herpes.

Finally, *chlamydial infections* are caused by a bacterium. Chlamydia usually has no symptoms. It can cause infection of the urethra in males and infections in the reproductive system of females. It can lead to a fatal tubal pregnancy or infertility in women (Miller et al. 2004). If caught early, chlamydia is readily treatable with antibiotics. If untreated, it can contribute to a number of diseases, including pneumonia and blindness (Ojcius, Darville, and Bavoil 2005).

Incidence. A substantial number of Americans suffer from one or more sexually transmitted diseases. The Centers for Disease Control (2009) estimates that there are about 19 million new cases of infection each year (the estimate includes diseases such as the human papillomavirus and genital herpes, which are not reported to the Centers), almost half of them occurring among

**TABLE 4.3 Reported Cases of Sexually Transmitted Diseases, 1960 to 2007
(In thousands of cases)**

Disease	Year					
	1960	1970	1980	1990	2000	2007
Gonorrhea	259	600	1,004	690	359	356
Syphilis	122	91	69	134	32	41
AIDS				42	41	38
Chlamydia				702	1,108	

Source: U.S. Census Bureau 1989:111 and 2010b.

young people aged 15 to 24 years. In fact, about one out of four teenage girls has some kind of sexually transmitted disease (Centers for Disease Control 2008).

The rates of sexually transmitted diseases vary by racial/ethnic groups as well as by age (Centers for Disease Control 2009). African Americans have disproportionately high rates. Although they are only 12.8 percent of the population, African Americans accounted for more than 70 percent of gonorrhea cases in 2008. And their rates for Chlamydia and syphilis were about eight times higher than those for whites.

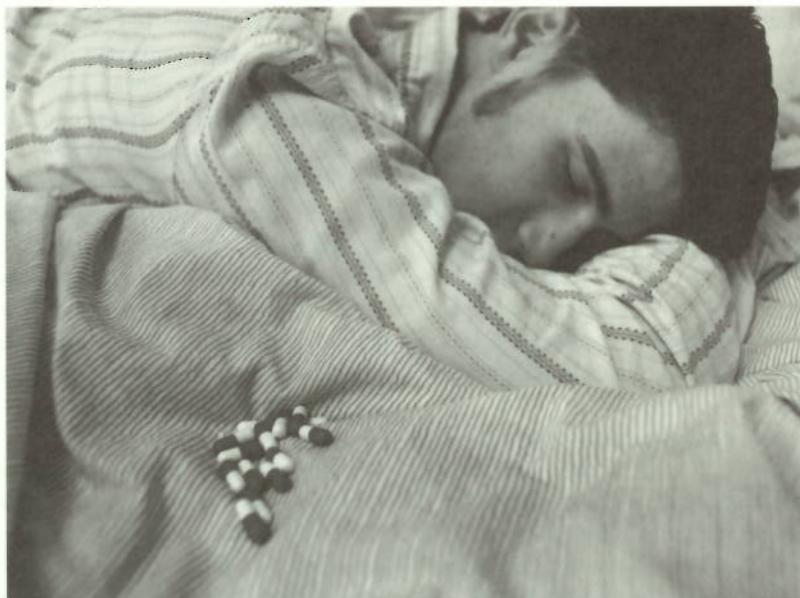
Hispanics and American Indians/Alaska Natives also have higher rates than whites (Centers for Disease Control 2009). For Hispanics, the rates of reported infections for gonorrhea and syphilis were about double that

of whites, and for Chlamydia the rate was three times higher. For American Indians/Alaska/Natives, the rates, compared to those of whites, were: 3.6 times higher for gonorrhea, 4.7 times higher for Chlamydia, and about the same for syphilis.

Table 4.3 shows how the numbers of new cases of the four sexually transmitted diseases reported to the Centers for Disease Control have varied over time. Decline in some of the rates reflects people's growing awareness of risks and increasing use of protective measures.

Clearly, while some racial/ethnic groups have higher rates of certain diseases, a considerable number of Americans of all races suffer from a sexually transmitted disease at one time or another in their lives. "Suffer" is the appropriate word, because, depending on the particular disease acquired, people may experience fear, anger, guilt, and a damaged self-esteem in addition to the physical consequences (Swanson and Chentiz 1993).

Sexually Transmitted Diseases and Sexual Behavior. The possibility of acquiring a sexually transmitted disease has done little in the past to change sexual behavior. An individual's sexual behavior may change once he or she has contracted the disease, of course. But few people have abstained from sexual relations or from having a variety of sexual partners out of the fear of disease. Rather, people continue to engage in risky sexual



Unprotected sex has left millions of Americans struggling with deadly AIDS.

behavior that exposes them to sexually transmitted diseases (Javanbakht et al. 2010; McCree et al. 2010). When concern about, and fear of, AIDS first arose, it appeared that people might exercise more caution. But despite knowledge about AIDS, some people continue to practice the risky sexual behavior that makes them vulnerable to this lethal disease (Kalichman et al. 2007). Some may do so because there is an increased belief that newer HIV treatments reduce the chances of transmitting the virus. Some do so because they apply the “illusion of unique invulnerability” (discussed in the section on contraceptive use) to their risk of contracting HIV/AIDS (Dolcini et al. 1996). Whatever the reasons, risky behavior continues at a high level. For example, a study of older men who either have, or are at risk for, HIV infection reported that only 58 percent of the HIV-positive men always used condoms with their sexual partners (Cooperman, Arnsten, and Klein 2007).

Worse, some of those already infected do not inform sexual partners of their condition. A study of HIV-positive adults found that 42 percent of gay or bisexual men, 19 percent of heterosexual men, and 17 percent of all women admitted having sex without telling the partner of their condition (Ciccarone et al. 2003).

Sexual Dysfunctions

Famed English author and reformer John Ruskin courted a young woman to whom he wrote such flowery phrases as, “You are like the bright—soft—swelling—lovely fields of a high glacier covered with fresh morning snow” (Rose 1983:54). Ruskin won her heart, and they were married. A few years later, they were divorced because Ruskin could never consummate the union. He was one of many people for whom sex is more of a problem than an experience of intimacy.

Types of Sexual Dysfunctions. A sexual dysfunction is any impairment of the physical responses in sexual activity. For males, the major sexual dysfunctions have to do with penile *erection* and *ejaculation* (Mackay 2001). A man may be unable to have or maintain an erection that is firm enough for intercourse. Or he may ejaculate before the woman is sufficiently aroused for orgasm or even before inserting his penis into her vagina. In a few cases, the man’s problem may be the opposite: difficulty ejaculating or even an inability to ejaculate within the vagina. Gay men also have problems with erection and ejaculation. In a large-scale study, gay men reported erectile problems more frequently than did heterosexual men, while heterosexual men reported the problem of

rapid ejaculation more than did gay men (Bancroft et al. 2005).

For women, the main kinds of sexual dysfunction include *vaginismus* (involuntary spasms of the muscles around the vagina, preventing penetration by the penis or making it painful), *anorgasmia* (difficulty reaching or an inability to reach orgasm), and *painful intercourse*.

From 10 to 20 percent of sexual dysfunctions have organic causes, such as diabetes, drug abuse, and infections. A variety of psychological and social factors are involved in most cases. The individual may have developed negative sexual attitudes, suffer from anxiety or guilt, feel hostile or alienated from the sexual partner, and so forth. Stress—whether from the job, or finances, or family, or other causes—also affects sexual functioning (Bodenmann, Ledermann, and Bradbury 2007). Whatever the problem, and whatever the cause of the problem, therapy often can help people recapture a satisfying sex life.

Prevalence of Sexual Dysfunctions. Many people have to deal with sexual dysfunction at some point in their lives. The prevalence of sexual dysfunction in community studies varies widely, from 10 to 52 percent of men and 25 to 63 percent of women; a national sample reported rates of 31 percent for men and 43 percent for women (Heiman 2002). **Impotence**, the inability to get or sustain an erection, is the most common problem among men, while low sex drive is the most common problem for women. The prevalence among both men and women tends to increase with age (Lewis et al. 2004). A number of drugs, beginning with Viagra in 1998, have appeared on the market to help men with erectile problems. Various ways exist to help women with low sex drive, including such things as sex therapy and prescription testosterone.

Inhibited Sexual Desire

Inhibited sexual desire is a problem but not, strictly speaking, a dysfunction because it does not necessarily involve a physical impairment. It occurs in both men and women, though it is more often reported by women (Gregoire 2000). Like sexual dysfunctions, it may be rooted in such things as hostility, fear, and anxiety. It also may result from drug abuse or be a side effect of certain drugs such as those used to reduce high blood pressure or depression. A temporary lowering of sexual desire also occurs in the majority of women during pregnancy (Regan et al. 2003).

Inhibited sexual desire can lead to a distressed relationship and even to major conflict between husband and

Comparison

Unwanted Sex in China

Unwanted sex occurs among married people as well as those not married. The sex may involve verbal or physical coercion. Or it may be a matter of the wife passively acceding to the husband's desires even though she doesn't want to have sex at the time. In a national study of Americans, Basile (2002) found that 34 percent said they had had unwanted sex with a husband or partner at some time in their lives, and 20 percent had unwanted sex with their current husband one or more times. Among the reasons given for the unwanted sex were a sense of duty, being persuaded by begging and pleading, and submitting after being bullied.

How much unwanted marital sex is there in other nations? Although there is little available research, one team of researchers surveyed a national sample of 1,127 married women in China (Parish et al. 2007). The women's age ranged from 20 to 64 years. Thirty-two percent of the women reported unwanted sexual intercourse during their current marriage, with a fifth of those saying that force was involved. In addition to intercourse, the researchers asked about unwanted sex acts (such as oral sex and touching the genital area). Twenty-two percent indicated unwanted sex acts in the past year. Finally, the researchers asked the women if they ever agreed to sex just to please their husbands, and 72 percent said they did at least sometimes.

There is, then, a good deal of unwanted marital sex among Chinese wives. "Unwanted," however, does not mean that the wives were sexually repressed or lacking in sexual desire. Rather, a number of factors determined whether the sex was wanted. One important factor was the quality of the relationship. Women who indicated that their husbands gave them daily experiences of intimacy, engaged in sexual foreplay, and attended to their sexual needs were less likely to report unwanted sex. Interestingly, Chinese women may not be as receptive to sexual experimentation as women in some other nations, because wives who said their husbands engaged them in varied positions (such as the wife on top of the husband), who caressed their breasts, or who gave them oral sex were more likely to also say the sex was unwanted.

Another factor in sex being unwanted were attitudes and expectations. Some of the wives did admit they regarded sex as dirty, and they were also more likely to say that the sex was unwanted. A curious finding, however, is that wives with more education and more permissive sexual attitudes (such as approving of premarital sex) also had higher reported rates of unwanted sex. The researchers speculated that such women may have higher standards of what is acceptable and appropriate, or may be victimized by husbands who equate their permissiveness with desire and willingness.

A third factor involves bargaining position. Women with higher levels of income reported more unwanted sexual activity. While this would appear to give them greater bargaining power (in other words, the power to resist unwanted sex), it is consistent with findings in the United States about women whose income is relatively high compared to their husbands as having an elevated risk of being abused. Such behavior is an effort by the husband to maintain control and authority in the marriage.

One other question emerged about unwanted marital sex. If it occurs in the context of marriage, does unwanted sex become only an annoyance or does it have more serious consequences? When the sex is the result of physical force, it is emotionally damaging to the woman. But even if no physical force is involved, having unwanted sex tends to diminish the emotional well-being of women.

In short, although the Chinese and American cultures differ on many dimensions, the amount and consequences of unwanted sex are comparable. The techniques used by husbands to persuade or coerce their wives are also comparable. In both societies, there are husbands who seem oblivious or indifferent to the fact that unwanted sexual activity may provide them with short-term relief, but it is detrimental both to the well-being of their wives and of their marriages.

wife (Gregoire 2000). A study of 90 married women with sexual problems found a number of differences between those with inhibited desire and those with various dysfunctions but normal desire (Stuart, Hammond, and Pett 1987). Those with inhibited desire, compared to the others, perceived their partners to have less affectionate

interaction and more negative attitudes toward sex. They were more likely than those with normal desire to have had premarital intercourse. And, most importantly, those with inhibited desire reported far greater dissatisfaction with the quality of the marital relationship, including such factors as trust, commitment, emotional

closeness, love, and attractiveness of the spouse. For these women, inhibited desire grew out of poor marital interaction, a conclusion underscored by the fact that most of the women developed the problem gradually after they were married.

We do not know how many people have inhibited sexual desire. Probably anywhere from 20 to 50 percent of people experience it at some point in their lives, some more severely than others. The problem may go away if the couple can outlast it and build or maintain a generally good marital relationship. For some, however, the problem will require therapy.

Safe Sex

The only truly safe sex is no sex. Few people are so concerned about safety that they will opt for celibacy; for all others, it is helpful to consider some guidelines for maximizing safety:

1. Be careful about whom you allow to be a sexual partner. How well do you know the person and his or her sexual history? Does the person have any signs of infection?
2. Minimize the number of sexual partners you have. Having multiple partners greatly enhances the risk of acquiring a sexually transmitted disease, including AIDS. The safest sex is between two people who have an exclusive relationship.

3. Discuss health and sexual concerns with the partner before you have sexual relations. It isn't an invasion of privacy to question someone about his or her sexual history when the issue is one of your health and even your life.
4. Use available protection during sexual relations. In particular, experts recommend that males always use a condom, even if the woman is using another birth control device. Condoms do not give absolute protection, but they maximize the safety of sexual intercourse. Experts also recommend that you wash your genitals carefully and thoroughly both before and after sexual relations.
5. Have regular medical checkups. You should be specifically checked for sexually transmitted diseases if you or your partner have sexual relations with more than one person.
6. Know the symptoms of the various diseases. We have briefly noted many of them. But you should be familiar with all the symptoms. Some of the diseases are insidious in that they may appear to go away, only to return in a more advanced and damaging phase.
7. Consult a physician immediately if you have contracted or been exposed to a sexually transmitted disease. You may be embarrassed, but keep in mind that you are dealing with your health, your reproductive capacity, and perhaps even your life.

SUMMARY

Sex is both a physical and a social phenomenon. The social nature of sex is illustrated by variations in sexual arousal and techniques and by the amount of unwanted sex in which people engage.

Sex is an important part of intimate relationships. The need for intimacy has primacy over the need for sex. Sexual activity is a natural expression of the feeling of intimacy with someone.

The majority of teenagers become sexually active between the ages of 15 and 19. One consequence of teenage sex is a high rate of unwanted pregnancies at an early age. Teenagers get pregnant for a variety of reasons, including a lack of responsible use of birth control measures. Some teenagers may want to get pregnant because of loneliness, alienation from parents, or the need to assert their independence or to do something creative.

The consequences of teenage childbearing are mostly negative. The parents are less likely to complete their

education and more likely to remain poor. Only a minority of women marry the father, so the woman assumes the child-rearing responsibilities. Some of the mothers will escape poverty, but the risks of a poorer quality of life for them and their children are much higher than they are for those who bear children after their teen years.

Contraception refers to methods of preventing fertilization. Some, such as the rhythm method and withdrawal, are of little use. The pill, condoms, and the diaphragm are common devices. Among married women, there has been a dramatic increase in sterilization since 1965.

Abortion is a form of birth control for some people. The proportion of legal abortions has risen dramatically since 1973. A slight majority of Americans favor the woman's right to choose whether to have an abortion. There are some psychological risks; many clinics have both pre- and postabortion counseling.